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DISSOCIATION, TRAUMA AND SELF-HARM

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The presented analytical review considers the main approaches to the relationship between dissociation, trauma and self-harm. This relationship is functionally complex and depends on many variables. In regards to trauma dissociation and self-harm are (1) defense mechanisms, activating to traumatic cues; (2) destructive pathological self-regulatory modes. Meantime functional links between dissociation and self-harm reveal two tendencies: anti-dissociation (regaining control) and dissociation-inducing (rejecting one's feelings). Dissociation is widely considered a mediator between trauma and self-harm. At the same time psychological mechanisms, such as emotion regulation and body rejection, exert significant influence on pathological post-traumatic development. We discuss the psychopathological aspects of the links between trauma, dissociation and self-harm in borderline personality and eating disorders. We also take note of the gender- and age-related peculiarities of these issues.

Keywords: dissociation, trauma, self-harm, borderline personality disorder, eating disorders, emotion dysregulation, body rejection.

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ДИССОЦИАЦИЯ, ТРАВМА И САМОПОВРЕЖДАЮЩЕЕ ПОВЕДЕНИЕ

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В аналитическом обзоре рассмотрены основные направления исследований связи диссоциации, травмы и самоповреждающего поведения. Эта связь функционально сложная и зависит от многих переменных. В отношении травмы диссоциация и самоповреждающее поведение выступают: 1) как защитная реакция на травматическое событие; 2) как деструктивный, патологический способ саморегуляции. В свою очередь, функциональные связи диссоциации и самоповреждающего поведения определяются двумя тенденциями: антидиссоциативной (восстановление контроля) и диссоциативной (отказ от чувств). Во многих исследованиях диссоциация определяется как медиатор связи травмы и самоповреждающего поведения. Наряду с этим значительное влияние на патологизацию посттравматического развития оказывают психологические механизмы эмоциональной дисрегуляции и неприятия тела. Психопатологические аспекты связи диссоциации, травмы и самоповреждающего поведения рассмотрены на примере пограничного расстройства личности и расстройств пищевого поведения. Также описаны некоторые половозрастные особенности исследуемой проблемы.

Ключевые слова: диссоциация, травма, самоповреждающее поведение, пограничное расстройство личности, расстройства пищевого поведения, эмоциональная дисрегуляция, неприятие тела.

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Dissociation is defined as "a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" [7, p. 291]. Its origins vary, but the leading one is being exposed to a traumatic event or subsequent stress [1; 2; 11; 48; 49]. Traumatic stress is rooted in extreme events that pose danger to life and health, have a strong negative impact and require extraordinary effort to cope with their consequences [6]. Physiological and psychological adaptation in these circumstances can occur via peritraumatic dissociation, that is, a set of subjective experiences, including alterations in the perception of time, place and oneself during or immediately after traumatic exposure [2; 49].

Dissociation gives rise to a wide array of subjective experiences, ranging from absorption when some aspect of consciousness is singled out and the others are blocked, to loss of autobiographic memory and control over one's emotions, thinking and behavior [2; 32; 48]. Dissociative symptoms are commonly categorized into positive and negative ones. Positive symptoms are characterized by undesirable intrusions into consciousness and behavior (e.g., flashbacks). Negative symptoms refer to the feeling of losing control over mental functions that are otherwise available and controllable (e.g., dissociative amnesia) [47].

Grounded in the traumatic nature of dissociative phenomena, the theory of structural dissociation proposes two more types: psychoform (mental) and somatoform (bodily) dissociation [2]. The former implies disintegration of psychological structures (cognitions, affects, memory, identity, behavior) and the latter refers to disintegration of bodily functions, sensations, and movements.

In addition to dissociation the consequences of traumatic exposure include self-harm, and many researchers consider these phenomena interlinked [16; 17; 23; 25; 37; 45; 48; 60]. Self-harm (SH) is defined as socially unacceptable behavior aimed at causing oneself physical harm and including non-suicidal self-injuries and suicide attempts [4; 5; 26; 37]. Non-suicidal self-injury is the most prevalent form of SH* [5; 26; 37]. It manifests as deliberate damaging of the body surface (self-cutting, pinching, scratching, burning, etc.), posing no immediate damage but once it becomes regular it can leave scars and welts and turn into a common behavioral pattern in emotionally painful situations.

