

**Self-mutilation, pathology, and performance: Implications for art therapy**

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## ABSTRACT

Self-mutilation, pathology, and performance: Implications for art therapy

Maya Shalmon

This research addresses the phenomenon of self-mutilation, as practiced by adolescents and adults living in contemporary Western society, as found in the imagery of clients in art therapy, and as performed by artists as part of their body of work. Literature on self-mutilation in the fields of psychiatry, psychology, and art therapy is compared to and contrasted with art historical literature on a selection of contemporary performance artists using self-mutilation in their work. The principle aim of this research is to examine the motivations and functions of self-mutilation performed in the contexts of pathology and of performance art. The subsidiary aim of this research is to investigate the relationship between the actor and the viewer, be it the performance artist and the audience, or the client and the therapist. This study uses a theoretical methodology in order to review divergent discourses on acts of self-mutilation performed within different contexts, in the hopes of finding interrelationships between them, thereby contributing to a new perspective on the subject relevant to the field of art therapy. Treatment implications for art therapists explored in this study include the way in which the art making process may aid in overcoming the obstacle of therapist counter-transference towards self-mutilating clients, and facilitate the resolution of unconsciously driven acting out behavior. The relationship between self-mutilation and ritual informs a discussion on the parallels between ritual space, contained within established cultural boundaries, and transitional space, contained within the art therapeutic frame, and how both offer conditions favorable for transformation.

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**TABLE OF CONTENTS****INTRODUCTION**

0.1. Overview	1
0.2. Definition of terms	1
0.3. Primary and subsidiary research questions	2
0.4. Methodology	3
0.5. Assumptions about truth	5
0.6. Limitations	6
0.7. Chapter outline	7

**CHAPTER 1: PATHOLOGICAL SELF-MUTILATION**

1.1. Overview	9
1.2. An adolescent phenomenon	9
1.3. Psychiatric diagnosis	10
1.4. Causal and contributing factors	12
1.4.1. Childhood trauma	12
1.4.2. Dissociation	13
1.4.3. Attachment	14
1.4.4. Transitional object	16
1.4.5. Symbolization	17
1.5. Functions and limitations	18
1.5.1. Affect regulation	18
1.5.2. Dissociation	19
1.5.3. Interpersonal conflict and manipulation	20

1.6. Summary	21
<b>CHAPTER 2: SELF-MUTILATION AND ART THERAPY</b>	
2.1. Overview	23
2.2. Alternative coping strategy for action-oriented individuals	24
2.3. Symbolization and verbalization	26
2.4. Traumatic memories	28
2.5. Dissociation	29
2.6. Body image distortion	30
2.7. Self-soothing and attachment	32
2.8. Self-mutilation imagery and enactment	33
2.9. Summary	35
<b>CHAPTER 3: SELF-MUTILATION AND PERFORMANCE ART</b>	
3.1. Overview	36
3.2. Functions and intentions of performance art: An overview	37
3.2.1. Postmodernism	37
3.2.2. Social and political change	38
3.2.3. Transformation and catharsis	39
3.2.4. Psychopathology, attachment, and trauma	40
3.2.5. Relationship artist and audience	42
3.3. Description of artists	43
3.3.1. Gina Pane	43
3.3.2. Marina Abramović	47
3.3.3. Viennese Actionists	50

3.3.4. Ron Athey and Bob Flanagan	52
3.3.5. Orlan	55
3.4. Parallels and differences between performance artists and pathological self-mutilating individuals	57
3.5. Summary	59
CHAPTER 4: TREATMENT IMPLICATIONS	
4.1. Overview	61
4.2. Counter-transference	61
4.2.1. Audience and therapist reactions	61
4.2.2. Sadomasochism and complicity	64
4.2.3. Therapeutic distance	65
4.2.4. The role of artwork within the transference-counter-transference relationship	67
4.3. Ritual and transformation	70
4.3.1. Self-mutilation, performance art, and ritual	70
4.3.2. Liminal space and transitional space	73
4.3.3. Scapegoat transference	76
4.3.4. Acting out versus enactment	77
4.4. Summary	78
CONCLUSION	
5.1. Description of research	80
5.2. Summary of findings	81
5.3. Contributions and limitations	86

5.4. Directions for future research	87
REFERENCES	88



## **Introduction**

### **0.1. Overview**

This research addresses the phenomenon of self-mutilation, as practiced by adolescents and adults living in contemporary Western society, as found in the imagery of clients in art therapy, and as performed by artists as part of their body of work. Psychological perspectives on pathological forms of self-mutilation and research on art therapy with self-mutilating clients will be contrasted with research on contemporary Western performance artists using self-mutilation in their work, in order to gain a deeper understanding of the dynamics at play when self-mutilation surfaces in the artwork of clients.

### **0.2. Definition of terms**

Self-mutilation is broadly defined as, “the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent” (Favazza, 1998, p. 260). For the purposes of this study, decorative, socially accepted, and thus non-pathological forms of self-mutilation, such as tattooing and body piercing, will not be considered. Neither will gross acts of self-mutilation typically performed by psychotic individuals, such as castration, limb amputation, and eye enucleation. Stereotyped acts of self-mutilation, such as biting and head banging, performed by autistic and developmentally delayed individuals, will also be excluded (Favazza, 1998; Suyemoto, 1998; Walsh & Rosen, 1998). The focus of this study is limited to repetitive, low-lethality skin cutting and burning – the most common acts of pathological self-mutilation performed by

adolescents and adults today (Favazza, 1998; Laye-Gindhu & Schonert-Reichl, 2005; Milia, 2000; Ross & Heath, 2002; Suyemoto, 1998; Suyemoto & MacDonald, 1995; Walsh & Rosen, 1998; Zila & Kiselica, 2001).

### **0.3. Primary and subsidiary research questions**

Comparative research in psychiatry and anthropology (Favazza, 1987) has placed self-mutilation on a continuum from pathological to culturally sanctified, designated by the degree of conscious meaning with which, and the cultural context within which, the act is performed. This work has aimed to gain insight into the unconscious motivations that may be fuelling acts at both ends of the spectrum, and to increase empathy among clinicians. Recent years have seen a number of professional artists within the context of performance art begin using acts of self-mutilation in their work. These artists confront and pose a challenge, not only to their viewers, but also to the assumption that acts of self-mutilation within contemporary Western society are associated with deficits in an individual's capacity for symbolization. If self-mutilation does exist on a continuum, designated by the degree of conscious meaning with which, and the cultural context within which the act is performed, where do these contemporary performance artists fall and what can we, as art therapists, learn from them? I contend that a study of performance artists using acts of self-mutilation in their work may hold important implications for art therapists witnessing acts or images of mutilation in the artworks of their clients. This work will add to the comparative work already done in the fields of psychiatry and anthropology with the aim of exploring further the motivations and functions of self-mutilation performed in different contexts, in addition to the relationship

between the actor and the viewer, be it the community in a culturally sanctioned ritual, the audience in a performance, or the art therapist in a session. The primary question addressed by this research is: What implications does an examination of the motivations and functions of self-mutilation in the work of contemporary performance artists have for art therapists witnessing acts or images of mutilation in the artwork of clients? The subsidiary research question is: What implications does an examination of the relationship between audiences and performance artists using self-mutilation in their work have for art therapists treating self-mutilating clients? This research will be the first of its kind to examine self-mutilation and the role of the witness in the work of both artists and their audiences, and art therapy clients and their therapists.

#### **0.4. Methodology**

This study is based on a theoretical methodology. Consisting mainly of a literature review and a discussion of emergent themes, this methodology is well suited for interdisciplinary inquiry, comparing and contrasting divergent approaches. No actual research participants will be used for this study. A selection of performance artists using self-mutilation in their work will be related to clinical populations of adolescents and adults engaging in pathological self-mutilation. This study will be grounded in a comprehensive review of contemporary psychiatric perspectives on self-mutilation, as this informs most clinical art therapists writing on the subject. The discussion of performance art will include a brief rather than extensive overview of this movement, and will be limited to artists engaging in acts of self-mutilation most commonly reported in the psychiatric literature, such as cutting and burning the skin. As the fields of

psychology and art history are informed by very different paradigms, such as positivism and postmodernism, that hold radically different assumptions about the objective or subjective nature of truth, in addition to the process of research itself, the challenge of this study will be one of “paradigm bridging” (Politsky, 1995, p. 308), the synthesis of multiple and conflicting explanations. Theoretical research, according to Junge and Linesch (1993), “critiques and integrates existing theories in an attempt to generate new knowledge and theory” (p. 66). The researcher begins by finding limitations and contradictions in the theory under question and uses the tools of analysis, evaluation, and synthesis to eliminate them. In the case of this research, a literature review on psychological theory and research on self-mutilation revealed the hypothesis that acts of self-mutilation in contemporary Western society are associated with deficits in an individual’s capacity for symbolization. Art therapists writing on the subject of self-mutilation have generally tended to maintain this hypothesis, with powerful implications on how they interpret images or acts of mutilation in the artwork of their clients. This study questions this hypothesis by examining artists using acts of self-mutilation in their work. These artists have been well documented and researched from an art historical perspective that, unlike psychology, does not pathologize what it studies. It is my hope that the examination and analysis of these divergent discourses on similar acts of self-mutilation performed in different contexts, will serve to enrich the theories art therapists have at their disposal when encountering and interpreting mutilation in the artwork of clients.

Ultimately, this project is concerned with the hermeneutic process, that of interpretation, and of the relationship between the interpreter and that which is interpreted

(Junge & Linesch, 1993). An important area of investigation in this study will be the relationship between artists and their audiences, and art therapy clients and their therapists. It is my hope that an examination of the ways in which acts of self-mutilation affect the audience in an artistic performance may hold important implications for art therapists finding themselves in the position of witness to similar imagery in a therapy session. Additionally, the art historians reviewed in this research are concerned with the hermeneutic process of interpreting artwork and placing it, as well as themselves, within a socio-political, cultural, economic, and gendered context. Interpretation of artwork plays a prominent role in the vast majority of art therapy studies used for this project, even if the hermeneutic process is not being consciously employed. Furthermore, psychological theory and research is concerned with understanding, and therefore interpreting, human behavior, in this case self-mutilation. According to Kneller (as cited in Patton, 2002), while hermeneutics originated in the interpretation of written texts, it can also apply to the interpretation of a human act or artifact. In this case, the “text” to be interpreted is sliced or burnt skin.

#### **0.5. Assumptions about truth**

Since this research is based primarily on theory, the nature of truth in this work is at the level of hypothesis. While psychological research stemming from the positivist tradition, with its assumptions that objective truth can be known through the use of empirical methods, points to certain tendencies or correlations in its findings, these studies have used mostly an inpatient, and in some cases an outpatient population, which may not be representative of all the cases of self-mutilation that go unreported and

untreated (Favazza, 1987). In addition, case studies are bounded by time and place (Creswell, 1998), and thus assertions made may not be generalized to a wider population. In both instances, then, results are tentative and context-specific. Hermeneutics also acknowledges the nature of interpretation as bounded by time and place, by historical and cultural context. Absolute “truth” is not sought for or even recognized as possible (Patton, 2002). Furthermore, texts are viewed as containing multiple and contradictory meanings (Prasad, 2005). Postmodernist discourse, which evolved as a challenge to the metanarratives or knowledge systems that seek to explain all human activity in terms of a single theoretical framework, asserts that there is no truth or reality that exists independent of language. As such, it seeks to recover and empower those voices that have been lost or marginalized within the great modernist systems (Prasad, 2005). Within all these approaches, the “truth” about self-mutilation, if there is one, remains elusive. What I am concerned with, however, is if different readings of the act within different discourses can have anything meaningful to say to one another, and whether an investigation into the interrelationships between these different readings can contribute to a new perspective on the subject.

## **0.6. Limitations**

Limitations of this study include the possibility that the results of such a comparative analysis will not be generalizable to art therapists working in a clinical setting. In addition, due to the limited nature of this project, the study proposed is only a preliminary venture into a rich field of inquiry.

## **0.7. Chapter outline**

This study is divided into the following four chapters: pathological self-mutilation, self-mutilation and art therapy, self-mutilation and performance art, and treatment implications

Chapter 1 addresses the phenomenon of pathological self-mutilation as practiced by non-psychotic adolescents and adults living in contemporary Western society. Reviewing the psychology literature, this chapter examines self-mutilation as a phenomenon rooted in adolescence, associated psychiatric diagnoses, causal and contributing factors, and the functions and limitations of this behavior.

Chapter 2 addresses the treatment of pathological self-mutilation through the modality of art therapy. Reviewing the art therapy literature, this chapter examines the ability of art therapy to offer an alternative coping strategy to action-oriented individuals, facilitate the development of symbolization and verbalization capacities, uncover and process traumatic memories, access dissociated states, address body image distortions, repair attachment deficits, and promote the ability to self-soothe. This chapter also addresses the phenomenon of self-harm imagery and enactments within the therapeutic art of self-mutilating clients.

Chapter 3 examines the phenomenon of self-mutilation as practiced by contemporary Western artists within the context of performance art. Reviewing the art history and criticism literature, this chapter surveys the primary themes associated with performance art, such as postmodernism, social and political change, transformation and catharsis, psychopathology, attachment, and trauma, and the relationship between artist and audience. A selection of artists – Gina Pane, Marina Abramović, the Viennese

Actionists, Ron Athey, Bob Flanagan, and Orlan – engaging in self-mutilation as a principal part of their body of work, are presented and discussed, with emphasis placed on the intentions of their actions and the effects of these upon their viewers. Finally, parallels and differences between performance artists using self-mutilation in their work and contemporary self-mutilating individuals are drawn.

Chapter 4 addresses critical issues in the treatment of pathological self-mutilation, synthesizing the information presented in the last three chapters. Using psychology and art therapy literature to support its claims, it examines the way in which the art making process may aid in overcoming the notorious obstacle of therapist counter-transference towards self-mutilating clients, and facilitate the transformation of unconsciously driven acting out behavior. The relationship between the artist and audience in performances involving acts of self-mutilation is compared to and contrasted with the relationship between the self-mutilating client and therapist. Transference and counter-transference reactions to the artwork produced in therapy, and the way in which artwork may operate as a mediating factor within the therapeutic relationship is explored. The relationship between self-mutilation and ritual, as practiced by performance artists and by contemporary self-mutilating individuals, informs a discussion on the parallels between ritual space, contained within established cultural boundaries, and transitional space, contained within the therapeutic frame, and how both offer conditions favorable for transformation.



## **Chapter 1: Pathological self-mutilation**

### **1.1. Overview**

This chapter addresses the phenomenon of pathological self-mutilation as practiced by non-psychotic adolescents and adults living in contemporary Western society. It will examine self-mutilation as a phenomenon rooted in adolescence, associated psychiatric diagnoses, causal and contributing factors to the development of this behavior, and its functions and limitations.

### **1.2. An adolescent phenomenon**

Self-mutilation is largely an adolescent phenomenon. Studies overwhelmingly indicate that repetitive self-mutilation begins in adolescence, 14 to 16 years being the most commonly cited ages of onset (Cross, 1993; Favazza, 1987; Favazza, 1998; Pattison & Kahan, 1983; Ross & Heath, 2002; Suyemoto, 1998; Suyemoto & Macdonald, 1995; Zila & Kiselica, 2001). It is difficult to assess the prevalence of self-mutilation as most episodes go unreported, yet it is estimated to be a fairly common behavior (Favazza, 1987). One study investigating the prevalence of self-mutilation in a community sample of high school students found that 13.9% of the students reported engaging in self-mutilation at least once, grades 7 and 8 being the most frequent periods of onset (Ross & Heath, 2002). Another study of high school students supported these results with a prevalence rate of 13.2% (Laye-Gindhu & Schonert-Reichl, 2005). Studies using adolescent psychiatric inpatients found the prevalence rate to be as high as 40% to 61% (Suyemoto, 1998), while a survey of therapists working in private practice revealed that

47% had treated at least one outpatient self-mutilating adolescent, 15.26 years being the average age of onset (Suyemoto & Macdonald, 1995). Out of these adolescent outpatients, 70% had stopped cutting at a mean age of 18.8 years, suggesting that for the majority of adolescents, self-mutilation may be a temporary behavior limited to developmental crises during the period of adolescence (Suyemoto, 1998; Suyemoto & Macdonald, 1995). This hypothesis is supported in a study of high school students in which the majority of adolescents reported that they no longer engaged in self-mutilation (Ross & Heath, 2002). However, an analysis of 56 published case reports of self-mutilating individuals indicated that while the behavior typically began in adolescence, it tended to continue over many years (Pattison & Kahan, 1983).

### **1.3. Psychiatric diagnosis**

Some researchers have made a case for the inclusion of a Deliberate Self-Harm Syndrome in the DSM IV, under an Axis I disorder of impulse control (Favazza, 1987; Favazza, 1998; Pattison & Kahan, 1983). This syndrome is characterized by multiple episodes of compulsive, low-lethality self-harming acts including repetitive self-mutilation (distinguishing it from episodic self-mutilation, acknowledged as a symptom of borderline personality disorder), eating disorders, substance abuse, and kleptomania. It typically begins in early adolescence and runs a course of 5 to 15 years, episodes peaking from 16 to 25 years of age, with behaviors either co-existing or replacing each other in cycles (Favazza, 1987; Favazza, 1998). The strong association between self-mutilation and eating disorders, bulimia in particular, has been widely documented (Cross, 1993; Farber, 2000; Favazza, 1987; Favazza, 1998; Pao, 1969; Turell & Armsworth, 2003; Zila

& Kiselica, 2001), as has the fact that self-mutilation is significantly more prevalent in females than in males (Cross, 1993; Favazza, 1987; Favazza, 1998; Ross & Heath, 2002; Suyemoto, 1998; Suyemoto & Macdonald, 1995; Zila & Kiselica, 2001). It has been proposed that conflict around the onset of menstruation is a triggering factor for the development of a variety of adjustment problems in adolescent girls, in particular self-mutilation, eating disorders, and substance abuse (Cross, 1993; Suyemoto, 1998; Zila & Kiselica, 2001).

