How Attachments Go Haywire

Nothing is more dear to them than their own suffering—they are afraid that they will lose it. They feel it, like a whip cracking over their heads, striking them and yet befriending them; it wounds them, but it also reassures them.

Ugo Betti, *Landslide*

Attachments can be so passionate that they tie two lovers together and bind wildness to her cub. Yet passionate attachments can become prisons, attaching one to pain and suffering the way shackles bind a prisoner. This bondage to pain and suffering derives from our primary relationships, our earliest basic attachments. The attachment the baby has to a mother or caregiver will influence the kind of attachments the child will form to others later in life. It is in an early attachment to neglect, traumatic separations, or abuse that the seeds of a deep attachment to neglectful or abusive object relations and to neglect or abuse of the self are born. The earliest attachments mold the development of the child’s ability to care for himself physically and emotionally, and to feel either deserving or unworthy of good care and treatment. If he feels unworthy, he may grow up neglecting his body or being passionately attached to self-harm.

The attachment to neglect, trauma, and self-harm may even become imprinted in the child’s regulatory processes in the brain and change his brain chemistry. As dire as this sounds, the good news from attachment research is that the attachment to self-harm imprinted on the brain can be biochemically altered through the development of a secure attachment relationship to a parent, friend, spouse, significant other, teacher, pet, or psychotherapist.
Despite differences in terminology, attachment theory and research, like Mahler's separation-individuation theory, is based on the poles of attachment and separation. Both develop the concept of proximity-seeking as contrasted with exploratory behavior with an awareness of the accessibility of an attachment figure. What is similar in both theories, based on observations of infants and toddlers, is that self-reliance and autonomy develop gradually as trust and confidence develop in the attachment figure. While Bowlby prefers the concept of self-reliance and the ability to find needed attachment figures in the environment when dependency needs require it, Mahler prefers the concepts of the introjection of love objects and object constancy. While Bowlby avoids the term symbiosis, which is considered phase-specific, Mahler and others regard the symbiotic quality as attaining internalized psychological significance. The term symbiotic is used here to represent greater degrees of attachment need, even when the symbiotic object no longer derives conscious or unconscious gratification from the relationship.

Attachment theory defines the inclination of human beings to form strong secure bonds with others, and explains how ruptures of these bonds, such as traumatic separations and loss, give rise to anxiety, depression, anger, and emotional detachment. Attachment behavior, seen more clearly when a person is frightened or exhausted or ill, is any form of behavior that results in that person bringing himself nearer to some other person whom he perceives as being a source of comfort and strength. The main thrust of Bowlby's attachment concept is the degree to which a child's parents provide him or her with a secure base that not only allows but also encourages him to explore further and further away from it. If the attachment figure remains available and responsive, providing protection, help, and comfort when needed, the child then can develop the psychological, emotional, and cognitive skills necessary for mastery and a firm sense of security in the world. At the same time that we understand the importance of attachment bonds, it must be recognized that solitude, the capacity to be alone and to enjoy spending time alone, and attachment are complementary, and both are essential developmental and biological needs for children and adults (Buchholz 1997).

As will be demonstrated, the child who has formed attachments in infancy that are marked by affection and security will become capable of enjoying his own company and capable of forming affectionate attachments with others. Anxious attachment originates in the individual's repeated experience of inconsistent caregiving that prevented the sense of security from forming. A pseudo-independent stance or compulsive self-reliance may appear to be the opposite of anxious attachment, but is an indicator of attachment difficulties. The pseudo-independent individual is unable to seek the love and care of others, insisting on doing everything for and by himself. He, too, has had the experience of not having his needs met and not having developed a sense of security, and has managed to convince himself and often others that he has no need of anyone else. Lacking the flexibility to bear up well under the stresses of life, he is prone to falling ill with psychosomatic symptoms. Emotionally detached individuals are not able to maintain a steady affectional bond with anyone.

Both attachment and separation-individuation theories can help us to understand how a person can become so attached to pain, suffering, and harm, including the self-inflicted kind, that he cannot imagine living without them. Attachment theory provides a relational context for identifying, locating, and understanding such disturbing feelings as separation anxiety; sadness about loss; protest and anger at separation; rage, guilt, and terror in reaction to trauma; envy of those who seem to form easier attachments; and disturbingly conflicting feelings toward attachment figures perceived as withholding (Holmes 1996). In addition, attachment theory explains how people might clutch so tenaciously at an attachment to pain and suffering that they would rather lose their life than relinquish that attachment, and how some individuals' sense of their own existence is enlivened by masochistic suffering and flirtations with death. It helps us to understand how our best clinical efforts to help such individuals fill them with such anxiety that they are determined to thwart and defeat us. Even those who consciously want to give up their self-harm may end up defeating our best efforts to help them. They emerge triumphant with their cherished spoils—their bloodied or wasted selves.

Attachment theory and research does not supersede but rather enriches many existing theoretical perspectives. It provides a new hope for working more successfully with these patients in enabling them to form an attachment to their therapist that promotes intimacy and autonomy (Holmes 1996) and further develops their ability to regulate their moods, emotions, and physiological states. Jeremy Holmes's (1996) understanding of human attachments gives clinicians a framework for thinking about relationships to human objects (persons) in one's life that can also be enormously helpful in understanding the relationship to the self and the body, especially when those relationships are harmful or self-destructive. He emphasizes that it is intimacy within the attachment relationship in psychotherapy that is the key to the development of more autonomous functioning and intimate relationships.

Attachment, however, does not necessarily mean intimacy. There are strong attachment relationships in which there is no true intimacy and no autonomy. These are the relationships based on power, in which a dependent individual is attached strongly to the other through fear and insecurity. This is commonly seen in cases of child abuse when the abused child clings fearfully to his abuser, bound to him as if magnetically. It is also seen in battered women, who, despite the availability of shelters, social services, and legal assistance, cling desperately to their abusive partners and lie to law enforcement investigators, becoming their abusers' protectors.

The work of several authors has provided an invaluable foundation for understanding the attachment to the perpetration of violence on others and on the self. Felicity de Zulueta (1994) traces how the increasing violence in modern
ATTACHMENT THEORY AND RESEARCH

Each species in the animal kingdom has its own unique biologically based attachment system that attaches its offspring to its caregiver and caregiver to its offspring in order to protect the infant from predators in the environment (Bowlby 1969). The infant clings to its mother instinctively, as the Moro response demonstrates when the infant tries to grab onto or cling to his mother when she is moving too rapidly (Brazelton 1972). The survival of the species demands that the adult female take good care of the newborn for a period that is especially long in humans because the human infant, compared to offspring of other species, is born with an exaggerated head size that requires support, and so is peculiarly helpless for a longer period of time than are other animals (Stone 1988). The mother must have a deep, indeed a passionate, attachment to the child to ensure his biological survival, and to provide the sense of security that is necessary for both the development of self-regulatory functioning (Hofer 1995) and a climate of intimacy (Holmes 1986). When closeness with the mother or caregiver is not established or the sense of security is disrupted, the child does not have sufficient protection from others who might harm him, and thus is in danger of falling prey to harm, either from predators in the environment or from himself as he turns his aggression on his body with self-harm behavior.

Hartmann (1939) believed that in the first weeks of life the newborn’s means of discharging drive energy took the form of a silent physiological discharge to his body’s interior. To adapt to his environment, the infant must develop the ability to discharge drive energy outward to the exterior and must develop instincts for protecting and caring for himself. If the child is to adapt to his environment and thrive within it, he needs the intimate contact with the mother that is the basis for the development of both self-regulatory functioning and the self-care function of the ego.

The primary focus of attachment theory is on how the child’s inner world is influenced by the environment, or how, to use Freud’s famous phrase (Bollas 1987), “the shadow of the object” falls upon the subject. While Freud’s early work emphasized the instinctual basis of the mother–infant relationship, in his later work Freud (1938) spoke of the attachment to the mother: “A child’s first erotic object is the mother’s breast that nourishes it; love has its origin in attachment to the satisfied need for nourishment” (p. 188). The infant’s powerful tie to the mother is “unique, without parallel, laid down unalterably for a whole lifetime, as the first and strongest love-object and as the prototype of all later love relationships—for both sexes” (p. 188). Attachment research has shown that a child’s sense of security is greatly influenced by his parents’ responsiveness, consistency, and attunement to him. Responsive mothers with securely attached children pick up their babies more quickly and frequently than do mothers of insecure children; these children experience their mothers and develop object representations of her as being a secure home base. That is, the child can tolerate her leaving because he knows she will return, and the child can leave her, to make forays into the world, knowing that she will be there when he comes back. When the handling of the child was inconsistent, unattended, or rejecting, it led to anxious patterns of attachment (Ainsworth et al. 1978, Holmes 1996). A central assumption of psychoanalytic models is that parents respond to their children’s behavior and characteristics with expectations based on their own experiences with their primary caregivers (Fonagy et al. 1995). Each mother’s or father’s own childhood experience will therefore influence the way he attaches himself to his child and the way that the child becomes attached to him.

Mary Ainsworth, co-developer of attachment theory, studied attachment patterns in 1-year-olds, using the “strange situation” as a measure of attachment status. Observation of behavior in the strange situation involved two 3-minute separations and reunions between caregiver and infant in a clinic waiting room. The babies considered to be secure were those who protested upon separation, and when reunited with their caregivers could be sufficiently calmed that they could return to exploratory play (Ainsworth et al. 1978). Two-thirds of normal children behave this way. Children who do not show this pattern are considered insecure and are inhibited in exploring their environment. There are three recognized patterns of insecure attachment: insecure-avoidant, insecure-ambivalent, and insecure-disorganized. Insecure-avoidant children do not protest much when separated from their caregivers, and when reunited with them they anxiously hover nearby. The insecure-ambivalent children protest upon separation, but cannot be pacified when reunited. They either bury themselves in their caregivers’ lap or cling furiously to them, seeming very passive or very angry. The insecure-
disorganized children showed no coherent pattern of response. Some froze when reunited, and others collapsed on the floor or leaned vacantly against a wall, seeming disoriented.

These insecure attachment patterns are used defensively as strategies for maintaining contact with the rejecting or inconsistent parent. The 1-year-olds' attachment pattern has been found in long-term follow-up studies to have predictive power for subsequent behavior (Holmes 1996). The 1-year-olds classified as secure in general still show signs of security when they enter school, interacting well with classmates and teachers. On the other hand, the insecure-avoidant children were more likely to be loners, prone to unprovoked aggression, while the insecure-ambivalent children tended to be potential victims, clinging to their teachers for protection but unable to ask for help appropriately. The good news, however, is that an insecure child may become secure if his mother's situation improves or if the mother can resolve her own attachment difficulties (Holmes 1996). For example, the treatment of anxious preschool children often is not a direct treatment at all, but an indirect treatment through the treatment of the mother. If the mother can develop a secure attachment to the therapist, then an improvement in the child's attachment status often results. At times the tripartite treatment of the insecurely attached dyad, in which the therapist works with mother and child together, promotes a change in the attachment of mother to child that allows the child's attachment to the mother to become more secure.

