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ADOLESCENT SELF-INJURY IN THE CONTEXT OF CONTEMPORARY PSYCHOPATHOLOGY AND PSYCHOTHERAPY

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self-injury
non-suicidal self-injury (NSSI)
self-aggressive behaviors in adolescents

Summary

Self-aggressive behaviors, including non-suicidal self-injury (NSSI), constitute a growing clinical concern among adolescents and young adults. The increasing prevalence of these behaviors in this age group highlights the need for in-depth diagnostic and therapeutic reflection. The aim of this review article is to systematize current knowledge on the phenomenon of self-injury within the framework of contemporary classifications of mental disorders, such as the DSM-5 and the ICD-11, which in recent years have begun to distinguish NSSI as a separate diagnostic entity requiring further empirical investigation and refinement of diagnostic criteria. The article presents the clinical characteristics of self-injurious behaviors, including the diversity of their forms, course, frequency, and associated psychopathological symptoms, such as anxiety, depressive disorders, and personality disorders. The functions of self-injury are discussed, and epidemiological data concerning the prevalence of NSSI in adolescent populations are reviewed. Furthermore, risk factors are identified, including traumatic experiences, attachment disorders, impulsivity, impaired emotion regulation, and the presence of comorbid mental disorders. The second part of the review focuses on theoretical models explaining the etiology of self-aggressive behaviors, with particular emphasis on psychoanalytic perspectives, which conceptualize NSSI as an expression of intrapsychic conflict and unconscious aggression directed toward the self.

Introduction

Self-injurious behaviors are increasingly observed in the population of adolescents and young adults. The following literature review discusses this phenomenon from the perspective of the classification of mental disorders. It then presents the clinical picture of self-injury, its functions, as well as its prevalence among adolescents and associated risk factors. The second part describes theories explaining the development of self-injurious behaviors, with particular emphasis on psychoanalytic theories that address the phenomenon of autoaggression.

Background

The literature on self-aggressive behaviors contains a wide range of terms used to describe them, including self-injury, self-harm, self-wounding, self-destruction, autoaggression, and suicide. These terms are used to refer both to acute forms of the phenomenon (e.g., suicide) and to less drastic manifestations, which may appear in the form of addictions, neglect, or engagement in risky behaviors.

Depending on the adopted socio-cultural norms, self-injurious behaviors may be regarded as either normative or deviant. An example is body art, such as professional tattooing or piercing, in which the cultural understanding of what is considered acceptable bodily modification and injury has been broadened.

Psychiatrists and psychologists point out that self-injurious behaviors are increasingly observed among young people and often constitute a phenomenon that is difficult to classify unequivocally. Particularly relevant in the context of adolescence is the issue of accurately distinguishing normative behaviors, appropriate for age, gender, and cultural context, and not serving an emotion-regulatory function, from suicidal and self-destructive behaviors that require therapeutic intervention. The need to define the boundary between normative and pathological behaviors has therefore contributed to the development of research on the mechanisms and risk factors of self-injury, which has subsequently been reflected in diagnostic classifications [1–6].

Self-injury from the perspective of mental disorder classifications

In the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) [7] published by the American Psychiatric Association, self-injury is defined as socially unacceptable, intentional damage to one's own body that results in bleeding, bruising, or pain and is undertaken in order to reduce psychological distress. It is understood either as one of the symptoms occurring in association with emotional and developmental disorders of various etiologies or with personality disorders, or as a separate nosological entity referred to as non-suicidal self-injury (NSSI).

In the DSM-5 classification, separate diagnostic and coding criteria are provided for non-suicidal self-injury (NSSI) and for suicidal behaviors, referred to as Suicidal Behavior Disorder (SBD). These criteria are presented in Table 1 and Table 2.

Table 1. **Diagnostic criteria for non-suicidal self-injury (NSSI) according to the DSM-5 [7]**

1) Within the last year, the individual has, on at least five days, engaged in intentional self-inflicted damage to the surface of their body likely to cause bleeding, bruising, or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will result only in minor or moderate physical harm (i.e., without suicidal intent).

Note: The absence of suicidal intent has either been stated by the individual or can be inferred from the fact that the individual repeatedly engages in behaviors that they know, or have learned, are unlikely to result in death.

2) The individual engages in the self-injurious behavior with at least one of the following motivations:
   a) seeking relief from negative feelings or psychological states,
   b) attempting to resolve interpersonal conflicts,
   c) seeking to induce a positive feeling state.

