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Self-Mutilation, Obsessionality and Narcissism

By A. R. GARDNER and A. J. GARDNER

INTRODUCTION

This paper describes a controlled study of 22 non-psychotic female habitual self-cutters. In this study an habitual self-cutter is defined as a patient who has cut herself with a sharp object on at least two separate occasions.

A wide variety of self-mutilating acts have been observed in psychiatric patients for centuries, but Offer and Barglow (1960) have focussed interest on the patients, usually female, who repeatedly cut their wrists. Since their paper a number of reports have appeared, mainly from the U.S.A. Thus, Graff and Mallin, (1967) described the typical wrist-cutter as 'an attractive, intelligent, unmarried young woman, who is either promiscuous or overtly afraid of sex, easily addicted and unable to relate to others . . . she slashes her wrists indiscriminately and repeatedly at the slightest provocation, but she does not commit suicide. She feels relief with the commission of her act'. Ping-Nie Pao (1969) has labelled these patients 'delicate self-cutters' to distinguish them from those who cut once, deeply and suicidally. Rosenthal *et al.* (1972) have suggested tentatively that the patients cut themselves while in a depersonalized state 'in an effort to re-integrate'. These and other American papers are essentially descriptive, almost all are uncontrolled, and owing to the different diagnostic criteria and semantic differences that exist between the U.S.A. and the U.K. (Cooper J. *et al.*, 1972) great caution is required in comparing the data in the present and other British papers with the American literature.

Only three studies of consequence appear in the British literature. They are McEvedy's (1963) work, which lacks a control group, McKerracher *et al.*'s (1968) paper describing self-mutilation in subnormal criminal psychopaths, and Waldenburg's (1972) study, which was controlled, involving 13 subjects and their controls.

The background to our present state of knowledge can be summed up thus: some useful descriptive and interesting but speculative work has been done. There has been only one satisfactorily controlled study among patients of normal intelligence, namely Waldenburg's, and much remains to be established and confirmed about a common group of patients, examples of which must have been seen by all psychiatrists.

The aims of the present study were: (1) To elicit the clinical and biographical features of non-psychotic, female, repeated self cutters, as defined above. (2) To attempt a detailed study of the patients' mental state at the time of the act. (3) To test the prediction, based on clinical observation, that self-cutters exhibit a marked obsessional trait. (4) To examine the possible relationship between self mutilation, obsessionality and narcissism.

The above relationships were suggested by the impression that self-cutters, although often casually dressed and made up, had clearly spent much time and effort achieving this effect. This impression of preoccupation with appearance was strengthened by the fact that 7 out of 7 male self-cutters (subjects of a current ongoing study) were exceptionally particular about their personal appearances. Further hints lay in McEvedy's conclusion that 'in our culture the female devotes a great deal more time to such grooming activities as skin care and hair grooming' and his suggestion that the production of superficial lacerations could be seen as an extension of grooming behaviour. The well known decorative facial scars of certain African tribesmen and the self-esteem boosting, highly prized, sabre-inflicted facial wounds of German students are two further examples supporting the idea that narcissism and superficial cutting of the skin might be related.

METHOD

The 22 subjects were repeated self-cutters, female, non-psychotic in-patients. Patients whose self mutilations occurred when their mental state was altered by alcohol, drugs or epileptic phenomena were excluded.

Eight patients were drawn from the psychiatric ward of an undergraduate teaching hospital, and 14 from a large, traditional mental hospital. Most previous studies involved only teaching hospital or special unit patients, and we hoped that our wider sampling would provide a more representative series.

The patients form only a proportion of the self-cutting patients treated at the two hospitals between 1 July 1972 and 30 June 1973, during which period the study ran. The patients were seen by one or other of us when our service commitments allowed, and although no doubt a variety of undetermined selection factors did intrude, no patient was deliberately selected or excluded other than for reasons already stated. Thus the sample was as random as could be achieved within the limits indicated. In practice no truly random sample of these patients has yet been described.

The 22 subjects were matched with 22 non-psychotic female controls for age, social class and ward. The choice of the control patient was made by the relevant ward sister, who was otherwise ignorant of the aims of the study.