* According to the results of our study in the Russian community sample (N=706, mean age = 21.11; SD = 4.97) 3.7% were frequently self-cutting and 16% engaged in self-cutting at least once [5].

Self-harm fulfills both intrapersonal [4; 26; 38] and interpersonal functions [4; 25; 46]. Psychological trauma, particularly child maltreatment, predicts both non-suicidal self-injuries and suicide attempts [50; 51; 59], while dissociation mediates this relationship [15; 17; 23; 51].

Initially emerging as defense reactions to traumatic experiences, in unfavorable circumstances, especially in the presence of psychopathology, e.g., borderline personality disorder or eating disorders, dissociation symptoms and SH take on the functions of psychological self-regulation [3; 30]. These disorders are highly comorbid; exposure to trauma is considered an etiological factor for both of them [12; 14; 44; 58].

Links between dissociation, trauma and SH are studied in various contexts: with regard to the functions of SH [17; 26; 38; 51], the mediating role of dissociation [17; 45; 50; 51; 60], and the impact of emotion dysregulation [17] and body rejection [8; 9] on the development of dissociation and SH.

The goal of this review is to summarize and systematize the results of different studies (reported in research papers, systematic reviews, meta-analyses, and others) in the functional framework discovering the meanings of the links between trauma, dissociation, and SH.

Dissociation and Trauma

Dissociation can arise as a result of traumatic stress from maltreatment and witnessing violence in the family, including physical, sexual, emotional abuse and neglect [2; 27; 49; 53; 54; 58]. In reaction to hostile treatment from caregivers a child forms insecure (disorganized) attachment defined as “the unusual approach–avoidance response patterns of an infant toward a caregiver who should be the source of safety and security, but is also simultaneously the source of fear and threat” [2*].

Dissociation mechanisms help an individual survive the trauma and distance him/herself from fear and anxiety, especially in childhood, as children are more often than not physically incapable of defending themselves or fleeing. As a reaction to a threat, they can exhibit both peritraumatic sympathetic

* The translated paper uses the quote from the original publication: Van der Hart O., Nijenhuis E.R.S., Steele K. The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization. New York: Norton, 2006. 418 p. The original paper quotes the Russian translation of the book [2].

dissociation (flight reactions manifest as anxiety, fight reactions – as anger and acting out) and peritraumatic parasympathetic dissociation (tonic immobility, lack of voluntary movements, de-afferentiation pains, etc.) [48]. In time peritraumatic dissociation becomes maladaptive, activating inappropriately in response to emotional threats or situations triggering traumatic memories [48; 54]. Dissociation's prolonged functioning as a way of coping with stress impedes the ability to cope with problems in the present [48] and increases the risk of developing psychopathology.

The Dual Link between Dissociation and Self-Harm

SH can develop along with dissociation both on the level of symptoms and the functional level. The former implies that their development is determined by underlying traumatic exposure and both of them constitute attempts to adapt to the traumatic situation at first, and maladaptive coping with its consequences later on. The latter implies that both of them take on psychological functions. For example, SH turns out to be a way of controlling states of dissociation, stopping them and thus returning the ability to control feelings, perceptions and bodily sensations, or on the contrary, it can initialize dissociation to cease negative affect and escape traumatic memories.

