



Self-harm behavior among individuals with intermittent explosive disorder and personality disorders



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ABSTRACT

Self-harm behaviors are a major public health concern across the lifespan, particularly among individuals with psychiatric disorders. Little research, however, has examined these behaviors among individuals with a diagnosis characterized by recurrent acts of impulsive aggression, Intermittent Explosive Disorder (IED). Furthermore, extant research has not examined variables that might mediate the relationship between IED and self-harm. The current study examined the rates of non-suicidal self-injury (NSSI) and suicide attempts among individuals with IED as compared to healthy controls, individuals with personality disorders (PDs; which are highly comorbid with IED), and individuals with comorbid IED and PD. The study also examined the indirect effects of aggression, impulsivity, and affective lability in the relationship between diagnosis and self-harm. Participants were 1079 community individuals and prevalence rates among the total sample were 18% for NSSI and 13.2% for suicide attempts. Scores on measures aggression, impulsivity, and affect lability showed significant indirect effects on the relationships between IED + PD and NSSI; scores on aggression showed a significant indirect effect on the relationship between PD and NSSI; scores on impulsivity showed a significant indirect effect on the relationship between IED + PD and suicide attempt. These results suggest that individuals with PDs, and particularly those with comorbid IED and PD, are at increased risk for engagement in self-harm behaviors. Furthermore, traits of aggression, impulsivity, and affect lability significantly accounted for the relationship between diagnostic status and self-harm, particularly in regards to NSSI.

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1. Objectives

Self-harm behaviors are a major public health concern across the lifespan. Between 2% and 9% of people in the U.S. attempt suicide at some point in their lives and 4–38% engage in non-suicidal self-injury (NSSI; Briere and Gill, 1998; Gratz, 2001; Kessler, Borges, & Walters, 1999; Klonsky, 2011; Nock et al., 2008; Whitlock et al., 2006). These rates are higher among individuals with psychiatric

disorders such as mood, anxiety, substance use, eating, and personality disorders (PDs; Beautrais et al., 1996; Black et al., 2004; Nock et al., 2006; Soloff et al., 2000). Recent research on the correlates of self-harm behaviors has identified behavioral and trait aggression as notable risk factors for self-harm (Haavisto et al., 2005; McCloskey et al., 2012; Tang et al., 2013; Turecki, 2005). Such research suggests that individuals with disorders marked by high levels of other-directed aggression may be particularly vulnerable to engagement in self-harm.

Intermittent explosive disorder (IED), a psychiatric condition characterized by recurrent acts of affective aggression, affects approximately 5–7% of the population (Coccaro et al., 2004; Kessler et al., 2006), and up to 63% of clinical samples (Coccaro et al., 2005). Individuals with IED often meet criteria for comorbid Axis II disorders, particularly antisocial personality disorder and borderline personality disorder, which are also characterized by impulsive-aggressive traits (Coccaro, 2012). Despite this, little research has examined self-harm among individuals with IED. Coccaro et al.

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(1998) found that, among 76 IED subjects, 21% endorsed a history of suicide attempt and 9% endorsed NSSI. These rates are somewhat surprising as research typically suggests higher rates of NSSI than suicide in community samples (Briere and Gill, 1998; Nock et al., 2008; Whitlock et al., 2006). Coccaro et al. (1998), however, did not employ a measure specifically designed to assess for NSSI and therefore, the rates of this behavior may have been underreported in that study. Recently, McCloskey et al. (2008a, 2008b) found similar rates of self-harm among a sample of 376 IED subjects without a history of BPD. Results from this study revealed that the presence of (non BPD) co-morbid PDs was a risk factor for suicide attempts among IED subjects, suggesting that comorbidity between IED and PDs increases the risk of self-harm over the presence of IED alone (McCloskey et al., 2008a).

Though McCloskey et al. (2008a, 2008b) suggest that self-harm behaviors among individuals with IED may reflect a combination of emotional lability and aggressive response styles, these constructs were not assessed in that study. Therefore, although research has established a link between IED and self-harm, several core psychological constructs associated with both IED and self-harm have not yet been examined. Extant research on PDs, particularly BPD, has revealed that several key constructs play a role in self-harm behaviors. These include: 1) emotional lability, the tendency towards unstable, disproportionate emotional responses (e.g., Anestis et al., 2011; Linehan, 1993); 2) impulsivity, the tendency towards rapid, unplanned actions without regard for consequences (Anestis et al., 2011; Mann, Waterneux, Haas, & Malone, 1999); and 3) trait levels of anger and aggression (Ribeiro and Joiner, 2009; Selby et al., 2011; Turecki, 2005). Not surprisingly, these traits have also emerged as central to the presence of other-directed aggression in IED (Coccaro et al., 1998). For example, individuals with IED are typically impulsive in their aggression, meaning that they do not usually plan their aggression behavior in advance. These individuals also tend to be highly emotionally labile, with anger and aggression that is disproportionate to the provoking situation. Finally, individuals with IED necessarily have high trait levels of anger and aggression (McCloskey et al., 2008b).

