Scheftel, Susan A.

ALL THE KING'S HORSES AND ALL THE KING'S MEN: A CASE OF RADICAL SELF-MUTILATION AND ITS EFFECTS ON AN ENTIRE HOSPITAL

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ALL THE KING'S HORSES AND ALL THE KING'S MEN:*

A CASE OF RADICAL SELF-MUTILATION AND ITS EFFECTS ON AN ENTIRE HOSPITAL

by

SUSAN SCHEFTEL

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* The author is grateful to Dr. A. Razin whose clever title this is.

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1/10/85 — Laurence J. Gould
date — Chairman of Examining Committee

January 16, 1985 — Herbert D. Saltzstein
date — Executive Officer

Laurence J. Gould Ph.D.

Irving H. Paul Ph.D.

Paul Wachtel Ph.D.
Supervisory Committee

The City University of New York

ABSTRACT

All the King's Horses and All the King's Men:
A Case of Radical Self-Mutilation and its Effects
on an Entire Hospital

by Susan Scheftel

Advisor: Professor Laurence Gould

This is a case of a radical self-mutilator and his effects upon the staff of a hospital where he has been a medical patient for the last two years. In a psychotically analgesic state, the patient performed what is seemingly the most drastic self-mutilation recorded: he removed virtually his entire face. In an attempt to shed light on the act, literature pertaining to minor and major self-mutilation is reviewed. Attention is given to countertransference reactions to self-mutilation, as well as to reactions engendered by ugliness, disfigurement and freakishness.

The patient's history and hospital course are described and he is compared to other radical self-mutilators. Like many, his mutilation occurred in a context of psychosis, delusional religiosity, sexual guilt and experiences of abandonment. Unlike others, his choice of the face is unprecedented, as is his disavowal of responsibility for the act. A psychoanalytically-based theory is advanced that the

patient's face served as a symbolic switching point where conflictual sexual, affective and identity themes converged.

The hospital staff's adjustment to this patient is explored, noting that distinct phases of reaction characterized the behavior of all who dealt with him. Initial responses of shock and excitement were transformed into familiarity and solicitude. There seemed to be a ubiquitous need to deny the malignancy of this patient's psychopathology and appearance in favor of an almost banal view of him. This shift in attitude is interpreted in terms of individual and group defenses against sado-masochistic impulses and fantasies. Moreover, the patient's facelessness is seen as a key factor in eliciting positive projections. Yet ultimately this process of transformation has failed. The hospital staff has become demoralized in their efforts to help a patient who is blind, grotesquely disfigured and has been abandoned by his family. Furthermore, no appropriate placement has been found. The fact that little changes, even with high level institutional involvement, bears witness to the ultimately unsurmountable ramifications of this case.

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I would also like to give special thanks to both of my parents whose love and interest are boundless (without my father's urging, this material would never have become a dissertation. His cautionary tale of the reporter sent to cover the christening of a ship who returned without a story because the boat sank, led me to change my thesis topic. It did seem ironic to write on other matters when such extraordinary clinical material was unfolding right around me.). Last but not least, I would like to thank Rick Finkelstein, whose companionship is an abiding source of strength.

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CHAPTER ONE

Introduction

I have had the unique and powerful experience of working for the last two years with a young man who performed the most bizarre, and possibly the most extensive self-mutilation on record. In a psychotically analgesic state, this patient removed virtually his entire face: his cheeks, the soft tissue on his nose, his lips, the anterior portion of his tongue, and his left ear. He also completely enucleated his left eye and partially enucleated his right eye. Mr. G, a (then) 19-year-old black male carrying a pre-existing diagnosis of schizophrenia was first seen in this mutilated state in the medical emergency room of _____ Hospital two days prior to Christmas, 1982. At the time of admission, Mr. G was fully conscious and in no discernible pain or distress. As a member of the hospital's consultation-liaison psychiatry team, I, together with several of my colleagues, was given the daunting assignment of "evaluating" and "following" this patient. Over time, the continuing psychological care of Mr. G became the province of myself and one other staff member. This responsibility has entailed almost daily co-therapy sessions with the patient, as well

as contact and co-ordination with a host of other medical, surgical and rehabilitative professionals working with (or upon) Mr. G. Mr. G has been in our hospital for almost two years to date. As a consequence, I have become extremely familiar with him and with the ramifications of his extraordinary situation.

As both a participant and an observer, I have a great deal to say about the last two years' work with this patient--enough, I think, to fill a dissertation. Not that I haven't encountered some skepticism about writing a thesis on such a topic. I have been queried as to what general points can be made by documenting one highly unusual case. I have been dubiously questioned about the nature of my hypothesis. Eyebrows have been raised at the suggestion that a scholarly work could (or should) be fashioned out of material seemingly better suited to the pages of the National Enquirer. At the same time, the mere mention of this case seems to generate fascination, curiosity and excitement in all who hear of it. That this patient should generate such an intense response, even in those who simply hear of him, has suggested that there is another dimension to the case and has created an additional area to be investigated.

My goals for this dissertation have become twofold. On the one hand, I firmly believe that the case possesses intrinsic fascination and significance. Something can be

learned from this one bizarre instance of self-mutilation, if only that it makes its own ineluctable sense in light of Mr. G's past history and his more recent phenomenology. Like a classic dream image, Mr. G's destruction of his own face can be seen as a kind of symbolic switching point, where dominant life-historical themes converge. Even though he himself cannot explain his self-mutilation, an examination of his history provides some fairly convincing evidence as to how his face was chosen for eradication. An attempt to confer meaning on what otherwise seems an incomprehensible act is the first aim of this dissertation. Yet, as I continued to work with Mr. G and those caring for him, I discovered an equally fascinating aspect of the case that had less to do with the patient himself. In addition to the case of the patient, there is another "case" to be studied: the case of the hospital staff's adjustment to a profoundly disquieting patient. A private psychotic act, the mutilation, has taken on a "public" dimension. In my liaison role, I have been able to observe the vicissitudes of staff reaction (my own included) to Mr. G. Though the disciplines working with Mr. G vary in sophistication and training, all of us who are involved with him seem to have gone through similar processes of initiation and working through. That such similar processes should occur seems related to both individual and group dynamics. Because Mr. G engenders such strong and

often consistent reactions in those who deal with him, the second aim of this dissertation will be to explore the phenomenology of reaction to Mr. G.

This dissertation will thus have two foci: this patient and his self-mutilation and the impact this patient has had on the individuals and groups working with him. The literature review, presented in Chapter Two, will attempt to cover material relevant to both aspects of the dissertation. Literature on self-mutilation will be reviewed; the same literature will be reviewed from the point of view of reactions to self-mutilation. As the literature documenting reactions to self-mutilation is scanty, related areas will be explored. Particular emphasis will be given to the literature which stresses reactions elicited by physical disfigurement. A case history of Mr. G. will follow. After the case is presented an attempt will be made to come to a psychodynamic understanding of Mr. G's self-mutilation in the context of his life history. After that, a naturalistic account of Mr. G's impact on those working with him over the course of his year in the hospital will be given. This will be followed by a discussion of the dynamics underlying the typical patterns of response.

Perhaps the best way to introduce this dissertation is with a brief evocation of my first encounters with Mr. G and the profound effect that he had on me. In speaking

with others, I discovered that the phenomenology of my own first reaction was not dissimilar from those around me who were meeting with Mr. G for the first time. Our first shocking meetings with Mr. G have evolved into routinized visits that evoke little conscious anxiety. I suspect, however, that our initial response to Mr. G is never very far out of unconscious (or preconscious) reach.

For those of us who heard about Mr. G before we saw him, our first encounter actually began when we heard the words: "There's a patient who cut his face off." I remember experiencing contradictory emotions. On the one hand, I felt utter revulsion and aversion; on the other hand, I wanted nothing more than to know, hear and see everything I could about the patient. Once I knew about Mr. G, it was difficult not to take the next step; so, with a mixture of trepidation and impunity, I accompanied two other liaison staff members to the patient's room. We tried as best as we could to alert the anticipatory function of our egos by "educating" ourselves about the circumstances of Mr. G's admission before we actually saw him. Yet no amount of information, knowledge or forewarning could lessen the impact of seeing an individual without a face, especially when one knew that his condition was self-inflicted. When we entered Mr. G's hospital room, we saw him unbandaged, lying calmly in bed. It seemed as if we had happened upon an improbable special

effect from a horror film. Due to the featurelessness and the expressionlessness of Mr. G's appearance (not to mention the skinlessness of his face), he conveyed a startling ambiguity. It was not clear whether one was in the presence of something living or dead, human or animal, healing or decomposing. Even more disconcerting than Mr. G's appearance was the fact that he seemed to be resting so comfortably (we learned later he was on relatively little pain medication). He was obviously quite alert and greeted us cordially--albeit rather unintelligibly, owing to the absence of the front of his tongue and the obvious presence of a psychotic process.

In that first session, I felt that I had entered the company of an alien--someone who seemed finally to be the exception to Sullivan's credo that "We are all more human than otherwise." I want to emphasize that Mr. G's otherworldliness had to do not merely with his appearance but with the startling discontinuity between his calm and placid affect and his grotesquely mutilated face. If Mr. G had displayed signs of fear, upset or pain he would have seemed more recognizably human.

The knowledge that Mr. G's appearance was <u>not</u> the result of trauma or accident but was the product of his own driven labors created a further sense of alienation. Without expression or the demonstration of appropriate affect, Mr. G's face encompassed the stasis and the impla-

cability of a death mask; at the same time it was immanent testimony to the scope of his self-destructiveness. When we deal with patients who are mentally ill, their psychopathology is ultimately intangible; it exists in their thoughts and behaviors. Those thoughts and behaviors are not fixed or permanent. They occur at moments in time and alternate with thoughts and behaviors that are more recognizably "normal." When we work with those who are suicidal, their suicidal self-destructiveness usually remains ideational and is abstract unless it occurs. Even if an individual commits suicide, he/she is gone, and the power of his/her self-destructiveness is again an abstraction. Both of the above instances are different from being confronted with an extreme mutilation, insusceptible to concealment. What made the first encounter with Mr. G so chillingly unique was that upon meeting him one was forced to confront the concrete embodiment of both his psychosis and his self-directed aggression. If one kept one's eyes open, there was no way to forget even for an instant what Mr. G had done. His madness had driven him to carve away the hallmarks of his humanity, disfiguring himself to the point where he bore greater resemblance to a slab of meat than to a human being. Perhaps even more incredible, he seemed blithely indifferent to his condition. Meeting him thus, I experienced a stark failure of empathy.

The first meeting with Mr. G lingered long after I left his room. It was impossible to eat that day, to attend properly to work, to speak of anything other than Mr. G. Much as I tried, a graphic image of Mr. G kept returning to my mind. I felt haunted by it. I remember having the sense that, even if I never saw Mr. G again, seeing him once had left an indelible mark. Yet much as he was strange and alien, the feelings evoked were also dimly reminiscent. I felt as if I had finally met the proverbial "Bogey-Man" which had lurked under my bed in childhood, or the creature whose habitation was the half-open closet door. Mr. G was at once totally foreign and unfamiliar, but at the same time he harkened me back to all the projected terrors of childhood. He was in a class with the "magical" stones which couldn't be touched, the fearsome old women on the street that I "knew" were witches and the Walt Disney (no less) edition of stories with pictures of the Headless Horseman which had to be removed from my room before I could sleep. The major difference was that Mr. G was real and had performed a seemingly impossible act.

Meeting Mr. G was a frighteningly novel experience. Nonetheless, his singular reality confirmed the existence of long-forgotten childhood fantasies. Though I had obviously never met or seen anyone like Mr. G before, he already had a life in my infantile unconscious. Just such

a combination of familiarity with "all that arouses dread and creeping horror" is the defining characteristic of that which Freud (1919) has called "the Uncanny" (p. 219). In his essay by that name Freud attempts to demonstrate that the Uncanny "is that class of the frightening" (p. 220) which stimulates repressed fears and magical thinking. Using etymology, Freud shows the close connection between the German words unheimlich (uncanny) and heimlich (familiar). His point is that certain experiences force long buried fantasies or magical thoughts back into consciousness, temporarily breaking through the barriers of repression and loosening the hold of rational thought. Freud gives a number of examples of that which he considers capable of bringing such a re-emergence of repressed material. He notes that human beings seem uncanny when we can attribute magical powers or "evil intentions" (p. 243) to them. Images of dismemberment are uncanny in that they evoke fears of castration, while tales of dead people being resurrected or buried alive blur the boundaries between imagination and reality. Though Freud dwells on instances of the uncanny in art and literature, he does assert that "[a]s soon as something actually happens in our lives which seems to support the old discarded beliefs, we get a feeling of the uncanny" (pp. 247-248).

Mr. G certainly fulfilled the above condition of uncanniness. Moreover, being confronted with his muti-

lated face evoked fears of bodily intactness, if not castration anxiety. Realizing that Mr. G's mutilation was both self-inflicted and painless raised the suggestion of magical (and possibly evil) powers at work. The safe reasonable world in which faces are not torn off and people do not have superhuman powers was suddenly called into question. Seeing Mr. G for the first time temporarily undermined the hard won defenses of adulthood and plunged one back into the Dark Ages of childhood.

Being with Mr. G at present, I feel none of that initial uncertainty. I, like the rest of the hospital staff who works with him, come to greet him with kindness, civility and familiarity. In Chapter Five, I will try to document the process of transformation by which Mr. G went from being "unheimlich" to being "heimlich." In addition to relating to changes in Mr. G himself, I would advance that this process was necessary in order that those of us working with Mr. G could restore the world to its original rational order. Yet, just as the surgeries that have attempted to repair Mr. G's face have been partial and incomplete, so too are our defenses against his self-mutilation. I suspect that the first experiences with Mr. G were sufficiently uncanny that their impact can never be eradicated. All subsequent dealings with him must necessarily involve some degree of defensive avoidance. My dissertation is just such an attempt to give meaning and

shape to initially (and ultimately) inchoate and primitive anxieties--to make them explicable and palatable. If I did not try, I would be left alone with my Bogey-Man.

CHAPTER TWO

Literature Review

What constitutes self-mutilation? Unlike other psychiatric or psychological phenomena, its nosological boundaries are rather unambiguous. Whether authors are writing about extreme or minor variations, whether the underlying pathology is psychotic, borderline, neurotic or even organic, there is no major definitional dispute. The terminology used by different authors can vary--Ross and McKay (1979) have collected a total of 33 "illustrative terms." These authors have also assembled a typology of the different self-mutilative techniques. They include: cutting, biting, abrading, severing, inserting, burning, hitting and constricting. Yet these nominal and categorical distinctions belie a basic descriptive homogeneity. As in this case, self-mutilation involves a purposeful, non-suicidal and seemingly gratuitous violation of the body's intactness. A recent article suggests that self-mutilation is so clearly different from suicide that there should be a separate diagnostic category under which self-mutilative acts should be subsumed: "the deliberate self-harm syndrome" (Pattison & Kahan, 1983).

The relationship between self-mutilation and masochism is obviously significant but beyond the scope of this dissertation. Suffice it to say that numerous authors writing on the subject have noted that self-mutilation is connected with the simultaneous expression of both masochistic and sadistic impulses.

Because self-mutilative acts are so difficult for most of us to consciously conceive of, they beg for explication. Unfortunately, the corpus of literature on this subject tends to be rather circumscribed and a-theoretical. We do not find self-mutilation addressed by all the "great" psychiatric or psychoanalytic authors. For the most part, those who write about self-mutilation are those who have encountered it, and this dissertation is no exception.

Though at a grossly descriptive level there is little definitional dispute, it has been noted by numerous authors that self-mutilation occurs in a variety of contexts and under assorted conditions. This review will dwell longest upon those psychopathological forms of self-mutilation that seem most relevant to our area. Before so doing, we will review instances of other major variations of self-mutilation.

Little has been done to bring theoretical unity to the topic of self-mutilation. Articles generally concern themselves with one or another sub-type of self-mutilative

behavior. Ross and McKay (1979) have written the most compendious study of this subject, yet they despair of coming to an integrative understanding that can encompass the whole range of self-mutilative behavior.

> The mind-boggling array of explanations offered for self-mutilating behavior not only reflect the host of disciplines which have studied this phenomenon but often represent the rigid loyalty of the investigator to a particular school of thought. There is a distinct lack of any coherent theory, even less an attempt to integrate the hodgepodge of conjecture, hypothesis, speculation, post hoc interpretation, suggestions, and commentaries. (p. 75)

Perhaps the most ambitious attempt to come to theoretical terms with the seemingly disparate aspects of self-mutilation was written in 1935 by Karl Menninger entitled "A Psychoanalytic Contribution to the Significance of Self-Mutilation." This study provides a useful dynamic orientation to the paradox of self-mutilation, as well as demonstrating some of the various manifestations this phenomenon can assume.

Though his discussion ranges between cultural, organic, neurotic and psychotic self-mutilations, Menninger posits a similar underlying principle involving the placation of conscience and the exoneration of guilt.

> Self-mutilation is the net result of a conflict between 1) the aggressive destructive impulses aided by the superego and 2) the will to live, whereby a partial and local self-destruction serves the purpose of gratifying irresistible urges and at the same time averts the prelogical but unanticipated consequences thereof. (p. 465)

Menninger believes that the impulses involved in self-mutilation are similar to suicide but with a major ironic difference; self-mutilation, in directing those impulses to a part of the body, is actually a self-preservative act. For this reason, Menninger (1938) later coined the term "focal suicide" (p. 201). He further theorizes that self-mutilation is modeled upon the unconscious "prototype" of castration. He goes on to speculate that self-mutilation/symbolic castration affords considerable secondary gain by transforming active, aggressive impulses to passive ("castrated" yet erotized) ones.

Friedman et al. (1972) discuss the connection between self-mutilation and suicide. In both cases, they see placation of the superego as the central aim. While in suicide, the whole body is attacked as the seat of unwanted urges, in self-mutilation those urges are displaced onto a body part which becomes unconsciously equivalent to the genitalia and must be eradicated. They also make the

interesting point that with self-mutilation, a primal scene fantasy may be being enacted in which the same individual plays both an active and passive role.

