From the Body Surface Through Psychopathology: The Pursuit of the Early Trauma Traces on the Brain-Body-Mind-Skin Axis
(Evaluation of Psoriasis Patients With the Rorschach Test)

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Declaration of Originality

I hereby declare that all information in this document has been obtained and presented by academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

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Abstract
The human is a complex psychosomatic being whose body records any sensations and experiences. The intertwined relationship between brain and skin begins in the womb and continues throughout the lifespan. Hence, skin, the organ of the neuro-immune-cutaneous-endocrine (NICE) network, has become the subject of interdisciplinary studies. Neuroscientific studies elicited devastating consequences of early unregulated stress on child’s developing body-brain-mind system, which entails future psychopathologies. As known from the trauma literature, the earlier trauma, the more severe damage to the body; hence, today psychosomatic disorders are seen as an extension of personality disorders. According to the psychoanalytic psychosomatic approach, skin disorders are the outcomes of early adverse object relations, which assumes skin symptoms occur as the compensation of the absent tactual experiences or cutaneous lesions are the reflection of narcissistic wounds and incorporated negative objects within deprivation (Szwec, 2008; Marty, M’Uzan, & David, 1963). Also, Spitz (1965) demonstrated that orphans, who don’t have a consistent maternal figure, are disposed to develop an immune deficiency, depression, eczema, and other disorders. Psoriasis is an auto-immune disease occurring without a clear cause. Recent studies show a relationship between adverse childhood experiences, trauma, and psoriasis disease (Simonic et al., 2010; Crosta et al., 2018). Therefore, it was applied Rorschach Inkblot Test and brief psychoanalytic interview to 10 psoriasis patients for data collection. Content analysis of French School was used to find a relationship between early traumatic experiences and the pathogenesis of psoriasis. Hypotheses of the study based on the relationship between psoriasis and early traumatic experiences were largely confirmed.

Keywords: psoriasis, psychodermatology, psychosomatics, object relations, brain-skin development, The Rorschach Test
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Chapter 1: CHAPTER 1: ON PSYCHOANALYSIS

1.1. Introduction

Skin is the largest organ covering the entire body, where we perceive the world through tactility, and “our presence, selfhood and body image is dependent on the stimulation coming from others” (Diamond, 2013). Hence, how we describe ourselves, once was engraved beneath our skin by our families, society, and the environment that we were born into. Hence, the skin might be considered a sort of map where we can pursue one’s personal history.

Skin is composed of many characteristics including pigments, folds, layers, pores, hairs, scars, and wrinkles; also, skin texture contains many features flexibility, curability, smoothness and roughness, smell, etc. (Anzieu, 1995). All these physical features also give information about one’s personal history. Our skin is part of our identity which gives information about our age, gender, ethnicity, personal history, injuries, lifestyle, etc. to an outside observer. Also, different meanings were assigned by society, and cultures (cluster of social constructions) to these physical features endemically.

Undisputedly, the skin has vital importance as being a conjunction point where the complex brain-body-mind-skin axis of two people meet. Skin is more than being a natural protective frontier, but also it is a socialization instrument with other surfaces in the relational arena, where the initial contact with the others and external world blossoms during the preverbal period. Moreover, psychosomatic integrity in adulthood is closely related to these early corporeal exchanges that take place between the skins, where the primitive sense of self derives from (Gallese, 2009; Fotopoulou & Tsakiris, 2017). As Freud (1923) asserted the formation of self is based on a bodily-rooted process, and he says psychical apparatus develops from physical wrapping through psychical wrapping, in Bion’s words (1962), from somatic beta elements through abstract alpha elements by the mediation of mother. Anzieu (1995) likened the porous skin to an envelope which enables sensorial and affective transmission between infant and mother. This permeable skin also projects out the unspoken mute contents of transmitted messages through lesions, patches, and inflammations.

Psoriasis is an autoimmune cutaneous disease, that becomes visible by thickening the skin surface with plaques, scales, patches, etc. Also, psoriasis is a repetitive chronic
disease, and stress plays an important role in psoriatic flare-ups. Although the pathogenesis of psoriasis hasn’t been understood entirely yet, some researchers claim that inflammatory skin disorders occur due to neuronal deficit or dysfunction (Azimi, Lerner, & Elmariah, 2015). This neuropathy probably derives from early traumatic relationships, as Schore (1994, 2001) illustrated how the direct impact of maternal-infant interaction on the HPA axis of infants is a predictor of future health and diseases and psychosomatic disorders. The fact that psoriasis is a stress-triggered disease indicates that psoriasis patients might have some damage in the HPA axis regulating stress. In this thesis, it is investigated the roots of early relational trauma, which is thought to underlie psoriasis disease.

Moreover, the comorbidity of skin and psychiatric disorders is very high. While some neurological or psychiatric disorders might entail secondary cutaneous disease, also skin disorders cause psychiatric iatrogenic illnesses (Jafferany, 2007). Although secondary cutaneous disorders do not jeopardize someone’s life, they might be burdensome psychologically due to their visibility and evolve into a source of stigma, which affects an individual’s social life, body image, well-being, self-esteem by increasing depression, anxiety, suicidal thoughts, etc. (Koo & Lebwohl, 2001; WHO, 2016). Thus, psychological treatment is of vital importance as much as a medical treatment for dermatological patients. Therefore, psoriasis disease is chosen as a subject of research.

**1.2. Psychosomatics in History**

The human is a complex psychosomatic being compounded by psychical and somatic entities who can become ill. The concept of psychosomatic originates from ancient Greek by conjugating "psyhke" which means the breath, soul, and "somatikos" which means corpse, dead body; briefly, psychosomatic means the breath of the dead body by referring to a disintegrated diseased body.

The problem of body and mind duality has been debated for long centuries. René Descartes was the first person in history who put this problem parallel to the current dualistic approach of today by dividing the mind and brain into two groups. While Descartes (1641) was identifying the mind with consciousness and self-awareness, he explained the brain as a set of organizations where the intelligence settles. In the
Cartesian/Substance Dualism Thesis, Descartes (1641) systematized the body-mind problem, where he asserted that there are two sorts of entities: mental and physical. Although the mind and body duality has caused many heated arguments until the end of the 19th century, the birth of psychosomatic inquiry may be admitted as debuting of Hippocrates, who looked from corporeal problems through the mental circumstances of patients (Parman, 2005; Dejours, 2015, p.112). The first humanistic attempts were initiated by Hippocrates, the father of modern medicine, and he was the first person in history who put forward the idea that the mind and body are compounded unity (Parman, 2005). Subsequently, he has taken the first step to explain human idiosyncrasy/temperament within secreting organs and four liquids in the body in the theory of four humors (Kalanchanis & Michailidis, 2015). According to the Humourism of Hippocrates, the state of health is described as homeostasis of four fluids, and disease occurs when the harmony between these fluids is corrupted; these liquids are aligned, such as the blood associated with sanguine temperament, the yellow pile related with choleric humor, the black pile linked with melancholic personality; the phlegm connected with phlegmatic temperament) (Kalanchanis & Michailidis, 2015).

This term 'psychosomatic' was first propelled by German psychiatrist Heinroth in 1818, and he has used the word tacitly in the following sentence, "As a general rule, the origin of insomnia is psychosomatic, but it is possible that every phase of life can itself provide the complete reason for insomnia" (Margetts, 1950; Lipowski, 1984). From the cited sentence, Margetts (1950) remarked that the body and mind are evaluated as a single unity by Heinroth; nonetheless, there are few findings on the connotation of the employment of the 'psychosomatic' word in his notes (Lipowski, 1984). Afterward, eminent British psychiatrist Bucknill (1857) employed "psychosomaticist" word, while he was seeking answers to explain lunacy around three hypotheses, including 'somatic, psychic and somato-psychic' (Margetts, 1950; Lipowski, 1984). Thus, the concept of psychosomatic did not gain currency until the end of the 19th century with the involvement of Sigmund Freud and psychoanalytic theory.

1.3. Freud As a Pioneer of Modern Psychosomatic Approach
Sigmund Freud might be accepted as a pioneer of the modern psychosomatic approach who has worked with hysterical women. Since the beginning, Sigmund Freud has never
used the psychosomatic term during his entire life, and he only mentioned four types of symptoms: hysterical conversion, actual neurosis, hypochondria, and organic disturbances.

The very famous case of Breuer and Freud (1883-1885) named Anna O. (Bertha Pappenheim) profoundly shaped the trajectory of the psychosomatic clinic. American psychologist Walter A. Stewart (1972) called her a Rosetta stone of psychiatry due to her profound role in discovering unconsciousness (Teber, 2018, p.104). Anna O. has come with nonorganic symptoms such as hysterical pregnancy, neurotic coughing, paralysis, etc., into Breuer's office, and today's psychodiagnosticians consider that she has a dissociative personality rather than hysteria (McWilliams, 1994, p. 325). At this time, Freud (1895) considered that these corporeal symptoms of hysterical people might have an unconscious meaning derived from the oedipal complex due to the repression mechanism. Moreover, Freud claimed that those repressed contents create physical tension implicitly; hence, the only way to discharge this agitation is seen as a projection through bodily expressions, symptoms, or conversions (Parman, 2005; Debray, 2015).

In the beginning of the 20th century, Freud adopted a new perspective about actual neurosis by the beginning of World War I; he observed corporeal symptoms in soldiers without apparent cause or organic base, which were also recalcitrant to medical treatment (Gutiérrez-Peláez, 2018, p.30; Parman, 2005). Freud has evaluated these veterans and soldiers closer to the actual neurosis category rather than hysteria because neither these bodily symptoms had implicit, emblematic meanings nor were they deriving from oedipal complex or unconscious conflicts. Freud asserted that actual neurosis is triggered by current traumatic events or startling circumstances, a danger that the ego is not ready for (Parman, 2005). Moreover, Freud mentioned hypochondriac symptoms in the case of Schreber, a paranoid personality accompanying a grandiose self with narcissistic patterns (Freud, et al., 1958). Finally, he mentioned that organic disturbances induce irretrievable deterioration in health without apparent cause, which is aligned with today's psychosomatic diseases (Debray, 2015, p. 16-17).

In 1938, Freud articulated his last words about psychosomatic, stating that both psychical and corporeal facts affect each other diffusely and bilaterally, and psychical facts -influenced by corporeality- appear on the stage of the body severely with relentless, harsh actions referring to death drive and their dynamics. (Ikiz, 2008).
After Freud, the psychoanalytic psychosomatic studies gathered speed during World War II, and many psychoanalysts embraced different perspectives because classical psychoanalytic theories were not feasible and beneficial enough when working with patients with somatic stress. Sandor Ferenczi made remarkable contributions to psychosomatic medicine with his theories where he investigated the psychic roots of somatic illnesses; moreover, his studies triggered the foundation of Chicago School in the United States by his previous student Franz Alexander (Debray, 2015). Franz Alexander was the first person who tackled the physiopathology and psychical facts on the one hand and indicated that there is an inextricable link between psyche-soma-disease, who assumes that the existence of pathology is linked to psychological agitation, so if psychical tension is extinguished, pathology will disappear (Parman, 2005). Moreover, he found a relationship between personality types and illnesses; hence he constituted disease clusters based on character types. While taking the first steps for forming the insurance system in the United States, Alexander also spread Chicago School doctrines in Europe territory that provided a basis for the foundation of the Paris Psychosomatic School (IPSO) (Debray, 2015).

There are two dominant models in the current psychosomatic approach; one derives from this hysteric conversion model, and the other is closer to the Freudian perspective that separates psychosomatic symptoms from conversion. While the conversion model is followed by M. Klein School in England, Franz Alexander Chicago School in the USA, and Angel Garma in Argentina, the psychosomatic model is followed by P. Marty, M. Fain, R. Debray, M. de M’uzan, etc., who are the pioneers of Paris Psychosomatic School (IPSO) (Ikiz, 2008; Debray, 2015, p. 18, 19; Parman, 2005).

1.4. Development of Freudian Concepts in Psychoanalytic Psychosomatics
The dreams aroused Sigmund Freud's interest since childhood; he kept notes about his dreams and tried to analyze them. While working with neurotic people, his patients frequently mentioned their dreams. It was the starting point of decoding dreams like symptoms, going beyond the physical through the psychical apparatus to discover repressed memories and associated symbolic meanings burdened into the body with somatic markers (Akvardar et al., 2015, p. 179-180). Initially, Freud restricted psychical phenomena only in the area of consciousness within the neurophysiological approach via
"excitation" deriving from the neural system (Tükel, 2015, p. 29). However, he realized that physical terminology is inadequate to explain the nature of the unconscious and the psychical apparatus due to the human being's position settled as an interface between the psychical and physical world, body and mind (Akvardar et al., 2015, p. 25-26). Thus, the topographical model was established to explain mind structure compounded of conscious, preconscious, and unconscious.

Initially, there were two types of stimuli that organisms were exposed to; the exogenous stimuli coming from the outside and the endogenous stimuli coming from internal excitations; which were integrated lately around sexuality and drives by Freud (Akvardar et al., 2015, p. 69). The concept of drives (trieblinstinkt) is vitally important to explicate the interconnection between psyche and soma gathering around sexuality, precisely because drives are defined as "representative" between mind and body that governs the mental life (Freud, 1905; Tükel, 2015, p. 28; Akvardar et al., 2015, p. 38-39). The source of unconscious desires comes from drives or their representatives compounded around the pleasure principle and primary process, whose main aim is to be satisfied (Akvardar et al., 2015, p. 30-35). Freud (1905) presented the concepts of the "component drives" and "erotogenic zones" to point out the autoerotic pregenital sexuality of infants, which does not have an external object yet until the maturation of 'genital' sexuality by the consolidation of partial drives with external other; physical and psychical development are integrated at the end of shifting infantile sexuality and introduction to genital intercourse (Freud, 1905; Freud, 1914). Followingly, the concept of "libido" is substituted for drives because what reaches the terrain of consciousness is the representative thought of drives “libido”, not the drives (Freud, 1915). The duality in Freud's approach occurred again while describing the libido; the one is "ego libido" constituted around the primary narcissism and autoeroticism when the child chooses his/her body as an object, and the other one is "object libido" that occurs with the breakdown of child's omnipotence when the infant chooses mother as an object (Tükel, 2015, p. 36-37, 49-53; Freud, 1914). Also, Freud underlines the importance of primary care for future object selection and relationship patterns. In years, Freud made many alternations in drive theory, but it is taken its final form by drawing inspiration from Greek myths "Eros" and "Thanatos." In the paper "Beyond the Pleasure Principle" (1920), he split drives into two groups "life and death drives" while the life drives are elucidated
with sexual drives, anabolism, the death drives are explained with catabolism and aggression (Gerber, 2019). Repetition compulsion, which stems from early childhood traumata, is tackled with death drives go against to pleasure principle (Freud, 1920; Tükel, 2015, p. 124-128). In addition, Freud (1919) published a paper, "The Uncanny (Unheimlich)," where he mentioned a feeling of "alien entity," the estrangement to one's own body and not feeling at home, referring to the effects of early traumata over sensorial lived space, the body. Moreover, these uncanny, uncomfortable feelings, in Laplanche’s words (1958), "the spine in the flesh," is called depersonalization and derealization today (Diamond, 2013, p. 125-126). Turning back to death drives, French psychoanalyst Claude Smadja (2005) associated death drives with psychosomatic diseases, referring to somatic regression and disorientation. Smadja (2005) asserted that death drives, whose primary purpose is self-destruction until death, leave irreversible, progressive damage on the body through psychosomatic diseases. In addition, André Green (2001) indicated that devastating death drives are aimed to destroy objects and vitality and become objectless to get through annihilation; precisely because the one has to make investments in others to create own mental representations and become an object, death drives attack to self, vitality in the absence of objects.

In “Ego and Id” (1923), the psychical apparatus evolved into a more complex organization, and the ego (Ich) is illustrated as a mediator between the id (Es) and superego (Über-Ich); in the meanwhile, the topographical model was still maintaining its importance (Anzieu, 1995, p. 122-129). In the structural model, the ego evolves out of the id and leans on it, and also it is composed of bodily sensations and experiences (Leiblichkeit) throughout the body surface, the skin (Freud, 1923; Anzieu, 1995, p. 116-127). The ego as a psychical structure is responsible for meetings the demands of the id, such as sexuality, aggression, feeding, etc., and the superego is established by the introjection of the parent’s superego, societal norms, rules, etc. The mother's shielding for her baby plays a vital role in ego formation, and she protects her baby not only from external threats but also from the baby's internal urges, sensations that the child cannot overcome alone (Akvardar et al., 2015, p. 65-76). The infant perceives the external world depending on skin-to-skin interaction with his/her mother, and the mother does not solely hold together the physical entity of the child but also psychical, and the porous skin is a transitional area where the somatic and mental entities are intertwined (Anzieu, 1995).
Moreover, Freud (1923) asserted that the surface of the mental apparatus, 'the skin', is where the consciousness lies and thinking action originates from the detection of the time lag between actions and demands of the id (Anzieu, 1995). Followingly, Freud (1923) propounded his very well-known sentence, "The ego is first and foremost a bodily ego [ein körperliches]; it is not merely a surface entity [Oberflächenwesen], but is itself the projection of a surface" (GW XIII [1923], p. 253; 1923, p. 26.) that explains the ego originates from corporeality, substantially from skin-to-skin communication. Hence, the object which has been concretely and visibly covered by touch becomes psychically contained too implicitly (Anzieu, 1995, p. 127). Tactility comes with double-sided perception regarding internal and external milieu that traverses between touching other surfaces and being touched by others (Freud, 1923), in line with that skin as a natural frontier with other surfaces is associated with the homeostasis process whose primary purpose is to maintain the internal equilibrium of object towards shifting external conditions. Followingly, W. R. Bion (1962) appended that the psychical apparatus develops from beta to alpha elements, or in other words, the concrete, embodied touching, breastfeeding experiences are needed for the formation of psychical abstract, symbolic representations of "containment" which emerges by thinking action (Anzieu, 1995, p. 173-174).

1.5. Paris Psychosomatic School (IPSO) and Pierre Marty

Paris Psychosomatic School was founded by Pierre Marty, Michel de M'Uzan, and Michel Fain in 1972 in Paris by grasping the notion that “every one of us is a psychosomatic individual” and following the psychosomatic doctrines of Freud tightly, whose main purpose was to investigate psychoanalytical roots of somatic diseases (Izik, 2008). M'Uzan and Marty introduced the idea of “operational thinking (pensée opératoire)” by giving a speech at a congress in 1962 (Wilson, 2012). Operational thought was explained as a concrete, actual and factual way of thinking focused on material and present facts, characterized by dementalization that expresses the impairment in mental functioning and impoverishment of fantasy and emotions (Debray, 2015, p. 25; Wilson, 2012; Jaeger, 2019). The operational world, which can be explained as mechanical living without leaving space for feelings, induces dysfunction to link affective states with the mind and might be related to early deprivation or traumatic conditions. Marty has conceptualized
operational thought around phantasmatic poverty and somatic disorganization, and he
underlined that soma and psyche must be tackled on one hand because diseases occur
when the balance is lacking among them (Debray, 2015, p. 25). Hence, M’Uzan, Marty
and David suggested treating psychological pathology at the same level as lesional
pathology and aimed to express somatic markers in the scope of intrapsychic dynamics
by referring to Freudian conscious, preconscious, and unconscious (Parman, 2005).
Nonetheless, today psychosomatic diseases are associated with more archaic problems in
the preoedipal phase, where the fully-fledged ego is absent and massive usage of primitive
mechanisms definitive. In addition, it is impossible to mention repression or intrapsychic
conflicts because psychosomatic symptoms are devoid of meaning due to early traumatic
conditions, which have an unbinding impact on a child's inner dynamics (Mucci, 2018;
McWilliams, 1994).

The book “L’investigation psychosomatique” published in 1963, is accepted as a
declaration of the Paris Psychosomatic School's founding as a different ecole (Jaeger,
2019). In this book, it has been demonstrated psychopathological inquiry of seven patients
coming from the different backgrounds by asking repeatedly “what are you thinking
now?” to evoke free associations and checking their phantasmatic mimics to detect
mechanical and concrete way of thinking and lack of dreaming capacity seen in
psychosomatic patients (Marty, de M’uzan, & David, 1963). During the interviews, severe
narcissistic vulnerability, lack of healthy libidinal growth, and a higher disposition to
somatization have been detected in these patients, which are also the main characteristic
features of borderline psychopathologies (Ikiz, 2017; Mucci, 2018). For the first time in
literature, the term “borderline psychosomatic” was used by Marty in the case of Eugéne,
which brought a new theme to clinical practice setting “distance” between analyst and

Pierre Marty has a special place who coined new concepts in the psychoanalytic
psychosomatic clinic. He mainly asserts that the psychosomatic economy of a human
being is consisted of “les mouvements progrédients” that aim to move forward throughout
the childhood and “les mouvements regrédients” brought by inevitable adverse facts of
life (referring to trauma), and the main aim of psychosomatic economy is to save
homeostatic balance between these movements (Debray, 2015, p. 26-28). Marty indicates
that inner and outer states influence imprinting, but primary maternal care is very
important. Regressive movements, which cuts off the progressive movements, are mainly related to environmental factors that induce fixation points, and progressive disorganization in the body comes into sight with somatic markers, pathology under the pressure of death drives (Debray, 2015, p. 28-29). In addition, disorganization in mentality -which traumata might trigger- emerges with essential depression accompanied by operational thoughts diffusely; precisely because of the nature of objectless depression affiliated with unknown, unidentified loss, and by the “surinvestissement” (overinvestment) to the operational thoughts of actual, factual and mechanic things, the operational world spread throughout the consciousness that does not leave any gap for past memories (Debray, 2015, p. 38-39).

1.6. Contributions of IPSO to Psychosomatic Clinic

Mentalization: It is related to the quality and quantity of mental images. Usually, the organism applies narrative or mental activities to relax and get rid of experienced tension. However, some people, who suffer from psychosomatic diseases, are emotionally blind due to early trauma and use somatization generally due to dysfunction in preconsciousness and symbolic, phantasmatic poverty.

Essential/Objectless Depression: The concept of “basic depression” was coined by Marty in 1996 instead of objectless depression, which is characterized by prevalent negative low mood, anxiety, and stress in the absence of loss. Differing from neurotic depression, the libidinal ties are unbound with drives, and there is no indication of vitality at all. Furthermore, it is accompanied by operational thought generally.

Operational World: It is based on operational thinking that revolves around concrete, mechanic, tangible facts unrelated to symbolization due to interruption in preconsciousness. So that reason, when the intangible affect/drive-laden representations are not welcome in consciousness, it finds an alternative pathway for discharge of psychical tension via somatization tangibly.

Allergic Object Relation: It defines the effort to be close to the object as much as possible but also needs to go away, briefly sort of a fusional relationship that object is immobilized in, it can neither get closer nor farther away (Marty, 1958).

Self-Soothing Techniques: They are associated with the regulation of affects/internal urges to maintain internal equilibrium, which does not function appropriately in
psychosomatic patients. Hence, psychosomatic patients, whose symbolization capacity and precociousness are underdeveloped, apply to somatization for soothing themselves as a final resort by shifting their focus from the illegible unconscious world to on body.

1.7. Attachment and Object Relations Theories in Psychoanalytic Literature

1.7.1. Ferenczi As a Pioneer of Object Relations Ecole

Sandor Ferenczi made the first contributions to object relations theory, whose works also steered the future studies of Spitz, Bowlby, Mahler, Kohut Winnicott, Klein, Masud Khan, and many others (Ludin, 2021). In 1912, Ferenczi published a paper called “The Definition of Introjection,” and he asserted that the internalization -almost he refers to identification- of others is the cornerstone for selfhood development, and where the basis of affective life stems from is the object relations with parental figures, so-called 'primary object love and hate’ (Berman, 2007, p.21-35). Ferenczi first enounced the idea of introjection, and afterward, it was adopted by Sigmund Freud to explain superego formation and by Melanie Klein to express the introjection and projection process in the early stages of life (Berman, 2007, p. 23). Ferenczi (1912) claimed that newborns come into the world with integrated perception, and the separation of sensations into good/bad categories is gained experientially. Ultimately infants learn to project their bad sensations to the outside world -unlike M. Klein, who assumes the contrast, from splitting through integrative perception by cumulative, consistent care - that might be admitted as a birth certificate of object relations Ecole (Ferenczi, 1912; Berman, 2007, p. 23-25). While Freud was centering drives at the heart of psychoanalysis, Ferenczi emphasized the importance of relationships over drives. In contrast to Freud, Ferenczi has considered that the death drive is more dominant in the first years of life due to child helplessness and underdeveloped fragile self that might be collapsed, ruptured, or fragmented in traumatic conditions (Bertrand, 2021). Ferenczi (1929) found a connection between organ neurosis and death drives, and he articulated that many common organic diseases have psychological roots; he affiliated death drives with somatization and saw psychosomatic diseases as consequences of narcissistic scar comes from early relational trauma (Bertrand, 2021). Furthermore, it has been mentioned about “unwelcomed child” whose emotional needs are not supplied by her/his parents or who has been maltreated, harassed, etc., and it has remarked the proneness of the unwelcomed child to kill or harm
himself/herself willingly and easily (as a result of introjected negative figures). In addition, in some circumstances, the unwanted child turns into a “wise baby” who treats like an adult and bears the burden of parents' pain and meets their emotional needs instead of them, which induces pseudo-self (Vartzopoulos, 2021). Finally, Ferenczi brought a more humanistic approach to the clinic by giving freedom to patients to behave like a child, and he denoted that a psychoanalyst must have a “tender-mother approach” (Mutterzärtlichkeit), especially while working on "abstinence" with severely traumatized people who have never had a binding mother (Ludin, 2021; Şensoy, 2021).