Clinical cases of chronic self-mutilation are often associated with diagnoses of borderline personality disorder and depersonalization disorder (Favazza, 1987; Pao, 1969; Suyemoto, 1998). However, compelling evidence from both clinical and neurobiological research suggests that borderline personality disorder and dissociative spectrum disorders have their origins in severe, early childhood trauma (Herman, 1992; Herman & van der Kolk, 1987; van der Kolk, 1987), and may be better conceptualized as manifestations of what Herman (1992) calls “complex post-traumatic stress disorder” (p. 119). Other research has not found any clear association between self-mutilation and existing personality disorders (Pattison & Kahan, 1983), one study indicating that the majority of adolescent self-mutilating outpatients are referred to their therapists with the diagnosis of an adjustment, rather than a personality disorder (Suyemoto & Macdonald, 1995). Depression is often found in clinical cases of repetitive self-mutilation (Favazza, 1998; Pattison & Kahan, 1983; Turell & Armsworth, 2003), and has been a significant factor in differentiating a community sample of self-mutilating adolescents from adolescents who do not self-mutilate (Ross & Heath, 2002). An analysis of the case study literature indicated that despair, anxiety, anger and cognitive constriction are the most

predominant psychological symptoms associated with repetitive self-mutilation (Pattison & Kahan, 1983).

#### **1.4. Causal and contributing factors**

##### **1.4.1. Childhood trauma**

Self-mutilation is highly correlated with an early history of physical and, most notably, sexual abuse (Attias & Goodwin, 1999; Cross, 1993; Farber, 2000; Favazza 1987; Favazza, 1998; Harris, 2000; Herman, 1992; Hewitt, 1997; Milia, 2000; Miller, 1994; Suyemoto, 1998; Suyemoto & Macdonald, 1995; Turell & Armsworth, 2003; van der Kolk, 1987; Zila & Kiselica, 2001), some studies showing that earlier onsets of abuse increase the likelihood of later self-mutilation (Favazza, 1998). Clinicians have noticed the tendency of abuse survivors to compulsively reenact the trauma they experienced as children onto their bodies in various forms of self-abuse, including self-mutilation, perhaps reflecting unconscious attempts to communicate and master the trauma (Farber, 2000; Herman, 1992; Milia, 2000; Miller, 1994). However, reenactments involving the body usually prevent the survivor from remembering and integrating the traumatic event (Herman, 1992), aid in the avoidance and suppression of traumatic memories (Scott, 1999), and may be indicative of a deeper “psycho-physiological addiction to trauma” (Farber, 2000, p. 79). Self-abusive reenactments such as self-mutilation imply that identification with the aggressor and with the victim is occurring simultaneously (Milia, 1996). Physically abused children may imitate their parents and treat themselves abusively, having internalized parental hostility and rejection (Favazza, 1987; Stronach-

Buschel, 1990). They may also form an association between pain and care (Favazza, 1987), an association that allows them to maintain a connection to the abusing parent (Milia, 2000). Sexually abused children may carry a deep sense of shame and sexual guilt, for which they feel the need to repeatedly punish themselves (Favazza, 1987; Milia, 2000; Suyemoto, 1998). The development of primary and secondary sexual characteristics during adolescence typically serves to intensify shameful and guilty feelings, and may act as a catalyst for the onset of self-mutilating behavior (Walsh & Rosen, 1988).

#### **1.4.2. Dissociation**

Dissociation is a capacity of human consciousness easily triggered by traumatic events, which serves a protective function yet also prevents the integration of traumatic experiences, keeping them split off from conscious awareness (Herman, 1992; van der Kolk, 1987). Dissociation and depersonalization, characterized by disturbing feelings of numbness, unreality, and disconnection from the body, are not only highly correlated with childhood trauma and neglect but are very often associated with self-mutilation as the act of cutting appears to be highly effective at terminating such states (Cooper & Milton, 2003; Cross, 1993; Farber, 2000; Favazza, 1987; Favazza, 1998; Herman, 1992; Hewitt, 1997; Milia, 2000; Miller, 1994; Scott, 1999; Suyemoto, 1998; Suyemoto & Macdonald, 1995; van der Kolk, 1987; Zila & Kiselica, 2001). Abusive experiences that repeatedly violate the boundaries of the body and severe neglect that ignores the body's needs may both impede the development of a healthy relationship to one's body, the latter being experienced as ego-alien. Body alienation, exacerbated by the pubertal

changes in adolescence, is a crucial precipitating factor in the development of self-mutilation (Attias & Goodwin, 1999; Cross, 1993; Cohen & Mills, 1999; Farber, 2000; Hewitt, 1997; Hirsch, 1994; Milia, 2000; Walsh & Rosen, 1988; Zila & Kiselica, 2001), one author stating that only when the skin is experienced as an essential part of the self will self-mutilation end (Kafka, 1969).

### **1.4.3. Attachment**

It is emphasized in the literature that self-mutilation results not only from early traumatic experiences, but a combination of these and insecure attachments, resulting in disturbed object relations and a consequential inability to self-soothe (Cooper & Milton, 2003; Farber, 2000; Favazza, 1987; Herman, 1992; Hirsch, 1994; Kafka, 1969; Milia, 2000; Suyemoto, 1998; Suyemoto & Macdonald, 1995; van der Kolk, 1987). Indeed, one study found that self-mutilating individuals were significantly more likely to have experienced the loss of a primary attachment figure during childhood through divorce or foster placement (Walsh & Rosen, 1988). Neurological research supports the importance of healthy early attachments in the development of a biologically based, affective self-regulating function, indicating that early trauma and neglect may, due to the immaturity of the central nervous system in children, alter the brain imprinting related to this function (Favazza, 1998; Klorer, 2005; Schore as cited in Farber, 2000; Schore as cited in Malchiodi, 2003). Trauma experienced in adulthood may also result in hyperarousal of the autonomic nervous system with difficulty regulating negative affective states, aggression, and anxiety. However, these symptoms are more pronounced in those whose attachment styles are insecure (Herman, 1992; Klorer, 2005; van der Kolk, 1987). From

an object-relations perspective, a lack of secure early attachments due to separation, abuse, or neglect results in a failure to develop a stable and cohesive sense of self, capable of containing and withstanding affective experiences. Another consequence is the failure to internalize a “good mother”, namely the internal sense of a benevolent, caring environment, which acts as a foundation for the ability to self-soothe and regulate emotional states (Cooper & Milton, 2003; Farber, 2000; Favazza, 1987; Herman, 1992; Milia, 2000; Suyemoto, 1998; Suyemoto & Macdonald, 1995). A lack of positive attachments may cause the child to develop a “negative self introject” (Suyemoto, 1998), or a “negative ego ideal” (Noshpitz, 1994). This pervasive sense of badness and unworthiness is often experienced as monstrous (Herman, 1992), and may be localized, in the act of self-mutilation, onto the part of the body subject to self-inflicted damage (Favazza, 1987; Hirsch, 1994; Milia, 2000).

It has been hypothesized that individuals who self-mutilate are fixated at, or regress to, the separation-individuation phase in infancy, the task of which is to separate from the mother and develop an autonomous identity, yet still retain a sense of connectedness to her. This stage of development cannot be resolved if the infant does not have a secure attachment to separate from, and is a stage that is revisited during adolescence due to emerging needs for independence and identity, a process that may reactivate early trauma (Farber, 2000; Favazza, 1987; Herman, 1992; Milia, 2000; Pao, 1969; Suyemoto, 1998; Suyemoto & Macdonald, 1995). Supporting this hypothesis is the clinical observation that a perceived abandonment, whether threatened or actual, almost invariably precipitates an episode of self-mutilation (Suyemoto, 1998; Suyemoto & Macdonald, 1995). An argument with a parent may also act as a trigger (Zila & Kiselica,

2001). Difficulties originating in the separation-individuation phase may result in extreme, uncontrollable emotional states, unstable self and object representations, and an inability to relate to objects in a soothing manner. All of these are basic characteristics of borderline personality disorder, the pathology with the strongest association to self-mutilation, yet these may also exist in self-mutilating individuals without a diagnosable personality disorder (Farber, 2000; Favazza, 1987; Suyemoto, 1998). They are also characteristic of survivors of prolonged early childhood trauma (Herman, 1992).

#### **1.4.4. Transitional object**

A key feature of the separation-individuation phase in infancy is the use of a transitional object, a “not-me” object such as a favorite blanket or teddy bear that is magically invested by the infant with soothing properties to symbolize the mother and feel comforted in her absence (Winnicott, 1971/ 2002). It is used in the service of resolving the separation-individuation crisis, promoting the development of self-soothing capacities and the future use of transitional phenomena for the regulation of affective states. It has often been observed that the act of self-mutilation, the implements used, the blood, and the scars may all operate as transitional objects, providing a soothing function in times of intense and overwhelming negative affect for those who lack healthy self-regulatory capacities (Cooper & Milton, 2003; Cross, 1993; Farber, 2000; Favazza, 1987; Harris, 2000; Herman, 1992; Hewitt, 1997; Hirsch, 1994; Kafka, 1969; Milia, 2000; Suyemoto, 1998; Suyemoto & Macdonald, 1995). Clinicians have described self-mutilating patients that refer to their self-mutilation as a special friend in time of need, and who use a blood stained cloth or a jar filled with their own blood as transitional



objects (Favazza, 1987). In a seminal and heavily quoted text, Kafka (1969) presents the case of a self-mutilating adolescent girl who spoke of her blood as a “potential security blanket capable of giving warmth and comforting envelopment” (p. 209). According to Winnicott (1971/ 2002), the body cannot serve the function of a transitional object, for the transitional object must be a “not-me” possession, offering warmth and capable of surviving both affection and mutilation. However, the pathological split between body and self that characterizes the sense of body alienation felt by the self-mutilating individual allows the body itself to be perceived as a “not-me” object (Walsh & Rosen, 1988), to be taken possession of and treated as such, thus serving the function of a transitional object (Hirsch, 1994). Yet using the body as a transitional object does not promote the development of a cohesive sense of self, nor does it facilitate the ability to symbolize, failing to resolve the crisis of the separation-individuation phase and leaving the self-mutilating individual in a compulsive and ritualistic cycle (Farber, 2000; Milia, 2000).

#### **1.4.5. Symbolization**

Individuals engaging in repetitive self-mutilation are typically unable to verbally express their emotions, which are felt to be extremely intense, threatening to overwhelm their precarious sense of self (Cooper & Milton, 2003; Cross, 1993; Farber, 2000; Favazza, 1987; Favazza, 1998; Milia, 2000; Scott, 1999; Suyemoto, 1998; Suyemoto & Macdonald, 1995; Zila & Kiselica, 2001). It is thought that, due to disturbed object relations, the development of the symbolizing function is impaired with a resultant inability, or weakened ability, to use symbolization for communication of affect and self-

soothing (Farber, 2000; Milia, 2000; Suyemoto, 1998; Suyemoto & Macdonald, 1995). The development of symbolization is related to the degree of anxiety experienced by the infant in the earliest years of life, with too much or too little anxiety interfering with the process (Milia, 2000). A diminished capacity for symbolization, fantasy, and the sublimation of emotions is characteristic of traumatized individuals, as is alexithymia, the inability to recognize, identify, and make sense of emotional reactions (van der Kolk, 1987). According to Deri (1984) in her classic text, *Symbolization and Creativity*, “true symbols both connect and separate inner and outer worlds” (p. 203), creating order out of chaos by means of words or images, and offering a reflective distance from affective subjectivity. Compulsive, stereotyped acting out behavior, on the other hand, is presented as the consequence of a failure in the symbolizing function, whereby, due to the inability to achieve distance from affect, “direct action becomes the only means of tension release” (p. 161). Deri (1984) maintains that acting out may be limited in otherwise articulate individuals to specific unresolved conflicts that are so repressed as to resist symbolization. In the case of self-mutilating individuals, these unresolved conflicts may center upon traumatic memories, separation-individuation issues, and a fear of abandonment.

## **1.5. Functions and limitations**

### **1.5.1. Affect regulation**

Acts of self-mutilation often simultaneously contain a multiplicity of divergent motivations, and may serve as many functions (Milia, 2000; Scott, 1999; Suyemoto,

1998). However, the main function of self-mutilation is the regulation of intolerable negative affect (Cooper & Milton, 2003; Cross, 1993; Crouch & Wright, 2004; Farber, 2000; Favazza, 1987; Favazza, 1998; Harris, 2000; Herman, 1992; Hewitt, 1997; Hirsch, 1994; Laye-Gindhu & Schonert-Reichl, 2005; Suyemoto, 1998; Suyemoto & Macdonald, 1995; Walsh & Rosen, 1988; van der Kolk, 1987; Zila & Kiselica, 2001). It is used to express, externalize, control, and ultimately avoid distressing emotions that are felt to be too difficult to otherwise transform or contain. As such, self-mutilation is remarkably effective at reducing tension and releasing anger, but its effects are short lived and the underlying conflict never gets addressed (Favazza, 1987). Two thirds of a group of self-mutilating patients in one study reported symptomatic relief lasting only a few hours (Favazza, 1998). The immediate experience of relief may nonetheless serve to reinforce the behavior (Suyemoto, 1998).

### **1.5.2. Dissociation**

As previously mentioned, self-mutilation is highly effective in terminating episodes of dissociation, apparently due to the sight of blood (Cooper & Milton, 2003; Cross, 1993; Farber, 2000; Favazza, 1987; Favazza, 1998; Herman, 1992; Hewitt, 1997; Milia, 2000; Suyemoto, 1998; Suyemoto & Macdonald, 1995; Zila & Kiselica, 2001). The majority of self-mutilating individuals claim not to feel any pain when they perform the act, attesting to their state of dissociation from the body (Favazza, 1987; Suyemoto, 1998). The flow of blood brings them back by proving that they are indeed alive and forcing them to notice the limits of their body, as delineated by the skin border (Cooper & Milton, 2003; Hewitt, 1997; Favazza, 1987; Milia, 2000; Suyemoto, 1998).

### **1.5.3. Interpersonal conflict and manipulation**

Episodes of self-mutilation are often precipitated by interpersonal events, such as conflicts, arguments, and separations (Crouch & Wright, 2004; Suyemoto, 1998; Walsh & Rosen, 1988; Zila & Kiselica, 2001). Conversely, acts of self-mutilation and the resulting wounds and scars almost invariably elicit powerful reactions from other people when exposed, thereby affecting family, couple, and group dynamics (Suyemoto, 1998; Walsh & Rosen, 1988). The choice of making an act of self-mutilation public or keeping it private is an important indication as to whether the act was motivated primarily by interpersonal or intra-psychic reasons (Walsh & Rosen, 1988). In addition to obtaining the attention and concern of others (Suyemoto, 1998), self-mutilation may be used to “restore a terminated relationship or gain dominance in an interpersonal conflict” (Walsh & Rosen, 1988, p. 88). Emotional reactions may be sought from families that are otherwise unresponsive (Cooper & Milton, 2003; Walsh & Rosen, 1988), reinforcing the self-mutilating individual’s belief that only overt actions will effectively communicate the intensity of their distress to others (Walsh & Rosen, 1988). Even when acts of self-mutilation are concealed, they may have interpersonal effects. For example, anger redirected onto the self not only avoids retaliation from the other (Favazza, 1987; Milia, 2000), but protects the other and thus preserves him or her, avoiding abandonment (Suyemoto, 1998; Milia, 2000).

Systems theory views self-mutilation as a means to express or redirect attention away from systemic dysfunction. Whether the system is familial, environmental, or societal, self-mutilation plays a role in the maintenance of a state of homeostasis (Suyemoto, 1998), and may effectively reinstate harmony within a group (Walsh &

Rosen, 1988). In some cases, social status among a peer group may be a motivating factor. This is especially true of adolescent inpatient units, within which contagion and competition among patients over the greatest number or severity of cuts are well-documented phenomena (Suyemoto, 1998; Walsh & Rosen, 1988). However, it is important to note that most self-mutilating individuals do not consider their behavior a reaction to an interpersonal event, and may have great difficulty consciously perceiving or accepting the profound effect their self-mutilation has on other people (Suyemoto, 1998). While professionals have a tendency to focus on the interpersonal aspects of acts of self-mutilation, perceiving them as fundamentally hostile or manipulative in intent (Suyemoto & MacDonald, 1995), clinical observation and research suggest that intrapsychic explanatory models are better suited to the internal experience of the majority of individuals engaging in this behavior (Herman, 1992; Suyemoto, 1998).

### **1.6. Summary**

Self-mutilation is a complex behavior often precipitated by adolescence. It is possible that the developmental tasks of this stage, such as separating from the parents and developing an autonomous identity, in combination with pubertal changes and the onset of menstruation in females, can reactivate early traumas, sexual abuse in particular, and unresolved issues originating in the separation-individuation phase of infancy. The self-mutilating individual suffers from deficits in affect regulation and symbolization capacities. Affective states are experienced as intolerable and threatening to overwhelm the individual's fragile sense of self. Dissociation may also be an issue, especially if the individual was abused as a child. The body is perceived

as ego-alien and there may be a deep sense of shame and unworthiness, possibly even self-hatred, which may be localized onto a part of the body and subsequently attacked. Self-mutilation reduces unbearable tension, ends states of dissociation, punishes and redirects anger onto the self, and may serve as a transitional object in navigating the challenges of adolescence. Treatment of this population is difficult because self-mutilating individuals may be hard pressed to give up their behavior, lacking the necessary tools to cope with their emotions, especially in relation to interpersonal conflict and perceived abandonment.

## **Chapter 2: Self-mutilation and art therapy**

### **2.1. Overview**

Self-mutilation is a notoriously difficult behavior to treat (Favazza, 1987; Favazza, 1998; Suyemoto, 1998; Suyemoto & Macdonald, 1995; Walsh & Rosen, 1988; Zila & Kiselica, 2001). Most clinicians agree that treatment should focus on the development of the capacity to express emotions symbolically and the creation of more adaptive strategies for managing negative affect (Cooper & Milton, 2003; Farber, 2000; Favazza 1987; Favazza, 1998; Laye-Gindhu & Schonert-Reichl, 2005; Milia, 1996; Mlia, 2000; Ross & Heath, 2002; Suyemoto, 1998; Suyemoto & Macdonald, 1995; Zila & Kiselica, 2001). Certain clinicians also believe that therapy should attempt to repair early deficiencies in object relations (Cooper & Milton, 2003; Farber, 2000; Suyemoto, 1998). The psychological literature indicates an urgent need for effective treatment strategies geared towards self-mutilating adolescents (Favazza, 1987; Favazza, 1998; Suyemoto, 1998; Suyemoto & Macdonald, 1995; Zila & Kiselica, 2001). The art therapy literature maintains that a non-verbal, playful, action-oriented treatment such as art therapy could be appealing to adolescents, as well as adults, who may be resistant or simply unable to profit from traditional verbal psychotherapy. This chapter addresses the treatment of pathological self-mutilation through the modality of art therapy. It examines how art therapy offers an alternative coping strategy, strengthens both symbolizing and self-soothing capacities, is effective in the processing of trauma, dissociation, and body image distortions, and may be helpful in the repair of attachment issues. The occurrence of self-

harm imagery and enactments within the therapeutic art of self-mutilating clients, a common phenomenon upon which little has been written to date, will also be addressed.