Clearly influenced by Menninger, Fenichel (1945) presents a brief discussion of "severe self destruction" (p. 264) in the Psychoanalytic Theory of Neurosis. He too stresses that the main goal of "all" self-destructive acts is the alleviation of a burdened superego. Fenichel notes that there is actually active mastery involved in an act of self-destruction, as it actively initiates a punishment that might otherwise occur passively. Fenichel emphasizes the object relations inherent in an act of self-mutilation. Through introjection the ego is confounded with an object which can be simultaneously destroyed and palliated. Consequently, severe self-destruction "is not 'beyond the Pleasure Principle' as it represents an undesired consequence of something desired" (p. 364). In this regard, Fenichel notes the pride which often accompanies ascetism.

The Scope of Non-Psychiatric Self-Mutilation

Menninger (1935) makes the important observation that like all psychopathological behavior, self-mutilation exists on a continuum which ranges from the normal to the bizarre. It is to this notion of a continuum that we will cursorily turn. Menninger observes that even most ordinary

rituals of daily life, such as hair cutting, shaving and nail trimming, can actually be viewed as culturally acceptable variations of self-mutilation. To his mind these acts have a civilizing purpose and at a deeply (and collectively) unconscious level involve the "renunciation" of primitive impulses, at the same time conferring ongoing protection against the expression of those impulses.

He also remarks upon religious and anthropological practices which involve self-mutilation. Even when not specifically self-inflicted, Menninger views all rituals of mutilation (including puberty rites and circumcision) as belonging to the category of self-mutilation, owing to the willing zeal with which initiates permit their bodies to be mutilated. Menninger and subsequent authors (Kushner, 1967; Lester, 1972) remind us that various cultures and epochs have condoned self-flagellation and self-mutilation for the purpose of purification (usually for "sins" of a sexual nature). One particularly striking anthropological example of culturally sanctioned self-mutilation is the violent Sun Dance ritual that Erikson (1950) describes in Childhood and Society. In the Sioux Sun Dance, men drive skewers through their chests and hang from a pole, dancing frantically until their flesh rips. Erikson describes this macabre ritual as "only one variation of the countless ways in which, all over the world, a sense of evil is atoned for, and the continued generosity

of the universe insured" (p. 132). Erikson's discussion is useful as it attempts to fathom the process by which the Sioux' collective superego comes to select the chest for mutilation. Beyond the overall goal of propitiation, the form of self-attack to the chest in particular is derived from a culturally specific "infantile trauma." Among the Sioux, babies were given unlimited access to the materal breast until the biting stage was attained. At that point, children were cruelly beaten for doing the same thing that had once provided them with sustenance and support. Erikson interprets the particular symbolism of the Sun Dance ritual in terms of ambivalence toward the maternal breast. The seemingly senseless act of men ripping open their own chests is the "climax to the vicissitudes of that deliberately cultivated rage at the mother's breast . . . Here the faithful turn the consequently awakened wish to inflict sadistic injury on the mother's breast by making their own chests the particular focus of their self-torture" (p. 132). Because of the satisfactions and frustrations experienced at the site of the maternal breast, the Sioux are left with a residual sense of sinfulness which in turn seems to account for the self-direction of their sadistic rage. As will be seen in the case of Mr. G, an analogous process seems to have determined his choice of the face for destruction.

To futher support the connection between a sense of sinfulness and self-mutilation, various authors (Arons, 1981; Clark, 1981; Goldenberg & Sata, 1978) note the injuctions in the New Testament which enjoin self-mutilation for the purpose of purification. Matthew 5:29 is one of several similar passages: "And if thy right eye offend thee pluck it out and cast it from thee for it is profitable that one of thy members should perish and not thy whole body be cast into Hell." Chapter Nine of Mark suggests that not only eyes but hands and feet as well should be cast off if offensive. These injunctions were taken quite literally (and to their symbolic source according to Menninger's premise) by the Skopsi, a Russian orthodox sect which existed until the 19th century (Lester, 1972; Ross & McKay, 1979). Adherents had to self-castrate as a way of atoning for the "sins" of Adam and Eve.

Just as Menninger (1935) places religious or puberty rites involving mutilation by a second party under the rubric of self-mutilation, elsewhere he (1934) makes a similar assertion about the phenomenon he labels "polysurgical addiction." His view was that those who undergo multiple elective surgeries are actually placating a guilty conscience. They are placing themselves in a sado-masochistic relationship with a surgeon who, as a father surrogate, will perform a symbolic castration. This may be relevant in the case of Mr. G who performed no further

self-mutilations while here in the hospital, his multiple surgeries perhaps serving the same purpose in his psychic economy. The quest for unnecessary surgery is a central characteristic of Munchausen syndrome (Nadelson, 1979) and of sex-change operations. Munchausen syndrome is a more strictly psychopathological entity whose dynamics are not fully fathomed. What is known is that individuals with Munchausen syndrome have usually experienced bodily traumata (usually involving hospitalization) in childhood. Moreover, the syndrome seems to involve a sado-masochistic repetition of the original trauma in relation to doctors and hospital staff. The jury is still out on the degree of psychopathology in those who seek a sex change. As the media has shown us, some individuals who have had these operations lead highly functional and productive lives (viz. Jan Morris and Renee Richards). In spite of this, John Money (1980) has dubbed the quest for a sex change a "body-image psychosis" (p. 210). There have also been instances of supposedly non-psychotic individuals, eager to become transexuals, who have actually self-castrated (Krieger et al., 1982).

A preoccupation with amputation and disfigurement has become part of today's more extreme sexual mores. Wakefield et al. (1977) describe an otherwise well functioning individual whose "hobby" was the amputation of digits (in conjunction with fetishistic fantasies about female

amputees). Though highly uncommon, this individual's fantasies and actions are by no means unique. The above authors mention that he was a member of a loosely affiliated "organization" whose major activities included the dissemination of literature on amputation as well as actual acts of self-amputation. In light of Menninger's formulations about self-mutilation, it is likely that severe castration anxiety (transformed from passive to active) may be the substrate for such bizarre "hobbies."

Though Menninger and others insist upon the centrality of superego formation in the dynamics of self-mutilation, there are obviously instances where mediation by any of the "higher" agencies of the mind simply cannot be posited. Green (1967) remarks upon the distinction between "a primitive pre-conflictual type of self-mutilation coinciding with immature ego development and a later self-destructive activity which is psychologically motivated and related to guilt and conflict" (p. 236). Lester (1972) reminds us that self-mutilation occurs in animals as well as humans. Maternal deprivation (Bach y Rita, 1974) and isolation (Jones & Barraclough, 1978) seem to be conditions which drive mammals reared in captivity to self-mutilate. In human populations, such as prisons or institutions where environmental deprivation is a given and early deprivations and assaults have usually been the norm, reports of self-mutilation are also not uncommon.

Along these lines, a higher than usual incidence of self-mutilation has been seen in populations of abused or battered children (Green, 1978). In their study of a group of 62 prisoners, Bach y Rita (1974) note a correlation between "habitual violence" (p. 1018) and self-mutilation. Though some institutional self-mutilations are seen as manipulative attempts to gain release from a facility (Lion & Conn, 1976), Virkkunen (1976) notes that lack of environmental stimulation may in itself be a precipitant. Self-mutilation can, in other words, comprise a form of self-stimulation. Self-mutilation can become an emblem of deviance, as in the Japanese racketeer group, the Yakuza, who amputate fingers and insert small objects into their penises as a way of denoting membership in the group (Tsunenari, 1981). Fox (1976) has described the significance of "self-imposed stigmata" (p. 3201), the phenomenon of tatooing among a group of female prisoners.

Self-mutilation can also occur in certain organic conditions. There are frequent reports of such behavior among retarded people (Bates & Smeltzer, 1982; Bright et al., 1981). More specifically, self-mutilation of the fingers and lips is a pathognomonic feature of Lesch-Nyhan Syndrome (Christie et al., 1982). Self-destructive behavior characterizes the De Lange Syndrome as well (Mueller & Hsiao, 1980). Self-mutilation can occur in temporal lobe conditions and in Gilles de la Tourette Syndrome

(Lion & Conn, 1976). In the literature on primitively differentiated autistic children who functionally can resemble retarded children, there are many reports of self-mutilation. Green (1967) asserts that in such cases, self-mutilation seems to satisfy "more primitive physiological needs such as tactile, kinesthetic and mobility requirements and help[s] to delineate their bodies from that of the outside world" (p. 240). That self-mutilation does occur in conditions where it is difficult to posit intrapsychic conflict of symbolic meaning (as well as the fact that analgesia is a common finding) has led some researchers to a biological hypothesis about self-mutilation in general. Lycaki et al. (1979) suggest that self-mutilators have a "deficit in their arousal centers" (p. 1224). While others have linked self-mutilation to increases in metenkephalin (Coid et al., 1983). Cataldo and Harris (1982) posit a predisposing constellation of deficiencies in neurotransmitters and in the development of the CNS sensation thresholds, together with the production of endogenous opiates.

Head banging is a minor form of self-mutilation which often occurs in normal infants (Lester, 1972). Anna Freud (1968) labels the expectable variants of that behavior "autoerotic." To her thinking, when such behaviors persist past age appropriate limits they become more pathological. In such cases, she attributes the tendency to

self-injury to "the absence of fusion, or defusion between erotic and destructive urges, one important cause of the former being an underdevelopment of the libidinal side owing to innate or environmental conditions" (p. 617). In "The Presuperego 'Turning Inward' of Aggression," Cain (1961) argues that self-mutilation which occurs in the absence of guilt or conflict is still not simply an atavism akin to behaviors found in animals. For a human, however undeveloped, to turn to aggression upon the self rather than direct it externally requires a certain psychological (albeit primitive) mechanism. Cain states that the body part which is injured must come to represent an introjected (and frustrating) object and by so doing becomes non-self. Cain remarks that this is a "paradoxically self-destructive self-protective device" (p. 199).

Having briefly spanned the strictly non-psychiatric range of the continuum of self-mutilation, we will now turn to the literature on the more unequivocally psychopathological variants of self-mutilation.

Psychopathological Self-Mutilation

Though the literature on the incontrovertibly psychopathological forms of self-mutilation is not vast, two major prototypes (in adults) emerge with startling uniformity: the so-called delicate cutter and the psychotic

self-mutilator who goes so far as to remove a body part or cause irreparable physical damage (Schaffer et al., 1982). I will dwell at some length upon these two major categories. Though there are an assortment of other categories of self-mutilation (inserting, burning, constricting), these will not be explored in depth. My assumption is that an in-depth exploration of the above two categories of self-mutilation (both of which actually involve cutting the flesh) will suffice to outline the principal dynamics that may shed light on my case. As it happens, the literature on delicate cutting has more depth, both theoretically and clinically, than the reported cases of radical self-mutilation.

Delicate Self-Cutting

The phenomenon of repetitive, painless and superficial self-cutting by a non-suicidal female was observed as long ago as 1914 (Emerson). The fact that these elements might pertain to a discrete psychopathological syndrome was not recognized until much later. In 1960, Offer and Barglow described a group of hospitalized adolescent females who habitually cut themselves with razors and sharp objects and aroused powerful countertransference reactions in staff. At the time of their writing, these authors saw such behavior as distinctly suicidal in intent. Pao, writing in 1969, described a similar group of girls but formulated that their seemingly suicidal acts were endemic

to the "syndrome of delicate self cutting" (p. 195). His review of 27 cases seen over a ten year period revealed a dramatically similar phenomenology in 23 of those cases. Moreover, the similarities perceived by Pao are consistent with the findings of other authors who have subsequently observed the delicate cutting phenomenon. Asch (1971) has pointed to the "remarkable and precise similarities of both the phenomenon itself and the psycyhopathology" (p. 611). Shelly Doctors (1981), who has written the most integrative study on this subject, notes that there is sufficient "concordance" on both a descriptive and an explanatory level that a "composite" portrait of the delicate cutters can be sketched.

Doctors describes the prototypical cutter as an adolescent female (always post-menarche) who, during disassociative states, cuts herself superficially (usually on her wrists) to relieve feelings of isolation and "tension." The anxiety and tension states occur as a response to threats (or fantasies) of separation or abandonment. The act of cutting serves to temporarily allay the tension and to restore a sense of equilibrium.

Diagnostically, the young women who engage in self-cutting have been seen as primarily borderline (Novotny, 1972). Schaffer et al. (1982) argue that a tendency to self-mutilative acts may in itself be a diagnostic feature of the borderline syndrome, and have obtained some

empirical validation for the above hypothesis. Siomopoulous (1974) argues that these behaviors comprise a type of impulse disorder. Though this is not the consensus, there is agreement that the histories of these young women are characterized by various forms of acting out and self-destruction. Most who have observed these patients concur that the cutting is done in a depersonalized and hence transiently psychotic state (Asch, 1971; Doctors, 1981; Pao, 1969; M. Simpson, 1975).

A temporary loss of ego boundaries seems to underlie these depersonalized states. More specifically, a dedifferentiation of sadistic and masochistic impulses is seen to figure in the determination of the symptom of self-mutilation (Burnham, 1969; Podvoll, 1969; Roy, 1978). As Emerson (1914) notes, during the act of self-cutting, an individual can simultaneously express both aspects of a sado-masochistic relationship. The body is attacked as a substitute for a frustrating and depriving introject; at the same time the self is punished as a way of preserving the same desperately needed introject against whom rage is not permissible. This enclosed cycle creates a state of "omnipotent self-sufficiency" (Burnham, 1969, p. 224).

Asch (1971) states that "a primitive form of depression" (p. 603) accounts for the unique phenomenology of cutting. He emphasizes the aspect of anger turned upon the self, rather than sado-masochism per se. In his view,

the major difference between self-mutilation and depression is that the former is enacted upon the body, whereas the depressive struggle is more internalized. As with others writing about delicate cutting (Crabtree, 1967; Pao, 1969), Asch stresses fear of abandonment or loss as a central precipitant:

> Threats of separation . . . are terrifying and release massive waves of aggression which flood the whole psychic structure. They ward off the aggression, turn the drive on to themselves, go into a psychotic withdrawal and use massive repression of the affect. . . . Episodes of depersonalization or chronic states of being empty or dead follow. (p. 616)

Numerous authors writing about delicate cutting remark on the fact that pain is not experienced during the act of cutting (Novotny, 1972; Siomopolouos, 1974). Such analgesia is a concomitant of the depersonalized state in which all feelings--both physical and emotional--are temporarily eradicated (Asch, 1971; Doctors, 1981). Pao (1969) remarks that delicate cutting may in itself be akin to depersonalization and derealization--the major difference being a motor discharge. Yet it is apparent that cutting is not merely a defense against affects, but is in itself a means to the restoration of affectivity. Kafka

(1969) suggests that when the body is cut, it has entered a transitional realm and has become "not me." Only through cutting can the body be reintegrated (Rosenthal & et al., 1972) and re-owned. Further, it is emphasized that the sight of blood may be the key factor in terminating the depersonalized state (Miller & Bashkin, 1974). As Asch (1971) puts it, "the cutting has as its main aim the recathecting of the depersonalized body-image of the self-representation through trauma and color shock" (p. 612). Additionally, a state of relief and relaxation is noted to occur after bleeding (M. Simpson, 1975).

That there is a preponderence of females among the delicate self-cutters has been observed by most authors already referred to. Doctors (1981) notes that those who present with this syndrome are always post-menarche, while Rosenthal and Rinzler (1972) state that in their study of 24 individuals, 60% were actually menstruating at the time they cut themselves. Pao (1969) suggests a correlation with castration issues, while Emerson (1914) posits a connection with masturbation and sexual trauma. Siomopoulous (1974) goes so far as to say that delicate cutting is

a symbolic equivalent of masturbation and that the cuts themselves are like tiny genitals.*

The majority of authors stress dysregulation of affects in the context of ambivalent object relationships as the central dynamic of the delicate cutting syndrome. However, the above psychosexual issues are also obviously significant. Shelly Doctors (1981) has written a study which attempts to integrate both aspects of the delicate self-cutting syndrome. She notes an "isomorphic relation between the features of object relations and the features of sexual development" (p. 447). Through an intensive study of nine adolescent female self-cutters, she came to the conclusion that,

> the symptom of self-cutting can be understood in the context of developmental disturbances which constitute the clinical features seen in such patients: a heightened tolerance for feelings of tension (experienced as physical tension); a lack of faith in

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* It is of interest that there are very few accounts of women actually mutilating their own genitals (in contrast to the men who will be discussed in the next section). There have been several studies which link reported cases of female genital self-mutilation with eating disorders and hysterical personality disorders (French & Nelson, 1972; Goldney & Simpson, 1972; Simpson, 1973). Goldfield and Glick (1970) also posit a connection with multiple surgeries and promiscuity.

> others to provide help (and a markedly impaired capacity for self-soothing); a very limited capacity to verbalize affect and a deficiency in the capacity to represent experiences in higher symbolic modes; and a definite propensity to turn passively experienced diffuse distress into active, focal experiences designed to achieve a feeling of control over self and thereby, a feeling of relief. While each of these elements can be seen to be one or another vicissitude of early object relations and self-development, the very same elements also characterized the vicissitudes of these patients' sexual development: the heightening of feelings of sexual tension and intolerance for such feelings; the lack of expectation of sexual relief and the absence of sexual self-soothing; the limited ability to use verbal and higher symbolic means to master feelings of sexual tensions; and the propensity to turn passively experienced diffuse sexual distress into active, focal experiences designed to achieve a feeling of control and relief. (pp. 445-446)

Etiologically, Doctors views this isomorphism as arising from early experiences of unrelieved bodily distress. Such distress in turn is seen to derive from excessive early physical traumata. Compounded by a

failure of maternal empathy, girls with developmental histories of this nature consequently fail to establish a well-established sense of self. Similarly, they cannot master or regulate their own genital sensations. Owing to such instability, conflicts relating both to sexuality and to self-development are concretely played out upon the body.

From a less intrapsychic perspective, other authors substantiate a relationship between family problems and similar instances of self-mutilation. Simpson (1981) observes a pattern of separation and abuse in the early life histories of those who engage in minor forms of self-mutilation. Carroll et al. (1980) also found a link between parental abuse and self-mutilation. They theorize that patients who self-mutilate may come from a family environment where outward expressions of anger are not tolerated and as a consequence must be turned upon the self. The 14 individuals (10 females) that these authors studied showed a constellation of significant early separations (before age 10) in a family atmosphere pervaded by violence, abuse and anger prohibition. Simpson and Porter's (1981) study of 20 patients (4 of whom were male) also confirms serious disturbances in the family milieu of self-mutilating adolescents. They too note interruptions and disruptions in early object relationships, as well as patterns of physical abuse.

