To the patient who wrote the following to me:

Thank you for the opportunity to express my feelings and for the attention you are paying to my problem. I believe there is a larger truth at work in the riddle of self-harm which is important for society as a whole to penetrate.

May you find the answers which you seek.
**Preface to the Third Edition**  ix

**PART I  MUTILATIVE BELIEFS, RELIGION, EATING, AND ETHOLOGY  1**

1 Mutilative Beliefs, Attitudes, Practices, and Images  3
2 Self-mutilation in Myths of Creation, Shamanism, and Religion  20
3 Self-injury and Eating Disorders  43
4 Animals and Automutilation  57

**PART II  MUTILATION AND SELF-INJURY OF BODY PARTS: CULTURAL AND CLINICAL CASES  71**

5 The Head and Its Parts  73
6 The Limbs  113
7 The Skin  129
8 The Genitals  157

**PART III  INSIGHT AND TREATMENT  195**

9 Understanding Self-injury  197
10 The Assessment, Psychology, and Biology of Self-injury  221
11 Treatment  244
12 Personal Reflections  272


**REFERENCES  297**

**INDEX  323**
The awakened and knowing say: body am I entirely, and nothing else; and soul is only a word for something about the body.

—Nietzsche, *Thus Spoke Zarathustra*

My introduction to the first edition (1987) of *Bodies under Siege* was only four pages long. Its opening paragraphs are worth repeating:

In the vast repertoire of human behaviors, self-mutilation ranks among the least understood and the most puzzling. Is it possible to strip away the mysterious aura that surrounds it? What could possibly motivate people to alter and destroy their body tissue or to consent to the mutilation of their bodies by others?

In an attempt to answer these questions, this book explores the many variations of self-mutilative acts across cultures and through time, utilizing the perspective of cultural psychiatry. Just as culture strives to organize a society into a logically integrated, functional, sense-making whole, so too cultural psychiatry strives to integrate the components of complex, problematic behaviors such as self-mutilation and to make sense out of what may appear to be senseless. Thus, we shall examine the wide variety of forces—ranging from congenital insensitivity to pain to hypersecretion of adrenal hormones, from castration anxiety to intolerable guilt, from the experience of child abuse to confused perceptions of maleness and femaleness—that may impel or compel people to mutilate themselves. Further, we shall examine the vast array of cultural practices, attitudes, and beliefs—ranging from religion and mythology to folk healing, from infibulation to initiation rites, from artistic and literary depictions to blood customs—that form the theater within which self-mutilation is performed.
My preface to the second edition (1996) was much longer. I related how I became interested in bodily harm, including an encounter with a Sudanese graduate student's wife who as a child had had her clitoris ritually removed and then became depressed when her American girlfriends described the joy of orgasmic sexuality that she would never experience. I later discovered self-mutilation as a therapeutic tool among Moroccan mystics, who slashed open their own heads and offered bits of bread drenched in their own healing blood to the sick. And then there was my opportune reading about the first reported case of repetitive nonsuicidal self-injury in the fifth chapter of the Gospel of Mark, which describes a demon-possessed man chained in a cemetery, who, night and day, cried and cut himself with small stones. Jesus exorcised the demons, who then entered a herd of swine, which committed suicide by drowning in a river (was it possible that the man had suicidal urges that were kept in check by his repeated skin cutting?).

I described the exciting discoveries about self-mutilation that I uncovered as I wrote the book as well as my loneliness because so few others seemed interested. I praised the Johns Hopkins University Press for allowing Fakir Musafar to write an epilogue. Fakir, the guru philosopher of the “modern primitives” movement, is a man of great artistic talents and exceptional knowledge about body modification. He is my good friend and has personally experienced many types of body modification. His new epilogue recounts his discoveries about the possibilities, the rewards, and the dangers of these practices. When I was asked by the president of the American College of Psychiatrists, in 1999, to provide a “San Francisco experience” for society members, I, in turn, invited Fakir to make a presentation. The august audience was stunned. Some thought he was bonkers but most were mystified and intrigued. At that time, body modification was a cottage industry and the spirituality movement was beginning to gear up. Along came Fakir, who talked about things that were foreign to most psychiatrists and that brought them out of their comfort zone. Nowadays, the “San Francisco experience” has become a global one with Fakir at its epicenter. And, although psychiatry is focused on the primacy of cellular, genetic, and neuronal approaches, there is growing recognition that culture cannot be ignored. For a scholarly discussion of Fakir’s work, see Graver (1995).