## **2.2. Alternative coping strategy for action-oriented individuals**

It has been observed that self-mutilating individuals tend to have an action-oriented cognitive style, comprising the belief that only physical acts, such as aggression, substance abuse, or self-harm, will effectively reduce their tension (Walsh & Rosen, 1988). While most of the strategies for tension reduction proposed in verbal therapy are typically not action-oriented enough to accommodate the cognitive style of self-mutilating individuals (Walsh & Rosen, 1988), art therapy offers an immediate and viable alternative to self-destructive actions that bypasses the need for words yet still expresses powerful emotions (Cooper & Milton, 2003). The expression and control of emotions have been identified as the primary tasks of therapy with this population, these being the reasons most cited by therapists for termination or decreases in self-mutilation (Suyemoto & MacDonald, 1995). As the communication issues of self-mutilating individuals often stem from preverbal difficulties (Scott, 1999), the replacement of action with words may be an unrealistic expectation on the part of the therapist, at least initially (Cooper & Milton, 2003). Alternative means of communicating and channeling affect are therefore required (Suyemoto & MacDonald, 1995).

That self-mutilation is most common during the period of adolescence is not surprising given the natural adolescent propensity for acting out. The term “acting out”, originally used by Freud within the context of analysis, refers to the repetitive reliving of the traumatic past. Rather than aid in the mastery of the traumatic memory, acting out is



performed in the service of avoidance and denial, whereby the memory is “remembered” through a disguised reenactment but remains unavailable for integration by the ego (Amini & Burke, 1979; Blos, 1979). Later conceptualizations focused on acting out beyond the confines of analysis, giving special attention to this behavior as a phenomenon specific to adolescence. Blos (1979), in his influential work, *The adolescent passage*, proposed that, “acting out during adolescence is as phase specific as play is for children and direct language communication is for adulthood” (p.254). His focus was on benign and transient forms of acting out that he viewed as serving the maturational process of this developmental phase. Other authors focused on maladaptive, antisocial, and persistent forms of acting out as the result of early deprivation, trauma, and pathological object relations (Amini & Burke, 1979; Noshpitz, 1994). While the theory of masked depression (Lesse, 1979; Riley, 2003), asserting that all childhood and most adolescent depressions take on a masked character may be outdated, a review of the literature has indicated that the co-occurrence of antisocial acting out behaviors and overt juvenile depression is a distinct, albeit complex, clinical phenomenon (Ben-Amos, 1992). Indeed, it has been found that self-mutilating adolescents in a non-clinical setting are significantly more likely to report depressive symptoms than adolescents who do not self-mutilate (Ross & Heath, 2002). As reliance on acting out forfeits the development of the ability to tolerate, contain, reflect on, and manage difficult emotions (Farber, 2000), an emotion-based approach in which emotions can be safely experienced is highly recommended with this population (Laye-Gindhu & Schonert-Reichl, 2005). It has been observed that acting out individuals, “tend to think in *pictures* and to have an extremely vivid visual sense” (Deri, 1984, p. 182). In addition to developing the capacity for

symbolization, art making, with its emphasis on imagery and its unique proclivity for the containment, catharsis, and transformation of affective states, may offer important therapeutic benefits for acting out individuals. Art making has also been found to be particularly effective in overcoming the notorious adolescent resistance to therapy, making it a potentially valuable tool in the treatment of adolescent acting out and depression (Riley, 2003).

### **2.3. Symbolization and verbalization**

The initial aim of treatment with self-mutilating adolescents is to create a holding environment capable of withstanding the extent of the client's un-integrated rage and emotion (Zila & Kiselica, 2001). Verbalization and symbolization of complex feelings should then be encouraged as alternatives to repetitive physical reenactments (Haeseler, 1987; Suyemoto & MacDonald, 1995; Zila & Kiselica, 2001). It has been suggested that self-mutilating individuals may need to see physical evidence of their emotions, as their capacities for abstract symbolization may be very weak (Suyemoto, 1998). If that is the case, then the physical objects produced in art therapy may be quite helpful at mirroring back to the individual his or her emotional state, a process that often acts as a bridge to verbalization (Cooper & Milton, 2003; Farber, 2000; Milia, 2000; Riley, 2003; Schaverien, 1999; Wilson, 2001). Not only do art objects reflect affect but they contain it, offering the distance and the structure necessary to make verbal exploration of affective states possible (Cooper & Milton, 2003; Milia, 2000; Robbins, 2001; Schaverien, 1999; Wilson, 2001). Symbolization is developed through the safe expression of chaotic feelings onto an art object that will contain and transform them, making the experience of

these feelings more tolerable and, with the support of the therapist, strengthening the ego in working them through (Cooper & Milton, 2003; Milia, 2000; Robbins, 2001; Wilson, 2001).

Art therapy offers this population the opportunity to learn to externalize their emotions into art making, redirecting expression away from their bodies and onto the art materials (Cohen & Mills, 1999; Cooper & Milton, 2003; Haeseler, 1987; Milia, 2000; Schaverien, 1992). The art object can be experienced as an extension of their bodies, the surface a symbolic substitute for the skin, onto which the enactment of aggressive impulses and experimentation with boundaries may be safely performed (Cohen & Mills, 1999; Cooper & Milton, 2003; Milia, 1996; Milia, 2000). Aggression and negative affect can thus be channeled into the art and transformed in an act of sublimation, or, at the very least, appropriately discharged (Appleton, 2001; Cooper & Milton, 2003; Milia, 2000; Murphy, 2001; Schaverien, 1992). Murphy (2001) recognized the view of several art therapists in hypothesizing that “if abusive feelings could be recognized and directed safely through art materials, it would be less likely that either a cycle of abuse would be perpetuated, or that a pattern of self-harming behaviors would become established” (p. 7). One study found that within the first six months of an art therapy group for adolescent survivors of sexual abuse, self-harming and other destructive behaviors were reduced (Brown & Latimir, 2001). In addition, several authors have presented cases in which, over time, impulses towards self-mutilation were successfully recognized and redirected into art making, decreasing or eliminating the incidence of the actual behavior (Cooper & Milton, 2003; Estep, 1995; Kupfermann, 1996; Schaverien, 1992; Scott, 1999).  
Introducing new coping mechanisms by developing symbolic and communicative

capacities through art may thus strengthen the ego, develop self-control, and reduce the propensity for acting out aggression against the self or others. In addition, through direct and positive feedback and mirroring by the therapist, movements towards creative and constructive expression can be reinforced. In so doing, patterns of obtaining environmental responses through primarily destructive means may be counteracted (Cooper & Milton, 2003; Suyemoto & MacDonald, 1995).

#### **2.4. Traumatic memories**

As mentioned in chapter 1, many self-mutilating individuals have traumatic early histories of physical and sexual abuse. These individuals may benefit from the power of art to uncover, process, and integrate traumatic memories that often strongly resist verbalization and, in some cases, conscious awareness (Appleton, 2001; Cooper & Milton, 2003; Engle, 1997; Klorer, 2005; Milia, 1996; Milia, 2000; Rankin & Taucher, 2003; Riley, 2003). It has been hypothesized that amnesia for traumatic events is caused by the difference in the cognitive state used in the encoding and retrieval of traumatic memories. Research has shown that these memories are encoded in sensorimotor and iconic form, and stored as sensations, motor reactions, and images in the right, visual-spatial cerebral hemisphere of the brain (Greenberg & van der Kolk, 1987; Herman, 1992; Klorer, 2005). Such memories are easily reactivated by affective, auditory, olfactory, tactile, and visual cues, but are difficult to retrieve linguistically. Non-verbal therapies such as art therapy may be more effective in the retrieval and processing of traumatic memories since they do not rely on linguistic processes and capabilities, which are the domain of the left cerebral hemisphere (Appleton, 2001; Klorer, 2005). Both

hemispheres of the brain may then be activated as the visual descriptions are translated into verbal ones, the art acting as an illustration and stimulus for the creation of a comprehensive, coherent, and manageable linguistic narrative (Chapman et al., 2001). Clinicians and researchers have observed that traumatic experiences, if not remembered and integrated into the life story through a verbal narrative, are often repeated compulsively, not only through nightmares and flashbacks, but also through reenactments involving the body (Herman, 1992). The processing of early trauma through art may help to break this harmful cycle and overcome the need for destructive acting out behaviors.<sup>1</sup>

## **2.5. Dissociation**

As discussed in chapter 1, self-mutilation is highly correlated with episodes of dissociation; altered states of consciousness that keep traumatic experiences and related affect split off from conscious awareness. The integration of dissociated material is one of the challenges facing therapists working with individuals suffering from trauma-related symptoms such as self-mutilation. Dissociative disorders are typically difficult to detect and diagnose, yet they tend to respond well to art, making art therapy one of the most effective therapeutic modalities for accessing and communicating with dissociated states (Cohen & Mills, 1999; Engle, 1997). Part of an interview investigating the experience of self-mutilation in a sample of dissociative-disordered women involved asking participants to draw a life size silhouette. They were then asked to show, as accurately and with as much detail as possible, where they physically hurt themselves. This researcher observed that new information emerged as a result of this exercise that

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<sup>1</sup> For more information on the use of art therapy with trauma survivors, see Malchiodi (1997).

had not been accessed in the solely verbal interview, concluding that different modes of inquiry may be better suited for reaching different states of consciousness (Scott, 1999).

Individuals that have suffered repeated trauma, such as sexual abuse, may be confused about and disconnected from their emotions. It has been observed that the tactile nature of art materials may connect to sensation and emotion, evoking these in even strongly dissociated clients (Brooke, 1997; Pifalo, 2002; Murphy, 2001). Emotions or depictions of traumatic events may be difficult to deny when they appear, unbidden, in the artwork of clients (Engle, 1997; Hagood, 2000). In both cases, the “evidence” may validate the individual’s experience and allow for further exploration. In addition, the capacity of artworks to physically contain traumatic emotions, allowing them to be put out of sight in between sessions, may afford the individual enough distance and protection to continue the therapeutic process, reducing the risk of overwhelming the system and causing yet more fragmentation (Brown & Latimir, 2001; Engle, 1997; Rankin & Taucher, 2003). The fact that art objects are permanent may also provide an important sense of continuity and concreteness of existence for the individual prone to dissociation (Cooper & Milton, 2003), a need that may otherwise be fulfilled by the scars produced by self-mutilation, reminders of painful events in the individual’s life (Favazza, 1987).

## **2.6. Body image distortion**

As stated above (see chapter 1), body alienation is a crucial precipitating factor in the development of self-mutilation. It has been observed that many self-mutilating individuals experience their body as a hated object or as “other”. Indeed, it is often this

psyche-soma split that allows the mutilation to occur, which may itself be regarded as an observable manifestation of a distorted body image (Cohen & Mills, 1999; Walsh & Rosen, 1988). Consequently, issues related to body image distortion and body hatred have been a central focus in the treatment of self-mutilating individuals (Attias & Goodwin, 1999; Cohen & Mills, 1999; Cooper & Milton, 2003; Goodwin & Attias, 1999; Walsh & Rosen, 1988). Investigating these issues in therapy, with the aim of reducing the gap between mind and body so that these are experienced as an integrated unit, has shown initial promise in significantly reducing the frequency of self-mutilating behavior (Walsh & Rosen, 1988).

Imaging the body through art is an excellent means of communicating, assessing, and working with body image distortions (Attias & Goodwin, 1999; Cohen & Mills, 1999; Goodwin & Attias, 1999). Art therapists have observed that body image distortions are often translated, through isomorphic processes, into distortions in the art imagery of their clients. Distortions in art imagery may allow body image distortions to be approached and examined in a non-threatening manner (Cohen & Mills, 1999; Engle, 1997). It is not unusual for individuals suffering from trauma-related disorders to reveal body images that are disorganized, fragmented, deformed, dismembered, and, in the case of dissociative identity disorder, multiple (Engle, 1997; Goodwin & Attias, 1999). As body image distortions are worked through and ultimately resolved, improvements are typically observed in areas such as self-cohesion, emotional containment, bodily pleasure, reality testing, self-soothing, self-mastery, and general feelings of effectiveness (Attias & Goodwin, 1999).

## **2.7. Self-soothing and attachment**

Research has found that images affect emotions, transform mood states, and have the ability to create a soothing effect on viewer and artist alike (Malchiodi, 2003). Published cases of art therapy with self-mutilating clients have indicated that over the course of treatment, art making became an effective form of self-soothing and tension release, in some cases replacing self-mutilation altogether (Cooper & Milton, 2003; Estep, 1995; Kupfermann, 1996; Milia, 1996; Milia, 2000; Schaverien, 1992; Scott, 1996). The art materials provide pleasant sensory stimulation (Milia, 2000), and the art making process offers the opportunity to enter transitional space (Winnicott, 1971/ 2002), an “as-if” space between internal and external reality in which the individual can play in the presence of the therapist, much as the developing child plays in the presence of the mother, and from which the capacity for creative living develops. The self-mutilating individual has been compared to a child that cannot play (Farber, 2000), as the capacity to use transitional phenomena for purposes of self-soothing may be quite weak. As discussed in chapter 1, the self-mutilating individual uses acts of self-mutilation, the associated implements, blood, and scars as transitional objects, yet may be unable to use other transitional phenomena for the regulation of affective states. Within the context of a reparative attachment relationship, the ability to enter transitional space through the process of art making and the capacity of artworks to function as transitional objects may help the self-mutilating individual replace self-destructive actions with creative ones (Cooper & Milton, 2003; Milia, 2000; Schaverien, 1992). Feeling safe and held in the therapeutic environment, early object relations may be repaired, and the ability to



symbolize and self-soothe may be developed (Cooper & Milton, 2003; Farber, 2000; Lachman-Chapin, 1979).

The impact of early trauma and neglect on brain imprinting related to attachment and the development of healthy affect regulation was stated in chapter 1. Recent developments in neuroscience have found that the right orbitofrontal lobe, the area of the brain in which early attachment is imprinted, is highly plastic. Thus maladaptive imprinting can be repaired in response to secure attachments formed later in life (Schore as cited in Farber, 2000; Schore as cited in Malchiodi, 2003). The left cortex of the brain, associated with language, is slower to develop than the non-verbal, right one. As art making is mediated by the right cortex, it may be better able to access pre-verbal attachment deficits than verbal therapy alone. By activating the right part of the brain within the context of a trusting, secure relationship, new patterns may be encouraged to develop and healing may begin to take place (Malchiodi, 2003).

## **2.8. Self-mutilation imagery and enactment**

Studies in art therapy with self-mutilating clients have demonstrated the tendency for self-destructive impulses to be enacted onto art materials (Cohen & Mills, 1999; Haeseler, 1987; Milia, 1996; Schaverien, 1992). It has been observed that the mutilation of symbolic self-representations projected onto art objects reduces and relieves tension, paralleling the effects of self-mutilation and constituting a powerful therapeutic tool in redirecting the expression of anger away from the body (Milia, 1996). It has also been noted that the communication of self-harm ideation through art engages the therapist's protection against such impulses (Haeseler, 1987), eliciting the caring witness's gaze

while maintaining an appropriate boundary between client and therapist (Cohen & Mills, 1999). Skin-related wound imagery is frequently found in therapeutic art. However, it is unclear whether such imagery is correlated primarily with self-harm ideation or actual behaviors (Cohen & Mills, 1999). It is also unclear whether representations of self-mutilation always provide enough release to eliminate the need for performing the act. Therapists should be aware that, in certain cases, depictions of self-mutilation may function as rehearsals for a future act (Schaverien, 1992).

The responses of art therapists to self-mutilation in the art images and processes of their clients have varied. Some art therapists do not regard these artworks as exercising a symbolic function, but rather as “reenactments” of a client’s pathology, requiring intervention (Haeseler, 1987). While art materials may be substituted effectively for the body, producing a temporary sense of release and respite, the intention of the act remains to avoid, rather than address, the powerful and confusing feelings underlying the impulse to self-mutilate. It is therefore recommended that art therapists encourage clients to move from the literal to the symbolic, from art used as a reenactment of unconscious self-harming impulses to art used as a metaphor for complex internal states. The ability to use art as a metaphor for internal states begins by first identifying and then expressing difficult emotions that the client has avoided through reliance on acting out behaviors such as self-mutilation.

Other art therapists advocate the healing potential of destructive acts in the context of the creative process, and stress the importance of working with, rather than against violence (Milia, 1996; Milia, 2000). From this point of view, the role of the art therapist is simply to witness such acts, offering, when deemed appropriate, technical

assistance and support in the service of integration. The channeling of aggressive and destructive energies should be encouraged with the aim of eventual transformation. Therapists, however, should base their interventions on the level of coping strengths presented by their client.

## **2.9 Summary**

This chapter has examined the ways in which art therapy may benefit the self-mutilating individual. It has been seen that art therapy offers an alternative coping strategy for action-oriented individuals; it increases symbolic capacities and the verbalization of emotion; it is an effective means of both uncovering and processing traumatic memories and dissociated states; it is unique in its ability to address distortions in body image; and, in its capacity as a transitional phenomena, it strengthens the self-soothing function and may repair deficiencies in object relations. As a non-verbal modality governed by the right brain cortex, art therapy is especially useful in accessing the preverbal states and attachment deficits that may contribute to the development of self-mutilation. Images and enactments of self-mutilation are common phenomena in the therapeutic art of self-mutilating individuals. The views of different art therapists on this subject have been presented.