That delicate cutting is a syndrome characterized by transient psychotic states (in individuals who are likely borderline and female) has been established above. Those who perform these acts are often covered with a multiplicity of fine scars. These patients have not performed irreparable damage to vital body parts nor permanently transformed their body-image. The stakes are much higher in the next group of self-mutilators to be discussed. These are the radical self-mutilators, whose acts go beyond superficially cutting. On the contrary, a separate term is more accurate to describe the nature of damage done; Ross and McKay (1979) have seen fit to describe the following self-mutilative behaviors as "severing."

Radical Self-Mutilation

Psychosis has been said to be a ubiquitous concomitant of radical self-mutilation (Esman, 1954). Though there are those who suggest that the psychotic state may be temporary and may occur in the context of character pathology (Greilsheimer & Groves, 1979), the most typically encountered diagnosis in these cases is schizophrenia (Blacker & Wong, 1963), usually paranoid (Shore, 1979). Depressive features are often present, either superimposed on a schizophrenic picture (Feldshuh et al., 1977) or in the context of a psychotic depression (Arons, 1981; Clark, 1981; Hemphill, 1955). Drug involvement may have a potentiating effect but rarely seems to be the primary

causative factor (Crowder et al., 1979; Goldsmith, 1973; Moskovitz & Byrd, 1983; Rosen, 1972). Several cases in which radical self-mutilation has occurred seemingly in the absence of psychosis (or ritual) have been reported (Slawson & Davidson, 1964; Stinnett & Hollender, 1970; Wakefield et al., 1977). However, severe defects (Stinnett & Hollender, 1970) or alterations (Cleveland, 1956) in ego functioning must be present in order to account for such profoundly self-destructive acts.

Delusions, hallucinations and ideas of reference seem to provide the impetus for radical self-mutilation, particularly when the content is religious or mystical (Feldshuh et al., 1977; Goldenberg & Sata, 1978; Kushner, 1967; McClean & Robertson, 1976). A preoccupation with the Bible, especially with those passages urging self-mutilation for the purpose of purification, seems to precede many psychotic self-mutilations (Clark, 1981). Many authors point out that prior to self-mutilating, their patients believed themselves to have a special relationship to God or Jesus. At times this may involve a psychotic identification (Betts, 1964) at other times a belief in being God's functionary (Feldshuh et al., 1977; Goldenberg & Sata, 1978). The self-mutilative act is often viewed by these patients as having a divine significance. Goldenberg and Sata (1978) make an analogy between those who injure themselves in response to psychopathological

religiosity and the subjects in Milgram's famous experiment. They so revere the source of authority "endorsing" an absurd and destructive act that they do not stop to question it. Shore (1979) makes a similar point. The more a person "trusts" or "values" his/her delusions or hallucinations, the greater is the likelihood that these psychotic experiences will lead to action.

An incredible observation contained in practically every case report of psychotic self-mutilation is the virtual absence of pain (Lion & Conn, 1982; Shore, 1979; Tapper et al., 1979; Tenzer & Orozco, 1970). To date little is known as to how such analgesia can occur. It has been suggested that it may be an extreme version of the blunting of affect typically found in schizophrenia (Shore, 1979). McClean and Robertson (1976) state that in order for an individual to perform the kind of self-mutilation we are describing, he/she must have a "disorder of body image, a perception that a change of an alarming nature is occuring" (p. 248). This experience of transformation "in the presence of ideas of reference, delusion and hallucinatory experience provides the 'rationale' for an act such as self-mutilation" (p. 248). Somehow, with such a disturbance in body-image, the typical thresholds and sensitivities associated with an intact body-image might be absent. The extent and location of Mr. G's self-injury reinforces the above point; the face is likely the

most highly innervated area of the body, yet initially he felt no pain.

Szasz (1957) sheds further light on the possible disruption in body image that may precede radical self-mutilation. He asserts that a pre-existing psychic mutilation must occur in order for an actual bodily mutilation to take place. At the point the mutilation does occur, the body is merely being updated to correspond to an already truncated image. Analgesia occurs because the ego has already extruded the mutilated part. A similar conjecture has been made by Hemphill (1951) who suggests that an abnormal body schema may underlie an act of extreme self-mutilation. He likens those who self-injure in that manner to organic patients who have been known to totally disregard a paralyzed limb. Obviously an actual organic factor such as those mentioned above may also contribute to the phenomenon of analgesia in self-mutilation.

Rather than pain, these patients seem to experience a sense of relief and a reduction of tension after their acts. The urgency and agitation described when patients so inclined are prevented from harming themselves bespeak the intensity of the psychotic need (Davidson, 1962).

Minimization and denial of injury also seem to characterize those who psychotically self-mutilate. Tapper et al. (1979) describe a patient who blinded himself and then denied that he could not see. Feldshuh et al.

(1977) remark on their patient's "almost monotonous indifference to her blindness" (p. 151).

There is discussion in the literature concerning the connection between radical self-mutilation and suicide. Is the person who self-mutilates in this way destroying a part of the self as an alternative to total destruction, i.e., performing a "focal suicide"? Though there are reports of patients who have subsequently committed suicide (Stewart & Lowrey, 1980), most radical self-mutilators are not overtly or consciously suicidal at the time of their actions. We nevertheless see (both in the recent and past histories of those patients) losses which could lead to the rage and despair often associated with suicide. Some authors report a recent abandonment or rejection preceding radical self-mutilation (Betts, 1964; Kushner, 1967). There is evidence that backgrounds of neglect and impoverishment characterize the past history of some radical self-mutilators (Blacker & Wong, 1963; Greilsheimer & Groves, 1979). It has also been noted that self-mutilators may turn upon themselves murderous rage intended for (but not expressible toward) an important object (Arons, 1981). Impotent rage of this sort is likely to be associated with loss. As will soon become evident, past and present losses figured significantly in the case of Mr. G.

In the literature on drastic self-mutilation, patients are repeatedly described as possessing "tyrannical

consciences" (Feldshuh et al., 1977; Shore et al., 1978). The self-mutilating act seems to provide expiation for real or imagined transgressions. Several authors have compared the acts of individual patients with religious and/or historical mutilation for the purpose of purification (Kushner, 1967; Menninger, 1935).

Sexual issues (involving either homosexual panic or heterosexual conflict) and oedipal concerns are frequently implicated in the overpowering sense of guilt that can lead to extreme self-injury. Certainly such dynamics are highly relevant in Mr. G's case. Sometimes the patient imagines that he/she has done something reprehensible; self-orchiectomy was the solution one patient found for masturbation (Pabis et al., 1980). In other cases an actual crime of rape or murder preceded the self-mutilation (Arons, 1981; Yang et al., 1981). While there are instances of the self-mutilator being the offender in a sexual assault, there are also cases where self-mutilation occurred after sexual victimization, including incest (Rosen, 1972; Yang et al., 1981).

It is of note that certain body parts seem more subject to radical self-mutilation than others. The genitals and the eyes seem to take precedence (Blacker & Wong, 1963; Clark, 1981; Crowder et al., 1979; Lion & Conn, 1982; Tapper et al., 1979). There are fewer reports of

hands (Arons, 1981; Hall, 1981) and digits (Mintz, 1964) being amputated and only rare cases of self-inflicted glossectomy (Michael & Beck, 1973; Tenzer & Orozco, 1970). There is one report of a patient who pharmacologically anaesthetized himself and removed his adrenal glands (Kalin, 1979). There are no comparable examples in the psychiatric literature of individuals removing cheeks, lips or nose, as our patient did. There are several reports of nasal self-mutilations, but none involving all the soft tissue of the nose (Akhtar & Hastings, 1978; Barton, 1977). Two cases involving the removal of an ear have been described, one of which is Van Gogh (Lubin, 1981; Rada & James, 1982).

Even when the organ/appendage removed is not explicitly sexual, the sexual symbolism of these acts seems to be taken for granted by some authors (Davidson, 1962; McClean & Robertson, 1976; Menninger, 1935). There are other views, however, as to the significance of the body part removed.

Kohut (1972) does not view radical self-mutilation as primarily related to sexual guilt. On the contrary, he attributes such acts to the "breakup of the body-self" (p. 376) that is endemic to psychosis. According to Kohut's view, in order to be removed, an organ must already have lost its "narcissistic libidinal cathexis" (p. 375). His discussion does not dwell on the choice of body part

mutilated. Arieti (1974) has suggested that contrary to the obvious symbolism, self-castration is often connected to birth fantasies. Rosen (1972) speculates that the eye which is enucleated is a "symbolic condensation of the self, the being guilty of the horrendous act" (p. 1011). Several other authors point out that in addition to the symbolic meaning, the body part removed may have an "actual" meaning as well. In his discussion of three individuals who self-castrated, Cleveland (1956) observes that each one of them had experienced prior injury to the genitals. The patient who cut out his tongue, described by Michael and Beck (1973), had been afflicted with a childhood speech impediment. Griffin et al. (1982) describe a patient whose epilepsy had predominantly left-sided movements; this man believed his left eye was the locus of his seizures, and for this reason removed it. It has also been suggested that those who self-enucleate may be attempting to stem visual hallucinations or graphic LSD flashbacks (Feldshuh et al., 1977). At this level, the self-mutilation seems to serve as a cure rather than a punishment, and indeed some patients refer to their acts as having just such a curative function (Kalin, 1979).

As to prediction of drastic self-mutilation, little is known. There has been one retrospective study done which indicates that a dramatic change in appearance may presage self-mutilation (Sweeny & Zamecnik, 1981). Aside

from factors which can be arrived at only by hindsight, little else has been reported as to predictive factors.

Summary of Psychological Self-Mutilation

Having now discussed the syndromes of delicate self-cutting and radical "severing," brief mention should be made of some of the major similarities between the two. In both syndromes, there is a confounding of sadistic and masochistic impulses so that the body becomes both attacker and attacked. A portion of the body comes to represent impulses, affects and/or objects which are unwanted and must be extruded. A hypertrophied superego seems to prompt an act of radical self-mutilation and the site of the self-mutilation tends to have a more calculated and symbolic significance. By contrast, delicate self-cutting seems to occur in a more disassociated and impulsive context, with fewer obviously symbolic overtones. Nonetheless, in both types of self-mutilation there is a striking similarity in terms of analgesia, followed by relaxation and relief. Moreover, both types of self-mutilation seem to produce powerful countertransference trends of a somewhat, but not wholly, different nature. It is to the topic of countertransference in self-mutilation that we will now turn.

Reactions to Self-Mutilation

So far an attempt has been made to review the literature on self-mutilation from the point of view of the mutilator and the psychodynamics of the mutilative act. As indicated in the introduction, this dissertation will also focus upon the effects self-mutilation can have on those caring for the self-mutilator. The following constitutes a review of the scanty but pertinent literature pertaining to this interesting aspect of self-mutilation.

Though addressing himself to the treatment of psychotic and antisocial patients, Winnicott's (1949) classic essay, "Hate in the Countertransference," is crucial to understanding reactions engendered by self-mutilation. Winnicott's central point is that certain patients can exhibit "objectively" difficult qualities which can evoke complicated and intense feelings in therapists, reactions which can be destructive if unexamined. Winnicott maintains that primitive affects will inevitably emerge in the therapist treating greatly disturbed patients. The work cannot proceed until this expectable (albeit distasteful) countertransference pattern is acknowledged and worked through. Winnicott underscores the importance of studying "the ways in which anxiety of psychotic quality and also hate are produced in those who work with severely ill patients" (p. 203).

Countertransference Trends in Cases of Delicate Cutting

It is basically the above points which reverberate throughout the literature on delicate self-cutting and it is to that literature we will turn again. Numerous authors point to the parallelism that exists between the dynamics of the (delicate) self-mutilator and those attempting to treat her/him. Common countertransference trends seem to emerge in work with these patients. These trends seem to derive from the fluctuation of sadomasochistic dynamics within the patient and within the therapist and staff working with the patient. Through the mechanism of projective identification a cyclical process is set up in which the staff and patient mutually collude to perpetuate the symptom of self-mutilation.

Delicate self-cutters often become "cause celebres" in inpatient units in their capacity as, what Burnham (1966) has dubbed, "The Special-Problem Patient." "Special" patients (though not always self-mutilators) are those who inevitably evoke ambivalence (Grunebaum & Klerman, 1967) and rescue fantasies (Pao, 1969) among hospital staff. Main (1957) has also written of the particular liabilities intrinsic to work with "special patients." He mentions that "the temptation to conceal from ourselves and our patients increasing hatred behind frantic goodness is the greater the more worried we become" (p. 130). These patients arouse omnipotent strivings in staff which

are dashed when self-mutilative acts recur. Splitting can be a frequent outcome in such a process (Burnham, 1966). The recrudescence of mutilating behavior in a therapeutic milieu has been said to produce feelings of helplessness, isolation (Burnham, 1969), frustration (Crabtree, 1967), confusion (Offer & Barglow, 1960) and rage (Podvoll, 1969) in staff working with such a patient. As Burnham (1969) points out, these are all experiences which mirror the self-mutilating patient's inner state.

The fact that self-mutilation does tend to recur even in protected settings, in spite of an excess of staff solicitude, has been noted by authors writing on this subject. That this should occur does not seem coincidental, and has been linked to the ward "milieu" (Kroll, 1978). The cyclical and at times contagious aspects of self-cutting seem to be related to the intensity of countertransference reactions elicited in staff members (Offer & Barglow, 1960) and by the failure of therapists and the staff to acknowledge countertransference "hate" (Crabtree, 1967). Podvoll (1969) remarks that the phenomenon of "social compliance" (p. 213) characterizes the milieu in which self-mutilation recurs. He outlines the ways that staff can unwittingly (and unconsciously) collude with repetitive episodes of self-mutilation. By self-injuring "the outward aggressive thrust is checked, (and) in this way the patient manages to preserve intact his split off

and idealized object" (p. 220). This internal split which exists within the patient is simultaneously experienced by the staff so that a reciprocal splitting occurs; the self-mutilator is thus preserved from the helpless rage that her/his acting out engenders in her caretakers. Crabtree (1967) echoes this point when he stresses that the "maternal caring attitude" (p. 96) typically evoked in staff is actually defensive against their own helpless and angry feelings. These less "therapeutic" feelings lead to guilt which in turn leads to reaction formation against the negative feelings. Podvoll (1969) makes the important point that the staff's constraint about their authentic emotions vis a vis a repetitively self-mutilating patient in itself expresses rage at the patient; it is just such unacknowledged rage which is presumed to induce the patient to harm him/herself again.

As many have discussed, it is when therapist and staff recognize and begin to confront their own countertransference "hate" that the patient's symptom of self-mutilation abates. Kafka (1969) saw the curative factor in his treatment of a self-mutilating patient as related to the shifting vicissitudes of sado-masochistically tinged transference and countertransference. Crabtree (1967) makes a similar point. When the "hate" aroused by self-mutilation is verbalized to the patient, the therapist no longer seems as vulnerable to the patient's ag-

gression. Other authors note that the difficulties in working with such self-mutilating or "special" patients in a therapeutic setting were ameliorated as a consequence of a frank countertransference discussion (Burnham, 1966; Main, 1957; Offer & Barglow, 1960).

The emphasis in the above mentioned articles is on self-mutilating as a repetitive form of acting out that the staff feels powerless to control. The countertransference seems to derive from the staff's and therapist's good will being thwarted by the patient's recurrent acts of self-destruction. Relatively little is mentioned about the reactions to the mere fact and appearance of self-mutilation apart from the threat of recurrence. Podvoll (1969) suggests that there may be two "levels" of "social compliance" (p. 213). The first, as discussed above, relates to the perpetuation of the symptom. The second seems more to involve an awestruck reaction to the phenomenon of self-mutilation itself for "we find these patients engaging the more poorly integrated aspects of ourselves" (p. 221). He points out that staff can associate self-mutilation with Christian ascetism and martyrdom, and as a result can even experience unconscious "envy" and "admiration" toward the self-mutilator. From a different point of view, Pao (1969) suggests that self-mutilation may evoke castration anxiety among staff members.

Countertransference Trends in Radical Self-Mutilation

Little has been discussed about reactions to more radical forms of self-mutilation; it seems evident, however, that the countertransference trends in those cases have much more to do with the fact or phenomenon of self-mutilation than with the potential for further acting out. Menninger (1938) remarks that extreme self-mutilation can be more "repugnant" than suicide; he attributes this differential reaction to a vicarious experience of pain. McClean and Robertson (1976) also note the profound distress that an act of radical self-mutilation can evoke in staff members. They too make a comparison with suicide, concluding that, in terms of staff response, radical self-mutilation is tolerated even less well. Other authors (Hall et al., 1981; Lion & Conn, 1982) similarly emphasize the feelings of stress and fright that are elicited when such a patient is present in a hospital. Ross and McKay (1979) emphasize that no amount of expertise or experience can strengthen any professional from the repulsion engendered by gross self-inflicted mortifications of the flesh. Yet Greilsheimer and Groves (1979) suggest that the phenomenology of reaction to self-mutilation may involve more than simply aversion. They have observed a peculiar dual response involving not just disgust, but titillation as well. Not surprisingly, contradictory emotional vicissitudes can be evoked in those who

encounter radical self-mutilation. Rada and French (1982) describe the immediacy of staff response to males whose self-mutilation consisted of inserting objects into their urethras. They also describe the clear fascination that accompanied staff reaction to those acts, as well as the hospital-wide fame gained by the patients who self-mutilated in this manner.

The impact of radical self-mutilation can be so profound that it can permeate the unconscious minds of even those peripherally involved with such patients. Greilsheimer and Groves (1979) describe a hospital janitor who reported having a dream about a patient who had self-castated, while Cleveland (1956) describes the almost apoplectic rage of a policeman who had to escort a self-castrator.

There is little else which directly addresses reactions to radical self-mutilation. Moreover, none of the authors cited above go very far in explaining the nature of the alarm and revulsion experienced by those who view these patients, let alone do they attempt to fathom the "titillation" reactions described. As might be expected, there is nothing whatsoever written about reactions to radical self-mutilation of the entire face. Some answers may be found in several related, but not wholly parallel, areas such as the reactions evoked by physical stigma, ugliness, anomaly and facial disfigurement.