1.7.2. The Disparity in Trauma between Freud and Ferenczi: Fantasy or Real?

Ferenczi was the first person who bravely put forward the existence of real childhood trauma in contrast to Freud; therefore, he has excluded from the psychoanalysis community. Chronically, Freud has studied hysteria, obsessive neurosis, and actual neurosis regarding war context; furthermore, he focused on uncanny feelings regarding traumatic memories and death drives come along with repetition compulsion in his last years (Gutiérrez-Peláez, 2018). Freud focused on psychical sexual trauma rather than the real one because at that time he was working with hysterical women and less severe cases compared to Ferenczi; hence divergence between Freud and Ferenczi occurred in the trauma clinic. In 1897, Freud states that the early experiences of seduction and sexual abuse are repressed and kept in silence in the unconsciousness until the second scene. Hidden traumatic memory (phantasmatic seduction or sexual abuse) (Nachträglichkeit) becomes significant with the second act and then deferred after effects called “apres-coup” come into play as it is happening right now (Mucci, 2013). However, Freud gave up his neurotica at one point, emphasizing how an individual copes with traumatic memory, whether it is real or imaginary. Meanwhile, Ferenczi was confronting more severely traumatized people in his clinical practice and preparing to publish “Confusion of tongues between adults and the child” (1932). However, this paper caused many heated arguments and commenced the war between Freud and Ferenczi on the trauma aspect, Ferenczi who was insistent on addressing the reality of trauma which was almost banished to utter and its destructive impact on the vulnerable psyche of infant (Bokanowski, 2021).

In “Confusion of tongues between adults and child” (1932), Ferenczi elucidated that the poor signifiers of trauma banished from language and victimized child is silenced
to maintain the good image of parents who have been nice and benevolent to a child once, now they are the perpetrators who torment to a child physically, sexually or psychologically (Gutiérrez-Peláez, 2018). Also, Ferenczi addresses the language of trauma, the language of “tender” spoken by the child is exploited by the adult who speaks the language of “passion” (Berman, 2007). The adult, who has erotic tendencies, confuses the child’s mind like the sexual desires come from the child, or he/she is willing; hence, the abused child doubts her/his sensation and takes upon the adult’s guilty feelings, and the roles are switched. An innocent child fragments himself/herself to escape the excessive burden of aggression and guilty feelings which do not belong to him/herself and becomes immobilized in total confusion where the reality is distorted. The child cannot defend herself/himself, distrusts his/her inner senses, and introjects the external reality deformed by the adult to protect her/his secure, good parental figure; consequently, the child becomes paralyzed in the state of helplessness, being both guilty and innocent at the same time that shakes his/her psyche profoundly (Gutiérrez-Peláez, 2018). Briefly, Ferenczi (1932) has gone beyond the linguistic metaphor with the confusion of tongues by exhibiting how the reality is voiced by the child’s tender tone and silenced by the adult’s erotic tone and how the innocent child is entrapped in aggression, guilt, shame at the same, when the inner senses of child corrupted by seductive, malignant adults (Gutiérrez-Peláez, 2018, p. 208).

1.7.3. René A. Spitz

Austrian psychiatrist and psychoanalyst René A. Spitz was one of the researchers who focused on a developmental area by conducting empirical studies with infants who have been separated from their mothers for long periods by following the footsteps of Ferenczi. Spitz was investigating the impact of maternal deprivation on institutionalized infants, who do not have stable bonding figures. In 1945, Spitz published a ground-breaking study called “Hospitalism” depending on his observations for around a decade. This study presented the importance of the relational needs of infants for socio-emotive growth rather than physiological exigencies on the onset of psychosomatic diseases and psychopathologies. In this study, the “anaclitic depression” term is used to explain the state where the child is surrounded by excessive grief and anxiety and his/her immunity is corrupted in the loss of a loving primary caregiver temporarily (less than five months)
that might be repaired. Moreover, the coined term “hospitalism” is used to define the constant or long-lasting state of deprivation or separation (over five months) from the maternal figure, which deteriorates the health condition of the infant and even may lead up to death (Spitz, 1945). Spitz (1945, 1946) addressed the importance of maternal care and loving caregiver for the bio-psycho-social-emotional development of a rudimentary child in contrast with the motivational drive aspect that oversimplifies an infant to an organism solely seeks for physiological needs and the discharge of tension created by drives. Followingly, he conducted many other studies focused on the relationship between deprivation and psychogenic diseases in infants, etc., and his studies affected the trajectory of imminent studies of Harlow (1958) and Bowlby (1969) (Spitz, 1945; 1946, 1965; van der Horst, van Rosmalen & van der Veer, 2019).

1.7.4. Donald W. Winnicott

Maternal deficiency and deprivation were the interest of psychoanalysis starting from 1945 with the studies of Spitz and Winnicott (Anzieu, 1995), which sealed the fate of psychoanalysis departing from the intrapersonal approach to the intersubjectivity by emphasizing the emotional, and social needs of infants. British pediatrician and psychoanalyst Winnicott (1960) uttered his very famous words “there is no such thing as an infant,” meaning an immature infant is dependent on his/her mother to maintain his/her psychical and physical continuity, and the mother-infant dyad exist in need of other (Winnicott, 1960). At the same time, there must be a “good enough mother” who brings the “holding environment” to the infant to cover his needs, which is necessary for the healthy growth of “the continuity of being” because the mother binds physical and psychical entities of her child-like a glue throughout the holding and handling periods (Winnicott, 1962; Anzieu, 1995; Tükel, 2011). The continuity of being is related to having infants’ omnipotent fantasies, which claim that the mother is the narcissistic appendices of an infant to satisfy his/her drives. (Tükel, 2011). Illusionary thoughts of the baby are consolidated by “primary maternal preoccupation” in the first year of life, which is explained as a state of the mother's being devoted to her spring by presenting herself as a caregiver from birth to following one and half years (Tükel, 2011). Maternal preoccupation and symbiotic relationship were cut off within triangulation (by the father's involvement usually), and the child gets into the symbolic order and learns
abstract thinking and language. This situation opens an area of transitional space that creates the capacity to be alone and playing in the presence of (m)other (Winnicott, 1971). According to Mucci (2018), the participation of a third person is quite important to avoid borderline personality organization because a father or second caregiver might repair the lack of attunement between mother and child. Furthermore, both parental relationships must be distorted for the emergence of borderline personalities (Mucci, 2018).

According to Winnicott (1984), the severity of psychopathologies is related to experienced early maternal deficiency; hence he used the “deprivation” term to define a state of relational, ecologic failure that breaks a child’s trust in environmental reliability that disrupts the child’s continuity of being by referring to traumatic circumstances (Szwec, 2006). In addition, “privation” is used to describe the state of lacking maternal care and living standards in the first place through the following periods. For Winnicott, the continuity of a child’s being is dependent on maternal holding and handling capacity (Anzieu, 1995). Furthermore, psychoanalyst Philippe Jaeger, who worked on urticaria and skin irritations, associates Winnicottian holding and handling theme with chronic dermatological diseases. It’s claimed that chronic dermatological diseases occur in the absence of “good enough holding and handling” by referring to an unpublished paper by Winnicott (1969) called “supplementary note,” where Winnicott attributes all skin diseases to the psychotic core (Szwec, 2006).

### 1.7.5. Melanie Klein

According to Melanie Klein (1957), a human infant is born with a sophisticated, creative, compressed (telescopagé) self that enables the organism to feel anxiety (“annihilation” threat) and establish his/her own inner “good/bad” objects. She assumes that psychical development of an infant expands to a year approximately. Klein asserted that there are two positions that every infant has to proceed for healthy physical development by the companionship of the mother. The first position is the “paranoid-schizoid” phase (0-6 months) characterized by envious, aggressive, paranoid acts -which are explained with innate temperament- come from the frustration of annihilation, catastrophes, and external threats. In this position, there is no integrated sense of self and other, and everything is divided into two forms; all good and all bad (good mother/bad mother) (Klein, 1957). While the infant is introjecting the good object and its features inside, he/she projects out
(she uses “expulsion” term) the bad object and its traits to protect himself/herself from harmful senses that she/he cannot overcome alone. Commonly used defense mechanisms are projection, introjection, splitting, projective identification due to lack of mature psychic formation, and secondary defenses. The second position is named as “depressive position” (6th month-1 year), which is characterized by the integration of split objects (bad mother + good mother = integral mother) (Klein, 1957). When an infant realizes that there is one and only mother who is devoted, loving, and caring even though destructive, devastating attitudes are coming from her baby, a major shift occurs from a paranoid-schizoid position to a depressive one. Hence, infant is preoccupied with being rejected or abandoned by his/her mother due to previous aggression/persecutions he/she exhibited towards his/her mother (Klein, 1957). In addition, another earlier position proposed by Thomas Ogden (1992) called the “autistic contiguous position,” which is the period of archaic meaning-making process based on sensory information, principally on “tactual” sense coming from skin superficies (McWilliams, 1994, p. 43). Moreover, this fear of abandonment or rejection is at the heart of borderline psychopathologies, along with distance and separation-individuation problems. Also, Otto Kernberg has been benefited from Kleinian concepts while describing and constructing borderline psychopathologies.

1.7.6. John Bowlby

John Bowlby (1969) depicted the neonate’s evolutionary disposition of “proximity seeking” attitudes and forming an emotional bond with his/her mother due to consistent, repetitive care from the sixth month up to the second year. He has formed attachment theory by taking inspiration from the imprinting phenomenon of Lorenz, Frisch, and Tinbergen. Imprinting theory claims that helpless neonates or hatchlings follow the first salient, moving object following the first days after birth/hatching and become attached to this object in time (van der Horst, van der Veer, & van Ijzendoorn, 2007). Differently, Lorenz and his colleagues observed that in natural conditions bonding figure is a mother, but also a substitution might be replaced instead of the mother (Lorenz substituted himself) because lack of an attachment figure causes severe anxiety and feeling of terror in newborns (Hess, & Petrovich, 2000). Bowlby draws an analogy between instinctive attitudes of baby animals and the attachment relationship that human infants establish with their mother, at the same time keeping in mind Spitz’s, Winnicott’s, Klein’s object
relation studies and “clinging instinct” and “filial instinct” concepts of Hermann’s and Abraham (Anzieu, 1995 Göçer, 2019). Later, the attachment theory was formulated by Mary Ainsworth (between the 60s-70s), an indispensable colleague of Bowlby at Tavistock Clinic, and she posited that all infants develop attachment bonds but in different styles. Hence, attachment styles divided into three groups initially; secure attachment (group B), ambivalent attachment (group C), avoidant attachment (group A) (Ainsworth, 1978) and, afterward insecure-disorganized attachment (group D) is added by Main and Hesse in 1990 (Mucci, 2013, p. 10).

Bowlby (1969) stated that “there is a potential in the healthy neonate to enter into an elemental form of social interaction,” and he emphasized that mutual interactions between the child and environment mold the character of a child both physiologically and psychologically (Diamond, 2013, p. 206; van der Horst, LeRoy, & van der Veer, 2008). Moreover, Bowlby underscores the quality of early social and experiential interactions whose effects will remain over future interpersonal and intrapersonal relations.

1.7.7. Margaret Mahler

Mahler brought a breath of fresh air by tearing down Freudian psychosexual development phases and putting emphasis on an infant’s interaction with the environment and mother (addressing the mother-child dichotomy) from a “state of relative unawareness of others to symbiotic relatedness” in the early two years and following phases (McWilliams, 1994, p. 42-43). She worked with severely disturbed children and observed the infant’s separation process from his/her mother. Following, this separation-individuation process called as “psychological birth of a human infant” is theorized by Mahler; basically, it is assumed that disturbed children have difficulty identifying their mother as the “beacon of orientation” and forming a symbiotic relationship with her, which is an indispensable part of the formation of separate self and other mental representations (Mahler, Pine, & Bergman, 1975). Separation-Individuation Theory consists of subphases for healthy psychological development followingly: (1) normal autistic phase (first weeks of life, an infant is detached from the environment and sleeps boundlessly), (2) normal symbiotic phase (up to 5 months, mother-child dyad is perceived as fusional being, sense of self has not formed yet but separated from milieu), (3) separation-individuation phase (symbiotic relation ends, and a barrier between self-other, inward-outward is formed, and
the sense of self and cognitive abilities are developed), (3a) hatching (first months, getting out of the autistic shell and being aware of outside), (3b) practicing (9-16 months, characterized by blissful states, infant discovers the outside world with ambulatory behaviors under the watchful eye of mother, brief separation periods encouraged and followed up by reunion periods), (3c) rapprochement (15-24 months) (child gets into depressive moods by realizing that physical proximity exhibits psychical distance, separateness from mother) (Schore, 1994; McWilliams, 1994; Mahler, Pine, & Bergman, 1975). Moreover, Masterson (1976) postulated that borderline people fail and become immobilized in the separation-individuation process, which might be related to the mother's discouragement and reluctance for her child’s separation or rejection/neglect of the mother when the child seeks a soothing object right after the separation (McWilliams, 1994, p. 80). Beyond that, the core of individuality, selfhood, body ownership, and how one relates himself/herself with the environment lie down in separation-individuation.

1.7.8. Wilfred R. Bion

Wilfred R. Bion, who engorged on Freud's and Klein's thoughts, made many contributions to psychoanalysis by bringing mathematical understanding. His most notable contribution was to the theory of mind, and he put forward the “container-contained model” in 1962. This model illustrates that physical concrete somatic experiences (beta elements) deriving from the child's inner and outer senses are contained and processed by the mother's developed psychical operating system (alpha elements) due to the child's immaturity. Mother lends symbolization capacity to her child to transform his/her beta elements into alpha elements. Thus, the mother who tolerates and absorbs the aggression of her child becomes a “container-breast,” and a rudimentary child who cannot cope with plaguesome beta elements becomes “contained” by the mother. Abstract symbolic thinking action stems from affect-laden, corporeal experiences mediated by the mother; the sense of “containment” must be experienced at the physical level initially to be represented at the psychical level, in line with Freud's word (1923) from physical, bodily wrapping by touch through psychical wrapping (Anzieu, 1995, p. 173-174). Moreover, Bion (1967) associated containment and projective identification mechanism, asserting that the elements infants cannot contain or get rid of are expelled via projective identification; also, projective identification serves as an emotional communicative tool between mother
and child (Hafsi, 2011). If a mother is unresponsive, inaccessible to the child’s call, or unable to contain what the child projects, this situation might induce devastating consequences by internalization of a “dead mother,” what Bion called (1967) a “nameless dread” (Anzieu, 1995, p. 127). In addition, incorporation or projection of lived discrete experiences and transformation into intangible symbolic forms are procured by porous, permeable skin, which is of vital importance placing between body-brain and mind (Anzieu, 1995, p. 42).

1.7.9. André Green
André Green's well-known study of “dead mother” (1993) was asserted to represent a state of identification with an emotionally inaccessible mother who is absent (physically or psychically) and unapproachable for her child and its devastating irretrievable impacts on the child’s psyche. Although the mother is responsive, containing, and caring towards her child in the first phases, the mother cuts off her emotional engagement with her child instantly, and she becomes an insensible, emotionally blind person due to the loss of beloved ones, trauma, or mourning story in family history, etc. (Green, 1993). Sudden withdrawal or absence of mother corresponds to death for a child, and it is incorporated by a rudimentary infant whose psychical formation has not formed yet. This maternal deprivation or emotional distance causes a sense of internal void and emptiness, which also characterizes borderline personalities (Green, 1993). If no object nourishes the child’s narcissism, a child can make libidinal investments on death drives and tries to be objectless by diverging from vitality. Moreover, Green (2001) mentioned the existence of “negative narcissism” in contrast to the common tenet that tackles narcissism positively around life drives, which is seen in the clinic as “dead mother syndrome.” Green (1980) advanced Freudian drive theory by coining “life and death narcissism” concepts. While life narcissism implies vitality, the capacity to make the libidinal investment to others to create one's mental representations, death narcissism prevails in cases of being objectless that leads to self-destruction under the domination of death drives basically (Padar, 2015).
1.8. The Concept of ‘Skin’ In Psychoanalytic Literature

“I feel between myself and epiderm a gap, a thin space, where the wedge of spiritual dissociation could be set.”

John Updike (1976) from the Journal of Leper

1.8.1. Didier Anzieu’s “Le Moi-Peaup”, The Skin-Ego


According to Anzieu (1995), the skin-ego is a metaphor that addresses the need for “narcissistic wrapping” for healthy development of psychical apparatus that is based on a physical “touch”, bodily contact; in line with that, he elucidated that “every psychical activity leans anaclitically on a biological function.” (Anzieu, 1995, p. 44). Moreover, Anzieu (1995) aimed to explain intertwined mind-skin connection starting from ectoderm in utero through following developmental periods over symbolization, mentalization capacity, etc. Also, Anzieu emphasizes the importance of libidinal investments made by mother throughout skin-to-skin “contact” because the skin is the first and only communication channel between mother and neonate in preverbal phase, where the records of early relationships are kept by favour of “psychic envelopes” (Lafrance, 2013; Szwec, 2008; Anzieu, 1995). The skin-ego is consisted of psychic envelopes (les enveloppes psychique), which are equipped with filtering and holding features of the multisensorial input (Anzieu, 1985). Therefore, Henri Wallon Called the skin as a “seat of proprioceptive sensations” (Anzieu, 1995, p.42). The representation of self and psychical contents is initially established at a skin-deep level between body surfaces (Szwec, 2008). Also, there are many other functions of the skin as follows: holding and handling, protective shield against external threats, containment, interface between
interoceptive and exteroceptive systems, multisensorial integration, communication tool, filtering and keeping records of sensorial data, libidinal investment object and interface for adult genital excitation or sexuality (Parman, 2005; Anzieu, 1995; Szwec, 2008; Lafrance, 2013).

Referring to Brazelton, Anzieu mentioned about illusionary common skin fantasy where the mother-child dyad shares the only skin metaphorically as an extension of the symbiotic relationship in early periods (Anzieu, 1995, p. 67-68), and with this phantasy mother binds, holds the psychical and physical entities of her child. With the recognition of m-other, a major shift occurs from primary narcissism/masochism to secondary narcissism/masochism based on the quality of contact, and common skin fantasy collapses and induces sorrow and resistance (Anzieu, 1995, p. 45-47). Additionally, he states that if the skin-ego grows in a more masochistic way, the common skin is sensed like phantasies of “flayed/stolen skin” or “damaged/murderous skin,” as usually happens in psychosomatic, borderline personalities (where the skin surface is disrupted, irritated, distorted or slashed, unlike narcissistic patients), who develop thick skin ego (Anzieu, 1995, p. 48, 67-68; Gabbard, 2002). Thus, his papers include ‘void,’ ‘inside-outside,’ ‘negation’ and ‘deficiency’ terms frequently (Parman, 2005). Followingly, Anzieu (1995, p. 36) states these words about cutaneous symptoms;

“...skin irritation is confused with mental irritation and the eroticisation of the damaged part of the body emerges belatedly to make pain and hatred tolerable and to try to turn unpleasure into pleasure....because the skin, acting as the mirror of the soul rather than as a boundary, allows an interlocutor to read directly the sexual and aggressive desires the patient is ashamed of but also because the skin is revealed to the other person as a fragile wrapping that invites physical penetrations and psychical intrusions.”

Danièle Pomey-Rey, who is specialized in the psychodermatology field with dermatologist, psychiatrist, and psychoanalyst identities at the Hôpital Saint-Louis, has asserted this hypothesis about cutaneous pathologies as follows “the depth of the damage to the skin is in proportion to the depth of psychical harm done” (Aloupis, 2005).
Subsequently, Anzieu put this hypothesis referring to Pomey-Rey “the seriousness of the damage to the skin is related to the quantitative and qualitative extent of flaws in the Skin-ego.” (Anzieu, 1995, p. 37).

1.8.2. Esther Bick’s Second Muscular Skin

“My body is also Violette's body. The smell of Violette is like my second skin. My body is also the body of dad, the body of Dodo, the body of Manès ... Our body is also the body of others. ”

Daniel Pennac (2012), from Storia di un corpo (translated by myself)

Esther Bick, a psychoanalyst and child psychiatrist who worked with severely disturbed psychotic children, developed the “second muscular skin” metaphor in 1968, impressing by Bion and Klein. This model represents the need for containment by external objects to hold together the internal milieu of an infant with the “binding forces” of the mother-that does not exist in infants- throughout the skin periphery (Bick, 1968). Containment functioning is provided by introjection of an exterior mother during the breastfeeding periods, while the baby is experiencing the nipple of his mother is contained to his body, and his body surface is contained to his mother is throughout holding and handling periods between skins. At that point, the extraneous mother is experienced as a skin-deep facet contained to the child’s skin, which corresponds to the common skin fantasy of Brazelton in some sense and also similar to the imaginary space of Sami-Ali where the mother-child dyad is sensed as a compounded being in enmeshed form in metaphorically (Anzieu, 1995, p. 217-218; Bick, 1968).

In cases of maternal deprivation, projective identification prevails against the introjection and induces pathological disorganizing states in a child’s selfhood, and consequently, the infant goes looking for an object that he/she can hold himself/herself together to soothe himself/herself (Anzieu, 1995). Dysfunction in the formation of “first skin” drags the child into the creation of “second skin,” a substitute object (a light, voice, smell, etc.) or muscular/skeletal investments followed by agitated states in the absence of the container mother (Bick, 1968). Infants, particularly psychotic and autistic children,
create “**muscular second skin**” as a self-soothing strategy to cope with destructive, catastrophic thoughts (Bick, 1968). In addition, Anzieu considers that his skin-ego notion coincides with Bick’s first skin idea (Anzieu, 1995, p. 218).

1.8.3. **Frances Tustin’s Autistic Skin**

“...I felt the wall of my skin: I am I. That stone is a stone. My beautiful fusion with the things of this world was over...and again: “Skin [...] peels away easy as paper.”

Sylvia Plath, American poet and novelist, (Ocean, 1212–W)

Frances Tustin (1981, 1988), a student of Bick, appended the autistic skin concept to psychoanalysis literature, and she associated psychogenic autism with early traumatic separation from mother. Tustin (1981) discusses that children who have experienced perturbating relationships or the absence of a caring mother cut off the communication and seek refuge in the autistic shell as the last resort (Spensley, 1995). Moreover, Tustin (1981) goes into the division of autistic envelopes; while “encapsulated” children, who have a healthy physical body but receive inadequate tactile stimuli, become entrapped in hyper-sensitive states and develop hard-shell “crustacean” skin; “entangled” children, who are morbid and lacking good health, develops jelly “amoeba” skin where their bodies are waxy flexible and devoid of boundaries inside and outside, self and other (Spensley, 1995, p. 34-35). However, the sensation of autistic children works properly, and their concrete physical body turns into wilderness due to the absence of tactility (Diamond, 2013, p. 145). Hence, intact bodies cannot display any awareness of tactile stimuli or skin boundaries; hence, they cannot perceive the proximity of others and vitality of themselves (Tustin, 1988). Those untouched children cannot experience the separated-skin living because they have to be unified once to have separate skin; consequently, they create an illusionary autistic shell for themselves by withdrawing from the rest of the world (Tustin, 1988; Diamond, 2013, p. 150-151).
1.8.4. Jacques Lacan’s Möbius Strip

“The skin is me, I can’t get out of it.”

John Updike (1976) from the Journal of Leper

French psychoanalyst Jacques Lacan (1978-1979) has proposed a topographic understanding of the expunction of boundaries between inward and outward in relational terrain regarding skin, which was against to dichotomous approach of conventional psychoanalysis. In “Seminar 26: Topology and Time”, Lacan (1978-1979) elucidated those binary opposite concepts co-exist continuously in enmeshed form like a Möbius Strip or Klein Bottle, kind of an oxymoron that eliminates the borders and combines the contradictory meanings in one hand such as objectivity/subjectivity signifier/signified, interior/exterior, etc. (de Florence, 2011; Diamond, 2013, p. 187). Möbius Strip is a boundless nonlinear model that represents inextricable continuous margins of the body and its surface between inside-outside; thus, Lacan conceptualized “extimite” term by the conjugation of ‘intimite’ (interior) and ‘exterieur’ (exterior) in a versatile fused form to eliminate paradoxical duality (Kaçar, 2018; Zizék, 2014). Also, he claims that there is constant synchroneity between the inner and outer sides of our bodies which is strengthened by reciprocal traversable actions such as touching, holding, mirroring, etc., which create protean doubling perception about what is endogenous or extraneous. Hence, subjectivity comes from a boundless field where the borders are not delineated yet, and others are scratched under a child’s skin throughout intercorporeal exchanges (Diamond, 2013, p. 124; Toadvine, 2019). In line with that, Fabrizio Palombi (2009) alludes, “our subjectivity no longer has an interior or an exterior; we are always on neither inside nor outside of our identity.”

