Self-Injurious Behaviour in Adolescence[i]

Athanasios Bazoukis, Secondary Education Teacher, Former Head of the Counselling Service, Secondary Education Administration, Prefecture of Pella

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Abstract

In this paper, which starts with the current definition of non-suicidal self-injury and then adopts a psychodynamic perspective, adolescents' various self-injurious behaviours are examined as an aspect or area of a wider range of behaviours, which includes, on the one hand, suicidal behaviours and, on the other hand, various body modification practices (e.g. tattoos, scarification). These are behaviours and practices that concern the subject/adolescent's relationship with their own body, a central factor of their identity, which is under formation, and a stage on which their internal conflicts are enacted. Adolescents' self-injurious behaviours are also a subset of violent behaviours, behaviours that involve an actual breach of the boundary of the body, of either the self or the other.

Keywords: Non-suicidal self-injury, suicidality, indirect self-injurious behaviour, self-harm by omission, self-harm by commission, psychic skin, self-preservative violence, malicious or sadistic violence, core complex, body modification, disavowal of and claiming ownership of the body, pulsion anarchiste

What is it that forces a young person to direct violence against themselves? What would stand as a responsible attitude of an adult, whether it be a teacher or counsellor, towards an adolescent who self-harms? How could this adult reconcile their willingness to accept as valid the adolescent's assurance that their intention is not to end their life with their own concern that the adolescent might at some point, through carelessness or loss of control, cause irreparable harm to himself/herself? How could an adult understand/explain the adolescent's tendency at other times to surround the details and consequences of his/her self-injurious behaviour in secrecy, and at other times to exhibit them, and also to participate in "communities" where experiences are being shared? These and other similar questions were the starting point of a very interesting journey, with unexpected stops along the way, through

which a network of routes was developed that broadened my own understanding of the human, and especially the adolescent, experience.

Non-suicidal self-injury: definition (Slesinger, Hayes, & Washburn, 2019)

According to the International Society for the Study of Self-Injury (ISSS), non-suicidal self-injury (NSSI) is defined as "the deliberate, self-inflicted destruction of body tissue that is not socially sanctioned and without suicidal intent". NSSI is a purposeful behaviour brought about by the individual that is being injured, it is not accidental nor is it done by another person. NSSI results in direct damage of human tissue, either soft (e.g., skin) or hard (e.g., bones). This criterion of tissue damage excludes from the scope of the concept a wider range of self-destructive behaviours that do not involve direct tissue damage, such as eating disorders, substance abuse or reckless behaviour. NSSI does not include injuries that are self-inflicted for cosmetic, religious or culturally significant reasons, such as tattoos, piercings, or other forms of body art or modification.

Moreover, this definition makes a clear distinction between suicidal self-injury and self-injury for other reasons. In DSM-5 tentative criteria are proposed for the recognition of NSSI as a separate diagnostic entity (*NSSI Disorder*), as well as of suicidal behaviour (*Suicidal Behaviour Disorder*).

The relationship of NSSI to suicidality (Muehlenkamp, 2014; Zareian & Klonsky, 2019)

NSSI differs from suicide attempts in several parameters, such as functions, type, variety and lethality of the methods used, frequency of occurrence and prevalence. Despite their differences, NSSI and suicide attempts often co-occur. Several hypotheses have been put forward to explain the association between NSSI and suicidality.

According to the gateway theory, NSSI and suicide attempts belong to a continuum of self-harming behaviour, of escalating severity, with mild tissue damage at one end of the continuum and attempted suicide at the other end. NSSI acts as a gateway to more severe self-injurious behaviours, paving the way for a suicide attempt.

Another hypothesis, that of an acquired capability for suicide, was proposed within the framework of the interpersonal-psychological theory of suicide (Joiner, 2005). According to this theory, a person will engage in suicidal behaviour only if he/she has both the desire to die by suicide and the capability to act on that desire. Joiner argues that the ability to die by suicide is acquired through repeated exposure to painful and provocative experiences. Repeated exposure to painful and provocative experiences leads to habituation, which, in turn, leads to greater pain tolerance and a sense of lack of fear about death. A history of child abuse, occupational exposure to death, a history of substance use or eating disorder behaviours resulting in self-inflicted harm, and NSSI can all be considered painful and provocative experiences.