Reactions to Physical Anomalies

In his book Stigma, Goffman (1974) sets out to examine the sociology of stigmatization, usually physical. He notes quite aptly that the encounter between "normals" and stigmatized individuals happens to be "one of the primal scenes of sociology" (p. 13). In discussing the etymology of the word 'stigma,' Goffman observes that its original meaning was "bodily signs" (p. 13) etched in an individual's skin to denote moral inferiority. Though strictly speaking the word 'stigma' no longer carries that literal meaning, Goffman points out that physical stigma, in particular, still evokes negative inferences about an individual's character. He also notes that stigmatized individuals are often viewed as not being fully human or as endowed with a "supernatural cast" (p. 5). By implication, obvious self-mutilation may constitute a sort of double stigma -- the stigma of the mind emblazoned in the mutilated body part.

Niederland (1975) sheds further light on the psychological impact of physical disfigurement by another excursion into etymology. He discusses the derivation of the word 'ugly'; he states that it stems from the Gothic 'ogan,' "meaning to incite fear to terrify. It is related to the German verb 'augen' -- to stare or eye intensely with fear" (pp. 451-452). The suggestion here is that in addition to the fear that is engendered by ugliness,

something in its nature makes it impossible to ignore. This ambivalent attitude elicited by extreme physical disfigurement--fear coupled with awe--is supported in the literature on facial disfigurement. One author suggests that a facial disfigurement can be viewed as "an indication of virtue and goodness meriting special reverence" (Wright, p. 106). On the other hand, that same disability can be imputed to "causes of a negative evil signification" (Wright, p. 159). Meyerson (1948) echoes this view, as does Barker (1948) who contrasts Francis Bacon's identification of deformity with badness to Robert Burton's view of the intrinsic spirituality of those who are deformed. Ladieu et al. (1948) emphasize a slightly different dichotomy evoked by "visible injuries" (p. 55), namely, "unwarranted pity" (p. 55) alternating with curiosity. Hentig (1948) points out that understanding the genesis of facial disfigurement may modify negative attitudes.

Rickman (1940) has offered a psychoanalytic explanation as to why ugliness might incite such profound and contradictory reactions in an observer. He states that the "defects in the object itself" (p. 298) are less distressing than their ability to trigger buried unconscious impulses. Rickman believes that ugliness stimulates primitive sadistic and rapacious fantasies and attendant anxiety. He maintains that "the fear which

ugliness raises is due to the irrefutable evidence it provides that the will to destructiveness has been let loose and we turn from it in part through the dread of the temptation of complicity, in part because we cannot bear to contemplate what in our unconscious fantasy we have already done" (p. 311). Malcove (1933) alludes to some of the unconscious fantasies that may be stimulated by viewing mutilated body parts. In her article entitled "On Bodily Mutilation and Learning to Eat," she suggests that a fear of being mutilated (and, by implication, a fear of those who have been mutilated) has primitive developmental origins. "The fear of being dismembered, cut to pieces, or mutilated, has a prototype in the universal experience of learning to eat. It is in this procedure that the child sees food cut into pieces, mashed, broken up and finally eaten" (p. 557). She states that eating evokes "cannibalistic" and "animalistic" fantasies which, in turn, evolve into projections of being eaten, mutilated and castrated.

In a book entitled Emotional Care of the Facially Burned and Disfigured, Bernstein (1976) stresses that the power of a viewer's reaction to facial disfigurement is attributable to "the threat of repressed affects returning" (p. 18) rather than from the "objective disfigurement" (p. 18) itself. He also mentions the evocation of castration anxiety, as well as emphasizing the

interpersonal impact of extreme facial mutilation. Damage to the face is particularly disconcerting as the face is the primary conduit of interpersonal communication. Bernstein goes on to say that a damaged face challenges "the sense of inner security and the confident self-system of everyday life" (p. 18). As another author remarks: "A facial deformity is not a secret" (Longacre, 1973, p. ix). Kobo Abe (1966) is a Japanese novelist who has devoted a novel to the tale of a man whose entire face was blown off in an explosion. Abe poignantly describes the inevitably problematic nature of facial deformity. He elaborates on Carlyle's point that if "the robe makes the priest and the uniform the soldier, perhaps the face makes the monster" (p. 61). Similarly, a psychologist whose face was mutilated, wistfully describes the children who ran screaming from her despite her benign and affectionate intentions (Brown, in Longacre, 1973).

The subject of monstrousness in general also bears upon our subject matter. In a particularly fascinating anthropological analysis of "taboo," Mary Douglas (1966) tackles the realm of teratology. From an anthropological perspective, she shows the differing strategies by which "primitive" cultures have handled those in their midst who are anomalous or dysmorphic. As will become apparent, some analogous strategies went into effect when our putatively sophisticated hospital culture encountered Mr. G.

Her basic premise is that those individuals who are monstrous or deformed defy a culture's agreed-upon categories of what is human. Those who do not "fit" these categories provoke great anxiety by challenging the boundaries between the human and non-human worlds. The ways non-literate societies handle instances of monstrousness are several. A monstrous human birth can be relabelled as non-human so that the border defining that which is human can be reestablished (i.e., a deformed baby might be renamed a hippopotamus and placed in its obvious natural habitat: a river!). Alternatively, the anomaly can be eradicated by outright methods such as infanticide. Another strategy is avoidance. By avoiding that which is monstrous the culture "affirms and strengthens the definitions to which they do not conform" (p. 39). Anomalous beings can also be "labelled dangerous" (p. 39). Conversely, they can be elevated to the status of powerful cultural symbols to be utilized advisedly in ritual and art "to enrich meaning or to call attention to other levels of existence" (p. 39). Douglas' central point throughout this essay is that those elements or beings which a culture labels anomalous or unclean are so deemed because they challenge essential (though not absolute) semantic demarcations, thus inviting anxiety and chaos. The various strategies employed to handle anomalies occur

because of a need to titrate the intrinsic power of anomalousness.

The literary critic and essayist Leslie Fiedler (1978) has devoted an entire volume to the subject of "freaks." Fiedler explores the age-old fascination/revulsion with congenitally deformed or dysmorphic individuals. Though the shapes and sizes of "freaks" vary, Fiedler believes that the key to their appeal is universal and consistent. He too notes the powerful, though ambivalent, reactions that can arise when one encounters a "freak."

> The true freak . . . stirs both supernatural terror and natural sympathy, since . . . he is one of us, the human child of human parents, however altered by forces we do not quite understand into something mythic and mysterious, as no mere cripple ever is. Passing either on the street we may be simultaneously tempted to avert our eyes and to stare; but in the latter case we feel no threat to those desperately maintained boundaries on which any definition of sanity ultimately depends. Only the true freak challenges the conventional boundaries between male and female, sexed and sexless, animal and human, large and small, self and other and consequently

> between reality and illusion, experience and fantasy, fact and myth. (p. 24)

Fiedler skillfully evokes the semi-pornographic atmosphere of the freak show where voyeurism is a necessary component of the entertainment. Despite oneself, one is drawn in and forced to participate. He speaks of the human need to <u>create</u> monsters, citing the bizarre chimeras of medieval bestiaries as examples of this tendency. Fiedler's ultimate explanation for the age-old preoccupation with freaks is psychodynamically informed. He attributes the fear/fascination dichotomy to "our basic uncertainty about the limits of our bodies and our egos" (p. 27). He asserts that the myth and actuality of monsters have "twice-born" (p. 31) roots in our psyches, originating in childhood and re-evoked in adolescence. Fiedler's view is that the magnetism of "freaks" for "normals" stems from an unconscious process of identification. We identify with those who are ugly or dysmorphic owing to long-repressed fears (and wishes) about the potentials and "limits of our bodies and our egos" (p. 27). He notes that the basic repertoire of freaks as revealed by the choice of displays in a freak show gives physical embodiment to "our basic insecurities . . . about scale, sexuality, our status as more than beasts, and our tenuous individuality" (p. 34). Freaks are not so foreign after all, but turn out to be,

in the words of Fiedler's subtitle, "Myths and Images of the Secret Self."

The Elephant-Man is cited by Fiedler as a prime example of this dualism. Ashly Montagu's (1971) book on this singularly anomalous human being underscores the powerfully ambivalent reactions that such a freakish human being can evoke. On the one hand, John Merrick was so horribly deformed that unless he was completely enshrouded on the street, he would become the victim of a screaming mob. On the other hand, once ensconced in his permanent chambers in London Hospital and under the benign care of Sir Frederick Treves, he was capable of becoming an object of notoreity, admiration and even reverence in English drawing room society. "He must have been visited by almost every lady of note in the social world" (Montagu, p. 28). The dynamic process by which John Merrick became respectable and famous is likely quite similar to the process which transformed Mr. G from "unheimlich" to "heimlich."*

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* The above literature is relevant to our case not only because the dynamics seem similar to the dynamics occuring in radical self-mutilation, but because physical ugliness is such a central consequence of our patient's act. Yet, not only is our patient's face ugly, it became so as a consequence of an even uglier act. A brief mention should be made of an article which addresses itself specifically to staff countertransference to an act of murder--itself an ugly act. In their case report of a man who was psychiatrically hospitalized after he murdered his wife, Belleau and Arsenian (1967) note the extreme countertransference elicited in staff members. As long as the patient seemed penitent and guilty, the

Summary of Areas Related to Self-Mutilation

We have been discussing the literature on disfigurement, anomaly and freakishness with the suspicion that the phenomenology of reaction is similar to that which emerges in response to radical facial self-mutilation. We see similar patterns of aversion and fascination, repulsion and titillation. Though the literature on radical self-mutilation does not explore the above ambivalence, the other literature suggests that it derives from a threat to the conventional ways we view ourselves as human. Anxiety arises not simply as an objective consequence of seeing someone who appears ugly or freakish but because of his/her power to catalyze the very aspects of ourselves that we have not fully tamed. Basically, these notions lead us back to Freud's concept of the Uncanny.

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staff could could apparently handle their feelings toward him. Once the patient became less remorseful, however, the staff's response changed. The authors note many unusual mishaps and delays in processing the case, which they attribute to countertransference. It is of note that the authors assume that the staff were more unconsciously identified with this patient than with other non-murderous patients.

CHAPTER THREE

Methods

As this is a clinical case study, the methods used are less than purely empirical. I have used my own experience as a participant and an observer to gain some understanding of Mr. G and of the institutional "culture" that grew up around him. As Chapters One and Two contain a plethora of intense and often unnerving material, this short section both fulfills a formal requirement and serves to reorient the reader to the remaining direction of the dissertation.

Thus far, a brief account of Mr. G and the initial reactions that he elicited in both myself and my colleagues has been given. The literature on self-mutilation, albeit circumscribed, anecdotal and generally atheoretical has been reviewed. Even more delimited aspects of that literature (particularly pertaining to the phenomenon of "delicate self-cutting") suggest that self-mutilation inevitably evokes powerful (and predictable) countertransference trends. Related areas have also been explored. Particular attention has been paid to the ways that physical defects affect those who view them. That

neutral reactions are more the exception than the rule is implicit in this literature as well.

The chapters which are to follow will discuss Mr. G and the evolution of his hospital course. This will be done from two separate vantage points. Chapter Four will be a case history of Mr. G, proceeding both backward and then forward from the nodal point of his self-mutilation. Following the presentation of this data, Mr. G will be briefly compared to other radical self-mutilators, noting the way his case does and does not correspond to others. An attempt will also be made to understand Mr. G's unique self-mutilation by means of a psychodynamically based theory. How Mr. G's unique psychic structure and life experience could conspire to cause him to so radically harm himself will remain an enigma. That he chose his face as the site for mutilation becomes almost comprehensible when examined (post hoc) in light of his past history. Chapter Five is a clinical description of the institutional "countertransference" that characterizes the behavior of those who care for Mr. G.

Two assumptions will be made throughout the final chapters: one is that countertransference-like reactions can occur in all manners of helping professionals (not only therapists); the other is that all those interested in or caring for Mr. G became, by dint of their similar purpose, a group. That there have been consistent phases

and patterns of response seems both a reflection of the generic horror elicited by any act of profound self-mutilation, as well as being specifically related to the type of self-mutilation that Mr. G performed. Chapter Six will attempt to analyze the "countertransference" trends from the perspectives of individual and group psychology. The ramifications of Mr. G's facelessness (the other side of his ugliness and disfigurement) will be discussed as comprising a significant determinant of the particular type of responses that he elicited in his caretakers. Finally, Chapter Seven will constitute an epilogue describing the current status quo as well as Mr. G's ongoing reverberations both inside and outside of our institution.

CHAPTER FOUR

Case Report of the Patient

When he performed his act of compound self-mutilation, Mr. G was a 19-year-old man in the throes of a schizophrenic decompensation. Though seemingly occuring at random, his choice of the face for self-mutilation seems to have been quite overdetermined. My interpretation of the mutilation, which will follow the case study, is necessarily speculative as the patient denies his own agency in the act. On the other hand, the circumstances surrounding the act, coupled with Mr. G's past history, shed some suggestive light on the meaning of Mr. G's self-mutilation. Further, in following Mr. G for almost two years, I have gained some understanding of his psychodynamics and the way they pertain to his self-mutilation. Before attempting to explore the significance of Mr. G's facial mutilation, the facts of his life both immediately prior to and predating the mutilation will be presented to the extent that they are known.

History of the Self-Mutilation

Two days before Christmas 1983, Mr. G was brought by the EMS to _____ Hospital, the soft tissue covering most of his face having been "avulsed." To repeat, his left eye, left ear, nose, lips and the anterior portion of his tongue had been removed. His remaining eye had been badly damaged. In the medical emergency room, an "ATR" was called. This stands for the most extreme form of medical emergency the hospital can mobilize for.

Amazingly, and despite the extent of his injuries, Mr. G was not in shock and was conscious at the time of his arrival in the emergency room. As the hospital staff proceeded to treat Mr. G's injuries as expeditiously as possible, there was a concurrent effort to obtain an accurate understanding of the way this devastating trauma had occurred. From the outset, there were two differing accounts, both supported by the facts at hand. One account had Mr. G as the agent of his self-mutilation, while the other had him as the passive victim of his dogs. Almost immediately Mr. G told the doctors that the family's several Belgian Shepherds "had done it." Indeed, there were dog hairs found in Mr. G's wounds, suggesting that the dogs were somehow involved. Further, when the mother dog (who was actively nursing a litter of pups) was given Ipecac, the contents of her stomach contained Mr.

G's facial parts. On the other hand, Mr. G's father stated that neither he nor his other son (both of whom had been sleeping at the time of the mutilation) had heard any signs of a struggle: no screaming, no growling. Only Mr. G's face had been injured; there were no marks anywhere else on his body to suggest that he had tried to resist an attack. Mr. G's father reported finding a mirror with bloody edges near Mr. G, suggesting that this may have been used as a cutting implement. One of the EMS drivers reportedly told "someone" in the emergency room that a razor had been found in Mr. G's bathroom as well.

Though there were surgeons and doctors in the emergency room who felt that Mr. G's wounds were consistent with dog bites, the majority seemed to feel that Mr. G's wounds were more in keeping with methodical self-injury (i.e., sharp clean edges) than with the ragged tearing that one would expect from a dog's teeth. Yet how to explain the portions of Mr. G's face in the mother dog's stomach? An expert from the New York City Animal Bites Registry who subsequently examined the regurgitated facial parts (macabre but true) believed that the edges of the disembodied features were "too even" to have been bitten off. He ventured the ghoulish but ultimately more plausible suggestion that Mr. G may have cut off his own face and thrown it to his dogs (the fact that the pieces were not masticated suggested that they had been gulped

down, i.e., fed to them). Perhaps the most definitive corroboration that Mr. G's facial trauma was a self-mutilation came from a staff member in the emergency room who claimed he had heard Mr. G tell the policeman who brought him in that his wounds were self-inflicted.

As to the events which led up to the mutilation, our information is not complete. The following is assembled from information given by Mr. G and his father, as well as by other professionals who saw him in the days preceding the mutilation. Though already deemed schizophrenic since the age of 15, Mr. G's decompensation seemed to have some key precipitants. Most central perhaps was his family's imminent move to another state and their failure to include him in their plans. Mr. G had learned of this decision in the weeks prior to the mutilation. Although he had no overt reaction, he became increasingly withdrawn and seclusive. For two weeks, Mr. G's family observed him to be fasting and reading the Bible a great deal. He seemed to have certain delusional and omnipotent preoccupations such as being "Master of the Beasts"; in this capacity he was apparently beating his dogs. He also believed that as a "test," God had ordered him to eat the dogs' feces and he did so on at least one occasion.

Because Mr. G's emotional condition was deteriorating, his family saw fit to take him to _____ Hospital on the day preceding the mutilation. Ironically, though

he was observed to be hearing voices, he was not deemed immediately dangerous; he was told to return for evaluation with his family the next day. It was also learned that several days before this screening visit, Mr. G himself had presented himself at another hospital where he had previously been a patient. He had apparently come knocking on the door of his former ward, requesting admission. He was walking with a cane (though he had no discernible limp), looking "like an orphan." Mr. G was such a sorry sight that the unit chief personally escorted Mr. G to the hospital's emergency room so that he could be admitted. Unfortunately, Mr. G did not even sign in and disappeared before he could be interviewed.

From his subsequent reports we can ascertain that on the day of the mutilation, Mr. G was involved in both sexual and aggressive behavior. He claims to have had a fight with a relative which resulted in his getting his lip bloodied. He apparently returned home to be "comforted" by his dogs, allowing them to lick the blood away. (This was at least several hours prior to the mutilation.) Mr. G also stated that he wanted "to mother the dogs and be mothered by them." He also reported that on the same day, he was "seduced" by a somewhat older woman who was the girlfriend of a distant relative. He described having several prior invitations from her which he refused. (He also described feeling ambivalent in general about being

found attractive by women.) During the sexual act, this man walked in on them. Feeling himself to be delusionally all powerful at the time, Mr. G "ordered" this interloper to self-castrate, believing full well that his orders would be carried out.