Note: The anticipated relief or response is experienced during or shortly after the self-injury, and the individual may display patterns of behavior suggesting dependence on repeated engagement in self-injury.

3) The intentional self-injury is associated with at least one of the following:
   a) the presence of interpersonal conflict or negative emotions or thoughts (e.g., depression, anxiety, tension, anger) in the period immediately preceding the act,
   b) preoccupation with the intended behavior in the period immediately preceding the act,
   c) recurrent thoughts or ruminations about self-injury.
4) The behavior is not socially sanctioned (e.g., tattooing, body piercing) and is not limited to scab picking or nail biting.
5) The behavior or its consequences cause clinically significant psychological distress or impairment in functioning.
6) The behavior does not occur exclusively during a psychotic episode, delirium, intoxication, or withdrawal syndrome and cannot be better explained by another mental disorder or medical condition (e.g., autism spectrum disorder, intellectual disability, Lesch–Nyhan syndrome, stereotypic movement disorder with self-injury, trichotillomania, or excoriation/skin-picking disorder). In individuals with neurodevelopmental disorders, the behavior is not part of a pattern of repetitive stereotypies.

Table 2. **Suicidal behavior disorder (SBD) according to the DSM-5 [7]**

1. A suicide attempt has occurred within the past 24 months (a suicide attempt is defined as an act carried out with at least some intent to die at the time the act was initiated).
2. The act does not meet the criteria for non-suicidal self-injury (NSSI).
3. This diagnosis is not applied to suicidal ideation or preparatory acts (suicidal tendencies).
4. The act was not carried out in a state of impaired consciousness.
5. The individual was not motivated by political or religious reasons.

Current Suicidal Behavior Disorder (SBD): less than 12 months since the most recent attempt. SBD in early remission: 12–24 months since the most recent attempt.

The primary factor differentiating NSSI and SBD in the DSM-5 is intent. Non-suicidal self-injury (NSSI) is distinguished from suicidal behaviors, which are acts carried out with the individual's intent to cause death (Table 2). Frequency and lethality of the acts are also relevant – although not included in the formal criteria, they are observed in clinical practice. NSSI is typically associated with low-lethality forms of self-aggression, such

as biting, hitting, burning, or scratching. Self-injurious acts with suicidal intent generally involve higher-lethality methods, such as drug overdoses or wrist cutting. NSSI occurs significantly more frequently than SBD [7].

In the International Classification of Diseases and Related Health Problems (ICD-10) [8], self-harm is coded as "intentional self-harm" (X60–X84), which includes both non-suicidal self-injury and suicide attempts. In the previous edition, DSM-IV [9], as in ICD-10 [8], self-injury also appears as one of the symptoms of borderline personality disorder. The prevailing view among researchers and clinicians has been that self-injury should be understood as a symptom of Axis II disorders. However, findings from recent studies do not fully support this perspective. They demonstrate that self-injury occurs in adolescents and young adults at a much higher frequency than borderline personality disorder in the general population. More than half of adolescents hospitalized in psychiatric units for self-injury do not meet the diagnostic criteria for Axis II disorders, and self-injury can also co-occur with Axis I disorders, suicidal thoughts and behaviors, or serve as a strong predictor of future suicide attempts [4–6].

A comparison of DSM-5 and ICD-11 [7, 11] shows that in both classifications, self-injury is treated as a symptom occurring as part of other diagnoses. Self-injurious behaviors can also be divided into impulsive and compulsive types, as illustrated in the tables below.

Table 3. **Comparison of the occurrence of impulsive self-injury in ICD-11 [11] and DSM-5 [7]**

ICD-11 and DSM-5 impulsive self-injury	
ICD-11	DSM-5
• co-occurring symptom	• co-occurring symptom • a separate nosological entity: non-suicidal self-injury (NSSI) (section of disorders requiring further research)

Table 4. **Comparison of the occurrence of compulsive self-injury in ICD-11 [11] and DSM-5 [7]**

ICD-11 and DSM-5 compulsive self-injury	
ICD-11	DSM-5
• Trichotillomania • Dermatillomania • Onychophagia Body-focused repetitive behaviors (BFRBs)	• Trichotillomania • Dermatillomania • Onychophagia Obsessive–compulsive and related disorders