The later attachment research moved well beyond Ainsworth's behavioral descriptions of infant attachment status to exploring the inner worlds of mother and child. In his infant observation studies Daniel Stern (1985) found that if the infant's nascent sense of self is to develop into a coherent and stable sense of self, the parent's attunement to the child's inner experience is necessary. Mary Main and colleagues researched attachment patterns in adults, paralleling the strange-situation classification. They developed and used the Adult Attachment Interview (AAI), an audiotaped semistructured psychodynamic assessment session, designed to "surprise the unconscious" into making itself known by asking questions about relationships with parents and significant others, and about experiences of loss and separations and how the subject coped with them (Holmes 1996). The AAI's scoring system is based more on the form and structure of the subject's narrative style than on the content. The adult narratives were classified as secure-autonomous, insecure-dismissive, insecure-entangled or preoccupied, and disorganized or unresolved. In the secure-autonomous narratives subjects speak coherently, logically, and succinctly about their past and their trials and tribulations. In the insecure-dismissive narratives subjects reveal and elaborate little. In the insecure-entangled narratives, on the other hand, subjects seem stuck emotionally in their history, rambling on without conclusions as if the pain from the past were alive today. The disorganized or unresolved category is rated separately and coexists with the others, referring to points in the narrative in which the logical flow is broken or disjointed. Main believes that these ruptures in the narrative may represent the emergence of previously repressed traumatic memories.

The AAI developed from a theoretical framework that predicted that there would be connections between attachment status in childhood and narrative style in later life. This hypothesis has been supported by data from other studies, showing that 1-year-olds' attachment patterns are remarkably predictive of adolescents' AAI status measured at age 16 and that the outcome of the AAI administered to prospective parents was a good predictor of attachment status of the subsequent 1-year old children twenty months later. The mothers with secure autonomous narratives had children who tended to be secure in the strange situation, while the dismissive parents tended to have insecure-avoidant infants.

Even more significantly Peter Fonagy and his associates (1995) found that the capacity to think about oneself in relation to others, what the authors term the reflective self or what in the clinical situation is usually called the capacity for insight, determines whether mothers whose own childhoods were traumatic will have infants who turn out to be insecure in the strange situation. The capacity to think about oneself in relation to others, even when one has experienced horrible trauma, is a critical protection against psychological vulnerability in the face of external difficulties.

The studies of Ainsworth, Main, Fonagy, and others demonstrate that there is a continuity of attachment over time. The attachment patterns of the parents influence the security or lack of security in their infants. The early infant attachment patterns influence school behavior, the capacity for reflection about the self in relation to others, and the capacity for intimate relationships with others. There are links between the preverbal psychobiological attachment of infancy and the verbal attachment narrative, suffused with meaning, in adult life. The strange situation measures the enactment of the child's attachment status; the AAI, in contrast, defines individuals' descriptions of their relationship to their own life. It is a movement from enactment to meaning (Holmes 1996).

Henry Hansburg (1980, 1986) studied attachment disorders in early adolescents and discovered certain self-destructive patterns. He developed the Separation Anxiety Test (SAT), a projective test for adolescents for which Bowlby's analysis of protest, despair, and detachment provided a basic orientation. The SAT, consisting of twelve drawings, elicits the patterns of response with which young adolescents handle separation. Six of the drawings depict a child separating from an attachment figure in a situation designated as mildly stressful (e.g., "The child is leaving her mother to go to school"); the other six are considered very stressful (e.g., "The judge is placing

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1. Hansburg dedicated the first volume to his father, George B. Hansburg, "whose inventive genius in developing the pogo stick, the baby toddler, and the baby-den set an example in fortitude and creativity."
this child in an institution"; "The girl and her father are standing at the mother’s coffin"). There were several assumptions in developing the SAT. First, pictures of separation experiences can stimulate children sufficiently to be able to project their reactions. Second, children can select and report reactions to separation that genuinely reflect how they feel. Third, these reported reactions will show patterns that can be useful in diagnosis and treatment of separation problems, such as problems of attachment need (object relations), individuation (autonomy), hostility (regulation of aggressive drive), painful tension (anxiety tolerance), reality avoidance, and reality testing affects, and identity stress. The superego problems center around patterns of self-love and self-esteem. Fourth, the response will help to reveal what mechanisms of defense against separation anxiety are mobilized. Fifth, the nature of object relations, whether symbiotic on one end or isolated on the other end, will be revealed. Sixth, the responses will show aspects of the capacity for autonomy that can be useful in treatment.

Using the SAT, Hansburg (1976) found that certain self-destructive tendencies emerged in early adolescents in response to separations. While psychoanalytic theory traditionally employed the concept of an attack on the introjected love object and of aggression turned inward to understand depression, suicide, and self-destructiveness, Hansburg instead gives more attention to attachment frustration with its accompanying emotional turmoil that intrudes on the capacity to cope with environmental demands. Abandonment, whether actual, perceived, or threatened, is seen as an experience that disrupts functioning capacity. "There is extensive support for the view that anxious attachment is a common consequence of a child having experienced actual separation, threats of abandonment or combinations of the two" (Bowlby 1974, cited by Hansburg 1976, p. 226).

Although anger is regarded as a normal healthy component of attachment deprecation and as an effort toward regaining the association with the love object, anger can also become pathological, a serious consequence of continued frustration of the attachment need. Failure to achieve dependency from an attachment figure may lead to attacks against the self under certain conditions. Hansburg found that youngsters who experience the conflict of strong attachment need and equally strong frustration in the gratification of this need suffer from a severe separation ambivalence. This ambivalence is coupled with severe emotional turmoil, which, even if temporarily assuaged, continues as a subsurface phenomenon that will reappear, sometimes without warning, if abandonment or threats of abandonment develop or are anticipated. This turmoil will be accompanied by a great sense of helplessness, pain, hostility, intense denial, difficulties in maintaining self-esteem, and inability to face the normal identity stresses of adolescence. It is a pattern that is likely to lead to self-destructive reactivity or a psychotic break during the increasing demands of adolescence.

The dynamics of depression in adults suggest that when hostility cannot be acknowledged or expressed outwardly, it is turned against the introjected objects, which, because they are part of the self, results in the attempted or actual destruction of the self. The same is true of children, but because children are dependent on their parents, whenever children feel the threat of the loss of a love object or the loss of the object’s love, they develop not only feelings of rage toward the object, but also feelings of helplessness and worthlessness, resulting in a depressive equivalent. When tension is extremely high and the defense mechanisms break down or become ineffectual, suicide or suicidal equivalents may appear in the form of an attenuated attack on the introjected object, which manifests as a depression, accidental injury, antisocial acts, or other self-harm. It is a desperate effort at regaining contact with the lost gratifying object (Farberow and Shneidman 1957). Hansburg elicited patterns of response to the SAT that was easily diagnosable as a suicidal equivalent or self-destructive reactivity in children who were not diagnostically similar, who ranged from psychopathological to neurotic problems and character difficulties. In the presence of a strong attachment need, some children cannot accept even mild separation experiences, indicating disturbances in the separation-individuation process. This results in tremendous emotional turmoil and an effort to retrieve the lost object, but, at the same time, a lowering of self-love, corroborating Bowlby’s concept of protest and despair. What ensues are strong feelings of abandonment and the inability to handle the normal identity stress and regressive pulls of early adolescence, producing an unusual combination of depression and impulsiveness, which endangers the welfare of the child. When combined with a pull toward denial, a temporary delusional reaction is possible.

The SAT was found to be appropriate as a gauge of adult separation issues, and was used to study attachment disorders in adult patients with eating disorders, with the finding that women with eating disorders in an inpatient facility manifested significantly more severe separation and attachment difficulties than is normal in adolescence and in adults undergoing developmentally based relationship crises (Armstrong and Roth 1989). Anxious attachment was demonstrated by 96 percent of the sample, and the more extreme separation depression was manifested by 85 percent. The patients made no cognitive distinction between brief, everyday leave-takings and more permanent breaks, reacting similarly to both. The clinical implications are that separations in therapy such as the end of the session, the weekend, or vacation break may reinforce patients’ beliefs that long-term intimate relationships are not feasible. What is also implied is that attachment disturbances are functionally associated with specific eating-disorder behaviors. For example, restrictive dieting or self-starvation may be a means of sustaining a nurturing attachment at a safe distance, without acknowledging this need, while binging may fill a void for nurturance and can be a mechanism for self-soothing in those who cannot trust that an intimate relationship with significant others can meet these needs (Armstrong and Roth 1989).

Another study of attachment difficulties in adult eating-disordered patients in inpatient treatment used Potthast’s Attachment History Questionnaire (Chassler 1997). Chassler’s study found that the mothers of individuals with
eating disorders failed to provide a secure home base from which to separate, fostering either dependency or failing to foster autonomy. Not having had a strong attachment base in childhood, these patients enter adolescence and then adulthood without having acquired the necessary skills and resilience to deal effectively with the world. As a result, eating-disordered persons develop unconscious strategies to ensure the proximity of their attachment figures (Chassler 1997); an eating disorder diagnosis is often an effective way to get otherwise distant or self-absorbed parents to rally around the ill child. The study also linked aversive forms of discipline as a factor in the development of eating disorders, supporting Bowlby’s premise that children’s difficulties arise more frequently from the ill effects of premature and excessive punishment, which places a heavy burden on the developing attachment system. A history of parental threats of separation was a significant predictor of the development of anorexia nervosa and bulimia nervosa. Peer relationships were significantly and negatively affected by the attachment difficulties, supporting Bowlby’s (1969) claim that an early secure base facilitates the child’s ability to explore the world and to develop rewarding relationships with peers. The study has linked anorexia nervosa and bulimia nervosa to feeling unwanted. In terms of attachment theory, children feel unwanted when one or both parents persist in not responding to the child’s care-seeking behavior. Because of their attachment difficulties, these patients are usually resistant to psychotherapy, confounding the therapist’s best efforts to become a secure attachment figure.

It was hypothesized that the frequency of self-mutilation would increase in seriously disturbed adolescents in residential treatment at a time of interpersonal loss (Rosen et al. 1990). Thirty-two adolescents were studied over a four-year period for the frequency of self-mutilation. It was found that each time a staff member announced he would be leaving his job, the frequency of self-mutilation increased significantly during the two-week period following the announcement and before the date of departure. Interestingly, there was no significant increase in the frequency of self-mutilation immediately following staff firings, suggesting that the time of anticipated loss was the period of highest risk for these adolescents in terms of self-mutilation. This suggests to me that the ego function of anticipation had not developed properly in these adolescents, which implies that treatment efforts should include focused efforts to develop this ego function in relation to loss. This also suggests that these adolescents were inflicting violence upon themselves to communicate what they could not say in words to the staff members to whom they had become attached, and that the behavior had an unconscious intent to coerce the staff member to change his mind and stay. That is, as long as the staff member was physically present, there was hope that he could be induced to stay, but once he had gone, the adolescents’ harming themselves would be to no avail. It should be noted that the everyday separations from the therapist that eating-disorder patients must endure as well as the longer vacation separations often result in an increase in disordered eating after the separation. I would suggest that in these cases, the self-mutilation and disordered eating served transitional functions of soothing and calming the anguished self and expressive functions by bodily expressing angry feelings toward the therapist or departing staff member that they could not otherwise express in words. I suggest that the increase in these self-harming behaviors in the absence of the therapist is an indicator of severe attachment anxiety, just as other regressive behavior in patients who do not harm themselves is an indicator of lesser attachment anxiety.