To summarize, our subjective being is subsequent and inconsistent in the relational milieu where other comes first. Hence, the Self is in an everlasting change in intersectional terrain of other body surfaces, and others are scratched beneath an infant’s skin for Self-formation (Diamond, 2013, p. 187).
1.9. Borderline Personalities and Early Relational Trauma Model


Although the history of borderline personality goes back 1800s, first it was described in 1978 and classified as a diagnostic category of borderline personality disorder (BDP) in DSM-III in 1980 (Hodges, 2003; Austin, Riniolo, & Porges, 2007). Otto Kernberg (1967) was the first clinician to describe borderline personality organization, and he settled this category among the personality organizations ranging from neurotic to psychotic on the linear continuum (Bateman, & Fonagy, 2018, p. 5). Kernberg, who was inspired by Klein and Mahler, mentioned about four characteristics of borderline personalities: (1) “identity diffusion”, (2) “massive usage of primary defenses” (projective identification, projection, denial, and splitting), (3) “distorted but maintained reality testing”, (4) (typically negative) “internal object relations” (Bateman, & Fonagy, 2018, p. 5). Moreover, Kernberg discusses that borderline people have narcissistic flaws deriving from early experiences of deprivation or abusive relationship that induces negative intrapsychic organization (Clarkin, Yeomans, Kernberg, 1998, p. 2-10) coincides with the negativity of Green; negative narcissism aims to kill vitality by being objectless and corrupting emotional, libidinal relations, in some cases somatization is used by borderline patients as an implicit self-harming behavior where the borders of the body (between self-other, inside-outside) are corrupted, so these people have difficulty on separation process -that corresponds to practicing period of Mahler-, and they never reach to the depressive position of Klein. Borderline people apply splitting mechanism pervasively and other primitive mechanisms due to lacking consistent internal object and failure of object permanence (Clarkin, Yeomans, Kernberg, 1998); it might be associated with interruption of the “continuity of being” (Winnicott, 1962) and absence of holding “container mother” (Bion, 1962). Kernberg placed the drives -libido and especially the innate aggressiveness- at the heart
of psychopathologies (Clarkin, Yeomans, & Kernberg, 1998; Bateman, & Fonagy, 2018), and as many of the classical psychoanalysts, he almost did not mention about Ferenczi, attachment, early traumata and dissociation (he refers to splitting and identity diffusion instead of dissociation in Kleinian perspective (Mucci, 2018).

Recently, it has been approved that adverse childhood experiences, including physical, sexual and emotional abuse, dissociation and disorganized attachment, play a fundamental role on the pathogenesis of BPD and all psychiatric disorders in adulthood, by altering infant’s brain structure whose effects remain lifelong (Gunderson et al., 2018; Schore, 1994, 2001; Fonagy, 2000; Paris, Zweig-Frank, & Guzder, 1993; Herman, Perry, & van der Kolk, 1989; Mosquera & Steele, 2017; Modell, 1963). Moreover, Clara Mucci (2013, 2018) created a model of trauma, where she emphasized the importance of early cumulative relational experiences on the occurrence of borderline personalities, and she claims the intergenerational transmission of encoded traumatic memories and disorganized attachment implicitly throughout right brain communication referring to Schore (1994). In this model, Mucci (2013) mentions about 3 levels of interpersonal traumatization as it follows: (1) “Early Relational Trauma” originates from insecure/disorganized attachment relationship, where the mother is unresponsive to her child and synchronization between mother and infant is missing, and it may generate affect dysregulation and other severe consequences up to dissociation (referring to Schore), (2) “Maltreatment, Abuse, and Identification with The Aggressor” is identified with actual abuse, maltreatment or severe neglect combined with misattunement, and excessive arousal states in addition to neurobiological impairment, and finally it ends up with internalization of perpetrator and his affects such as shame, guilt, aggression, rage where the child immobilized being both victim and persecutor (referring to Ferenczi), differentially Mucci propounded the transmission of the internalized victim-persecutor dyad onto the body with self-harming behaviors, suicidality, impulsivity, loosing sense of body ownership, etc., (3) “Massive Trauma and Intergenerational Transmission” is described with collective massive trauma such as extermination, genocide, war etc., where the victims entrapped in the state of hopelessness and initial trust and internal objects of victims are distorted by the excessive aggression, rage, dehumanization, and these disrupted object relations and disorganized attachment might be transmitted to future generations epigenetically, which means genetic disposition to psychiatric
disorders is triggered by environmental factors starting from in utero throughout methylation process to consecutive relational periods (van Ijzendoorn, Bakermans-Kranenburg, & Ebstein, 2011). Mucci (2018) proposes that silenced, unnarrated, and unmourned traumata significantly impact the second and third generation, preparing the ground for borderline personality pathogenesis.

In “Borderline Bodies,” Mucci (2018) underlines the importance of corporeal exchanges between mother and child because the body is the depository place of early living during the preverbal phase; in van der Kolk’s words, “the body keeps the score” (2014) and followingly becomes an arena for the revival of those engraved early interactions by reenactments. In line with that, Diamond (2013) mentions that “semiotics” consist of corporeal marks imprinted under the skin of a child by others, and she sees semiotics or bodily experiences as a sort of proto-conversation that constructs a prototype of future interpersonal and intrapersonal relations and body ownership. Turning back to van der Kolk (2014), he demonstrated how trauma is recorded in the neuroendocrine-immune system implicitly and how negative encoded experiences strike the body with affect dysregulation, muscular and skeletal problems, autoimmune disorders, etc. and speak through the body. Traumatized people are imprisoned in the margins of their “own” body with extreme hyperarousal states, and van der Kolk calls this situation “speechless terror” referring to Shakespeare because when the traumatic memory is recalled, the dorsolateral prefrontal cortex associated with chronology and Broca field related to narration is deactivated. Therefore, traumatic memory is encoded in the nonverbal affective amygdala in the right hemisphere with dissociated sensations accompanied by intense emotions due to the collapsed homeostasis (van der Kolk, 2014). Victims of trauma are immobilized between knowing and not knowing, remembering and not remembering, past, present and future, life and death situations; moreover, they don’t feel secure and fully alive in their “own” body due to dissociation, depersonalization, derealization (van der Kolk, 2014; Mucci, 2013).

The human infant is a social being preprogramed to be attached to others, even if they are abused because being objectless is equivalent to death. As the state of helplessness increases, so does the need for attachment; the comforting object is also the source of pain and terror. van der Kolk (2014) says that victims are addicted to their trauma, and he describes this situation as “pleasure of pain” and “pain of pleasure” at the
same time, which might be linked with “jouissance” concept of Lacan (1986) where pain and pleasure are intertwined. Jouissance, pleasure in the pain or pain in the pleasure, might be considered as an extreme compulsive behaviour (in this case, traumata) that brings immeasurable pleasure that ultimately causes severe discomfort and pain and disorganizes itself in the end (Benvenuto, Kennedy, & Lacan, 1986, p. 209). Hence, Lacan associated jouissance with the relentless repetition compulsion mechanism used for repressed traumatic memories.

1.10. Narcissistic Pathologies

Narcissistic personalities are generally described with grandiose selves on the surface, but underneath they have very fragile self-esteem and constantly seek attention and affirmation from others. Hence, even the slightest criticism or disapproval may pose a hazard for their self-coherency, and it might reveal “fear of breakdown” (Winnicott, 1974) or fragmentation, which prompts narcissistic to exhibit antisocial, self-harming, impulsive behaviours, seductive/manipulative language to protect their vulnerable self-esteem. According to Kernberg (1975), who tackles pathological narcissism as a structural problem, antisocial proneness takes place in the scope of innate aggressiveness and enviousness (referring to Klein), and he settles malignant narcissism at the end of borderline personality disorders’ continuum as a most severe case (Kernberg, & Yeomans, 2013). Kernberg (1975) explains the etiopathogenesis of narcissism around innate aggressiveness toward disappointment in early relations, and he characterizes narcissism with extreme perfectionism and unrealistically high ideals, lack of empathy for others, antisocial tendencies, more importantly, the sense of emptiness beneath the grandiosity. Also, this narcissistic pathology is explained as a disruption of “psychosomatic integrity” (Winnicott, 1949) by the formation of a “false self” (Winnicott, 1960) under the influence of overbearing “ego ideal” in a relational context, where the children are seen as a narcissistic extension of their parents (Erten, 2015). Mervin Glasser (1992) expresses narcissistic personality formation around “simulation” -that converges on Winnicottian false self- and “core conflict” concepts referring to difficulties in the individuation process.

From a relational perspective, the infant creates an internal empty space to run away from an intruder by creating a simulation in the case of an intrusive mother who does not
leave a space for her child’s separation (Glasser, 1992; Erten, 2015). In contrast with Kernberg, Heinz Kohut (1971) sees pathological narcissism as a developmental and relational interruption, who considers that when “selfobjects” of a child—which are in fused form with the infant’s self- cannot provide optimal care and contain narcissistic needs of a child, the continuity of child’s being is damaged, and it prepares the ground for pathological narcissism (Ak, & Sipahi, 2015).

McWilliams (1994) explains the intimacy and morality problem of narcissists within the deprivation, what she calls “basic failure of attachment.” Narcissistic personalities are driven by two main feelings “shame” and “envy”; they are envious of other’s gratitude that they have never experienced due to a lack of consistent, caring, secure object relationships probably, and shame feeling arises from humiliation experience. The sense of emptiness, non-integrative, inadequacy, or inferiority (Kernberg, 1975) arises from “internalization of and identification with the bad object” (Fairbairn, 1952); despite the unbearable affects and shame, the infant incorporates the bad object/dead mother instead of “de-objectification” that corresponds to psychical death (Green, 1993, 2001; Mucci, 2018, p. 181, 205). Thus, the body becomes the only object narcissists can relate to themselves; therefore, they are excessively focused on their body to run away from these plaguesome inner senses, as observed in severe hypochondriac cases.

Narcissistic personalities are divided into two groups called several names by clinicians as follows “obvious” vs. “hypervigilant” (Gabbard, 1989), “thin-skinned” vs. “thick-skinned” (Rosenfeld, 1987), “overt” vs. “covert” (Cooper, 1988) (McWilliams, 1994, p.181; Mucci, 2018, p. 179, 187). While thin-skinned narcissists are introvert types who display excessive fragility, shyness, impoverished vitality, and anxiety about being rejected by others; thick-skinned ones are the arrogant, boastful, pretentious type with grandiosity, and even the slightest criticism may induce arousal dysregulation (hyperarousal in overt type, hyperarousal in covert type (Mucci, 2018, p. 187-188).

1.11. **Psychosomatic Disorders**

Psychosomatic disorders are “half way between the mental and physical, are in a rather precarious position” (Winnicott, 1954), and the body makes the pain visible through somatization, diseases, skin rashes, aches, etc. In psychosomatic patients, the body is
defenceless towards external stimuli, and the mind/psyche is almost devoid of symbolic capacity that prohibits the creation of mental representations and the narration of psychical conflicts through the language, hence it strikes onto the body (Limnili, 2015). Therefore, an impassable barrier is built between “psyche-soma” that corrupts “psychosomatic integrity” (Winnicott, 1949, 1954), and the body turns into an arena where the early preverbal conflicts go on the stage, with McDougall’s (1989) words, “Theatres of the body” begins as an only possible way of communication in case of impoverished symbolization capacity (Baudin, 2005).

Winnicott (1960) says pseudo self or “false entity” results from an imperfect environment by the prohibition of taking optimal care physically and emotionally, interrupting a child’s continuity of being. In line with that, Corrigan and Gordon (1995) coined the “Mind Object” term to indicate overinvestment in mental defences in the absence of corporeal experiences (shared with m-other), referring to Winnicott’s (1949) “body-in-dwelling,” which is commonly observed in narcissistic pathologies, especially on hypochondriacs (Erten, 2015). In the case of unbinding mother, libidinal wires between soma and psyche are ruptured due to identification with death mother, as a result it is seen the enforcement of death narcissism and internalized negativity through turning against self with masochistic attacks on one’s own body (Green, 2001; Padar, 2015).

McDougall (1989) asserts that psychosomatic adults have infant-like psychical functioning, and she puts emphasis on the “infant” word that means “unable to speak,” referring to somatic symptoms’ lack of symbolic meaning (Ciğeroğlu, 2015), in Winnicott’s (1974) words bodily expression is “dumb.” An infant, who cannot speak verbally, speaks through his/her body by manifesting symptoms as psychosomatic patients do. There is no division between inside and outside, self and other, in preverbal phases, what McDougall (1989) calls “one body and one psyche for two people” this sort of symbiosis turns into a pathological situation in psychosomatic patients by not having their “own” body and mind due to non-container mother (Ciğeroğlu, 2015). Symbolization is a high-order ability gained through internalization of consistent care, allostasis, and affect regulation, which is absent in psychosomatic patients. Moreover, when a mother projects her negative affections and parts onto her child, it diffuses under the child’s skin and fragments the child’s rudimentary psyche into pieces (Mucci, 2018) due to the child’s low threshold for excitations and arousal (Fogel, 1982). Besides that,
McDougall (1989) uses the “archaic hysteria” concept to differentiate pregenital psychosomatic symptoms lacking symbolic meaning from neurotic conversion originates from the oedipal complex, whose main purpose is not only to protect their identity or sexuality like hysteric people but to protect their body and psychosomatic integrity rooted in the early relationship during preverbal phase (Baudin, 2005).

1.12. The Importance of Skin on Borderline Functioning as A Frontier

“I elaborate my sensation that the leprosy, chased from my skin, is fleeing to deeper tissue, will wait there to be reborn, in more loathsome and devilish form.”

John Updike (1976) from the Journal of Leper

The skin has a special place as a conjunction point of the complex brain-body-mind system. Since the second week of gestation, skin and brain development are interpenetrated at ectoderm whose interwoven relationship remains a lifetime. Hence, dermatological diseases are more than skin disturbances that occur on a body surface, considered an extension of dysfunction in neuro-immune-cutaneous-endocrine (NICE) systems (Yucha, Tamamoto, & Kaplan, 2019).

Since prenatal life, the foetus is tactually in touch with the placental periphery. Thus, skin is the relational territory where the archaic, nonverbal, somatosensory, and tactile communication initiates between infant and (m)other via touch throughout holding or handling experiences (Winnicott, 1960; Anzieu, 1995). Skin as an interface keeps the records of implicit early relational/libidinal experiences conducted with other surfaces, and this exteroceptive information is combined with proprioceptive knowledge for multisensorial integration.

Skin is the body’s largest organ and a natural barrier/protective shield against external physical threats (injury, light, heat, etc.), and it avoids hypothermia by regulating body temperature (Shiel, 2018). Moreover, skin as a covering sheet represents the whole body, and it is related to interoception and body-awareness; hence it plays a fundamental role in selfhood formation in relation to social milieu (Fotopoulou, & Tsakiris, 2017). Skin is a transitional position between body-mind, interior-exterior, and self-other, so
disturbances on the skin periphery represent the corruption of boundaries, early deprivation, and lack of holding capacity, and many other psychological phenomena attributed to borderline, narcissistic, and psychosomatic psychopathologies (Parman, 2004).

There are many paradoxes and dualities about skin qualities; pervious and impervious (between mind and body, inside and outside, self and other), skin-deep and profound, vulnerable and durable, flexible and inelastic, protean (manifests righteous or fallacious sensations), and stable, abstract (related to selfhood and sexual orientation) and concrete (tangible surface) at the same time (Anzieu, 1995, p. 19). Furthermore, doubling perceptions arousing from tactility might be attributed to its two-layer texture; while the thin, sensitive layer epidermis on the top demonstrates its congenital impotence and vulnerability in the face of exterior dangers; the interior thicker layer dermis (contains blood vessels, sweat glands, nerve ending, etc.) plays a role on multisensorial integration and differentiation (Karakaya, & Çınar, 2018). Consequently, porous skin extending through the margins of the body surface is of great importance due to its complex make-up between NICE systems, crucial role in the psychological organization, and its many unidentified qualities, besides being an interface between many dualities.

Neonates come to the world with a thick xanthous adhesive layer of “vernix caseosa” on their skin, which is consisted of sebum (skin oil) due to an underdeveloped thinner layer of the dermis, which precludes hypothermia, prevents rotting/decaying of infant’s skin in utero, varnish the body as a protector towards external threats (Karakaya, & Çınar, 2018; Shiel, 2018). Accordingly, enveloper and conserving vernix might be associated with maternal shielding, holding, containing, and binding functioning in psychoanalysis. An infant, who is entrapped in helplessness, seeks embodied skin-to-skin proximity of the mother rather than fulfillment of physiological needs because mother attenuates distress/pain of the child, regulates his/her affects, scatters anxieties (Shamay-Tsoory, & Eisenberger, 2021), provides a sense of security like vernix caseosa via tactual interactions. In cases of deprivation, maltreatment, abuse, etc., skin speaks through irritations and rashes nonverbally (Parman, 2004), and it becomes a battlefield where internalized early negative relationships turn into cutaneous diseases (Mucci, 2018), which also creates negative templates for future interpersonal and intrapersonal relationships and notably relationship with “own” body” (Schore & Schore, 2008;
McDougall, 1989). In case of deprivation (dead mother state), the introjected absence of mother projected onto skin with dead epidermal cells or dermatological symptoms are used to compensate for lacking tactual stimulation of m-other such as creating hallucinatory satisfaction like being touched by others (Marty, 1958; Szwec, 2006; Marty & de M'uzan, 1963).

Psychosomatic illnesses, hypochondria, and alexithymia emerge developmentally due to the intersubjective developmental deficits, often with severe neglect and following trauma history. The body and skin evolve into a stage for enacting or re-performing previous maltreatment, abuse, and severe neglect; however, the conscious mind does not remember (due to undeveloped hippocampus and prior amygdala detection) and embodied records of traumata are repeated on the body surface with peculiar symptoms. Psychosomatic diseases are the expression of affect dysregulation between body-brain-mind systems that strike the soma per se (nerves, organs, skin, and physiological functions such as sleep, digestion, heartbeat, and blood pressure) (van der Kolk, 2014). According to the psychodynamic approach, all these symptoms are attributed to a deficit in core functioning of skin related to maternal shielding, holding, and containing capacity.

Recently, it’s been demonstrated that early comforting/pleasant touch experiences effect interoception, body-ownership (Della Longa, Filippetti, Dragovic, & Farroni, 2020; Crucianelli, Metcalf, Fotopoulou, & Jenkinson, 2013; Jenkinson et al., 2020), and body representation (regarding interoceptive and exteroceptive perceptions) and consequently, associated psychopathologies in adulthood. Löfller et al. (2022) showed that people with borderline personality disorders had a negative evaluation tendency of comforting touch and decreased body-ownership compared to the healthy group. From a clinical point of view, negative assessment and bodily awareness in BPD have been affiliated with dissociative living and early relational trauma (Löfller et al., 2022); as Ferenczi (1932) said, an immature child, who doubts his/her sensations due to seductive and deceitful language of adults, loses his/her body-ownership. In this case, disconnection from one's body and feelings might be related to a lack of comforting or disconcerting/abusive touch experiences. Also, in another study, it has been represented that people diagnosed with anorexia nervosa (AN) were less pleased during social tactile interactions (based on their facial expression) compared to healthy groups (Crucinelli et al., 2016; Keizer et al., 2014). Experienced anhedonia in AN patients might be related to reduced bodily-awareness due
to body dysmorphia; hence affective touch plays a crucial role on the somatosensory process and proprioception underlying body-ownership (Crucianelli, Metcalf, Fotopoulou, & Jenkinson, 2013).

Furthermore, social touch establishes a sort of liaison between toucher and touched one, which activates the reward system for both, reduces pain/distress (arousal states), and activates oxytocin release (Shamay-Tsoory & Eisenberger, 2021). Also, it's known that unregulated distress, long-standing hyperarousal states induce high number of cortisol secretion which results indelible impairments (cellular death in amygdala, malfunction in the area of prefrontal and orbitofrontal cortex and underdeveloped parasympathetic neuron system, etc.) on malleable brain of infant, and all these impairments also found in pathogenesis of further borderline, narcissistic, antisocial personality disorders (Winnicott, 1960, 1949; Bick, 1968; Mucci, 2018; Schore & Schore, 2008; van der Kolk, 2014).
2. CHAPTER 2: ON NEUROSCIENCE

2.1. Departing from One-Body-Mind Aspect Through Intersubjectivity

The human is a complex psychosomatic being that has been considered around the body-mind dualism as a subject of heated debates, and this binary aspect has underpinned the classical psychoanalytical approach. Self as a form of subjectivity—in some sense ‘mind’ or ‘psyche’—originates from these (inter)corporeal exchanges as an intangible reflection (Freud, 1923). According to Freud (1915), first and foremost, there was a biologically fixed motivational body fuelled by internal urges or ‘instincts’, whose main aim is to discharge of tension. In this perspective, from the very beginning, there was a reified concrete body law of nature, and the origin of subjectivity—so-called ‘bodily ego’—was inscribed in early (inter)corporeal experiences depending on others (Freud, 1923). However, the scaffolding m-other who nurtures the child was considered a subsequent collateral fact instead of an active player who shapes the trajectory of her child’s developing brain-body map (Schore, 1994, p. 24-25).

As opposed to motivational theory, which is focused on satiation of biological vital exigencies “depending upon other,” Fairbairn propelled that the human infant is oriented on object-seeking patterns rather than pleasure-seeking ones (Mucci, 2013). With this incompatibility, and ignored forgotten m-other gained currency, which comprised a basis for the foundation of object relation school in Britain in the following years (Schore, 1994, p. 24-25). Meanwhile, a ground-breaking study of Rene A. Spitz’s (1945) “hospitalism”—conducted with institutionalized children—shed light on the importance of environmental, relational factors rather than physiological ones on the onset of psychogenic diseases. It has been emphasized how vital it is to have a stable bonding figure for the socio-emotive growth of a child to cope with anxiety and to develop immunity to somatic diseases and psychopathologies, which may lead up to death in the circumstances of long-lasting periods of separation or deprivation from bonding figure (Spitz, 1945, 1946, 1951). Spitz (1951), who addressed the importance of maternal care and nourishing mother, also affected the trajectory of imminent studies of Harlow (1958) and Bowlby (1969) (van der Horst, van Rosmalen, & van der Veer, 2019). Harlow’s (1958) experiment with rhesus monkeys called “nature in love”, was giving empirical confirmation to Spitz’s (1945) assumption that fulfilment of physical exigencies is not enough; an infant also needs the socio-affective communication to sustain a sense of
security and protection (Mucci, 2013; van Rosmalen, van der Horst, & van der Veer, 2012). Following, British paediatrician and psychoanalyst Donald W. Winnicott (1965) asserted that “there is no such thing as an infant, of course, that whenever one finds an infant one finds maternal care, and without maternal care, there would be no infant,” which was as a first attempt to compound the motivational and relational development aspects in one hand. Moreover, Winnicott articulated the importance of maternal and ecological factors on a child’s psychical and psychical development by propelling the concepts such as “facilitating environment”, “good enough mothering,” and “the mirror role of a mother” by referring to Lacan’s “mirroring stage” (Winnicott, 1965; 1966; 1971). In Lacanian “mirroring” concept, it was enunciated that the ego is shaped by the intervention of others and a wider socio-cultural milieu due to a child’s helplessness and dependence on others (the imaginary construct of the Self is forged by external Real m-Other and Symbolic father) (Licitra Rosa, Antonucci, Siracusano, & Centonze, 2021). All these studies contributed to the tectonic formation of attachment theory commemorated by John Bowlby (1969), demonstrating neonate’s evolutionary tendency to affiliate with m-other and develop affective relationships socially. Attachment theory, which has been objurgated and sent to coventry by psychoanalysts for a while, led to today’s interpersonal studies and underlined the influence of interaction on bio-neuro-psycho-social health of two people departing from one body-one mind aspect in classical psychoanalysis.

French philosopher Merleau-Ponty (1964) –who is known for studies on the ontology of flesh and embodiment– coined a new term of “intercorporeality” by revising Freudian bodily rooted ego, and he underlined the importance of corporeal interactions for the construction of Self by moving away from motivation oriented one-body and one-mind approach (Toadvine, 2019). He emphasized how “child's relations with others” affect an infant’s experiences with his/her body derived from others’ mirrors via touching, gazing, etc. (Diamond, 2013, p. 150). Thus, there is no such thing as an intact unblended individuality, “I” (Ich or Ego) is built in the terrain of “Otherness”; the self-image is composed by others (Merleau-Ponty, 1962; Diamond, 2013; Toadvine, 2019). Thus, the quality of early bodily interactions is engraved beneath the skin of a child as a primordial form of communication with the child’s own body and others –called “sensory semiotics” by Diamond (2013) --, or in other words, these early interactions are imprinted on branching brain-body map of an infant that eventually shapes the child’s body ownership
experience (Diamond, 2013, p. 149-150). Followingly, Diamond says, “Otherness is a condition for a sphere of ownness” even in the state of ‘primary narcissism’—that is described with the autoerotic heightened pleasure of urges—there is an Other who shapes the embodied Self and cognition of child (Diamond, 2013, p.150-152; Freud, 1914).