In their meta-analysis Calati et al. note that both non-suicidal self-injuries and suicide attempts correlate with higher indicators of dissociative experience and dissociative disorder in clinical settings, and the power of these links leads them the suggest the existence of the transdiagnostic dissociative type [13]. Ford and Gomez point out that dissociation isn't just a mediator of the link between traumatic experience and suicidal behavior; it has a greater and a more specific input than other types of psychopathology; it is also as a rule related to impulsivity and avoidant behaviors within the complex post-traumatic personality disorder [22]. According to the systematic review by Edmondson et al., the link between self-harm and dissociative experiences is confirmed in 48% of quantitative studies and 38% of qualitative ones [21]. Stronger dissociation positively correlates with more severe SH (both more frequent and various in methods of infliction and locations of injuries), moreover, these correlations are yielded both on the symptomatic and functional levels [15; 28; 45]. The most prevalent type of non-suicidal self-injuries, self-cutting, is linked to neglect, attempts to regulate affect, dissociation as a defense from overwhelming emotions and social disintegration of personality [16; 20; 54].

Functions of Self-Harm in Relation to Trauma and Dissociation

Back in 1996, Robin Connors described four functions of SH in connection to trauma:

1. Re-enactment of the original trauma, its literal or symbolical recreation, when self-harm is used to experience physical pain and stage the traumatic event using one's body;

2. Expression of feelings and needs, when self-harm is a way of liberating negative affects (anger, disappointment, guilt, shame), punishing oneself and communicating emotional pain and the need for comfort;

3. Reorganization of the self, restoration of physiological and emotional balance/homeostasis through self-harm, when the sight of one's blood is comforting, tension is relieved or significantly decreased and the feeling of being in control of one's affects and sensations arises;

4. Management of dissociative process, when inflicting self-harm either ceases or initiates dissociative states [18].

In fact, the aforementioned functions constitute the ways in which SH psychologically regulates traumatic experiences. Recently there has been an increase in studies investigating the regulatory functions of SH (not only in the traumatic context). In particular they distinguish between its inner- and interpersonal functions [26; 38]. Innerpersonal functions include ceasing dissociation and decreasing negative emotions [26], whereas interpersonal functions help regulate relationships with others, get help and support, attract attention and establish closeness. Meanwhile, trauma remains one of the main etiological factors in the development of SH. For example, child maltreatment is considered a distal factor of vulnerability to non-suicidal self-injuries [38].

The mechanisms linking dissociation and SH are fairly complex and not always clear [16]. Černis et al., the authors of one of the latest systematic reviews on the relationship between dissociation and SH, conclude that it's difficult to define, whether self-harm is used to cause dissociation or to avoid it, citing different conceptualizations of the term *dissociation* and different methods of its assessment as an explanation [16]. This leads to differentiating between two functions of self-harm in relation to dissociation.

The anti-dissociation function of self-harm implies that it is used as a way of overcoming dissociative states [26] – that is, numbness and detachment from reality. Emotional and physical stimulation generates the feeling of being alive [16; 18; 21; 25]. The more severe the trauma, the more frequently self-injuries take on the anti-dissociation role [22]. For example, in the study on 86 ado-

lescents with borderline personality disorder dissociative symptoms positively correlated to the frequency of self-injury; in particular, dissociation, identity disturbances, and feeling of emptiness were related to interpersonal functions of self-injury (e.g., establishing boundaries, seeking autonomy, bonding with peers), whereas intrapersonal functions, including anti-dissociation, were employed more frequently when emotion dysregulation was endorsed [46].

Dissociation-inducing function implies that self-harm initializes dissociation as a way of getting rid of overwhelming experiences [21; 48]: in this case, self-harm helps cease any feelings and reach the state of numbness. Dissociation is a component of the fear response that helps relieve tension and emotional discomfort associated with the initial stages of fearful arousal and active defense [49, p. 111]. Nevertheless, this way of relieving tension can elicit stress due to cognitive impairments and altered state of consciousness (loss of control) [32], which increases the risk of psychopathology and further traumatization. According to John Briere, dissociation symptoms can lead to further trauma, when individuals with dissociation become more vulnerable to interpersonal violence due to reduced vigilance [11].

Fig. 1 shows the summarized functional paths of overcoming trauma through maladaptive mechanisms, namely, dissociation and SH.

We tried to name the functions in such a way as to reveal the chief mechanism instigating dissociation and/or SH. The two common mechanisms regulating the development of the link between dissociation, trauma, and SH are adapting to trauma and developing psychopathological symptoms. In the first case, dissociation emerges as a defense reaction to traumatic exposure; it helps the individual distance from trauma for the price of psychological/somatic disintegration. SH can become a way of ceasing dissociation (thus taking on the anti-dissociation function in the framework of adapting to trauma).