## **Chapter 3: Self-mutilation and performance art**

### **3.1. Overview**

This chapter examines the phenomenon of self-mutilation as practiced by contemporary Western artists within the context of performance art. Emerging in the 1960s and peaking in popularity in the 1970s, performance art, also known as “live art”, “body art”, “event art”, and “post-object art”, fundamentally challenged the nature and function of art in the Western world, including the object-centered institutions of the art market, gallery, and museum, by stressing the process of art making over the resulting product (Dennis, 1998). This type of art form utilizes the human body as its material (Dennis, 1998; O’Dell, 1988), yet rather than use the body to convey a metaphor, as in theater or dance, performance art regards the body as a metaphor in its own right (O’Dell, 1998). In spite of the intentions stated by artists and the contexts given by art historians and critics, working with the body has a tendency to evoke contradictory reactions in viewers (Warr, 2000), particularly when acts of self-mutilation are involved (McEvelley, 1983). This chapter will briefly survey the primary functions and intentions associated with performance art in order to situate such work within its proper critical and historical context. It will therefore examine the following themes: postmodernism, social and political change, transformation and catharsis, psychopathology, attachment, and trauma, and the relationship between artist and audience. A selection of artists engaging in self-mutilation as a principal part of their body of work will then be presented and discussed, with emphasis placed on the intentions of their actions and their effects upon their

viewers. Finally, parallels and differences between performance artists using acts of self-mutilation in their work and contemporary self-mutilating individuals will be drawn.

### **3.2. Functions and intentions of performance art: An overview**

#### **3.2.1. Postmodernism**

Performance art is interested in exploring issues pertaining to the location of human subjectivity, integrity, experience, and identity, emphasizing the body as the interface where the public and the private converge and interact (Dennis, 1998; Jones, 2000; Jones, 2004; Warr 2000). Performance art discredits the assumption of disinterestedness, derived from Kantian aesthetic discourse, upon which conventional Western art history and criticism rests (Jones, 1998; Jones, 2000). This discourse, outlined in Kant's (1790/ 1987), *Critique of aesthetic judgment*, differentiates the aesthetic experience from the sensory one. The aesthetic experience, requiring a level of rational contemplation and reflection, is deemed superior to the more common or vulgar sensory experience, and is the basis upon which art should be judged. Works that induce a physical response in the viewer operate within the sensory mode of experience and are therefore unsuitable for aesthetic judgment. This discourse presupposes the necessity of the viewer to retain a state of disinterest, or neutral rationality, in relation to the artwork. Transcendence of the body is then, in the Kantian view, the cornerstone of the aesthetic experience. This ideal has resulted in the veiling of the typically privileged European male body of both artist and critic behind a veneer of universality (Jones, 2000; Jones & Stephenson, 1999). Modernism, a philosophical doctrine favoring the disembodied,

transcendent and supposedly universal subject over the embodied, socially embedded, “primitive”, “feminine”, or “deviant” one, is the ideological structure against which performance artists rebelled. By foregrounding the individual artist’s body and emphasizing the intersubjectivity between artist and audience, performance art both situates itself within and enacts a post-modernist philosophy. This philosophy recognizes the body as the main conduit through which social practices and ideologies are created, modified, and transmitted (Jones, 2000).

### **3.2.2. Social and political change**

The social and political implications of performance art have been important considerations for most artists and critics of the movement (Chalupecky, 1978; Dennis, 1998; Goldberg, 1998; Jones, 2000; Jones, 2004; O’Dell, 1998; Phelan, 2004; Pluchart, 1978b; Vergine, 1974; Warr, 2000; Weibel, 1978). It has been argued that the artist’s body acts as a metaphor and a mirror for the social body (Phelan, 2004; Pluchart, 1978b; Weibel, 1978), and that acts of self-harm within the context of performance art should be interpreted as social critiques (O’Dell, 1998). Performances involving acts of self-harm, particularly popular in the 1970s, resurfaced once again in the late 1980s. O’Dell (1998), an art historian, attributes this phenomenon to the political and social turmoil of the Vietnam war and the subsequent cultural war on AIDS, asserting that many of these artists “acted out of a desperate lack of other viable means to critique these institutionalized facts” (p. 55). These performances served to provoke awareness about public complicity in a variety of social and political issues, from domestic violence to US foreign policy, through the audience’s complicity, however passive or unintentional, in

the harmful acts perpetuated by the artists (Dennis, 1998; O'Dell, 1998). In addition to addressing social issues that entail damage to the body on a large scale, self-harming performances also make visible the body in pain. Socially marginalized bodies, wounded physically by illness or metaphorically by prejudice, are presented to challenge social homogeneity and the silencing of undesirables (Jones, 2000; Jones, 2004; O'Dell, 1998; Warr, 2000). In challenging social expectations of the body, performance art wields a powerful tool for attacking social and sexual taboos (Goldberg, 1998).

### **3.2.3. Transformation and catharsis**

Performance art has often been motivated not only by a desire for the merging of art with life, but a belief in the power of art to transform life by profoundly affecting both artist and audience (Jones, 1998; Phelan, 2004). Communication and identification on a deep level was therefore sought between artist and audience (Chalupecky, 1978; Pluchart, 1978b; Vergine, 1974). Performance art was used to reduce the sense of alienation between artist and audience by allowing both to experience the artwork simultaneously (Goldberg, 1979). It was often also used as an attempt to break through the socially acceptable persona and resulting isolation imposed by cultural norms, with the aim of reaching an ideal of authentic relating between self and other (Chalupecky, 1978; Vergine, 1974). Performance art sought to peel away the layers of social expectations for the body in order to reach and communicate a deeper truth of existence (Vergine, 1974).

Performance art was frequently concerned with the transformation of the artist through the process of the artwork. The ritualistic origins of theater and performance, especially in relation to transformation of consciousness and identity, were reclaimed in

pursuit of the ancient marriage of art and the sacred, and the reestablishment of sacred time and space within contemporary Western society (Chalupecky, 1978; McEvelley, 1983; Phelan, 2004; Pluchart, 1978a). The mind-body connection was investigated and explored through the appropriation of ancient, non-Western ritual practices, knowledge of which was made accessible through anthropological research. Self-mutilation, physical pain and extreme, often dangerous tests of endurance and will, characteristic of most initiation rites and shamanic activities around the world, were employed towards the attainment of alternative states of consciousness (McEvelley, 1983; Phelan, 2004; Warr, 2000; Weintraub, 1996). Most artists engaging in such work claimed that their performances resulted in powerful personal experiences of a cathartic nature. Certain also believed that their audiences shared in this experience, and tended to view their work as holding therapeutic value (Goldberg, 1998; McEvelley, 1983; Pluchart, 1978a; Warr, 2000). These artists were concerned with re-attributing to art and performance the healing, transcendental, and transformational powers with which they were once fused (McEvelley, 1983). “This approach to performance art is both the most radically advanced – in its complete rejection of modernism and Eurocentrism – and most primitive – in its continuance of the otherwise discredited association of art with religion” (McEvelley as cited in Phelan, 2004, p. 21).<sup>2</sup>

#### **3.2.4. Psychopathology, attachment, and trauma**

Some art critics have called into question the mental health of performance artists who inflicted harm upon themselves in the name of their art. Their work was dismissed as

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<sup>2</sup> For an excellent review of the parallels between shamanic rituals aimed at drawing illness and disorder away from the community and performance art, see McEvelley (1983).



psychopathological and interpreted as expressing sadistic, masochistic, narcissistic, hysterical, obsessive, and autoerotic impulses (Chalupecky, 1978; Goldberg, 1998; Vergine, 1974). O'Dell (1998) wrote a book examining the characteristics and concerns of five performance artists working in the 1970s who perpetrated violence upon their bodies in what she termed "masochistic performance." However, she acknowledged that these artists typically rejected the use of the term "masochistic" in relation to their work. Her investigation focused on the use of masochism, or self-inflicted harm, within the context of performance art as a metaphor for painful key moments in early psychic development, particularly those stages leading up to the oedipal, symbolic stage. She supported her arguments with Anzieu's (1989) theory of the skin's role in attachment formation between infant and caregiver. Anzieu (1989) postulates that the infant, in a fantasy of symbiotic dependency, perceives its own skin and the skin of its caregiver as one. While suppression of the common skin fantasy is required for separation and individuation, the concomitant anxiety may be manifested in painful feelings and aggressive fantasy attacks upon the skin that was once believed to bind together infant and caregiver. The formation of a secure attachment enables the infant to internalize the skin's functions of containment, protection, and communication, whereas a disturbed or insecure attachment may predispose an individual to masochistic fantasies or acts, such as are enacted in the performances of which O'Dell (1998) speaks.

For many art critics and historians, it is clear that in addition to challenging dominant philosophical doctrines, addressing social issues, investigating the relation between art and the sacred, and accessing alternative states of consciousness, performance artists who harm their bodies work with psychic and emotional material of a

deeply personal and often painful nature (Goldberg, 1998; O'Dell, 1998; Vergine, 1974). In the words of one artist, "I re-opened old wounds and then sewed them back up" (Parr, 1978, p. 53). The frustrated need for unconditional love turned into aggression, the attempt to deal with a re-emergence of previously repressed material, the anguish of loss and longing, the need to externalize intolerable tensions, and the compulsion to repeat acts of aggression followed by acts of reparation have all been suggested as motivational factors in the choice of harming one's body as an art form (Vergine, 1974).

### **3.2.5. Relationship artist and audience**

Both the creation and the reception of a work of art serve to bring it into existence. The viewer, then, is an active and essential part of the artist's work (O'Dell, 1998; Warr, 2000). Typically, an art object mediates the relationship between artist and viewer. However, in the case of performance art in which the artist's own body is the "object", the relationship between artist and audience increases both in complexity and significance.

Performance artists emerging out of the 1970s were interested in eliciting a bodily reaction from the spectator (Chalupecky, 1978). Antonin Artaud's (1932/ 1976) *Theatre of Cruelty*, concerned with eliminating traditional boundaries such as the stage in order to physically overwhelm and affect the audience, was often cited as an inspirational text (Goldberg, 1998; Jones, 1998). Performances that were painful for the artist to endure were generally also very difficult for the audience (Goldberg, 1998; Jones, 1998; McEvelley, 1983). Viewers accustomed to the traditional boundaries of art were often shocked, disturbed, repelled, offended, and even insulted by these performances

(McEvelley, 1983; Vergine, 1974). In witnessing such actions and images, viewers found themselves confronted with their own wounds and conflicts, past and present, internal and external (Jones, 2004; Vergine, 1974). Furthermore, through the unconscious process of identifying with the performer, viewers were made to experience the roles of both aggressor and victim, and face the uncomfortable fact that these existed simultaneously within them (O'Dell, 1998; Vergine, 1974). Performances involving self-harm or dangerous tests of endurance also raised ethical issues about the audience's complicity in their capacity as witnesses to these violent or risky actions (Dennis, 1998; Goldberg, 1998; O'Dell, 1998). O'Dell (1998), in her work on masochistic performance, emphasizes the importance of the implicit contracts made between performers and audience members, such that non-interference on the part of the audience signified silent acceptance of, and thus complicity with, self-harming acts.

### **3.3. Description of artists**

Acts of self-mutilation have featured prominently in the performance practice of the following artists – Gina Pane, Marina Abramović, the Viennese Actionists, Ron Athey, Bob Flanagan, and Orlan. This section will explore the role of self-mutilation in the work of these artists, focusing on the intentions behind such actions and their impact upon the viewer.

#### **3.3.1. Gina Pane**

Gina Pane (1939-1990), a French body artist and sculptor who received her formal training at the *Ecole des Beaux-Arts* in Paris (O'Dell, 1997), used her body as her

primary artistic material (Pane & Stephano, 1973). She created a language for her performances consisting of four key elements – blood, pain, milk, and fire – which she chose for their primitive and universally evocative nature (Pane & Stephano, 1973). Her performances involved such acts as putting out fires with her bare hands, enduring physically painful and challenging situations, and repeatedly inflicting cuts to her face, lips, tongue, forehead, ears, hands, feet, arms, belly, and back (Blessing, 2002; Goldberg, 1979; Martins, 1983). Usually, wounding gestures were alternated with repetitive gestures suggestive of child’s play or sport (Blessing, 2002). She discontinued these actions in 1979, after suffering injuries serious enough to make her decide to bring an end to her performance career (O’Dell, 1998).<sup>3</sup>

Despite assertions to the contrary, Gina Pane did not consider herself a masochist or her actions pathological, stating that she loved life and hated pain and suffering. Yet as a self-identified artist with a social conscience, she felt it necessary to undergo these in order to reach what she called an “anesthetized society” (Pane & Stephano, 1973, p.), and bring awareness to the everyday violence concealed by habitual and comfortable patterns of behavior (Pluchart, 1978b; Stephano, 1973). By juxtaposing the application of makeup and nail polish with the drawing of blood around her eyebrows and nails in performances such as *Autoportrait(s)* (1973) and *Psyche* (1974), Pane addressed the socialization of women, critiquing their conformity to patriarchal beauty standards (Blessing, 2002; Pane & Stephano, 1973; O’Dell, 1997). By climbing up and down an iron ladder with sharp edges until, bleeding profusely from both hands and feet, she could no longer endure the

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<sup>3</sup> Examples of self-mutilation can be found in the following performances: *Escalade sanglante*, 1971 (Pane & Stephano, 1973; Pluchart, 1978b; O’Dell, 1997); *Le lait chaud*, 1972 (Blessing, 2002; Pane & Stephano, 1973); *Action sentimentale*, 1973 (Hixon, 1991); *Transfert*, 1973 (Stephano, 1973); *Autoportrait(s)*, 1973 (Blessing, 2002; Pane & Stephano, 1973; O’Dell, 1998); *Psyche*, 1974 (O’Dell, 1998); *Discours mou et mat*, 1975 (O’Dell, 1998); and *Laure*, 1976 (Blessing, 2002; Pane, 1978).

pain in *Escalade sanglante* (1971), Pane addressed the inhumanity and disrespect accompanying man's quest to rise in the social hierarchy (Pane & Stephano, 1973).

Through challenging all of the senses (Martin, 1983), and affecting her spectators viscerally (Blessing, 2002; O'Dell, 1998; Pane & Stephano, 1973; Stephano, 1973), Pane claimed that her performances operated on a cathartic and transformative level (Blessing, 2002; Kontova, 1979). She likened her practice to that of the medicine men of ancient Greece who inflicted wounds upon their own bodies in the context of healing rituals (Kontova, 1979). She used the wound in her performances to represent the pain and vulnerability of the body, and therefore to capture, in her view, most authentically the reality of corporeal existence (Hixon, 1991). In contrasting acts of self-mutilation with repetitive play gestures, Pane wished to explore and integrate both suffering and play as polar aspects of the human condition, portraying and experiencing these without fear or anesthesia (Blessing, 2002). In some performances, self-mutilation was employed to attack taboo subjects. In *Le lait chaud* (1972), for example, Pane confronted issues of aestheticism, narcissism, and the canons of feminine beauty by cutting herself on the face, an act that provoked high levels of distress in her audience (Pane, 1978; Pane & Stephano, 1973). In other performances, self-mutilation served to demarcate important life transitions, resembling in this sense initiation rituals and ceremonial rites of passage. In the last of three phases of *Autoportrait(s)*, for example, Pane gargled milk and then spat it out, repeatedly and in an increasingly violent manner, until a cut she had previously made on her lower lip re-opened and blood mixed with the spit milk (Pane & Stephano, 1973; O'Dell, 1998). This action was intended to represent rejection of childhood dependency, symbolized by the milk, in favor of adulthood responsibilities,

symbolized by the blood (Pane & Stephano, 1973). Another performance with this theme was *Discours mou et mat* (1975). After playing with cymbals covered in cotton while a tape recorded text related nostalgic memories of her mother and her breasts, Pane smashed two mirrors with her bare fists and arms before cutting herself on the lip with a razor blade. Upon one mirror was drawn a mouth, upon the other was written the word “alienation.” The combination of these symbols, in the view of one art historian, relates to the pain of separation from a symbiotic state with the mother during the late oral stage (O’Dell, 1998). Themes of emptiness and mourning for a lost love object are, in the view of another art historian, typical of Pane’s performances (Vergine, 1974). Her work is so closely connected to memories and the discharge of intense emotions that this art historian questions, “if she is liberating herself from the weight of the traumatic event or trying to bring it back to life so as better to be able to hold onto it” (Vergine, 1974, p. 27).

Gina Pane intended for her performances to have a disturbing visceral effect upon her audience (Blessing, 2002; O’Dell, 1998; Stephano, 1973), in order to break through and modify the numbing layer of habitual comfort from which she felt society suffered (Pane & Stephano, 1973). Yet audiences typically responded to her efforts with resistance and hostility, insulting and dismissing her work as pathological (Pane & Stephano, 1973). In spite of the alienating effect that her actions produced (O’Dell, 1998), Pane’s stated wish was to transcend the alienation between self and other (Blessing, 2002; Pane & Stephano, 1973). *Autoportrait(s)*, a work addressing the social conformity of women, used a camera to record and project the live reactions of female spectators. As implied in the title, Pane intended that her “self-portrait” be a portrait of others as well (Blessing, 2002; Pane & Stephano, 1973). In pointing a camera at the audience in this work and in

*Le lait chaud*, Pane attempted to transcend the alienation between performer and spectator by subverting the traditional roles of subject and object into a more reciprocal relationship (Blessing, 2002). In presenting the audience with images of itself in the act of viewing her performance, Pane wished to emphasize to them their role as witnesses and thus their complicity in the events that transpired (Blessing, 2002). Complicity with, as opposed to rejection of, self-harming performances requires empathy on the part of the spectator, a difficult feat for those who feel that they are being presented with violent, disturbing acts against their desire and will. While some spectators respond to these acts with fascinated attention, others are made so uncomfortable that they refuse to participate, either vocally or by physically turning away, as documented in the taped reactions of *Autoportrait(s)*. The relationship between artist and audience is highlighted in performances such as these, as the artist makes demands on the audience that are either accepted or refused (Blessing, 2002).