Subsequently, Merleau-Ponty (1964) pointed out that the skin membrane is the territory of ‘socialization’ with other surfaces, and there is indistinction between boundaries of self-other, inside-outside due to its porous make-up (Toadvine, 2019). Therefore, Merleau-Ponty (1962, 1964) mentioned that the faith of doubling deceitful perception derives from somatosensorial stimulation mediated by skin envelope, and he associated permeable skin with a glove inside-out outside-in (Diamond, 2013). The “reversible” interplay is conducted between two or more discrete bodies; nonetheless, the boundaries between inward-outward and self-other are wiped out in the relational territory like a nonlinear boundless möbius strip (Merleau-Ponty, 1964; Diamond, 2013; Lacan, 1978-1979). Relentless disguise of inner and outer perceptions and erasure of barriers occur due to the child’s immaturity. Finally, the external Other is engraved under the skin of a child by interactive exchanges in fused form—that resembles Mahler’s “symbiotic phase” (1975), Anzieu's “mutual skin” (1985), and Ulnik's “common skin” (2007)—, which comprises a basis for subjectivity moulded by others. For this reason, there is no intact individuality when the exterior other is incorporated and the encapsulated one is projected. Also, reciprocal actions, where the recipient and sender are anonymized, such as touching, mirroring, handshake, etc., induce doubling perceptions (for ex., being touched traverses to touch or vice versa) (Diamond, 2013, p. 124; Toadvine, 2019; Merleau-Ponty, 1964). Furthermore, this overturning glove model is proximal to Lacan’s Möbius Strip (1978-1979) that represents the continual, nonlinear, borderless relational model against to dualistic approach of psychoanalysis, where its emphasized selfhood is secondary and open to change in relational dynamics (de Florence, 2011; Diamond, 2013, p. 187).

Followingly, Atwood and Stolorow (1984,1996) brought novelty by presenting a new term, “intersubjectivity,” by grasping Lacan’s “mirroring” concept, which is created to indicate a wider relational web based on multiple interpersonal interactions in broader socio-cultural milieu rather than the dyadic or monodic approaches. Also, according to Lausanne Triadic Play, the human infant is not only disposed to establish a dyadic
relationship with his/her mother but from the beginning child is in the learning process to build triadic relations in a massive relational territory (Fivaz-Depeursinge & Corboz-Warnery, 1999). Intersubjectivity underlines “reciprocally” and “constantly” ongoing interactions between two or more organisms in greater relational terrain, which plays an essential role in the intrapsychic constitution of individual beings as a premise of further psychopathology, unlike traditional psychoanalytic theories (Stolorow & Atwood, 1992, 1996). Thus, Atwood and Stolorow proposed that human is not isolated intrapsychic being, and what is called subjective mind/psyche is an outcome of the “child-caregiver system of mutual regulation” (Atwood & Stolorow, 1992, 1996), and “intersubjective context has a constitutive role in all forms of psychopathology” (Stolorow, Brandchaft, & Atwood, 1987, p. 3).

In 1977, Meltzoff and Moore observed instinctual mimicking gestures of manual and facial expressions in infants devoid of purpose or meaning, 42 minutes right after birth, which has been considered a form of mirroring like primitive proto-conversation. It was a ground-breaking datum that demonstrates human infant is a socially growing corporeal being rather than an isolated organism; however, it was in contrast to a common tenet among the developmental psychologists who suppose imitation behaviour emerges around two years, considering Jean Piaget’s works (Iacoboni, 2009, p. 47-48). In the following years, many neuroscientific research has been conducted to enquire about the neurobiological basis of intercorporeal being in a social territory (bodily ego) and to find traces of early interactions beneath our skin, buried in our body implicitly. Giacomo Rizzolatti and his colleagues first monitored the mirror neuron systems in 1996 in the F5 area in the ventral premotor cortex in the macaque monkey’s brain. Moreover, the mirror neurons’ counterpart is tracked in the posterior parietal cortex in the monkey brain while it is watching someone's action, such as grasping, holding an object, etc. (Rizzolatti, Fogassi, & Gallese, 2002; Fogassi et al., 2005). These experiments sparked dozens of researches on mirror neurons and predications to comprehend the complexity of the human brain based on intersubjective experiences (Rizzolatti et al., 1996; Gallese et al., 1996; Iacoboni et al., 2005). However, the macaque brain is not as complex and big as a human brain, and they are akin to each other morphologically and anatomically; both brains are compounded of right and left hemispheres, with resemblance in major bumps (gyri) and grooves (sulci), and the situation of mirror neurons are in proximal areas in
frontal and parietal lobes (Iacoboni, 2009). Besides that, the location of mirror neurons in the left frontal lobe is the Broca area which strengthens evolutionary assumptions that mirror neurons might be extremely important for the human brain in the language learning process (Iacoboni, 2009). Additionally, neuroscientists were stressing the individual differences such as decreased mirror neurons activity and its impacts on the severity of the autism spectrum, which is identified with social-relational difficulties (Volkmar et al., 1993) and that might be an outcome of disturbed maternal communication due to lack of bonding process (Hyman et al., 2020).

The discovery of mirror neuron systems was a ground-breaking finding that approves the thesis of Merleau-Ponty’s (1964) “in perceiving the other, my body and his are coupled, resulting in a sort of action that pairs them.” In other words, the mirror neurons system is the neurological correlate of intercorporeality (Rizzolatti et al., 1996; Iacoboni & Dapretto, 2006). As Gallese (2006) elicited, “it is as if the other becomes another self” or with Merleau-Ponty’s words “it is as if the other's intention inhabited my body, and mine his”, for individuality “other comes first”, depending on somatosensory stimulation deriving from others we realize our animacy/vitality and those qualities of early tactile interactions constitute our “own” Self (Gallese & Sinigaglia, 2011). The mirror neuron system is a key figure for intercorporeal experiences that give us a deep understanding of others’ actions, affections, and motivations and to duplicate them (Iacoboni, 2009, p. 78). Some research has found a correlation between decreased mirror neuron activity and severity of autism syndrome, inclined mirror neuron activity and empathy, and socialization ability (Dapretto et al., 2006; Oberman et al., 2005; Gallese, 2006; Perkins et al., 2010). Intriguingly, the following studies demonstrated that neonatal imitation/mirroring or emotional contagion might be a sort of simple repercussion to link his/her actions with others’ rather than attachment because it is claimed that the mirror neurons system has a pairing grid that binds actions and affections of observed other in us (Gallese, 2007; Gallese, 2003). Hence, it has been posited “reciprocation” term to describe intersubjectivity by emphasizing the mutually co-constructed interplay between two and avoiding the previous hypothesis about the passive being of an infant (Gallese, 2007). Beyond the visible interference and intercorporeal exchanges, more is happening under the skin and inside our bodies. Attachment relationship is more than simple social bonding, shaping the psycho-socio-neuro-
biological make-up of human infant through emotive regulation of mother and child via right-hemispheric transmissions implicitly; moreover, the selfhood as a form of individuality originates from reciprocal bodily-based exchanges shared with others (Schore, 1994).

2.2. Interpersonal Neurobiology of Attachment-Affect Regulation- Self Formation

Allan Schore (1994) provided a neurobiological ground for attachment theory by stressing neonates’ socially structured experiential body-brain-mind development. He brought novelty by combining attachment theory with an Anglo-American intersubjective perspective, and he searched the neurobiological impact of intercorporeal transactions between two bodies, brains, and minds, which he called “interpersonal neurobiology”. Intriguingly, Schore illustrated the importance of postnatal living on localization of neonate’s developing brain, in inhibiting or promoting way. Nonetheless, recent studies show that also the neuroplasticity of the mother’s brain (grey matter in the limbic area) is altered during the postpartum era while in a relationship with her baby by favor of intense blissful affections between mother and child (Kim et al., 2010; Mucci, 2018, p. 33).

From the very first moment, the human infant is immersed in multiple relational milieus; undoubtedly, m-other figure is vital because an infant is entrapped in helplessness at the encounter of overwhelming affective states and does not know how to soothe himself/himself. However, the flux of interoceptive and exteroceptive information cannot be differentiated due to the infant’s puniness, and as a result exteriorized mother becomes the internal “hidden regulator” of her child’s neuroendocrine system (Hofer, 1990). Also, the mother promotes and mediates homeostasis during holding, breastfeeding, and maternal care; these activities require the mother’s physical proximity, which is based upon tactility initially. Allostasis, regarding the internal physiological equilibrium including cardiac rhythm (Feldman et al., 2011), body temperature (Feldman, 2007), sleep and arousal states, etc., is maintained by the mentalization of homeostasis, or in other words, by consistent maternal care (Atzil et al., 2018; Fotopoulou & Tsakiris, 2017).

Importantly, Schore (1994) demonstrated that the first year of life is crucial to developing attachment and neurobiological regulation with the mother depending on bodily-based interactions, which take place between the right brain (in subcortical
regions, amygdala, orbitofrontal cortex, limbic systems) of mother and child implicitly. Indeed, these early corporeal experiences -mediated by the external mother- are embedded in the archaic right hemisphere of an infant (Tucker, 1992), which thoroughly impact the maturation of synaptogenesis, dendritic arborization, myelination processes (Denenberg et al., 1978; Horn, Bradley, & McCabe, 1985; Schefflen, 1981; Schore, 1994, p. 31, 165). Moreover, the primordial right brain influences the linguistic left hemisphere, and the left brain becomes dominant in the second year of life by developing the hippocampus and Broca field related to narration and conscious memory. The precocious right hemisphere is bigger and heavier than the left one (Kertesz, Polk, Black, & Howell, 1992; Nonneman & Whishaw, 1982). The maturation of the intuitive right brain expands through the first year of life mainly, and it speeds up during the visuospatial era, in connection with the limbic system and subcortical areas (Joseph, 1982), including the orbitofrontal cortex (associated with socio-emotional development) (Denenberg et al., 1978; Yamamoto et al., 1984; Tranel, Damasio, & Damasio, 1988), prefrontal cortex (the most significant part of the human cerebral cortex) (Uylings & Van Eden, 1990). Around 10-12th months, a major shift commences from a dyadic to the triadic relationship with ambulatory behaviours of infant -what Mahler called the ‘practicing period’- which might be accepted as infant socialization (Schore, 1994). Furthermore, this alternation prepares the ground for abstract representation of emotional faces, especially the mother’s face (Goldenberg et al., 1989; Blonder et al., 1991; Suberi & McKeever, 1977). The mother’s face is the socioemotional and neurobiological mirror of her child, where the internal representations for future relationships are rooted (Papousek & Papousek, 1979; Steklis & Kling, 1985; Diamond & Doar, 1989; Mrzljak et al., 1990; Strauss, 1979; Bowlby, 1973).

Initially, the imprinting process initiates right after the birth via tactile, gestural, visual, olfactory, and thermal stimulation. However, the visual-affective dialog prevails as the densest form of communication between mother and child (Tomkins, 1963), whose received inputs substantially influence the developing limbic system (Schore, 1994, p.72). The face of the mother is the main source of optic stimuli, and pupil dilation occurs during intense gazing transactions -which is the proof of neurobiological attachment between mother and child dyad- (Schore, 1994, p.143; Petrovich & Gewirtz, 1985; Atzil et al., 2018). Mother as an external object mediates the allostasis of her child (implicating HPA
axis activity, oxytocin level, immune and affect functioning (Gunnar & Sullivan, 2017); she regulates hyperarousal states in the sympathetic system deriving from blissful, joyful (via oxytocin and dopamine segregation) during visual-affective phase, whose influences take place over the maturing orbitofrontal cortex and corticolimbic. (Schore, 1994, p.79).

The structural growth of the orbitofrontal cortex extends the first year of life anatomically, which is responsible for more complex tasks, including emotional behaviours, memory functions, decision making, multisensory integration, and cognitive skills (Rolls, 2004; Stuss et al., 1982; Thorpe et al., 1983). Multi-modal sensorial inputs deriving from exteroceptive and interoceptive are integrated at agranular cortices (becomes notable in postnatal life) during homeostasis through maternal behaviours, including holding, vocal intonation, breastfeeding, etc. (Stein, Stanford, & Rowland, 2014; Atzil et al., 2018). A significant change occurs from the first through the second years of life, and the toddler immerses in multiple relationships. Toddler discovers an enriched environment under the mother’s watch for brief periods of separation -which is called by Mahler (1975) “psychological birth of a human infant,” and it is followed by reunion periods to re-synchronize and consolidate attachment (Schore, 1994). During these short separations, the child learns auto-regulation and internalizes the image/face of the mother as if she was there (Goldenberg et al., 1989; Blonder et al., 1991). Herewith, the psychical act begins with the introjection of maternal care, and the origin of ‘Self’ emerges from the archaic schema of attachment and relationships engraved in a child’s body. So that reason, disturbances in self are related to early maternal dysregulation and consequently disorganized/avoidant/anxious attachment experiences.

To put it in a nutshell, early emotion-laden, corporeal transactions with the primary caregiver are crucial for the maturation of malleable brain systems, autoregulation, and mentalization capacity as a premise of future good relation capacities and social abilities, whose influences remain for a lifelong process (Schore & Schore, 2008; Fonagy et al., 2004; Mucci, 2013; Schore, 1994) ). Briefly, attachment and affect regulation are prerequisites for the healthy development of brain-body-mind system that shapes future intrapersonal and interpersonal behaviours and body ownership experience as a premise of future psychosomatic and psychiatric disturbances (Fonagy, 2000; Gunderson et al., 2018; Beeghly & Cicchetti, 2019; Mucci, 2018; Schore, 2001).
2.3. Epigenetics–Neuroplasticity

There is an interpenetrated relationship between environment and biology; even “biology is experience-dependent” (Diamond, 2013, p. 29-30). Ecologic factors directly impact the biologically pre-determined make-up of human infants from utero through postpartum life, particularly the maternal stress may alter the genetic structure of infant throughout the methylation process in DNA and RNA starting from embryonic life through postnatal development (Weaver et al., 2007; Tost, 2010; van Ijzendoorn, Bakermans-Kranenburg, & Ebstein, 2011). Also, it is observed that severe stress deriving from the mother-child dyad causes irreversible impairment in the child’s HPA axis that might predict future psychiatric and psychosomatic disorders (Schore, 1994, 2001; Mucci, 2018, p. 48).

Although the neuroscience is illuminating fallacies related to the genetical fixation of human beings, this semi-structured genetic make-up is still a vital bedrock that provides a ground for the imprinting process under the influence of social interactions; hence, ‘epigenetic’ term is coined to emphasize the inseparable connection between environment and biology (Ramachandran & Blankeslee, 1999; Ramachandran & Rogers-Ramachandran, 2000; LeDoux, 1996).

The growth of the human brain commences in prenatal life and extends through 25 years of postpartum life (Stiles & Jernigan, 2010), which is reshaped relentlessly by cumulative social experiences. The maximized neuroplasticity decreases from the first weeks of gestation to the ongoing periods of postnatal life but never disappears (Atzil et al., 2018). Indeed, the brain neuroplasticity of an infant is very sensitive to those intrapersonal and interpersonal experiences (Kandel, 1998; Garland & Howard, 2009; Greenough, 1987; Wilson, Willner, Kurz, & Nadel, 1986). Hence, Cozolino (2014) remarked that “brain is a social organ” molded experientially. The human infant is disposed to be social and engage with others since the 11th of pregnancy, as Castiello et al. (2010) demonstrated on other-directed movements among twin fetuses. Nonetheless, a human infant is not born with pre-set ‘social brain’ but physiologically capable of socializing as an outcome of homeostasis and allostasis affiliation (Atzil et al., 2018). While consistent homeostasis and allostasis regulation maximize infant growth, the multiple maladaptive dysfunctions (social, neural, cognitive, emotional) might emerge in
a child’s behaviors in cases of maternal dysregulation as happens in postpartum depression, trauma or loss of beloved ones, etc. (Leerkes et al., 2016).

The early two years of life is a critical vital period for the maturation of the developing brain of an infant, which has a transient architecture to be forged and the quality of relationship with the primary caregiver inhibits or props up the synaptogenesis, dendritic arborization, myelination, alternation in limbic and cortical areas for the morphologic settlement of infant brain (Goldman-Rakic et al., 1983; Ruijter, Baker, de Jong, & Romijn, 1991; Horn, Bradley, & McCabe, 1985; Schefflen, 1981). Also, it has been proven that synaptic and dendritic growths are closely associated with corporeal experiences shared with the mother and surrounding milieu (Jacobson, 1978; Petanjek, Judaš, Kostović, & Uylings, 2008; Schore, 1994, p.165). Evolutionarily, a human infant is born with surplus neurons up to %15-85 more than adults, and those excessive neurons are sentenced to the death/silence depending on use or misuse, which is similar to natural selection (Fischer & van Geert, 2014; Kandel, 1998, 2006; Joseph, 1982). Schore (1994) emphasizes that the mother does not just alter the brain “structure” but also its functions.” Therefore, early reciprocal interactions impact the growing limbic area, orbitofrontal and prefrontal cortex, and expansion of amygdala volume, etc. Moreover, higher cognitive monitoring (Stuss et al., 1982; Thorpe et al., 1983) and executive skills, abstract representation capacity (Watt, 1990; Diamond & Doar, 1989), (implicit) memory functions (Mancia, 2006) are gained by the mediation of mother, who promotes for multimodal integration via homeostasis and allostasis; even totally abstract and endemic concepts regarding their race, culture, religion, etc. are learned by favour of maternal multisensorial integration (Atzil et al. 2018; Bornstein & Bradley, 2003). In addition, it has been demonstrated that empathic ability is associated with the somatosensory cortex, where the interoceptive and exteroceptive information are overlapped for the ontogenesis of the brain-body map (Diamond, 2013, p.126-130; Zaki et al., 2009); however, there is no disparity between exterior and interior rooted stimuli characteristically for newborns (Roitblat, 1982; Schore, 1994, p. 174). Multimodal integration is learned postnatally and occurs in agranular cortices -which are not traceable in newborns- (Stein, Stanford & Rowland, 2014; Atzil et al., 2018). Also, the agranular association cortices (the anterior insula, anterior cingulate cortex, and ventromedial prefrontal cortex) are seen as a network of the ‘social brain’ which plays an essential role in the obtainment of social
abilities, including empathy, personal inference, and perception; moreover, these cortices are responsible for the regulation of the autonomic nervous system, the immune system, and the neuroendocrine system, as part of a predictive allostasis regulation (Stein, Stanford, & Rowland, 2014; Barrett & Satpute, 2013; Kleckner et al., 2017; Barrett, 2017). The studies conducted with macaque monkeys illustrated that agranular circuits in the F4 area in the premotor cortex are responsible for integrating tactile, visual, auditory, and proprioceptive stimuli (Fogassi et al., 1996; Graziano, 2001; Rizzolatti, Fogassi, & Gallese, 2002; Bremmer et al., 2001). The multisensorial integration has been tackled by neuroscientists in Embodied Simulation Theory (EST) recently, whose main aim was to explain ‘the psychopathological aspects of intersubjectivity’ from embodiment through to cognition (Gallese & Ebisch, 2016; Rizzolatti & Sinigaglia, 2010). Within EST, it has been illustrated that how the mirror neurons and premotor cortex of passive objects are activated solely during the observation of others, which might be accepted as a primitive form of empathy to understand others’ actions, intentions, or affections as putting ourselves into their situation in the margins of our body. (Rizzolatti & Sinigaglia 2010; Gallese & Ebisch, 2016).

Shortly, early corporeal interactions between the mother-child dyad are dominant for the ultimate formation of the neonate’s brain, and consequently, “the infant is now conceptualized to be more of a sensoriaffective than a sensorimotor being” (Carpenter & Stechler, 1967).

2.4. Intercorporeality- Bodily Self - Embodied Mind

“...I understood that identity is not just on your skin or outside your skin; maybe the bigger part, the more important part of identity, is what is going on inside your body, in your mind, etc. Then I started to get under my skin, cutting myself, still bleeding. I started piercing myself, tattooing...in order to investigate about my identity under my skin”

Frank Uwe Laysiepen (2022) from the documentary of No Predicted End

(German performance artist professionally known as Ulay)
The corporeal component of intersubjectivity has been excluded from the interest of psychoanalysis and neuroscience for a long time. On the contrary, recent studies show a complex interrelation between the body-brain-mind system of two or more organisms ‘reciprocally,’ and interaction between soma and the surrounding world goes hand in hand relentlessly (Schore, 1994; Gallese, 2009).

However, the brain is at the heart of neuroscience, it cannot be tackled without soma because the brain also registers affective states and controls housekeeping functions rooted in the body, which are required for homeostatic balance (Damasio, 1999; van der Kolk, 2014). Hence, Damasio (1999) mentions “proto-self” as an archaic form of individuality rooted in “wordless knowledge,” or in other words, bodily-based processing. van der Kolk (2014) adds that “visceral communication is the royal road to emotion regulation”; hence, interoception is at the centre of internal consciousness, and even more early relational (mis)adventures are encoded in viscera with skeletal/muscular problems, frustrating/terrorizing effects, autoimmune diseases. Thus, interoception is at the centre of body ownership which influences embodiment, multimodal integration, and the mentalization process; consequently, it predicts neuropsychiatric disorders (Fotopoulou & Tsakiris, 2017; Tsakiris, 2016).

Followingly, Mark Solms (2013) has spoken of dual consciousness; one is internal consciousness (inner mental body) regarding affects in response to homeostasis, and another one is external consciousness (outer body) associated with embodiment during homeostasis mediated by others. Solms (2013) asserts that subjective affective states are endogenous biological values in response to altering external conditions linked with homeostasis (Barrett & Simmons, 2015; Fotopoulou, 2015). Hereupon, interoception and homeostasis are closely affiliated because interoceptive inputs give information about homeostatic states in soma which is in constant relation with other bodies (Fotopoulou 2015). Hence, Gallese (2009) used the “intercorporeal-self” concept rather than bodily self to emphasize that interpersonal bodily interactions shape embodiment; consecutively, embodiment shapes the mind through the mentalization of sensorimotor signals (Lemma, 2015).

Although “mentalization” term is used traditionally to refer to “reflective functioning” ability to put ourselves in other’s position to comprehend their mental states (Fonagy et al., 2002); currently, it’s used to highlight self-awareness regarding our own
body and schematization of bodily signals (in relationship with other organisms) during homeostasis; so that reason, “the mentalization of one’s body can include other bodies in physical proximity” due to an infant’s helplessness (Fotopoulou & Tsakiris, 2017; Apps & Tsakiris, 2014). Nonetheless, the “embodied mentalization” (Fotopoulou & Tsakiris, 2017) of proximal others and comforting touch during a homeostatic state are the major components of interoception (Damasio, 1994; Seth et al., 2012); moreover, internal allostatic balance is dependent on the mentalization of homeostasis (Fotopoulou, von Mohr, & Krahé, 2022; Fotopoulou & Tsakiris, 2017). Consequently, corporeality is the vital bedrock that bridges physical (soma) and mental (body representation) entities through mentalizing of embodied experiences, interior and exterior milieu via multimodal integration during homeostasis. In line with that, philosopher Merleau-Ponty said (1962, p. 239), “we are in the world through our body and in so far as we perceive the world with our body [...] perceiving as we do with our body, the body is a natural self and, as it were, the subject of perception” (Gallese & Ebisch, 2016). The sense of self, or in Fotopoulou and Tsakiris’ words (2017) “minimal selfhood” is co-constructed in a corporeal intersubjective field within affective touch, embodied proximity and proprioceptive awareness.

Embodiment means the mental representations of the physical reified body and its actions and agencies (Gallese & Sinigaglia, 2011). Subsequently, the discovery of mirror neurons -the neurobiological correlate of intersubjectivity- enables us to understand embodied cognition theory, particularly language acquisition and social cognition (Caramazza et al., 2014). In addition, while early intercorporeal exchanges shape an embodiment, also cognition that is structured through the mentalization of embodied relational states (Gallese, 2007, 2009; Iacoboni et al., 1996; Rizzolatti et al., 1996; Gallese, Keysers, & Rizzolatti, 2004; Iacoboni et al., 2005). In 2012, Gallese posited Embodied Simulation Theory (EST) to help us understand ‘psychopathological aspects of intersubjectivity’; embodied simulation creates “as if” situations in the observer’s body to match with actions, affections, and intentions of watched person and it is not simple imitation or emotion contagion (Rizzolatti et al., 1996; Gallese, Keysers, & Rizzolatti, 2004; Iacoboni et al., 2005). Embodied simulation (ES) is about putting ourselves into the place of others to grasp their mental state in the margins of our bodies (Rizzolatti & Sinigaglia, 2010), and it is very important to understand a complete abstract concept such
as empathy, social cognition, which are, first and foremost, embodied (Gallese 2003, 2005; Gallese, Keysers, & Rizzolatti, 2004).

The sensorimotor cortex is the region where the multimodal integration has occurred, and the body-brain map extends. Furthermore, sensorimotor and mirror neurons are activated throughout ES, not solely during first-hand experiences but also during observation of touched others (Ebisch et al., 2008). Also, the same neuronal activity emerges as long as touching happens, and there is no difference between whether touching an object is animate or inanimate or whether touching is intended or unwillful (Keysers et al., 2004). ES in the somatosensory motor cortex facilitates multimodal integration of our interoceptive affective states with exteroceptive perceptions regarding the surrounding world (Ebisch et al., 2008). ES provides ground for intercorporeality empirically, more importantly, it demonstrates how we try to grasp the mentality of others by using our motor, somatosensory and visceral-motor sources (Gallese & Ebisch, 2016).

Memory is more than a cognitive process rooted in embodied somatic states. Neuroscientists Ansermet and Magistretti (2007) have seen “memory as trace” of experienced living embedded in neural pathways. Moreover, Ansermet and Magistretti (2007) discuss memory-body-brain within neuroplasticity, and they mention somatic plasticity to re-inscribe memory traces besides neuroplasticity; because memory is dependent on affective, visceral states evoked in the body (Damasio, Tranel, & Damasio, 1991). Koch and colleagues (2012) suggest “body memory” as a more comprehensive concept comprising diverse types of memory, including traumatic memory, procedural memory, etc.