In the second case, SH and dissociation start to regulate emotions and behavior in a destructive (pathological) manner with no regard for the threat of trauma. Here self-harm takes on the dissociation-inducing function and dissociation takes on the regulating function (managing emotions and behavior), which can lead both to the increase in psychopathological symptoms and to high-risk behavior in interpersonal relations and repeated exposure to trauma.

Thus, the links between trauma, dissociation, and self-harm may have various functional roles in the framework of post-traumatic development in general:

— Dissociation helps the individual distance from trauma, but it comes hand in hand with symptoms of psychological and somatic disintegration;

— The individual self-harms to regain self-control and the feeling of integrity;

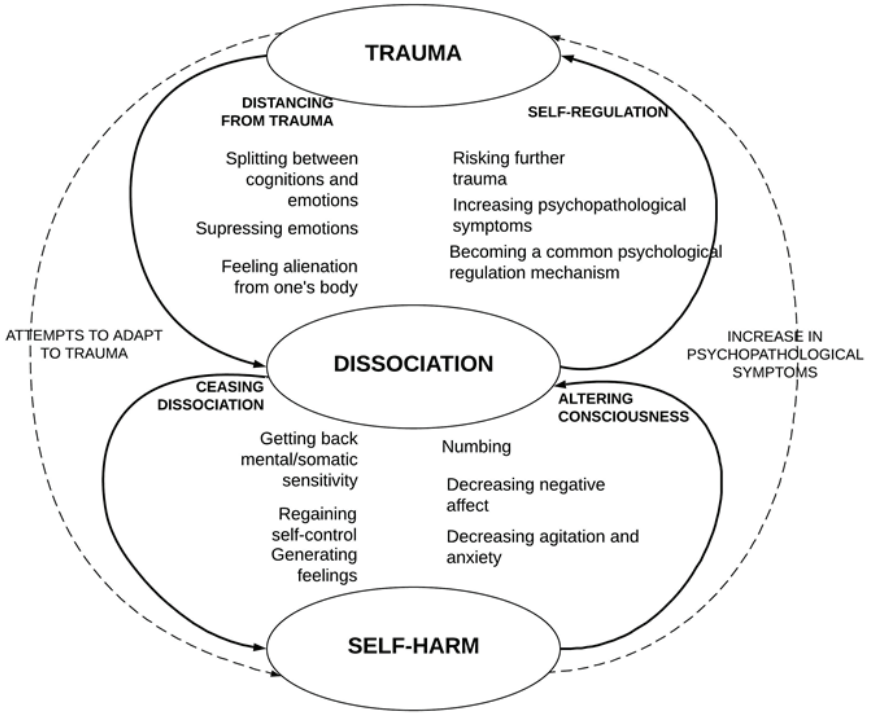

Fig. 1. Functional links between dissociation and self-harm in the context of the traumatic experience

— However, self-harm may increase negative trauma-related experiences; actions associated with self-harm may also be experienced in an extremely negative fashion, therefore self-harm becomes a way of ceasing overwhelming emotions, thus transforming from a reaction to a function;

— This may lead to more severe forms of dissociation, when it's functioning as a destructive method of self-regulation, thus increasing the risk of psychopathology and further traumatic exposure.

Dissociation and Self-Harm as Symptoms of Psychopathology

The clinical assessment of the links between dissociation, trauma, and SH encompasses a large circle of disorders including borderline personality disorder (BPD) and eating disorders (EDs) [30; 32; 42; 47]. The combination of

traumatic etiology with current dissociative states and self-injuries is indicative of the severity of psychopathology. For patients with BPD dissociation is related to more severe impairments of neuropsychological functions and for patients with EDs to the frequency of binging [32]. The prevalent type of dissociation in BPD is psychoform dissociation [55] and in EDs it depends on the specific type of the disorder. Patients with anorexia are more prone to depersonalizing associated with body schema disturbances and patients with bulimia to amnesia, time perception distortions, and involuntariness [32]. Patients with binge eating disorder are characterized by an increase in both psychoform and somatoform types of dissociation compared to healthy controls and patients with diagnosed obesity without EDs [40; 41].