Fakir follows a universally noble tradition in which spirituality is gained by taming the bonds of the flesh. By conquering pain and transforming his body, he walks on the path to enlightenment. He places his practices outside of Christian culture, but had he lived in earlier centuries, he might well have found soul mates among the company of the Desert Fathers, the athletes of God who sought salvation through mortification. Properly speaking, Fakir does not truly mortify
his body but rather attempts to transcend pain. Even with the proper spiritual training, those who would emulate him do so at grave personal peril. I for one cannot even think about putting holes in my body without shuddering, yet there are many persons who carve and cut themselves. As an uncontrollable behavior, the morbidity may be high. As a controlled behavior, however, it may have its rewards. In this edition, Fakir discusses the astonishing growth of the body modification community, which contains both shallow poseurs and, sad to say, frightening extremists.

I also recounted the lifting of my spirits because of the favorable reviews of the book in professional journals. One reviewer described his reaction to my presentation of the new Deliberate Self-Harm syndrome as “a sense of sharing in a clarifying discovery, as I imagine an early reader of Gull’s description of anorexia nervosa might have felt.” Another reviewer wrote in the *British Journal of Psychiatry*: “A comprehensive, lucid, and interestingly written book which is likely to become a classic on the subject.”

Given that the book has remained in print since 1987, that it is still referenced in both professional and lay publications, that it has resulted in my appearing on many major television and radio shows and lecturing at a large number of prestigious universities both at home and abroad (Columbia, Harvard, the Karolinska Institution, Mayo Clinic, Yale, etc.), and that it is now available in a third edition, I suppose that it might be considered a “classic.”

In preparing for this third edition, I no longer felt lonely. The literature has grown enormously, and I have selectively included several hundred new references. I have offered advice to many students who have written master’s and doctoral theses on the topic. The term self-mutilation is still used in some psychiatric journals but has been replaced by the more precise nonsuicidal self-injury (NSSI) in recent years. Although NSSI is an inclusive term, I have decided to retain “self-mutilation” when referring to major acts of self-injury, such as eye enucleation and amputation of body parts. I do use “NSSI” when referring to moderate/superficial acts, such as skin-cutting and burning, which are the most common form of self-injury as well as the major focus of current research and treatment.

Special praise should be given to Karen Conterio for her enduring efforts in educating the public about self-injury and developing “S.A.F.E.” therapeutic programs. Praise is also due to three psychologists: Matthew Nock of Harvard University and Janis Whitlock of Cornell University, for their work and leadership in the scientific study of self-injury, and Barent Walsh, for producing practical guides for treatment. Although the new literature (Nock 2009a) significantly expands
and clarifies our knowledge about self-injury, provides models for understanding it, and offers more hopeful treatments, the fundamental findings in the first two editions of *Bodies under Siege* remarkably remain valid.

It is instructive to compare two articles that were published twenty years apart: my article “Why patients mutilate themselves” (1989), and Nock’s “Why do people hurt themselves?” (2009b). The titles are telling. I, as a physician, focus on patients, while Nock, a psychologist, focuses on “people.” I use the term *mutilate*, while he uses the term *hurt*.