Autobiographical memory is explicit conscious memory referring to one’s personal history and consists of unconscious procedural memory. Schore (1994) claims that even the declarative memory is partially embodied, rooted in implicit right brain transfers underlying early embodied interactions. Trevarthen (1978) calls this intercorporeal exchange a “proto-conversation” to emphasize the primitive way of communication perpetuated nonverbally, affectively, and corporeally. Furthermore, this embodied information leaves its traces in affective patterns beneath automatic, unwillful re-enactments or acting-outs related to procedural memory (Diamond, 2013). While explicit memory can be recalled and re-inscribed intentionally, implicit procedural memory appears with sudden automatic flashbacks embedded with somatic markers and affective
states, which might be both comforting or threatening for somatic coherency (allostasis), body ownership (interoception) and selfhood (homeostasis and affective touch experiences) (van der Kolk, 2014; Fotopoulou, von Mohr, & Krahé, 2022). In trauma literature, it has been approved that body memory is almost corrupted; the Broca area - related to conscious, narrative memory - goes offline when the past traumatic event is rekindled by sensorial stimuli; hence, victims are stuck in knowing and not knowing, remembering and not remembering, past and present. Also, traumatic memory is almost accurate and engraved in bodily states because if you cannot call it, you cannot change it (van der Kolk, 2014).

In cases of early maltreatment, severe neglect, or relational trauma (physical, sexual, or psychological), the trauma traces are inscribed in body with dissolved sensations (visual, tactual, olfactory, thermal, etc.) accompanied by intense emotions (shame, pain, enrage, disgust, horror, etc.) nonverbally, because homeostasis is collapsed due to unregulated excessive distress (van der Kolk, 2014). Hence, the traumatized object does not feel secure in the margins of his/her “own” body due to intrusive, uncanny, somatic states, moreover, they feel agitated because of the sudden perturbing flashbacks that put them into hypervigilant position to detect any signal of threat (van der Kolk, 2014). Victims feel imprisoned in a state of helplessness between past and present; hence they do not have vitality and body ownership, as Lemma (2010) said “the body one “is” it, and the body one “has” it”, (Mucci, 2018, p. 17). Also, the numbing effect of trauma is demonstrated on Rorschach Inkblot Test, and it is has seen that the protocols of traumatized people widely differ from normal people, and projective tests help them to reflect on their traumatic memories (unmourned loss, maltreatment, deprivation (E) response) with intensive terror, rage, pain, etc. (clob) responses.

2.5. Affective Touch

“My torture is skin deep”

John Updike (1976) from the Journal of Leper

Skin-to-skin contact is a primitive and influential way of communication that initiates right after birth. An infant entrapped in his/her puniness seeks physical proximity of
others not solely to fulfill his/her physiological exigencies but also to cling and create an emotional bond with others, as Harlow (1958) demonstrated on rhesus monkey infants. Also, parental touch is included in almost all caregiving activities (breastfeeding, holding, etc.), which is a stress-alleviating tool (Jean & Stack, 2009) involved in maintaining homeostasis (Fotopoulou, von Mohr, & Krahé, 2022). Moreover, it has been shown that tactile care plays a fundamental role in the attachment (Ainsworth, 1979), sexual orientation (Suvilehto et al., 2015), socio-affective (Cascio et al., 2019), and cognitive development of infant (Fotopoulou & Tsakiris, 2017), rather than being solely sensorial stimuli (Shamay-Tsoory & Eisenberger, 2021; Brauer et al., 2016). Hence, it is possible to say that tactility comes first to develop as a premise of many developmental aspects.

Innervated skin detects any type of touch (animate/inanimate, pleasant/unpleasant) through mechanoreceptors, but the “C-tactile (CT)” afferent is a special type of C fibres. These CT afferents are unmyelinated low-threshold nerve receptors, fired robustly during gentle slow stimuli (between the rate of 1–10 cm/s) (Löken et al., 2009). From this point of view, CTs are hypothesized to build the neurobiological basis for affective touch, social bonding, and pain regulation (McGlone et al., 2007). Furthermore, Walker and her colleagues (2017) claimed that these CT afferents -hypothesized to appreciate social touch- might be a mediator of oxytocin release. Also, CT touch entails alternation in the frequency of glucocorticoid receptors in the frontal cortex related to cortisol secretion known as stress hormone (Meaney et al., 1985) and nonverbal emotive right hemisphere, which is proficient in tactual perception coming from interior and exterior side of the body and remembering spatial templetts of touch in implicit memory (Schore, 1994, p. 252-253; Milner & Taylor, 1972). In addition, early parental tactile-kinesthetic stimulation imprints the malleable growing “social brain” of an infant, as Brauer and colleagues (2016) demonstrated in 43 five years old children. They found high frequency of maternal touch increases activity in the right posterior superior temporal sulcus (pSTS) and entails surplus connectivity in right dorsomedial prefrontal cortex, which are attributed to social brain (Brauer et al., 2016).

Furthermore, social touch conveys emotions and establishes a liaison between touched and touched one, which is important for maintaining “social” relations (Hertenstein et al., 2006). Also, affective touch induces pleasant feelings in the receiver, activates oxytocin release and reward system for both, attenuates pain, decreases
perceived stress, and consequently contributes to well-being (Uvnäs-Moberg, Handlin, & Petersson, 2015; Shamay-Tsoory & Eisenberger, 2021), as it is shown that affective touch reduced blood pressure (Crusco, 1984) and heart rate (Triscoli et al., 2017). Hence, interpersonal touch is an indispensable part of interoception and allostatics through the mentalization of homeostasis (Fotopoulou, von Mohr, & Krahé, 2022; Fotopoulou & Tsakiris, 2017). Fotopoulou and Tsakiris (2017) emphasized the importance of early tactile interactions, especially maternal touch, and they have seen these tactual exchanges as a premise of a primordial sense of self, or in other words, “minimal selfhood.” Also, it's known that unregulated distress and long-standing hyperarousal states induce a high number of cortisol secretions which results in indelible impairments in an infant’s brain (cellular death in the amygdala, hippocampus, malfunction in the area of prefrontal and orbitofrontal cortex and underdeveloped parasympathetic neuron system), which are the indicators of future psychopathologies including borderline, narcissistic, antisocial personality disorders (Winnicott, 1960, 1949; Bick, 1968; Mucci, 2018; Schore & Schore, 2008; van der Kolk, 2014). In cases of deprivation, including social touch or tactile-kinesthetic stimulation, infants' mental, neuro-biological, socio-affective, and behavioral development are interrupted, as MacLean (2003) demonstrated in institutionalized children. Social touch enables auto-regulation of perceived distress by heightening prefrontal activity; thus, homeostasis is the predicted outcome of touch-related actions according to Predictive Model of Comforting Touch (Fotopoulou & Tsakiris, 2017; von Mohr, Krahé, Beck & Fotopoulou, 2018). In this case, disconnection from one’s body and feelings might be related to lacking comforting touch or the existence of discomforting/abusive touch. Moreover, Scalabrini and his colleagues (2017) illustrated the relationship between brain activity and prediction of social touch and how anticipation of social touch throughout the brain is affected by individual narcissistic features.

Recent studies demonstrated that early pleasant touch experience influences interoception, body-ownership (Della Longa, Filippetti, Dragovic, & Farroni, 2020; Crucianelli, Metcalf, Fotopoulou, & Jenkinson, 2013; Jenkinson et al., 2020), and body representation (regarding interoceptive and exteroceptive multimodal integration), moreover, it predicts psychopathologies in adulthood. Löfler et al. (2022) showed that people with borderline personality disorders had a negative evaluation tendency of comforting touch and less body-ownership compared to the healthy group. From a clinical
point of view, negative assessment and bodily awareness in BPD have been affiliated with dissociative living and early relational trauma (Löffler et al., 2020); as Ferenczi (1932) said, an immature child, who doubts his/her sensations due to seductive and deceitful language of adults, loses his/her body ownership. Also, it has been demonstrated that anorexic people were unpleasant during social touch interactions (based on their facial expression) compared to healthy individuals (Crucinelli et al., 2016; Keizer et al., 2014), which has been related to anhedonia and reduced bodily awareness deriving from impaired body representation and somatosensory impairments. Furthermore, it has been demonstrated that affective touch plays a crucial role in multisensorial integration and increases body-ownership sense (Crucianelli, Metcalf, Fotopoulou, & Jenkinson, 2013; Della Longa, Filippetti, Dragovic, & Farroni, 2020; Jenkinson et al., 2020).

2.6. Permeable Skin Between Neuro-Immune-Cutaneous-Endocrine Systems

“I elaborate my sensation that the leprosy, chased from my skin, is fleeing to deeper tissue, will wait there to be reborn, in more loathsome and devilish form.”

John Updike (1976), from the Journal of Leper

Skin is a complex sensorial organ endowed with sensory nerves, immune and epithelial cells; hence it is a part of the NICE network. Neurologically, there is an interpenetrated relationship between brain and skin development at ectoderm since the second week of gestation, whose relationship remains during the lifetime (Altunay & Mercan, 2006). Immunologically, keratinocytes (KCs) in the epidermis establish a natural border and protects the organism from external threats. Moreover, environmental signals detected by peripheral sensory nerves and receptors are transferred to the central nervous system (somatosensory cortex and thalamus) subsequently to mediate neuroimmune response through the release of neuropeptides and neurotransmitters from peripheral terminals (Lowy, Makker, & Moalem-Taylor, 2021). Thus, neuroimmune interaction in the skin initiates, which is essential for homeostasis. From an endocrinological perspective, the skin represents endocrine nuclear receptors (GC, thyroid, and mineralocorticoid receptors) and participates in homeostasis by secretion of several hormones, including
glucocorticoids, mineralocorticoids, and thyroid hormone (Jin, Luo, & Zheng, 2022). Also, the production of cortisol and corticosterone towards emotional stress is regulated by the HPA, which exemplifies neuroendocrine interplay.

Skin is the largest sensory organ wrapping the entire body, which is in direct contact with the exterior world; thus, it plays a fundamental role in body representation depending on perceptions coming from the external world (touch, holding, etc.) in the cutaneous system and their sensations evoked endogenous nervous, endocrine, and immune systems. Hence, it is considered that skin is the interface of multimodal integration throughout homeostasis (Fotopoulou, von Mohr, & Krahé, 2022); while superficial epidermis - consisting of keratinocytes, melanocytes, and Langerhans cells - is referred to exteroception (for ex. detection of touch by skin mechanoreceptors); profound dermis - consisted of fibrocytes, nerve endings, vasculature, and immune cells- is attributed to interoception (transmission of detected stimuli to the somatosensory cortex and thalamus) (Shamay-Tsoory & Eisenberger, 2021; Nejati, Kovacic, & Slominski, 2013).

For many years, it has been considered that the only function of the skin is a natural protective frontier against external threats. Recently, it has been revealed that skin also participates in the maintenance of homeostasis through bidirectional information transmissions between neuro-immune-endocrine systems and giving cutaneous immune response to hazardous stimuli in different ways (hormone secretion, inflammation, etc.) under the control of the central regulatory system (Jin, Luo, & Zheng, 2022; Lowy, Makker, & Moalem-Taylor, 2021). Hence, complex skin is seen as a part of the Neuro-Immune-Cutaneous-Endocrine (NICE) Network, as Jin and colleagues (2022) called skin a “trinity of a neuro–endocrine–immune organ.” Today, cutaneous diseases are tackled as a result of homeostatic imbalance through the dysregulation of the NICE network (Lowy, Makker & Moalem-Taylor, 2021), and even more, it is seen that emotional stress might trigger the exacerbation of dermal symptoms (Kimyai-Asadi & Usman, 2001; Kaplan, 2017). In addition, it’s coined “neurogenic inflammation” term to explain the occurrence of some cutaneous diseases (rosacea, psoriasis, eczema, atopic dermatitis, etc.) in the scope of neuropathy and neuronal dysfunction (Azimi, Lerner, & Elmariah, 2015). Also, it is known that some neurological or psychiatric disorders might entail skin disturbances as iatrogenic illnesses, presumably because of the neural de-activation. Therefore, the skin has special importance as a conjunction point, where the disturbances
in the complex brain-body-mind system come into play in concrete form. Moreover, these neuronal dysfunctions might be associated with exposed relational and environmental stressors starting from in utero through postnatal experiences; As Schore (1994, 2001) illustrated, the high level of cortisol secretion due to maternal and relational distress induce impairment in HPA axis, amygdala, limbic system, etc. Also, peripheral cutaneous response towards noxious stimuli or stressors is mediated by the HPA axis by releasing neurotrophies and neuropeptides (Slominski, 2005). These studies consolidate the neural deficit hypothesis to explain the pathogenesis of cutaneous diseases concerning immune and endocrine systems.

2.7. Psychodermatology

“For you
I have saved poems
Under my skin”
Sanober Khan (2020) from
A Thousand Flamingos

Psychodermatology is a co-constructed field of dermatology and psychiatry disciplines that aims to investigate the interplay between skin and mind (Jafferany & Franca, 2016). While dermatology studies skin-deep symptoms on the body surface, psychiatry looks beneath the surface and probes an individual’s internal dynamics, object relations, etc. As part of the NICE network, the skin is the target organ of cognitive, bio-behavioral, socio-affective, and perceptual distortions; hence, dermal symptoms are settled between physical and psychical. Also, it has been demonstrated that between 25-33% of cutaneous diseases are driven by psychological factors (Jafferany, 2011); moreover, it has been exhibited that emotional stress disturbs cutaneous permeability barrier homeostasis and entails inflammatory dermatoses such as atopic dermatitis, psoriasis, eczema (Garg et al., 2001).

Psychodermatological diseases are divided into three categories; psychophysiological diseases, primary psychiatric diseases, and secondary psychiatric diseases (Jafferany, 2007). Psychophysiological diseases have an organic physiological
basis initially, but the trajectory of diseases might be shaped by ongoing stress factors, including acne, alopecia areata, eczema, psoriasis, urticaria, rosacea, etc. Primary psychiatric skin diseases are self-induced diseases derived from delusional parasitosis such as trichotillomania, damaging body and skin (might be related to body dysmorphia, eating disorders, obsessive-compulsive disorder, etc.) (Koo & Lebwohl, 2001). Secondary psychiatric diseases are comorbid skin diseases. Although these iatrogenic illnesses do not jeopardize someone’s life, they might be burdensome psychologically for people due to their visibility and evolve into a source of stigma and restrict one’s lives (Koo & Lebwohl, 2001). Psoriasis, severe acne, chronic eczema, psoriasis, vitiligo, or genital herpes affect an individual’s social life, body image, and self-esteem and intensify depression, anxiety, social phobia, etc.

2.8. Psoriasis Disease

“Psoriasis keeps you thinking. Strategies of concealment ramify, and self-examination is endless. You’re forced to mirror again and again; psoriasis compels your narcissism, if we suppose a Narcissus who did not like what he saw.”

John Updike (1976) from Journal of the Leper

Psoriasis is a repetitive, complex autoimmune disease that becomes apparent and spreads mainly around the scalp, elbows, and knees with multiple plaques and patches in different areas of the body at the same time (National Psoriasis Foundation, 2022; Cole, 2022). Also, it is one of the most common non-contagious diseases whose prevalence is %2-3 among the world population and affects 125 million people globally. While psoriasis is less common among African and South American populations, it is more common among European people (WHO, 2016). Psoriasis disease is divided into five groups; (1) psoriasis vulgaris or plaque psoriasis is the most prevalent type, seen in almost %90 of patients with erythematous scaly plaques, (2) psoriasis guttate is the second most common type, appearing with small, red, teardrop-shaped lesions, (3) pustular psoriasis is an uncommon and severe variant of psoriasis characterized with yellow/white pus-filled spots and diffusely inflamed skin, (4) erythrodermic psoriasis is rare and aggressive -almost life-
threatening-variant, which is characterized with generalized dry, red, peeling skin rash (erythema) (at least 75% of the skin), (5) inverse or flexural psoriasis appears with shiny, smooth, brown/red/purple-colored lesions in skinfolds, mostly in armpits, under the breasts, genitals, etc. (Martins et al., 2020a).

Psoriasis is basically the thickening of the skin surface with plaques, scales, patches, etc., due to uncontrolled rapid production of T cells due to immune system dysfunction (health.harvard.edu). According to the neuro-endocrine-immune pathogenesis model, psoriasis is driven by the bidirectional interplay between environmental (stressors) and genetic factors (abnormal innate/adaptive immune routes). In the face of psychological or environmental stress, activated HPA axis and released neuropeptides worsen the progression of psoriasis disease by inducing hyperproliferation of keratinocytes (KCs) (Martins et al., 2020a; Lowy, Makker, & Moalem-Taylor, 2021). Hence, aberrant KCs are thought to be a key factor in the pathogenesis of psoriasis (Eberle et al., 2017); DCs, T cells, and resident KCs produce inflammatory and immune responses (Martins et al., 2020a). Moreover, the serotonin hormone is thought to be a pathogenic neurotransmitter entailing psoriasis disease, which mediates the neuroendocrine system and skin; also, transmission disturbance in serotonin receptors (5-HT) is one of the most common comorbidities of psoriasis disease, which is the main factor for depression (Martins et al., 2020b). Visibility of the disease influences deeply an individual’s self-esteem, psychological well-being, intimate relationships, and sexual and social life, which often entails social difficulties, discrimination, and isolation (WHO, 2016); in dermatologist Cram’s (2013) words, “psoriasis hurts, not just the body, but the psyche as well.” Hence, psoriasis patients wear covering clothes to hide their visible dermatosis - the source of huge embarrassment- and their narcissistic scars, fragile personality, as much as their skin. Furthermore, the absence of a determined cure or treatment for psoriasis leaves the patients in a state of helplessness, hopelessness, and deep ambiguity, which increases their vulnerability, depression, anxiety, and suicidal ideas (WHO, 2016; Cram, 2013). So that reason, psychological treatment is of vital importance as much as a medical treatment for psoriasis patients.

The more severe form of early-onset or Type I psoriasis is generally seen before 40-year-olds without gender differentiation, which is triggered by psychological or environmental stress (Karaduman, 2000). It is known that while psychological stressors
may aggravate the progression of psoriasis, psoriasis itself may lead to stress. Clinically, it has been observed that patients with psoriasis are more prone to address stress on the onset of their disease and higher strain at the encounter of stressors among all dermatologically diseased people; hence some researchers stated “the mechanism for stress-induced psoriasis flare-ups” (health.harvard.edu; Kimyai-Asadi & Usman, 2001). Furthermore, the role of stress and negative/traumatic experiences on psoriatic flares has been postulated by several studies (Simonic et al., 2010; Crosta et al., 2018; Elsayed & Connor, 2018; Erfenian, 2018). Also, some neuropeptides (vasoactive intestinal peptide (VIP) and substance P) and hormones (cortisol) have been approved to how neuropeptides released by the central nervous system elicit peripheral psoriatic lesions, briefly stress and psoriasis relation within the NICE network (Kimyai-Asadi & Usman, 2001). Even though the pathogenic factors of psoriasis have not been understood entirely yet, the recent finding supports the neuronal deficit hypothesis, which assumes preexisting peripheral/central neuronal damage induces motor, sensory or sensorimotor deficits and consequently neurogenic inflammatory diseases, including psoriasis (Azimi et al., 2015).

2.9. Clinical Relevance

It’s known that the structure and functions of the infant’s brain are directly influenced by early environmental and interpersonal factors since utero through ongoing postnatal life. Especially, the parent-infant relationship is vital for HPA axis programming that is responsible for stress regulation, hence it is the precursor of physical and mental health in adulthood (Schore, 1994; Feldman, 2007, 2015; Xiong & Zhang, 2013). In cases of early life stress (seen in postpartum depression or anxiety generally), severe neural, social, cognitive, and development deficits are seen in infants due to impaired HPA axis and allostasis imbalance (Leerkes et. al, 2016; Atzil, et al, 2018). Thus, early relational trauma (disorganized/insecure attachment, lack of attunement, maltreatment, severe neglect, deprivation, etc.) results in irretrievable consequences on a child’s developing brain-body-mind system; on the prefrontal and orbitofrontal cortex, HPA axis, amygdala, limbic system (Schore, 1994; Xiong & Zhang, 2013), hippocampus (Teicher et al., 2012; Luby et al., 2012), hormone segregation and future sexuality (Fonagy, 2007; Target, 2007; LeVay, 2011); which are the indicators of future psychopathologies (Mucci, 2018, Schore & Schore, 2008). Also, stressful life experiences engender disorganizing states on
higher cognitive skills, mentalization, abstract thinking, symbolization capacity, language, conscience, and empathy development and they jeopardize a child’s health due to an infant’s low threshold for arousal (Fogel, 1982; Mucci, 2018, p. 190; Goldenberg et al., 1989; Winnicott, 1969). Concordantly, Allan Schore (1994, p. 207-208) posited neurobiological evidence linking unregulated shame and increased cortisol secretion, long-standing disgust/humiliation states and heightened hypo arousal activity in the parasympathetic system starting from the 18th month up to the second year (Weil, 1978). Intriguingly, parasympathetic low/hypo arousal was the common indicator of all future psychiatric and psychosomatic diseases, especially of all personality disorders (Schore, 1994, 2001). At the same time, long-standing shame, disgust, and humiliation states make the child feel rejected or unwanted by her/his parents as Ferenczi (1929) articulated “unwelcome child” and causes narcissistic flaws. Hence, today narcissistic personalities driven by “shame” and “envy” and characterized by low self-esteem under the grandiose self, are seen as epigenetically constructed pathology around affect regulation and attunement processes rather than being a structural problem (Schore, 1994, 2001; McWilliams, 1994; Mucci, 2018, p. 244-249).

Recently, it has been demonstrated a strong link between the pathogenesis of BPD and early childhood (particularly) sexual (Zanarini et al., 1997; Paris, Zweig-Frank, & Guzder, 1993, 1994; Fonagy, 2000), physical and emotional abuse (Herman, Perry, & van der Kolk, 1989), dissociation (Mosquera & Steele, 2017; Liotti, 1999; Lyons-Ruth, 2003) and disorganized attachment (Modell, 1963). Also, it is observed that disorganized children with aggressive or disconnected patterns under five years old developed more psychiatric disorders than affectively tuned children in adulthood (Boris, Fueyo, & Zeanah, 1997; van der Kolk, 2014). Moreover, %81 people diagnosed with BPD at Cambridge Hospital reported that they had been exposed to severe neglect and maltreatment, and the great majority indicated that the maltreatment began before age seven (Herman, Perry, & van der Kolk, 1989). In addition, neuroscience studies have linked altered brain structure in BPD (prefrontal-limbic dysfunction, reduced volume of amygdala and hippocampus, abnormalities in the HPA axis, emotion dysregulation, increased cortisol and reduced oxytocin secretion, opiate system and anterior cingulate dysfunction) with poor mentalizing capacity, disturbance in selfhood and body ownership which are the main characteristic features of BPD (Gunderson et al., 2018; Kreisel et al.,
Today, psychosomatic disorders are seen as an appendage of personality disorders (especially narcissistic and borderline personalities) because psychosomatic symptoms are tackled as unidentified manifestations of a complex brain-body-mind system which are closely associated with early relational traumata (insecure/disorganized attachment, affect dysregulation, and narcissistic scar) (Krystal, 1998; Anzieu, 1995, p. 133-148; Erten, 2015; Lecours, Briand-Malenfant, & Descheneaux, 2013; Mucci, 2018, p. 244-274; Green, 1997). Reinhard Plassmann and his colleagues (1986) considered psychosomatic diseases as “secret self-mutilation” where the early negative traumatic experiences turn against the self and are moved onto the body with diseases. Moreover, Clara Mucci (2018) places psychosomatic disorders as the most severe case at the end of the narcissistic and borderline personality disorders because the earlier the trauma, the more damage to the body (Mucci, 2018, p. 244). While hysterical people -who reached to oedipal phase- have the symbolization capacity to narrate and reconstruct their personal history; psychosomatic patients, who have impoverished symbolization capacity, are imprisoned in their past, in the margins of their body; hence they speak through somatization that might be considered as a proto-conversation method to communicate with others, to tell their implicit embodied memories (van der Kolk, 2014). Also, alexithymia, which is described as a state of losing effective (interoceptive) awareness, is another significant characteristic of psychosomatic patients (also of all personality disorders) (Krystal, 1998; Joyce McDougall, 1989); probably alexithymia is the consequence of early unmodulated severe stress and devastated HPA axis.

Moreover, trauma literature shows how early negative experiences are encoded in viscera with fragmented somatic states and intense emotions due to homeostasis imbalance and how these adverse livings strike the body with affect dysregulation, muscular and skeletal problems, autoimmune disorders, etc. and the body speak through somatization (van der Kolk, 2014). Experiencing visceral insecurity and distorted allostatic dysregulation during childhood might entail disorganized attachment (except the relational traumata) as it happens in the absence of a “good enough” caregiver and the
front of excessive stress alone (van der Kolk, 2014). Also, Arnsten and Goldman-Rakic (1998) and Mayes (2000) linked excessive stress and arousal dysregulation, which are closely associated with traumata (Fonagy & Bateman, 2008). While insecure attachment and adverse childhood conditions increase the risk of psychosis in the future (Read & Gumley, 2010; Rutten et al., 2013; Read et al., 2014), secure attachment decreases the future trends of psychosis that functions as a psychological protective shield for a child towards environmental threats (Debbane et al., 2016). Also, these traumatic memories appearing with sudden unwelcomed flashbacks are threatening somatic integrity (allostasis), body awareness (interoception), and selfhood (homeostasis) (van der Kolk, 2014; Fotopoulou, von Mohr, & Krahé, 2022).