On the night that the mutilation occurred, Mr. G was watching television. He states that he heard an announcer give the bulletin that "the world went broke," and that this news upset him tremendously. The above suggests a frightening world destruction fantasy accompanied by ideas of reference and/or thought broadcasting. Such is the extent of the information obtained which pertains to the period immediately preceding the mutilation.

Past History

Mr. G's past psychiatric history is rather extensive for such a young man. Before delineating the particulars, it should be noted that Mr. G's has been a life studded with loss, disruption and abandonment. As will become clear, there was fertile soil for the development of severe psychopathology, above and beyond whatever biological factors may also be contributing to Mr. G's schizophrenia.

Mr. G was the oldest of five natural children. At the age of seven, his mother, to whom he was very close, died. Her death occurred shortly after the birth of her

second son, caused by complications arising from appendicitis and hepatitis. Mr. G had been his mother's favorite, that favortism extending beyond expectable bounds. Mr. G was allowed to sleep in his mother's bed, and did so consistently. Moreover, Mr. G's father has reported that between the ages of one and four, Mr. G's mother would perform fellatio on her son in the course of bathing him. Mr. G's father would stand by and observe this perverse bathing ritual. Though initially he thought his wife's behavior inappropriate, the older Mr. G eventually developed the conviction that his wife was merely exhibiting loving behavior toward her small son.

After his mother's death, Mr. G was placed in the care of his maternal grandmother; she died a year later, again leaving him bereft of a mother figure. Mr. G's father took over the care of his children, remarrying a woman who had two children herself.

By age ten, Mr. G was manifesting serious emotional difficulties, including aggressive acting out in school, stealing and encopresis. Though his father beat him severely for stealing, he also brought his son to see a psychiatrist. It is unclear how much treatment occurred (or whether this was just a consultation). What is known is that the psychiatrist believed that Mr. G was still reacting to his mother's death. When Mr. G was eleven, the house in which he lived burned to the ground,

seemingly as a result of an accidental fire set by Mr. G's brother. Though there were no injuries, all the family's possessions were destroyed.

In spite of the fact that Mr. G is described as having been a parental child who took a good deal of responsibility for his younger siblings and step-siblings, his behavioral difficulties persisted, resulting in frequent suspensions and trouble in school. At age fifteen, Mr. G confessed to his father that he had molested two of his step-siblings. It was not clear to therapists subsequently working with Mr. G whether these molestations were actual or imaginary; nevertheless, Mr. G's father beat him severely. Shortly after the beating, Mr. G put both hands through a glass window with the intention of severing them (he sustained lacerations). This act was the direct outcome of Mr. G's guilt over molesting (or fantasizing about molesting) his step-siblings and eventuated in his first psychiatric hospitalization.

This initial hospitalization lasted three months, during which time Mr. G's psychosis was quite refractory, characterized by hypersexuality and aggression. He was maintained on a substantial dose of neuroleptic medication which eventually controlled his aggressive acting out. A variety of diagnoses were entertained during this hospitalization, including reactive psychosis, personality disorder with depressive and sociopathic features, and

schizophreniform disorder. Despite these different diagnostic possibilities, there was a consensus that Mr. G's family atmosphere was deleterious to his mental health (particularly owing to Mr. G's father's observably inadequate parenting). Plans were made to place Mr. G in a residential home. It is of interest that Mr. G himself requested a place with "a very strict military atmosphere."

Mr. G was transferred to a residential school for disturbed boys where he remained for over a year, until the residence closed. During his first year at the school, Mr. G was viewed as depressed and was placed on an antidepressant. Mr. G's family's lack of involvement was thought to be related to his depression. They visited rarely and did not keep appointments with staff. Mr. G was again psychiatrically hospitalized after he had been found wandering on a bridge in his pajamas. He claimed to have been hearing his mother's voice urging him to jump into the water and join her.

Mr. G's second hospitalization lasted two months, during most of which time he was quite psychotic. Preoccupied with past guilt over sexual feelings for his siblings, Mr. G was again treated on high doses of antipsychotics. He was discharged with a diagnosis of paranoid schizophrenia.

Mr. G returned to the residential school at the time of discharge, but could not remain as the school closed.

Mr. G returned home to his family and rather quickly deteriorated to a psychotic state. This necessitated a third psychiatric admission; Mr. G was then only 18 years old. During this admission, Mr. G exhibited religious delusions in addition to his sexual preoccupations and aggressive behavior. He admitted to hearing voices and having experiences of external control. He was tried on increasingly high doses of antipsychotic medication (up to 100 mg. of Haldol daily) with little effect. He was eventually discharged back to his family on injectable Prolixin.

The time following this hospitalization and his next one is not well accounted for. Clearly little had changed to prevent his requiring yet another psychiatric hospitalization. The major precipitant for Mr. G's most recent psychiatric hospitalization seems to have been his father's decision to move, without Mr. G, from New York. During his fourth psychiatric admission, Mr. G was acutely psychotic. In particular, he was preoccupied with guilt over not caring for his siblings and he was delusional about his dogs, believing that they had brought him to the hospital. Once again, his family was insufficiently involved with his treatment and in his discharge planning. As before, he required treatment with increasingly high doses of antipsychotics. Hospital staff felt that further treatment at a long-term institution was indicated, but

Mr. G's family refused. Upon discharge (after months), Mr. G had not recompensated. Mr. G did not pursue outpatient follow-up. He returned once to the hospital at which time he reported that he had been living in the street and in shelters. Little else is known about Mr. G's intervening life until the time he came to our attention three months later.

Hospital Course: ICU

When Mr. G first arrived in the Intensive Care Unit of the hospital, he was in an acutely psychotic state. No crystallized delusions or hallucinations could be elicited, though the form of his thinking was often loose and incoherent, the content quite regressed. There were periods of agitation but for the most part Mr. G was calm and cordial. It was this quality of eerie calm that was in fact the most dramatic marker of Mr. G's psychosis. He seemed indifferent not only to the fact of his injuries and blindness, but to the experience as well. He neither remarked on feeling pain nor requested pain medication. Similarly, he made no reference to not being able to see.

Within the first week in the hospital, Mr. G was started on a high dose of neuroleptic medication and had the first of his many surgeries. This involved the manufacture of "delto-pectoral flaps": grafting skin from his

chest to cover his cheeks. In order for the grafts to "take," flaps connecting the chest skin to the cheek area had to remain in place for several weeks. Utter immobility was required for Mr. G, so that this connective skin would not tear. Though this surgery ameliorated the skeleton-like aspect of Mr. G's appearance, the fact that his cheeks were attached to his chest added a new dimension of monstrosity.

Mr. G did not like the immobility required of him, nor the fact that all his feedings had to come through a nasal tube. Despite these dreadful constraints, Mr. G basically complied with the restrictions placed upon him. As the weeks passed, Mr. G's cognition became more and more intact, as did his perception of physical pain. He began to register how much discomfort he was in and to ask for ways to alleviate it. Amazingly enough, it took longer for Mr. G to acknowledge his blindness. It had been established by the opthalmologists that, at the very most, Mr. G had some awareness of light in his remaining (mutilated) eye. Nevertheless, Mr. G never referred to an inability to see, at times even asserting that he could see things around him.

By the end of his first month on the ICU, Mr. G had become less psychotic and, in spite of his blindness and lack of mobility, was acutely aware of his surroundings. Initially deemed incapable of signing consents for the

various procedures done on him, Mr. G became quite capable of knowing and understanding the nature of the surgery he was having and was given permission to sign for it. Though he had still not left his bed, Mr. G was always well oriented to time and place. He could recognize the voices and/or footsteps of virtually everyone who attended to him. He knew the names of the medicines and procedures he was having, as well as the placement of the various equipment in his room.

As Mr. G's mental status improved, so too did his appreciation of his wretched physical condition. He became increasingly able to speak poignantly about his discomfort and fear of surgery. During his stay on the ICU Mr. G had a total of ten major surgical procedures, several of which involved complicated skin grafting. Among the operations performed upon Mr. G were: the construction of an eyelid for the remaining eye (manufactured with skin from the web space between his toes); the fabrication of an external nose (constructed by stretching the skin from his forehead and scalp); and the fashioning of a lower lip (from chest skin) and an upper lip (from forearm skin and arteries). The refinement and rerefinement of each of these operations entailed more surgery still. Despite these physical ordeals, Mr. G remained a "model patient," able to cooperate with all that was done to him. He was polite and deferential to his doctors. He

occasionally irritated the nurses by lewd and inappropriate remarks which basically never went far beyond age-appropriate flirting. This was a far cry from his initially psychotic invitations to the nurses to masturbate him.

Throughout his first year in the hospital, and despite his seeming improvement, Mr. G continued to deny any responsibility for his facial trauma. If asked, he usually insisted that "the dogs did it," expressing disbelief that we could deem him capable of such a thing. He never brought the subject up spontaneously and rarely wanted to dwell on it when the issue was raised. One nurse on the ICU states that Mr. G did "confess" his responsibility to her, but swore her to secrecy stating that if the psychiatric staff knew, we would surely institutionalize him. There were reports of other strange stories that Mr. G told when he was questioned as to the etiology of his injuries. He told a social worker that he had climbed into a cage at the zoo and had been mutilated by "timber wolves." On several other occasions, he told people that he met that "rats did it," attracted by the "cheese" that he had been "eating in bed." Mr. G acknowledged to his therapists that the above were conscious fabrications. Moreover, he did state that he felt a "nervous breakdown" was indirectly responsible for his condition. He was willing to admit that his state of mind had allowed him to "let" his dogs maim him.

Obviously the bizarre tales Mr. G told were clues to his underlying psychopathology. Yet it was very striking that there were few other flagrant manifestations during Mr. G's first year on the ICU. When stressed, either by an approaching surgery or lack of contact with his family (aside from some early visits from his father and erratic visits from his sisters, Mr. G has been virtually abandoned by his family during his lengthly sojourn in the hospital), Mr. G would temporarily exhibit an overreliance on the defensive mechanisms of projection and denial. He would become withdrawn and angry, often accusing trusted staff members of not liking him or talking about him. At other times, he would become slightly delusional, insisting that the doctors had told him something that they had not (i.e., that he was scheduled for an operation to restore his vision). When the period of stress would end, however, Mr. G would return to his more typically affable and at times gregarious state. Mr. G's sense of humor should also be remarked upon. Even when quite uncomfortable, Mr. G could joke with staff members, punctuating his interchanges with good natured belly laughs.

By Mr. G's fourth month in bed it was decided that he needed physical rehabilitation to tone up muscles which had atrophied due to inactivity. A regimen which involved going to the outpatient rehabilitation department was instituted. These were the first occasions that Mr. G

would leave his room. To protect Mr. G from unsolicited comments, staff suggested that he wear a paper surgical mask (turned around) over his head. In addition, the physical therapists working with Mr. G added sunglasses to augment his disguise. These trips out of his room seemed to contribute to Mr. G's burgeoning sense of self-consciousness, as he became quite aware of the flurry that his masked presence caused in elevators and corridors. This was compounded by an incident in which Mr. G's physical therapist took him for a walk around the ICU without his mask. Mr. G. reluctantly complied with this plan, only to be shoved back into his room by an almost hysterical nurse who stated that Mr. G's appearance could give other patients "a heart attack." There were at least several other incidents in which Mr. G overheard people discussing his appearance. A particularly traumatic one involved a visitor running into his room and proclaiming that he must repent, as he had been possessed by demons. It should be clarified that Mr. G's multiple surgical procedures did succeed in making him look less like a skeleton. Yet this is the most one can say. Mr. G's "eye," "nose," and "lips" were crude similacra of the lost facial parts and bore only the grossest ressemblance to their predecessors. Since the skin grafts were from areas of the body where pigmentation differed from the face, Mr. G's remodeled face had a random patchwork appearance.

Perhaps most upsetting was the fact that in mutilating his face Mr. G had severed the facial nerves that give the face its animation and mobility. Though outer facial skin could be restored, it would remain necessarily fixed and immobile; the underlying nerves had been irrevocably destroyed.

Though initially compliant with the trips out of his room, Mr. G came to refuse them. This refusal was likely attributable to his growing awareness of his impact on others. The greater Mr. G's awareness of his condition became, the more depressed he got. The realization that surgery would not ideally transform him (nor return him to his familiar pre-mutilated condition) began to dawn on him. Though he came to acknowledge his blindness, he held out hope that a corneal transplant could restore vision in the remaining eye. (This was seen as a dim possibility by the plastic surgeons but not by the opthalmologists; this difference of opinion basically amounted to a lengthy deadlock between the two disciplines.) That Mr. G was offered blind training as well as physical therapy in his trips off the ICU also contributed to his refusal to leave his room. To Mr. G, "blind training" meant he was going to be permanently blind. His blindness was acceptable only as a temporary condition. A further factor which contributed to Mr. G's increasingly withdrawn state was the continued absence of his family. Mr. G himself found

their telephone number (they had not left it) and managed to contact his father on several occasions. Each time a promise would be made that a family visit was imminent, but it never occurred. In addition to the experience of his family's rejection, Mr. G also experienced several losses in the form of staff members to whom he was close rotating off the ICU. At times Mr. G could talk quite movingly about his losses and disappointments; at other times he would simply withdraw and one would have to infer the motivation.

After almost a year on the ICU, it was decided that Mr. G should be transferred. Having been allowed to remain on the ICU longer than any patient in the history of the hospital, pressure was finally applied to transfer Mr. G. Clinically it was also thought that Mr. G would be better off in a less isolated setting. After much in-hospital negotiating, Mr. G was transferred to the rehabilitation unit where he was to receive physical therapy and blind training. As a patient on that unit, Mr. G would no longer be considered in the "sick" role, but would hopefully be engaged in a process of active recuperation. Instead of the hospital garb he had worn for almost a year, Mr. G would be expected to dress himself (in clothes donated by staff members; he himself had none). Instead of lying alone in a room and interacting exclusively with

staff, Mr. G would be considered a part of the rehabiliation unit's therapeutic milieu.

Hospital Course: "Rehab"

Mr. G made an instantaneously excellent (almost too excellent) adjustment to the new environment. He was friendly and gregarious with both staff and patients, initially participating fully in all ward activities. At all times he wore a paper surgical mask over his head, yet lifted it half-way when he ate in the dining room with the other patients. When questioned about his disfigurement, Mr. G matter-of-factly would state that "dogs had done it." For a brief period, the depression and withdrawal that Mr. G had been exhibiting during his final months on the ICU abated; however, Mr. G's ready adjustment was deceptive. The holidays and the continued lack of family involvement rapidly contributed to a decline in Mr. G's spirits. This was even further compounded by a disastrous tenth operation which involved an ambitious surgical attempt to improve his mouth. Rather than "just providing coverage," the plastic surgeons attempted to improve Mr. G's lips so that he would be able to actually use them to chew. In addition to the procedure not working, Mr. G sustained a terrible post-operative infection. His temperature rose to 105 degrees and his face grew as large as a watermelon. Not only was Mr. G disappointed in the

results of the surgery, he also lost faith in his surgeons. How could they let him get so sick?

Mr. G's renewed withdrawal and depression involved spending a lot of time isolated in his room, "watching" TV, listening to the radio, just lying there or sleeping. Mr. G had already become attached to a number of patients on the ward who had left; he spoke about and was clearly affected by these losses. He described feeling reluctant to become involved with new people who would wonder about his face, finally get used to him and leave. He stated that he preferred isolation to that repetitive cycle.

Mr. G's depression and withdrawal were exacerbated when he was told by his doctors that a final decision had been made about a corneal transplant. There was too much scarring; nothing could be done to restore his vision. A similar decision was made to halt plastic surgery. The plastic surgeons had determined that no significant improvement could be obtained. At first Mr. G refused to accept the doctors' decisions. He stated that there must be doctors at other hospitals who could perform the procedures he had been denied. He talked about signing out of the hospital, and wondered if the doctors would operate on him if he gave them "a lot of money." After a period of denial, Mr. G seemed to go into a period of mourning. He would remain listless in bed, for hours on end, communicating little and apparently contemplating his losses. He

spoke of wanting to die or to be "taken away," but said he did not want to kill himself. He spent time remembering "how things used to be" before he was in the hospital, and acknowledging that he knew they would never be the same again.

On the other hand, Mr. G's abiding depression and despair have not precluded some rather discordant behaviors. Over the months Mr. G had been developing romantic fantasies about several of his female caretakers. I became the focus of an erotic "transference." Mr. G would tell me that he "wanted me" and would take offense when I told him this was not possible. Touchingly he would ask if I were rejecting him because he was black. In the face of my constant explanations that any extra therapeutic contact would not be helpful, Mr. G would insist, "You'll see." On one occasion Mr. G actually blocked the door as I was trying to leave saying that he wanted to "keep" me in there (this was the only occasion since Mr. G's arrival in the hospital that I was consciously aware of being afraid of him).

As Mr. G remained shut up in his room on "rehab," there were a number of instances of acting out and manipulating the truth. On a variety of occasions, staff would think they smelled marijuana coming out of Mr. G's room, but when they would investigate Mr. G would deny that he had been smoking and there would be no obvious evidence

that he had. There were several rumors that Mr. G had asked the maintenance man to buy him a bottle of rum; when questioned Mr. G denied this as well. After he was pressed by me, Mr. G finally admitted that this was true, but stated that he had been prompted by another patient. Another time Mr. G told one staff member that he had acquired LSD; he showed her several small white pills to "prove" this to her. As she was enjoining Mr. G to hand the pills over, he flushed them down the toilet. Subsequently he said this was a "practical joke" and that the pills he showed were Cogentin tablets that he had been secreting. It was unclear whether this was so or if Mr. G had actually acquired LSD. There were numerous minor incidents that involved Mr. G doing something and subsequently denying it. (Using the telephone in an office where he was not allowed to be; going down the stairs unaccompanied to visit the ICU). In a sense these disavowals were small versions of the most important disavowal of all: the self-mutilation. As indicated above, Mr. G clung tenaciously to the dog-bite story (modifying it occasionally to inculpate other animals, as described above). Only once did he suggest any other etiology to me, and on that occasion the liberties that Mr. G took with the truth made it impossible to confirm or disconfirm what he said. Mr. G told me that he had committed a serious crime, and that he removed his face so that he

would not be discovered by the police. This came up in the context of some aggressive fantasies that Mr. G described. [This section is necessarily ambiguous owing to the ethical issues involved.] Mr. G admitted to committing a felony and leaving the scene of the crime undetected by the police. Mr. G claimed that this "crime" was the reason his father decided to abandon him. In order that he not be discovered, Mr. G stated that he cut off his face singlehandedly.* Shortly after Mr. G's confession, he recanted, telling me he had made the whole story up as a way of getting me "off [his] back" about the self-mutilation. On future occasions, Mr. G continued to deny that he had committed a crime. Despite assurances that I would not report what he had told me, Mr. G continued to assert that the story was an invention. In addition, he reverted to denying responsibility for the self-mutilation. (On earlier occasions, Mr. G had admitted to committing some misdemeanors. He had never been in jail, but

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* This admission obviously placed me in a moral dilemma. I consulted a number of colleagues, including a hospital lawyer and ethicist, as well as a psychiatrist who deals in forensic matters. The law seemed ambiguous on the point of a client admitting a past crime, and the decision to report seemed to rest on the clinician's judgment. In other words, such an admission could be considered privileged information. I elected not to report as I did not feel that Mr. G was imminently dangerous, nor did I feel that he belonged in the penal system.

had been in court. He seemed to feel no need to deny those incidents). Owing to the fact that I have never checked, I have only Mr. G's (denied) word to go on and as demonstrated, the value of that is rather equivocal.

