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# SELF-HARM IN PSYCHOANALYTIC PSYCHOTHERAPY – A PSYCHOSOCIAL CASE STUDY

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**self-harm**
**psychoanalysis**
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**Summary**

Presented is the case of a 17-years old girl engaging in self-harm since she started emancipation from the institutional care. The psychoanalytical analysis of self-harm taking into consideration the psychosocial context in which the emancipation took place, revealed that depressive episodes and anxiety states, especially the 'fear of falling apart' triggered self-harm symptoms, which were a progressive element of dealing with the separation-individuation process when deficits in the mental and environmental structure were parallelly present. This psychoanalytical case study shows the value of psychoanalytic thinking combining biopsychological and environmental perspectives and the practical utility of such a marriage.

## Introduction

Self-harm ("self-harm", "self-injury", "dermatillomania") belongs to those disorders which change the appearance of the skin and body [1] and is increasingly discussed in scientific reports as being a psychosocial phenomenon. The huge increase in its prevalence among adolescents and young adults, confirmed by research conducted in Poland [2] and the world [3, 4] has contributed to the widening interest of researchers in this intriguing disorder, which is now recognized as a disease [5], the basic mechanism of which is still being studied through the use of various psychoanalytical trends. In the first decade of the 20th century, self-harm was conceptualized according to the Freudian model of psychosexual drives. It was described as a symbolic substitute for masturbation [6] and partial suicide [7]. Presently, the attention of psychoanalysts has clearly shifted to the internalized process of the early relationship with the object [8–11], thus triggering a discussion in which the state of the skin and body became a paradigm for psychosocial thinking. This new direction refers to the earlier thought of Sigmund Freud, who noted that "The ego is first and foremost a corporeal body; it is not merely a surface unit, but is itself a projection of a surface" [12, p. 26], which derives ego from bodily

sensations, especially those coming from the surface of the body coming in direct contact with the environment, of which the external object is an important part. The primary object, on the one hand, can help the developing child's ego understand both its internal and external environment, protect the integrity of the sense of self and activate mental processes that enable the recognition and management of feelings, and, moreover, tolerance of frustration of differences, or as Wilfred Bion wrote in "Attention and interpretation" of "no-thing" [13, p. 19]. On the other hand, however, it can become an "obstructive object" [14, p. 90], *i.e.* one that unleashes destructiveness, hatred of objects and/or self and leads to the "dangerous inhibition of development" [14, p. 106]. According to Donald W. Winnicott [15, 16], for an adolescent balancing upon the line of biological and psychological development, the social environment is favourable if it ensures "holding"[1] [15, 16]. Good mothering fosters a favourable environment and "gives a sense of being held physically that is more real... than if a real holding or nursing had taken place" [17, p. 96-97].

In this light, the development of the subject's ego, the permanent tangling and untangling of the threads of one's own mental structure, and their unbinding and bonding with social threads is the process of creating a specific affective and relational pattern in the life cycle, based on a conceivable idea of reality and relationships. Self-harm in adolescence may be the manifestation of rapid discharge of affect, *i.e.* acting out [18], occurring in the context of a network of relationships with significant others. In other words, certain parts of the self and the object as well as specific types of relations are laid down within relationships, *i.e.* a process whose foundation is more action than thinking, *i.e.* the inverted "alpha function" described by Bion [14, 19–21]. In this sense, structural regression within the ego and the transformation of prepsychotic symptoms into psychobehavioural symptoms, *i.e.* the expression of separation fears by a repetitive desire or impulse to self-injure one's own skin or body, allows the adolescent to protect his living self despite damage accrued in the psyche (split self, no limits between self-object, lack of internalized object) or physical (wounds, body deformation), or social (role of the victim, perpetrator, patient, etc.) by maintaining a self-object relationship. The treatment of self-harm as the implementation of an obsessive-compulsive urge to repeat and regulate feelings that cannot be uttered [22] seems to correspond well with Freudian understanding of acting out as a "wild transference" [23], on the one hand driven by unconscious beliefs and desires (senseless even, strange and bizarre fantasies), and on the other illustrating the unconscious relational dynamics played out interpersonally and/or somatically in the current "playground" – a specific time and place, sometimes with violent and hostile transference reactions.