Karen Walant (1995) has found that individuals prone to alcohol and drug abuse or promiscuous sex have disordered attachments, having been deprived in infancy of ongoing merger or symbiotic experiences. The standard child-rearing practices in our highly individualistic society, says Walant, often amount to normative abuse of children, forcing them to develop a premature self-reliance. As such children grow and develop, they despair of establishing meaningful human attachments and attempt to compensate for them by inducing merger states chemically through the use of drugs and alcohol. Immersive moments in psychotherapy, those memorable moments that feel like complete understanding between patient and therapist, can enable the patient to emerge from behind the alienated and detached self to build a firmer attachment to the therapist, and ultimately to others (Walant 1995).

**SELF AND MUTUAL REGULATION**

The mother–infant dyadic attachment as well as its separations serves as the prototype for other attachments and separations that follow, including father–infant and adoptive parent–infant attachments, friendships, couple relationships, other object relations, and the attachment of the parent to his own child. The infant’s psychobiological experiences of attunement, misattunement, and reattunement construct the brain in terms of neurological connections and neural circuitry. In fact, the interaction between the mother’s brain and the infant’s brain is required for the baby’s brain to grow (Schore 1997). In the earliest phase of the symbiotic mother–child attachment, the libidinal and aggressive drives are the point where mind and body join to bear both drive energy and affect, and to create self-regulatory processes. “All psychopathology,” says Grotstein (1986), “constitutes primary or secondary disorders of bonding or attachment and manifests itself as disorders of the self and/or interactional regulation” (p. 108).

As early as the classical era of psychoanalysis, drive discharge, or the reduction of drive tension, was thought to be the governing principle during the neonatal period, following the pleasure principle (Freud 1911, 1915a). The first weeks of life are generally regarded as a stage of pre-mentation, when the infant’s behavior is determined by drives in response to stimuli and the primitive ego is “first and foremost a body-ego” (Freud 1923, p. 27). Freud (1915a) defined instinct as “a concept on the frontier between the mental and the somatic, as the psychical...
representative of the stimuli originating from within the organism and reaching the mind" (pp. 121-122). He thought that the instincts and external stimuli both produce excitation within the mental apparatus; as the amount of excitation increases, it is experienced as unpleasant internal tension that must be discharged.

Freud's drive theory was a model of psychosomatic process that combined two models of psychosomatic illness, the model of homeostatic disruption and the model of faulty developmental regulation. Freud believed that even at the beginning of mental life the mental apparatus constantly strives to reduce or keep constant the degree of excitation experienced within it in order to maintain a pleasurable peaceful state. The homeostatic model suggests that when excitation is blocked or inhibited from psychophysiological expression, this damming up of emotion is accompanied by visceral changes that, over time, account for pathophysiology (Freud 1920). The model of faulty developmental regulation suggests that the normal development and control over autonomic and affective processes becomes derailed, resulting in an arrest or regression to somatic processes, manifested by massive autonomic or endocrine responses.

René Spitz (1945, 1946) found that hospitalized infants who were separated from their mothers at 6 months of age, even though they were provided the necessary physical care, suffered marasmus and even death. Marasmus, or anaclitic depression, consisted of sadness, indicators of apprehension, weeping, withdrawal, and refusal to eat. Its appearance was dependent on a good mother-infant relationship for the first six months of life, followed by the absence of the mother or caregiver for at least three months. If the mother or caregiver returned within three months, the symptoms disappeared, but if the separation continued longer, the symptoms became more severe, progressing to insomnia, weight loss, retardation of development, apathy, stupor, and even death. Influenced by ethology, Spitz combined findings from animal studies with his observations to propose a new concept—that it is essential to life that the newborn's innate equipment be "quickened" through the relationship with the mother.

Bowlby's and Spitz's early studies were on a small scale, but more recently the Romanian and Russian children adopted from orphanages by American parents have become the largest group of deprived babies available for study (Talbot 1998). There are more than 14,000 of these adoptees in the United States now, and 20 to 30 percent, the most traumatized among them, are being studied. Although their adoptive parents were prepared to lavish on the children the affection and sensory stimulation they had severely lacked, this was insufficient for some of these children who manifested complex affective and behavioral neuropsychological difficulties. They spent their earliest years curled up with feeding bottles in their cribs for 18 to 22 hours a day, cared for by rotating staff who might spend 10 minutes a day talking to them or holding them.

Using ideas from ethology to bridge the gap between psychoanalysis and neurobiology, Myron Hofer (1995) has measured the nature of attachment processes and separation in rat pups, with important implications for understanding the nature of human attachments. Hofer has proposed a unified theory in which the early attachment processes can be broken down into distinct mother-infant interactions that regulate various physiological and behavioral systems in the infant. The research of Hofer and others suggests that the prototypical separation distress experienced by all mammals is the separation of the infant from the mother. More recent research has found that simulated maternal touch can restore physical regulation. For example, rat pups who were separated from their mothers for 45 minutes underwent major internal changes, including a dramatic drop in growth hormones that did not respond to injections of growth hormones. They did, however, respond markedly to touch. When a graduate student stroked the rat pups with a moist paintbrush, mimicking their mothers' tongues, their hormone levels increased (Colt 1997). Hofer has found that the separation of the infant from its mother has both an acute phase and a chronic, slow-developing, despair phase. The behavior in the acute or protest phase included agitation, vocalization, and searching for the mother, while the corresponding physiological responses included increased heart rates, cortisol levels, and catecholamines. The behavior in the chronic or despair phase included decreased social interaction, mouthing and rocking, hypo- or hyperresponsiveness, variable food intake, and sadness, while the corresponding physiological responses included weight loss, sleep disturbance, decreased REM sleep, decreased core temperature, decreased oxygen consumption, decreased heart rate, increased ectopic beats, decreased growth hormone, and decreased T-cell activity. In short, the sudden loss of a specific maternal regulator led to a rebound response in the opposite direction, to altered patterns of function, or both.

These hidden regulators operate to some extent in separations and losses through life, but nowhere are they more apparent than in bereavement responses, which in the acute phase often resemble trauma responses. Hofer's (1995) work suggests that some of the symptoms of grief may be due to the loss of numerous real physical and temporal interactions with the deceased, as well as to the inner psychological loss of any remaining conscious or unconscious expectations of the deceased in relation to the self. The death of a parent, however, is the final separation. Anticipating the death of his father, James Atlas (1997) wrote in The New Yorker:

“When my father died I was for a long time sunk,” Saul Bellow wrote to his first biographer, Mark Harris, consoling Harris on the death of his father. I think of that simple, eloquent confession whenever I come home from work and see my father, doting on the sofa. I'm seized with a sensation of emptiness, a prefiguring of abandonment that's primal in its intensity; I felt this way, it occurs to me, when my parents left me alone at Camp Shewahmgon twenty years ago and drove off down the dusty road in their old Oldsmobile, leaving me by the door of my bunk with a knapsack and a sleeping bag. How would I ever get through the night without them? How will I ever get through a quarter century of nights? [p. 55]
The death of both parents can leave competent mature adults feeling adrift and lonelier in this world than they ever could imagine, like orphans in the rain. Gates of Repentance, the Reform Jewish prayerbook for the memorial service, states, “A final separation awaits every relationship, no matter how tender. Some day we shall have to drop every object to which our hands now cling” (Stem 1978). The loss may explain why, when we are bereaved, our heart beats slower, we may fall ill or suffer physical pain, or we may sleep or eat too little or too much. Sometimes we may curl up like a fetus and cry like a baby. And sometimes the longing to be with the dead can exert its seductive pull (Freud 1913a) toward melancholia, toward suicide attempts, and toward self-harm. Blake Morrison recounted in his memoir the prolonged stages of his father’s dying, and his inexpressible grief: “I feel as if an iron plate had come down through the middle of me, as if I were locked inside the blackness of myself,” he wrote. “I thought that to see my father dying might remove my fear of death, and so it did. I hadn’t reckoned on its making death seem preferable to life” (Atlas 1997, pp. 57–58).

The concepts of self and mutual regulation allow us a more microscopic view of the mother–infant interaction and the development of the attachment process (Lachmann and Beebe 1997). In mutual regulation, both partners actively contribute to the regulation of the exchange, but not necessarily in equal measure or like manner. The self-regulation model describes self-comfort and the ability to regulate one’s state of arousal and organize one’s behavior in regular and predictable ways. In mutual regulation, experience takes on characteristics—predictable coordinated rhythms, tempos, sequences, affective intensities, greetings, and separations, while at the same time self-regulatory styles form based on adaptive and nonadaptive patterns of mutual and self-regulation (Lachmann and Beebe 1997).

Human beings fit together like the pieces of a puzzle, and so examining how they fit together tells us about their mutual regulatory processes and bonds of attachment. The mother serves the biological regulation between herself and the infant in an overarching organization that we recognize as symbiosis. Oxytocin, a hormone found in human breast milk, is known as the hormone of love and attachment because it is associated with “affiliative impulses” that help form a bond between mother and infant (Angier 1994). However, there is also a biochemical process that enables adoptive parents, fathers, and others to fall in love with a baby. Cuddling and stroking a newborn, holding it against one’s naked breast, and smelling its fontanel, the soft spot on its head, seem to release similar brain chemicals.

Both before and after birth, both parts of the dyad adapt to each other in the context of a developing and reciprocal psychobiologic human attachment (Benedek 1949). Breast-feeding is not only symbolic of the reciprocal attachment but also seems to be a key factor in protecting infant and mother from certain illnesses and decreasing the incidence of infant ear infections, diarrhea, allergies, and bacterial meningitis, and may also protect against childhood lymphoma, sudden infant death syndrome, and diabetes. It also provides numerous other hormones that help in tissue growth and natural opioids that may help form the baby’s brain (Angier 1994). For the nursing mother, the risk of early breast cancer, ovarian cancer, and postmenopausal hip fractures is reduced. The health benefits are so great that in 1997 the American Academy of Pediatrics took its strongest stand, urging mothers to breast-feed for at least a year, six months longer than had been previously recommended, or for as long as is mutually desired. (Currently about 60 percent of new mothers breast-feed, with about 20 percent continuing beyond six months.)

Communication can regulate the ordinary operations of the brain and nervous system (Conway and Siegelman 1995), with an unconscious preverbal communication between mother and infant that begins after conception in the normal pregnancy. With conception and after the first trimester, the increased hormonal and general metabolic processes necessary to maintain a normal pregnancy produce an increase in vital energies and a calm experience of well-being in the mother (Benedek 1949). These same feelings that enhance the mother’s well-being also increase her pleasure in carrying her child despite the discomforts of pregnancy. As she feels a growing ability to love and take care of her in-utero child, she feels an improved emotional balance, enhanced body image and self-esteem that enable her to master previously disturbing emotional conflicts. Studies suggest that the unborn child can see, hear, experience, taste, and even learn very primitively and experience precursors of true emotion before birth, and that a mother’s chronic anxiety or wrenching ambivalence about motherhood or other persistent patterns of disturbing feeling can leave a physically based impression on the fetus that begin to shape his sense of himself (Verny 1981). There is evidence that suggests the father, too, to a lesser degree, transmits emotional messages to the fetus.