Direct and indirect forms of self-injury

Hooley & St. Germain (2014) define indirect self-injurious behaviour (SIB) as purposeful behaviour that is a source of concern for clinicians or family members, occurs in repetitive

patterns (i.e., is not sporadic or context dependent), and which, in indirect ways, has the potential to compromise physical integrity and be harmful to one's body. According to this definition, individuals who abuse drugs and alcohol or who engage in severe eating-disordered behaviours (e.g., restriction, purging) would be classified as engaging in indirect SIB. Additionally, this broadened class of SIB also includes individuals who repeatedly engage in abusive relationships, as well as those who habitually and deliberately engage in risky or reckless behaviours. It could be argued that some types of self-harm occur "by omission" in the form of inadequate self-care behaviours (Turp, 2003). However, the suggestion to recognize direct SIB as a distinct and independent syndrome,favours a view according to which direct and indirect self-injury constitute distinct clinical conditions.

Turp (2003) suggests that self-harm should be conceptualized in terms of a continuum, with 'good enough self-care' at one end and 'severe self-harm' at the other. This conceptualization provides for an intermediate area that both connects and separates self-harm from 'normal' behaviour and includes various culturally acceptable self-harming acts/activities (Favazza, 2011), which have a specific role and meaning, functioning as rites of passage or signifying identification with a group or subculture (e.g., tattoos, scarification, piercing), or are associated with religious practices (self-flagellation). A third category of culturally acceptable self-harming acts, which includes everyday, ordinary actions and behaviours that may nevertheless result in injury or illness, such as smoking or chronic overwork, reminds us that the question of the boundary between normal, albeit flawed, self-care and actual self-harm has no definitive, a priori answer.

Turp (2008) points out that the capacity for self-care emerges smoothly through the internalization of adequate 'maternal' care - in quotation marks because it is not always or exclusively provided by the mother - and that inadequate 'maternal' care is associated with a reduced self-care capacity and a higher risk of self-harm. Clustering and co-variation of forms of self-harm by commission and omission in clinical populations suggest that the dynamics underlying the different forms of self-harming behaviour are, in general, similar.

She also argues that the concept of the psychic skin, introduced by Esther Bick (1968, 1986), provides a theoretical framework for understanding both self-harm by commission and self-harm by omission: toughened psychic skin is associated with self-harming behaviours by commission, while porous psychic skin (Briggs, 1998) is associated with self-harming behaviours by omission. The concept of the psychic skin is an eloquent metaphor. The physical skin, when healthy, allows messages from and to the external world to be received and transmitted (in the form of a variety of tactile sensations and sensations of hot and cold), while at the same time maintaining a boundary between what is inside and what is outside the individual. In the perspective opened up by the concept of the psychic skin, the communication of the inner with the outer world depends on the degree of psychological sensitivity, permeability and resilience. When the degree of permeability and resilience is appropriate, the individual is able to accommodate the emotions of others without being "flooded" and at the same time communicate his or her feelings to others without losing the sense of a private inner space. The person that engages in self-harm by commission feels that they are in a state of painful emotional isolation, numb and walled-off, and desperately seeks to escape, to feel real. Self-harm offers a temporary relief, as physical pain or illness restores a sense of normality and connection to self and others. The person with porous psychic skin gives the impression that they lack a sense of taking the initiative for action and that their

ability to take care of themselves is limited. They may neglect health issues or be accident prone or unable to protect themselves from misbehaviour by others. In the therapeutic relationship, they seem open to communication and available to accept something of what is being offered. However, the evolution of the therapeutic relationship shows that what was initially accepted has once again leaked out, without contributing to the construction of an internal object.

A hypothesis

Turp's proposals served as a bridge to psychoanalytic approaches to self-injurious behaviours in adolescence, approaches that provided the main orientation of this work. They also provided a theoretical basis for organizing the presentation of these approaches, according to a hypothesis/proposal, aiming at a more global understanding, that self-injurious behaviours are an aspect or area of a broader spectrum of behaviours, which includes, on the one hand, suicidal behaviours, and on the other hand, various body modification practices (e.g., tattoos, scarification). These are behaviours and practices that concern the subject/adolescent's relationship with his/her body. Self-injurious behaviour, as violence perpetrated by the subject on himself/herself, has been considered an aspect or subset of violent behaviours, behaviours that involve an actual breach of the boundary of the body, but with an emphasis on the underlying mental representation or phantasy that motivates the violent act. Some hypotheses have also been formulated as to what differentiates the direction of violence, towards the other or towards the self.