As Offer and Barglow (1960) and McEvedy (1963) have shown, repeated self-cutting appears to have an 'infectious' quality leading to outbreaks involving several patients. This suggests that factors in the ward milieu play their part and these should ideally be the same for subject and control. An attempt was made to allow for this by drawing the controls from the same wards as the subjects, their periods of in-patient care to coincide. This latter provision proved difficult and was achieved in only half the pairs. The best that could be achieved for the remaining pairs was for their admissions to be as near each other as possible; this was never more than a few weeks apart. It is acknowledged that the ward dynamics could have changed substantially during this time.

A detailed psychiatric interview was carried out on all subjects and controls. The accepted

psychiatric diagnosis was that made independently by the psychiatrist in charge of each patient. Special attention was paid to the patient's mental state during self-cutting. An important aspect of this was the patient's avowed reason for the act. In clarifying this we felt a choice had to be made between either asking each patient the same questions in a set order or allowing this part of the interview to develop as spontaneously as possible, noting whatever reasons were given. The former approach has the advantage of being easier to replicate, but it was our impression that the subjects were often vague about their motives and easily led. Because of this we chose the latter, less structured approach.

All patients and controls filled up the Middlesex Hospital Questionnaire (Crown and Crisp, 1966), which measures six common groups of symptoms and traits (see Table III). Similarly the 40 question section of the Tavistock Inventory (Sandler, 1954) relating to obsessive and compulsive traits was completed.

No reliable questionnaire to assess Narcissism has been designed. However, Sandler and Hazari (1960) showed by factor analysis that the section of the Tavistock Inventory just referred to contained two distinct factors. Factor A they tentatively called 'realistic-narcissistic', as they felt that this described the character pattern which exhibited the items clustering round factor A. For similar reasons they felt that factor B approximated the so-called 'obsessional personality'. We predicted that the self-cutting group would cluster significantly nearer the realistic-narcissistic pole than would the controls.

RESULTS

The data are summarized in Tables IA-Id.

It can be seen from Table IA that although the mean age is quite young the range is relatively wide from 18 to 56 years.

That self-cutting behaviour can commence as early as 9 years of age and as late as 56 is noteworthy. As very little is known about the long-term prognosis in these patients, the fact that it has lasted 26 years in one patient is of interest.

TABLE IA
Age of onset and duration of self-cutting

Mean age of patients ..	28.8 years (extremes 18 yrs.-56 yrs.)
Mean age at first cut ..	23.9 years (extremes 9 yrs.-56 yrs.)
Mean duration of cutting behaviour	5.0 years (longest 26 yrs.)
Number who first cut as in- patients	14
Number who first cut outside hospital	8

TABLE IB
Site and number of cuts

Wrists and/or forearms ..	22
Face	2
Neck	1
Abdomen	1
Thigh	1
Leg below knee	1
Feet	1
Toes	1
Number of cuts per subject ..	2 to well over 100
Act always in private ..	21
Act always in public ..	1

TABLE IC
Reason given for self cutting and feelings at time of act

'Relief of tension'	19
'Suicide'	9
'Anger at others'	7
'Anger at self'	4
'To get attention'	5
'Sexual frustration'	1
Number who felt no pain at time	16
Number depersonalized at time of cut	7
Number claiming Amnesia for the event	7

} Same subjects

TABLE ID
Social class

Social class I	5
II	4
III	4
IV	6
V	3

The wrists or forearms were the chosen site in all cases, though a few patients cut themselves elsewhere in addition.

The initially private nature of the act is well emphasized.

The reasons given for self-cutting require further clarification. By far the commonest experience leading to self-cutting was the onset of an unpleasant feeling of tension, this increased in intensity until the patient cut her skin, which brought an immediate lessening of tension and a feeling of relief. Sometimes the feeling of tension was related to angry feelings towards self or others, but more often than not there was no apparent precipitating factor. Although in some ways the build-up of tension and repeated act resembled obsessional behaviour, in only three cases was there any inner struggle to resist the act, and two of these patients were suffering from a definite obsessional illness.

The 9 patients who alluded to suicidal motives all put forward this explanation in a half-hearted perfunctory fashion, and during further discussion it became obvious that in no case was self-destruction the aim. Similarly, 7 patients claimed that they had no recollection of the act, but as the interview progressed all seven gave a very detailed description of their feelings at the time. In no case did a true amnesia exist. It was interesting to note that these same patients all suffered depersonalization before the self-mutilation.