Our first real experiences of life occurred in utero as we floated in the bath of amniotic fluid, curled up in the womb’s total embrace. We swayed to the undulations of our mothers’ body and we heard the steady rhythmic beat of her heart. We shared her body’s rhythm and chemistry. Apparently in utero the fetus can also hear the voices of those around him, and so it registered with us that those voices were mostly calm or mostly loud and strident (Verny 1981). When the fetus is not unduly disturbed by its immediate environment or by the emotional upset of the mother, it would seem to be a blissful experience. But paradise is lost in the trauma of being born, as the infant is exposed to the shockingly sudden loss of intimate body contact. No wonder he cries at he emerges into the bright lights of the delivery room. Who would not want to go back to the womb and its lost comforts?

To compensate the infant for what was lost, the infant needs a great deal of maternal care, contact, and intimacy. At the same time, the birth experience can be considered a trauma for the mother as well, bringing with it the possibility of postpartum depression or anxiety. To compensate the mother for the loss and
has become a more popular burial rite. As President Kennedy said, "I really don’t know why it is that all of us are so committed to the sea... I think it’s because we all came from the sea. And it is an interesting biological fact that all of us have in our veins the exact same percentage of salt in our blood that exists in the ocean. And therefore we have salt in our blood, in our sweat, in our tears. We are tied to the ocean and when we go back to the sea... we are going back from whence we came."

Skin is of fundamental importance as a means of communication between parent and child, transmitting smell, touch, taste, and body warmth (Pines 1980). Consider that premature babies who are massaged regularly gain weight as much as 50 percent faster than preemies who are not massaged. They tend to be more alert, active, responsive, and aware of their surroundings. They cry less, sleep better, have easier temperaments, are more able to calm themselves, and thus are more appealing to their parents. Enough babies born prematurely become the victims of child abuse to suggest that the difficulties in raising these children create attachment problems that may account for their becoming abused more often. Those children born with heightened sensitivities to sound or touch, for example, present more difficulties to which the mother must make the lion’s share of adaptation. She must work harder to adapt to the infant because his stimulus barrier makes it harder for him to adapt. The intimate touch with which she yearns to comfort her baby may only further irritate her sensitive-to-touch child. Nothing she does is right. Even “good-enough” mothers (Winnicott 1965), who ordinarily might make a good fit between themselves and a more average baby, may not be up to this difficult task of adapting so much and so well to this unusually sensitive child. It is presumed that the attachment status of the infant depends on the “goodness of fit” between a particular parent with her own personal attachment history and the unique inborn temperament of her child. In the psychosomatic dyad, the scenario that is enacted over and over again is “Mommy I need you and you need me, too.” When the mother feels useless to calm her child, she tends to feel that her child does not need her and cannot regard herself as a good-enough mother, and the attachment that is needed to protect the infant does not grow but is instead thwarted. Under such circumstances, the mother may not go the extra distance to discover what other ways might help to calm this difficult-to-calm child but may well become more likely to abuse her child, increasing the disorder of attachment.

According to Mahler and colleagues (1975), from birth on there begins a complex and circular developmental process that optimally results in the infant’s awakening from a symbiotic stage and navigating through the process of psychological separation from the mother and individuation, resulting in “the psyc-

2. Said by President John F. Kennedy, September 14, 1962, on the eve of the America’s Cup Yacht Race, to an audience in Newport, Rhode Island.
logical birth of the human infant." From the very beginning, the infant observers Stern, Trevarthen, and Brazelton agreed that the infant is alert, and Mahler too ultimately abandoned her concept of a normal autistic phase, replacing it with the concept of the infant awakening from symbiosis (Stern 1985). The newborn's tolerance for stimulation, however, is limited and he spends most of his time sleeping. But the newborn does have optimal levels of stimulation, below which stimulation will be sought and above which stimulation will be avoided, with some help from an attuned mother who serves to help the infant regulate the stimulus barrier (Stern 1985). The infant's earliest sense of himself exists prior to the development of language and self-awareness. From age 2 to 6 months the infant's sense of a core self, a separate, cohesive, bounded, and physical unit, is consolidated (Stern 1985). The first inklings of a body self come from within his own body from the very beginning through sensations, especially by proprioception (Mahler and McDevitt 1982). The subjective experience of union with another can occur only after a sense of a core self and core other exists. The mother-child relationship then is symbiotic, the essential feature of which is a hallucinatory, somatopsychic omnipotency with fusion with the representation of the mother and, in particular, the delusion of a common boundary shared by the two physically separate individuals (Mahler 1968). The autistic child's awareness of his body as separate from the mother's is traumatic because he has experienced her as a limb or other part of his body (Tustin 1981, 1990).

The mother's expressive face stimulates the child's interest in it, especially her eyes, leading him to track her gaze and engage in periods of intense mutual gazing (Schore 1997), which mediates "the dialogue between mother and child" (Spitz 1958, p. 395). The infant is held by the mother's gaze and she, too, feels held and affirmed in him. In addition to gazing, vocalizations and tactile and body gestures serve as channels of communication that not only affect the infant's brain, specifically the right hemisphere, but also are required for its growth (Schore 1997).

There is a lag of around six months before the infant's experiences expand from solely body based to include the mind (Stern 1985). Thus, the mother functions as a hidden regulator of different physiological and behavioral systems in the infant, providing a physiological basis for both the development of the affective state that we call security and the beginnings of the capacity for intimacy. At the same time, the infant's sucking serves to quicken the mother's psychophysiological responses by stimulating the secretion of oxytocin, which elicits the let-down response in nurses and elicits loving and nurturant emotional responses of the mother, to help her navigate that adult phase of development that we call parenthood (Benedek 1959). The goodness of fit between both parts of the psychosomatic unit serve as regulators for each part. As Hofer (1995) said, it is the mutual regulation that takes place that gives meaning to the use of the word symbiosis. What is essential for healthy development is optimal symbiotic gratification. It is in the gross failure of symbiosis that lies the etiology of childhood psychosis (Mahler et al. 1975), whereas insufficient gratification during symbiosis may result in a borderline structure.

A hungry infant's cry is piercing and unrelenting, expressing a primitive psychophysiological oral libidinal tension (Jacobson 1964) that demands relief. When and how the mother gratifies the infant's hunger leads to unique experiences of pleasure and "unpleasure," which constitute the first and most important connection to the mother (Jacobson 1964). The cries are so painful for parents to hear that they may spend many sleepless nights doing whatever they can to quell their baby's cries—holding and rocking the baby for hours until exhausted, even driving around aimlessly so the rhythms of the car can lull the baby to sleep. For some the cries are so painful that they may provoke the parent to smother or beat the infant in order to stop him from crying.

The earliest feeding experiences regulate the psychophysiological responses of mother and infant. Optimally when the infant cries from hunger, the mother soon appears, as if by magic. It is not magic, however, but the mother's patience in determining what is wrong, that leads her to satisfy her baby's hunger. She determines that no, he is not too chilly, not too warm, not in need of changing his diaper, and yes, he is hungry. The nursing mother is glad because her breasts have become painfully engorged, and now they can be relieved by her baby. She is pleased that she could determine how to make her infant more comfortable. The moment she touches his mouth with her nipple, the infant's rooting reflex causes him to turn in the direction of the stimulus, surround the nipple with his mouth and suck. He knows the smell and taste of her milk and can distinguish it from the smell and taste of others. As he sucks she experiences the pain-pleasure of the let-down reflex and then the milk flows, mercifully relieving her engorgement. The infant sucks differently at the breast than at the bottle, sucking in a burst-pause pattern that suggests that babies are programmed for more social interaction when being fed at the breast. She feels the glow of maternal love and yearning as she caresses and embraces the baby and talks and sings to him. His skin is stimulated by her touch, and he further relaxes into her embracing arms, continuing to suck until he is sated and asleep, and she is relieved and calm.

Sometimes though, the feeding is disrupted because the baby is crying, an indication that something is wrong, that there is a disturbance in homeostasis. In the first weeks of life the infant's physiology is not mature enough to permit sufficient discharge of drive energy to the exterior. In many infants considerable gas is discharged to the interior because the pathways to the exterior are not developed enough to allow discharge through burping or flatulence, accounting in part for the infant colic that can so unnerve mothers. Worried parents are frequently told by the pediatrician that by the time the infant is 3 months old, his systems will have matured and become more self-regulating and the colic will be gone. Until then the parents may need to learn various burping techniques to help the gas bubble rise in the infant's alimentary canal and be discharged. A relatively calm and secure mother, after determining that he has a gas bubble,
holds him firmly in one of the several positions that each mother must find through trial and error to suit her baby best. As she pats or rubs him to help release the bubble, her voice, touch, and facial expression all tell the baby that he is loved and cared for. She serves as a mirror, reflecting back to him a sense of goodness and wholeness, introducing him to his body, which can produce, among other things, burps. She introduces him to his psyche when she laughs as he burps, saying approvingly “Good, good. You pushed that burp out.” She introduces his mind and body one to the other, a process Winnicott (1949) called personalization, facilitating the baby’s sense of his body as being the dwelling place, the home, for his developing psyche. The baby’s sense of himself is forged as a good and competent mind-body self. Having been helped to expel some gas, he can now continue to nurse. As he becomes satiated, he may even want to stop a while to play. Maybe he wiggles his toes, and maybe she, in turn, leans over to kiss his toes, or even engage in a game of “This Little Piggy Went to Market” until he turns again to the bottle or breast for a few moments longer. The infant, “through its cries, bodily gestures and somato-psychic reactions to stress, gives nonverbal communications that only an attuned mother or caretaker can interpret. She functions, in this respect, as her baby’s thinking system, and finds an adequate response to her infant’s distress” (McDougall 1989, p. 169). As his hunger is satisfied, he falls asleep in blissful comfort, while his mother rests, enjoying the interlude of separation and her increased sense of competence in her maternal role. This is the nature of symbiosis in its most literal sense. Infants arrive in the world equipped to establish an attachment relationship, equipped to keep the mother close by, and can, through their responsiveness in sucking patterns and other indicators of pleasure and pain, motivate adults to attune themselves to the infant and his needs (Ellman and Monk 1997).

The mother’s capacity to be attuned to her infant, to engage in reverie, and to be free enough of anxiety to be able to be “ordinarily devoted,” a good-enough mother derives from her ego strength. Winnicott (1963) called this attachment of the mother for her child “primary maternal preoccupation” (p. 85). It is an attachment that is powerful and passionate. An attuned mother stimulates her baby when he communicates to her that that is what he needs, and calms him when he lets her know that that is what he needs. As he falls asleep after drinking the breast, her milk supply already is replenishing itself in anticipation of the next nursing episode, when the infant’s hunger returns. Her hunger for a satisfying encounter with her infant has been fed for the time being. They continue the process of attachment by means of countless daily interactions that offer the possibilities for intimacy. Attuned mothers sleep with a level of wakefulness, listening while they sleep, attached even through sleep. Even years later mother and father may not be able to sleep peacefully until they hear their adolescent return home, secure once again. These earliest yearnings of the infant and his overwhelming need for comfort reverberate throughout the human life cycle in the need for physical contact and intimate connection (Bowby 1969, Morris 1971).

“And for however long it is fed at its mother’s breast, it will always be left with a conviction after it has been weaned that its feeding was too short and too little” (Freud 1938, p. 189).