### 3.3.2. Marina Abramović

Marina Abramović (1946 -), a performance artist from Yugoslavia who worked solo as well as in collaboration with fellow artist and lover Ulay, began using her body as artistic material in 1972 (Goldberg, 1995). Initially, her work centered upon an exploration of the experience of pain, and involved such acts as whipping and cutting her body with knives and razors (Kontova, 1978). Placing her body in extremely dangerous situations, pushing its limits and exhausting its resources were also characteristic of her performances (Denegri, 1998; Goldberg, 1995; Kaye, 1996; Kontova, 1978; Weintraub, 1996). Much of this work explored the interplay of submission and will (McEvelly,

1995). According to Abramović, the self-destructiveness of her earlier work stemmed from sexual frustrations, isolation, and unhappiness (Kontova, 1978). Extreme and risky actions, aimed in part at shocking the public (Kontova, 1978), and at rebelling against a restrictive familial and political environment (Goldberg, 1995), evolved into equally intense yet less destructive events aimed at achieving a state of transformation for both artist and audience (Celant & Abramović, 2001; Denegri, 1998; Goldberg, 1995; Kaye, 1996; Kontova, 1978; Weintraub, 1996). Confrontation with and transformation of her own fears and emotions, as well as those of her audience, lay at the root of much of her work (Goldberg, 1995). Examples of acts of self-mutilation can be found in the following performances: *Rhythm 10* (1973), in which she recorded the rhythm of her stabbing a set of 10 knives between her fingers, switching knives each time she cut herself, and then played it back, attempting to repeat the rhythm of the stabbings, including the moments in which she cut herself (Kaye, 1996; McEvelley, 1995); *The Lips of Thomas* (1975), in which she drank a liter of red wine and ate a kilo of honey, cut a 5-pointed star into her belly, whipped herself until she could no longer feel pain, and lay on a block of ice for 30 minutes (McEvelley, 1995); *Art Must be Beautiful, Artist Must be Beautiful* (1975), in which she began brushing her hair, the action turning more and more violent until she was scratching and destroying her face (Abramović & Novakov, 1997); and *Talking About Similarity* (1976, in collaboration with Ulay), in which Ulay sewed his mouth shut while Abramović answered questions from the audience in the manner in which she believed he would respond if he could (O'Dell, 1998).

In employing her body towards an exploration of her physical and mental limits, Abramović discovered that she could use her performance practice to achieve an ecstatic



state of heightened alertness and awareness (Denegri, 1998; Goldberg, 1995; Kaye, 1996; Kontova, 1978; Weintraub, 1996). Her work was ultimately concerned with the generation and transmission of energy, enough to produce a state of total engagement with the present in both herself and her audience, from which escape was not possible (Goldberg, 1995). Catharsis and regeneration were often the result of such events (Celant & Abramović, 2001; Goldberg, 1995; Kontova, 1978). Research into Eastern philosophies, with an emphasis on rituals and ceremonies designed to produce heightened states of awareness in participants, greatly informed her practice, which bore a striking similarity to the practices of shamans (Goldberg, 1995; Phelan, 2004; Weintraub, 1996). Ultimately, Abramović viewed art as a form of medicine, with the capacity to profoundly affect and heal the psyche (Celant & Abramović, 2001).

The relationship between artist and audience, especially in terms of audience presence and participation, was essential for Abramović's practice. Indeed, she acknowledged that without the energy generated and exchanged with the audience, she would never have been able to meet the challenges she set for herself in her performances, nor to go beyond her limits as she strove (Denegri, 1998; Kaye, 1996). Abramović did not offer any answers to her viewers, preferring to leave them within the unbalanced and unfamiliar space, akin to a void or state of shock, that her performances typically induced (Kontova, 1978). She wished audiences to come to their own conclusions, based on their own experiences, herself taking the role of guide or companion leading them towards new depths of self-discovery (Denegri, 1998). Engaging all the senses promoted communication with her audience on multiple, non-

rational levels (Denegri, 1998). Like in Pane's performances, Abramović always filmed her audience's reactions (Kontova, 1978).

### 3.3.3. Viennese Actionists

Viennese Actionism, a movement that took place in the late 1960s, consisted of the following four Austrian artists: Gunter Brus (1938 -), Otto Muhl (1925 -), Hermann Nitsch (1938 -), and Rudolf Schwarkogler (1940 – 1969) (McEvelley, 1983; Ursprung, 1999). The work of this group of artists, who did not work explicitly in collaboration with each other, centered upon themes of self-mutilation and sacrifice (McEvelley, 1983), and made frequent use of blood, excrement, food, and dead animals in a ritualistic manner (Ursprung, 1999). These provocative, taboo-breaking works typically had a therapeutic intent. Performances by Brus involving the combination of female imitation, self-mutilation, and the performance of taboo acts such as urinating, defecating, eating his own excrement, and vomiting in public, find close parallels in shamanic rituals and activities designed to draw illness and disorder away from the community (McEvelley, 1983). A series of performances by Nitsch, begun in the early 1960s and grouped together to form what became known as the Orgies Mystery Theatre (OMT), explicitly had purification and redemption as its goal (Goldberg, 1979; McEvelley, 1983). The OMT recreated in part the *sparagmos*, an ancient Dionysian ritual of dismemberment. This ritual consisted of initiates relinquishing their individual identities in an ecstatic drug, alcohol, and dance induced state, tearing open and eating raw a goat representing the god Dionysus, incorporating his power, and reemerging divine. Nitsch's performances consisted of performers ripping apart and disemboweling a lamb or bull,

pouring the entrails upon one another and covering the performance space with the animal's blood (McEvelley, 1983). These events were designed to release man's repressed aggressive instincts, culminating in a state of catharsis for performers and audience members alike (Goldberg, 1979; McEvelley, 1983). The concept of art as a cathartic tool was inspired by the psychoanalytic writings of Sigmund Freud and Wilhelm Reich (Goldberg, 1979), as was most of the rhetoric used by the Viennese Actionists (Ursprung, 1999). The fact that Brus, Muhl, and Nitsch all held a professional background in psychology and psychotherapy was no doubt influential in their use of art as a therapeutic tool to explore the forbidden, the unconscious, and the repressed (Ursprung, 1999).

The work of the Viennese Actionists was also in many ways a response to the traumatic influences and repressive social circumstances that shaped their lives and the lives of their audiences. In addition to the many personal traumas suffered by the artists (Ursprung, 1999), the larger-scale trauma of the Second World War was highly influential, particularly the mutilation and slaughter of the human body in the battles, death camps and medical experiments (Warr, 2000), and the trauma that "Austrofascism" posed for Austria's national identity (Ursprung, 1999). It may well have been these traumas that incited these artists to develop their vision of the cathartic role and social responsibility of the artist. The social motivation of these artists was strong, and the state was targeted as the primary audience for their confrontational performances (Ursprung, 1999). While the state, including the judicial system and the popular press, reacted hysterically to these performances, resulting in numerous arrests, the larger student audience reacted with amusement. Student activists, however, did not appreciate the work

of the Viennese Actionists as it subverted the distinction between victim and aggressor, rendering it, in their view, politically compromised (Ursprung, 1999).

#### **3.3.4. Ron Athey and Bob Flanagan**

Ron Athey and Bob Flanagan are two American performance artists who did not work in collaboration, yet whose autobiographically based work explored the use of self-inflicted violence as a means of dealing with painful internal states and difficult life circumstances. These artists used highly ritualized forms of pain and suffering to exorcise the internal and uncontrollable suffering wrought upon their bodies by AIDS and cystic fibrosis, their respective illnesses (Jones, 2000). Sadomasochism featured prominently in both their personal lives and their performance practice (Athey, 1997; Athey, 2004; Cash, 1995; Jones, 2000; Kauffman, 1998; O'Dell, 1998).

Athey (1961 -), raised in a dysfunctional fundamentalist Pentecostal family, recalled his first experience of self-mutilation as a child when, longing for the gift of stigmata, he sliced his own hands with a razor blade. Adolescence was very turbulent for Athey, who, leaving his faith, entered a period of rebellious acting out, heroin addiction, self-mutilation, depression, dissociation, and a series of suicide attempts (Cash, 1995). The ritualized practices of body piercing, tattooing, sadomasochism, and fetishism were later embraced by Athey, which he viewed as his salvation (Athey, 1997; Athey, 2004). His work as a performance artist is typically very bloody and incorporates these types of ritual practices with religious themes and imagery. In performances such as *4 Scenes from a Harsh Life* (1993 - 1995), he pierced his arm with hypodermic syringes from the wrist to the shoulder, repeatedly and violently stabbed his scalp with a 6-inch needle, and

pierced his body and that of other performers with fish hooks, from which hung limes and bells. These eventually tore and fell off in the course of frenzied dancing, accompanied by drumming and cathartic shouting (Cash, 1995). This work used fetishism as a backdrop to explore the human need for rhythm in the form of rituals and rites of passage, emphasizing the healing aspect of these dark practices (Athey, 1997). In performances such as *Martyrs and saints* (1992 - 1993), Athey explored the grandiosity of the martyr complex he suffered from as an AIDS victim by piercing his head with 24 needles, forming a metal crown of thorns (Athey, 1997). The transformation of the public's perception of self-destructive behavior from the idiosyncratic and senseless to the ceremonial and therapeutic was one of his primary concerns (Athey, 2004). However, when presenting a young cutter in the process of a session of self-mutilation in one of his performances, Athey acknowledged that, "The reality is that this mutilation is not art or performance, but a recorded mental illness, edited into the script" (Athey, 2004, p. 87).

Flanagan (1952 – 1996), born with cystic fibrosis, a painful hereditary disease that affects the respiratory and digestive systems, died from his illness at the age of 43, outliving most afflicted individuals (Kauffman, 1998; O'Dell, 1998). He began using masochistic activities in childhood to distract him from his condition, and in accordance with his slogan, "Fight sickness with sickness," he credited his unusual longevity to them (Kauffman, 1998, p. 33). Most of his masochistic practice stemmed from the desire to externalize his almost constant inner pain and thereby obtain a degree of control over it (Jones as cited in O'Dell, 1998). He met his life partner, dominatrix Sheree Rose, in 1980, at which point they began performing sadomasochistic scenes at alternative art spaces, examples of which included sewing his penis inside his scrotum and, on another

occasion, nailing it to a board (O'Dell, 1998). His artistic practice, much like his life, was based upon the merging of cystic fibrosis and sadomasochism, using the latter as a therapeutic agent upon the former. His unusual and often humorous means of battling the effects of his illness earned him the title among some, "shaman for the twenty-first century" (Kauffman, 1998, p. 33).

The performance of extreme sadomasochistic acts has intense visceral effects upon the audience. The performance of Athey's *4 Scenes in a Harsh Life* has been described by one art critic as, "gut-wrenching," "emotionally compelling," "exhilarating," "exhausting," and "oddly inspirational," as the endorphins released by the performers were vicariously felt by the audience (Cash, 1995, p. 99). In one especially bloody performance at an American nightclub, so many audience members fainted that they had to be laid out in the rain outside the club by security (Athey, 1997). However, the authentic desire to communicate rather than simply shock and repel an audience is demonstrated in Flanagan's *Visiting Hours* (1992, 1994). In this work, viewers could go into a simulated hospital room in the center of the performance space amidst television monitors depicting parts of Flanagan's body in masochistically induced pain, and enter into a live dialogue with the artist himself (O'Dell, 1998). Ultimately, the work of both of these artists goes beyond the subculture from which it stems to, "raise critical issues about freedom, pleasure, pain, suffering, disease and surviving" (Cash, 1995, p. 100).

### 3.3.5. Orlan

Orlan (1947 -) is a French performance artist who uses her body as a medium for self-transformation. She received international notoriety for *The Reincarnation of Saint Orlan* (1990–1993), a series of nine operations recorded in an “operating theatre” and broadcast live around the world via satellite, in which she underwent plastic surgery in order to challenge prevailing Western concepts of beauty and identity (Lovelace, 1995; Rose, 1993; Weintraub, 1996). Electing to remain fully conscious during these operations, yet denouncing any claims of purification or redemption in the experience of pain, Orlan numbed herself with the aid of epidural blocks, running the risk of paralysis in addition to death and disfigurement (Ayers, 2000; Jones, 1998; Rose, 1993; Weintraub, 1996). While her work does not conform to the definition of self-mutilation presented in this paper, it is nonetheless relevant inasmuch as it involves self-directed damage to body tissue and the cutting of the skin for idiosyncratic, socially unacceptable reasons. Orlan’s use of plastic surgery is atypical in that her goal is not a youthful, more attractive appearance in accordance with conventional Western beauty standards, but an inquiry into technologically based possibilities for transformation and the relationship between identity and the body (Rose, 1993; Weintraub, 1996). Orlan is as interested in the process of plastic surgery as the final product, exhibiting not only the surgery itself in graphic detail, but visually documenting the healing process, two aspects normally hidden by patients from public view (Lovelace, 1995; Weintraub, 1996). Her mental status has frequently been called into question, to the point that it was the focus of an entire issue of VST (September – December 1991), a French psychoanalytic journal, which came to the conclusion that she was sane (Rose, 1993; Weintraub, 1996).

Orlan received her inspiration for *The Reincarnation of Saint Orlan* when undergoing an operation for an extra-uterine pregnancy under local anesthetic, which afforded her the dissociated and painless experience of observing her own body being operated upon as if it were an object (Rose, 1993). The dissociated interplay of subject and object, in which the self assumes both roles and treats itself as Other, serves to fragment not only the assumption of a unified identity but its location within and relation to bodily experience. This fragmentation is central to the execution and meaning of Orlan's work (Ayers, 2000; Clarke, 2000; Jones, 1998; Lovelace, 1995; Rose, 1993; Weintraub, 1996). Orlan identified with Artaud's concept of an imaginary body without organs, transcendent and invulnerable (Clarke, 2000), taking pride in the fact that she could remain "serene and happy and distant" while her body suffered repeated surgical interventions (Ayers, 2000, p.). Orlan took the role of director, choreographer, set designer, scriptwriter, and star in her performances, these being highly theatrical affairs replete with elaborate sets, props, costumes, music, poetry, and dance that aimed to blur the boundaries between art and life (Lovelace, 1995; Rose, 1993; Weintraub, 1996). Orlan's work also played with the taboos, transgressions, and rituals associated with the opening of the body, including notions of transcending the body through its sacrifice. Her work contained an abundance of references to Catholicism, against which it rebelled (Clarke, 2000; Lovelace, 1995; Rose, 1993; Weintraub, 1996).

The desire to make a strong visceral impact upon the audience was also inspired by Artaud, and played an important role in Orlan's practice (Lovelace, 1995; O'Bryan, 2005). Images of her face being cut open, the skin lifted and her flesh removed invariably generated high levels of alienation, revulsion, horror, distress, and, in some cases, morbid



fascination among her viewers, in addition to a renewed sense of their own embodiment (Jones, 1998; Lovelace, 1995; O'Bryan, 2005; Rose, 1993; Weintraub, 1996). While Orlan made sure that she did not suffer during the course of her performances, the suffering of her audience was something she apologized for, but did not try to prevent (Jones, 1998; O'Bryan, 2005; Weintraub, 1996). Viewing her own work as a radical social project, Orlan's desire to interact with her audience was sincere, embracing technologically advanced media to this end. Communication with the audience in the midst of surgical proceedings was achieved through interactive networks linking the operating room with receptive sites around the world. Audience members, viewing the operation live via satellite, were able to converse with Orlan with the aid of fax machines and videophones (Weintraub, 1996).

#### **3.4. Parallels and differences between performance artists and pathological self-mutilating individuals**

An investigation into the characteristics and motivations of performance artists using acts of self-mutilation in their work has yielded a number of parallels with those of pathological self-mutilating individuals. First, it can be observed that an element of dissociation, or a psyche-soma split enabling the self to treat the body as an object, simultaneously occupying the roles of aggressor and victim, is present in both populations. Second, it can be noted that self-mutilation is used by both populations for the attainment of similar outcomes, such as catharsis or affective discharge, and the transformation of consciousness and internal states. Third, the need for ritual in both populations can be perceived, especially the ritual use of self-mutilation in an attempt at

purification and healing from illness, disorder, and trauma, whether political, social, familial, physical, mental, or emotional. Finally, parallels can be drawn in terms of the shocking and disturbing effects upon those who bear witness to acts of self-mutilation and/ or the resulting wounds, regardless of the context in which they occur or the intentions with which they are performed.

However, some significant differences also exist between these two populations. The first and most obvious difference is that performance artists mutilate themselves in public whereas pathological self-mutilation is usually a private act. The second difference is that, in spite of the repelling effects of their actions, performance artists consistently demonstrate an authentic desire to communicate and interact with their audiences whereas self-mutilating individuals tend to keep themselves interpersonally isolated, despite intense and often ambivalent wishes for connection. Third, performance artists are highly concerned with affecting group dynamics whereas self-mutilating individuals are typically more focused on producing intra-psychic changes. Last, the actions of performance artists are premeditated whereas the actions of self-mutilating individuals are most often impulsive. As a rule, performance artists have spent a great deal of time contemplating their intentions and carefully considering the meanings of their actions, which they then articulate to the public in artist statements and interviews. Self-mutilating individuals, on the other hand, are generally hard pressed to discuss their behavior, often lacking the capacity to reflect on, make sense of, and express complex internal states using the abstract, symbolic realm of language.

### 3.5. Summary

Acts of self-mutilation within the context of contemporary Western performance art have been motivated by several key factors. These include: foregrounding the body of both artist and audience in an effort to emphasize the inter-subjectivity of all artistic production and reception; questioning the rooting of identity within the body's parameters and experience; using the artist's body as a metaphor for the social body in order to critique social and political issues; enlisting the body in an exploration of physical and mental limits in the quest for self-transcendence and the transformation of consciousness; using ancient rites and rituals to promote catharsis and healing; working with painful psychological material, including emotional wounds and traumatic life influences; provoking strong visceral responses from the audience; and confronting audience members with their role as complicit witnesses to these performances. An examination of the work of Gina Pane, Marina Abramović, the Viennese Actionists, Ron Athey, Bob Flanagan, and Orlan, a selection of contemporary performance artists repeatedly using acts of self-mutilation in their work, has been instrumental in the illustration and elucidation of these themes. Significant parallels and divergences in the use of self-mutilation by these artists and by pathological self-mutilating individuals have been presented. It appears that a psyche-soma split with sadomasochistic overtones, the transformation of internal states, and the use of ritual as a reaction to disorder are common to both. The primary differences between the two lie within the interpersonal sphere. Performance artists, unlike self-mutilating individuals, require witnesses, aspire to affect group dynamics, and are motivated and capable of reflecting upon and articulating the intentions and meanings associated with their actions. Nevertheless, in

both cases, typical reactions from others include shock, disgust, abhorrence, and fear, posing problems for the validation of these controversial artists and for the psychotherapeutic treatment of self-mutilating individuals.