Clinical presentation of self-injury

Non-suicidal self-injurious acts commonly include cutting the skin of the arms and hands, legs, and less frequently, the face, using knives, scissors, or other sharp instruments. Other forms may involve burns from hot water, steam, or various chemical substances; hitting oneself; banging against walls; or striking one's head against hard surfaces. Additional types of self-injury include scratching, picking at healing wounds, stabbing or piercing oneself, biting, pinching, hair-pulling, rubbing, inserting sharp objects under the skin or into body orifices, and taking medications in doses exceeding therapeutic levels. Other behaviors may involve swallowing sharp objects or harmful substances. The most prevalent forms of self-injury are:

- cutting the skin: 70–90%
- hitting oneself: 21–44%
- burning: 15–35%

Individuals who engage in self-injury often use more than one method. Women more frequently engage in cutting and scratching, whereas men are more likely to burn themselves. Self-injuries most commonly occur on the hands, wrists, forearms, upper arms, thighs, and abdomen [5, 6, 12–14].

In the literature on self-aggression, various classifications of self-injury can be found. For example, Eckhardt [12] distinguishes between overt and covert self-aggression:

- overt self-aggression involves cutting oneself with sharp objects, hitting various objects, or exposing oneself to burns,
- covert self-aggression refers to a mental disorder characterized by feigning symptoms of illness to gain material and/or psychological benefits. This may manifest as hidden self-injury or factitious disorder.

Favazza [cited in: 12] uses three categories of self-injury:

- major self-injury, such as limb amputation or self-castration,
- stereotypic self-injury, occurring, for example, in individuals with autism spectrum disorder,
- superficial or moderate self-injury, most commonly observed among adolescents.

Favazza further subdivides this last category into compulsive self-injury, such as trichotillomania or nail-biting, which is often ritualized and repeated multiple times a day, and impulsive self-injury, such as cutting or burning, which occurs episodically or repeatedly.

Suchańska [1, 16] divides self-aggression in a manner similar to Favazza [cited in: 12], distinguishing between direct and indirect forms. Direct self-aggression involves intentional attacks on one's own body and/or life. The acts may be carried out with varying levels of awareness of their consequences and are not culturally or socially accepted. Behaviors included in this category are:

- major self-injury – amputations, eye-gouging; occurs in psychotic states or severe intoxication;
- stereotypic self-injury – rhythmic head banging, finger biting; these behaviors are harmful to the body, follow a consistent pattern, and are observed in organic syndromes and acute forms of mental disorders;
- superficial/moderate self-injury – the most common form; it can take a compulsive form (e.g., hair-pulling, scratching to relieve tension or prevent some perceived danger) or an impulsive form, which is further divided into: Episodic – shallow cutting, hair-pulling and Chronic (recurrent) – similar methods to those observed in the impulsive form, but occurring with greater intensity and often forming part of the individual's identity.

Indirect forms of self-injury include:

- active behaviors – actions with visible negative health consequences, such as substance abuse or engagement in dysfunctional risky behaviors, e.g., speeding while driving or casual sex;
- passive behaviors – various forms of neglect, including medical, dietary, or hygiene-related neglect.

Walsh, in turn, classifies NSSI according to the potential lethality of the act, the mode of action (direct/indirect), and whether the self-injury occurred once or repeatedly [1, 3, 6, 14–17].

Functions of self-injury

Self-injurious behaviors most often occur during periods of intense emotional tension and frequently follow a sudden, unexpected impulse. This phenomenon primarily affects individuals in early adulthood. It may represent a reaction to major life problems, growing up in a family marked by violence, or a lack of care and support. Common triggers also include difficulties related to one's sexuality and experiences of peer victimization. Young age contributes to this phenomenon because coping skills for managing psychological stress are not yet fully developed, which can lead to self-aggressive behaviors. Self-injury may serve as a means of gaining control over one's body and as a way to express independence and identity [12–14, 18].

The literature identifies various functions of self-injury, including:

- affect regulation,
- alleviation of negative emotions, such as anxiety, guilt, loneliness, or anger,
- restoration of a sense of reality in response to periods of dissociation or depersonalization,
- prevention of suicidal behavior,
- influencing others,

- establishing boundaries of the self,
- self-punishment or punishing others,
- expressing traumatic experiences or re-experiencing trauma,
- inducing emotions in situations of inner emptiness.

Adolescents who engage in self-injury more often rely on maladaptive stress-coping strategies (e.g., avoidance), exhibit low self-esteem, higher impulsivity, and more frequent experiences of negative emotions and dissociative states [4, 5].