The mother’s or caregiver’s availability as a secure base is the basis for the infant’s emergence from symbiosis (Mahler et al. 1975). The observations of Margaret Mahler and associates of normal infants in the first three years of life demonstrated that the journey from symbiosis to separation-individuation consists of several subphases—differentiation, practicing, and rapprochement. In the symbiotic phase the infant smiles in response to experiencing the mothering half of his symbiotic self, an unspecified, social smile. The differentiation subphase occurs at around 5 months of age, and is marked by the specific smiling response to the mother, the indicator that a specific bond between the infant and mother has been established. There is a “hatching process,” a gradual evolution of the perceptual-conscious system that allows the infant to remain more permanently alert when he is awake, no longer drifting in and out of alertness. At around 6 months, infants begin tentative forays into separation-individuation, with the quickening of the infant’s sensory perception as the sense of touch, smell, taste, vision, and hearing are stimulated by the outside world. In time these stimuli facilitate the infant’s ability to discern the self from the surroundings, thus forming the eventual boundaries of the body image. In the differentiation subphase normal infants take their first steps in breaking away physically from their status as lap babies. No longer content to mold their bodies into their mother’s body when held, they strain away from her in order to get a better look at her, experimenting with touching the mother’s face, pulling at her hair, knocking her eyeglasses off, putting a bit of food in her mouth. It is in these ways that the infant differentiates between his bodily self and that of the mother.

The infant also has repeated experiences of his mother’s absence. With her repeated return to him when he needs her, the infant develops the idea that her existence is permanent, regardless of his state of need, that she does not cease to exist when he no longer perceives her physical presence (Piaget and Inhelder 1969). From this representation of the mother’s existence as permanent, this object representation is retained in the infant’s mind regardless of whether or not he needs her. That is, the mother becomes transformed from being an object who is called into existence by power of the infant’s omnipotent need, to an object who exists on her own, who is not created by the infant’s need. The mother may delight her baby with peekaboo games, demonstrating “now you see me; now you don’t, but I am still here” (object permanence). A hallmark of increasing sense of separateness is a greater curiosity about strangers. In the more securely attached infants, the interest in strangers is more open, less affected by stranger anxiety. Overlapping the differentiation subphase is the practicing subphase. In the early part, from approximately 7 to 10 months of age, the infant begins to delight in moving away from the mother by crawling, climbing, and standing while holding on. Even while standing up in her lap and holding onto her for support, he is
looking over her shoulder at enticing vistas to be explored. He takes exquisite pleasure in his exercise of autonomous functions. In the later part of the practicing subphase, or the practicing period proper (about 10 or 12 months to 16 or 18 months), he reaches those vistas by his free and upright locomotion, often exhausting his mother as she struggles to run after and keep up with him, as he can easily disappear over a rise in the park or around a corner. His mother must be able to tolerate the anxiety of her infant’s distancing himself from her, and still remain available to protect him. He does not know he needs a protector because he is “His Majesty the Baby,” the king of the universe, on the move, running quickly, omnipotently exploring, oblivious of danger, drunk with elation. His is “a love affair with the world” (Greenacre 1957, p. 57). Mother is his dutiful servant, following and hovering discreetly behind with juice and diapers; he will not deign to acknowledge her presence until he needs her. Throughout the practicing subphase, she is still a safe and secure base, to which the infant returns momentarily to touch base and refuel physically and emotionally. The infant takes a more active role in determining his closeness to and distance from the mother. She is still the center of his universe. He cannot be distant from her for too long; he is, after all, only practicing; she “is still the center of the child’s universe from which he only gradually moves out into ever widening circles” (Mahler et al. 1975, p. 66).

Just as this practicing period is devoted to the developmental tasks of autonomy and individuation, it is equally devoted to the seeking and creation of intersubjective union with the mother, learning that the contents of one’s mind and the qualities of one’s feelings can be shared with another (Stern 1985). The hallmark of this period is the child’s great narcissistic investment in his own functions, his own body, and in asserting his own individuality as indicated by the “no” response (Spitz 1957) to the mother. This semantic “no,” accompanied by the head-shaking gesture, is often the first abstraction the infant forms, following on the heels of tantrums. It is the “no” of a baby secure enough of his attachment to his mother that he can dare to be a separate person who can defy her. Saying no to the mother means saying yes to himself. The baby who says no requires a mother who has the ego strength to tolerate this without undue anxiety or anger.

By the middle of the second year of life, the distancing of the practicing subphase is replaced by a rapprochement, a need for closeness with the mother. The rapprochement subphase is marked by what seems like a constant concern with the mother’s whereabouts and by separation anxiety, making it of utmost importance that the mother be emotionally available. This is a difficult challenge for a mother, because just as she is beginning to enjoy the freedom provided by child’s apparent independence from her, her need for greater closeness can be readily regarded by the mother as regressive, and can be resented. Whereas in the practicing subphase the mother must be able to tolerate more the feeling that her baby no longer needs her in the same way, in the rapprochement subphase she must be able to tolerate the feeling that she must be almost constantly avail-

able, to be clung to or rejected. The mother’s reliability as a secure base and her emotional attunement and flexibility are paramount. Simply put, mothers must be there to be left. Mother and toddler communicate more through symbolic language and play. The rapprochement subphase is the root of humankind’s eternal struggle against both fusion and merger. It is during rapprochement that the elated mood of the practicing subphase and the depressive mood of the rapprochement subphase crystallize as the basic moods of the developmental expansion of the affect array (Pine 1980). If development continues unimpeded, eventually the child will have developed a fuller range of affect that may include guilt, shame, longing, dread, awe, excitement, loneliness, glee, anxiety, euphoria, and satisfaction.

If the mother is not a secure base, there to be left and to be returned to, the child’s aggression, manifested as self-injurious habits or disturbances of feeding, is evoked. When this anger is experienced during the practicing subphase, the distress is often manifested as anger directed toward the self (McDevitt 1985). It has been found that destructive aggression in childhood has a hostile intent aimed at destroying a structure that has proved highly thwarting (Paren 1979). For the expression of aggression to develop in a way that promotes the development of a separate self, it needs to be expressed and contained within the context of an object relationship that will contain the child’s anger. In the absence of adequate object relations, children will use any available method to substitute for a containing mother–infant relationship and to reduce tension, including thumb sucking, tongue chewing, enuresis, rocking, and head banging (Silverstein et al. 1966). Children tend to select these techniques opportunistically, depending on the age at which tension arises and the availability of particular sensations at that phase of their development (Silverstein et al. 1966). The rhythmic motor patterns of some of these activities are normal phenomena in infants that satisfy an instinctual need and facilitate motor and ego growth and development (Lourie 1949). The rate of the rhythmic movements appears to have a definite relationship to one of the time beats in the body, with usually the heart or breathing rate acting as the pacemaker (Lourie 1949). This is the most elemental form of human experience, what Ogden (1989, 1990) terms the autistic-contiguous mode, a primitive, presymbolic sensory dominated mode of experience.

It is a sensory-dominated mode in which the most inchoate sense of self is built upon the rhythm of sensation, particularly the sensations at the skin surface. The autistic-contiguous mode of experiencing is a presymbolic, sensory mode and is therefore extremely difficult to capture in words. ... Contiguity of surfaces (e.g., "molded" skin surfaces, harmonics sounds, rhythmic rocking or sucking, symmetrical shapes) generate the experience of a sensory surface rather than the feeling of two surfaces coming together either in mutually differentiating opposition or in merger. There is practically no sense of inside and outside or self and other; rather, what is important is the pattern, boundedness, shape, rhythm, texture, hardness, softness, warmth, coldness, and the like. [Ogden 1990, pp. 83–84]
However, when such primitive modes become prominent in the child’s motor patterns, they serve other needs, including the expression of pleasure, expression and relief of tension and anxiety, and provision of a form of compensatory satisfaction, and may well persist past the infantile period. They follow the pleasure principle, which regulates the need to re-create any situation—by action or fantasy—that, in the past, has provided gratification through the elimination of drive tension (Moore and Fine 1990). The rhythm of these infantile activities as well as the rhythmic stereotyped activity of hair pulling, scratching, and nail biting, and the rhythmic repetitive hand-to-food-to-mouth-and-chew-and-swallow activity of binge eating may replicate the mother’s breathing or heartbeat, and therefore serve transitional functions.

Research has found that the early mother–child experiences are imprinted on the child’s developing brain (Schorer 1997). When the self-injurious “habits” and feeding disturbances of early childhood grow out of these experiences, these means of expressing aggression and soothing the self become imprinted on the brain, serving as the developmental forerunners of the eating-disordered and self-mutilating behaviors that we typically see later in preadolescents and adolescents. When mother–child interactions are secure and rewarding, this attachment pattern becomes structured in the brain, thus serving very well for continued healthy development. When mother–child interactions are disturbed, however, they too become encoded in the right orbitofrontal area, the executive regulator of the entire right brain, and later manifest themselves in failures of affect regulation. In fact, recent research, mostly brain-imaging studies, shows evidence of impaired right orbitofrontal activity in various psychopathologies, including autism, schizophrenia, mania, unipolar depression, phobic states, posttraumatic stress disorder, drug addiction, alcoholism, and borderline and psychopathic personality disorders (Schorer 1997).

If we look at this neurobiological theory in the context of understanding what happens when a mother fails to be a good-enough mother, failing to protect the child from overstimulation by overly frustrating him by ignoring his needs, or by intruding into his quiescent states, the child does not feel held and contained, but rather experiences the very ordinary and common trauma of impingement. The feeling of containment, what Winnicott called the experience of “going on being,” so crucial for psychological growth, fails to be sustained, causing cumulative psychic trauma (Khan 1963) or “strain trauma” (Kris 1956). That is, the child is not traumatized by what we ordinarily think of as “shock trauma” such as physical or sexual abuse, or physical abandonment, but is instead traumatized repeatedly over time by the nature of the mother–child interaction. So we can understand that each such impingement is encoded as an interactive representation in the right orbitofrontal area, with each ordinary little trauma adding to what came before in a snowball effect, to be encoded as cumulative psychic trauma.

While this may sound very ominous, the good news is that the right orbitofrontal area is the most plastic part of the brain. It can be modified through the establishment of a subsequent secure attachment relationship. Attachment is very good medicine that can change the structure of the brain to repair what trauma has damaged.

ATTACHMENT PROBLEMS WOVEN INTO THE DEVELOPMENT OF CRITICAL EGO FUNCTIONS

He who returns has never left.

Pablo Neruda, Adiós

The separation-individuation phase usually ends during the third year of life, followed by what Mahler and colleagues (1975) call “the psychological birth of the human infant,” heralding the beginnings of object constancy and the consolidation of individuality. There is the evolution of a higher level of object relations, a more constant mental representation of the object regardless of the infant’s need. The infant has progressed from the objectless stage of primary narcissism, through the stage of experiencing the object as only a need-satisfying object, to an object relationship. There is the loss of the infant’s sense of omnipotence. The infant has begun the journey of on the way to object constancy, a lifelong developmental process. Optimally the infant has reconciled and integrated the image of the good mother of symbiosis with the mental representation of the ambivalently loved mother after separation, dangerous because she is potentially reengulfing. There is no longer the need to maintain the split image of the good mother and the bad or dangerous mother. With psychological birth, gender identity is normally established. The subphase of on the way to object constancy is marked by the development of certain ego functions, among them signal anxiety, transitional object development, and a cohesive and benign body image, which fuel the development of bodily self-care.