[1] „Holding", a term introduced and described by Winnicott referring to the bonding method through which a mother takes care of a child, which is the basis of the original idea of the object.

René Spitz [24, 25] was one of the first to take into account the social context, accurately describing the deprivational relationships between objects at certain critical periods in early childhood, leading to catastrophic effects[2] and impacting on the future development of children. He argued beyond a doubt that the deficit[3] in their development was associated with deficiencies in terms of the closest relationships (isolation from an important object and deprivation with regard to other social ties). In children whose need for contact with an important object was unrecognized and unfulfilled, the most commonly seen manifestations were anaclitic depression and auto-aggressive behaviours, with a possibility for their repetition in later life, in the form of difficulties in establishing and maintaining social bonds.

Nowadays, psychoanalytical case reports of self-mutilating individuals are increasingly pinpointing the key role of the mutual interplay between self and objects (the theory of the relationship with objects), and are thus, perhaps, moving towards the recognition of self-injury as a classic psychosocial symptom. However, the statistics – a negligible number of psychoanalytically analyzed case studies, taking into account not only the existence of a physical stressor (traumatic event) in early childhood, but also the current psychosocial predicament of the adolescent, which may exacerbate his susceptibility to self-mutilation[4], - alongside the question of scientific reliability – impose restraints on the formulation of such judgments and leave them squarely in the sphere of hypotheses which cry out for the undertaking of further research.

If self-harm is a form of play understood as a transfer in the relationship of an adolescent with significant others, *i.e.* the answer of the adolescent – the question arises – why and in what social network does it occur? The psychosocial matrix is a puzzle that this case study is trying to solve.

## Method

The use of psychosocial analysis, in the light of the psychoanalytical theory of the relationship with the object, was aimed at examining the patient's ego structure and the psychosocial network in which K. carried out her self-injury, facing up to the developmental tasks associated with progression into adulthood, *i.e.* problems in separation-individuation, intensifying anxiety and depression.

### Research Procedure

The patient was consulted several times, and permanent sessions of individual psychoanalytical psychotherapy twice a week with one therapist along with being in a social care institution created a projection surface for the representation of the parental object and stimulated the

[2] Complete disorder of social behaviour, signs of autistic and auto-aggressive behaviour, lack of interaction and relationships with others.
[3] "Deficit" - in other words the sense of lacking, the underdevelopment of some elements [26].
[4] Perhaps because of fear of being stigmatized for promoting an accusatory culture.

transfer process, which was subjected to analysis. Prior to consultations with K., several conversations with educational staff (care-givers, teachers) were conducted and her personal files were analyzed in order to outline relationship patterns with the objects and to expand the clinical material, which was then psychoanalytically analyzed [27–29]. Sources and variables are shown in Table 1.

Table 1. **Sources and variables used in the therapeutic procedure**

| Sources | Variables |
|---|---|
| Data from individual psychotherapy carried out under the conditions of a social care institution (observation and clinical interview with an adolescent) to determine the transference and countertransference | Feelings, ideas, and actions connected with the body |
| Data from the patient's personal file documenting biographical data and childhood behaviours connected with the body. | Hospitalism[5] |
| Data from interviews conducted with the pedagogical and psychological team, pertaining to, *e.g.*, staff attitudes, in order to determine the transference and countertransference | Feelings, ideas, and actions of staff |

**The patient**

A 17-year-old girl resident in a social care institution was referred to a therapist due to self-harming and many other psychosocial difficulties, such as her refusal to comply with school responsibilities and her plan for achieving independence. During contact sessions, K. was apathetic, very dissatisfied with both herself and her relations with peers and care-givers whom she angrily rejected, repeatedly saying "I do not need them". She was passive at school, not passing any class tests. K. met the diagnostic criteria for DSM-V borderline personality disorder, with mainly depressive episodes and feelings of hopelessness [5]. The interview revealed that the first episode of self-injury coincided with the beginning of the process of becoming independent, as did the occurrence of other psychosocial and psychiatric symptoms. At the beginning of the therapeutic consultation, the patient's skin was consistent with the typical signs of self-injury, with numerous scratches and wounds, especially on her thighs and forearms, which she hid under tight clothes. However, she did not require medical assistance.