## **Chapter 4: Treatment implications**

### **4.1. Overview**

This chapter will address critical issues in the treatment of pathological self-mutilation, synthesizing the information presented in the last three chapters. It will examine the way in which the art making process may aid in overcoming the notorious obstacle of therapist counter-transference towards self-mutilating clients, and facilitate the transformation of unconsciously driven acting out behavior. The relationship between the artist and audience in performances involving acts of self-mutilation will be compared to and contrasted with the relationship between the self-mutilating client and therapist. Transference and counter-transference reactions to the artwork produced in therapy, and the way in which artwork may operate as a mediating factor within the therapeutic relationship will also be explored. The relationship between self-mutilation and ritual will inform a discussion on the parallels between ritual space, contained within established cultural boundaries, and transitional space, contained within the therapeutic frame, and how both offer conditions favorable for transformation.

### **4.2. Counter-transference**

#### **4.2.1. Audience and therapist reactions**

As was seen in the previous chapter, acts of self-mutilation within the context of performance art are difficult for audience members to endure or appreciate. Typical reactions include hostility, repulsion, outrage, and fear. The mental health of performance

artists engaging in self-mutilation has often been called into question and their work has been resisted and dismissed as pathological. Audiences have found it difficult to empathize with these artists or understand their intentions, criticizing their work as containing little more than aggression and shock value. These reactions parallel the reactions of those who come into contact with acts of pathological self-mutilation, including professionals in the field of mental health. A description of the counter-transference reactions of therapists working with self-mutilating individuals has dominated the psychiatric literature on this subject, and poses one of the greatest challenges to successful treatment (Favazza, 1998). On numerous occasions, the presence of self-mutilation in psychiatric inpatient settings has negatively affected staff morale and led to staff arguments, contributing to disrupted and inconsistent treatment (Walsh & Rosen, 1988; Zila & Kiselica, 2001). Just as audience members have viewed these acts within the context of performance art as incomprehensible, mental health practitioners have traditionally interpreted acts of pathological self-mutilation as senseless, impairing their ability to respond with empathy (Farber, 2000; Favazza, 1987; Favazza, 1998; Milia, 2000). Typical reactions among mental health professionals and other caregivers include a combination of fear, repulsion, shock, frustration, bewilderment, helplessness, guilt, anger, sadness, disgust, betrayal, fascination, and awe (Favazza, 1998; Walsh & Rosen, 1988; Zila & Kiselica, 2001). In some cases, the shock expressed by others may reinforce acts of self-mutilation in individuals who wish to be perceived as notorious or frightening (Walsh & Rosen, 1988). This type of interpersonal reinforcement is usually more pronounced in institutionalized settings such as hospital inpatient units (Suyemoto, 1998; Walsh & Rosen, 1988), and prisons (Hewitt, 1997). In these cases, as in the work

of Marina Abramović and the Viennese Actionists, self-mutilation may be used as a form of resistance against a restrictive environment, and as a means of challenging authority figures or doctrines.

Gina Pane used self-mutilation in her work to shock viewers out of their complacency in order to direct their attention to troubling issues, a motivation shared by most of the performance artists discussed in the previous chapter. This is paralleled by the motivation of certain individuals who display their acts of self-mutilation in an attempt to communicate their distress and receive an empathic response or care (Hewitt, 1997; Scott, 1999). However, just as empathy may be a difficult feat for audience members presented with disturbing and violent acts against their will, individuals who display their self-inflicted wounds to others may find it difficult to obtain the caring response they overtly or covertly desire. In many cases, the disgust, lack of sympathy, and hostile care received from doctors and nurses in hospital emergency rooms may intensify feelings of worthlessness and shame, contributing to further acts of self-mutilation (Harris, 2000). Therapists have reported the tendency to attribute hostile and manipulative intent to acts of self-mutilation, often at the expense of exploring the intrapsychic motivations and experience of their clients (Suyemoto & MacDonald, 1995). Even after years of therapy, the majority of self-mutilators in one study reported that no one had ever listened to their detailed descriptions of acts of self-mutilation without judgment (Scott, 1999).

#### **4.2.2. Sadomasochism and complicity**

Acts of self-mutilation highlight an internal sadomasochistic dynamic in which the self-mutilating individual simultaneously occupies the roles of both aggressor and victim. While audience members witnessing acts of self-mutilation within the context of performance art may vicariously experience their own capacity to occupy either role, therapists may also, within the context of a treatment relationship, find themselves constantly alternating between these roles with their self-mutilating clients (Cross, 1993; Farber, 2000; Frankel, 2001; Herman, 1992; Milia, 2000; Woods as cited in Suyemoto, 1998). Just as performance artists may use self-mutilation to critique social ills or draw attention to social dysfunction, so may acts of pathological self-mutilation reflect an abusive environment, past or present, the internalized dynamics of which will often be played out within the therapeutic relationship. Acts of self-mutilation within the context of performance art raise ethical issues about the audience's complicity as witnesses to these actions. Acts of self-mutilation within the therapeutic relationship also raise ethical issues about therapist complicity and the limits of confidentiality, especially in cases of adolescent treatment (Frankel, 2001). The internal sadomasochistic or abusive dynamic played out interpersonally within the transference of the therapeutic relationship, and the ethical challenges of remaining complicit to self-harming acts are two issues that serve to heighten the already strong counter-transference reactions usually evoked in the treatment of self-mutilating individuals.



### 4.2.3. Therapeutic distance

Maintaining the degree of therapeutic distance necessary to protect oneself against counter-transference reactions may be quite difficult in the face of the intensity of the emotional experience of most self-mutilating individuals (Suyemoto, 1998). This is paralleled by the difficulty in maintaining a state of disinterestedness or neutrality when viewing performances involving acts of self-mutilation, the intention of which is often to physically and emotionally overwhelm and disturb the audience. Gina Pane desired to transcend the alienation between artist and audience by provoking her viewers on a visceral level. Marina Abramović wished to create a total engagement with her audience from which escape would not be possible. Both artists used self-mutilation, among other dangerous acts, towards this end, frightening and alienating many of their viewers in the process. The paradox between the longing for connection and the repelling effects of their actions is common to both performance artists and individuals engaging in self-mutilation.

Self-mutilating individuals are often characterized as lacking secure early attachments, resulting in the failure to develop a cohesive sense of self, capable of regulating and withstanding affective experiences. They may be arrested at the separation-individuation phase of infancy, the task of which is to separate from the mother while retaining a sense of connection to her, a theme, according to O'Dell (1998), explored by several of the performance artists under discussion. This stage cannot be resolved without a secure attachment to separate from, and is revisited in adolescence due to emerging needs for autonomy and independence. It has been suggested that therapeutic distance may actually impede the effectiveness of treatment with self-mutilating

individuals, as a reparative object experience involving a state of merger with the therapist prior to separation, individuation, and the mastery of symbolic communication may be required (Suyemoto, 1998). Rather than take a neutral, interpretive stance with clients exhibiting difficulties stemming from the pre-oedipal period, therapists are recommended to respond with the nurturing attention, emotional attunement, and empathic mirroring that could prove reparative for these early developmental deficits (Lachman-Chapin, 1979; Lachman-Chapin, 2001; Robbins, 2001). Yet many therapists resist forming the intense attachments required for the treatment of self-mutilation and have difficulty truly empathizing with their clients (Farber, 2000). The force of the client's emotions and desire to enter a symbiotic state with the therapist may provoke anxiety in the therapist about being overwhelmed and getting lost within such a merger (Suyemoto & MacDonald, 1995). Acts of self-mutilation may also force witnesses to confront their own destructive impulses and potential for violence, dark and primitive forces that they would prefer to keep unconscious. Empathy for self-mutilating individuals may be impaired by the unconscious need to defend against these threats (Farber, 2000; Favazza, 1998; Milia, 2000).

It has been asserted that the ability to move beyond one's initial resistance and tolerate the witnessing of pain and self-directed aggression is paramount if the audience is to gain an understanding of what the performance artists under discussion are trying to communicate (Vergine, 1974). The authentic presence, complicity, and creative engagement of the audience is required if this controversial work is to be understood and validation is to be received (Blessing, 2002; Goldberg, 1995; Kaye, 1996; Vergine, 1974). It is through the recognition and validation provided by the audience that a

performance reaches completion and the artist's identity is confirmed (Vergine, 1974). Likewise, self-mutilating individuals may require the authentic presence, complicity, and creative engagement of a therapist if their pain is to be understood and their fragmented sense of self consolidated. Through the witnessing of the client's pain, through the recognition and validation of what may have been previously dissociated and denied, intolerable feelings of isolation may be relieved. This in turn may enable clients to face their painful feelings, experiencing these as simultaneously more real and more tolerable (Frankel, 2001).

#### **4.2.4. The role of artwork within the transference-counter-transference relationship**

Intense and turbulent transference reactions often characterize the treatment of self-mutilating individuals (Farber, 2000). Issues of power and control within the therapeutic relationship may be particularly problematic, and therapists may find themselves alternately being cast into the role of either persecutor or victim. The enactment of these roles, indicative of the abusive dynamics often unconsciously perpetuated by many traumatized individuals, is usually unavoidable and may even be a necessary part of therapy as it allows the therapist to become familiar with these aspects of their client's world (Frankel, 2001; Milia, 2000). The use of art within the therapeutic relationship may bring about more flexibility in these roles, allowing both client and therapist to take a more objective stance while the drama is played out through the art images and processes (Milia, 2000). Artwork may act as a mediating object between client and therapist, at certain times expressing transference reactions to the therapist, while at other times evoking transference reactions itself (Milia, 2000; Rubin as cited in

Agell, et al., 1981; Schaverien, 1992). Aggressive and destructive impulses or modes of relating may be expressed and contained through the artwork, rather than through the transference, allowing client and therapist to connect on the level of violence while preserving their relationship of respect. This may enable the therapist to take the role of witness or companion, maintaining an appropriate boundary while fully recognizing and validating the client's pain and struggle (Cohen & Mills, 1999; Milia, 2000; Schaverien, 1992).

Just as artworks may serve as objects of transference, they may evoke counter-transference reactions in viewers. Artworks viewed within the neutral context of an art gallery will evoke personal responses from the audience, which may be understood as counter-transference reactions. Artworks created and viewed within the specific context of a therapeutic relationship, intimate and laden with personal history, will not only evoke responses similar to those experienced in a gallery, but others more particular to the issues brought into therapy and the relationship between the therapist and the client (Schaverien, 1992). Violent imagery will usually elicit powerful emotional reactions from viewers, whether in a gallery or a therapeutic context, and may be interpreted as an aggressive act. When presented with violent imagery, particularly in a group setting, the therapist may question whether the intention of the artist-client is to shock, to punish, to ask for help, or to be labeled as notorious (Graham, 1994; Haeseler, 1987). Just as the attention and concern of others, as well as the obtainment of status among peers, may operate as interpersonal reinforcers for acts of self-mutilation, these may also be influential in the choice to present the viewer with imagery of a violent nature. While images and acts of mutilation in the therapeutic artwork of self-mutilating clients is a

common phenomenon (Cohen & Mills, 1999; Haeseler, 1987; Milia, 1996; Milia, 2000; Schaverien, 1992), it has to be mentioned that this type of imagery is in no way limited to self-mutilating individuals, nor is it a feature of the therapeutic art of every self-mutilating individual.

Violence done to the artwork or to the art materials may be painful for the viewer to tolerate. The therapist may, in the counter-transference, identify with the artwork and feel disempowered or victimized; urges to intervene, offer assistance, and otherwise “rescue” the artwork from its fate may, in these cases, be difficult to resist (Milia, 2000). Counter-transference reactions to violent images may be especially strong when the therapist is included within them (Schaverien, 1992). The ability of the therapist to accept and tolerate the witnessing of destructive images and processes is necessary when working with self-mutilating individuals producing this type of work (Milia, 2000; Schaverien, 1992). It is through the capacity of the therapist to survive the witnessing of destructive images and processes within a good-enough holding environment that separation and individuation, the tasks most often facing self-mutilating individuals, may begin to occur (Schaverien, 1992). While art therapists may be especially sensitive to the powerful, nonverbal, primitive communications from clients exhibiting deficits in their preverbal developmental (Robbins as cited in Agell et al., 1981), they may use their own artwork as a tool to uncover and better understand their counter-transference reactions (Rubin as cited in Agell et al., 1981). The way in which counter-transference reactions are dealt with may profoundly influence whether the treatment of self-mutilating individuals is to progress or whether it is to be destroyed by further acting out (Farber, 2000).

### **4.3. Ritual and transformation**

#### **4.3.1. Self-mutilation, performance art, and ritual**

The relationship between self-mutilation and ritual has been well established by anthropological research (Cross, 1993; Farber, 2000; Favazza, 1987; Favazza, 1998; Hewitt, 1997; McEvelley, 1983; Milia, 2000; Frazer as cited in Schaverien, 1992). According to Favazza (1987), culturally sanctioned forms of self-mutilation are universal, serving, “to correct or prevent a pathological, destabilizing condition that threatens the community, the individual, or both” (p. 191). Acts of pathological self-mutilation do not fall into the category of the culturally sanctioned ritual but are often compulsively ritualized and may serve a similar function (Cross, 1993; Favazza, 1987; Hewitt, 1997; Milia, 2000). Bloodletting, for example, an ancient and prevalent technique used for spiritual purification and the healing of physical and mental illness, was believed to purge the individual of the demon or toxic entity residing within the body and causing his or her suffering (Ackerknecht as cited in Cross, 1993; Farber, 2000; Favazza, 1987; Frazer as cited in Cross, 1993). In a similar vein, contemporary individuals turning to self-mutilation in order to regulate pathological levels of negative affect may be instinctually attempting to rid themselves of poisonous emotions, memories, or parts of the self through the spilling of their own blood (Farber, 2000; Favazza, 1987; Harris, 2000; Hewitt, 1997; Milia, 2000; Schaverien, 1992). The majority of cultural traditions involving the practice of mutilation, self-inflicted or otherwise, are adolescent initiation rituals and rites of passage, ceremonially marking the transition from child to adult (Favazza, 1987; Hewitt, 1997). This corresponds with the fact that contemporary acts of

self-mutilation often begin in, and in some cases are limited to, the period of adolescence. This suggests for some authors that certain adolescents may be unconsciously trying to master the developmental tasks of this stage in a time honored way, yet lacking community structure and validation for their efforts (Favazza, 1987; Hewitt, 1997). According to Dosamantes-Beaudry (1998), “As faith in science, rationalism and individualism became central to the worldviews of western urban industrialized societies during the nineteenth century, communally-practiced rituals gradually lost their connection to the sacred and became interiorized and individualized” (p. 83). These rituals and rites of passage, once consciously performed and communally recognized, continue to be enacted unconsciously or semi-consciously, yet remain unresolved and divorced from meaning (Meade as cited in Dosamantes-Beaudry, 1998). Lacking “a ritual surrounding that offers caring emotional containment, guidance and meaning” (Dosamantes-Beaudry, 1998), resolution of these unconsciously performed half-rituals cannot be achieved.

Differentiating culturally sanctioned rituals involving self-mutilation and ritualized acts of pathological self-mutilation is the degree of conscious meaning with which, and the cultural context within which, the act is performed (Favazza, 1987; Hewitt, 1997; Milia, 2000; Schaverien, 1992). Culturally sanctioned rituals are performed with conscious intentions towards transformation, healing, and/ or the preservation of social harmony, whereas pathological acts of self-mutilation are typically driven by unconscious impulses. Culturally sanctioned rituals are socially accepted and involve the presence of witnesses or the participation of the community, whereas pathological acts of self-mutilation are socially unaccepted and usually performed in solitude, the wounds and

scars hidden in shame. Culturally sanctioned rituals follow a prescribed order and are performed within an established space, designated and recognized by the community as sacred, whereas pathological acts of self-mutilation are idiosyncratic and lack an established context.

Performance artists using acts of self-mutilation in their work have often made reference to ancient, non-Western, religious customs and rituals, especially those belonging to shamanic traditions around the world. Performance artists have consciously attempted to employ self-mutilation for purposes of healing, transcendence, and transformation, as shamans, religious devotees, and initiates have done. Yet the use of self-mutilation in performance art, which occupies a subversive position between established and radical discourse from which vantage point it may critique social norms and address social conflict, does not itself constitute a culturally sanctioned ritual (Hewitt, 1997). Acts of self-mutilation in performance art are usually performed with conscious intent, in the presence of witnesses, and in an established space. However, this space has not been designated or recognized as sacred by the audience, who typically does not share or even understand the intentions of the artist. Performance artists may, in some cases, be appropriating the ritual use of self-mutilation in order to critique the desecration of art and the lack of sacred space within contemporary society. Nevertheless, the fact that they are lacking a ritual surrounding remains problematic. The rituals that have inspired their actions are foreign to the culture within which they are performed and therefore not socially accepted. This may explain why audience members so often respond with hostility, repulsion, fear, and incomprehension in the face of such performances.



Culturally sanctioned rituals occur within a sacred space and time delineated by established boundaries, rules, and expectations. Art therapy and performance art, while differing from culturally sanctioned rituals, are nonetheless both performed within a particular context, in the presence of at least one witness, and with specific intentions aimed at transforming consciousness through the deconstruction of established thought patterns and modes of relating (Whitaker, 2005). Art in the context of therapy, as in the context of performance, may be enacted as a rite of passage or as, “a kind of focused ritual to explore new territory, that which is stored unconsciously in both body and mind” (Whitaker, 2005, p. 32). Yet artwork created within the therapeutic alliance differs from artwork created in the world in that it takes place within an empowered relationship and in a safe, predictable environment, specifically set apart for self-reflection and exploration (Schaverien, 1992). The therapeutic alliance, providing boundaries and support, as well as emotional containment, guidance, and meaning, may come to be experienced as a type of sacred space or ritual surrounding promoting self-transformation and healing (Dosamantes-Beaudry, 1998; Milia, 2000). Within this space, the holding, recognition, and validation provided by the therapist may help the individual overcome feelings of helplessness and isolation associated with self-mutilation and begin to address the deeper issues contributing to this behavior.