Basically Mr. G has remained in a mostly withdrawn and depressed state to the present. At times, he is despairing, at times playful, at times lacivious. He is not overtly psychotic, and is usually well behaved. He has had a few loud angry outbursts, and has threatened to hit other patients or staff with his blind cane when frustrated; however, he has never done anything self-destructive or assaultive to date.

His angry outbursts do have precipitants, and are often quite comprehensible in the context of his situation. Most recently Mr. G became incensed when asked to remove his Jobst mask. This is a made-to-order mask, usually for burn victims, to smooth out scar tissue. Though he found it uncomfortable at first, Mr. G has worn it steadily for the last several months. Despite the fact that it felt hot and tight, Mr. G would wear the mask even to sleep. Of late, the mask was causing his face to swell and the "rehab" staff insisted that it be removed. When Mr. G firmly responded that he would not remove it, he was told it would be cut off. At that point Mr. G began to make aggressive threats and I was called to speak to him. I discovered that Mr. G did not want to remove his mask as

it had become his "new face." Removing it or having it cut off were initially unthinkable for Mr. G. Only when its value was recognized and the danger to his remaining real face underlined did Mr. G relinquish the mask. He would not hand it back to the staff but insisted it remain in the room near him. It was clear that losing the Jobst mask amounted to another facial mutilation; this was clearly not an experience Mr. G wanted to repeat.

At present Mr. G remains suspended in a kind of limbo. There will be no more surgery for now, and it is obvious that the hospital is no longer the best environment for Mr. G. He states that he feels bored and out of place on the "rehab unit." Moreover, Mr. G says he does not want to make any new friends as they always leave him. He is willing to let staff find a safe place for him, as he knows now that his family cannot provide this. Despite his impatience with the hospital, Mr. G can admit that he feels afraid to leave stating, "You all have become more like my family than my own family."

Discussion

This case of self-mutilation has commonalities with other cases of self-mutilation referred to in the literature above. As with many of the other cases reported, Mr. G's self-mutilation occurred in a context of psychosis,

delusional religiosity, sexual guilt, a "tyrannical conscience," and threats of abandonment superimposed upon a history of early loss. Moreover, he manifested the remarkable analgesia described by so many of the authors who have written on the topic of radical self-mutilation.

There are other features, however, that make this case unique. A strikingly different element is Mr. G's sustained refusal to admit that he mutilated himself. Even as his thinking has become clearer, even as his reality testing has improved, even as he has gained trust in the staff working with him, Mr. G continues to assert that his dogs did this to him. This type of outright disavowal after the act seems uncharacteristic of psychotic patients who have mutilated themselves under the sway of delusional beliefs. Typically, the mutilative act is delusionally justified. Other patients have been described as lying or concealing before the act, so that their psychotic intentions will not be thwarted. Once the act is complete, however, delusional thinking seems to supercede the need for concealment. If a patient is psychotic enough to radically self-mutilate, this usually seems to obviate the need for subsequent denial. Not so with this patient. Even when he retained certain delusional beliefs (if only retrospectively), Mr. G refused to acknowledge that his facial self-mutilation was the result of those beliefs. On the one hand, he did say that he

believed himself powerful enough to command another man to self-castrate; on the other hand, he responded with outright negation when it was suggested that he could have been equally capable of self-harm.

Mr. G's motives for concealment may be overdetermined. While the mutilation was likely performed to expiate guilt, it became its own source of guilt. For one thing, a direct consequence of his act was the extermination of two of his dogs. Though we do not know a great deal about Mr. G's relationship to his dogs, we can speculate that they may have been more constant and reliable objects than any family members. Not only did Mr. G's self-mutilation result in the loss of his dogs, it was actually the reason for their demise. Mr. G's family was never particularly available to him, and by moving were making themselves less available. The fact that they have visited little while he has been in the hospital may be ascribed to Mr. G by the nature of his act. He may feel that not only did he drive the family away, but that his grotesque appearance keeps them away. If he denies his role in the injuries, Mr. G may feel that he stands a better chance of regaining the affection of his family.

Mr. G's unwillingness to speak about mutilating himself implies the existence of an "observing ego" of sorts. He seems aware of the implications of such a profound self-mutilation. He understands that his injuries are

more acceptable if dogs caused them than if it is known that he did this to himself. It also bespeaks Mr. G's wishes to conform to social expectations, and to be liked. No matter how his reality testing has varied during his hospital course, Mr. G has almost consistently maintained the position that he was the victim of his dogs. From the start it seems, he has been enough "outside" his delusional beliefs to see the unacceptibility of their consequences.

As to whether Mr. G was so dissassociated when he mutilated himself that he actually does not know that he did it, this seems unlikely. There is evidence instead that he is suppressing and withholding discussion of the incident. When queried about the etiology of his injuries, Mr. G becomes litigious and cites circumstantial evidence to "prove" his case. He says that the dogs "must have done it" because "the doctors say they have seen a thousand dog bites, so they know this was done by dogs." In addition to "protesting too much," Mr. G has made slips of the tongue that betray his direct involvement. He has said, "when I cut my face" at least once, but rapidly "corrected" himself when he heard his own words. As mentioned, Mr. G also apparently confessed to a night nurse (and did not take it back), but warned her not to reveal what he had told her. He was frightened, he said, that if the psychiatric staff could confirm his

responsibility for the mutilation, we would institutionalize him. Institutionalization would obviously bring further rejection and abandonment from the hospital staff to whom Mr. G has become attached. In telling me the story of his "crime," Mr. G was also making a confession of sorts; however, the purpose of this story may have been to provide a more rational explanation for a profoundly irrational act.

Although those who radically self-mutilate are obviously an exotic sub-group, they tend to mutilate similar parts (eyes, genitalia, digits). This patient's mutilation of his entire face is unprecedented. No where in the literature is there reference to a "physiognectomy." Because Mr. G is so guarded on the subject of the mutilation, it is not possible to reach a definitive understanding of the personal meaning of this act. Using both his past history and his current behavior as guideposts, one can, nevertheless, make some preliminary speculations.

The question of the symbolic equivalence between radical self-mutilation and castration is certainly relevant in this case. We do know that the same day he mutilated his face, Mr. G commanded another man to remove his penis. This occurred after that man had caught Mr. G sleeping with his girlfriend. One can speculate that being caught "in flagrante delicto" with another man's girlfriend stirred up powerful sexual and oedipal guilt.

It stands to reason that Mr. G had a resevoir of such guilt, considering his early incestuous experiences with his mother (which happened, apparently, under the watchful eye of his father). It will also be remembered that after Mr. G was beaten by his father for supposedly molesting his siblings (in a sense, was "caught" in his incestuous transgressions), he performed his first self-mutilation.

The above may explain some of the guilt that drove this patient to punish himself so massively; it does not explain why he chose his face to be the site of the punishment. Mr. G did speak of being ambivalent about his attractiveness to women; was he attempting to destroy an aspect of himself that he knew women were drawn to? Another more specific conjecture that would link Mr. G's present and past sexual life is the possibility that his face actually "became" a sexual organ as his mother's had been. It does not seem terribly far-fetched to suggest that he may not only have been caught having sex with another man's girlfriend, but may have been performing cunnilungus. If this was so, it would have been a reversal of the original incestuous situation in which the patient's mother performed fellatio upon him. In destroying his face, Mr. G may have been punishing a maternal introject that satisfied him, frustrated him (by abandonment, if not by cessation of the fellatio) and probably terrified him. Like the Sioux Warriors (p. 17 of

dissertation) who mutilate their own breasts to exorcize ambivalent emotions toward their mothers, Mr. G's self-mutilation likely has similar early determinants.

There is another clue that residual guilt from Mr. G's bizarre oedipal victory figured in the selection of his face for mutilation. Perhaps the most gruesome, Grand Guignol-ish aspect of the case is the supposition that Mr. G must have fed his facial parts to one of his dogs. This act may contain a literal reference to Mr. G's experience of being (to put it crudely) "eaten" by his own mother. That the dog whose stomach contained the fragments of Mr. G's face was a nursing mother hardly seems fortuitous in the context of this history. It is also notable that the fanciful explanation given by Mr. G on several occasions (mutilation by "timber wolves" and "rats"), though hardly any worse than what actually happened, involves animals known for their oral aggression.* It seems plausible that Mr. G's early experience of seeing his own penis disappear into his mother's mouth must have been as fearsome and terrible as it was sexually stimulating. (There is some corroboration that this early experience left some fairly

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* In a provocative paper, Shengold (1971) has suggested an unconscious triad linking rat imagery, oral aggression and overstimulation. Given the fact that Mr. G was the victim of oral aggression and overstimulation, it is perhaps only fitting that he should telescope these experiences into a tale of rats attacking him in bed.

explicit memory traces. When Mr. G was asked whether he had ever heard of anything akin to a self-mutilation, after first denying that he had, he then recounted that he had "heard of a girl who ate a pencil." Surely one does not have to strain too hard to link this imagery to the incestuous scenario.) Such an experience likely formed an unconscious template which reveals itself in the mutilation itself as well as in Mr. G's factitious, post hoc accounts of what happened. The gratuitous detail of rats gnawing his face "in bed" suggests a sexual dimension; while the story that timber wolves bit him when he climbed into their cage contains a possible reference to his ventures into forbidden (incestuous) territory.

These notions concern the possible sexual significance of Mr. G's facial self-mutilation. It is also possible that the face was chosen for its affective symbolism as well. Despite his schizophrenic diagnosis, Mr. G has clearly had periods of depression. At the same time, Mr. G has manifested a tendency to deny his depression. A striking example of such denial is portrayed in a chart dating back to his second psychiatric hospitalization (six years ago). Though staff observed Mr. G to be sad over lack of contact with his family, Mr. G said he did not feel sad. At the same time, he told his doctor that he was not going to look at himself in the mirror. We do not know exactly why he said he did not want to look in

the mirror; however, this may have been related to another comment reported in that chart. Mr. G stated that staff should not assume he was sad, even if his face appeared sad.

Perhaps Mr. G felt similarly at the time of this self-mutilation. Though we know now how much Mr. G is affected by his family's lack of involvement, we know from his father that he did not admit to being upset about the family's upcoming move. Denial notwithstanding, it is likely that he may have looked very sad. Could it be that as much as Mr. G tried to deny his depression, the expression on his face (viewed in mirrors) provided a source of affective feedback too powerful to deny successfully? If this is so, one should not then be surprised that one instrument of his self-mutilation seems to have been a broken mirror.

There is yet one other dimension that may pertain to the choice of the face for self-mutilation: that of the face as the marker of one's identity. Again, one of Mr. G's fabrications (?) provides a suggestive cue. Mr. G stated that he committed a crime and destroyed his face as a way of escaping detection and punishment. In a sense by eradicating his face Mr. G was relinquishing his unique identity. This was the sacrifice for the "crimes" (oedipal victory, bad son, worthy of abandonment) he had committed. In a sense, the primary process thinking goes:

If I'm not me, then I'm not guilty. Even if the story of the crime is in fact true, its symbolic significance does not necessarily vary.

These preliminary speculations suggest that Mr. G's choice of the face for self-mutilation may have had multiple determinants, obtaining symbolic "fuel" from both affective and sexual domains of his life. In addition, Mr. G's face may have served as the concrete representation of his very identity.

CHAPTER FIVE

Hospital Course: Staff Reactions

From his first day in the hospital, Mr. G was clearly a "special patient," mobilizing hospital staff at every level. As will become evident, the parameters of professional behavior were stretched and even transgressed as individuals (singly and in groups) attempted to accommodate to an entirely novel patient in an eminently unique predicament.

Certain trends became evident in the way staff responded to Mr. G, as well as the fact that these trends were apparent at every level, from the most menial and non-skilled hospital staff to the most psychologically sophisticated and medically trained. In order to best illustrate the evolution of these trends, I will give a general description of the "hospital's" reaction to Mr. G, at times including my own and other individual's responses to this patient. For lack of a better word, I will label the unusual responses to Mr G "countertransference," though I am usually referring to an extra-therapeutic phenomenon.

There seem to have been distinct phases that those of us who work with Mr. G have gone through, phases which had their own particular characteristics. To some extent these phases could generally characterize groups and individuals who have had to master other kinds of anxiety provoking tasks or "difficult" patients; at another level the "countertransference" seemed to have a great deal to do with the unique situation of Mr. G. The following will be a clinical description of the major phases of reaction to Mr. G.

Phase One: Excitement

The initial period of adjustment to Mr. G seemed to involve certain predictable patterns (and counter-patterns) of response. For one thing, Mr. G's initial presence in the hospital instantly generated intense excitement, curiosity and preoccupation, far in excess of professional decorum. From the most highly trained staff to the least, curious throngs flocked to Mr. G's room to gape at him. There were reports of medical staff actually pushing each other into Mr. G's room "to get a look." In addition to the accounts of vomiting and near fainting, there was a description of one medical resident who fell on the floor outside Mr. G's room after looking at him, convulsed with laughter. A janitor brought his wife to see the patient, drawn by tales of what Mr. G had done

which had rapidly circulated throughout hospital elevators, patient lounges and doctors' waiting rooms. So great was the curiosity about Mr. G--one nurse described it as "a sideshow"--that he had to be moved to the most secluded area of the ICU to deter the steady stream of spectators. Accompanying this flurry of excitement was a commonly-described experience of dread and fright. Both myself and my colleagues were unable to eat after seeing Mr. G. A physician's assistant who initially worked on Mr. G described how a six hour drive he took the night after meeting him was pervaded with thoughts and images of Mr. G. In order to keep from thinking about him, the physician's assistant "turned the radio up loud" in an unsuccessful attempt to distract himself.

In line with Mr. G's capacity to preoccupy the minds of staff, discussions of Mr. G became the most exciting topic of conversation. Most of us who had seen Mr. G felt an almost compulsive need to share our initial contacts with Mr. G. These discussions extended far beyond the boundaries of the workday, often violating the canons of objectivity and confidentiality. Many staff -- myself included -- described an intense need to speak of Mr. G to family and friends (even those known to be squeamish or those with whom work is not typically discussed). Ironically, discussions about Mr. G often seemed to occur at mealtimes. Two of Mr. G's nurses riding a train together

described how they riveted the curiosity of two complete strangers sitting opposite them by discussing Mr. G. As one of these nurses put it "you want to get a reaction." I initially felt (and indulged) a temptation to bring up the topic of Mr. G in inappropriate social contexts, thereby making myself "the life of the party." Related to this is the contagious quality of the story of Mr. G. Those merely told of Mr. G themselves become intensely curious and cannot resist the need to pass the story along (legit emptor!). I recently heard from an acquaintance that a mutual friend had kept an entire group transfixed over dinner in a restaurant, regaling them with the graphic details of Mr. G's self-mutilation. Also apparent in the need to discuss Mr. G was the influence his act had on the choice of words used to describe him. The psychologically-oriented staff found our own vocabularies unduly scattered with words that somehow pertained to Mr. G's self-mutilation. Words like "parts," "bits," and "pieces" seemed to recur with disarming frequency.

Alongside the need to see, know and say all that one could about Mr. G was the difficulty most staff had in actually grasping the facts of his self-mutilation. A good deal of distortion occurred, creating a variety of rumors as to the etiology of Mr. G's facial trauma -- all of them positing an external agency or semi-comprehensible rationale. One rumor involved Mafia hit men doing this to

Mr. G, while another rumor ascribed the mutilation to the rituals of an "African cult." Even when staff had been clearly informed that Mr. G's mutilation was not drug-related, many continued to attribute it to PCP intoxication. Despite the fact that the majority of plastic surgeons believed Mr. G's facial trauma to be self-inflicted, their official diagnoses up until four months post-admission continued to be "Mutilating Dog-Bite to the Face" or "Multiple Facial Trauma." Indeed, the psychiatric staff were never exempt from distortion, vacillating in their conviction that this had been a self-mutilation in response to Mr. G's often persuasive allegations to the contrary. Yet even when we were convinced, we could maintain a final recourse of external responsibility: "His schizophrenia did this to him."

Seemingly the other side of the curiosity and excitement described above were displays of inappropriate and unprofessional avoidance manifested by some staff during Mr. G's initial weeks in the hospital. At the grossest level this involved staff who refused to enter Mr. G's room, let alone work with him. An anaesthesiologist refused to intubate Mr. G without keeping a sheet over the patient's face. At least one member of the dietary staff used to leave Mr. G's trays on the floor outside his room rather than entering for the moment that it takes to lay down a tray. In more subtle ways even those who could

look at Mr. G were most comfortable seeing him in a certain way: in the position of a prone, medically ill patient. This was most acutely so during Mr. G's first hours in the hospital. Several staff who attended to Mr. G at that time described the ability to look and not be frightened as long as Mr. G was lying down, apparently unconscious or stuporous. At the point when he sat up and talked, i.e. became more obviously "alive," he instantly became less tolerable. The fiction that Mr. G's injuries were accidental, medically derived happenings rather than the consequence of purposeful intentions, could best be maintained if Mr. G remained lying down, in bed, in his room. I remember feeling chillingly unnerved the first time I came upon Mr. G standing up and walking around his room, even though I thought that I was used to him. On one occasion relatively early on in his hospitalization, Mr. G was walked around the intensive care unit only to be confronted by an agitated nurse who rushed Mr. G back to his room lest he "give another patient a heart attack." It is quite likely that the need to avoid Mr. G as an ambulatory otherwise medically healthy young man contributed to the fact that he spent almost a year on the ICU, an almost unprecedented amount of time considering the fact that for most of that time he was not acutely ill.