[5] Otherwise known as anaclitic depression in children, which is triggered by lack of contact with the mother.

Biographical data

The patient had a long, 11-year history of neglect and abuse, starting from a very early age. She was born into a family with alcohol problems (both parents abused alcohol). Her mother left home and abandoned the family – her husband and children, when K. was 3 years old, and completely severed all contact with them. For the next 3 years, until the death of her alcoholic father, the patient remained under his insufficient care, together with her brother, who is 2 years older. At the age of 6 years, K. was placed in a social care institution and at the age of 11, she was transferred to a youth educational centre because of difficulties in fulfilling her schooling obligations. At the time of her referral to therapy, she had been in the YEC for 6 years and had been preparing to become independent for several months. Mood disorders, withdrawal, a sense of apathy, hopelessness and worthlessness, and difficulties in establishing social bonds had been diagnosed earlier in the patient, mainly in situations of environmental change (graduation from primary school and the beginning of junior high school; placement in the social care institution, then the educational institution). Analysis of personal files also showed that the symptoms of hospitalism, nodding, apathy, tearfulness, and lethargy occurred in the social care institution, and behavioural disorders with the subsequent change into the educational institution.

Psychosocial environment

Pedagogical and psychological staff informed the therapist that in contact, K. showed clear reluctance and resentment, became surly when increasingly censored and accused of a lack of involvement in her self-empowerment, which caused the care-givers and teachers to feel under attack as well as helpless. The staff of the institution had undergone mainly pedagogical and not psychodynamic training, which meant that K.'s resentment and difficulties were treated only as specific phenomena resulting from a negative attitude, undeserving of any deeper understanding (or study of their aetiology). In addition, a dispute arose within the team responsible for helping the girl develop her independence, about whether it is possible to effectively help a teenager by way of psychotherapeutic measures, and they split into two factions. The "pedagogical faction" insisted on the taking of more radical educational measures, while the "analytical side" argued for putting a stop to violent behaviour and focusing attention on providing the patient with a container (a secure social network), the function of which would be to contain her fears and enable the integration of the internal state of chaos with her emerging self and object representations, while supporting the development of her thought apparatus [14].

## Results

The initial phase of individual psychotherapy can be defined as the re-staging of an early traumatic episode – a “relational hole” – consisting of the sense of lacking an understanding object. A state of coldness, hunger, and uncleanliness experienced through a strong impression of tearing the continuity of the “skin ego”[6] [30, 31] is the source of the first fantasies about one’s self and the object. “Anzieu perceives the surface of the body – his skin – as a key and primitive component of the structures and functions of the mind” [32, p. 16]. According to Esther Bick, “skin self”, or “psychic skin” [33, 34] is a primary container and firstly, has properties that integrate different parts of self and integrate with the object, and secondly, is reductionist, because it encompasses the experience of a boundary and differentiation or separating various aspects of self from the object [34, 35].

K.’s strong anxiety, caused by her approaching inevitable return to her hometown, part of the process of becoming independent, “opened up old wounds”, extracting from the depths of unconsciousness a representation of an unnecessary, suffering self and a representation a cold, indifferent (destructive) object, leading to disorganization in her functioning. The patient experienced strong anxiety and uncertainty, clearly associated with the history of very early life trauma [20, 36], and difficulties in forming attachments [37, 38]. K. interpreted the procedure of becoming independent as an attack, a rejection, similar to rejection by her mother, which induced a state of depression and fear, in her opinion threatening her life. K. felt that, just as her mother once was, the care-givers were also now helpless to provide her with the necessary development in terms of holding and “containment”[7], typified through holding her in their arms (= in their minds) and accommodating fears and worries (the relatively stable, established largely by adherence[8] relationship with the object/environment was falling apart, threatening social disintegration and the breakup of her fragile self). The educational staff, focusing on the task of becoming independent, mainly offered physical care without the emotional sphere. There was no object, neither internal nor external, which would notice her terrified baby self or understand her needs or feelings, by taking into account previous traumatic experiences with the object (ego structural deficits). When K.’s negative feelings and baby self failed to find a “mental home” in the mind of the educational staff, K. began to self-mutilate, *i.e.* to play out her drama by abusing her own body [10]. The strong pressure and demands coming from her external environment caused her fragile mental structures to further fall apart, her depressive thoughts and feelings overwhelmed her, causing a prepsychotic state and a number of behavioural

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[6] “Skin ego” - the first narcissistic psychic envelope described by Didier Anzieu [32].