Prevalence of self-injury among adolescents

Self-aggressive behaviors fall within the clinical domain and may co-occur with borderline personality disorder, suicidal behaviors, and substance overdoses. Estimating the true scale of self-injury is further complicated by the fact that most acts of self-aggression do not require medical intervention and therefore are not recorded or captured in statistical analyses. Adolescents often conceal self-injury, claiming that their injuries resulted from accidents or incidental cuts. Assessing the prevalence of self-injury in the general population is particularly difficult due to the lack of sufficient research in non-clinical groups. Available studies conducted in various countries suggest that self-injury primarily affects adolescents and young adults (approximately 13–42%), with prevalence decreasing with age (about 4–6% in adults). Self-injury is considerably more frequent in clinical populations of adolescents, with estimates ranging from 40% to as high as 80%. Żechowski and Namysłowska [19] note that the number of individuals engaging in self-injury is rising in both general and clinical populations. Gmitrowicz, Warzocha, and Pawełczyk [20] emphasize that 27% to 47% of adolescents hospitalized in psychiatric units engage in self-injury. Studies by Pawłowska and colleagues [4] conducted in high schools indicate that 13.7% of adolescents aged 16–19 engage in self-injury, including 15.7% of girls and 6.9% of boys [4, 5, 13, 14].

Non-suicidal self-injury (NSSI) typically begins during adolescence and most frequently occurs between the ages of 12 and 15, while suicidal thoughts and behaviors usually emerge later. Adolescence is therefore considered a period of increased risk for self-injury. These behaviors may be initiated by the adolescent themselves or influenced by peers, and the average duration is about two years. Most researchers report that NSSI is more common in adolescent girls than boys, with girls more frequently engaging in cutting and boys in hitting. However, some studies have found no association with gender, cultural factors, or socioeconomic status [5, 6].

Risk factors

Risk factors for the emergence of self-injury include abnormal personality structure and the presence of mental disorders. In clinical samples of adults with borderline per-

sonality disorder, self-injurious acts affect 50–78% of patients. Onset of symptoms is typically reported in late childhood or adolescence, which is likely indicative of maladaptive personality development [5]. Research over the past two decades has shown that self-injury often co-occurs with other personality disorders, including antisocial, histrionic, avoidant, dependent, and obsessive–compulsive types, as well as with externalizing and internalizing disorders in children and adolescents. A further risk factor is a sense of hopelessness [5, 6].

It is estimated that approximately 24–63% of adolescents who engage in self-injury exhibit conduct disorders, and 14–60% additionally use psychoactive substances. Among adolescents who self-injure, higher rates of anxiety disorders, affective disorders, suicidal thoughts and attempts, attention disorders (with or without hyperactivity), and eating disorders have been observed, along with an increased incidence of post-traumatic stress disorder [4–6].

Family conditions and traumatic experiences also constitute significant risk factors. The strongest predictors include unstable or traumatic relationships with close caregivers, disrupted attachment, early separation from caregivers, parental divorce or the death of a parent, excessive parental criticism, lack of support from significant others, alcohol problems in the family, childhood traumatic events, physical and/or sexual abuse, and peer victimization [4, 5].

A meta-analysis conducted by Hamza and colleagues [cited in: 6] shows that NSSI is a significant predictor of suicidal thoughts and attempts. Some studies also confirm a relationship between the frequency of NSSI and suicide attempts, while others suggest that NSSI can predict future suicide attempts more effectively than suicide attempts predict NSSI.

Identifying risk factors in adolescents is therefore a crucial part of diagnosis, risk assessment, and subsequent therapeutic interventions. Individuals who engage in self-injury exhibit a higher risk of developing psychiatric and emotional disorders and are more likely to experience impairments in psychosocial functioning [6].

Factors that reduce the risk of self-injury include stable attachment patterns, a multigenerational family and a satisfying social support network, good academic and occupational functioning, adequate financial resources, cultural and religious background, effective use of leisure time, and institutional support [5, 17].

Some studies also describe NSSI as a protective factor against suicidal behaviors. In the anti-suicide model, self-injury is viewed as an attempt to avoid destructive outcomes by redirecting suicidal tendencies into non-lethal self-aggression. In this context, acts of self-injury serve a regulatory function in response to intense emotions and help prevent suicide. Self-injury allows young people to reduce the intensity of suicidal thoughts [6].

Theories explaining the development of self-injury

For many years, there has been an ongoing discussion regarding the mechanisms underlying self-injury. To better understand these mechanisms, it is useful to refer to theoretical

constructs and empirical research that conceptualize the functions of self-injury and the mechanisms that maintain these behaviors [5].