The Failure to Develop Signal Anxiety

In the early weeks of life, if there is an abrupt rupture of the symbiotic bond, the child may feel an overwhelming and disorganizing anxiety threatening to annihilate or shatter his sense of himself. This can occur if the mother does not heed his cries, allowing him to continue to cry alone without soothing. The child who has developed signal anxiety, however, is the child who has been soothed by the mother after such a rupture or when other events have caused the infant distress, and who has developed the ego function of anticipating that the mother will come forth to comfort him. Over time, there is a transition from reliance on the mother for relief from anxiety to soothing and comforting that become internalized. These transmuting internalizations build the ego so that somewhere in the second year of life the annihilating or traumatic anxiety and reliance on the
external object for emotional regulation are replaced by signal anxiety, a signal for invoking defense (Tolpin 1972). The child who is not traumatized by his anxiety, but develops the ability to heed the internal signal to defend against it, is capable of inventing a transitional object for himself, an act of supreme creativity that leads to promoting the separation-individuation process and to object constancy.

Problems in Transitional Object Development

Winnicott's (1953) concept of transitional objects, transitional phenomena, and the transitional space that the mother establishes for the child between her and the world can easily be understood in terms of attachment. Key to furthering the separation-individuation process is the development of transitional object relationships and transitional phenomena. Winnicott wrote: "I have introduced the terms 'transitional objects' and 'transitional phenomena' for the designation of the intermediate area of experience, between the thumb and the teddy bear, between the oral erotism and the true object relationship, between primary creativity and the projection of what has already been introjected, between primary unawakened of indebtedness and the acknowledgment of indebtedness" (p. 510). Winnicott calls the transitional object the first possession. As an example of transitional phenomena Winnicott refers to "the infant's babbling and the way in which an older child goes over a repertory of songs and tunes while preparing for sleep" (p. 511). Transitional phenomena thus is a term to describe activities or the mental products of these activities, for example, singing or the tunes themselves. When my son was being toilet trained, he would awaken at night and would wordlessly hurry alone in the darkened hallway to the bathroom with only the night light illuminating the darkness where unknown predators might lurk. Sometimes his courage would falter and his voice would ring out in the dark: "Talk to me while I'm making my pee-pee." Speaking coherently is difficult when one is awakened out of sleep, but "I'm talking to you while you're making your pee-pee" was sufficient. Talking to him seemed to illuminate the darkness, making it grow lighter.3 The clumsy words were a transitional substitute for the feel of loving arms around him, holding him as securely as if he were enfolded in a warm embrace.

Contact with the mother's or another's hair or skin can play a transitional function. Anzieu (1980) presents the observation of baby Helene, as reported by Monique Douriez-Pinol, as examples of transitional phenomena that all have as a common denominator Helene's seeking contact with parts of the body or objects that either are characterized by very soft hair or are made of material that provides a similar tactile experience of contact with skin: "Helene blinks her eyes and wrinkles her nose with an air of complete contentment when, about to fall asleep, she explores her eyelashes with a finger; she then extends this behavior to exploring her mother's eyelashes and her doll's, to rubbing her teddy bear's ear on her nose, and finally, when calling her mother back after an absence or at the approach of other babies, to touching a cat, fleece slippers, or fuzzy pajamas" (pp. 20–21).

A transitional object (Winnicott 1953) is an object the child seizes upon and holds close to himself when he is alone; he creates the illusion that he is being held and comforted by his mother. It is used when the child is in need of comfort and experiences a sense of the mother's loss, albeit a temporary one. It is a not-me object, not part of his body, and is usually something like a teddy bear or favorite old blanket, which may evoke the feel and smell of the mother when held close. Although it is a not-me object, the child may experience it as being part of himself and feel enveloped in safety and comfort, especially when falling asleep or experiencing other anxiety about separation from mother, and that is its function. There is a gradual transition from reliance on the mother, the infant's first object, for relief from anxiety that becomes internalized, in this way building the ego so that signal anxiety replaces both traumatic anxiety and reliance on the mother, and leads to separation-individuation and object constancy (Tolpin 1972). Winnicott related the concept of transitional objects and phenomena to developmental stages, as quoted by Barkin (1978):

As soon as they are born [infants] tend to use fist, finger, and thumbs in stimulation of the oral erogenous zone, in satisfaction of the instincts of that zone and also in quiet union.... Then after a few months infants of either sex become fond of playing with dolls, and most mothers allow their infants some special object and expect them to become.... addicted to such objects, the first not-me possession, an attachment to a teddy, a doll or soft toy, or to a hard toy... Sometimes is important here other than oral excitement and satisfaction though this may be the basis of everything else. [p. 513]

Barkin (1978) delineates those important other aspects of the transitional object: (1) the nature of the object as either animate or inanimate, soothing rather than stimulating; (2) the infant's capacity to recognize the object as not-me; (3) the place of the object in relation to the child's inner reality, outer reality, and the intermediate area at the border of his experience; (4) the infant's creative capacity to create, think up, or devise an object linked to undoing the separation between mother and child; and (5) an affectionate kind of an object relationship.

To understand childhood self-harm, it is important to distinguish between transitional objects and phenomena and those objects that serve pretransitional functions. Before the development of a transitional object, the infant has objects that serve the pretransitional functions of consoling and comforting the infant.

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3. This experience resonated with the title of Lynda Schare's book on dream analysis, *If Someone Speaks It Gets Light.*
in the absence of the mother (Gaddini 1975, 1978, Krueger 1989, Sugarman and Jaffee 1989, Tustin 1981). The use of these objects is thought to be a precondition for the later development of true transitional objects and transitional phenomena. Unlike true transitional objects, these precursor objects are not created out of his need for illusion (Gaddini 1975, 1978). Instead, the precursor object may be either an object provided by the mother, such as a bottle or pacifier, or it may be a part of the infant’s body, such as his thumb or hair, or it may be part of the mother’s body. It may be a knob of the crib, a button on his clothing, a piece of the blanket or mother’s clothing. These precursor objects are of two types—the earliest into-mouth type and the later skin contact/tactile sensation type (Gaddini 1975, 1978). Because these objects are experienced as “me” objects, as an extension of the infant’s body, Tustin (1981) also refers to them as normal autistic objects. These autistic or precursor objects, like transitional objects, may also function as external biological and behavioral regulators until a more complex mental organization evolves (Tustin 1981). The into-mouth objects serve to re-create for the infant a fleeting experience of being with the mother in the act of feeding, of having the nipple in his mouth (Sugarman and Jaffee 1989). Anzieu (1990) states that skin serves transitional functions, serving as a psychic envelope, a plane of demarcation between the internal and external worlds, between the internal psychic world and the psychic world of other people. Precursor objects often involve the use of both into-mouth objects and skin contact/tactile objects at the same time, as when the infant suckles on his thumb while twirling his hair or rubbing a soft blanket on his face while sucking on it.

Transitional phenomena all serve the same purpose, fostering the internalization of key self-regulatory functions, thus helping the individual make increasingly complex adaptations to internal and external demands (Sugarman and Jaffee 1989). There may be a series of objects and phenomena serving transitional functions, often in a developmental line of increasing organization and complexity that parallels other developmental lines. For example, the infant may use his body as a precursor object for self-soothing, promoting self-regulation at a sensorimotor level by defining what is inside from what is outside. The toddler may create a transitional object proper, as defined above, to neutralize and internalize drive energy, to modulate the wider and more differentiated range of affects that are characteristic of rapprochement, and to promote the development of mental structure. The contents and activity of fantasy (imaginary companions, twin fantasies, the family romance, comic book heroes) play a role as transitional phenomena in the lives of oedipal- and latency-age children, promoting secondary process thinking and helping the child move further into peer relations. In adolescence, ideas serve transitional functions as symbolic representations of the youth culture promote internalization of key regulatory functions. The symbolic representations include career aspirations, music, art, literature, and adolescent mores, and usually are infused with sexual and aggressive drive derivatives in earlier adolescence. Esoteric philosophies, religious and political views, and social causes replace the

more drive-infused transitional phenomena of early adolescence. Abstractness is used to render drive derivatives less real, and thus, less anxiety provoking. The adolescent can view his world in a hypothetical sense: feelings of rage do not have to lead to murder, oedipal feelings do not have to lead to incest, and yearnings do not have to lead to fusion.

Problems in Body Self, Body Image, and Self-Care

The body is the soul’s house. Shouldn’t we therefore take care of our house so that it will not fall into ruin?

Philo

The image we have in our minds of our own bodies is central to our concept of who we are. Freud (1923) recognized that the ego of the infant is first and foremost a body ego, and that bodily experiences are the basis for the developing ego and sense of self. Before there can be a mind, there is the body. Before there can be a representational world, there is eating and defecating. Winnicott (1949) emphasized that these bodily experiences occur within the maternal caregiving environment and are the earliest experience of the psyche-soma, the unity of mind and body. “I suppose the word psyche here means the imaginative elaboration of somatic parts, feelings, and functions, that is, of physical aliveness” (p. 244). That is, the body is experienced as the dwelling place, the home, the container for the self. The infant feels alive and vital, a sense of confidence that he can continue going on being.” The notion of the body as the dwelling place for the self is derived from Freud, who said, “The dwelling-house was a substitute for the mother’s womb, the first lodging, ... in which he was safe and felt at ease” (Freud 1930, p. 90). This psychosomatic unity is one of those things we have no reason to think about or trouble ourselves about (Sackstede 1988), until perhaps we fall ill or are injured, or we are reminded that our bodies do not measure up to the cultural ideal of physical attractiveness. Then illness or culture can cause us, unhappily, to focus on our bodies in a way that had not been necessary before.

Anzieu’s (1980) concept of the skin ego complements Bowlby’s concept of attachment and Winnicott’s concept of dependence. “The ego is based on a body ego, but it is only when all goes well that the person of the baby starts to be linked with the body and the body-functions, with the skin as the limiting membrane” (Winnicott 1965, p. 59). Anzieu postulates that the skin, the surface of the infant’s entire body and his mother’s body, is the focus of experiences that are as important in terms of their emotional value, in stimulating confidence, pleasure, and thought, as are the experiences associated with sucking and excretion. The mother’s touch in caring for her baby involuntarily stimulates his skin, while intentionally caressing and touching his skin to provide pleasure. The infant receives these gestures first as excitation, then as communication: “The massage becomes a message” (Anzieu 1980, p. 29). Through these loving messages, the
infant develops a skin ego, an image that the child’s primitive ego uses during the early stages of development to represent itself on the basis of his experience with the surface of the body. It is a sense of security and pleasure in living in his own skin. The skin has three psychic functions:

In its first function, the skin is the sack that holds in the goodness and fullness that accumulates from being suckled, cared for, and bathed with words. In its second function, the skin is the surface that marks the boundary with the outside and keeps it on the outside; it is the barrier that protects against the greed and aggression of others, persons, or things. Lastly, in its third function, the skin—along with the mouth and at least as much as it—is a place and principal means of exchange with others. [Anzieu 1980, pp. 29–30]