[7] "Containment" - a synonym for the process of accomodation, receiving projective identifications and described by Wilfred Bion in the mother-child diad [16–19].

[8] "Adherence" - a synonym for following and staying close to the object, *i.e.* the behavioural attachment system as an innate defense mechanism, discovered by John Bowlby [39].

disorders, including self-injury. In her opinion, actions taken by the pedagogical and psychological staff could never be sufficient to pull her out of the "relational hole" in which she found herself.

Self-harm was aimed at realizing the fusion desired by id[9] with the object, consisting of achieving actual and expected physical consequences [40]. K., engaged in specific behaviours (self-harm), symmetrical with specific actions – once it was her mother as the object and now a current external object – her care-givers, *i.e.* by way of response, she identified with the abusing, neglectful object and attacked/rejected her desperate self. The incision into the skin of the legs and hands gave the illusion of pseudo-independence and control, because in a concrete way it allowed for the denial of unacceptable feelings and the unacceptable splitting off of part of oneself, equated with the unacceptable partial object described by Bion as the "obstructive object"[10].

In other words, it can be said that the act of self-harming the body was based on the "primary thought process"[11], including the creation of a "second skin" by changing its texture and appearance and by the assuming of protective colours that repel bad objects and attract others. K. regulated her distance from the split object, and thus protected her own partial self and adapted to the environment/object[12], remaining in a primitive, superficial relationship with it, devoid of depth.

Regarding the increase in social requirements related to self-empowerment, in the absence of internal and external containment objects, which would have supported the development of "skin self", integrating different fragments of the patient's self, and differentiating the self from the object, the patient responded with depressive dejection and "fear of falling to pieces"[13] [34], and then with the commitment to self-injury, *i.e.* "she took matters into her own hands" (an all-powerful and narcissistic pseudo-independent form of defence in the "dermal/skin phase"[14] using muscle tension and the musculo-motor system to take protective actions (mimicry) in a disadvantageous environment. Behavioural focus on specific attempts to cope with the lack of a containment object, *i.e.* patching the "relational hole" in the ego and the environment through alternate self-injury and wound healing was paradoxically, a progressive state of emotional stabilization for K. Her deeply

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[9] Id - the primary system of mental organization, which is the source of ego and superego shaping [41].

[10] "Obstructive object" - in Bion's concept, an external object capable of containment projection and transforming "beta elements" (raw sensory sensations) into "alpha elements" (acceptable imaginations, feelings) [12, 14].

[11] "The primary thought process" in which thoughts are experienced in the form of things, events, or actions, and entire objects are separated and split, and then treated as if they were separate objects, without any problem and without any connection with the reality with which they are connected [29].

[12] "Mimicry" – a phenomenon well described in animals, especially insects; defensive adaptation in homo sapiens consisting of becoming similar (imitating appearance, color, smell, behaviour, or other features, due to adhesive identification) of a defenseless self to an object/environment, playing by recognizing its ability to protect the role of a guide in exploring the world.

[13] "Childhood unintegration status" [34, p. 485]

[14] "Dermal/skin phase" – as yet not described, probably one of the earliest stages in human emotional and mental development (prenatal period – 3 months old [33, 34]), preceding the oral phase in psychosexual development as described by Sigmund Freud, which consists of deriving pleasure from touch, from one's own skin, which allows for separation and opening as mechanisms to regulate distance and find a place near to or within the object.