The Experiential Avoidance Model (EAM) is based on behavioral theory and the mechanisms of classical and operant conditioning. It assumes that self-injury serves to regulate affect, which subsequently leads to the development of a maladaptive method of coping with tension. Self-injurious acts are intended to eliminate difficult emotions, and these behaviors are reinforced by the experience of relief and relaxation. The longer the strategy of avoiding and suppressing difficult emotional experiences is used, the more automatic it becomes, eventually appearing as a response to any emotional arousal. Difficulties in emotion regulation, high emotional reactivity, and low tolerance for distress contribute to the emergence and maintenance of maladaptive coping strategies involving self-injury. This model, however, does not take into account the social context of self-injury [5].

The Emotional Cascade Model (ECM) complements the EAM by adding a cognitive component. The ECM is based on the assumption that individuals develop strong tendencies to ruminate on distressing events, which leads to an escalation of difficult emotions such as sadness, anxiety, and anger. This, in turn, increases sensitivity to subsequent negative stimuli and intensifies both rumination and distress. Through a mechanism of positive feedback loops, this process may result in the development of what is termed an emotional cascade, which remains largely outside the individual's control and significantly prolongs the time needed to return to a baseline emotional state. Individuals with personality disorders, particularly borderline personality disorder, tend to trigger emotional cascades in response to almost any negative event. They often find it difficult to employ normative coping strategies for managing tension, such as distraction, shifting attention, or seeking social support, and therefore may resort to destructive behaviors, such as self-injury. Research supports the usefulness of the ECM in conceptualizing self-injurious behaviors [5].

In the biopsychosocial model, Walsh considers the interconnections between various aspects: environmental, cognitive, affective, behavioral, and biological. The author emphasizes the role of the patient's personal and family history (the environmental aspect). Triggers for self-injury include current environmental circumstances, such as conflict or the loss of a loved one, problems at school, or observing another person engaging in self-injury [3, 5, 13, 17].

Biological aspect

Some studies indicate that the opioid system plays an important role in the development of non-suicidal self-injury. One explanatory model assumes that during an act of self-injury, endogenous opioids are released, producing analgesic effects and reducing stress levels. Another model suggests that individuals who engage in self-injury have a higher baseline level of endogenous opioids, which leads to greater pain tolerance and facilitates self-aggressive behaviors. In an integrated model of self-injury, a deficit in endogenous opioids is understood as a consequence of chronic stress experienced in childhood (resulting from

abuse, neglect, or loss) or as a biological predisposition. This deficit is associated with an inadequate opioid response to stress. As a result, individuals may engage in self-injury in order to increase opioid levels and restore homeostasis. Researchers also point to the possibility of abnormalities within the reward system and differences in the regulation of pain responses [3, 5, 13, 17].

Self-injury from the perspective of psychoanalytic theories

Sigmund Freud [22, 23], in his psychoanalytic theory, described unconscious defense mechanisms whose function is to protect the individual from internal conflicts and anxiety. Self-injury can be understood as one such mechanism. According to Freud's theory, individuals experience conflicts between three structures of the psyche: the id, governed by instincts; the ego, representing the realistic component of the psyche; and the superego, associated with moral standards. When the ego can no longer cope with the tensions and anxieties generated by these conflicts, defense mechanisms emerge, such as repression, projection, or regression. Self-injury may be interpreted as a form of regression, that is, a return to earlier and less mature ways of responding to stress. In this view, individuals cope with emotional pain through direct and physical behaviors rather than through more mature defense mechanisms [22–24].

According to drive theory, in which Sigmund Freud distinguished the life drive (Eros) and the death drive (Thanatos), self-injury may be understood as a manifestation of aggression that cannot be directed outward and is therefore turned toward the self. It can also be interpreted as a compromise between the life and death drives, leading to a postponement of the death instinct, whereby the impulse toward self-destruction is weakened [22–24].

Another defense mechanism described by Freud is projection, in which an individual transfers their own unacceptable emotions or impulses onto other people. A person who is unable to accept their negative emotions may direct them toward others; however, by splitting the body and the psyche, they may also project anger onto their own body in the form of self-injury. Self-injurious behaviors can therefore be understood as an attempt to externally express internal conflicts [24].

In 1938, Karl Menninger [cited in: 13] identified three components in self-injury and suicide: the wish to kill, the wish to be killed, and the wish to die. Psychoanalysts argue that individuals who engage in self-injury experience difficulties with aggression, both directed inward and outward. Mollon [cited in: 13, p. 71] writes: "A person who deliberately cuts their skin enters an intimate world of omnipotence, where they are both the persecutor and the persecuted. Overwhelming rage is thus released into the body, which is then punished for having become the victim of violence."