For Ogden (1996), too, it is as the boundary between inside and outside and life and death that skin has its overriding importance. “Physiologically, it is essential that one’s skin be continually generating a layer of dead tissue that serves as a life-preserving outermost layer of the body. In this way (as in Freud’s concept of the stimulus barrier), human life is physiologically encapsulated by death” (p. 181). Marc Lappe (1996) states, “We have tended to think of the skin as our boundary, a watertight covering that enfolds ourselves and our organs and keeps them separate from the world out there. We visualize the skin in purely Euclidean terms, as a two-dimensional sheet that envelopes us in a kind of perpetual Saran Wrap” (p. 71). However, we know that the skin is both a barrier and a sieve, “denying access to the body of some things and actively encouraging the passage of others. . . . Under some conditions it lets water out, permits toxic chemicals in, and allows bacteria to reside within its own confines” (p. 70). Diane Ackerman (1990), too, writes about the functions of the skin:

What is a sense of one’s self? To a large extent, it has to do with touch, how we feel. . . . Our skin is what stands between us and the world. It impregnates us, but also gives us individual shape, protects us from invaders, cools us down or heats us up as need be, produces vitamin D, holds in our body fluids. Most amazing is that it can mend itself when necessary and is constantly renewing itself. It can take a startling variety of shapes: claws (nails), spines, hooves, feathers, scales, hair. For most cultures, it’s the ideal canvas to decorate with paints, tattoos, and jewelry. But most of all it harbors the sense of touch. [pp. 95–100]

The skin is constantly mending and renewing itself, forming two new layers of cells every four hours or so and shedding cells at the rate of over a million every hour (Montagu 1971). Skin is our first medium of communication and quite literally our protector, insulating the soft tissues within the body. It can be the locus of pain or of pleasure. Skin is regarded as a window on the soul; clear skin is viewed as a sign of physical and emotional health, while blemishes and scars mark a life out of balance (Brumberg 1997). The skin is expressive, carrying its own memory of experiences as the array of life’s experiences is projected onto it. What happens to the skin ego of the child whose body does not mold together with the mother’s when she holds him, whose mother’s body tenses when she holds him? What happens to the skin ego of the child whose mother holds him to feed him but does not hold his gaze with her own, and looks away instead? The child does not experience his skin as soft and sweet, holding in his goodness. He experiences himself as something bad that causes the mother’s body to tense, or something ugly that she does not want to look at. Because the skin is such a profound organ of contact, it plays a major role in fantasies.

But of all the body substances, blood is the most symbolic. “Blood, pumped through the body by a beating heart, is the essence of the life force” (Strong 1998, p. 34). The center of the skin’s vitality lies deep within the dermis, where miles of blood vessels nourish the body with oxygen and nutrients and take away metabolic by-products (Lappe 1996). Blood is spilled when we are born, as we emerge into the world drenched in our mothers’ blood. We die when too much blood is spilled. When blood circulates well, it warms the body. When we die and our blood stops circulating, it may be removed from the body and replaced by embalming fluid. Blood can be healing and transformative, as in blood transfusions, but a transfusion of contaminated blood can kill. Bleeding has traditionally symbolized healing, from the bloodletting medical traditions to the religious healing that is often expressed as being washed in the blood of Christ. “Bad blood” between people poisons relationships, while getting rid of bad blood is healing and restorative. Cutting and mingling blood cements social ties and is the stuff of initiation rites. It is no wonder that its symbolic powers of healing and transformation beckon so powerfully to self-mutilators (Fava and Szasz 1987, 1996).

Scars are mysterious marks, evoking fear, revulsion, and a fascination with hearing the story of how the scars were acquired. Scars are also symbolic, providing a permanent concrete record of pain, injury, suffering, and healing (Strong 1998). “The scars of the process are more than the artless artifacts of a twisted mind. They signify an ongoing battle and that all is not lost. As befits one of nature’s great triumphs, scar tissue is a magical substance, a physiological and psychological mortar that holds flesh and spirit together when a difficult world threatens to tear both apart” (Fava 1996, pp. 322–323). In Mexican artist Frida Kahlo’s self-portraits, she portrayed herself wearing a Christ-like crown of thorns, gore dripping from her many wounds. The scars represent the pain of her life: polio at age 6, her back and legs badly scarred in an accident, her struggles in her family and with her sexuality. Scars can be something to be proud of, signs that one has endured and survived. They can even be signs of a healing process that has begun.

“Thus, with a few strokes of the razor the self-cutter may unleash a symbolic process in which the sickness within is removed and the stage is set for healing. . . . The cutter, in effect, performs a primitive sort of self-surgery, complete with tangible evidence of healing” (Fava 1996, p. 280).
Krueder (1989) elaborates that the foundation for our sense of self is found in our body and its evolving representations as they form in the maternal caregiving relationship. "The mother's hands outline and define the original boundary of the body's surface: they describe a shape of which there was no previous sense" (p. 5). The body self combines the psychic experience of body sensation, body functioning, and body image (Krueder 1989). Body image refers to the mental representations of the body self and is not limited to visual images (i.e., pictures in one's head of one's body) but include the schema of all sensory input, internally and externally derived—lived experiences processed and represented within a maturing psychic apparatus (Krueder 1989). Body image is how we perceive ourselves and is the way we think others perceive us (Fallon 1990). Body image is plastic, subject to modification by biological growth, trauma, or decline. Life circumstances significantly influence body image, as do culturally bound definitions of what is desirable and attractive. Because fat is considered ugly in Western culture, "feeling fat" is a code for a discordant mind–body experience, a mood or affect experienced in the body. For example, Krueder (1989) wrote of the psychic and body image changes in a 16-year-old bulimic girl, whose experience of "fatness" was confirmed by numerous other patients of different ages who also felt fat.

When asked to draw her body, the patient divided the page in half with a vertical line. On the left side, she drew a proportionate, distinct, cohesive body image. On the right side was a grotesquely overweight, disproportionate body that had protrusions in the stomach and leg areas. She explained that the normal-appearing image was how she looked when she felt good and things were going well for her. The image on the right represented her feelings and her image of herself when she felt bad, was depressed, rebuffed by others, or out of tune with things around her.

We examined in detail her experience of these body images. When she felt good, the drawing with the accurate boundaries corresponded to the image she saw when she looked in the mirror. However, when she felt bad, she saw herself as obese and said that the image corresponded exactly to what she saw in the mirror. When I asked her what she looked at specifically in the mirror, she indicated that when she felt good, she looked at her entire body, and when she felt bad and felt fat, she looked at the inner part of her thighs and occasionally at her stomach. She saw her inner thighs and hips as rounded, concluding that they were fat and that she was full all over. [p. 69]

The body self is a function of the mother. According to Jacobson (1964), the newborn has a primal psychophysiological self that exists within the psychosomatic matrix of the relationship to the mother. The development of an intact body image and physical boundaries, and the subsequent evolution of ego boundaries fall along a continuum, in which there is a parallel developmental line of body self and psychological self. In self psychological terms, the infant's body affects, and movements are initially experienced through the mirroring self-object (the mother). And in ego psychological terms: "Even if viewed from a purely biological point of view, the newborn infant is only a partial system: between the distress signal and the relief of need, there must be a mother" (Mahler and McDevitt 1982, p. 828). Soon after, in the early awareness of the body, it is immediate, felt experience, the emerging experience of unsatisfied need (e.g., hunger). Next, the body self is form, distinct patterns of behavior. By means of observation of normal infants' behavior and inferences from observations of pathology, Mahler and McDevitt (1982) have traced the emergence of the sense of self, particularly the body self, in the first 15 months of life. A new level of organized self-awareness begins at about 15 months, when infants come to discover themselves in the mirror and acquire the semantic "no," which encapsulates developmental statements, "I am not an extension of you and your body or your desire; this is where you end and I begin—my body is mine and mine alone. You are not the boss of me." By 18 months the infant has usually developed a cognitive sense of separate existence and body self. In normal development, the experiences and images of the inner body become, and the body surface becomes organized and integrated into an experiential and conceptual whole. Finally, the body-self is a concept, a relatively stable internal frame of reference that includes bodily and emotional images, concepts, and experiences. The consolidation of a stable, integrated cohesive mental representation of one's body is a key developmental task during this period, entailing delineation of what is inside from what is outside, with clear distinct boundaries. Those involved in the marketing of children's toys and books know that children become fascinated with the insides of their bodies and their bodies' products. Taking advantage of what is called the "yuck factor," toy chemistry sets are promoted as producing something simulating mucus, and the Gutsy Doll invites kids to reach in through the mouth and "Pull out my guts, one gross handful at a time." Grossology, a children's book describing body functions, proved so popular that three sequels were written.

As he develops, the normal child pays little attention to the inside of his body, although the orifices that lead to the inside are a source of exploration and pleasure. Children pay more attention to the body's surface and length, delighting in growing, seeing their height marked on measuring charts, and in getting clothing in larger sizes. In a study exploring the notions of children, they were asked what was under their skins and what was inside their bodies (Schilder and Wechsler 1935). They replied, "I am myself." If we regard the skin as the psychic envelope, the body's container for the self (Anzieu 1980, 1990), then having intact skin represents having an intact self (Grotenstein 1990, 1993, Ogden 1990, Rosenfeld 1990). For example, after getting a cut, a normal toddler may desperately insist that a Band Aid be put on his finger immediately to ensure that his insides will not drip out. (In the magical ways that children think, a Power Ranger or Batman Band Aid is thought to have enhanced healing powers.) A toddler may scream in fear when his mother breaks or cuts a piece of food in two for him, for fear that if the food can be broken in two, so can he himself be broken in two. (Later,
When the Body Is the Target

in puberty the longer and broader body surface captures far more of the child's attention, as do the hormonally induced processes occurring inside.)

The fear of fragmentation represents the fear of regressing to the infant's initial experience of his body, a fragmented one in which the borders of the various parts of the body are clearly marked (Lacan 1977). Lacan refers to these borders as cuts, like the boundary definition of cut glass or cut crystal, just as the grotesque muscle definition of body builders is referred to as the "cut" look: "The very delimitation of the 'erogenous zone' that the drive isolates from the metabolism of the function ... is the result of a cut (coupure) expressed in the anatomical mark (trait) of a margin or border—lips, 'the enclosure of the teeth,' the rim of the anus, the tip of the penis, the vagina, the slit formed by the eyelids, even the horn-shaped aperture of the ear" (Lacan 1977, p. 315). Like the horrifying paintings of Hieronymus Bosch, the fragmented body may manifest itself in dreams as disjoined limbs or internal organs that grow wings to conduct their "intestinal persecutions" (Lacan 1977).

How the child experiences his body as he grows and develops influences the development of language and symbolic thought. The child's experiences of touch, feeding, defecation, and bowel and bladder training are all experienced subjectively, endowing the involved organs with a subjective experience of victories and defeats. These organs can readily become eroticized, and so anal or urethral purging or vomiting can become a disguised form of masturbatory activity. Enuresis and soiling in the sexually abused child can serve as a form of erotic discharge (Daldin 1988b). The skin, too, can become eroticized (Anzieu 1980) and self-cutting can serve as a disguised form of masturbation (Bollas 1992, Daldin 1988a).