A high proportion, 16, claimed to feel no pain when they cut themselves, but all felt pain minutes or hours later.

The social class incidence reveals a trend suggesting that self-cutting might be commoner in Social Classes I and II.

Table II shows that the only difference between subjects and controls was a significantly higher incidence of psychosexual disorder among the subjects. As a group they were more likely to be frigid or actively lesbian.

We also had the impression that individual cutters took overdoses of drugs more often than the controls, but the actual number of cutters who had taken one or more overdoses was not significantly different from the control group.

The most striking feature of Table III is the cutter's highly significant score on obsessionalism.

TABLE II
Comparison of clinical and biographical data for 22 cutters and 22 controls

	Cutters	Controls	(P)
Clinical diagnosis:			
Personality disorder ..	15	14	N.S.
Depression	5	6	N.S.
Obsessional state ..	2	1	N.S.
Anxiety state	0	1	N.S.
Married	8	10	N.S.
Single	14	12	N.S.
History of abuse of drugs or alcohol	5	5	N.S.
Number of patients who had taken overdoses ..	12	8	N.S.
Nursing or paramedical occupation	5	3	N.S.
Psychosexual disorder ..	13	6	<0.05

χ^2 test with Yates' correction used throughout.
N.S. = Not significant.

Although not a significant difference, the controls scored higher on 'Hysteria' than did the cutters, which might surprise observers prone to describe self-cutters as 'hysterics'.

Table IV confirms the cutters' marked tendency to score significantly higher than their controls on measures of obsessionality. There was, however, no evidence that the cutters scored higher on the obsessionality questionnaire because of selectively higher marking of items relating to the realistic-narcissistic charac-

ter pattern. Their generally higher scores appeared to be due to an equal marking of both realistic-narcissistic and obsessional personality items.

DISCUSSION

The data related to the act of self-cutting are similar to those in earlier studies and tend to confirm much that has been described before. There are, however, a number of significant differences.

The figure for the number of subjects depersonalized at the time of cutting is lower than in other studies which give figures, and we cannot agree with Rosenthal *et al.* (1972) that depersonalization is the essential factor preceding self-mutilation. The fact that Waldenburg (1972) found the phenomenon of depersonalization as often in his control group as among wrist cutters tends to confirm our view. The surprisingly high (8) number of patients who first cut outside hospital suggests that this behaviour is not just a product of institutional life.

When the clinical and biographical data for controls and subjects are compared, the most striking feature is the *lack* of difference between them. This leads us to the conclusion that the general aspects of Graff and Mallin's literary description of the 'typical' wrist cutter would apply equally well to a random selection of

TABLE III
Mean Middlesex Hospital questionnaire scores and standard deviations of total groups of 22 cutters and 22 controls

	A	O	D	P	H	Total
Cutters	12.5±3.9	10.5±1.6	8.4±5.29	9.5±3.5	6.2±3.3	55.1±2.75
Controls	11.2±3.5	7.5±2.3	8.1±2.4	9.0±3.3	7.1±3.6	48.8±4.68
Probability (P) ..	N.S.	<0.001	N.S.	N.S.	N.S.	N.S.

N.S., Not significant; A, Anxiety; O, Obsessional; D, Depression; P, Phobia; S, Somatic; H, Hysteria

TABLE IV

	Cutters	Controls	(P)
Mean score on 'obsessionality' section of Tavistock Inventory			
Factor A (Realistic-Narcissistic)	24.5±10.2	15.5±6.7	<0.002
Ratio $\frac{\text{Factor A (Realistic-Narcissistic)}}{\text{Factor B (Obsessional personality)}}$	1.07	0.92	N.S.

N.S., Not significant

non-psychotic female in-patients; particularly if drawn from a teaching hospital or special unit population.

The need for controls in the study of this phenomenon is emphasized when one considers McEvedy's finding that 5 out of his 13 patients were nurses, and Goldwyn *et al.* (1967) also remarked that many of their patients were nurses or paramedical workers. The present study also shows a similarly high proportion of cutters from these occupations, but the control group shows that this finding is not necessarily significant.