#### **4.3.2. Liminal space and transitional space**

Ritual transformations of status, state, or identity typically involve three stages (Cole, 1990; Dosamantes-Beaudry, 1998; Hewitt, 1997). The first stage is characterized by a separation from the previous state or identity. The second stage involves entry into

“liminal” space, a transitory and regressive space in which all structures and identities are dissolved. The third stage entails the resolution of the second stage, reintegrating the initiate into society as a transformed being. It has been proposed that unresolved, unconsciously enacted rituals such as self-mutilation remain blocked at the liminal, regressive stage of the ritual process, a stage expressed primarily through non-verbal means such as actions and images (Dosamantes-Beaudry, 1998). The liminal space of ritual change and initiation has been compared to Winnicott’s (1971/ 2002) concept of transitional space, the “as-if” space between internal and external reality, the imaginal realm of childhood play from which all culture and religion derives (Cole, 1990; Lewis, 1998). It has been proposed that akin to entering liminal space in the presence of the shaman or ritual leader, it is through entering the transitional symbolic realm and playing there in the presence of the therapist that healing and transformation may occur in psychotherapy (Cole, 1990; Dosamantes-Beaudry, 1998; Lewis, 1998). The therapist must therefore, in addition to providing a holding environment capable of containing and withstanding all of the client’s destructive impulses and emotions, allow an empty space of “not-knowing” to exist, from which the liminal space conducive to transformation may form (Cole, 1990).

The use of liminal space for transformation and healing is contingent on the existence of a cohesive, individuated sense of self, one that has successfully separated from a symbiotic state with the mother (Cole, 1990). The development of the ability to use transitional space within a secure therapeutic alliance to promote separation-individuation may therefore be an important goal when working with self-mutilating clients. Lacking secure early attachments, self-mutilating individuals may be arrested at

the separation-individuation phase of infancy, using the implements and wounds associated with self-mutilation as transitional objects yet failing to develop the symbolization and self-soothing capacities that would lead to the resolution of this crisis and to the development of a cohesive sense of self. As discussed in chapter 2, the self-mutilating individual has been compared to a child that cannot play. According to Winnicott (1971/ 2002), overcoming the blocks preventing an individual from playing is the first step in conducting successful psychotherapy, as this occurs through shared playing between client and therapist. The ability to play is dependent upon trust in the environment based on the experience of having one's needs met in a reliable manner. A child having grown up in conditions of chronic abuse, neglect, or illness may not have had the opportunity to develop trust in the environment. Rather than responding to the environment creatively, such a child may have learned to respond to the environment with compliance in order to survive. The therapeutic environment, through its reliable and predictable frame, may come to be experienced as a safe and trusted space in which defenses may be relaxed enough to enter the formless, unintegrated state which is at the basis of playing and creativity. The creative spontaneous self, if reflected back by the therapist, may then become integrated into the personality of the client. Eventually, the creative process, facilitating the ability to symbolize and self-soothe, may come to replace self-mutilation as transitional phenomena of choice, affording the self-mutilating individual an opportunity to move beyond the need for ritualized aggression, as evidenced in the case studies presented by a number of art therapists working with self-mutilating clients (Cooper & Milton, 2003; Estep, 1995; Kupferman, 1996; Milia, 1996; Milia, 2000; Schaverien, 1992; Scott, 1996).

### 4.3.3. Scapegoat transference

The scapegoat transference within the context of art therapy is a means by which self-mutilating individuals may become conscious of and eventually own the impulses driving their acts of self-mutilation, offering the potential for choosing alternative solutions. The scapegoat ritual is a universally practiced method of ridding an individual or a community of illness and disorder. It is based on the assumption that “attributes and states”, such as ill affect and disease, may be separated from their original source through the process of splitting, and transferred onto an object. The subsequent disposal of this object serves to purify the individual or community (Schaverien, 1992; Schaverien, 1999). Scapegoat rituals exist in a variety of forms including animal and human sacrifice, self-mutilation, and simple procedures using inanimate objects (Schaverien, 1999). It has been observed that some contemporary Western individuals engage in self-mutilation to absolve themselves of the bad and impure elements, often the result of abusive experiences, which they feel reside within them (Harris, 2000; Milia, 2000). The projection of symbols (Harris, 2000), or the transference of attributes and states, may serve an important role in the tension reduction experienced by some self-mutilating individuals. Unconsciously split off attributes and states may also be transferred onto the art objects created in the context of therapy. Relief may be obtained through the externalization of painful or unacceptable affect and shadow material, the acknowledgement of this material by the therapist, and ultimately its disposal, which usually consists of putting the artwork out of sight to be safely kept by the therapist until future reference (Schaverien, 1992). Processes of splitting and disposal, when performed unconsciously and defensively, may be destructive and detrimental to others. However,

conscious awareness, acknowledgement, and eventual integration of the split off elements into the personality of the client characterize the successful resolution of the scapegoat transference within the context of art therapy (Schaverien, 1999). Externalization of primitive, threatening, and incomprehensible inner states onto art objects that will contain, organize, and reflect them back, within a secure therapeutic alliance that can survive the witnessing of violent images and processes, permits previously unconscious material to enter conscious awareness and subsequently be worked through. This process, unlike self-mutilation, encourages lasting transformation.

#### **4.3.4. Acting out versus enactment**

According to Schaverien (1999), acting out differs from an enactment in three respects: it is motivated by unconscious impulses, it occurs outside of the therapeutic frame, and it lacks a symbolic dimension. In this sense, it resembles the unconsciously enacted ritual, unresolved and devoid of meaning. Conversely, an enactment such as the scapegoat transference is performed within the bounds of the therapeutic frame, a culture in which its symbolic meaning can be consciously explored. Through consciousness, emotional containment, and the bestowing of meaning, resolution of unconsciously enacted rituals may take place. Pictures depicting self-mutilation and other violent acts may, in some cases, be understood as a form of acting out. In these cases, no conscious recognition or integration of the unconscious impulses that led to their making is achieved. While making such images might temporarily reduce tension, they are not used in the service of any real transformation (Haeseler, 1987). Rather, like acts of pathological self-mutilation, they involve catharsis through the simple displacement of

aggression, in which no constructive or symbolic activity occurs (Milia, 2000). At other times, pictures depicting acts of self-mutilation may operate as enactments. The state of consciousness and meaning accompanying the act may serve to differentiate acting out from an enactment. In consciously identifying the emotional triggers for acts of self-mutilation, experimentation with alternative solutions can begin. In successfully substituting the act with a representation of the act, the individual is entering an “as-if” mode of thinking, indicating a development in the capacities for symbolization, sublimation, and the use of transitional space (Schaverien, 1992).

#### **4.4. Summary**

Powerful transference and counter-transference reactions may pose serious challenges to the treatment of self-mutilating individuals, who often paradoxically long for connection despite the repelling effects of their actions. The use of artwork within the therapeutic relationship may help mediate between these reactions, allowing the therapist at times to take the role of witness, recognizing and validating the intensity of the client’s experience while maintaining an appropriate boundary. The relationship between self-mutilation and ritual established by anthropological research has led some authors to view contemporary acts of self-mutilation as unconsciously enacted, unresolved half-rituals, lacking in meaning and arrested at the liminal stage of the ritual process, a stage which has been compared to the concept of transitional space. Resolution requires a context of emotional containment, guidance, and meaning, which may be obtained within the therapeutic alliance. Through art making within a secure therapeutic alliance, the creative process may come to replace self-mutilation as a transitional phenomena of

choice, facilitating the development of symbolization and self-soothing capacities, and through the reflections of the therapist, a more cohesive sense of self. Through the transference of shadow material onto the artwork made in therapy, the unconscious impulses triggering acts of self-mutilation may be externalized, brought into conscious awareness, and eventually integrated into the personality, enabling the search for alternative solutions. The development of consciousness within a holding environment promoting self-transformation and the integration of split off material may help the self-mutilating individual enact, rather than act out, the impulses and conflicts that would otherwise trigger episodes of self-mutilation.

## **Conclusion**

### **5.1. Description of research**

This research paper has compared and contrasted literature on self-mutilation in the fields of psychiatry, psychology, and art therapy with art historical literature on contemporary performance artists using self-mutilation in their work. This research has examined the motivations and functions associated with acts of self-mutilation within the context of pathology and the context of performance art. It has also considered the relationship between the actor and the viewer when acts of self-mutilation are publicly displayed. The primary question of this research was: What implications does an examination of the motivations and functions of self-mutilation in the work of contemporary performance artists have for art therapists witnessing acts or images of mutilation in the artwork of clients? The subsidiary research question was: What implications does an examination of the relationship between audiences and performance artists using self-mutilation in their work have for art therapists treating self-mutilating clients? The impetus for this research was derived from the theoretical assumption underpinning much of the psychological and art therapy literature that self-mutilation is associated with deficits in an individual's capacity for symbolization, in addition to the clinical observation that images and acts of mutilation are a common phenomenon in the therapeutic art of self-mutilating individuals. It was also influenced by research in cultural psychiatry comparing and contrasting pathological acts of self-mutilation with those performed within the context of a culturally sanctioned ritual, suggesting that self-mutilation may be placed on a continuum designated by the degree of conscious meaning



accompanying the act, and the cultural context within which it is performed. A theoretical methodology was chosen for this study, as its primary intention was to review divergent discourses on acts of self-mutilation performed within different contexts in the hopes of finding interrelationships between them, thereby contributing to a new perspective on the subject.

## **5.2. Summary of findings**

An examination of the characteristics, motivations, and functions associated with acts of self-mutilation performed by contemporary individuals living in Western society as studied by mental health professionals, and by contemporary Western performance artists as studied by art historians, has yielded a number of similarities and differences between the two groups. Contemporary self-mutilating individuals are characterized in the literature as lacking secure early attachments and exhibiting difficulties stemming from the separation-individuation phase in infancy. They often present clinically with a history of early trauma, such as abuse and neglect, and episodes of dissociation from the body. Self-mutilation is primarily used to regulate and express intolerable levels of negative affect, which they are not otherwise able to contain or transform. It is also used to end episodes of dissociation and unconsciously reenact past traumas. As self-mutilating individuals typically suffer from deficits in the capacity for self-soothing, acts of self-mutilation and associated paraphernalia are often used as transitional objects and frequently take on ritualistic overtones.

According to the literature, a number of contemporary performance artists have also used acts of self-mutilation in their work in order to express, reenact, and liberate

themselves from disturbed attachments, painful moments in their early psychic development, and traumatic events on both a personal and a social level. Like the pathological self-mutilating individual, performance artists have employed self-mutilation as a means of externalizing and regulating intolerable internal states and transforming levels of consciousness. In addition, a degree of dissociation from the body, allowing the artist to treat it as an object or as artistic material, is present in this group. Self-mutilation has also often been used ritualistically in the work of performance artists interested in the mind-body connection and concerned with the reestablishment of sacred time and space within contemporary Western society.

Despite these similarities, performance artists and self-mutilating individuals also display some marked differences. Pathological acts of self-mutilation are typically impulsive, unconsciously driven, and associated with deficits in an individual's capacity for symbolization. They are usually motivated primarily by intra-psychic reasons, performed in isolation, and hidden from others in shame, although when exposed, they have a powerful effect on others. Pathological self-mutilating individuals, however, may not be consciously aware of these effects. On the other hand, acts of self-mutilation within the context of performance art are premeditated public events, consciously and deliberately designed to elicit strong reactions from the audience and provoke social change. Performance artists using self-mutilation in their work possess the capacity and the motivation to deeply contemplate the intentions and the meanings associated with their actions, and articulate these to the public in artist statements and interviews. Such is not the case with pathological self-mutilating individuals.

The relationship between artist and audience is of prime concern for performance artists using self-mutilation in their work. These artists strive to reduce the alienation between artist and audience, aspiring that through the process of physically affecting their viewers, communication, engagement, and identification on a deep level may occur. Performance artists disturb their viewers in order to bring their attention to troubling issues, challenging their audiences to respond with the complicity and the empathy that will validate and bring completion to their work. Yet performances involving acts of self-mutilation are difficult for many viewers to tolerate, much less appreciate, frequently evoking responses of repulsion, horror, hostility, and incomprehension.

Pathological self-mutilating individuals display a similar dynamic of repelling others with their actions while longing intensely for connection. Like performance artists, their acts of self-mutilation serve to indicate troubled internal and external circumstances, and may, in some cases, be believed to be the only way to communicate the extent of their distress to others. Due to their preverbal developmental deficits and insecure attachment styles, therapeutic distance may work against effective therapy with self-mutilating individuals. Rather, a reparative object experience may be required, involving a state of merger and emotional attunement with the therapist, if their separation-individuation issues are to be resolved. Powerful and disturbing counter-transference reactions, however, have been well documented as obstacles to forming the empathic attachments necessary for the treatment of this population.

Two principal themes with treatment implications for art therapists have emerged from this research. The first theme is the paradox between the desire for connection on the part of the self-mutilating individual and the reported difficulty on the part of the

other, whether audience member or therapist, in responding with empathy. The powerful counter-transference reactions frequently evoked by acts of self-mutilation have been known to impair empathy in even the most seasoned therapists. Within the context of treatment, the aforementioned paradox may be bridged by the artworks produced in art therapy. Artworks may act as mediating objects within the intense transference-counter-transference relationship often formed with self-mutilating clients, allowing the art therapist to take the role of caring witness rather than victim or perpetrator in an abusive dynamic. Artworks often enable the therapist to fully recognize, empathize with, and validate the client's pain and struggle, while maintaining an appropriate boundary. The ability of artwork to express and contain aggressive and destructive impulses not only protects the therapeutic relationship from experiencing these directly, but also offers the client a means of visually communicating distress to the therapist through a representation of the act rather than the act itself. Like acts of self-mutilation, violent artworks have the power to elicit strong counter-transference reactions on the part of the art therapist, who must be able to survive the witnessing of destructive images and processes within a good-enough holding environment.

The second emergent theme is the relationship between self-mutilation and ritual, within the context of pathological behavior and the context of performance art. Pathological self-mutilation has been presented as an unconsciously enacted ritual, communally unrecognized, unresolved, and devoid of meaning. Unlike the pathological self-mutilating individual, performance artists using self-mutilation in their work are conscious of their intentions for transformation and healing, and of the link between their actions and culturally sanctioned rituals, but their taboo-breaking actions are socially

unaccepted, usually constituting a social critique. The performance space, while culturally established, has not been designated as sacred by the audience, who typically does not understand or share the intentions of the artist, differentiating performance art from a culturally sanctioned ritual and accounting for the controversy provoked by this type of work.

Art therapy offers the self-mutilating individual a frame similar to the performance art space, in which acts of self-mutilation may be represented or enacted using art materials in the presence of the therapist, who takes the role of audience member or witness. Unlike performance artists, the impulses and conflicts driving pathological acts of self-mutilation are unconscious and preverbal. However, through externalization onto artworks, this material may begin to enter conscious awareness and be verbally processed with the aid of the therapist. Due to training and to the ability of artworks to take a mediating role within the transference-counter-transference relationship, the art therapist, unlike the typical performance art audience member, is more likely to respond with empathy, complicity, and attunement to the self-mutilating individual's communications. The safety and reliability of the art therapy frame, in addition to the emotional containment, guidance, and meaning provided by the therapeutic relationship, offers the self-mutilating individual a type of sacred space or ritual surrounding. Within this frame and in the presence of the therapist, transitional space, akin to the liminal space of the ritual process, may be entered through art making. The creative process, promoting the development of symbolization and self-soothing capacities, may eventually replace self-mutilation as transitional phenomena of choice, as suggested by published art therapy case studies. If self-mutilation may be placed on a

continuum, designated by the degree of conscious meaning with which, and the cultural context within which the act is performed, then this research posits that through artistic enactments performed within the cultural context of art therapy, the impulses and conflicts driving acts of self-mutilation may be made conscious and integrated into the personality of the client, a process offering the potential for lasting transformation.

### **5.3. Contributions and limitations**

This research has been the first of its kind to systematically study the parallels and differences between pathological self-mutilating individuals and a selection of contemporary performance artists using acts of self-mutilation in their work, in order to gain a better understanding of the dynamics at play when self-mutilation surfaces in the artwork of clients. It is also the first study of its kind to examine self-mutilation and the role of the witness in the relationship between performance artists and audiences, and art therapy clients and therapists. This research also has several limitations. First of all, it has presented a point of view that may not be relevant to or compatible with the theoretical framework used by all art therapists working with self-mutilating individuals, or encountering acts and images of mutilation in the artwork of clients. Second, its definition of self-mutilation is limited, as is the selection of artists it has studied, which may not be representative of all performance artists using self-mutilation in their work. Third, the relationship between self-mutilation and ritual, central to, but beyond the scope of this research, has been presented only briefly, in the hopes that the interested reader will turn to the extensive work already published on this subject.<sup>4</sup> Fourth, due to the

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<sup>4</sup> For numerous and detailed examples of acts of self-mutilation performed as part of culturally sanctioned rituals, the reader is advised to see Favazza, 1987; Hewitt, 1997; McEvelley, 1983; and Milia, 2000.

theoretical methodology chosen for this study, no actual case material has been presented to illustrate or corroborate its claims and findings, which therefore remain at the purely hypothetical level.

#### **5.4. Directions for future research**

Areas for future research include exploring the incidence, as well as the characteristics, of acts and images of mutilation in the artwork of art therapy clients that self-mutilate, as well as those that do not. An in-depth phenomenological study of the counter-transference reactions of art therapists witnessing acts or images of mutilation in the artwork of clients would also be of value. Finally, it would be interesting to study whether and how the inclusion of ritualistic elements to the art therapeutic frame could enrich the treatment of self-mutilating clients. Art therapy case studies with self-mutilating clients exploring themes of counter-transference, performance, and ritual would be natural extensions of the research already presented.