The body as a focus/locus for violence

Laufer (1995) raises the question of what happens mentally from puberty onwards that makes some young people particularly vulnerable to suicide. One of the conclusions he reaches is that the war experienced by the suicidal adolescent always involves the sexually mature body as one of the central enemies, or at least as one of the main sources of feelings of abnormality, madness or worthlessness.

Glasser (1995) suggests that we can identify two major types of violence. Self-preservative violence is caused by any threat to biological survival (self-preservative violence is associated with the standard 'fight or flight' response) and, more commonly, by any threat to an individual's psychological integrity. The second type of violence, malicious or sadistic violence, is intended to inflict physical and emotional pain, but without completely destroying the object of violence (the clearest example of malicious violence is sexual sadism). He also argues that psychological or emotional sadism is a derivative of physical sadism, which is more primary, and that sadistic violence occurs as a result of the sexualisation of self-preservative violence. Assessing the nature of the violence the adolescent inflicts on themselves can lead, as Glasser argues, to a prediction of the likely outcome and to the appropriate organization of therapeutic care. If violence has characteristics of the malicious/sadistic type, the behaviour has a self-punishing quality. If violence is of the self-preservation type, survival is likely a matter of good fortune. Suicidal adolescent directs their psychologically self-preservative, behaviourally self-destructive violence against their own body, which they experience as a

source of frightening impulses, or against internalized figures, which they experience as internal persecutors.

Glasser (1996) has also proposed the concept of the 'core complex', an acute psychological impasse, in which the subject, despite possessing a very strong desire to merge with the object, fears that if they achieve the merge, they will be absorbed by the object and lose their individuality, and if they do not, they will be driven to mortal decay. The notion of the core complex has a central place in the analysis of suicidal (Campbell & Hale, 2017) and self-injurious (Gardner, 2001) behaviour within the British psychoanalytic approach of object relations.

Fonagy & Target (1999) argue that habitual violence either towards the other or towards the self may reflect a failure to respond to the fundamental need of each infant to be 'mirrored' and 'contained', to discover its mind in the mind of the object. This failure may result in the other person's mind, with its distorted, absent or malignant image of the child, becoming part of the child's own sense of identity. This image becomes the seed of a potentially persecutory object that is grafted onto the self, but remains alien and unassimilable. Paradoxically and tragically, every subsequent attempt at separation leads to a movement towards fusion: the more the individual attempts to become themselves, the closer they come to becoming the object, since the object is part of the structure of the self. Developmentally, the crisis erupts when the external demand for separateness becomes inexorable, in late adolescence and the early years of adulthood. In those periods, self-destructive and, at the extreme, suicidal behaviour are perceived as the only possible solution to an insoluble dilemma: the liberation of the self from the other through the destruction of the other within the self. A person's attacks on their own body constitute a desperate attempt to clarify the distinction between their own sense of themselves and the object's sense of them. The unconscious phantasy of the individual may be that ideas reside in the body, therefore manipulations of the body have an impact on them, can establish their presence or nullify (expel) them.

Bateman (1999) elaborates on the earlier distinction between thin-skinned and thick-skinned narcissistic states (Rosenfeld 1987) and argues that, as the subject oscillates between these two states, violence may emerge either toward the other, if thick-skinned elements are in the foreground, or toward the self, if thin-skinned elements predominate.

Disavowal of and claiming ownership of the body

Fonagy & Target (1999) point out that subjects who self-harm, because of incomplete structuring of the self, partially disavow ownership of their bodies: they endure the pain of self-harm because they have separated the psychological representation of the self from the representation of the bodily state. Suicide, moreover, could be considered as the paramount, the ultimate option of disavowing the body. The issue of claiming ownership of the body - the movement that compensates for a feeling of alienation from the body - is acutely posed by the various methods of body modification (cosmetic surgery, permanent marking of the skin with tattoos, piercings and scarification). Body modification was studied from a psychoanalytic perspective by Lemma (2010).