Phase Two: Solicitude

Within a month or so of admission, Mr. G had become a fixture on the ICU. His open-ended length of stay there was a stark departure from the usually strict protocol of only keeping patients for whom intensive care is medically expedient (in fact, the ICU in this hospital is closely monitored so that the limited number of ICU beds are not "wasted" on those who don't require them). Not only did Mr. G come to be tolerated by his caretakers; as people grew accustomed to Mr. G, the level of staff solicitude increased, albeit with much of the same intensity that characterized initial reactions to his presence in the hospital. In a rather unusual departure from typical protocol, Mr. G began to be addressed on a first name basis by virtually everyone who worked with him. According to a member of the surgical team, this practice was particularly rare for the typically formal plastic surgeons.

Where once he had been a freak and a sideshow attraction, Mr. G had turned into what one staff member aptly described as "a mascot." By the time his 21st birthday rolled around, three months into his hospitalization, Mr. G was given a birthday party on the ICU with virtually the whole nursing staff in attendance. In addition to the numerous cakes and quarts of ice cream, the nurses also

bought Mr. G several pairs of pajamas, a robe and slippers. This party was emblematic of the special interest the all-too-overburdened staff of the ICU took in Mr. G. Even though he no longer required critical-care nursing, Mr. G was given extra attention that spilled outside the confines of job description. Often nurses would visit Mr. G at the beginning of each shift, taking time out just to talk, or sometimes sharing personal information (such as descriptions of family, love life or past operations). When staff members with whom Mr. G had developed a close tie left their rotation on the ICU they often returned to visit him, sometimes bringing him food or gifts. Several nurses' aides on the ICU who had been terrified of Mr. G when he first arrived developed a lunchtime ritual of watching soap operas with him.

Once an individual established a relationship with Mr. G, others would come to associate that person with him. Working with Mr. G became an intergral part of one's hospital-wide identity. In a sense one had become a member of a special subculture--characterized by its own passwords: "How's M doing?" Not only had Mr. G become famous but his reputation attached itself to those who worked with him, making them famous by association. For those who had never (or would never) work with Mr. G, working with him was a hallmark of heroism. On more than several occasions, colleagues described me as "so brave."

It is of interest that my enduring therapeutic contact with Mr. G has been as part of a pair. My responsibility for Mr. G has been shared throughout his hospital stay with a social worker. Though we don't always go to see him together, we consult frequently and visit Mr. G in tandem when there is a crisis. The initial rationale for this team approach was for the mutual provision of moral support and in order to better interpret Mr. G's dysarthric speech. As Mr. G has become more familiar and his speech more intelligible (through familiarity), co-therapy nonetheless maintains a life of its own.

It was Mr. G's fame coupled with the massively positive response staff had had to him that made it possible to transfer him (after almost a full year on the ICU) to the very selective rehabilitation unit. Though Mr. G was really not an appropriate patient according to their criteria (physical disability requiring physical and occupational therapy), they agreed to suspend their usual requirements and admit him. This was all the more striking in view of the fact that a number of months before "rehab" accepted Mr. G, they had adamantly refused him. At the time they had stated that Mr. G's presence would alarm a basically geriatric and wheelchair-bound population, and that his disabilities (disfigurement and blindness) were not within their domain. Though nothing in Mr. G's

condition had changed to make him a more desirable "rehab" patient, the staff's attitude clearly had.

Upon arriving on the rehabilitation unit Mr. G was instantly deemed, in one doctor's words, "a V.I.P." The transfer itself had been preceded by meetings and conferences between the rehabilitation staff and the ICU staff, mapping out plans which would best accommodate Mr. G. It was decided that he would be given the only single room on the floor, a room so large and spacious that it was called "the Penthouse Suite."

Mr. G's first days and weeks on "rehab" were characterized by a flurry of solicitous excitement. Staff instantly mobilized for him in a manner described as "the Elephant Man phenomenon" by one staff member. Specially trained rehabilitation nurses actually bickered over who would have the "privilege" of escorting Mr. G to visit his old friends on the ICU; the resident assigned to follow Mr. G admitted to writing the longest progress note of his career: thirteen pages. Several weeks after Mr. G's transfer to "rehab," it was Christmas. Nurses who had treated Mr. G on the ICU brought him a miniature Christmas tree and decorated his room with tinsel. In what perhaps was the culmination of the solicitude lavished on Mr. G, the "rehab" unit presented him with a tee shirt bearing the inscription: "_____ Hospital's #1 Man."

Present Phase: Withdrawal and Hopelessness

The above section chronicles the way in which a staff climate of horrified excitement was rather quickly transformed into one of familiarity and solicitude. A further turning point came after the first month of Mr. G's sojourn on the "rehab" unit, as he entered his second year in the hospital. Though the initial period of Mr. G's stay on the "rehab" unit was characterized by interest and zealous caretaking, this did not last. The final and current phase of staff reaction has been dominated by withdrawal and hopelessness. Shortly after the holidays Mr. G was operated on for the tenth time, and as mentioned above, became severely ill and infected after the procedure. Subsequent to this operation, which additionally did not succeed in accomplishing its purpose, the plastic surgeons seemed to lose interest in Mr. G's case. Though there had been clearcut plans to reconstruct Mr. G's ear and empty eye socket, these plans were not followed up. Though there had been considerable ambiguity all along as to whether and when Mr. G's vision could be restored, the final verdict came after the winter holidays. It would be impossible to give Mr. G any more sight than he already had.

Mr. G tended to withdraw more and more in response to this steady stream of disappointments, while staff working

with him responded in kind. Where strenuous efforts had once been made to involve Mr. G in meals and ward activities, little has been done to cajole Mr. G if he seems uninterested. Weeks pass with Mr. G spending the better part of each day in bed. Though several behavioral plans were designed to keep Mr. G out of bed and going to activities, staff has been unable (and unmotivated) to enforce them. A schedule was designed which spelled out the times which Mr. G could and could not be in bed. A plan was made to lock Mr. G out of his room if he did not comply with the schedule. Yet even when Mr. G has been blatantly non-compliant, no one has done anything to push these issues. I myself have found myself having bedside sessions with Mr. G at the very times I am aware he is scheduled to be in physical therapy. The "rehab" psychologist and occupational therapist had devised a routine which would involve acquainting Mr. G with the outside world (he had never left the hospital since his admission) by taking him on weekly walks outside the hospital; this was only implemented on one occasion. An analogous process occurred with the plastic surgeons who had made elaborate plans for further surgery but were pursuing none of them. When they were finally pressed as to their intentions, they declared Mr. G's case closed, stating they had done all they could to improve his appearance.

The staff atmosphere of excitement, curiosity and special solicitude has changed. No longer are there animated discussions of Mr. G, his injuries or his prospects. Where once he had been viewed as knowable, personable and trustworthy, staff now feel unsure of their ability to trust him (citing his minor episodes of acting out). Where once he seemed like "a pussycat," there have been several occasions where he has frightened female nurses by his lewd and suggestive comments. No longer do Mr. G's caretakers do more and more for him, but actually less and less. Whereas the earlier password had been "How's M doing?" this has been replaced with a despondent "So anything new happening with M?"

Disposition efforts for Mr. G have been stalemated for many months. He is obviously a disposition problem, yet a minimum of effort has been made to find alternative placement. Current planning is hampered by a climate of hopelessness, frustration and procrastination. At the time of this writing, staff seems to be stuck in a holding pattern with Mr. G, unable to proceed in a definitive manner.

The several prospects that have been found have not panned out, leaving staff in a rut that parallels Mr. G's. As he stays in his room, listlessly lying on his bed listening to the radio, his former admirers stay out, keeping contact to a bare minimum.

CHAPTER SIX

Analysis

The above is basically a chronicle of Mr. G's hospital course to date. The next section will attempt to make sense of the different stages of reaction to him. Granted that there is a strong reality component that has undoubtedly contributed to the responses described, it also seems evident that there have been processes at work which can best be understood from a psychoanalytically oriented perspective.

To recapitulate the phases of reaction to Mr. G, there was a period of intense excitement (accompanied by excessive demonstrations of curiosity, compulsive talking about the event, avoidance and distortion), one of familiarity and extreme solicitude, and the final and current phase of depression and hopelessness. In each of these phases, even highly trained staff members have deviated from their usual professional stance, first regarding Mr. G as a spectacle, then a mascot and finally a hopeless case. I would suggest that the above phases tell a great deal about the anxieties aroused by Mr. G, as well as shedding light upon the ways that individuals and groups

in a helping situation strive to defend themselves against the arousal of profound anxiety.

It seems that all who first met Mr. G could not help but respond with a flood of excitement which in turn led to several varieties of atypical professional behavior. The excitement and its sequelae were undoubtedly related to having a patient who was nothing if not utterly horrifying.

Horror seems to be the operative word here. Alexander (1972) makes the point that horror is a particular subtype of anxiety which taxes the ego's defensive armamentarium beyond its limits; or in Harvey Greenberg's slightly facetious terminology, horror is that which "blow[s] the lid off the id" (1975, p. 199). According to Alexander, something is horrible to the degree in which it can evoke "guilt-producing sadistic fantasies" (p. 197). Mr. G's self-mutilation surely qualifies as horrible from this perspective, being a veritable incarnation of sado-masochistic pathology.

As Rickman (1940) has pointed out, that which is merely unaesthetic, even if adventitiously created, is enough to destabilize a healthy ego. Mr. G's grotesque appearance, coupled with the knowledge that he had done this to himself, further compounded this quality of horror. Several of the initial impressions of Mr. G convey how profoundly horrible he was. A physician's assistant

who was one of the first people to see Mr. G described him as something worse than he had ever seen in a horror movie, adding that he tends to go to the most gory of films as a way of innoculating himself from the kinds of upsetting things he must view in the course of his work. One of Mr. G's nurses likened the experience of first seeing him as akin to an experience she had in childhood where she visited multiple victims of a gasoline explosion, their skin on fire and charred. Another physician's assistant described Mr. G as "number one on the list of things that have shocked me."

That Mr. G was able to cut his own face off suggests an almost bestial capacity for self-aggression. One nurse ventured the interesting proposition that in self-mutilating Mr. G had the intention of actually transforming himself into an animal. The fact that he fed his facial parts to his dogs conjures up boldly cannibalistic and oral sadistic themes.

What shocked and horrified was not simply the ugliness of Mr. G's appearance but the fact that his presence had the power to evoke discomfiting fantasies, memories and impulses. Further, the types of fantasies and impulses stirred likely contain derivatives of the kinds of unconscious motives that lead to the helping/healing professions, motives which belie the more altruistic side of our professional identity. Some of the early reactions to

Mr. G strongly suggest the nature of the type of impulses catalyzed by Mr. G. For one thing the excessive curiosity surrounding Mr. G seems connected to a scoptophilic desire to see and know the forbidden. The phenomenon of compulsively discussing Mr. G not only seems to be a defensive attempt to master and rework a traumatic encounter; the talk in itself constitutes another form of oral sadism. The fact that Mr. G was not just another patient, but that talk of him served self-aggrandizing purposes, reveals the narcissistic and exhibitionistic gratifications that can be obtained from the more sensational aspects of the healing professions. Enhancement seems to be a perquisite of contact with the forbidden. The phenomenon of Mr. G's capacity to mobilize others to talk about him at length and with relish seems related to what Arndt (1959) has described in his article "Community Reactions to a Horrifying Event." He describes the chauvinistic pride evinced by those who had been neighbors of a man who had performed gruesome murders. Leslie Fiedler (1978) makes the chastening observation that "nobody can write about freaks without exploiting them for his own ends" (p. 171).

The distortion and avoidance referred to above involves attempts to minimize and civilize that which has been stirred up; by <u>not</u> knowing, seeing or touching Mr. G., there can be a temporary diminution of his impact

(and of our own unwholesome reactions); yet this clearly occurs at a professional cost.

Given these initial reactions, whence the familiarity and solicitude? How did an almost fetishized and frightening Mr. G come to be transformed into a benign mascot? I would maintain that this transformation was essential in order that staff could allow themselves to provide the competent care that Mr. G's medical situation clearly required. On an individual level, this seemed to require a resort to reaction formation. Rather than being viewed as psychotic and bizarre, Mr. G's caretakers came to view him as almost ordinary--quite human, quite sane and worthy of great compassion. He was seen as "a young man reaching out," "a very nice person," as someone who "tends to bring out a maternal instinct," as "very lonesome," a "nice easy going fellow." It is telling that the descriptive terms used by many of Mr. G's caretakers belie the depth of psychopathology that drove him to self-mutilate. By viewing Mr. G in these innocuous and banal categories, we, his caretakers, could return to our own "nice" professional identities, taming our non-helping impulses and fantasies.

Harvey Greenberg (1975) has indicated that a similar "dialectical" process is responsible for the appeal of movie monsters whose "insensate savagery" (p. 213) is offset by a parallel fantasy of the monster's "childlike innocence."

Another perspective on the way Mr. G's horrible impact led to the evocation of positive attitudes is suggested in Martha Wolfenstein's (1957) study of individuals who have had a near miss with disaster. An "upsurge of loving feelings towards others" (p. x) seems connected "to a surfeit of vicarious gratification of hostile impulses by the extreme damage which has been done" (p. x). "Upsurge" is a key word here for it evokes the presence of powerful impulses, albeit in a positive direction. This is especially pertinent in Mr. G's case as it explains something about the way in which the most horrible patient in the hospital came to be viewed as the most deserving, literally the "#1 man." Just as many hospital protocols were dispensed with initially due to the high level of disgust and alarm, they remained suspended in another way due to the zealous kindness of Mr. G's caretakers. Staff would not merely tolerate Mr. G but would go to special lengths beyond the call of duty to please him. Staff members seemed to take an almost proprietary pride in performing special services for Mr. G. Perhaps "owning" Mr. G lovingly (one nurse actually referred to him as "my Christmas present") was a safer way of managing the unpleasant affects he evoked in us. By becoming our own pet "freak" (to use Fiedler's notion), Mr. G both embodied and obscured the "freak" in all of us.

How then the next transformation? What changed again so that instead of Mr. G being viewed as the hospital's "#1 man," he became our #1 burden, a patient to be disposed of rather than coddled. Just as Mr. G's actual cooperation was actually the reality component which facilitated his transformation from monster to #1 man, his burgeoning lack of cooperativeness and tendency to act out, coupled with the objective failure of his surgeries, contributed to his fall from grace. When nothing was required of Mr. G other than to lie in bed and suffer, there were fewer opportunities for him to disappoint us. Once the mandate was "rehabilitation," and it didn't happen, Mr. G was no longer the perfect patient, grateful for the solicitude lavished upon him. Instead, Mr. G would often hostilely refuse the programs offered him, spending his days lying in bed seemingly content not to talk to anyone. These behaviors raised the spectre of aggression and despondency that must have originally led to his self-mutilation. That no one on the staff was inclined to push Mr. G to do anything, as well as the fact that disposition plans proceeded at a snail's pace, seems indicative of a reluctance to rock the boat at all. I would suggest that a fear of the mutual aggression that might be unleashed in a power struggle with Mr. G led to the kind of inertia that has been described. This bears similarity to the murder case described above (Footnote, Chapter Two, p. 56).

As long as that patient was "good" and "sorry," staff could tolerate him. Once he became less penitent (his impulses not as well laundered), staff found him more unacceptable.

In going all out for Mr. G, each of his caretakers seemed to be harboring a savior fantasy that could not stand up to the objective unsalvagability of his situation. Where Mr. G's initial presence in the hospital may have exposed some of the impulses and fantasies which lead individuals to this kind of work, his current situation lays bare our ultimate impotence in the face of severe pathology and human destructiveness.

What has been discussed above approaches the phenomenology of Mr. G's treatment from an aggregate of individual perspectives. What follows will constitute an attempt to view the same data through a slightly different lens. Though there is clearly some overlap, it seems that viewing this material from the framework of group psychology can shed additional light on the evolution of Mr G's hospital course.

Certain authors have asserted that the manifestly rational functioning of groups is necessarily belied by underlying unconscious and non-rational processes. Bion (1959) believes that the mere act of association in a group reevokes regressive fantasies in group members. Just by coming together, individuals become submerged in a

"group mentality" (p. 60). The consensually agreed upon "primary task" (Menzies, 1961, p. 5) of any given group is at odds with more primitive and psychotic "basic assumptions" (Bion, p. 65). Groups of any kind are rife with conflict owing to the tension that necessarily exists between individual needs and "group mentality" (Bion, p. 60). Out of this inevitable dichotomy, a "group culture" (p. 60) grows. Studies of institutions, including hospitals, suggest that the rituals and credos of professional conduct conform to just such a "culture" and serve to defend against variants of "persecutory and depressive anxiety" (Jaques, 1955, p. 478). The more anxiety provoking the objective task of an institutional group, the more necessary it is for staff to shield themselves from the inevitable potential for anxiety. A collective reliance on primitive defenses such as denial, projection and splitting seems to predominate in relation to the anxiety level of the work.

As Menzies (1961) has pointed out, professionals, like nurses, must keep themselves highly defended, as there is often substantial synchrony between the nature of their work and the stuff of primitive fantasies. Rigid and dehumanizing rules and regulations (such as the kind of professional detachment that classifies patients as diseases or procedures rather than human beings) serve to minimize the linkup between fantasy and reality.

Institutional change is threatening in that it challenges inflexible social defenses, thus making way for the breakthrough of primitive fantasies and attendant anxieties. At just such times of stress, Bion (1959) would expect a regression to a "basic assumption" level of group functioning. Such "basic assumptions" belie the complexities of a more "sophisticated outlook" (p. 90) on the work. When so regressed, groups behave according to three expectable prototypes. Either a group will behave as if it must either fight or flee (the "fight-flight" paradigm); alternatively (and alternately) a group will behave as if it is subservient to and fused with a benevolent and omniscient leader (the "dependency" paradigm); finally, a group may subsume individual needs to vicarious participation with one (sexualized) pair. This is the "basic assumption" of pairing.