In my article, I considered self-mutilation as a product of mental illness and as a morbid act of self-help behavior that is inherent in the repertoire of human activity. I discussed biological, psychological, social, cultural, and patients’ explanations for its occurrence. Patients’ explanations for their acts of major self-mutilation were divided into two main themes: religious (a psychotic reading of the biblical injunction to tear out an offending eye or to become a eunuch for the kingdom of heaven’s sake, atonement for sins, etc.) and sexual (a man’s desire to become a woman, repudiation of one’s sexual organs, etc.). Patients’ explanations for moderate self-mutilation, such as skin cutting, included a host of themes, such as the release of tension, the cessation of feelings of emotional deadness and estrangement from the environment, and influencing the behavior of other persons. I discussed a number of psychological explanations, which included psychodynamic theories (the blood produced by cutting may serve as a solacing, transitional object; relief of sexual guilt in persons who were abused during childhood, etc.); an attempt to emotionally blackmail others or to force them to provide a caring, mothering response; a means for terminating episodes of depersonalization (the shock of seeing blood directs attention to the difference between the self and the environment); a response to command hallucinations or a preemptive gesture to forestall imaginary paranoid attacks; one form of impulsive behavior; and behavioral theories (e.g., self-mutilation is maintained by terminating or avoiding aversive stimuli and by positive reinforcement, or may represent “a morbid type of problem-solving in persons who have a low tolerance for distress, inadequate coping resources, and self-harm expectancies”). Under social explanations, I discussed endemic and epidemic self-mutilation in repressive settings such as prisons. As for cultural explanations, I provided details about my statement in the first edition of *Bodies under Siege* that “self-mutilation is not alien to the human condition; but rather it is culturally and psychologically embedded in the profound, elemental experiences of healing, religion, and social amity.” I noted that the weakest link in our chain of knowledge is the biological one and that no simple explanation can be applied to all patients.
Two decades later, Matthew Nock, the most prolific and astute current researcher on self-injury, published his article on the same topic. He used the new terminology, nonsuicidal self-injury (NSSI), and conceptualized it not as a symptom of mental illness but rather as a “harmful behavior” that can serve several functions both internally within a person and externally in a person’s relationships with others. This approach holds that NSSI is maintained by four functions through positive and negative reinforcement: NSSI may decrease internal aversive (unpleasant) thoughts or feelings, may generate desired feelings and stimulation, may facilitate help-seeking, and may provide an escape from undesired social interactions.

Nock then provided an integrated theoretical model of the development and maintenance of NSSI in a person. He starts with background distal factors such as experiencing childhood abuse, maltreatment, and familial hostility and criticism and having a genetic predisposition for high emotional and cognitive reactivity. These distal factors can affect persons who are vulnerable for NSSI because they have high levels of aversive emotions and thoughts as well as poor communication skills, problem-solving abilities, and tolerance in dealing with distress. In persons who possess these distal and vulnerability factors, experiencing a stressful event may trigger responses of underarousal or overarousal or may present unmanageable social demands. The final factor that results in engaging in NSSI is the interaction of a person’s stress response with that person’s NSSI-specific vulnerability factors, such as observing or learning about NSSI being used by others; a need for self-punishment resulting from repeated abuse or criticism by others; a need to signal personal distress dramatically because the usual methods of talking or yelling fail; a choice to use NSSI to achieve a desired goal or function because it is a fast and readily accessible method; an ability to experience NSSI with little or no pain; and a propensity to identify with NSSI and to value it as an effective means of achieving one of the desired functions, such as the regulation of a distressing social situation or of disturbing affects.

At first glance, there seems to be a wide gap between my consideration of NSSI as a product of mental illness and Nock’s contention that it is a harmful behavior, but both perspectives are useful in different ways. My knowledge about NSSI comes from patients who, by the time they arrive at my office, are usually in dire straits and clearly have a mental illness (ranging from schizophrenia to generalized anxiety disorder to borderline personality disorder) or mental retardation. I am trained, as a physician and psychiatrist, to recognize, diagnose, and treat patients who are mentally ill. Psychiatry has a formal *Diagnostic and Statistical Manual of Mental Disorders*, updated periodically, that lists obligatory criteria.
and associated symptomatic features for arriving at a diagnosis of a mental illness. Unfortunately, this manual does not deal with NSSI meaningfully; that is, it is a criterion only for borderline personality disorder (although this diagnosis can be made without the presence of NSSI) and for trichotillomania (pulling out body hairs), which, by definition, is a form of NSSI. One of my contributions has been to point out that NSSI may be an associated feature of many mental disorders. The manual is descriptive and does not deal with causality (e.g., it lists “dementia due to head trauma” but does not explain the processes by which head trauma may result in dementia). The reason for this is obvious: we simply do not understand the processes fully. Unlike many medical illnesses for which the processes are known, mental illnesses are just too complicated.