It is also worth referring to Melanie Klein [25]. She developed the theory of internal objects, which emphasizes the way a child forms internal representations of their earliest objects (caregivers). These internal representations (so-called internal objects) may be both positive and negative. When adequate physical and emotional needs are not met, the child

may experience intense anxiety and aggression that cannot find expression in the external world. As a consequence, these anxieties and aggressive impulses may be directed toward the self, which can lead to the development of self-injurious behaviors [24, 25].

Klein also described the paranoid-schizoid position, referring to an early phase of a child's psychological development during which they experience intense anxieties, such as the fear of being destroyed by "bad" objects. In this phase, the child experiences a separation of the "good" object from the "bad" and develops defense mechanisms to cope with these extreme internal representations. Self-injury can therefore be understood as a form of internal projection of anger and anxiety, representing an attack on the self in response to perceived hostility directed toward external objects.

As the child develops, they progress into a more advanced phase known as the depressive position. At this stage, the child begins to integrate the positive and negative aspects of their objects, which is associated with feelings of guilt, sadness, and longing for the "good" object. During this phase, the child may experience very intense emotions, such as fear of loss, separation anxiety, fear of abandonment, or feelings of rejection, which can lead to self-aggressive impulses. Through self-injury, feelings of terror are alleviated, and the reality of death is denied. Patients are often unable to tolerate the mental or physical absence of the mother and cannot endure the awareness that the mother's mind may be preoccupied with thoughts not focused on them. This can provoke feelings of rejection, anger, and despair. It is suggested that individuals who engage in self-injury may have formed early relationships with a mother who was not "good enough" during early childhood.

Glosser [cited in: 16, p. 74] describes the development of the self-injury symptom as follows: during the paranoid-schizoid phase, the child is consumed by a fantasy of fusion with the ideal mother. However, the image of the mother remains split, meaning that alongside the good, idealized object, there is also a representation of a greedy, threatening, or indifferent mother. This gives rise to two types of anxiety: fear of engulfment and fear of rejection, the latter resulting from separation. Characteristic defense mechanisms emerge in response. As a result of anxiety, aggression is maintained within the child, oscillating between the need to destroy the bad object and the need to protect the good object. This aggression is further stimulated by the child's inability to discharge it. There is also fear of one's own perceived omnipotent aggression and anxiety about the fragility of the object. The defenses that develop redirect aggression toward the self, activating whenever circumstances reminiscent of early trauma arise. This can explain intense emotional reactions to situations that objectively pose no threat. During adolescence, the problem of separation naturally reemerges, producing ambivalent feelings and potentially contributing to self-injurious behaviors. Self-injury is thus both a defense and a form of communication about the inner world of objects, the experience of harm, internal structure, and everything the self-injuring individual cannot verbalize. Self-injury may be associated with attempts to express intense, unconscious emotions or to manage internal conflicts [13, 16, 24, 26].

Melanie Klein emphasized that early experiences are crucial for shaping defense mechanisms, and consequently for adult emotional life and related difficulties. If a child

experiences intense fears of abandonment or rejection, they may respond externally (aggression toward others) or internally (self-aggression, including self-injury). Unstable or anxiety-laden early relationships may lead the child to develop internal images of "bad" objects, resulting in despair and frustration. This process reflects the normal developmental trajectory from the paranoid-schizoid to the depressive position. Within this theoretical framework, self-injury can be understood as a way of expressing unmet aggressive impulses toward external objects, which the child redirects destructively toward the self [24-26].

In Klein's theory, internal objects—the representations of objects that the child forms in the psyche—are central. In contrast, Donald Winnicott [27] emphasized the environment and introduced the concept of the "good enough mother", who provides the child with stability, safety, acceptance, and love, enabling development and identity formation. If the mother fails in the child's perception, the child experiences anxiety, threat, and anger, which can later manifest in various symptoms. Self-injury may therefore function as a means of coping with internal tension, fear, and frustration stemming from inadequate care. Both Klein and Winnicott considered frustration a natural part of development; according to Winnicott, a mother should be "good enough," helping the child cope with the disappointments inherent in reality [24].

Donald Winnicott [27] also developed the concept of the transitional space/transitional object, a space in which a child can safely experiment with roles and emotions before becoming more independent. When a child does not receive adequate experiences in this transitional space, frustration arises, potentially leading to internal conflicts, which may manifest as destructive behaviors, including self-injury.