Within the framework of these theories, it is apparent that a phenomenon like the arrival of Mr. G might produce a shake-up in the social defenses of the hospital, in contrast to other patients for whom mechanisms for keeping a safe distance between conscious work related tasks and unconscious fantasies are readily available. No such strategies initially existed to cope with Mr. G. In Menzies's words, the "primary task" came too dangerously close to the more psychotic underpinnings of group functioning. Mr. G defied the standard categories of

patienthood; what he had done was not only bizarre but unprecedented -- impossible to classify in terms of the usual lexicon of accident, disease or defect. As in Douglas's (1966) anthropological theory, Mr. G's monstrosity suddenly and unexpectedly challenged the agreed-upon hospital culture, leading to temporary chaos and confusion.

Given the above, one would expect to see a reactive shoring up of typical social defenses, as well as much utilization of denial, projection and splitting. Moreover, one would expect to see the evolution of a "group culture" dominated by basic assumptions. There are ways that the hospital-wide response to Mr. G fits neatly into this theoretical matrix. In contrast, there are ways that the institutional response to Mr. G runs counter to group theory. It is perhaps not surprising that initially and ultimately the hospital was <u>not</u> prepared to cope with Mr. G. One can view the initial series of inappropriate professional reactions to Mr. G as related to an overplus of "persecutory anxiety." Similarly, one can view the current climate of staff inertia, hopelessness and withdrawal from Mr. G as an equally unmitigated reflection of "depressive anxiety." Yet clearly there was a fairly long period in which staff <u>was</u> able to cope fairly effectively with Mr. G, never compromising the quality of care he

received (even if providing it in a less than typical fashion).

In order for Mr. G to become the hospital's "#1 man," the extremity of his psychopathology, the malignancy of his sado-masochism and the repulsiveness of his appearance had to somehow be disregarded. Though at an individual level this has been described in terms of reaction formation, one can also view the phenomenon as a mode of group denial. Such denial has been viewed as a necessary defense in the work with chronically ill and disabled people (Miller & Gwynne, 1972). In Mr. G's case, such denial made it possible to expand the ranks of his willing caretakers. If the general consensus was that Mr. G was not particularly threatening, then initial apprehensions about caring for him could be stilled. Yet if is of interest that the hospital-wide denial of pathology did not run in the direction that has been described. Menzies (1961) has observed a defensive trend toward dehumanizing and depersonalizing the patient. In Mr. G's case the opposite occurred. Rather than depersonalizing Mr. G, his care was highly personalized. People brought him gifts, shared personal information with him, spent their breaks with him. Rather than denying that they had feelings for Mr. G, they often admitted to strong affectionate and even familial feelings ("he reminds me of my son") toward Mr. G. Paradoxically, the distance so often sought by health

care professionals, rather than being increased, was reduced with Mr. G. Rather than downplaying Mr. G's individuality (as has been described in Menzies account), his singularity was tauted (viz. the tee shirt). Special exceptions were made for him at a hospital-wide level. Both his excessive length of stay on the ICU and his basically inappropriate transfer to the rehabilitation unit underscore the above point.

Obviously the use of projection as a social defense contributes to the phenomenon of mass denial. Not only was Mr. G's badness and sickness denied; in addition, he was imbued with a variety of qualities which likely existed more in the eyes of the beholders than in Mr. G himself. He was seen as "intact," "a person who made a mistake," "mentally nothing is wrong with him," "God-fearing," "He did it for attention," "intelligent," "nice easy going fellow," a "very bright person." Though staff did acknowledge both Mr. G's psychotic and suicidal potential, the more prevalent emphasis had to do with his positive qualities. Perhaps one can view the hospital-wide idealization of Mr. G as a variant of the "dependency" "basic assumption." As long as he was seen as special and good, then everyone else was safe. In a sense the message was "you're o.k., we're o.k." Moreover, as long as we all stuck together, either in pairs (like my colleague and

myself) or in harmonious association (no one challenging anything about Mr. G), the atmosphere seemed benign.

It is striking that even when staff acknowledged Mr. G's potential or underlying psychopathology, he was never viewed as bad or hateful. At worst he was seen as misled, "manipulative," or "attention-seeking." If Mr. G was not seen as bad, who was? One might expect that the psychiatric consultants, responsible as we were for monitoring Mr. G's mental state, would be the target for hostility and resentment (especially given the difficulties with disposition plans). On the contrary, we have been treated throughout with respect and deference by the rest of the hospital staff including the rather typically disinterested plastic surgery team (we were asked to give a ten minute presentation on Mr. G to the once weekly surgery conference involving senior attending surgeons from the affiliated major medical school. Rather than speaking for ten minutes, the talk was allowed to run nearly an hour!). In a sense, my colleague and I may fulfill the role of the salutary "pair" that Bion describes as developing in "basic assumption"-dominated groups. As long as we are involved, things stay interesting and hopeful. Although I have not been involved with all staff levels of those dealing with Mr. G, it is my overall impression that there has been minimal splitting among the staff. No individuals or groups seem to get singled out for bad

projections, nor does Mr. G. Further, there has been remarkable homogeneity of opinion about Mr. G and minimal disagreement.

One wonders what factors have served to minimize the kinds of negative reactions that have so frequently been described as typical responses to self-mutilators. I suspect that "bad" projections would have come too close to the stark reality of Mr. G's self-mutilation. Acting and thinking in concert has been a way to neutralize and defuse his threat. Provided we all liked (or withdrew from) Mr. G, we could avoid the kind of fragmentation engendered by negative splitting. Fragmentation is all too inherent in Mr. G's self-mutilation.

Mr. G's admission to the hospital clearly produced a shake-up in the typical patterns of institutionally sanctioned group behavior. Though the proliferation of projection and denial is perhaps quite predictable, what has been unusual about the group psychology of reaction to Mr. G is the uniformly positive (not-bad) direction of response, as well as the absence of overt splitting. These trends notwithstanding, the behaviors manifested by staff both at the beginning of his hospitalization and currently reveal Mr. G's potential for evoking unsurmountable quantities of "persecutory and depressive anxiety."

I have been discussing the ways that a gross amd seemingly inconceivable self-mutilation affected both

individuals and groups working in a hospital. The particular nature of this self-mutilation, removal of the face, coupled with the personality dynamics of Mr. G also seem central to shaping the inevitable "countertransference" reactions.

By removing his face, Mr. G eliminated the visible correlative of his identity--his persona. By so doing, he became a blank screen, albeit a highly disfigured one. Once faceless (or endowed by the surgery with an expressionless patchwork mask, or wearing an actual mask) there was no way to gauge Mr. G's emotional state by looking at him. His face was blank, immobile, unable to convey even gross expressions of affect, let alone subtle nuances. The fact that Mr. G was not only faceless, but also contextless (homeless, abandoned by his family) made him a kind of tabula rasa, fertile soil for projections. Faceless, blind, essentially orphaned, Mr. G not only required a new face and the restoration of his vision, but a new life as well. It is perhaps expectable that Mr. G and his particular condition might stimulate fantasies, not only of death and destruction, but also of rebirth and salvation.

The protean aspects of Mr. G's personality were additional factors that contributed to the positive light in which he came to be regarded. Particularly in the early months of his hospitalization, Mr. G presented himself as

mild-mannered, compliant and cooperative. He rarely evinced overt signs of psychosis and rarely displayed the kinds of aggressive or bizarre behavior that must have led to his self-mutilation. As mentioned earlier, he denied any responsibility for the self-mutilation, evincing as much shock as would any "normal" person when it was suggested that his injuries might be self-inflicted. Particularly on this last score, but with numerous smaller instances as well, Mr. G was often actively manipulating the truth. As also indicated above it is unlikely that Mr. G's denial of his self-mutilation was either amnestic or delusional; on the contrary, this denial seemed to be a way that Mr. G could protect his self-esteem.

Perhaps a reason why one often "forgot" that Mr. G had so violently mutilated himself is that it <u>really</u> <u>was</u> difficult to consistently know who he was and was not, what he had and hadn't done. The liberties that he took with the truth supported this ambiguity, while his inscrutable face revealed nothing more to confirm or diconfirm his statements. One can usually gauge something about an individual's genuineness by his face; in Mr. G's unique situation, the usual cues were absent. Within this framework, it was extremely difficult, at times impossible, to judge the authenticity of Mr. G's words. And words, from a grossly disfigured, prone, isolated and abandoned person were all we had to judge him by.

In becoming a receptacle for good or at least ordinary projections, Mr. G achieved what was possibly one of the goals of his self-mutilation -- a new identity. For a time Mr. G was transformed into what we wanted him to be, someone who was good, nice, intelligent, compliant, not crazy, not bad, not violent. Through a mutually reinforcing process, Mr. G became the possessor of a new and more positive identity. It is perhaps not surprising to note not only did Mr. G expect that the surgeons could successfully recontruct his damaged face; he expected that they would endow him with a new face, superior to the one he had lost. In fact, it was the very inscrutability of Mr. G's appearance, coupled with the amorphousness of his real identity, that permitted him to take on the role of the person we needed him to be. If Mr. G's face was the concrete symbol of the identity he had chosen to eradicate, his facelessness was the medium of his new persona. The fact that a poorly integrated, schizophrenic, probably sociopathic, radically self-mutilated man could become an entire hospital's "#1 patient" bespeaks not only the staff's need to defend against the profound anxiety aroused by Mr. G, but also attests to Mr. G's chimerical plasticity. As Burnham (1966) has noted, it is often by virtue of <u>being</u> poorly integrated that certain patients become "special." In Mr. G's case his inchoate and

probably fragmentary personality was given literal form by the removal of his face. At the same time, and ironically, Mr. G's self-mutilation has made him so singular that he could never be mistaken for anyone else.

Greenacre's essay on the imposter (1958) sheds further light on Mr. G's metamorphosis into "#1 man." She suggests that imposture is a process that cannot occur without collusion. In order for an individual to successfully pose as someone or something else, he/she must have "unconscious conspirators" (p. 94) whose credulity confirms the false identity. This notion relates to the process by which a faceless, and inchoate person came to be seen as a cohesive individual whose personality ("bright," "religious," "insightful") was assumed to be consistent over time. Though there were clearly moments of Mr. G evincing each of the above characteristics, it is unlikely that these fragments together constituted a homogenous identity. Mr. G was a collection of identity fragments, the sum less than the parts. To the extent that Mr. G was seen as having a continuous personality, it was because we bestowed it upon him. We manufactured the phenomenon of the "#1 man," usually overlooking the discordant elements of Mr. G's personality (the history of aggression, the sociopathic and possibly criminal acts) in favor of the more concordant "good" aspects. According to Greenacre, to the extent that a self exists for the

imposter, it is externally acquired, its reality derived and maintained from without. It is only through the feedback of an audience that the imposter comes to have any feelings of authenticity. Below the external facade, Greenacre notes, exists a being "frequently crude and poorly knit" (pp. 97-98). Due both to the individual and systemic needs, staff at the hospital became the creators of the acceptable Mr. G, providing him with the continuity of self that he lacked.

For a time the hospital staff were able to fulfill Mr. G's likely fantasy of becoming a new man. Yet this mutually collusive fantasy could not withstand the inevitable encroachment of reality. Even if we could help Mr. G reinvent a new self, we could not help him see, or be reunited with his family, or look human. In the face (!) of the very real hopelessness of the situation, no illusions could consistently be maintained. As we drew back from Mr. G in our depression and helplessness, he came to be more of a shadowy figure, never "bad" but no longer endowed with the former quality of intensity. Now it is more difficult to gauge Mr. G's state of mind, to tell from one day to the next what he is feeling. One can see him as being depressed, despairing or by contrast brave and even stoical, but it is difficult to know whether these are Mr. G's authentically experienced emotions, or ours. The magic lantern that created the illusion of the

"#1 man" has dimmed. The reality that we are left with is the bleakness of Mr. G's situation and our inability to ameliorate it.

CHAPTER SEVEN

Epilogue: Reflections on Some Further Clinical and Institutional Implications of this Case

The case of Mr. G is not yet closed. As of the final writing of this dissertation, his observable situation remains much the same. For the most part, he stays cloistered in his room, venturing out from time to time. He is never visited by family or friends. As the second anniversary of his self-mutilation approaches, there is still no place for Mr. G to go. There is a sense of timelessness about Mr. G's quandary, defying the usual mandates of hospital length-of-stay guidelines and utilization review boards. Hundreds of thousands of dollars have been spent on Mr. G, seemingly to no avail.

Despite a steady quest, no other institution has been found that is willing to take responsibility for this very unusual patient. Briefly it appeared that a place had been found. An adult home, specializing in the care of emotionally and physically handicapped people (ironically called the "Garden of Eden") expressed an interest in Mr. G. Yet after he visited, wearing a mask, a three-piece suit and cordovan shoes (the interview outfit a kind donation from a staff member), the Garden of Eden rejected

him. Though he was cordial and appropriate, the residence said they were incapable of coping with the magnitude of Mr. G's problems, nor did they think that other residents could tolerate his presence ("How could he have a roommate?"). Not a part of our institutional culture that finds Mr. G familiar and unthreatening, the Garden of Eden's reaction parallels the early stages of our hospital's reaction to Mr. G. There is one basic difference however; they had a choice whether or not to accept Mr. G. Our institution did not.

The only remaining disposition possibly is a recently opened unit at an upstate facility (the only one of its kind) devoted exclusively to the care of blind psychiatric patients. Months ago they were enthusiastic about accepting Mr. G, but pled overcrowding after they received our written material. They have not rejected him, but say they cannot take him yet. Meanwhile, our hospital's rehabilitation unit feels that Mr. G must be transferred as he is occupying a space that would be better suited to a bona fide "rehab" patient. They think it makes sense to transfer Mr. G to our hospital's inpatient psychiatric unit, but that unit also refuses to accept Mr. G as he poses too much of a disposition problem. Mr. G has also been rejected by the state psychiatric hospital as they are unable to meet his needs. Given the lack of appropriate placement and the need to place Mr. G, this

stalemate has gone to a higher level. Negotiations have begun involving the director of the hospital, the director of psychiatry, the director of the state hospital, and a director of the upstate facility with the blind unit. As is clear, Mr. G's future is no longer in the hands of individuals, but has become part of an intra and inter-institutional struggle. This dispositional standoff graphically underscores the dilemma: Mr. G's case is beyond the scope of individual efficacy. The "primary task" of caring for Mr. G is one with the "basic assumption" of dependency. By necessity, Mr. G and his caretakers have to subserve themselves to the benevolent (hopefully) intervention of omnipotent persons.

Much has been said about the individual and institutional countertransference in this case. What of Mr. G's transference? As has been indicated, Mr. G has formed an intense transference to particular staff members as well as to the hospital itself. As he has said, we're more like his family than his natural family. And there is the rub. As with so much in this case, the line that demarcates fantasy from reality is indistinct. In a very real sense, we <u>are</u> replacements. We <u>have</u> become surrogates, standing in loco parentis. And yet, in this position, the hospital is inevitably forced to extrude Mr. G, thus recapitulating the very situation that was likely the immediate precipitant for his self-mutilation.

Perhaps, not surprisingly, Mr. G's transference to the institution has responded in kind. Within the last month, Mr. G has made two threats to his therapists which suggest his continued potential for destructive acting out. The first threat was self-directed, the second aimed at his caretakers. The first threat stemmed from a fantasy of his own failure, the second from the conviction (actuality?) that the hospital had failed him. Both threats occurred on Friday afternoons, as brief weekend separations from his primary therapists approached. The first threat came several days after he was rejected by the Garden of Eden. Mr. G stated that not only was he planning to cut his penis off, but that he'd already begun the job. An immediate examination of his genital area revealed no lacerations. Mr. G's subsequent explanation was that he was "fooling" and admitted his hope that he might finally get his therapists to examine his penis.

On the second occasion, Mr. G confessed to a plan to get a gun and start shooting at random. He stated that this idea grew out of a sense of humiliation and defeat. Two days before he had gone to the hospital's eye clinic. While waiting to be examined, he overheard his opthalmologist telling a colleague: "There's the guy who cut his face to the bone." When he was told that the remainder of his remaining eye had atrophied, he attributed this final affirmation of his blindness to the prejudice of doctors

who could not want to treat a man who'd "cut his face to the bone." The same thought generalized to the plastic surgeons who had "given up" on him and to the staff who had failed to find him a home. The culmination was a diffuse fantasy of revenge and the dim hope that perhaps a correctional facility would then take him in (Mr. G's father had been a guard at a prison while Mr. G was growing up). Fortunately, once Mr. G discussed these fantasies, the need to act on them vanished.

Both of these threats occurred in response to actual experiences of disappointment and rejection and initiated a flurry of concern on the part of both his therapists; yet as members of the greater institution that housed Mr. G, we were also a part of the climate of rejection. Our renewed concern seemed to calm and strengthen Mr. G, who has been slightly more outgoing since these revelations. Yet at each point the therapeutic/institutional connection is strengthened it is also stressed, as there is even more for him to lose. The above examples give a sense of the complicated interactions between Mr. G, the staff and the institution that houses him. At times it is not clear what is transference and what is countertransference, what is a real relationship and what is an illusory one. As he affects us, we affect him. This is the dizzying hall of mirrors (this metaphor an inadvertant reference to the dynamics of reflection and mirrors that characterize this

case) that has been created in the unorthodox treatment (therapeutic and otherwise) of an extraordinary patient in an unlikely milieu.

In reflecting on the complex ramifications of this case, it does seem that ongoing discussions and conferences between all parties might have served to vitiate some of the anxiety that always lurked below the surface of the "group culture." This was certainly done initially with our liaison staff orchestrating conferences between the different services involved with Mr. G. Such interchanges have continued on an informal and more infrequent basis throughout the last two years. The diminution of such discussions seems to be part of the process which has unfolded around Mr. G. Maybe one could not work with Mr. G and always keep the big picture in mind. Perhaps too much self-examination would have made the underlying issues all too vivid, the boundaries between reality and fantasy even more vague. As long as Mr. G remains with us, it's going to be hard to gain full perspective. To quote Bion, "the fact that one is involved in an emotional situation makes clearheadedness difficult" (1959, p. 57). The hospital, the staff and Mr. G. It seems that we're all in it together. For the duration.

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