The goals of the current study were twofold. First, we wanted to compare the rates of NSSI and suicide attempts among individuals with IED with and without co-morbid PD to comparison groups of individuals with a PD without IED and those with no history of any Axis I or II psychopathology (Control). We also wanted to examine the possible indirect effects of several key constructs (i.e. aggression, impulsivity, and affective lability) on the relationship between IED, PDs, and self-harm behaviors.

2. Materials and methods

2.1. Participants

Participants in the current study were 1097 (355 Controls, 216 PD, 74 IED, and 452 IED + PD) individuals who were recruited as part of ongoing research studies in the Clinical Neuroscience and Psychopharmacology Unit at the University of Chicago. Participants were recruited from print and radio ads for individuals with interpersonal difficulties (e.g. arguments, unstable relationships), as well as healthy controls. Individuals were excluded from the studies if they reported experiencing traumatic head injury with loss of consciousness, histories of bipolar or psychotic disorders, or current substance dependence. Written informed consent was obtained for all subjects, and all study procedures were approved by the University Institutional Review Board. Participants in the current study were 53.6% female, 58.9% Caucasian, with a mean age of 35.1 ($SD = 10.3$, range 18–81).

2.2. Measures and procedure

Participants completed diagnostic and clinical interviews, which were conducted by trained doctoral-level diagnosticians. Diagnoses and self-aggression history were confirmed using a best estimate procedure (Klein et al., 1994; Leckman et al., 1982), in which the written diagnostic report and raw interview data were reviewed by a multidisciplinary team of psychologists and diagnosticians who were blind to the study hypotheses. This process resulted in good to excellent inter-rater reliabilities (mean $\kappa = .84$ range: .79–.93) across anxiety, mood, substance use, impulse control, and personality disorders.

Axis I disorders (including mood disorders, anxiety disorders, substance use disorders, eating disorders, somatoform disorders, childhood disorders, and adjustment disorder) were assessed with the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First, Spitzer, Gibbon, & Williams, 1997). The SCID has adequate inter-rater reliability with kappa values for modules reported to be between .70 and 1.00. Personality disorders were assessed via the Structured Interview for DSM-IV Personality (SIDP-IV; Pfohl et al., 1995). The SIDP-IV shows good inter-rater reliability ($ICC = .88-.99$). Intermittent explosive disorder was assessed with the Intermittent Explosive Disorder Interview – Modified (IED-M; Coccaro, unpublished instrument) which provides quantitative (e.g. frequency) and qualitative (e.g. description of most severe events) information about verbal and physical aggression as well as resulting distress/impairment. Preliminary data suggest the IED interview is a valid and reliable ($\kappa = 0.84$) instrument (McCloskey and Coccaro, 2003).

Several measures were used to assess self-harm. These included the Suicidal Behavior History Form (Spitzer and Enticott, 1978), the Deliberate Self-Harm Inventory (DSHI; Gratz, 2001), and the Life History of Aggression Questionnaire (LHA; Coccaro et al., 1997). All three of these measures have demonstrated adequate psychometric properties. Due to slight methodological variability across the studies, two dichotomous variables (aggregated across all measures) were created for lifetime history of suicide attempt and lifetime history of NSSI. Specifically, if a participant endorsed at least one act of NSSI or at least one suicide attempt (characterized by ambivalent or clear intent to die), on any of the aforementioned measures, he or she was coded as having a lifetime history of NSSI or suicide attempt, respectively.

Questionnaire measures included the Buss–Perry Aggression Questionnaire (BPAQ; Buss and Perry, 1992), the Barratt Impulsiveness Scale (BIS-11; Patton et al., 1995) and the Affect Lability Scale – Short Form (ALS-SF; Oliver and Simmons, 2004). Again, all three of these scales have demonstrated adequate psychometric properties.

2.3. Analytic plan

All analyses conducted were two-tailed at the .05 level of significance. For preliminary analyses, significant main effects were probed using Tukey HSD post-hoc tests (ANOVA) and single $df \chi^2$ tests (χ^2).

Demographic variables (i.e. sex, age, race and education), co-morbid psychopathology empirically associated with self-harm (i.e. major depressive disorder, other mood disorders, any anxiety disorder, any eating disorder, any substance use disorder, borderline personality disorder, any other cluster B personality disorder [PD], any cluster C PD), and related study variables (aggression, impulsivity and affect lability) were assessed as a function of (a) diagnostic group, (b) NSSI status and (c) suicide attempt status. Evaluations of comorbidity included only the clinical groups, as the Control group by definition had no psychiatric disorders. Likewise, Axis-II comorbidity was only compared between PD and IED + PD

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