Social touch is an indispensable part of maternal care, which mediates homeostasis and allostasis (Fotopoulou, von Mohr, & Krahé, 2022; Fotopoulou & Tsakiris, 2017). It has been postulated that maternal touch maximizes the development of an infant (Brauer et al., 2016) and its deprivation or deficit induces a disruptive impact on children’s mental, neuro-biological, socio-affective, and behavioral development as demonstrated in institutionalized children (MacLean, 2003). Recent neuroscientific studies emphasize the importance of early tactual interactions on interoception, body ownership, and multimodal integration, hence it’s thought to predict ongoing future psychopathologies. (Della Longa, Filippetti, Dragovic, & Farroni, 2020; Crucianelli, Metcalf, Fotopoulou, & Jenkinson, 2013; Jenkinson et al., 2020). While borderline personality disordered people had a negative assessment of pleasant touch and lesser body ownership compared to healthy individuals (Löffler et al., 2022), anorexic people showed anhedonia and uncomfortable facial expressions during interpersonal touch (Crucianelli et al., 2016; Keizer et al., 2014). According to clinicians, disconnection from one’s own body and feelings in BPD (negative evaluation tendency and reduced body-ownership) might be related to the absence of comforting touch or the existence of discomforting/abusive touch, in other words, dissociative living and estrangement to own body might be associated with early relational trauma (Löffler et al., 2020). Also, anhedonia in anorexics is linked with reduced bodily awareness probably as a result of somatosensory disturbances, which effects how the tactile stimuli is perceived (Crucianelli et al., 2016; Keizer et al., 2014). In addition, somatosensory impairments also seen in other eating disorders (Keizer et al., 2011), are linked with distorted body representation in unpleasant
touch experiences regarding early relational trauma context (Crucianelli, Metcalf, Fotopoulou, & Jenkinson, 2013).

The cutaneous disease is the outcome of affect dysregulation and imbalance in neuro-immune-endocrine systems (Lowy, Makker, & Moalem-Taylor, 2021), and they flare up in a stressful situation (Kimyai-Asadi & Usman, 2001), probably due to neuropathy (Azimi, Lerner, & Elmariah, 2015). These neuronal dysfunctions (impairment in the HPA axis, amygdala, limbic system, etc.) might have occurred due to early life stress (Schore, 1994, 2001). The skin permeability barrier homeostasis has been damaged in environmental or psychological stressful states due to the activated HPA axis that worsens inflammatory dermatoses by releasing neuropeptides and neurotrophies (Garg et al., 2001; Slominski, 2005; Martins et al., 2020a; Lowy, Makker, & Moalem-Taylor, 2021). A limited number of studies put forth the relationship between psoriatic flares and traumatic experiences, which strengthens the neural deficit hypothesis in the occurrence of cutaneous diseases within an early relational trauma context (Simonic et al., 2010; Crosta et al., 2018; Elsayed et al., 2018, Erfenian, 2018; Azimi et al., 2015).
3. CHAPTER 3: THE RESEARCH

3.1. Hypothesis

1. Psychosomatic patients are immobilized in symbiotic “one-body and one-mind for two” states and haven’t been individualized yet by their caregivers (McDougall, 1989). They have narcissistic fragility due to early traumatic relationships within the phenomenon of ‘unwelcome child’ (Ferenczi, 1929), ‘dead mother’ (Green, 1980) and ‘false self’ (Winnicott, 1960). Hence, it’s thought that psoriasis patients have poor mentalization and symbolization capacity, lesser body ownership and interoceptive awareness. Consequently, it’s assumed that psoriasis patients have distorted body image.

1.1. It’s expected to get a high number of anatomy responses (Anat) as a sign of the distorted sense of skin and body because of the absence of container mother. Also, anatomy responses are the indicator of operational thinking (Marty, 1958) prevalently seen among psychosomatic patients, which demonstrates overinvestment in corporeality.

1.2. Once it’s asked psoriasis patients to tell any kind of a dream and childhood memory in brief psychoanalytic interviews, it’s expected from psoriasis patients not remembering and responding due to poor preconsciousness, symbolization, and mentalization capacity or they will tell traumatic memories and frightening dreams.

2. Skin running as a permeable pellicle between ‘self - other’ and ‘inside – outside’ is distorted in psoriatic patients, thus it’s considered that patients with psoriasis have skin-ego dysfunction probably due to early adverse conditions and deprivation. Dermatological symptoms might substitute the absent tactile stimuli (holding and handling experiences) as a compensatory tool or it might be a reflection of the early traumatic living engraved in the body. Hence, it’s expected to get a negative image of self and others.

2.1. It’s sought for the expressions referring to maternal deficiency and negative conflictive relationships from the preliminary psychoanalytic interviews.

2.2. The negative form responses are expected from cards number I, VII, and IX referring to archaic mother image and maternal relationship, indicating that
the maternal relationship was threatening rather than being a container within the scope of early relational trauma (Ikiz, 2017).

2.3. Estompage responses (E) indicating tactile sensitivity, skin-ego dysfunction, and inadequate maternal containment, and white/blank detail (dbl) responses indicating the gaps and losses in the early period mother-child relationship, are expected to be significantly higher. Hence, all estompage (E) and blank (dbl) responses referring to skin-ego dysfunction will be analyzed profoundly.

3.2. METHOD

3.2.1. Participants

The study was conducted with 10 patients who have been diagnosed with psoriasis disease and under medical treatment at least for 6 months in the dermatology clinic of Trakya University Medical Faculty in Edirne, Turkey. The first 10 patients who applied to the clinic and willing to attend the study was chosen as a sample of study without restrictions except for the age condition. Hence, the sample of the study consisted of 4 male and 6 female participants, whose age range was between 25-60 to code Rorschach protocols according to Turkey adult norms.

3.2.2. Procedure

First of all, the research ethics committee approval was taken from the scientific research ethics committee of Trakya University Hospital, to conduct the study with the patients who were under the treatment in the hospital. Then a pilot study was carried out on two patients to detect any potential problems or factors that may threaten the reliability of the study. The main research was conducted with 10 volunteer psoriasis patients in the laser room of the dermatology clinic of Trakya University Hospital between the dates 23/09/2021-25/11/2021.

Initially, the informed consent form for the processing and sharing of personal data was given to the participants. Subsequently, the preliminary psychoanalytic interview was conducted as a part of the Rorschach Test application procedure according to French School. Right after the brief psychoanalytic interview, the instructions of the Rorschach Test were given and patients were encouraged to respond freely by knowing that there is no standard right or wrong answers, then the test has begun. During the Rorschach Test,
it has shown 10 cards in order, and it was calculated in how many seconds the patient gives the first answer for each card. Each statement/response of the patient was noted by the practitioner manually, but also the non-verbal contents including the patient’s posture, emotion, and gestures. Moreover, it was evaluated how many minutes they spend on each card and the total time of application. Before showing the last card, it was announced that the test will finish soon. When the test was over, it was asked to a patient picking a card that he/she liked the most and the least. This practice was continued by the same practitioner in the same environment face-to-face with all patients without any changes. Responses given Rorschach Test were evaluated according to Turkey adult norms. The content analysis method of the French School, which integrates projective tests with psychoanalytic theory, was used to process the data in this thesis. Rorschach report of each patient was written 1-2 weeks after the interview, not right after the application to gain a more neutral tone while evaluating protocols by moving away from strong countertransference that patient evoked in the examiner.

3.2.3. Tools

❖ 3.2.3.a) Preliminary Psychoanalytic Interviews

As a part of the Rorschach Test administration, brief psychoanalytic-oriented interviews are conducted to obtain fundamental knowledge about regression capacity, quality of object relations, mentalization, and symbolization capacity of patients. Mainly it’s compounded of five questions about the complaint of test taker, the relationship with mother and father, a childhood memory, and a dream.

❖ 3.2.3.b) The Rorschach Inkblot Test

The Rorschach Test, which was created by Herman Rorschach in 1910, is still up-to-date and is used for diagnosis in the clinic. Unlike other psychiatric classification systems, this test examines and evaluates each individual’s personality structuring, object relations, and internal dynamics within their subjectivity (Ikiz, 2017).

After brief psychoanalytic interview, the instruction of Rorschach Test was given and patients were encouraged to make free association. During the test, it is calculated in how many seconds patient gives the first answer for each card, if it takes more than 20 seconds it’s coded as shock response as a sign of poor mentalization capacity or re-kindle
of previous conflict according to context of each card, moreover it’s evaluated how many minutes they spend on each card, and total time of application. Each answer was written down by hand and it was marked on location sheet because responses gain meaning according to their location on card (global or detail, in void or compact content, etc.).

Rorschach Inkblot Test consists of 10 cards and each of them has its unique shape, color, movement, and shadow. While card numbers I, IV, V, VI, and VII are colored in black, white, and grey tones, card numbers II and III also include red tones to prompt drives. Card numbers VIII, IX, and X are composed of pastel colors. (Ikiz, 2017). Form responses are more easily given to compact cards consisting of gray, black, and white, and generally, a depressive mood is expressed through these dark cards. While cards number II and III, where the red color is significant, are related to impulsive discharge; the pastel-colored cards have more regressive features. All cards of the test refer to the body image. The cards of the Rorschach Test are drawn around a symmetrical axis and information about object relations and boundaries is obtained from the cards where the mirroring becomes evident. Also, Tevfika Ikiz (2017) likens Rorschach Test to the “transitional area” of Winnicott and she asserts that Rorschach Test enables the creation of one's world and designs by using his/her imagination and the materials (cards) provided by the practitioner.

There are two main coding systems in the evaluation of the Rorschach Test: the first one is American School using the Comprehensive System developed by John Exner, and the second one is the French School coding system developed by Roy Schafer and Catherine Chabert, (Ikiz, 2017). The French coding system differs from the American school by giving importance to nonverbal content (patient’s affect, posture, movements, gestures, etc.) and these non-codable contents gain value by being written in the report. Also, continuity and consistency of the discourse during the test are very important besides the content of the test (Ikiz, 2017). The answers given to the test are coded according to the norms of the age and country, and then the statistical psychogram of the patient is created. Finally, the report of the case is written by taking into consideration of the non-verbal content. In this study, the French school content analysis method was used to evaluate the role of early relational trauma on the occurrence of psoriasis disease by evaluating with Rorschach Projective Test according to the psychoanalytic psychosomatic approach.
3.3. FINDINGS

3.3.1. Evaluation of Preliminary Psychoanalytic Interviews

According to Parisian School, the psychoanalytic preliminary interview is conducted with each recipient before Rorschach Test to evaluate their regression, mentalization, and symbolization capacity briefly and to get some information about the object relations. During the semi-structured interviews, 5 questions are asked in order: (1) complaint of patient, (2) relationship with mother (3), relationship with father, (4) a childhood story, (5) one dream. It’s anticipated from patients to answer those questions freely and narrate their stories, and livings without any interruption.

In the selected sample, patients were timid and a bit anxious in the beginning. However, they have been familiar with the hospital environment and under the medical treatment of psoriasis disease more than 6 months in the hospital, many of them (except 2 patients) were meeting with a psychologist for the first time although some of them have a psychiatric background, and they had no contact between emotions and thought and many of them didn’t relate their illness with their hurt feelings and adverse childhood experiences. Also, they were in an alert situation probably because of the medical examination and hospital milieu. Besides that, half of the patients were hesitant to interview with a psychologist (shrink) due to the ongoing stigma today in Turkey.

3.3.1.a) Investigation of Memory and Dream Responses

In brief psychoanalytic interviews, it’s asked patients to tell any kind of childhood memory and a dream to evaluate their symbolization, mentalization, regression capacity, and functioning preconsciousness. However, these questions were asked in a neutral tone without indicating good or bad memory, 6 of 10 patients articulated traumatic relations and events that occurred during their childhood instead of good memories. In addition, patients 1, 4, and 8 declared that they had gone through difficult times and they didn’t have any good childhood memory. Only patient number 10 didn’t bring any memory. While bringing any kind of memory or dream is a sign of good regression capacity, its absence shows lacking regression capacity or it’s considered a freezing reaction due to the re-kindled of traumatic memory. As it is known that traumatic memories are kept in the unconscious mind, in embodied nonverbal right brain implicitly, which put the victims
in the state of knowing and not knowing situation (van der Kolk, 2014). Trauma also disrupts the preconsciousness, mentalization, and symbolization capacity.

Dreaming is closely related to symbolization capacity which is gained by internalization of consistent maternal care that directly affects the orbitofrontal cortex responsible for the cognitive, memory processing, creation of internal images, and symbolization capacity. If the maternal care is inconsistent or deficient, some irreversible impairment occurs on the symbolization capacity of children and “operational thinking” (Marty, 1958) becomes dominant. This mechanical way of thinking is very common among the psychosomatic who are devoid of symbolization and dreaming capacity. While patient numbers 6, 9, and 10 didn’t mention any dreams, 3 patients (numbers 2, 4, and 8) gave voice to their frightening, scary dreams. Additionally, patient 9 said that he has never seen a dream in his life, patients 10 and 6 represented that they barely/rarely dream but never remember what they have seen. Finally, patient 10 didn’t illustrate any memory or dream.

**Childhood Memories**

Patient 1, 50 years-old, woman

“I didn’t have good childhood ever under the eye of my step mother. When I remember it, I feel so sad. So, I don’t have any good (happy) memory in my childhood. I would also like to grow up freely. Because the reason that I have never felt that love (maternal love), I have taken care of my children a lot, I showed them my love, attention.”

Patient 2, 58 years-old, woman

“My childhood memory... I was 7. My aunt and son of my uncle were playing, it was a game played with a knife. My uncle and aunt argued and I realized that they are going to fight. And my uncle took the knife and threw it through my aunt. And the knife was stuck in my head. I have such a memory.”
Patient 3, 51 years-old, woman

“My childhood memory… I went through school, finished primary school. There was a nurse in the village whose children I looked after. That elder sister (nurse) had nail polishes, she put nail polish on me. When I arrived the house, my mother scraped of my nails with a razor blade. As if a putting nail polish is a something bad... Now you will make me cry.” (She started crying afterwards.)

Patient 4, 42 years-old, woman

“Good or bad? For example, when I was 13, he attacked me. I can never forget it. One day, in the forest, while I was grazing the animals with my sister. We were grazing the animals. She was 15 years older than me. She left me and said to me "come back in half an hour, ok?". Then, there was an old man, I asked him the time. Then, he told me “What are you going to do with the time, don’t you get bored?”. I said “I am bored but nothing can help”. Later, he clung on me tightly, he was an old man. I didn’t understand what was happening. He hugged me tightly, we struggled a lot. When I started screaming and shouting, he let me go. But we were 3-4 km away that day, I was so afraid. That man was around 55 years old worker in the field. My father knew him, but even he didn’t bring a charge against him. We don’t have such a good memory. I wanted to study but they didn’t allow me because of the money.”

Patient 6, 33 years-old, woman

“I don’t remember any of my memories. But if you consider that this is a factor that will affect my illness, my sister had leukemia. They were leaving me to my grandmother. They were taking care of my sister. I couldn’t see them whenever I want, but only on the weekends. Then, when there was a parents’ meeting neither my parents nor my old grandmother could go. I was left out in the cold. I was feeling sad of course. I might be obsessed with these.”

Patient 8, 46 years-old, man

“Well, once, when I was little, they sent me to the grocery store. 1000 lira, there used to be big moneys. While I was coming back, I’ve lost it. My mother undressed
me, poured sugared water on me, tied me to the apricot tree so that the bees could sting me.”

“...but mostly she beat me, she couldn’t wreak anger on me. Well, I spent my childhood with my grandmother. She was protecting me because I was beaten a lot. I was eating and drinking and sting with her for a while. She used to protect me.”

“...I asked to my mother “there is an image in my head, is there such a thing happened? My father grabbed me like this and threw me against to the wall. And I crashed there and fell onto the bed from there?”. My mother said “it’s true, that day you cried a lot, your father got angry and threw you on the bed. But it’s impossible for you to remember that, even you weren’t 40 days old yet”. Moreover, I have been gone through a lot. My wife cheated on me...”

3.3.1.b.) Maternal Deprivation and Relational Traumata

The answers regarding the mother figure are investigated thoroughly, it is seen that 2 of 10 patients (patients 1 and 7) have never met their mother. Patient number 1 mentioned the tragic loss of her mother when she was 3 and patient number 7 asserted that he has never met his mother until he turned 25. Whereas 2 patients (number 3 and 5) declared conflictive relationships another two patients (number 6 and 4) complained of their mothers’ neglectful attitudes and maternal care deficiency. Patient 6 told that she has been left to her grandmother due to her sister’s leukemia disease, and she could only see their parents during the weekends. Patient 4 repetitively narrated that her mother didn’t care about her children adequately due to the difficulties of rural life and the overload and responsibilities of the mother inside and outside the house. While one patient (number 8) was uttering he had a traumatic relationship with her mother that contains severe physical violence, and maltreatment, one patient (number 2) claimed that she had a distant relationship. Finally, two patients said that they have a good, normal relationship but intriguingly they couldn’t give an elaborated image of their mother and their relationships.
Interestingly, once it is asked about their relationship with their mother, 6 of 10 patients declared that they have a better and more intimate relationship with their father, comparing to one with a mother. In general, it was noteworthy that the basic physical and affective needs of these patients weren’t met due to early privation, loss, neglect, or traumata and due to the unmet emotive needs, they were seeming quite sensitive, and fragile to the outer stimulation.

Patient 1, 50 years-old, woman
“I have never seen my mother. I don’t have any idea of mother relationship. I have never had a such kind of relationship with my step-mother.”

Patient 2, 58 years-old, woman
“We are like friends with my father. With my mother, it is more timid, probably due to her rigidity. She is so thrifty, self-disciplined person.”

Patient 3, 51 years-old, woman
“We don’t get along with my mother. My mother and I disagree with each other. She is always more affiliated with males; her male children are like her rescuer who are going to keep the family name alive. They don’t care about the girls. I don’t know, I feel like I left out. Even if I say I don’t love my mother, it’s true.”

Patient 4, 42 years-old, woman
“My mother... we used to live in the village, we were doing livestock. She didn’t care about us well. We were 7 brothers. There was my brother the oldest and also his children. She didn’t care about us well. I always used to take a bath by myself, go to school alone. She couldn’t take care of us due to her work. But if she had a time, she was a person who would take care of us. She was used to working outside the house, vineyards and orchards, she couldn’t take care of use. Mostly my aunt and aunt-in-law did.”
Patient 5, 47 years-old, woman

“With my mother, I wouldn’t say problematic, we have conflictive relationship. There is a tension without a reason. In general, my mother is a person who make us do what she wants. Her words, her beliefs, her…. Constant intervention, constant thing…well, even she will know what I cook at home (she started crying). I’m fine. I start crying even at the smallest thing.”

Patient 6, 33 years-old, woman

“My sister had leukemia. They were leaving me to my grandmother. They were taking care of my sister. I couldn’t see them whenever I want, but only on the weekends. Then, when there was parents’ meeting neither my parents nor my old grandmother could go. I was left out in the cold. I was feeling sad of course. I might be obsessed with them.”

Patient 7, 60 years-old, man

“With my mother… I never met with my mother until the age of 24-25, anyway. My mother and father have been divorced. There was my grandmother. With her, it was very good.”

Patient 8, 46 years-old, man

“…Either, I didn’t have a relationship with my mother or father. We weren’t talking.” “…Sometimes I get angry with them. I go to the graveyard to fight with them.” “…Mostly, she beat me, she couldn’t wreak anger on me… I was beaten a lot.”

3.3.2. Rorschach Findings

3.3.2.a) Findings about Distorted Sense of Skin and Body Image

Somatic integrity in adulthood is rooted in early period object relations. A rudimentary infant, who is dependent on mother, perceives the exterior world through corporeal interactions between skins. Hence, the quality of intercorporeal exchanges influences how one perceives his/her body and skin. If there is no
internalized consistent caring object, an infant cannot sense his/her bodily integrity due to severe anxiety of object loss. Hence, psychosomatic patients, who have experienced deprivation or traumatic relations in an early period, have distorted images of skin and body. Anatomy responses referring to the human body, internal organs, or bodily parts are seen as a projection of disintegrated and deformed body perception, and they demonstrate the existence of anxieties about the body in psychosomatic patients.

**Obtained Anatomy Responses (Anat)**

Anatomy responses indicate poor symbolization and mentalization capacity, commonly seen among psychosomatic patients. Anatomy responses referring to corporeality are evaluated as a sign of operational thinking by clinicians, which is given with human detail (Hd) and animal detail (Ad) contents prevalently.

**Card II**

Patient 2, 58 years-old, woman

“Those below could also be a womb, female womb” D F- Anat

Patient 10, 25 years-old, man

“This reminded me of the hip part, it looks like a pelvis.” Ddbl F- Anat

**Card III**

Patient 1, 50 years-old, woman

“Are these human beings divided into two, a bird? They are separated from their torsos and waists, but they are trying to unite. There is a heart in the middle. These are the hearts, the hearts will unite, but there is an obstacle.” D K H/Anat

Patient 2, 58 years-old, woman

“….those could be the heart of two people” D F+ Anat BAN
Patient 4, 42 years-old, woman

“Like two hearts in the front, these two hearts look like butterflies.” D F+ Anat BAN

Patient 5, 47 years-old, woman

“I saw two hearts in the middle, the red ones.” D F+ Anat BAN

Patient 8, 46 years-old, man

“I see the lung”. D F- Anat

Patient 9, 34 years-old, man

“Here is the picture of liver shown always.” D F- Anat

Card VI

Patient 2, 58 years-old, woman

“Those may be the ribs of our back” (touched the card) D F- Anat

Patient 4, 42 years-old, woman

“It's like there are two lungs here too, below two lungs like walnut kernels.” Dd F- Anat

Card VII

Patient 9, 34 years-old, man

“There it’s a lung too, human liver, like liver.” D F- Anat

Card VIII

Patient 3, 51 years-old, woman

“How can I explain this to you my child, human body skeleton ... I see these as chest skeleton.” (Showed by touching) Ddbl F+ Anat
Card IX

Patient 8, 46 years-old, man

“Then it looks like an internal organ completely lung, stomach, kidneys. In fact, the esophagus and trachea pass through here.” G F- Anat

Patient 9, 34 years-old, man

“In the same way, like an organ of the body, like a lung, a liver.” Dd F- Anat

Card X

Patient 2, 58 years-old, woman

“These are our own being, these are our own pictures, our internal organs, our lungs that I thought (she indicated by touching). I couldn't understand the yellows, we are sick inside. That's it.” Dd F- Anat

Patient 6, 33 years-old, woman

“Those look like our internal organs, our lungs.” D F+ Anat

Patient 9, 34 years-old, man

“So, it's like the human liver structure.” D F- Anat

Patient 10, 25 years-old, man

“This one looks more like a rib; its middle is the junction area.” D F- Anat

3.3.2.b) Findings related to Early Relational Trauma and Negative Maternal Image

The answers given to card numbers I, VII, and IX refer to archaic mother image and pregenital maternal relationship.

Card I

The card I is the encountering card with the test and tester and it shows how the person takes a position in front of the foreign new object that refers to his/her position against unconscious archaic maternal imago. If there is traumatic relationship history, test takers may feel inadequacy and helplessness in front of the first card that might be
perceived extremely negative and threatening (Ikiz, 2017). Also, these agitated states may entail rejection of the card or inhibition in test takers shown with shock responses (being frozen and unable to respond for more than 20 seconds). This card briefly demonstrates the pregenital mother-child relationship whether the relationship is positive or negative. Transference in test starts with this card.

Patient 1, 50 years-old
“This is the eagle, you know, his arms are left behind like his arm and wing are broken. Its wings are torn apart from its body.”

“This is like a broken family like this, like an orphan.”

Patient 5, 47 years-old, woman
“What it reminds me is being split in two. It reminds me a war, a conflict with splitting. So, it doesn't remind me of anything else. Two... there is a split, a war of two hands. Two hands are against each other and I notice a very clear line in the middle”

Patient 6, 33 years-old, woman
“...a flying scorpion or a flying object.”

Card VII
Card number VII also gives information about the primordial maternal figure, sexuality, design, and depiction of femininity and it becomes easier to reach these unconscious materials and designs due to the weakening of the defenses since the beginning of the test (Ikiz, 2017). In this card, generally given responses refer to a symbiotic relationship with the mother, orality and anality, depressive position due to deprivation or loss, and excessive search for a good object. This card allows one to position himself/herself in front of the female model (such as opposition, conflict, or passive submission, idealizing or devaluing feminine images) and gives information about identification with the female object (Anzieu & Chabert, 2004).
Patient 1, 50 years-old, woman
“It’s ripped to shreds. It's like it's shattered... a person in the middle is shredded.”

Patient 3, 51 years-old, woman
“I saw 4 mice, I see all of them mice. I don't like mice”

Patient 4, 42 years-old, woman
“…there are malicious surrogates below too, it looks like a pig.”

Patient 6, 33 years-old, woman
“We would have ornaments in jars, spinning sticky ornaments just like them.”

Patient 7, 60 years-old, man
“Something mountainous”

Patient 8, 46 years-old, man
“…angry, his eyes like jinn, evil”

“...there is something like a monster.”