Good psychiatry operates on a model that considers all the biological, psychological, social, and cultural factors that cause people to become mentally ill. Nock (2009b) is correct when he writes that “suggesting that people engage in NSSI because it is a symptom of a disorder provides little explanatory power,” but a good psychiatrist observes a symptom of a mental disorder, such as NSSI, and then attempts to understand the biopsychosociocultural factors that have resulted in the symptom. It is unfortunate that nowadays many psychiatrists, urged by insurance companies to provide only “medication checks” services, do not make full use of the biopsychosociocultural model in evaluating and treating patients.

Both Bodies under Siege and my 1989 article derived from my clinical experience. I attempted to bring together a lot of disparate information, adding my unique cultural perspective, and through my classification to present the universe of culturally sanctioned and deviant deliberate self-harm behaviors as an integrated whole. I believe that my approach has succeeded in several ways. It has provided clinicians with a framework for conceptualizing self-injury, albeit within the context of mental illness. I have never suggested that labeling deviant self-injury as a symptom is an endpoint, but rather have urged clinicians to make use in their formulations of the various explanations that I provided in their formulations. I specifically mentioned explanations such as positive and negative reinforcement, low tolerance for distress, inadequate coping resources, and self-harm expectancies even though these factors were not widely discussed in the self-harm literature of the 1980s. My approach also succeeded in calling attention to the phenomenon of self-injury and to the plight of chronic injurers, as well as in legitimizing the study of self-injury as a topic worthy of academic research.

Over the years, psychologists have become the main students of self-injury. Nock, for example, has taken the importance of positive and negative reinforcements in NSSI far beyond my relatively brief mention of them. His theoretical
model of the development and maintenance of NSSI is integrative and far more advanced than mine. I took the first major step and he has taken the second. He and others have clarified, expanded, and made explicit what was implicit in my work, and for this I am grateful. This is not to say that we now fully understand self-injury. As Nock (2009b) noted, his model is not entirely satisfactory in dealing with the comorbidity of NSSI behaviors and mental illness. Additionally, many of the vulnerability factors in his model are relevant to NSSI but also increase the risk of differing psychiatric disorders. “If NSSI and some psychiatric disorders share an etiologic pathway and represent different forms of behavior that can serve the same function, one is left wondering why some people select NSSI rather than another pathological behavior to regulate their affective and social experience.”

The short answer to the question “Why do patients deliberately harm themselves?” is that it counterintuitively provides temporary relief from distressing situations and from a host of painful symptoms, such as anxiety, depersonalization, and desperation. The long answer is that it also touches on the profound human experiences of salvation, healing, and orderliness. Self-injury is a morbid form of self-help. In the hands of special individuals who are able to control the behavior, it provides some benefit. However, the training, discipline, and courage needed to attain such positive results is not my cup of tea, nor would it appeal to most people. Self-mutilation and NSSI are nothing to trifle with. For individuals who cannot control the behavior, it provides short-term relief but at a great cost, such as the loss of an eye or unsightly scars. It is encouraging that new understandings of NSSI have entered into clinical treatment via cognitive, interpersonal, and dialectic behavioral therapies, but a breakthrough in biological treatments remains elusive.

The numerous examples of self-injury in this book are painful to comprehend. The culturally sanctioned modification rituals may seem strange at first glance, but they are no stranger than going to church and worshiping a crucified god. Bodies under Siege is more than a catalog of horrors. It goes beyond mere description to search for meaning. Ultimately, it celebrates not death but rather the will to live. It chronicles the struggle of humankind to maintain equilibrium in the face of adversity. Therefore, dear reader, empathize if you can with the poor souls who are the victims of self-injury, but save your grieving for the dead.