The symptoms of dissociation in patients with EDs are exacerbated by traumatic experiences. Studies show that the history of physical abuse is linked with all types of EDs; sexual abuse with bulimia nervosa and binge eating disorder [14]. The urge to get rid of negative emotions and traumatic memories leads to dissociation and loss of control over eating behavior and eventually to binge eating. At the same time, the binge itself may block negative experiences and cause dissociation to elevate negative traumatic states [57].

Patients with binge eating disorder endorse more traumatic events in childhood than healthy controls; they also report more parental emotional abuse and neglect than obese patients without EDs [40]. In this case, food emerges as the external mechanism of self-regulation that allows managing affects, modulating the intensity of emotional states, and avoiding traumatic memories and painful experiences [44]. The similar results were yielded in other studies too: emotional abuse in childhood leads to the development of EDs [12].

Self-injuries in patients with BPD and EDs are rather frequent. For example, Pérez et al. note the high rate (83.7%) of patients with BPD who self-injured more than five times in a lifetime [42]. The most severe self-injuries, located on breasts and in the genital area seem to be unique to women with BPD who survived childhood sexual abuse [33]. According to the results of the meta-analysis, 27.3% of patients with EDs had a history of non-suicidal self-injuries, the number being higher for bulimia (32.7%) than for anorexia (21.8%) [19]. The most frequent non-suicidal self-injuries in this group of disorders are self-cutting and self-hitting [43].

Emotion Dysregulation and Body Rejection

Emotion dysregulation and body rejection increase the risk of SH and the occurrence of dissociative symptoms in trauma survivors [8; 11; 35]. Their de-

velopment is determined both by the severity of trauma and the lack of the necessary level of development and the corresponding integration of cognitive abilities and emotional and behavioral skills that help cope with the consequences of traumatic exposure [8; 59]. As maladaptive psychological mechanisms they can characterize chronic trauma [8; 9; 16; 17; 32; 59] and mediate the links between traumatic situations, dissociation, and self-harm [8; 30; 33; 34; 57]. Fig. 2 shows the hypothesized psychological pathways of the development of these links (fig. 2).

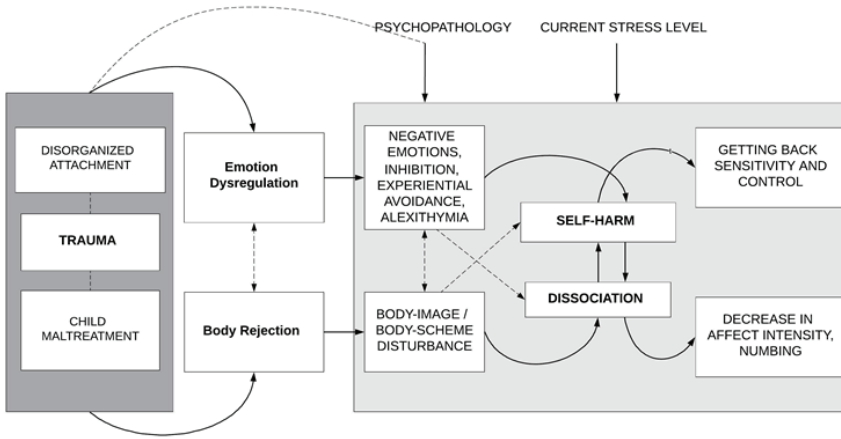

Fig. 2. The development of links between trauma, dissociation, and self-harm: hypothesized pathways

We shall now examine these maladaptive mechanisms and their input in dissociation and SH development in more detail. Body rejection* is characterized by disturbances in both body-image and body-schema [8; 59]. Based on Gallagher's studies Ataria distinguishes between body-image and body-schema, defining them as differing although interconnected systems. Body-image is a system of notions about one's body including perceptions, beliefs, and attitudes, and body-schema is a system of sensorimotor capabilities, managing without either being brought into awareness or monitored by perception [8]. Self-harm