“Here it is a someone got stuck between the stones.”

Patient 9, 34 years-old, man
“There it’s a lung too, human liver, like liver.”

Patient 10, 25 years-old, man
“…the horned creature in cartoons”

**Card IX**
Towards the end of the test, the person who took the test is becoming well regressed and, on this card, he/she gives answers referring to the fantasies of returning to the womb and reunion with the mother like conjoined twins. If the mother does not allow
the infant for individuation or if she shows excessive anxiety against separation, the symbiosis cannot be disrupted and pathologies occur (Mahler, 1967). This card is the most difficult and rejected card of the test, where the one stays all alone against the world. It gives information about the concept of pregenital mother, early maternal relationship, pregnancy and birth fantasies, mother and femininity designs.

Patient 1, 50 years-old, woman
“Is a person split in the middle... are these the bones of a split human...”

Patient 2, 58 years-old, woman
“It's like a mountain is on fire...”

Patient 3, 51 years-old, woman
“It looks like a half an apple.”

Patient 4, 42 years-old, woman
“Something went out like smoke. It both looks like a smoke and tasmanian devil.”

Patient 6, 33 years-old, woman rejected the card

Patient 7, 60 years-old, man
“it's like an island in the sea...on the edge of the island, that yellow is dirty water.”

Patient 8, 46 years-old, man
“...it looks like an internal organ completely lung, stomach, kidneys. In fact, the esophagus and trachea pass through here.”

Patient 9, 34 years-old, man
“I saw two animals something like anteater.”

“I saw a dinosaur.”
3.3.2.c) Findings regarding Skin-Ego Disturbances and Maternal Deprivation

Psychosomatic integrity in adulthood is based upon early skin-to-skin interactions in the nonverbal era, which comprise a basis for the primitive sense of self originates. Hence, the skin has a special place as an interface between physical and psychical apparatus, as Freud (1923) said from physical wrapping through the psychical wrapping. Also, permeable skin reflects intangible barriers between self-others, and inside-outside, which has been related to borderline functioning. Hence, cutaneous disorders are associated with early adverse conditions and deprivation, as Anzieu (1995) posited on the skin-ego hypothesis. The one speaks through skin irritations, lesions, patches, etc. due to the underdeveloped symbolization capacity and having traumatic experience in the preverbal period. These symptoms project an incorporated negative image of self, therefore dermatological symptom is much more important than being a physical lesion and carries a symbolic meaning.

DBL Responses indicators of Maternal Deficiency, Early Losses and Traumatic Relational Conditions

Blank detail (dbl) responses are given to the white area outside the black portion that covers the majority of the cards. Feelings of deprivation, dissatisfaction, dissatisfaction, inadequacy, inadequacy, and anger in early relationships with the mother make people sensitive to blanks and whiteness (Chabert & Anzieu, 2004). Particularly, depressive emotions in narcissistic and borderline processes, where emptiness, inadequacy, dissatisfaction, and deficiencies are at the forefront, are made visible by dbl responses. The desire to fill the whiteness on the card also represents filling the experienced feeling of emptiness in the early period (Ikiz, 2017). Dbl responses are often given to maternal cards numbers I, VII, and IX emphasizing the need for containment and sometimes they are accompanied by scary and threatening images.
Card II
Patient 1, 50 years-old, woman
“A lamp burned in their midst, but they will meet soon, they are heading towards the light. A lamp is burning between those two people. They come out of the dark to the light.” Ddbl Kob Nesne (Object)

Patient 4, 42 years-old, woman
“It looks like (hesitated), it looks like a woman's sexual organ over there.” (Pointed the void) Ddbl F- Sex

Patient 9, 34 years-old, man
“It's like a symbol of something in the middle of it, like a helmet.” Ddbl F- Nesne (Object)

Patient 10, 25 years-old, man
“This reminded me of the hip part, it looks like a pelvis.” Ddbl F- Anat

Card III
Patient 1, 50 years-old, woman
“There’s also something like water underneath. In the middle there is something like a basin, like water at the bottom, are they trying to lift it?” Ddbl F- Element

Card IV
Patient 1, 50 years-old, woman
“What is this, oh my god, something like a monster, with claws like a creature. If he throws a hand, it's like he's going to tear you apart. His body is prickly, ugly, scary thing! (got agitated, winced, grimaced). It's like she's going to tear apart a family. This is my stepmother's monster, someone who deprives me of everything, tries to rip me apart, constantly tries to oppress me.... Her feet are upside down, a monster comes out of the middle, there is a hole left.” Dddbl FClob ➔E (A)
Card VI

Patient 1, 50 years-old, woman
“Something like a vase came in the middle.” Dddbl F- Nesne (object)

Patient 7, 60 years-old, man
“Or like a region with a road running through the middle of the map.” Dddbl FE Coğrafya (geography)

Card VII

Patient 1, 50 years-old, woman
“There are also two eyes in the middle, one on one side and two on the other.” Dddbl F- Hd/Ad

Patient 3, 51 years-old, woman
“I liken these two whites to a man and a woman. That white one is like a road. It's like they're walking down a road, that little place.” Dddbl K H

Patient 7, 60 years-old, man
“I liken it to something like a stream that continues from both sides, this is the bird's eye view. It's like the stream is separating those.” Ddbl FE Coğrafya (geography)

Patient 8, 46 years-old, man
“There's a man stuck over there too, stuck in the rocks.” Ddbl F- H

Card VIII

Patient 2, 58 years-old, woman
“The mountains, this is the top of the mountain, this is the bottom.” Dddbl F+ Doğa (nature)
Patient 3, 51 years-old, woman

“How can I explain this to you my child, human body skeleton ... I see these as chest skeleton.” (Showed by touching) Ddbl F+ Anat

“I see this tied to a string, an object tied to a string. It looks like a rope to me, it's like something is pulling it down with the rope.” Ddbl Kob Nesne/Parça (object/part)

Patient 6, 33 years-old, woman

“I think that might be the tree.” Ddbl F+ Bitki (plant)

Patient 7, 60 years-old, man

“Like a butterfly in that area, I see this one like a butterfly. I have no comments. It's like its feet.” Ddbl F- A

Patient 8, 46 years-old, man

“There's a mushroom right in the middle of the bat.” Ddbl F- Bitki (plant)

Patient 10, 25 years-old, man

“That upper part looks like a mountain to me, the top of that mountain. It looks like a volcanic mountain underneath; the bottom of the mountain is volcanic.” Ddbl Kob Coğrafya (geography)

Card IX

Patient 2, 58 years-old, woman

“It's like a mountain is on fire. it didn't mean anything else. That mountain, those flames.” Ddbl Kob Doğa (nature)
Patient 4, 42 years-old, woman

“At the bottom it's like an upside-down violin and has a downward handle (turning the card over and showing the blank). The violin is like this, the violin handle is here.” Ddbl F- Nesne (object)

Patient 9, 34 years-old, man

“I saw a dinosaur.” Dddbl F- A

Card X

Patient 4, 42 years-old, woman

“Here's something like a human head in white place” Dddbl F+ Hd

Patient 5, 47 years-old, woman

“I also saw the greens, the middle ones, as a bud. The green at the bottom is for the inverted tulip or the rose that has not opened a bud yet…” Ddbl F- Bitki (plant)

Sensorial E Responses Evoking Tactual Sensitivity and The Skin-Ego Dysfunction

All estompage responses (E) were examined to investigate the skin-ego structures of the participants. According to Klopfer, estompage responses (E) are divided into three groups respectively; (1) surface, skin, and texture responses that evoke tactual sensitivity, (2) perspective responses including depth and three-dimensionality, (3) diffusion responses, where shapes become intertwined and boundaries become blurred or disappeared (Anzieu & Chabert, 2004). According to Anzieu (1995), the skin is shaped like an envelope, where sensory and emotional transmissions take place between infant and mother and the outside world from the first years of life. Therefore, fragility in the skin-ego structure is directly associated with maternal functions.

Given responses such as “fur”, “hide”, and “feather” refers to the lack of early tactile needs, in other words, it emphasizes childlike physical and emotional needs. At the same time, considering that the shadowing responses are
predominantly given on the 4th and 6th cards, the cards symbolizing authority and power, we can argue that the responses such as feather or fur arise from the need for an additional narcissistic wrapping as a second skin. But some interpreters see estompage responses as an expression of anxiety. It is also a valid second interpretation that there is a fragility regarding the protective function of the actual skin (Anzieu & Chabert, 2004). Responses such as “its wing is torn” and “its feathers are plucked” underline the inadequacies of the skin. Thus, the existence of anxieties and vulnerabilities regarding the skin-ego structuring was emphasized.

Card I
Patient 2, 58 years-old, woman
“It looks like a butterfly, you know there is an insect, with horns.” D FE A

“Clouds in the sky. It resembles the sky, the middle interior part.” (Pointed by touching and leaning on the card) Dd FE Doğa (nature)

Patient 4, 42 years-old, woman
“This is an insect like a bat, a winged insect, I couldn't liken it to anything else. It spread its wings like this, you are looking from above. This is the insect's eyes, this is what's on its head. This one felt like its wings too, as a whole.” G FE A

Patient 7, 60 years-old, man
“For example, like they dripped the paint. The paint might look like something dripped from above, except for the line. It's like it's spread out completely. I see this because I've never seen anything like it. What do you think it means, incidental?” G FE Parça (part)

“It could be like a map, a drawn map, we can liken to.” D FE Coğrafya (geography)
Card II

Patient 1, 50 years-old, woman
“...something like ice under their feet. It's like ice, did their feet freeze, did they step on the ice?” D FE Parça (part)

Card IV

Patient 2, 58 years-old, woman
“These are the cloud in the sky.” (Showed by touching the card and shaked her hands and got excited) D FE Doğa (nature)

“A community, there used to be such a thing, they slaughter an animal and separate its hide, something like animal skin.” G FE A

Patient 4, 42 years-old, woman
“When viewed from the bottom like this (turned the card), these things look like clouds.” D FE Doğa (nature)

Patient 7, 60 years-old, man
“I liken it to a bat. It's like he's flying with open wings, so the top view. These are the wings, these are like the tail.” G Kan ➔ E A

“I got on the plane. When viewed from the plane, it looks like an island, from above.” G FE Coğrafya (geography)

Card V

Patient 2, 58 years-old, woman
“So, this looks like a bird, I don't understand what kind of bird it is. A clawed bird.” (Handled it again and left the card) G FE A
Patient 3, 51 years-old, woman
“I liken it to the sheep's skin, to the sheep's skin. My grandmother had this, she used to pray on it, I liken it to her.” G FE A

Patient 4, 42 years-old, woman
“At first, this is like a bat with its wings spread, so you see it flying from behind.”
G Kan ➔ E A

Patient 7, 60 years-old, man
“Looking at it that way, it could be any map.” G FE Nesne (object)

Card VI
Patient 1, 50 years-old, woman
“This one also flies like a wing, it has a mustache on its head. Something like fur on itself, the wings spread like flying, just like this.” D Kan ➔ E A

Patient 7, 60 years-old, man
“Or like a region with a road running through the middle of the map.” Dddbl FE Coğrafya (geography)

Card VII
Patient 4, 42 years-old, woman
“Here it's like two children's heads, their hair flying back but hands like backwards, sometimes it looks like a lamb.” D K ➔ E Hd

Patient 7, 60 years-old, man
“Something mountainous” G FE Doğa (nature)
“I liken it to something like a stream that continues from both sides, this is the bird's eye view. It's like the stream is separating those.” D FE Coğrafya (geography)

Card VIII

Patient 5, 47 years-old, woman
“An unfinished picture, colors also got involved, or a picture to paint.” G FE Sanat (art)

Card IX

Patient 3, 51 years-old, woman
“I couldn't understand anything my child, I just made it look like a human face, that is the nose and the face. He has a beard, a mouth, a nose, goosebump hair.” Dd FE Hd

Patient 4, 42 years-old, woman
“Something went out like smoke. It both looks like a smoke and tasmanian devil. It's like this pooffff (got excited, jumped on her seat and raised her hands to show), like stuff coming out of smoke.” D Kob ➔ E Parça (part)

Patient 5, 47 years-old, woman
“This reminded me of the art of marbling, that’s all. So, you mix colors in the art of marbling, and it’s a unique thing, you can't do the same again, it reminded me of that.” G FE Sanat (art)

Patient 10, 25 years-old, man
“Those greens reminded me like a map, those greens show the forest area.” D FE Coğrafya (geography)

Card X

Patient 4, 42 years-old, woman
“This green place below is like a goat, it has beards, eyes, nose” D FE A
3.4. Discussion and Conclusion

Over the years, it has been understood that skin is the mediator of barrier homeostasis between complex neural, immune and endocrine systems, and its function goes beyond being a wrapping texture that covers the body. The pathogenesis of many skin diseases cannot be explained entirely even today and the studies show that pathogen factors of cutaneous diseases are not solely physiologically rooted. Moreover, their close relationship with psychological factors also attracted the interest of different disciplines and it has led to comprehensive interdisciplinary studies of skin diseases in recent years, but still, there is a limited number of studies about idiopathic psoriasis disease.

Although there are plenty of studies conducted with other inflammatory skin diseases (atopic dermatitis and eczema) in Italy and Turkey and only a few of them examined these patients by using projective methods, and it is found only one study in the literature that evaluated psoriasis patients with Rorschach Test (Pfitzner, 1976). This study can be considered the first study, where psoriasis patients were examined in a neuro-psychoanalytical framework with projective methods. For this reason, it is thought that the study contributed to the literature by bringing novelty in contrast to the traditional psychoanalytical approach. Thus, the sample of this study was selected from psoriasis patients to investigate the psychological roots of psoriasis disease in the light of psychoanalytic and neuroscientific findings. In general terms, it was hypothesized that psoriasis disease occurs in adulthood due to unregulated severe stress in the scope of early relational traumata. This explains psoriatic flare-ups in the face of ongoing life stress because the stress-regulating HPA axis was probably damaged in the early period.

In the first part of the study, broad psychoanalytic literature was given to demonstrate how early object relations dwelled in the body and have an impact on future somatic integrity and psychopathologies (Winnicott, 1949; van der Kolk, 2014). The psychoanalytic literature of this study has consisted of psychosomatic history, Freudian concepts, Paris Psychosomatic School (IPSO) approach, attachment and object relation theories, trauma clinic, skin-related psychoanalytic theories, borderline, narcissistic, and psychosomatic pathologies, and the skin functioning in psychopathologies.

In the second part, profound neuroscientific literature was given to represent how the brain-body-mind development of an infant is rooted in corporeal exchanges that take place in the early two years of life and how these early skin-to-skin interactions entail
future psychopathologies (Schore, 1994). Moreover, neuroscientific literature is combined with dermatology clinics by focusing on the tactility axis in the scope of intersubjectivity, neuroplasticity and epigenetics, intercorporeality, bodily self and embodied mind, affective touch, psychodermatology, skin as a NICE organ, and psoriasis disease. Finally, the neural, cutaneous, and psychological axis of psychosomatic and psychiatric disorders were discussed together to illustrate the complex relationship between brain-body-mind-skin systems.

In the third experimental part, it was explained the design of the study, including the hypothesis, participants, procedure, tools, analysis method, and findings. This qualitative study was conducted with a small sample of 10 chronic psoriasis patients to get profound knowledge about psychological factors underlying psoriasis disease. In the sample, while three of the participants were closer to borderline personality organization, the other seven participants had neurotic level functioning. All cases were included in the study because psychotic personality organization hasn’t been detected, which must be tackled in a separate study. Short psychoanalytic interviews and Rorschach tests were chosen from projective methods as data collection tools. Projective methods were used to obtain information about patients’ unconscious psychic representations, object relations, skin-ego functioning, body images, and relations with external reality through association chains and transference dynamics. Preliminary psychoanalytic interviews and the Rorschach Inkblot Test were selected as data collection tools to examine nonverbal contents in addition to the discourse of participants in detail. The content analysis method of the Parisian School was used for the assessment of data, which combines psychoanalytic psychopathology and projective methods. In the hypotheses, it was investigated the object relations and body image of patients in an interpersonal trauma context.

There were 2 hypotheses for preliminary psychoanalytic interviews; (1) once it’s asked psoriasis patients about their relationship with their mother, it was expected from them to give statements about the existence of early severe maternal neglect, deprivation, or conflictive relationship with their mother, (2) when patients were asked to describe a childhood memory and a dream, it was considered that psoriasis patients not to remember or tell any story or dream due to poor mentalization, regression, and symbolization capacity. Parallel findings with the hypotheses of the study were obtained from the
interviews. Eight of ten patients declared that they had a negative maternal relationship; one patient mentioned the tragic loss of her mother when she was 3, one patient stated he has never met with his mother until 25, two patients uttered conflictive relationships with their mothers, two patients articulated they were deprived of maternal care and love, one patient said her mother was a distant and unapproachable person, one patient underlined that he had a traumatic relationship with his mother and he has been severely abused and maltreated by her. Two of ten patients declared that they had good and ‘normal’ relationships with their mothers but once it’s asked them to elaborate on their relationships, they couldn’t achieve it to detail. Probably, the consistent good object hasn’t been internalized due to lacking the container and good enough mother (Winnicott, 1962; Bion, 1962). Intriguingly, these two patients drew negative images of maternal objects during Rorschach Test in contrast to what they have told. This presents that all of our patients had early relational traumata whether they accept or deny it, and these internalized negative experiences were projected through unclear inkblots evoking their unconscious memories and designs. More interestingly, when it was asked patients to define their relationship with mothers, six of ten patients articulated that they had a closer and better relationship with their fathers without question and tended to compare their maternal and paternal relationships. Consequently, As Spitz (1945) said the fulfilment of physical exigencies is not enough, even socio-emotional needs are of vital importance to cling to m-others due to infants’ puniness. It can be considered that the sample of the study was “unwelcome children” once (Ferenczi, 1929), probably their mothers were unresponsive or unapproachable due to ongoing adverse experiences, as Green (1993) described in the “dead mother” complex (also, it has been verified the existence of hard times during their infancy in the following paragraph).

The second assumption about the brief interviews was the existence of poor mentalization, symbolization and regression capacity, and preconsciousness functioning in psoriasis patients. It was expected that psoriasis patients will not bring any infancy memory or a dream due to inconsistent, unbinding, or persecutive maternal figures. It is noteworthy that although patients were asked to describe a childhood memory in a neutral tone, six out of ten patients uttered a traumatic childhood memory; one patient mentioned that she has been maltreated by her step-mother during her childhood and had no good memories at all, one patient described a memory of stabbing a knife in her head, one
patient told about her mother scraping her nails with a razor blade, one patient stated that his father’s friend attempted to abuse her sexually but her family did nothing to protect her, one patient told the story of her sister’s leukemia disease and her abandonment by her parents to grandparents, one patient articulated that he has been severely abused by her mother physically and psychologically during his childhood. This patient, who has been abused physically and psychologically by her mother, talked about a memory that he isn’t supposed to remember in normal conditions; a story where his father grabbed and threw him against the wall, when he was not even forty days old. This patient also adds that this haunting memory was also confirmed by her mother surprisingly. When investigating the Rorschach Test protocol of this patient, who was exposed to severe violence throughout his childhood, it is thought that he has a borderline personality organization in which manic defenses are frequently used. The reason for the referral to manic defenses might be intense object loss anxiety. This patient, who probably did not have an internalized good object in the early period, couldn't move into a depressive position because of not internalizing the object loss and mourning process. The fact that why this patient expressed such an early memory so vividly and excitedly shows that all intercorporeal experiences are encoded in soma with intense affects in the non-verbal era. “Body keeps the score” even though the conscious mind does not remember (van der Kolk, 1994). All these experiences, which were engraved under the skin of a child in body memory, show themselves when they were least expected, put the victims in a constant state of hypervigilance and hyperarousal and corrupt their somatic coherency and consistency. Moreover, the rest of the sample mentioned good childhood memories except one. This final patient neither brought a memory nor a dream, at the same time, the poverty in this patient’s discourse throughout the Rorschach protocol, low number of total responses (R=18), and simple child-like response contents might be accepted the indicator of poor preconsciousness, regression, mentalization, and symbolization capacity. As McDougall (1989) said psychosomatic people have infant-like psychical functioning, who is entrapped in “one body and one mind state for two” and haven’t been individualized from their mothers. Delineation of borders and symbiosis turns into psychosomatic pathologies due to lacking narrative ability and not having body ownership (Çiğeroğlu, 2015; Mahler, Pine, & Bergman, 1975). Hence, these people speak through somatization as the only possible way of expression.
There were several hypotheses constructed on Rorschach Test, first, it was assumed that there will be a high frequency of anatomy responses (Anat) as a sign of a distorted sense of skin and body in psoriasis patients, second, it was sought to obtain the negative image of a mother from the cards number I, VII and IX giving archaic unconscious maternal imago, third estompage responses (E) evoking tactility and blank detail responses (dbl) indicating maternal deficiency were expected to significant as a sign of skin-ego dysfunction and maternal deprivation. All these hypotheses built around early intersubjective trauma have been validated in the light of the data taken from the Rorschach Test.

Symbolization is a high-order skill gained through the internalization of consistent repeated maternal care and homeostasis, or in other words, the container breast/mother absorbs the aggression of her child and transforms into alpha elements (Bion, 1962). In cases of the absence or deprivation of a good enough container mother in the early period, the infant cannot symbolize his/her intense excitations and aggressive impulses alone due to his/her puniness, hence these persecutive impulses return to the self and strike to soma to be expressed in only possible way. This situation, the lack of symbolization and mentalization capacity, and the over-investment in corporeality, become visible in the anatomy answers (Anat) in the Rorschach Test. Also, anatomy responses indicate prevalent operational thinking and world common in psychosomatic people (Marty, 1958). When the anatomy responses given by psoriasis patients are examined, it has been reached frequently damaged, impaired bodily parts and internal organ contents, and all these answers indicate the deterioration of bodily integrity and distorted sense of skin and body. Moreover, Baudin (2001) compared the bodily expression/somatization of hysterical conversions and borderline pathologies. While there is a neurotic desire under the disguise of the body in hysterical conversions; in borderline pathologies, it is stated that bodily surrender to these severe sensations and affects to maintain vitality (Baudin, 2001). In psoriasis patients, it is observed that the body does not serve to hide unconscious conflict as it is in hysterical conversion, but rather the body is exposed to the skin sensations brought by the disease to resolve that conflict and release the tension accumulated in the body.

Designs of early object relations, femininity, and motherhood become more evident on cards number I, VII, and IX. In this study, it was observed that the theme of pregenital
maternal deficiency, ambiguity, and traumatic relationships, is thought to underlie psoriasis disease. These problematic early relations reveal the theme of symbiotic fantasies and unbinding maternal imago. It has been seen that psoriasis patients haven’t been separated and individualized from their mothers yet, and even worse they have internalized these conflictive traumatic relationships. Being objectless (de-objectification) corresponds to psychical death in the psychoanalytic plane (Green, 1993), hence, it is better to have an object, albeit a bad one, rather than being objectless to keep the subject alive. This explains why victims of trauma still cling to their parents despite suffering and persecution throughout their childhood because this is the only possible way of keeping a relationship with them. van der Kolk (2014) explains the addiction of trauma victims to their memories and perpetrators with these words “pain in the pleasure, pleasure in the pain”. Moreover, Plassmann et al. (1986) see psychosomatic diseases as “secret self-mutilation” due to internalized negativity and bad object relations in the early period. In parallel, it is suggested that the somatic symptom is a kind of record of the relational trauma (insecure, disorganized attachment, sexual, physical, emotional abuse, excessive deprivation, etc.) experienced in the early prelinguistic period and expressed with bodily markers such as a pre-symbolic communication (Trevarthen, 1978). Also, Mucci (2018) stated that these internalized early traumatic relationship models (persecutor-victim dyad) and conflicts are carried onto the body, which entails estrangement to one’s own body and reality called as depersonalization and derealization.

Skin functions as a permeable pellicle between ‘self - other’ and ‘inside - outside’ in the beginning, later its borders get strengthened and become more solid through consistent care and the internalization of a stable object figure. In cases of maternal deprivation deficiency or traumata, it is seen that the protection and holding functions of skin-ego -associated with maternal protective shielding-, cannot properly work and protect the organism from external stimuli. Therefore, deficiencies in the skin-ego structure are associated with maternal deprivation, dissatisfaction, and deficiency; hence, estompage responses evoking tactual maternal sensitivity and dbl responses evoking internal emptiness (internalized maternal deprivation) are examined together. Finally, it was hypothesized that psoriasis patients will give more frequent estompage and dbl responses as a sign of early traumatic experiences. When the Rorschach Test protocols were examined, the plenty of dbl and e responses -indicating maternal deficiency and
impairments in skin-ego functioning were detected, and the last hypothesis of the study has also been confirmed. When the contents of these E responses were examined, it was seen that while some patients have been trying to compensate for absent maternal and tactile stimulation with responses such as “hair, mustache, skin,”, most of them gave perspective and diffusion related E responses, where the maternal containment and boundaries are unclear. When the relationship between psoriasis patients and their mothers was examined in the Rorschach Test, the existence of maternal inadequacies was categorized into four groups: 1) conflictive/aggressive relationship, 2) persecutive/devastating relationship, 3) fusional/reflective relationship, and 4) converting maternal experiences into somatic concerns that cannot be mentalized (using anatomy responses). The reason why the skin of people with psoriasis disease cannot maintain their protective function and these people are quite sensitive to external stimuli is due to the inconsistent care, and unbinding mother; hence these people either create a “second muscular skin” (Bick, 1968) or an “autistic skin” (Tustin, 1981) entailing psychopathologies due to the absence of vital protective shielding.