depressing fantasies in the form of a near-delusional[15] belief about her sense of worthlessness ("I'm hopeless", "no-one needs me", "nobody wants me", "I'm just causing everyone trouble", "It would be better if I wasn't here") decreased. The patient felt a little freer from the attacks of her own rigorous superego. The outlined relational scheme was well known to the patient and constituted a new instalment of earlier humiliation through words and the use of her own self as a projection area in which aggressive fantasies were active long before she started to engage in self-harm, and which ultimately manifested her self-esteem problems upon the surface of her own skin, as a defence against falling apart – "You are dust and you will turn to dust" [43]. The other skin gave K. a greater sense of security and allowed for the finding of the object through "adhesive identification"[16] [34, 35]. The consequence of using adhesive identification by the patient was focusing on the skin (surface) and lacking a sense of depth within herself and in the object. The object was felt as an extension of the skin self, *i.e.* a flat space that required obsessive control, which prevented K. from perceiving herself as a young girl growing up, separate from the object. With such a primitive mental apparatus structure, ordinary projection, projection identification and introjection were not possible, but only imitation – acquiring object properties and acting out. K.'s relationship with objects was objective, as was her relationship with her own body. Her self became similar to the object by adopting its appearance, behaviour, and features assessed as protective from the point of view of survival of the self and social adaptation. It became clear that K's ego balances between extreme perceptions of the superego and id extremes and maintains "a bond with the historical reality of everyday life, by testing the insights, selecting elements of memory, directing the action and integrating the individual's ability to orient in other ways" [45]. In fact, the ego is highly dependent on the id[17], because it is the main source of energy, but the environment (the structure of the environment and the structure of the mind of the object) through constant interaction pushes the development of the ego in the correct or deviant direction. No action of the ego is accidental but it is guided by unconscious motives operating in a particular social context.

In the initial phase, the staff of the institution, under the influence of mutual transfer, denied the difficult feelings associated with K.'s independence, and succumbed to the child's desire to "hold

[15] "Delusions" - mental disorders present in psychoses and schizophrenia, concerning the content of thinking and consisting of falsehoods, misconceptions and judgments, characterized by resistance to all argumentation despite the presence of evidence indicating their falsehood [43].

[16] "Adhesive identification", a primitive form of relationship with an object taking place mainly at the skin level and providing a sense of consistency through constant contact with another external object [36, 37, 44]; a defense mechanism, used in infancy during the dermal/skin phase, involving various body muscles, verbal and perceptive abilities in undertaking actions that guarantee the experience of staying coherent and containerized; a method of distinguishing and gluing of the self and the object, and formation of a second skin.

[17] The action of the id is an uninterrupted and unconscious pursuit of immediate satisfaction of all egoistic needs and desires, regardless of the cost; motivates irrational and deviant or destructive effects of ego. According to Freud, the id activates defense mechanisms inherited by homo sapiens which were passed down from generation to generation during the phylogenetic development of the species (inheritance from ancestors).

on tight", which entailed not paying enough attention to her ego deficits – the lack of a "psychic skin" to separate herself from the facility and allow for the development of independence and separateness associated with adult functioning. With the metaphorical "plank in their eye," the educational staff were turned into "the obstructive object." When the educational team and the therapist began to deal with K more intensively, to better understand her emotionally and developmentally, the process of transforming [14] the very aggressive content of the patient's thoughts and ideas about her own self gradually began, because transference and countertransference had been understood. The transfer seemed to show that K. expected her tutors and then therapist to "hold her in their arms" and embrace her emotional states, and the team behaved (through projective identification) as overburdened, quarrelsome narcissistic parents (with a compulsion to repeat); more like a cruel God who bellows "get up and go". However, the therapist's gradual understanding of the countertransference experience allowed for better reintegration of the patient's chaotic experiences and understanding of the original mental process, so that a fairly solid foundation for necessary therapeutic cooperation was established, and the patient felt better able to study her instinctive desires in the light of their pre-Oedipal dynamics.

Despite numerous difficulties in coping with developmental tasks, K. gradually began to realize that the pedagogical and psychological team and the therapist cared about her, to the extent that the "improper procedure" of self-empowerment was extended to include individual psychotherapy in order to provide her with optimal care, adapted to her needs. However, due to the tenderness and primitiveness of defensive structures and the very traumatic relational situation in childhood (ego structural deficit), K. found it difficult to accept the requirements of a therapeutic technique and be able to see through insight what was happening to her. Nevertheless, she began to cope with her condition and crisis a little better. In the third month of therapy, she told of a dream she'd had during a longer therapeutic break because of a public holiday.

"I am in a damaged building, not a home nor a school, in my hometown, bombing is going on, I am terrified because I see only ruined houses and I try to hide somewhere. Then, the picture changes and suddenly, I walk around the city C [town where the educational institution is]. I look through the window of a glass building, like a factory or hospital, and see a woman speak to someone in a different language and I can't understand her."