* We use *body rejection* as an umbrella term for various types of body-image and body-schema disturbances, such as body disownership, body dissatisfaction, disownership of parts of the body, rejection of certain features of the body, and self-objectification.

related to body-image disturbances is aimed at claiming ownership and taking control of one's body. Body-schema disturbances lead to self-harm aimed at numbing the body, thus lessening traumatic experiences [8]. In the former case self-harm is a way to cease dissociation, in the latter, it helps reach dissociation, which substantiates the coexistence of anti-dissociation and dissociation-inducing functions of SH.

Self-injuries related to body rejection are characteristic both of patients with BPD and EDs. Body dissatisfaction can reach high intensity when the body is perceived as a hated object [34]; such objectification along with body-image disturbances [57] causes dissociation and self-harm becomes the way out of it [30; 43]. On the other hand both in EDs and BPD self-harm is determined by emotion dysregulation and aimed at overcoming acute emotional tension, distress, anger, even at the cost of giving up feelings altogether; this way self-harm leads to dissociation.

Emotion dysregulation refers to under- or over-regulation of affect [55; 56]; impaired identification and understanding of emotions, alexithymia, experiential avoidance or emotion suppression, high emotional sensitivity, reactivity, and low tolerance to frustration [27]. Under-regulation of affect refers to limited capability to decrease the intensity of the affect, including impulsivity and difficulties in goal-directed behavior (e.g., anger growing into fury). Over-regulation of affect implies that an individual rejects his/her emotions (e.g., he/she experiences profound emotional emptiness) [55].

Emotion dysregulation in various forms (avoiding painful emotional experiences, suppressing emotions, anxiety, alexithymia) leads both to dissociation and self-injury [36; 39]. For example, emotion suppression in patients with BPD and EDs leads to experiential avoidance and dissociation which increases their tolerance for pain during self-injuring [36]. Patients with anorexia nervosa endorse maladaptive emotional schemas, namely defectiveness, shame, subjugation, and social isolation, more often than the controls; they also experience troubled emotional awareness and clarity and use maladaptive strategies of emotion regulation (avoidance, negative problem solving style, rumination, emotion suppression) more frequently [39]. Emotion dysregulation was also discovered to be a partial mediator of the link between emotional abuse and subsequent symptoms of EDs [12].

BPD patients display two interconnected forms of emotion dysregulation and dissociation: (1) inhibitory experiencing states (over-regulation of emotions in connection to negative dissociative symptoms – e.g., amnesia, numbness) and (2) excitatory experiencing states (under-regulation of emotions in

connection to positive dissociative symptoms – e.g., intrusive traumatic memories) [56]. Trauma more often results in the development of the second form of emotion dysregulation, the latter in turn leads to psychopathological symptoms (in particular, BPD) [55].

Emotion dysregulation manifestations in young people with BPD symptoms (including SH) positively correlate to the following functions of non-suicidal self-injuries: negative affect regulation, anti-dissociation and self-punishment [46].

Thus emotion dysregulation can lead to self-injuries carried out on the peak of negative affect (anger, fear, anxiety). Painful emotions decrease through self-harm, which results in dissociation, manifesting in emotional numbness and feeling of relief. On the other hand, self-harm is carried out to generate emotions and to overcome the state of emptiness and numbness. In case of body-image disturbances self-harm is attempted to overcome disintegration and take control of the body (anti-dissociative function), and in case of body-schema disturbances it is used to cease somatic sensations and emotions – e.g., fear and pain (dissociation-inducing function).

Gender- And Age-Related Peculiarities of the Links between Dissociation, Trauma and Self-Harm

Different studies define gender- and age-related peculiarities of the links between dissociation, trauma, and self-harm in the context of trauma severity and the salience of its psychopathological consequences, as well as the age of traumatization and gender. Childhood trauma is extremely harmful to mental development [54]. The younger the child, the less mature are his/her psychobiological structures and hence the more severe are the consequences for his/her mental health [2; 48; 54].