In this study, only the Rorschach test was used as a projective method. It is thought that the additional use of the Thematic Perception Test in future studies will provide in-depth information about the patients’ object loss anxiety and the existence of traumatic relationships. The results of the study are consistent with the relevant literature. On the other hand, the small size of the sample is the biggest limitation of this study and reduces the generalizability of the findings. It is thought that the results that can be generalized more reliably and distributed more homogenously to the universe, once the study is conducted with a larger sample.
REFERENCES


### APPENDIX

- **Appendix 1: Ethical Committee Approval**

The Ethical Committee Approval Form from TRASYA Üniversitesi Tıp Fakültesi Dekanlığı is detailed below. The form outlines the approval details for the research project, including the study's title, ethical considerations, and the signatures of the committee members.

<table>
<thead>
<tr>
<th>Title of Study</th>
<th>Ethical Considerations</th>
<th>Signature/Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Project Title</td>
<td>Ethical Approval Details</td>
<td>Members' Signatures</td>
</tr>
</tbody>
</table>

The form is comprehensive, covering various aspects of the study's ethical considerations, ensuring that all necessary approvals are in place for the project's execution.
Appendix 2: Informed Consent Form

KIŞİSEL VERİLERİN İŞLENMESİ VE VERİ PAYLAŞIMI İÇİN AYDINLATILMIŞ ONAM FORMU
Sedef Hastası İçin

Sayın Katılımcı;

Sizin kişisel verileriniz, Bilgilendirilmiş Gönüllü Olur Formu’nda ifade edilen araştırmanın yapılabilmesi için kaydedilmiş ve işlenmektedir.

Kişisel verilerin hangi yöntemler ile toplanabileceği; Size ait kişisel veriler, açık rızanız ile onay verilmesi durumunda sizin tarafınızdan verilen veriler ve ilgili tedavi kurumundan derlenen veriler dâhil olmak ancak bunlarla sınırlı olmayan hangi yöntemle toplanabileceği belirtmektedir.

Kişisel verilerin aktarılabileceği kişi, şirket ve kurum/kuruluşlar;


a) İşlenip işlenmediğini öğrenme,
b) İşlenmişse bilgi talep etme,
c) İşlenme amacını ve amacına uygun kullanılıp kullanılmadığını öğrenme,
d) Eksik / yanlış işlenmişse düzeltilmesini isteme,
e) Kanun’un 7inci maddesinde öngörülen şartlar çerçevesinde silinmesini, yok edilmesini isteme,
f) Kişisel verilerin (d) bendi uyarınca düzeltildiği veya (e) bendi uyarınca silindiği/yok edildiği durumlarda, kişisel verilerin aktarıldığı üçüncü kişilere de söz konusu durumun bildirilmesini isteme,
g) Münhasıran otomatik sistemler ile analiz edilmesi nedeniyle aleyhine bir sonucun ortaya çıkmasını itiraz etme,
ğ) Kanuna aykırı olarak işlenmesi sebebiyle zarara uğramanız hâlinde zararın giderilmesini talep etme,
h) Kişisel Verileri Koruma Kanunu’nun 13’üncü maddesi kapsamında başvurunuzun reddedilmesi, verilen cevaben yetersiz bulunması veya süresinde başvuruya cevap verilmemesi durumunda Kurula şikayet hakkına sahibsiniz.

MUVAFAKATNAME:

Kanun uyarınca tarafıma yapılan araştırma ile ilgili olarak araştırmacı veri sorumlusunun ve bulunduğu durumda temsilcisinin kimliğine, benim kişisel verilerimin hangi amaçla işleneceği, işlenen kişisel verilerin kimlere ve hangi amaçla aktarılabileceği, kişisel veri toplanmanın yöntemine ve hukuki sebebine ilişkin bilgilendirme yapıldığımı beyan ve kabul ederim. Bu çerçevede, kişisel verilerimin toplanmasına, kaydedilmesine, depolanmasına, işlenmesine, veri tabanında tutularak periyodik olarak güncellemesine ve yeniden düzenlemesine, sınıflandırılmasına, anonim hale getirilmesine, Kanun’da sayılan diğer şekillerde işlenebilmesine ve mevzuatın izin verdiği durumlarda ve ölçüde üçüncü kişilere açıklanmasına, devredilmesine, aktarılmasına ve/veya paylaşılamasına muvafakat ediyorum.

Tarih :

İmza :
Ad : ..........................
Soyad : ........................
TC Kimlik No: ........................
Adres : .............................

................................
Appendix 3: Rorschach Protocol Sample

H. A., (hasta no:12) 51 yaşında/ ilkokul mezunu / boşanmış / uygulama tarihi:25.11.2021

Ön Görüşme (10.54-11.01=7 dk.)
1-Bugün kontrol amaçlı geldim. Sedefe bağlı romatoloji rahatsızlığı, eklem ağrılarm var.
4-Çocukluk anım mı… (hım mm, düşünüyor) okuldan çıktım, ilkokulu bitirdim. Köyde bir hemşire vardı, çocuklarına baktığım. O ablanın ojeleri vardı, bana oje sürmüştü. Annem eve gidince permatikle tırnaklarını kazımıştı, sanki oje süremmiş gibi. Şimdi beni ağlatacaksınız (dedi ve ağlamaya başladı).
5-Rüya görüyorum. Herhangi bir rüya…. (Düşünüyor) geçende mesela eltimi gördüm beyaz bir binanın içinde, güzel bir rüyaydı. Ama sık sık gördüğüm tekrarlayan bir rüyam yok.

<table>
<thead>
<tr>
<th>Rorschach Testi Protokolü</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YANITLAR</strong></td>
</tr>
<tr>
<td><strong>I. KART- 00.00-00.59 = 1dk</strong></td>
</tr>
<tr>
<td>1- Yarasa görüyorum, başka bir şey görmemiyorum.</td>
</tr>
<tr>
<td><strong>II. KART- 00.59-3.42 = 2.43sn.</strong></td>
</tr>
<tr>
<td>2- Bu bütün de bir bayanla bir erkek görüyorum. Erkeğin de öfkesinden sanki hırçınlanmış, ağzından köpüreyormuş gibi görünüyor.</td>
</tr>
<tr>
<td>3- Bunlar da domuzcuklar.</td>
</tr>
<tr>
<td>4- Aşağıdakini kelebek olarak görüyorum.</td>
</tr>
<tr>
<td><strong>III. KART- 3.42-6.23 = 2.42 sn.</strong></td>
</tr>
</tbody>
</table>
5- Burada da yetişkin iki insan, bir şeyi paylaşamıyorlar gibi. Ama şunlar iki insan benim için, bir tartışmaya girmişler.

6- Aşağıdaki sanki bir göğüs gibi. 5- D K H

7- Ortadaki de bir kırmızı kelebek. 6- D F+ Hd

8- Şunlar da sihirli bir değnek gibi sanki. Dokunsalar şekilleri değişecek gibi (ayağa kalkıp mendil aldı ve gözlerini sildi, ağlamaklığındı). 7-D CF A

9- (Başını salladı) Sanki çok kötü bir bulut gibi görüyorum. Dolu yoğun bir bulut kütesi gibi. Sanki çok kötü yağmur yağacakmış gibi. 8-D F- Nesne

10- Yani böyle yakından, buradan bakınca da çizgi filme ağaçlar ayaklı yürüyor ya onun gibi. Burada da iki *tane göz* bakiyor gri. (paranoyak, izleyen gözler, erken travma (?)) 9- G FC’ Doğa

11- Şöyle bakınca da asılan bir kedi. Kökü gözleri. => Kob

12- Şöyle ters çevrince de bir insan başı. Dediğiniz gibi çok farklı, kedinin başı insan yüzü gibi benim için. 10-G Kob Bitki/(A)

13- Ben bundan hiçbir şey çıkaramadım yavrum. Bu ayakları yarasaya benziyor. Sadece yarasa, bunlar ayakları, şunlar da kanatları. 11- D F- A / Sahneleme

14- Başka da bir şey görmedim. 12- D F- Hd

15- G F+ A (Ban)
<table>
<thead>
<tr>
<th>VI. KART-12.25-15.40 =3.15sn</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>14-Bunu da <strong>kuzunun</strong> postuna benzetiyorum, <strong>kuzunun</strong> postuna. (kuzu daha yumuşak, küçük, narin bir hayvan)</td>
<td></td>
</tr>
<tr>
<td>15-Şurada iki tane papağan gibi bir şey görüyorum yavrum.</td>
<td></td>
</tr>
<tr>
<td>16- Bunları da ayağa benzettim, insan ayağına. (neden bu kadar çüktü whatisit, uzuvlarla, fallik detaylarla uğraşıyor)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VII. KART-15.40-18.22=2.42sn</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>17-Fare görüşüyor yavrum, 4 tane fare (kartı çevirdi, eğildi, dikkatlice inceledi). Fare, hepsini fare görüşüyor.</td>
<td></td>
</tr>
<tr>
<td>18- Şu iki tane beyazı da <strong>bir bayanla bir erkeğe</strong> benzetiyorum. Şu beyazı da bir yol gibi. Bir yolda yürüyorlarsınız gibi. Şu küçük olan yer var ya.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VIII. KART-18.22-26.16=7.56 sn.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>19- (kart çevirdi) Nasıl anlatayım yavrum bu sana. İnsan vücud, iskeletine… (çok regrese oldu ve kettendi)</td>
<td></td>
</tr>
<tr>
<td>20- Şurada iki tane <strong>bir bayan bir erkek</strong>, bir çift diyelim, sanki bir yardım bekliyorlar.</td>
<td></td>
</tr>
<tr>
<td>Numara</td>
<td>Metin</td>
</tr>
<tr>
<td>--------</td>
<td>-------</td>
</tr>
<tr>
<td>22</td>
<td>Şuunu ipe bağlanmış görüyorum, bir nesne ipe bağlanmış.</td>
</tr>
<tr>
<td>23</td>
<td>Mesela bak (eliyle işaret ediyorum) şurada da iki kişi görüyorum. Şu yeşilin içinde, şuraya sıkışmış yardımcı olan iki bayan gibi.</td>
</tr>
<tr>
<td>21</td>
<td>Ya büyük fareye de benzetiyorum, domuz gibi tüysüz cildi. (dokunsal eksiklik) Şu ip gibi geldi bana, ipe bir şey aşağı çekiyor sanki onu.</td>
</tr>
<tr>
<td>22</td>
<td>Dddbl Kob Nesne/parça</td>
</tr>
<tr>
<td>23</td>
<td>Dd F- H</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numara</th>
<th>Metin</th>
</tr>
</thead>
<tbody>
<tr>
<td>IX. KART-26.16-29.39=3.23 sn</td>
<td>Sakalı, ağızı, burnu, diken diken saçları var. (dokunsal eksiklik)</td>
</tr>
<tr>
<td>24</td>
<td>Dd FE Hd</td>
</tr>
<tr>
<td>25</td>
<td>D K H</td>
</tr>
<tr>
<td>26</td>
<td>Dd F+ Bitki</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numara</th>
<th>Metin</th>
</tr>
</thead>
<tbody>
<tr>
<td>X. KART-29.39-36.30= 6.51 sn</td>
<td>Bunu deniz altına benzettim.</td>
</tr>
<tr>
<td>27</td>
<td>G FC Doğa</td>
</tr>
<tr>
<td>28</td>
<td>D F- A</td>
</tr>
<tr>
<td>29</td>
<td>D F- A</td>
</tr>
<tr>
<td>30</td>
<td>D F+ A</td>
</tr>
<tr>
<td>30-</td>
<td>Şu iki sarı da balık gibi geliyor bana.</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>31-</td>
<td>Ama şunları da tavşana benzettim ama deniz altında tavşanın ne işi var diyeceksiniz ama ona benzettim.</td>
</tr>
<tr>
<td>32-</td>
<td>Bu iki maviyi de tavus kuşuna benzettim. Ağzında böyle çok kıymetli bir vazo.</td>
</tr>
<tr>
<td>33-</td>
<td>Şunu da köyde hayvanların kakalarını toplayan böcekler var ya ona benzettim. Belgesellerde oluyor böyle.</td>
</tr>
<tr>
<td>34-</td>
<td>Bunu da sanki şey kelebek, tırtıl oluyor ya, şurada da <strong>gözleri</strong> var gibi (eliyle işaret edip gösteriyorum).</td>
</tr>
<tr>
<td>35-</td>
<td>Uzun olan da kuru bitki kökü ya schöyle baktıktça da tereyağıla yapılmış yar kaides mi diyorsunuz, ona benzettim.</td>
</tr>
<tr>
<td>36-</td>
<td>Şunlar kaya parçaları gibi geliyor bana deniz altında böyle pembe şeyler görübiliyoruz. (ayrılma anksiyetesi tavan yaptı, kartı bırakamadı uzun bir müddet)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>31-D F- A</th>
</tr>
</thead>
<tbody>
<tr>
<td>32- D FC A/Nesne</td>
</tr>
<tr>
<td>33-D F+ A</td>
</tr>
<tr>
<td>34- D F- A</td>
</tr>
<tr>
<td>35- D F- Parça/A</td>
</tr>
<tr>
<td>36- Dd FC Parça</td>
</tr>
</tbody>
</table>


**En sevmediği kart:** 7. Kart “Karamsar, kötü bir fotoğrafl, fareleri hiç sevmiyorum.”

> (kemiren bir anne figürü besleyen yerine)

R:36
Toplam süre: 38 dk.
PSIKOGRAM

G=7  
D=19  
Dd:7  
F+:9  
F-:13  
CF:1  
FC:2  
FC’:1  
FE:2  
E:1  
K:4  
Kob:2  
Κan=1  
Nesne/parça:1

G/dd:3  
D% 19  
D% 81  
G% 19  
D% 81  
Ban: 3  
Şok: 1  
Red:0  
F+:9  
G geliştirmiş:  
Hd:4  
19/32=59  
A:16  
TRi: 1,5/3= %50  
Anat:1  
F tamamlayıcı:  
Bıtki:1  
2/2,5=%80  
Doğa:2  
RC =18/36=%50  
Parça:1  
A % 41  
Nesne:1  
H% 16  
A/Sahneleme:1  
F % 61  
A/Nesne:1  
F+% 40  
Kob=1  
H: 6

Kob=1

Kan= 1
Dermatoloji kliniğinde sedef hastalığı ve ona bağlı eklem ağrıları şikayetinden dolayı uzun süredir takipli olan hasta, doktorun yönlendirmesiyle araştırma amaçlı uygulanan Rorschach Testi uygulanmasına gönüllü olarak katılmıştır. Test hastane ortamında, dermatolojik muayeneden hemen sonra uygulanmıştır. Hasta testin yönergesine ve ortamına uyum sağlamış ve testörle işbirliği kurmuştur. Lakin testin başlangıcında bir yere yetişmesi gerektiğini belirten ve acı çekten hastanın, testin ilerleyen zamanlarında regresif bir hale büründüğü ve bunun etkisiyle de testin içeriğine ilgisinin arttığı gözlenmiş ve testin sonlarına doğru anksiyetesiyle de birlikte hastanın kartları bırakmakta, testi bitirmek zorlandığı gözlenmiştir. Test psikolog hanım diyerek ve bir mesafe alarak başlayan hastanın, test ilerleyen zamanlarında “yavrum” diyerek yakınlık durumunu, tutunma (clinging) ihtiyacı güttüğü düşünülmüştür; keza bu durum depresif örgütlenmeli hastalarda sıkça görülen terapist tarafından kurtarılma ya da terapisti, psikoloğu kurtarıcı olarak görme fantezisiyle (rescue fantasy) ilişkilendirilebilir (McWilliams, 2018).

işlevinin anneyle dokunsal uyarının eksikliği nedeniyle yeterince gelişmediğini ve deri hastalığı olan kişilerin bu dokunsal uyarının eksikliğini telafi amaçlı dermatolojik semptom çıkardıklarını öne sürmüştür. Kernberg de (1967) içselleştirilen boşluğun (internal emptiness) veya kötü nesnenin (internalization of and identification with the bad object, Fairnbairn, 1952) mazoşistik paternlerle beden yüzeyine taşındığını (Anzieu, 1995) ve derinin aşındırılmasının, parçalamasının altında da ilk nesne ilişkisinin başarısızlığının kaynaklandan narsistik yaralar bulunduğu belirtmiştir.

Psikosomatik hastalarda yaygın olan duyguşalmadan yoksun, aktüele, gerçeğe odaklanan işlemsel düşüncenin varlığı hastanın şu söylemlerinde “…şunlar iki insan benim için” “…ona benzettim/benzetiyorum”, “bunları hayvan olarak görüyorum” gözlenmiş ve hastanın güncele, somuta tutunarak kendini doğrulama ihtiyacı güttüğü gözlenmiştir. Ama sembolizasyon kapasitesinin bunun aksine (D=81, R=36) somatik bir hasta için oldukça iyi düzeyde olduğu yanıt içeriklerinin zenginliğinde de görülmüştür. Toplam yanıt sayısı fazla olmasına rağmen yanıtın varlığı son üç karta verilmiştir, hastanın regresyon kapasitesi oldukça iyi durumdur fakat son karta verilen 10 yanıt, sembolizasyondan ziyade ağırlık endişesiyle ilişkilendirilebilir ve test bittikten sonra da hasta kartı elinde bir müddet tutması da anal sadistik savunma olarak değerlendirilmiş,人工智能的な分類を行った上で、この文は「Psikosomatik hastaların ayrılma-bireyleşme sürecine hiçbir zaman ulaşamadıkları, ilk nesneyle doyumu yaşayamadıkları için ötekiyle simbiyotik ilişki içinde takılıp kaldığı öne sürülmüştür. Bununla ilgili olarak McDougall (1989) somatik hastalarda iki kişi için tek bir beden ve ruhsallık (one body, one psyche for two people) olduğunu öne sürmüş ve bu kişilerin asla kendilerine ait ayrımsız bir bedeni olmadığı dile getirmiştir. Ben ve öteki, iç ve dış ayırının yapılamaması borderline örgütlenmeyi akla getirse de bu hastanın verdiği formların oldukça düzgün ve ayrıntılı olması bu ihtimali ortadan kaldırmaktadır. Duyguşambiltiliği işaret eden renk yanıtlarının ve dürüstüllüğü gösteren hareket yanıtlarının yok denebilecek kadar az olması hastanın libidinal bağlarının kopmuş olduğunu düşündürmektedir; ölü anne kompleksi bağlamında, somatik semptomlar da ölüm narsisizminin beden yüzeyine vurması olarak kabul edilebilir. Aynı zamanda K yanıtlarının az olması aleksitimi yani duyguşal körülük de ilişkilendirilmiştir (Porcelli,
Bazı araştırmacılar ise erken ilişkisel travmaya ilintili olarak aleksitiminin kişiye rahatsızlık veren negatif duygu ve bedensel duyumlarla bağlantının kesilmesi olarak değerlendirilmiş (Mucci, 2018, p. 247).

Dokunsallık, perspektif ve muğlaklık belirten E yanıtlarının norm健全en üstünde seyrettiği bu protokolde, bunun anneden gelen dokunsal uyarı eksikliğinin bir yansıması olarak görebiliriz, verilen yanıtta da “…domuz gibi tüysüz cildi” tüysüz ciltle dokunsal ve eksikliği ve annenin çocuğuna kapsayamadığı, sarmalayamadığı düşünülmektedir. Hastanın verdiği yanıtın içeriğine bakıldığında ise yanıtlarının oldukça sade, ayrıtık ve anlaşılır bir biçimde olduğu görülmektedir. Bunun ötesinde H yüzdesinin oldukça düşük olması, özdeşimlerin hayvanlar üzerinden yapılması da ilişkisel travma hipotezini desteklemekte ve buna ek olarak duygualanımla ilgili olan renk yanıtlarının da az olması, bu hastanın kişiler arası ilişkilerde zorluklar (empati kurma, düşük mentalizasyon kapasitesi, sözel/sembolik ifade güçlükleri) yaşadığı ve aleksitimik özellikler taşıyabileceği düşünülmüştür.

Hasta testin bütün kartlarını kabul etmiş ve verdiği yanıtlardan sembolizasyon kapasitesinin görece iyi olduğu gözlenmiştir, kuvvetle muhtemel hastanın anasesel ilişkisindeki noksanlığı tamir eden bir üçüncü kişinin varlığı (baba/anneanne?) mevcut olduğu için hastanın somatik rahatsızlıklarını çok ilerlededen bugüne gelebildi ve hasta daha çok nevrotik bir işleyişi sahip olduğu. Mucci (2018) borderline kişilik örgütlenmelerinin oluşabildiği için her iki ebeveynle de travmatik ilişkinin olması gerektiğini ve bu ilişkisel travmaya erken çocukluktan itibaren en az 10 yıl maruz kalması gerektiğini belirtir.

Psikosomatik hastalıklar Plassmann ve arkadaşları (1986) tarafından içe alınmış olan negativite ve kötü nesne ilişkisinin bedene kendini kesme davranışlarıyla taşındığını düşünmüşler ve somatik semptomları yürün kendini yaralama davranışını (secret self-mutilization) olarak görmüştür. Bununla paralel olarak birçok araştırmacı psikosomatik hastalıkları kişilik bozukluklarının (özellikle narsistik ve borderline) bir uzantısı olarak görmüş (Kernberg, 1967; Mucci, 2018; Green, 2001; Anzieu, 1995) ve bedensel semptomun erken dil öncesi dönemde yaşanan ilişkisel travmının (güvensiz, dağınık bağlama, cinsel, fiziksel, duygusal istismar ya da aşırı yoksuluk, vs.) bedenselleştirilmiş bir çeşit kaydı olduğu ve kişinin bedenini (pre-sembolik) iletişim kurma aracı olarak kullandığını öne sürülmüşlerdir(Thaverten, 1952). Erken dönemde

Hastanın kimlik tasarımına bakıldığında ise nesnel ve yüzeysel bir kimlik oluşturduğu görülmüş. Kadınsı ve anneliğe dair tasarımlarla ilgili yanıtlar aldığımız 1-7-9 numaralı kartlarda ise yukarıda bahsettimiz annesel eksiklik ve muğlaklık temasının devam ettiği görülmuştur; maternal eksikliklerden dolayı simbiyotik bağın kesilemediği, ayrımsa-bireyleşme sürecinin tamamlanmadığı düşünülmüştür. Buna ek olarak hasta ön görüşmede de annesini sevmediğini ve çatışmalı bir ilişkileri olduğunu belirtmiştir. Testin sonunda hasta en sevmediği kart sorulduğunda ise 7. kartı seçmiş ve “kemiren fareler”den rahatsız olduğunu dile getirmiş ve maternal figürün ne dengi yikıcı, yiyp bitiren bir figür olduğunu ortaya koymuştur. Buna ek olarak ön görüşmede çocuklarla ilişiğinde bir tabindexı bulan hastanın düşündüğü anlatılmıştı bu hikayedeki ilişkisel travma savını daha da güçlendirmektedir. Babayla ve üst benlikle ilgili temsilleri veren 4-6 numaralı kartlara bakıldığında ise her ne kadar hasta babasını daha çok sevdiğini ve babası tarafından sevildiğini hissettğini dile getirse de dokunsal eksikliğe (kuzu postu) gönderme yapan E yanılı burada da gelmiştir ve hastanın beynin aksine hastanın iki ebeveyn tarafından da ciddi şekilde ihmal edildiği (severe neglect) düşünülmektedir. Aynı zamanda test süresince hastanın çıkıntısı, uzuv ve fallik detaylarla oldukça ugraştığı gözlenmiş ve babayı tanımlanmaktadır.
zorlandığı düşünülmüştür. Hastanın babaya karşı ambivalent tutumu olduğu önce babayı güçsüz bir çizgi film karakterine ve asılan kediye benzeterek devalüe etmesinden ardından da dürtü ve agresyonun taşıdığı çok kötü yağacak olan bir buluta benzetmesinden anlaşılabilir.

Sonuç olarak hastanın verdiği yanıtlara bakıldığında çocuklu ruhsal işleyiş, durgun dürtüselt yaşam, duygulanımsal ifadelerin eksikliği, basit ve kısa cümlelerle ifadeler, net ayrıntık tasarımlar verilmesi psikosomatik yapılanmayı düşündürse de verilen yanıtların çokluğu, yanıt içeriklerinin farklılığı, (1 tane sadece) ve ret yanıtlarının neredeyse hiç görülmemesi ve de sembolizasyon ve mentalizasyon kapasitesinin somatik bir hastaya göre oldukça iyi durumda olması bu hastanın sınır işleyişten ziyade nevrotik bir işleyişe sahip olduğunu ve histerik bir örgütlenmeye sahip olabileceği düşünülülktedir. Bu hastanın erken ilişkisel travma ve maternal eksiklik kapsamında fakirleşme beklenen ruhsallığının gerçekten canlı olduğu gözlenmiş ve bu hastanın sınır işleyişlerde yer alan psikosomatik işleyişi uzaklaştırılmıştır. Zaten hastanın bunun dışında bedende ileri derece düzensizleşme eylem alan başka rahatsızlıklar da bulunmamakta ve kendisine dair iç görüşünün de iyi olduğu (duygularıyla bağlantısının hala sürdürdüğü) düşünülmektedir.