## References

- Abramović, M., & Novakov, A. (1997). Role exchange: Desire, beauty, and the public. Marina Abramović in conversation with Anna Novakov. In A. Novakov (Ed.), *Veiled histories: The body, place, and public art* (pp. 25-35). New York: San Francisco Art Institute Critical Press.
- Agell, G, Levick, M.F., Rhyne, J.L, Robbins, A., Rubin, J.A., Ulman, E., Wang, C.W., & Wilson, L. (1981). Transference and countertransference in art therapy. *American Journal of Art Therapy*, 21(1), 3-24.
- Amini, F., & Burke, E. (1979). Acting out and its role in the treatment of adolescents. *Bulletin of the Menninger Clinic*, 4(2), 249-259.
- Anzieu, D. (1989). *The skin ego*. (C. Turner, Trans.). New Haven: Yale University Press.
- Appleton, V. (2001). Avenues of hope: Art therapy and the resolution of trauma. *Art Therapy: Journal of the American Art Therapy Association* 18(1), 6-13.
- Artaud, A. (1976). The theater of cruelty: First manifesto. In S. Sontag (Ed.), *Antonin Artaud: Selected Writings* (H. Weaver, Trans.) (pp. 242-251). New York: Farrar, Straus and Giroux. (Work originally published 1932)
- Athey, R. (1997). Artist's notes. In M. Russell (Ed.), *Out of character: Rants, raves and monologues from today's top performance artists* (pp. 32-39). New York: Bantam.
- Athey, R. (2004). Reading Sister Aimee. In A. Heathfield (Ed.), *Live: Art and performance* (pp. 86-91). London: Tate.
- Attias, R., & Goodwin, J. (1999). Body-image distortion and childhood sexual abuse. In J. Goodwin & R. Attias (Eds.), *Splintered reflections: Images of the body in*



- trauma* (pp. 155-166). New York: Basic Books.
- Ayers, R. (2000). Serene and happy and distant: An interview with Orlan. In M. Featherstone (Ed.), *Body modification* (pp. 171-184). London: Sage Publications.
- Ben-Amos, B. (1992). Depression and conduct disorders in children and adolescents: A review of the literature. *Bulletin of the Menninger Clinic*, 56(2), 188-208.
- Blessing, J. (2002). Gina Pane's witnesses. *Performance Research*, 7(4), 14-26.
- Blos, P. (1979). *The adolescent passage*. New York: International Universities.
- Brooke, S. L. (1997). *Art therapy with sexual abuse survivors*. Springfield, IL: Charles C. Thomas.
- Brown, A. M., & Latimir, M. (2001). Between images and thoughts: An art psychotherapy group for sexually abused adolescent girls. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: Lost for words* (pp. 184-200). Hove: Brunner-Routledge.
- Cash, S. (1995). Ron Athey at P.S. 122. *Art in America*, 83(2), 99-100.
- Celant, G., & Abramović, M. (2001). Towards a pure energy. In G. Celant (Ed.), *Marina Abramović: Public body. Installations and objects 1965-2001* (pp. 9-29). Milan: Edizioni Charta.
- Chalupecky, J. (1978). Art and sacrifice. *Flash Art: The International Arts Review*, 80-81, 33-35.
- Chapman, L., Morabito, D., Ladakakos, C., Schreier, H., & Knudson, M.M. (2001). The effectiveness of art therapy interventions in reducing post traumatic stress disorder (PTSD) symptoms in pediatric trauma patients. *Art Therapy: Journal of the American Art Therapy Association* 18(2), 100-104.

- Clarke, J. (2000). The sacrificial body of Orlan. In M. Featherstone (Ed.), *Body modification* (pp. 185-207). London: Sage Publications.
- Cohen, B.M., & Mills, A. (1999). Skin, paper, bark: Body image, trauma and the Diagnostic Drawing Series. In J. Goodwin, & R. Attias (Eds.), *Splintered reflections: Images of the body in trauma* (pp. 203-222). New York: Basic Books.
- Cole, M.D. (1990). Ritual and therapy: Casting the circle of change. *Pratt Institute Creative Arts Therapy Review*, 11, 13-21.
- Cooper, B. F., & Milton, I. B. (2003). Group art therapy with self-destructive young women. In D. J. Wiener & L. K. Oxford (Eds.), *Action therapy with families and groups: Using creative arts improvisation in clinical practice* (pp. 163- 196). Washington, DC: American Psychological Association.
- Creswell, J. W. (1998). *Qualitative inquiry and research design*. Thousand Oaks, CA: Sage.
- Cross, L. W. (1993). Body and self in feminine development: Implications for eating disorders and delicate self-mutilation. *Bulletin of the Menninger Clinic*, 57(1), 41-68.
- Crouch, W., & Wright, J. (2004). Deliberate self-harm at an adolescent unit: A qualitative investigation. *Clinical Child Psychology and Psychiatry*, 9(2), 185-204.
- Denegri, D. (1998). *Marina Abramović: Performing the body*. Milan: Edizioni Charta.
- Dennis, K. (1998). Performance art. In M. Kelly (Ed.), *Encyclopedia of aesthetics* (vol. 3) (pp. 466-474). New York: Oxford University Press.
- Deri, S. K. (1984). *Symbolization and creativity*. NY: International Universities Press.
- Dosamantes-Beaudry, I. (1998). Regression-reintegration: Central psychodynamic

- principle in rituals of transition. *The Arts in Psychotherapy*, 25(2), 79-84.
- Engle, P. (1997). Art therapy and dissociative disorders. *Art Therapy: Journal of the American Art Therapy Association*, 14(4), 246-254.
- Estep, M. (1995). To soothe oneself: Art therapy with a woman recovering from incest. *American Journal of Art Therapy*, 34(1), 9-18.
- Farber, S. (2000). *When the body is the target: Self-harm, pain, and traumatic attachments*. Northvale, NJ: Jason Aronson.
- Favazza, A. (1987). *Bodies under siege: Self-mutilation in culture and psychiatry*. Baltimore: Johns Hopkins University Press.
- Favazza, A. (1998). The coming of age of self-mutilation. *The Journal of Nervous and Mental Disorders*, 186(5), 259-268.
- Frankel, J. (2001). A witness breaks his silence: The meaning of a therapist's response to an adolescent's self-destruction. *The American Journal of Psychoanalysis*, 61(1), 85-99.
- Goldberg, R. (1979). *Performance: Live art, 1909 to the present*. New York: Harry N. Abrams.
- Goldberg, R. (1995). Here and now. In C. Iles (Ed.), *Marina Abramovic: Objects performance video sound* (pp. 11-18). Oxford: Museum of Modern Art Oxford.
- Goldberg, R. (1998). *Performance: Live art since the 60s*. New York: Thames & Hudson.
- Goodwin, J., & Attias, R. (1999). Conversations with the body: Psychotherapeutic approaches to body image and body ego. In J. Goodwin & R. Attias (Eds.), *Splintered reflections: Images of the body in trauma* (pp. 167-182). New York: Basic Books.

- Graham, J. (1994). The art of emotionally disturbed adolescents: Designing a drawing program to address violent imagery. *American Journal of Art Therapy*, 32(4), 115-121.
- Greenberg, M.S., & van der Kolk, B.A. (1987). Retrieval and integration of traumatic memories with the "painting cure." In B.A. van der Kolk (Ed.), *Psychological trauma* (pp. 191-215). Washington, DC: American Psychiatric Press.
- Haeseler, M.P. (1987). Censorship or intervention: "But you said we could draw whatever we wanted!" *American Journal of Art Therapy*, 26, 11-20.
- Hagood, M. M. (2000). *The use of art in counseling child and adult survivors of sexual abuse*. London: Jessica Kingsley.
- Harris, J. (2000). Self-harm: Cutting the bad out of me. *Qualitative Health Research*, 10(2), 164-173.
- Herman, J. (1992). *Trauma and Recovery*. New York: Basic Books.
- Herman, J., & van der Kolk, B.A. (1987). Traumatic antecedents of borderline personality disorder. In B.A. van der Kolk (Ed.), *Psychological trauma* (pp. 111-126). Washington, DC: American Psychiatric Press.
- Hewitt, K. (1997). *Mutilating the body: Identity in blood and ink*. Bowling Green, OH: Bowling Green State University Popular Press.
- Hirsch, M. (1994). The body as a transitional object. *Psychotherapy Psychosomatics*, 62, 78-81.
- Hixon, K. (1991). New York in review: Gina Pane. *Arts Magazine*, 65(10), 94.
- Jones, A. (1998). *Body art: Performing the subject*. Minneapolis: University of Minnesota Press.

- Jones, A., & Stephenson, A. (Eds.) (1999). *Performing the body: Performing the text*. London: Routledge.
- Jones, A. (2000). Survey. In T. Warr (Ed.), *The artist's body* (pp. 16-47). London: Phaidon Press.
- Jones, A. (2004). Working the flesh: A meditation in nine movements. In A. Heathfield (Ed.), *Live: Art and performance* (pp. 132-143). London: Tate.
- Junge, M.B., & Linesch, D. (1993). Our own voices: New paradigms for art therapy research. *The Arts in Psychotherapy*, 20, 61-67.
- Kafka, J. S. (1969). The body as transitional object: A psychoanalytic study of a self-mutilating patient. *British Journal of Medical Psychology*, 42, 207-212.
- Kant, I. (1987). *Critique of judgment* (W.S. Pluhar, Trans.). Indianapolis: Hackett. (Work originally published 1790)
- Kauffman, L.S. (1998). Sadomedecine: Bob Flanagan's "Visiting Hours" and last rites. *Performance Research*, 3(3), 33-40.
- Kaye, N. (1996). Marina Abramović. In N. Kaye (Ed.), *Art into Theatre* (pp. 180-192). Amsterdam: Harwood.
- Klorer, P.G. (2005). Expressive therapy with severely maltreated children: Neuroscience contributions. *Art Therapy: Journal of the American Art Therapy Association* 22(4), 213-220.
- Kontova, H. (1978). Marina Abramović – Ulay. *Flash Art*, 80-81, 43-44.
- Kontova, H. (1979). The wound as a sign: An encounter with Gina Pane. *Flash Art: The International Arts Review*, 92-93, 36-37.
- Kupfermann, K. (1996). The importance of lines. *American Journal of Art Therapy*.

34(3), 62-74.

- Lachman-Chapin, M. (1979). Kohut's theories on narcissism: Implications for art therapy. *American Journal of Art Therapy, 19*, 3-9.
- Lachman-Chapin, M. (2001). Self psychology and art therapy. In J.A. Rubin (Ed.), *Approaches to art therapy: Theory and technique* (2<sup>nd</sup> ed.) (pp. 66-78). Philadelphia: Brunner-Routledge.
- Laye-Gindhu, A., & Schonert-Reichl, K.A. (2005). Nonsuicidal self-harm among community adolescents: Understanding the "whats" and "whys" of self-harm. *Journal of Youth and Adolescents, 34*(5), 447-457.
- Lesse, S. (1979). Behavioral problems masking depression: Cultural and clinical survey. *American Journal of Psychotherapy, 33*(1), 41-53.
- Lewis, P.P. (1988). Clinical focus: The transformative process within the imaginal realm. *The Arts in Psychotherapy, 15*(4), 309-316.
- Lovelace, C. (1995). Orlan: Offensive acts. *Performing Arts Journal, 17*(1), 13-25.
- Malchiodi, C. (1997). *Breaking the silence: Art therapy with children from violent homes* (2<sup>nd</sup> ed.). Levittown, PA: Brunner/ Mazel.
- Malchiodi, C. (2003). Art therapy and the brain. In C. Malchiodi (Ed.), *Handbook of art therapy* (pp. 16-24). New York: Guilford Press.
- Martins, K. (1983). Gina Pane. In B. Kunstlerhaus (Ed.), *Performance: Another dimension* (pp. 153-157). Berlin: Frolich & Kaufmann.
- McEvelley, T. (1983). Art in the dark. *Artforum, 21*(10), 62-71.
- McEvelley, T. (1995). The serpent in the stone. In C. Iles (Ed.), *Marina Abramović: Objects performance video sound* (pp. 45-53). Oxford: Museum of Modern Art

Oxford.

Milia, D. (1996). Art therapy with a self-mutilating adolescent girl. *American Journal of Art Therapy*, 34, 98-106.

Milia, D. (2000). *Self-mutilation and art therapy: Violent creation*. London: Jessica Kingsley.

Miller, D. (1994). *Women who hurt themselves*. New York: Basic Books.

Murphy, J. (2001). Introduction. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: Lost for words* (pp. 1-15). Hove: Brunner-Routledge.

Noshpitz, J. D. (1994). Self-destructiveness in adolescence. *American Journal of Psychotherapy*, 48(3), 330-346.

O'Bryan, C.J. (2005). *Carnal art: Orlan's refacing*. Minneapolis: University of Minnesota Press.

O'Dell, K. (1988). The performance artist as masochistic woman. *Arts Magazine*, 62(10), 96-98.

O'Dell, K. (1997). Gina Pane. In D. Gaze (Ed.), *Dictionary of women artists* (vol. 2) (pp. 1063-1066). London: Fitzroy Dearborn.

O'Dell, K. (1998). *Contract with the skin: Masochism, performance art, and the 1970s*. Minneapolis: University of Minnesota Press.

Pane, G., & Stephano, E. (1973). Performance of concern: Gina Pane discusses her work with Effie Stephano. *Art and artists*, 8(1), 21-27.

Pane, G. (1978). Artist contributions. *Flash Art: The International Arts Review*, 80-81, 47.

Pao, P. (1969). The syndrome of delicate self-cutting. *British Journal of Medical*

- Psychology*, 42, 195-205.
- Parr, M. (1978). Artist's statement. *Flash Art: The International Arts Review*, 80-81, 53.
- Pattison, E.M., & Kahan, J. (1983). The deliberate self-harm syndrome. *American Journal of Psychiatry*, 140(7), 867-872.
- Patton, M.Q. (2002). *Qualitative research and evaluation methods* (3<sup>rd</sup> ed.). Thousand Oaks, CA: Sage.
- Phelan, P. (2004). On seeing the invisible: Marina Abramović's *The House with the Ocean View*. In A. Heathfield (Ed.), *Live: Art and performance* (pp. 16-27). London: Tate.
- Pifalo, T. (2002). Pulling out the thorns: Art therapy with sexually abused children and adolescents. *Art Therapy: Journal of the American Art Therapy Association*, 19(1), 12-22.
- Pluchart, F. (1978a). Risk as the practice of thought. *Flash Art: The International Arts Review*, 80-81, 39-40.
- Pluchart, F. (1978b). Gina Pane. *Flash Art: The International Arts Review*, 80-81, 46.
- Politsky, R.H. (1995). Toward a typology of research in the creative arts therapies. *The Arts in Psychotherapy*, 22(4), 307-314.
- Prasad, P. (2005). *Crafting qualitative research: Working in the postpositivist traditions*. Armonk, NY: M.E. Sharpe.
- Rankin, A.B., & Taucher, L.C. (2003). A task-oriented approach to art therapy in trauma treatment. *Art Therapy: Journal of the American Art Therapy Association* 20(3), 138-147.



- Riley, S. (2003). Using art therapy to address adolescent depression. In C. Malchiodi (Ed.), *Handbook of art therapy* (pp. 16-24). New York: Guilford Press.
- Robbins, A. (2001). Object relations and art therapy. In J.A. Rubin (Ed.), *Approaches to art therapy: Theory and technique* (2<sup>nd</sup> ed.) (pp. 54-65). Philadelphia: Brunner-Routledge.
- Rose, B. (1993). Is it art? Orlan and the transgressive act. *Art in America*, 81(2), 82-88.
- Ross, S., & Heath, N. (2002). A study of the frequency of self-mutilation in a community sample of adolescents. *Journal of Youth and Adolescence*, 31(1), 67-77.
- Schaverien, J. (1992). *The revealing image: Analytical art psychotherapy in theory and practice*. London: Routledge.
- Schaverien, J. (1999). Art within analysis: Scapegoat, transference and transformation. *Journal of Analytical Psychology*, 44(4), 479-510.
- Scott, E. H. (1999). The body as testament: A phenomenological case study of an adult woman who self-mutilates. *The Arts in Psychotherapy*, 26(3), 149-164.
- Stephano, E. (1973). Interrogating the artist. *Art and Artists*, 8(5), 29-33.
- Stronach-Buschel, B. (1990). Trauma, children, and art. *American Journal of Art Therapy*, 29, 48-52.
- Suyemoto, K. L., & Macdonald, M. L. (1995). Self-cutting in female adolescents. *Psychotherapy*, 32(1), 162-171.
- Suyemoto, K. L. (1998). The functions of self-mutilation. *Clinical Psychology Review*, 18(5), 531-554.
- Turell, S.C., & Armsworth, M.W. (2003). A log-linear analysis of variables associated with self-mutilation behaviors of women with histories of child sexual abuse.

*Violence Against Women*, 9(4), 487-512.

- Ursprung, P. (1999). Catholic tastes: Hurting and healing the body in Viennese Actionism in the 1960s. In A. Jones, & A. Stephenson (Eds.), *Performing the body: Performing the text* (pp. 138-152). London: Routledge.
- van der Kolk, B.A. (1987). The psychological consequences of overwhelming life experiences. In B.A. van der Kolk (Ed.), *Psychological trauma* (pp. 1-30). Washington, D.C.: American Psychiatric Press.
- Vergine, L. (1974). *Il corpo come linguaggio*. (H. Martin, Trans.). Milan: Giampaolo Prearo Editore.
- Walsh, B.W., & Rosen, P.M. (1988). *Self-mutilation: Theory, research, and treatment*. New York: Guilford Press.
- Warr, T. (2000). Preface. In T. Warr (Ed.), *The artist's body* (pp. 10-15). London: Phaidon Press.
- Weibel, P. (1978). Artist's statement. *Flash Art: The International Arts Review*, 80-81, 48.
- Weintraub, L. (1996). *Art on the edge and over: Searching for meaning in contemporary society 1970s - 1990s*. Litchfield, Ct: Art Insights.
- Wilson, L. (2001). Symbolism and art therapy. In J.A. Rubin (Ed.), *Approaches to art therapy: Theory and technique* (2<sup>nd</sup> ed.) (pp. 40-53). Philadelphia: Brunner-Routledge.
- Whitaker, P. (2005). Moving art, moving worlds performing the body in visual arts and art therapy. *Canadian Art Therapy Association Journal*, 18(2), 27-34.
- Winnicott, D. W. (2002). *Playing and reality*. Hove: Brunner-Routledge. (Work

originally published 1971)

Zila, L. M., & Kiselica, M. S. (2001). Understanding and counseling self-mutilation in female adolescents and young adults. *Journal of Counseling and Development*, 79, 46-52.