Parenting style leading to disorganized attachment emerges as a predictor of dissociation symptoms in various age groups including adolescence and youth [2, p. 113]. Empiric data verifies that disorganized attachment in infants associated with maternal alienation predicts dissociation symptoms in adolescence [31].

Maternal dissociation and emotion dysregulation are closely related to dissociation in preschoolers and elementary school children [29] – thus parental models of emotion regulation increase the possibility of similar models developing in children.

A study conducted on a sample of children aged 3–6 (N=297) and their caregivers showed that the type and number of traumatic events and caregiver's traumatic history and psychopathological symptoms predict the development of psychopathological symptoms in children including dissociation [24]. Traumatic experiences (e.g., maltreatment, violence in the family or loss of a caregiver) during the sensitive developmental stage in early childhood may result in a wide range of symptoms in young children including PTSD and trauma-related dissociation. It was discovered that girls develop posttraumatic disorders with comorbid dissociation two times more frequently than boys, and sexually abused children three times more frequently than non-abused/emotionally abused children [24].

Sexual abuse is one of the most severe factors of traumatization that leads to the development of dissociation and self-harm as well as many other negative somatic and psychological symptoms; it is suggested that these links are transgenerational, based on the finding that children born to women who were abused in childhood are more likely to be abused [52]. 62% of adolescent girls (aged 13–17) who had been sexually abused as children self-injured at least once, and 37% of those who self-injured very frequently had clinical levels of dissociation [20]. Meanwhile, dissociation was observed to decrease with the passage of time in sexually abused girls, but not in boys [10].

The links between sexual abuse and self-harm, emotion dysregulation and dissociation are also endorsed in adolescents in the juvenile justice system (N=525, aged 12–18) [17]. In this sample sexual abuse was reported by nearly half of the girls, but less than 10% of boys. Girls with a history of sexual abuse demonstrated more proneness to non-suicidal self-injuries than boys (controlled for sexual abuse factor) [17].

In adulthood the victims of childhood abuse experience PTSD symptoms, depression, anxiety, BPD and EDs, as well as severe difficulties in interpersonal relationships with family, partners, in the professional settings; they poorly cope with acute and chronic stress. According to the results yielded by Swannell et al. on a large population sample (N=11423, aged 18–100), various types of child maltreatment predict non-suicidal self-injuries in adults differently [51]. In women, physical abuse and neglect increase the probability of non-suicidal self-injuries, whereas in men only physical abuse does. The link between child maltreatment and self-injuries in women is mediated by self-blame, and in men by dissociation. The authors interpret this as a result of gender differences in socialization – in case of failure men learn to suppress emotions, and women internalize blame [51].

Conclusions

The links between dissociation, trauma, and SH are complex, and at times conflicting, which can be explained by the specifics of mental development in the conditions of traumatic exposure and its consequences, as well as co-occurring psychopathological symptoms and psychological dysfunctions. Therefore it is crucial to assess and interpret the functional roles of these links. These functions can signify adaptation attempts emerging as reactive poorly differentiated defenses in traumatic situations, or associate with psychopathological maladaptive mechanisms replacing healthy adaptive psychological regulation pathways in no relation to the actual threat of trauma.

In our opinion, the least systematized and studied issues in this area concern the influence of emotional abuse and neglect on dissociation and SH development in population samples of various ages and genders. Currently, an abundance of persuasive data was yielded for the contribution of sexual abuse in psychopathology development, including dissociation symptoms and SH, but similar studies on the consequences of emotional abuse are sporadic. Evidence on the development and maintenance of the links between emotional abuse, dissociation, and self-harm is also lacking. In our opinion, there's also a need in studies focused on emotional and sexual abuse experienced by boys and men, as we are currently still largely restricted by culturally propagated beliefs on the masculine restraint, secrecy, characteristic avoidance and suppression of emotions. Further empirical studies are needed to confirm or disprove these beliefs.

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