Waldenburg found a diagnosis of personality disorder to be significantly commoner in his study, whereas we did not. This difference is easily explained by the fact that Waldenburg (1972) included psychotic patients amongst his controls, and although none of his wrist cutters turned out to be psychotic four of his controls were schizophrenics. All psychotics were excluded from the present study.

Thus we have found little difference between self-cutters and controls, but it remains possible, even probable, that differences do exist but are found perhaps in the quality of child/parent relationships and other areas difficult to assess with certainty in retrospect. Waldenburg (1972) presents some evidence that this is so, and of particular interest is his finding that a history of feeding disorder allied to anorexia nervosa is significantly commoner among wrist-cutters.

Turning to the Questionnaire evidence, the obsessionality of the self-cutters as a group is confirmed. McKerracher *et al.* (1968) also used the Middlesex Hospital Questionnaire, and they found that self mutilators scored significantly higher on obsessional, phobic and somatic items, the obsessional symptoms being the best for discriminating between subjects and controls. The similarity between their results and those reported here is particularly surprising when one considers that all McKerracher *et al.*'s patients were criminal, subnormal and psychopathic patients in Rampton Hospital; a very different sample.

Another hint that obsessionality is at least a factor in self-mutilation is to be found in Watson's (1970) paper concerning an intensive study of one self-mutilating patient, using a

repertory grid technique. He demonstrated that 'having the same thoughts in my head for a long time' could be identified as one of the elements most likely to make the patient slash herself. There is not enough detail concerning the 'thoughts' to confirm them as obsessional, but the statement is at least suggestive.

The Rampton workers point out that there is a compulsive and ritualized element in repeated self-cutting and suggest that each time it is carried out positive reinforcement occurs as a result of the pleasurable relief of tension, strengthening the patient's tendency to repeat her behaviour. 'Relief of tension' was easily the commonest reason for cutting in the present series, and this coupled with the evidence for a marked obsessional trait supports the Rampton workers' suggestion. If their explanation is even partially correct it has theoretical implications for the treatment of repeated self-cutting. All authors who discuss the problem acknowledge that modification of this particular aberrant behaviour is extremely difficult. It would seem logical to seek some other superior tension-relieving reward or alternatively seek to couple the self-mutilating act with an aversive stimulus.

In practice it is difficult to find a superior tension-relieving reward. However, it may be that Graff and Mallin (1967) employed such a technique successfully, though they conceptualized it quite differently. Graff and Mallin regard the self-cutters' method of tension relief as a pre-verbal message, and they based their treatment on what they describe as a physical pre-verbal approach. This involved holding the patient's hand when she was tense and even cuddling her when she felt like cutting herself. Thus, they state, 'periods of cutting were ended or staved off by the therapist's putting his arms around the patient'. It could well be that this behaviour of the therapist's 'in a nonsexually stimulating way' proved to be a comforting and tension-relieving reward, superior in effect to self mutilation.

If this explanation is correct, it would be logical to equip the patient with the means of controlling her distressing tension. Perhaps this could be achieved by teaching the patient auto-relaxation which she could apply whenever she

felt herself becoming tense. This approach does not appear to have been tried in these circumstances.

An aversive stimulus such as an electric shock has been used with considerable short-term success in a number of single case reports of self-injurious mentally handicapped children (Smolev, 1971; Callias *et al.*, 1973). The technique is to administer a painful electric shock immediately after the self-injurious behaviour (usually head banging). There are of course enormous differences between the adult self-cutter who self-injures relatively infrequently and the head banging child who carries out the act several hundred times daily. Obtaining the self-cutter's co-operation would be but the first of many possible difficulties. However, aversive shock treatment has not been reported in adult self-cutters, and it remains a new line of possible treatment to explore in what is still an extremely difficult treatment situation.

SUMMARY

A controlled study of the clinical and biographical features of 22 female repeated self-cutters is described.

The results of the assessment of these patients, using the Middlesex Hospital Questionnaire and the Obsessive-Compulsive section of the Tavistock Inventory, is presented.

The marked obsessionality of these patients is emphasized and the possible implications of these findings for treatment is discussed.

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