While we usually think of eating as an expression of orality, it can quite readily serve as an expression of anality. True orality aims at assimilating the food and leaving behind what is bad or excessive (Oliver 1988). Once incorporated, the nourishing part no longer exists as a separate entity, becoming part of the body, while the bad is eliminated as waste. "Stuffing the face" provides a visual image of how plugging oneself up with food can stuff emotions down and silence their verbal expression. Filling the stomach may provide an internal object to manipulate, to fill the emptiness, and calm forbidden genital excitement (Oliver 1988). The food-object is filling but considered bad, not nourishing. Virtually always the food that is eaten is described as bad—as junk, garbage, or even feces ("sh*t food"). Binge food is frequently chocolate, the color of feces. Often it is shoved in so rapidly that it is barely tasted. And so the overeater becomes the mechanized receptacle for and producer of something bad, a container for garbage, a toilet, a shit-producing factory. Filling their stomachs and intestines with "sh*t," they can control and manipulate it within their bodies, or they can expel it forcefully, vomiting it up or purging it anally. No wonder those who stuff themselves with food often describe themselves as feeling "like sh*t."

When the capacity to develop mental representations of the body and its contents, including feelings, has been interfered with, it forces the individual to rely upon the immediate experience of his own body to elicit some representation of the self (Fonagy 1997, Fonagy et al. 1995, Krueger 1997). When the parent cannot mirror a consistent sense of self for the child, the child must turn to something that is consistent to obtain some sense of self. And his body is consistently there, to be turned to in the way that other human beings cannot always be turned to. The contents of the body assume a special importance because of their permanence and because they provide an illusory sense of omnipotence. "I don't need you or anyone else. I just need my body and food." There is always blood, feces, partially digested food, urine. For the most part, food, too, is consistently there. Children can get their hands on some food, quickly consume it, and make it part of the self. So representations of the self become bound up with food, before it enters the body and after. The self becomes bound up with representations of whole food, before it is consumed, when it holds out the potential to nourish the body and become part of it, sustaining life. ("You are what you eat.") It becomes bound up with representations of food consumed by the body that cannot be tolerated or digested; it becomes bound up with the natural body wastes—feces and urine—and with the contents of the stomach and intestines that must be wasted or purged. And so it happens that an individual's sense of himself becomes bound up in images and words pertaining to waste and degradation. Their words thus become bound in bodily images. "To put it briefly, the instinctual stages, when they are being lived, are already organized in subjectivity. And to put it clearly, the subjectivity of the child who registers as victories and defeats the heroic chronicle of the training of his sphincters, enjoying (jouissance) the imaginary sexualization of his cloacal orifices, turning his excremental expulsions into aggressions, his repressions into seductions, and his movements of release into symbols" (Lacan 1977, pp. 52-53).

When a body image has not been sufficiently formed to sustain the stresses of developmental maturation, body image regresses along with one's functioning in response to emotional events. Self-image and body image will shift rapidly in narcissistically vulnerable individuals. In regressed states such as narcissistic rage or depression, the body image oscillates rapidly. Such individuals cannot use objective data, such as being attractive or of normal weight, to alter their notion of being ugly or fat. Instead they compulsively pursue physical attractiveness and social affirmation to serve as narcissistic supplies, compensating for an inner emptiness and attempting to insure against abandonment. Indeed, the ability of anorexics to insist not simply that they feel fat but that they are fat even after seeing the marker on the scale go down to eighty or seventy pounds, is delusional.

The concept of self-care is valuable in helping us understand the structures and functions of the ego that serve the survival of the self and keep the self from harm (Khnitzian and Mack 1983). Self-care includes (1) an emotional investment in caring about or valuing the self, requiring that the individual have sufficient self-esteem to feel himself to be worth caring for and protecting; (2) the capacity to anticipate dangerous situations and to respond to signal anxiety by
protecting oneself; (3) an ability to control impulses and forego pleasures that may have harmful consequences; (4) a sense of gratification in mastering risky situations; (5) sufficient knowledge of the world and of oneself to allow one to survive in a threatening world; (6) an ability to assert oneself or be aggressive enough to protect oneself; and (7) an ability to choose others who will not threaten one's existence for object relationships. The capacity to care for one's own self develops out of the mother–child attachment. From infancy on, there is a subtle balance between the parents' permission for the child to take the initiative and risk and explore, and the parents' protective function, which keeps the risks within moderate bounds.

Anna Freud (1966) described how a developmental line from irresponsibility to responsibility in body management grows out of the experiences the child has in the mother–infant dyad, reminding us that it is only gradually that the child takes on the satisfaction of essential physical needs such as feeding or elimination. It is only over time that the child's ability to care for and protect himself becomes internalized and developed through the experience of being cared for and protected by parents and caregivers (Khantzian and Mack 1983). When the child is well cared for by an attuned caregiver, he internalizes the sense that he deserves to be protected and well cared for, and so comes to take good care of himself. In individuals who are prone to harming themselves or to allowing others to harm them, it is clear that the capacity for self-care has been severely impaired. They have not been well cared for and sufficiently protected from danger early on, or they have been so overprotected that they never had the autonomy and opportunity to develop the self-care functions. Not only do they fail to care for and protect themselves from others, they fail to protect themselves from themselves.

Problems in Self and Object Representations

The regulatory interactions in infancy become the building blocks from which mental representations and their related inner affective experiences are built. They induce the searching and proximity-seeking behavior toward an increasingly specific and differentiated object throughout life span, which is the hallmark of attachment behavior. Mental representations of self and other, however, operate on a different level of organization from the hidden regulators, involving cognitive and emotional ego and self structures that over time come to be gradually and increasingly differentiated from the undifferentiated matrix of inborn ego apparatuses. These mental representations become established through the experiences of learning and through memory of past interactions. Stern (1985) has conceptualized the units of these representations into moments and scenarios that become organized in early development into internal working and narrative models.

The mother, too, develops mental representations of herself as a good mother, capable of soothing and caring for her child. The child's psychological self, that part of the self representation where the self is seen not as the physical entity but as an intentional being motivated by thoughts and feelings, develops through the perception of this self in the mother's mind (Fonagy 1997, Fona and Target 1995, Fonagy et al. 1995). For the infant, repeated internalization of the mother's processed image of his thoughts and feelings provides containment (Bion 1962).

In the potential borderline child, however, there remain split representations of a good and bad mother, manifested by the longing for fusion with the good mother at the same time there is the fear of engulfment by the bad mother. The potential borderline child also has an unclear gender identity derived from failures to develop a sound body image. Remaining fixated at this primitive level of object relations, as they develop into adulthood they develop the primitive defense of projective identification, projecting the bad parts of themselves in external objects (persons) in such a way that the object becomes identified with their projected parts. They then can feel threatened and persecuted by the object.

Failures in the Capacity for Reflection

For a child to move along developmentally from enactment to meaning, they must become able to be "alone... in the presence of the mother" (Winnicott 1958a, p. 30). When the mother can exist in the background as a quiet, no intrusive, calm presence, her ability to let her child exist separately from her allows him to turn his consciousness away from her and back toward his absorption in solitary play. He speaks to himself in an audible inner speech, a sort of babbling singsong flow of associations. It is through this ability that a secure sense of self develops. If the mother is not there as a quiet presence, or is inconsistent or unattuned, she keeps the child's consciousness focused on her, thus preventing him from losing himself in the creativity of play. The ability to play influences the development of the infant's ability to think symbolically and to experience emotion. It is when we are lost in play that we are so much our authentic selves, whether that is the solitary play of the infant in the presence of the mother, the playful mind of the adult absorbed in creative work, or the free verse and symbolic play-in the presence of the therapist.

Spitz (1955) says, "Only a reciprocal relation can provide the experiential factor in the infant's development, consisting as it does of an ongoing circuit exchange, in which affects play the major role. From the beginning of life, it is the mother, the human partner of the child, who mediates every perception, evaluation, every insight, every knowledge." (p. 95). Soon after the child can perceive objects as being separate and apart from the self, he acquires the semiotic function of the ability to represent something outside the self by means of a signifier such as a gesture or a verbal sound. The mother's attuned response to his signifi-quickens the development of operational thinking and symbolization. For example, the child sees the ice cream truck coming down the street and, not yet having...
words, points in excitement and squeals in anticipated pleasure. His mother responds animatedly, "Look how excited you are. Shall we buy an ice cream?" Joyce McDougall (1989) describes how, in the complex mother–infant psychosomatic scenario, the mother of the infant serves as her baby’s "thinking system," finding an adequate response to her infant’s distress, until the time that his mental processes are sufficiently developed and organized so that he outgrows the need for her to "lend him her mind." It is then that he begins to find words himself, "small shapes in the gorgeous chaos of the world... They bring the world into focus, they corral ideas, they hone thoughts, they paint watercolors of perception" (Ackerman 1990, p. 7). The mother’s ability to soothe the child serves as the child’s "feeling system," and by means of transmuting internalization (Tolpin 1972), what the mother had done for the child becomes something that he then can do for himself.

Fonagy (1997) and colleagues (Fonagy and Target 1995, Fonagy et al. 1995) have presented a dialectical theory of self development in which the psychological self develops through the perception of this self in another’s mind. When this mirroring function is absent or distorted early in life, transmuting internalization fails to develop, promoting a desperate quest for alternative ways of containing psychological experience. Lawrence Hedges (1994) has identified a pathological organizing experience in some infants as a failed contact with an unattuned mother that becomes internalized as the lost or dead mother of infancy. This internalization of the lost mother of infancy is manifested in the infant’s failure to use fantasy, symbolism, or abstraction. The capacity to develop mental representations of the body and its contents, including feelings, is interfered with, forcing the individual to rely upon the immediate experience of his own body to elicit some representation of the self (Fonagy 1997, Fonagy et al. 1995, Krueger 1997). The self representation is achieved not symbolically but through the experience of the body itself.

Maurice Merleau-Ponty, a French philosopher, developed a theory of language that posits that language is an extension of our gestures (McLange 1996). We interact bodily with the world, and as we do, the world comes to have meaning for us. "Speech is in fact a gift of language, and language is not immaterial. It is a subtle body, but body it is. Words are trapped in all the corporeal images that capture the subject" (Lacan 1977, p. 87). We extend that meaning into linguistic gestures that acquire layer upon layer of cultural meaning, but these gestures are made anew in the individual gestures of each person. When an individual’s interaction with the world is traumatic, and the impulse to give spoken voice to the inner pain has been thwarted, self-harm can develop as a gestural articulation of trauma (McLane 1996) as well as a perverse attack on language itself (Woodruff 1998). Self-harm is, after all, an attempt to blot out intolerable thoughts or images in one’s mind (Fonagy and Target 1995), an attack on the process of creating meaning (Woodruff 1998). "We come alive as human beings through our capacity to symbolize experience, but the cost of this capacity is to lose the immediacy of (bodily) experience" (Woodruff 1998, p. 3). Those who regress to self-harm cannot tolerate giving up the immediacy of experience in favor of tolerating grief and depression. To do so is to live more in the mind and less in the body. Because they live so much in their bodily experience and so little in the mind, they are additively driven to seek and attain an impossible fusion with the body of the mother. To accept that one cannot have what is so desperately wanted is to mourn, to use language to give meaning to the loss. To use words to stand in place of that thing signifies, is to destroy the immediacy and presence of the object it represents (Woodruff 1998). When confronted with their own impotence in resolving this quest and the realization that the fusion cannot occur, self-harmers cannot mourn this loss. It is too shattering to their sense of themselves. Instead, they regress to a primitive aggression, a destructive narcissism, that erupts violently against the dedifferentiated mother-body-self, once again reclaiming the immediacy of the mother, the body, and the self, in a gesture that assaults language.

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