At first, the patient did not have many associations, only remembering an episode from early childhood, when her mother burned her chest with boiling milk, which resulted in a visit to the hospital. Then, she graphically depicted the soreness of her skin covered with scabs, which took a long time to heal, and which she sometimes broke off. She returned to the present, mentioning the situation of a teacher who was very unpleasant and shouted at K. when she could not complete a task.

She went on to describe how her family home is in very bad condition because no-one has lived there for years, except for the homeless, and random "guests" and passersby committing acts of vandalism.

In my opinion, the transfer to the institution clearly shows that the first dream sequence represents the patient's psychological state, her self falling to pieces, with her damaged skin self identifying with the destroyed object/environment, and her difficulty in finding a calm, stable environment/object in the facility and during therapeutic sessions, who could have helped her make a mental effort and transform the baby self into a more mature self, and distinguish herself from the object, and thus give up the act of building a "second skin" (acting out). The patient rather experienced her home (the interior, facility, and therapeutic sessions) as a threatening and constantly destructive place with torn and damaged borders. The second part of the dream also had a transference aspect and represented the therapist in the form of a woman speaking in a different language which K. did not understand.

The illustrated pictorial sequence of the dream illustrated how biographical material and transference features overlapped. In the dream image, there were elements of processing maternal aspects of transfer to the institution and therapist.

In the further course of therapy, K's functioning was characterized by oscillation between depressive anxiety and despair, with a desire to engage in self-harm of the body, as well as recalling and overcoming early deficits and pre-Oedipal conflicts. The therapeutic process focused on working on the patient's countertransference defence and sought to establish cooperation with a more mature side of her personality, so that the patient could better see herself within the sphere of an adolescent young girl and accept herself as an adult – that is why the fear of separation and longing for a good object were containerized. When the patient left the institution, which brought the therapeutic process to an end, she seemed to be a little more reconciled to her fate, and her internal identification with her own self and images of good parents was just beginning to germinate, laying the foundation for better integration of her libidinal and aggressive impulses, which improved the functioning of the ego and social relations and could lead to a better and more satisfying life in the future.

## Conclusion

It should be emphasized that in K's individual therapy, important elements of her functioning were exposed: the structural ego deficit – lack of "skin self" – and an object relation based on adhesive identification and acting out with a non-internalized object, compensating for this deficit with a "second skin". In the initial phase of being flooded with an overwhelming sense of anxiety and depression due to separation from the object, the fragile defence of projection identification and adhesive identification collapsed and threatened to disintegrate the ego and break up the self and its ties with the object. With the development of behavioural symptoms in the form of self-harm, *i.e.*

with increased adhesion to the object and the formation of a "second skin", negative feelings and anxieties gradually disappeared. K. seems to have carried out her self-injury during the separation-individuation process to produce a "second skin" that firstly, was to protect self-cohesion and secondly to maintain integration with the environment/object. In addition, behavioural symptoms were defensive in the sense of "renouncing" weak, unacceptable aspects of the self-object and increasing the body's self-adhesiveness, allowing it to stick to the object/environment (finding hands that could ensure physical holding) that is part of the "second skin". The sense of rupture (separation) of the skin's self-aligned relationship functions as a permanent sensitivity and structural ego deficit that can hinder the development of an integrated representation of the self and the object, derail desire and attachment to the object, and lead to destructive behaviours, including self-harming illusions of the "second skin" and fusion with the subject. On the other hand, creating a "second skin" allowed it to at least partially separate from the object. After all, self-harming activities were coded by several factors[18] at once and went beyond single, one-dimensional psychodynamics.

Further research in this area of unconscious dynamics might answer the question of when does the condition of the skin affected by self-injury become only an epiphenomenon of the generalized psychobehavioural response from a biologically predisposed individual, and when does it point to a symptom of deviant development? It is, therefore, necessary to gather individual cases more intensively, utilizing information on the social background of self-mutilating people from different cultures, at different stages of the life cycle.

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[18] For example, drive conflict, conflict with an object, separation fear, fear of falling apart, fear of lack of affiliation, etc.

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