ORIGINAL ARTICLE

Volitional determinants of self-harm behaviour and suicidal risk in persons with borderline personality disorder

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Abstract

Background and objectives: We investigated differential mediators of the risk of suicidal behaviour and self-harm behaviour in a group of sixty-four patients with borderline personality disorder.

Methods: The study included an interview to assess suicidal attempts, the Childhood Trauma Questionnaire (CTQ), volitional competences and self-regulation (VCQ), depression (BDI) and self-harm (SH) behaviour. We postulated two different serial multiple mediation models originating in emotional neglect in childhood, one leading to suicide attempts (through threat-related state orientation and depression) and the other leading to self-harm behaviour (through prospective state orientation and demand-related stress).

Results: The serial multiple mediation models were confirmed, with the postulated variables serving as partial mediators of suicide attempts and of self-harm behaviour. In addition to emotional neglect, there were two additional predictors: Sexual abuse in childhood (for suicide attempts) and physical abuse in childhood (for self-harm behaviour).

Conclusions: The results highlight the critical importance of experiences of emotional neglect and other forms of abuse in childhood for the development of pathology in BPD patients. These early experiences of neglect promote deficits in self-regulation of emotion (state orientation), which together with depression or demanding circumstances, lead to an increase in the risk of suicide, or in self-harm behaviour, respectively.

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KEYWORDS
Borderline personality disorder; Risk of suicide; Depressiveness; Action vs. state orientation; Self-regulation

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Introduction

Personality disorder is sometimes accompanied by suicidal behaviour. As for borderline personality, research suggests that 10% of people who have committed suicide and kill themselves have been diagnosed with this disorder. One third of a group of young people who have committed suicide were also diagnosed with borderline personality. However, it is not clear how the personality disorder increases the risk of suicidal behaviour. Hawton et al. state that in the suicide risk groups there are people with clearly labile mood who are aggressive, impulsive, and experiencing feelings of alienation. This description fits borderline personality disorder (BPD); people with this disorder often attempt suicide on impulse during a large uncontrolled tension. Depressive experiences, and impulsiveness were the characteristics of people with BPD. Up to 60% of BPD patients attempt suicide, (90% among hospitalised patients), and 8–10% of patients suffering from this problem who attempt to commit suicide die as a consequence. Suicidal behaviour includes suicidal attempts, prepared and interrupted acts of suicide, and active vs. passive suicidal thoughts and potentially suicidal behaviour.

Borderline patients are not only characterized by suicide attempts but also by self-harm behaviour or “non-suicidal self-injury” (NSSI), which is considered to be any deliberate self-inflicted damage to the surface of the body likely to induce bleeding, bruising, or pain without suicidal intent and for purposes not socially sanctioned (see DSM-V; APA, 2013), such as skin cutting, burning, stabbing, hitting, scraping or carving. Self-harm behaviour (NSSI) is to be distinguished from suicide attempts, whether successful or not, and it is being proposed in the DSM-V as a condition for further study. Many patient groups show self-harm behaviour (i.e., of NSSI). Notable among them are BPD patients, who have a 60–80% probability of showing it. Despite their comorbidity, some researchers think that self-harm behaviour and suicidal attempts are distinct, each related to different degrees of lethality. Muehlenkamp and Gutierrez further argue that the purpose of self-harm behaviour in BPD is to relief pain, whereas the purpose of suicide attempts is to end one’s life. In addition, whereas suicide attempts are rare in BPD, instances of self-harm behaviours are more frequent. In other words, the main function of self-harm behaviour is emotion regulation, to keep on living despite personal distress, which is lacking in serious suicide attempts.

If self-harm behaviour and suicide attempts have different aims and functions in BPD patients it is important to identify the factors leading to each, from childhood on. It can be assumed that the roots of BPD are found in childhood experiences. The idea that BPD is associated with childhood trauma has been proposed for many years. It can be presumed that at least some patients with BPD experienced some kind of trauma in childhood, and the childhood trauma is associated with suicidal tendencies and self-harm behaviour. The Childhood Trauma Questionnaire is a self-report instrument to assess the degree of trauma experienced. In the present research we explore the hypothesis that both suicidal tendencies and self-harm behaviour in BPD can be traced back to traumatic events in childhood, as they are reported by the patient.

Research shows that an important factor protecting from suicide are self-regulation competencies. People who meet the criteria of BPD have problems with emotion regulation, showing impulsivity, high emotional intensity, and high reactivity to emotional evocative stimuli. Based on personality systems interactions (PSI; Kuhl, 2000) theory and dialectical behaviour therapy we assume that emotional support in the first years of life is a critical element for developing healthy self-regulation skills. Lack of emotional support or even emotional neglect after self-expression of needs in infancy should therefore be a risk factor in developing BPD and other maladaptive patterns of self-development associated with poor self-regulatory skills. One type of self-regulation deficit that may result from insufficient or inadequate responsiveness of the caregiver in infancy is state orientation. State orientation after failure (SOF) is characterized by the inability to calm oneself after failure and other aversive or threatening events and relates to perseverating negative affect. These persons cannot stop ruminating about painful events or unrealistic intentions, instead of concentrating on a realistic action plan. Prospective (decision-related) state orientation (SOD) is characterized by inaction or indecision and is related an inability to counterregulate low positive affect. Being unable to upregulate low positive affect these persons tend to procrastinate, especially when the intended activity is boring or difficult, or under demanding conditions. Depressive patients tend to have higher scores on either type of state orientation which ameliorates, however, after clinical treatment.

As a consequence of traumatic events or early experiences of emotional neglect related to an invalidating environment, BPD patients may develop a heightened sensitivity to emotional rejection in social interactions. Indeed, it has been found that BPD patients have increased scores on the rejection sensitivity questionnaire as compared to normal controls. It can be assumed that fear of losing social support (increased rejection sensitivity) may increase symptoms in BPD patients, including depression and suicide attempts. Social support is a resource that protects patients at risk from suicide attempts.

Note that BPD patients not only report higher levels of negative affect but also have higher alexithymia, that is, an inability to identify and describe emotions. New et al. found that BPD patients had higher scores in the Toronto Alexithymia Scale (TAS 20) and had more difficulties in identifying their emotions than control group participants. There are indications that the roots of alexithymia in BPD patients may be related to childhood abuse. According to PSI theory, perseveration of excessive levels of negative affect (presumably elicited by childhood trauma or emotional neglect in infancy) impairs self-access which in turn interferes with the quality of social interaction on a personal level.

In this study we carried out serial multiple media- tion analyses which allow to chain multiple mediators between predictor and outcome variables. Specifically, we aim to investigate in a sample of BPD patients the chain of variables starting with different aspects of reported childhood trauma comparing two different pathways, one leading towards suicide attempts, and the second resulting in self-harm.

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