According to Winnicott, for an adolescent navigating the biological-psychological developmental line, a supportive social environment provides holding. Holding refers to the physical and emotional care a mother provides, enabling the child to develop a sense of safety and initial representations of the surrounding world [27]. Self-injury in adolescence may reflect acting out, a sudden discharge of affect occurring within relationships with significant others.

Wilfred Bion [28–30] described the reversed alpha function, in which action precedes thinking. During adolescence, ego regression can occur, and prepsychotic symptoms may manifest as psychobehavioral patterns, such as expressing separation anxiety through repeated impulses toward self-injury. In this way, adolescents attempt to protect their lives despite psychological challenges (e.g., splitting of the self, blurred boundaries between self and object, absence of an internalized object), physical injuries (wounds), and social difficulties (assuming the roles of victim, perpetrator, or patient). In this framework, self-injury helps maintain the self–object relationship.

Viewing self-injury as a compulsion to repeat and regulate feelings that cannot be expressed verbally aligns with Freud's concept of acting out, understood as a wild transference driven by unconscious desires or beliefs, often accompanied by relational dynamics and intense, hostile transferential reactions [31].

René Spitz [24] demonstrated that developmental inhibition in children is associated with deficits in close relationships, isolation from significant objects, and deprivation of social bonds. Children whose needs for contact with important objects were unmet often exhibited anaclitic depression and self-aggressive behaviors, which could persist into later life as difficulties in forming and maintaining social relationships [24, 31].

Otto Kernberg integrated key elements of classical drive theory, Freud's structural model, Melanie Klein's object relations theory, and the developmental perspective of Freudian ego psychology (particularly Jacobson's ideas on pathological early identifications). Kernberg identified self-injury as a symptom in individuals with personality disorders, especially borderline, and in the context of broader difficulties in emotional regulation. He conceptualized self-injury as autoaggression linked to internal emotional conflicts and anxieties, serving as a defense mechanism to manage intense fear, rage, emptiness, and emotional instability.

In borderline personality disorder, self-injury helps eliminate internal chaos. Kernberg notes that individuals with borderline have unstable internal object representations, alternating between good and bad, provoking intense emotions such as anxiety and anger. Self-injury, in this framework, attempts to manage these unstable representations through external expression of emotions, which are otherwise frightening and unacceptable internally. The splitting of object representations into extremes produces chaos, limiting the ability to process experiences coherently. Self-injury thus expresses intense self-directed anger arising from difficulties in understanding and controlling internal conflicts. For individuals with borderline personality disorder, self-injury can reduce emotional tension, provide temporary relief during crises or emotional storms, and help regulate extreme internal states, though in a destructive manner [24, 32, 33].

Kernberg writes that in the therapy of individuals with tendencies toward self-injury, stability and safety in the therapeutic relationship are crucial. Self-injury often stems from the inability to establish stable, positive relationships in which the patient can feel secure. Psychodynamic therapy (e.g., Transference-Focused Psychotherapy for Adolescents, TFP-A) aims to address self-injury by restoring the ability to regulate emotions and gradually integrating split internal object representations [24, 32].

Contemporary psychoanalytic case studies of individuals who self-injure emphasize the key role of the dynamic interplay between the self and internal objects [31].

Concluding remarks

The theories discussed regarding the mechanisms of self-injury in adolescents indicate a multifactorial and complex psychological and biological basis. A common theme across most approaches is the recognition of self-injury as a maladaptive strategy for emotion regulation and a response to intense internal tension.

Behavioral and cognitive models (EAM, ECM) emphasize deficits in affect regulation, a tendency to avoid experiencing difficult emotions, and ruminative thinking, which heighten psychological distress and increase the risk of self-harm.

The biopsychosocial model incorporates a broad range of factors—from individual biological predispositions, through relational experiences, to environmental and social influences. It assumes that self-injurious behaviors do not arise solely from individual will or intent but are the result of interacting factors, including nervous system dysfunctions and abnormalities in the reward system. This perspective can reduce the burdensome sense of guilt in young people while providing a framework for psychoeducation on neurobiological mechanisms. Understanding that self-injury may serve to regulate difficult emotions via dopaminergic stimulation allows interventions to teach alternative, more adaptive ways of achieving emotional relief.

Psychodynamic and psychoanalytic approaches focus on internal conflicts, relationships with internal objects, early care deficits, and unmet emotional needs. In these frameworks, self-injury is often understood as a form of expressing unconscious content, controlling aggressive impulses, or serving as a substitute action when symbolic emotion regulation is unavailable.