Lemma describes three unconscious phantasies that she has observed in her clinical work with people in whom the (urge for) body modification has become compulsive. Of the

three phantasies the most relevant to self-injurious behaviours seems to be the phantasy of reclaiming the body, which involves the expulsion from the body of an object that is experienced as alien or contaminating. The subjective experience consists of a feeling of being possessed by the object, which is felt to be lodged in the body and from which the self must be liberated. Body modification, when motivated by the reclaiming phantasy, is the means by which the individual reassures themselves that they are indeed separate from the other and defends themselves against the wish to merge with the other.

In cases where the reclaiming phantasy is enacted through markings of the skin (tattoos, piercings, scarification), Lemma draws our attention to the question of the symbolic control of the body and the function of pain. Skin markings become significant not only in terms of the final, visible product, but also in terms of the process of physical transformation. Scar tissue or sore skin are tangible signs that the subject has endured pain, and visible evidence of a process of transformation or even 'healing', from which the subject emerges stronger or more “authentic”. In some cases, skin markings facilitate an experience of giving birth to a new self - which means that they are underpinned by a phantasy of self-creation (the self-made phantasy) - and the pleasure that the subject derives from caring for his/her wounds alludes to the pleasure that the mother derives from caring for her new-born.

Self-harm as request and as language (or script)

In Motz's (2009, 2010) view of self-harm, the central thesis is that self-harm is a sign of hope addressed to an environment that can respond to this message and bear its meaning, and that it functions as a call to a longed-for other to see, hear and respond to despair. Motz argues that Winnicott's (2016) description of the hope underlying the antisocial tendency applies equally to self-harm. Self-harm expresses something that cannot be 'spoken' and thought about and inscribes a narrative in the body itself.

Straker (2006) points out that people who self-harm feel a difficulty, a deficiency in terms of language, although they may be characterized by eloquence. The difficulty concerns communicating emotions in a way that creates the experience of intersubjectivity, on which the subject's experience of being understood is based. Failure lies not in the use of words per se, but in the perceived ability of words to reflect lived experience, to create shared mental states. Self-harm is a form of self-mirroring, a desperate attempt to get the inside out in a form that is visible and therefore can be known and contained, contributing to regulation of affects.

Self-destructiveness operating to free the self

By this heading, I attempt to summarize a dense and evocative text by Gerasimos Stephanatos (2016) regarding the "extreme" and self-destructive behaviours of adolescents. In this writing Stefanatos demonstrates the theoretical utility and clinical application of the concept of the anarchist drive (pulsion anarchiste), introduced by Natalie Zaltzman (1998).

The anarchist drive constitutes a particular, distinct version of the death drives. It is a force of disconnection, struggling against the unifying aspirations of the life drives. As separating and disconnecting, it liberates from suffocating libidinal bonds and narcissistic illusions and contributes, under certain conditions, to survival. In a liminal situation for the subject, only a resistance emanating from the subject's own death drive forces can counter the threat of annihilation and underpin self-preservation.

When the subject resorts to testing the thresholds and degrees of endurance of the body, it seeks an escape from the intrapsychic domination of another. Stephanatos reminds us that, initially, the activity of testing the boundaries of physical and biological endurance is in the service of self-preservation and individuation. It is only when the death drives have performed their intrapsychic separative work, that the physical and biological boundaries are mentalized and the subject does not need to verify the existence and preservation of these boundaries in the realm of reality, and indeed of physical reality. When, however, verification takes on the character of a repetitive compulsive testing, the results become self-destructive.

The adolescents' risk-taking behaviours converge with the operations of the anarchist drive, but also pose real risks to the adolescent's own life. Stephanatos' evocation of the concept of the anarchic drive opens up an invaluable anthropological and therapeutic perspective. He invites us to recognize that "expressions of the death drive do not always and everywhere constitute a factor of morbidity".

Conclusion

Stephanatos' writing summarizes various considerations that permeated this paper: the association between self-harm and suicidality, the relationship between indirect and direct forms of self-harm, the developmental dimension of self-harming behaviours, and body image in adolescence. It seems that most questions raised by adolescents' self-injurious behaviours remain open, certainly in the realm of the therapeutic encounter. I would not wish this claim to be taken as a demonstration of intellectual inertia and convenient avoidance of an attempt to unify the various psychodynamic hypotheses (which, as far as I understand, are complementary to one another), much less as an evasion of the need for a rigorous scientific investigation of these behaviours. I only wish that this paper has highlighted the challenges that any consistent effort to care for the adolescent who self-harms must take on.

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