A Comparison of Life Events Between Suicidal Adolescents With Major Depression and Borderline Personality Disorder

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The current study compared the correlations of different types of stressful life events (SLE) between suicidal adolescents with major depressive disorder (MDD) and suicidal adolescents with borderline personality disorder (BPD). Both groups were referred following an attempted suicide. Twenty adolescents with MDD and 20 adolescents with BPD who were consecutively referred to an outpatient clinic following a suicide attempt were evaluated. A community control group of adolescents with no lifetime history of suicidal behavior was also assessed. The following measurements were employed: the Suicide Risk Scale (SRS) Beck Depression Inventory (BDI), the Life Events Checklist (LEC), and the Childhood Sexual Abuse Questionnaire (CSEQ). Both groups of suicidal subjects reported more SLE in general and more physical abuse than community controls in the 12 months before the suicide attempt. The MDD adolescents had more lifetime death-related SLE than the BPD and control groups, while the BPD adolescents reported more lifetime sex abuse-related SLE than the other two groups. Thus, suicidal behavior in general may be related to the amount of SLE. However, different disease-specific life events may precipitate suicide attempts in adolescents with MDD and BPD.
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IT IS NOW generally accepted that approaches to the understanding of psychiatric disorders based on the assumption that factors from a single domain (i.e., biologic, psychological, or social) are responsible for its occurrence are untenable.[1] Stress diathesis interactions form the basis of most views on suicidal behavior.[2] Nonshared environmental factors in the pathogenesis of mental illness are an intriguing area of research. These relate to those nongenetic and life stress factors that are specific to each individual. They are of major importance in the understanding of gene-environment interactions in the etiology of psychiatric disorders.

The environmental factors most widely studied have been those related to stress and more particularly stressful life events (SLE). The study of SLE is complex and controversial and several different approaches to this topic have been suggested. The "objective approach‘ espoused by Dohrenwend[3] views stress as an environmental input independent of the person's reaction or emotional state. In this approach, a detailed evaluation of each event by independent judges is made, attempting to circumvent biases stemming from the respondent by ignoring self-reports about responses to the event. Raters make judgments about what most individuals would likely feel in similar circumstances. This contrasts with the "relational-cognitive-orientation approach" suggested by Lazarus et al.[4] that emphasizes the meaning attributed to the life event by the individual and the subjective impact of stress. It argues that an event cannot be identified as stressful independent of the person's attitude towards it.

Three general theories about the relationship of SLE to psychiatric disease can be delineated.[5] (1) The "general-quantitative" supposition[6] proposes a cumulative model of stress, claiming that the amount of events and their weight, but not their quality and meaning, are related to psychopathology. (2) The "general-qualitative" hypothesis states that not change per se, but its undesirability or threatening quality causes stress and is responsible for its adverse consequences. Hence, an accumulation of negative events, but not positive, contributes to the disorder.[7,8] (3) The "specific-qualitative" idea emphasizes the unique influence of special kinds of events on the occurrence of the disorder. Thus, events related to loss[9,10] or uncontrollable stressors[11] may be of special relevance to mood disorders.

Some of the most interesting work relating SLE to psychiatric disease has been done in the field of mood disorders. There is now accumulating support for the notion that episodes of depression and probably also of mania are associated with life events and the failure to adapt to them, a phenom-

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enon that was originally described by Kraepelin.[12] There are, however, those who believe that some depressions occur independently of external life events, a view related to the concept of "endogenous," "melancholic," and "psychotic" depressions.[13] These types of depression are sometimes felt to have a biological etiology.[14] Clinical research into the validity of the endogenous-reactive dichotomy has been inconsistent, and indeed the term "endogenous depression" with its etiological implications has been dropped from the official nosologies such as DSM-IV. Thus, even "endogenous" depressions may well be related to SLE.[10] In the current report, depression refers to those subjects meeting DSM-IV criteria for major depressive disorder (MDD).

Excess of general life events in depressed subjects supports the general quantitative approach.[10] However, in accordance with the specific qualitative approach, there is evidence that certain specific stressors, such as those involving loss, bereavement, separation, disappointment, and parent-related traumata, may occur in excess before the onset of depression both in clinical and in nonpatient populations, especially when these stressors occur in childhood and when the depression is severe.[13,15]

There is also increasing evidence that specific life stressors are common precursors of borderline personality disorder (BPD). These seem to be related to abuse by primary caretakers,[16] rather than separations or loss.[17] In addition, Stone et al.[18] found that incest was relatively common in BPD, and Paris et al.[19] reported higher incidences of serious sexual abuse rather than physical abuse in females with BPD. There may also be a relationship between sexual abuse and the gravity of the BPD.[20,21] It is possible that in males with BPD, physical abuse may be more a important pathogen than sexual abuse.[22,23]

The purpose of this study was to study the relationship between life events, MDD, and BPD in adolescence. Since suicidal behavior is common in both groups and is in itself highly related to life events, it was decided to control for this factor by investigating only adolescents referred for treatment following a suicide attempt.

The specific hypotheses of the study were that: (1) Adolescents with psychopathology would show more life events than normal controls (general quantitative approach), both during their lifetime and in the year preceding the suicide attempt. (2) Suicidal adolescents would show more negative life events than normal controls (general qualitative approach) both during their lifetime and in the year preceding the attempt. (3) Suicidal depressed adolescents would show more loss related life events such as bereavement, separation, and disappointment than suicidal BPD adolescents and normal controls (specific qualitative approach) both during their lifetime and in the year preceding the attempt. (4) Suicidal BPD adolescents would show more traumatic life events than suicidal depressed adolescents and normal controls (specific qualitative approach) both during their lifetime and in the year preceding the attempt.

METHOD

Population

Three groups of adolescents took part in the study: (1) a group of 20 adolescents who had made a first suicide attempt and were diagnosed as meeting DSM-IV criteria for MDD; (2) a group of 20 adolescents who had made a first suicide attempt and met DSM-IV criteria for BPD; and (3) a sex- and age-matched group of 20 adolescents who did not meet criteria for any psychiatric illness and had never made a suicide attempt during their lifetime. They were recruited from a high school in the clinic catchment area.

The patient groups represented consecutive referrals to a Child and Adolescent Psychiatric clinic in a university-affiliated hospital. The diagnoses were the primary diagnosis. BPD patients with comorbid depressive disorder were excluded from the study as were subjects with a lack of knowledge of Hebrew or mental retardation. Comorbid diagnoses for the MDD group were anxiety disorder (n = 6) and eating disorders not otherwise specified (NOS) (n = 3). Comorbid diagnoses for the BPD group were anxiety disorder (n = 3), eating disorders–NOS (n = 4), bulimia nervosa (n = 2), and oppositional defiant disorder (n = 2). None of the subjects had a diagnosis of substance abuse. Only two patients refused to participate in the study.

Mean ages of the MDD, BPD, and control groups were 16.73 ± 1.72, 16.72 ± 1.41, and 17.50 ± 2.76 years, respectively. There were 11 girls and nine boys in each group. There were no differences between the groups on demographic factors. All subjects were Jewish and Israeli. All subjects were of middle-class socioeconomic status and were high school students. Illness severity of the psychiatric groups was between 40 and 60 on the Global Assessment of Functioning scale, with no significant differences between the groups. This range involves moderate to severe symptom severity with some impairment in functioning in a few cases. All suicide attempts were of low lethality and involved self-poisoning with prescription drugs. None of the patients used other means to attempt suicide.

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