These models are complementary, offering a broader, multidimensional understanding of self-injury. Their integration allows for a more comprehensive grasp of the mechanisms of onset and maintenance of self-harming behaviors, forming a foundation for planning effective therapeutic and preventive interventions. At the same time, differences in etiological assumptions and therapeutic approaches pose practical diagnostic challenges.

The review excluded systemic approaches, which could significantly enrich the understanding of self-injury, particularly in the context of family relationships. A systemic perspective suggests that self-harming behaviors may be reactions to tensions and dysfunctions within the family system. Including this perspective in the theoretical framework is important both for analyzing causes and for planning effective interventions, such as family therapy.

Conclusions

1. Adolescent self-injury has a complex, multifactorial basis confirmed by cognitive-behavioral, biological, and psychoanalytic models. Across all approaches, self-harm is understood as a maladaptive way of coping with difficult emotions, psychological tension, and unmet emotional needs.
2. Emotional regulation difficulties, early childhood experiences, deficits in attachment to caregivers, disturbances in internal object representations, and social influences (e.g., abuse, peer violence, neglect, and lack of support) significantly increase the risk of self-harm. Therefore, in clinical practice, both psychotherapists and child and adolescent psychiatrists should conduct comprehensive developmental interviews, assess the occurrence of self-injurious behaviors, and develop a thorough case conceptualization based on clinical data, the patient's emotional functioning, and their environmental context.

3. Self-harm can serve regulatory, communicative, and defensive functions, which may vary depending on theoretical perspective and the individual's history. Clinicians should identify the specific functions self-injury fulfills for each adolescent, such as emotional regulation, expression of suffering, or a strategy for coping with tension. Self-injury is a strong predictor of suicidal behaviors and should never be minimized. Early identification and appropriate intervention are essential.
4. Early identification of risk, accurate diagnosis, and the integration of therapeutic approaches are essential in working with adolescents who engage in self-injurious behaviors.
5. Emotional education and the development of social-emotional competencies should constitute an important element of self-injury prevention, both in school settings and in therapeutic contexts. In the prevention of self-injury among adolescents, the quality of the parent–adolescent relationship, based on empathy, trust, and open communication, is of key importance. Psychoeducation for parents should therefore be implemented to increase their awareness of the mechanisms underlying self-injury and the role of emotional support in the child's recovery process.
6. Therapeutic recommendations:
   — Interventions should be individualized, taking into account the adolescent's emotional background, relational context, and any co-occurring personality disorders.
   — Dialectical Behavior Therapy for Adolescents (DBT-A) is recommended to reduce rumination, teach adaptive coping, and improve emotion recognition.
   — Psychodynamic therapy, such as Transference-Focused Psychotherapy for Adolescents (TFP-A) or Mentalization-Based Treatment for Adolescents (MBT-A), is recommended for adolescents with difficulties in relationships with internal objects, attachment deficits, and co-occurring emotional or personality disorders.
   — Psychoeducation for both the patient and parents regarding self-injury plays an important role.
   — Close collaboration between psychotherapists and psychiatrists is essential, especially when self-injury co-occurs with depression, anxiety disorders, or borderline personality disorder.
   — Stability and safety in the therapeutic relationship are crucial for adolescents with self-injury tendencies.
7. Preventive and educational measures:
   — Social-emotional skills training programs should be implemented in schools.
   — Children and adolescents should be educated about emotions, the reward system, and effective strategies for coping with tension.
   — Support programs for parents and caregivers should be developed to strengthen their emotional and parenting competencies, which may help prevent self-harming behaviors among adolescents.

8. Further research directions:
   - Longitudinal studies are needed to identify the mechanisms that sustain self-injury across developmental stages.
   - Research on the neurobiological basis of self-injury should be further developed, especially regarding the opioid system and reward circuitry.
   - Comparative studies of the effectiveness of different forms of psychotherapy (e.g., DBT-A, TFP-A, MBT-A) for adolescents who engage in self-harm are also needed.
   - Further investigation of the dual role of self-injury—as both an emotion regulation mechanism and a potential strategy for preventing suicide attempts, as well as a significant predictor of suicide attempts—is needed to improve diagnostic tools and therapeutic procedures.

In clinical practice, early recognition of risk factors, an interdisciplinary diagnostic approach, and the implementation of appropriately tailored forms of psychotherapy are essential. Preventive strategies, including emotional education and social-emotional skills development in children and adolescents, can effectively counteract the development of destructive ways of relieving emotional tension, such as self-injury.

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