

Harm avoidance, self-harm, psychic pain, and the borderline personality: life in a “haunted house”

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Abstract

This article investigates the pattern of temperament for patients with borderline personality disorder and the impact of psychotherapeutic treatment on temperamental variables. A cohort of patients treated in the Westmead Borderline Personality Disorder Psychotherapy research project completed the Tridimensional Personality Questionnaire. All patients had a diagnosis of borderline personality disorder according to the *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition*, criteria. This group scored highly on novelty-seeking and harm avoidance scales and moderately on reward dependence. There was a significant reduction in harm avoidance after 12 months of psychotherapy with a further reduction after 2 years in therapy. Although at variance with Cloninger’s original prediction of low harm avoidance in histrionic and borderline patients, results are consistent with other studies in this patient group. The paradox of “self-harmers” scoring highly on harm avoidance may be explained by recognition of the intensity of “psychic pain” in this group. Self-harming behaviors may frequently be motivated by avoidance of a “greater harm” in terms of the inner psychic reality for these patients. Reduction in harm avoidance with psychotherapy could suggest an impact of treatment on temperament or may indicate that the harm avoidance construct is influenced by state variables such as mood.

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1. Introduction

Modern geneticists recognize that “genes represent risk factors and not fated outcomes,” that we are not “doomed from the womb,” and that “genes and environment interact to increase vulnerability to psychopathology” [1]. Traditional debates focusing on “nature versus nurture” may fail to recognize the importance of both genetic makeup and environmental influence in the development of phenotype for many complex human traits and behaviors. In determining phenotype, it is often the *transcriptional function* of genes that is crucial. Regulation of this function is responsive to environmental factors and susceptible to social influence [2].

A standard psychiatric text from the 1980s defines temperament as “nature” ([3], p 1355), although the same text is critical of researchers that “rely on parental reports,” suggesting that difficult behavior may well reflect the specific interaction of mother and child ([4], p 1692). In contrast to the definition of temperament as nature, in a later

edition of the same text, Cloninger and Svrakic [5] define temperament as corresponding to “the sensation, association, and motivation that underlie the integration of skills and habits based on emotion” (p 1724). Such a definition is inherently dynamic, moving away from the notion of temperament as “fixed” [6].

If temperament is based on emotion, we must conclude that temperament is influenced by actual experience because our emotional lives, that is, our experience of affect and emotion, only occur in dynamic interaction with others and the wider environment. Newborns will have key affective experiences in relation to caregivers. Psychoanalytic conceptions such as “there is no such thing as an infant” [7] and modern neuroscientific formulations like the “social brain” [8] highlight the importance of not considering the infant in isolation. In the developmental account of Stern [9], the first 2 months of life culminate in a “core sense of self” based in the affective experience of relatedness.

It is this early organization of self that is likely to be associated with what are perceived to be temperamental characteristics. This is in keeping with Cloninger’s theory that temperament is based on emotion, whereas character “corresponds to the processes of symbolization and abstraction that are based on conceptual learning” [5]. Widiger [10],

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in describing a temperamental model of borderline personality disorder (BPD), highlights the prominence of “negative affectivity” in the makeup of patients with BPD. This dimension is also likely to be influenced by early patterns of relatedness involved with the establishment of the individual’s core emotionality. Of course, these formulations still leave room for significant genetic and constitutional contributions from both infant and mother/others.

In the area of personality research, we often think in terms of temperament and character variables. Usually, clinicians take this to mean temperament as “that which is purely heritable or constitutional” and character as “that which is the result of environmental influence.” This can be misleading because, as Cloninger argues, the more “fundamental distinction between character and temperament . . . appears to be that character development is a concept-based process whereas temperament involves differences between individuals in perceptual processes and habit formation. This corresponds to the distinction of conceptual memory and the perceptual memory system.” [11].

It may, therefore, be appropriate to think of temperament as developing in relation to “embryonic and infant environment” as well as purely genetic factors, whereas character is perhaps largely molded at a later period when a degree of perceptual differentiation has become established [12]. The “perceptual filters” that will affect temperament are likely to be the affectively toned relational experiences of early life: “Representations of interactions that become generalized” (Stern), the “prerepresentational self” and “affective core” (Emde) are attempts to formulate this aspect of development [9,13]. In patient groups where early development is characterized by significant trauma and/or neglect, it is likely that the temperament becomes dominated by an inner sense of undifferentiated psychic pain that lies outside the sphere of verbally accessible memory, in implicit memory systems [14].

Patients with BPD are typically individuals with backgrounds of early trauma [15,16]. Zanarini and Frankenburg [15] describe the intensity of emotional pain, more than the sense of abandonment, as a hallmark of this condition: “borderline patients are not so much afraid of staying in an empty house as they are terrified of being trapped in a haunted house—a house haunted by the memories of what others have done to them and what they, in turn, have done to themselves and others.” It is in this context that it is necessary to view some of the apparently self-destructive and harmful behaviors of these patients.

Cloninger’s model of temperament originally grouped BPD with histrionic personal disorder predicting high Novelty Seeking (NS), low Harm Avoidance (HA), and high Reward Dependence (RD) [17]. Initial studies seemed to confirm this finding [18]. Subsequent findings have led to a revision of this prediction with more recent publications suggesting that BPD is associated with high NS, high HA, and moderate RD [19,20]. Other studies have shown that HA varies in response to antidepressant treatment with

responders showing a lowering of HA scores, suggesting that HA may be influenced by state variables and hence may have limitations as a measure of temperament [21,22]. High HA scores have also been reported in some anxiety disorders, posttraumatic stress disorder [23], and adult attention deficit hyperactivity disorder [24].

The Tridimensional Personality Questionnaire (TPQ) [25] was developed on the basis of a “general biosocial theory of personality” [17] and sought to relate the stimulus-response characteristics of NS, HA, and RD to possible underlying genetic and neuroanatomical bases [17]. A fourth variable (persistence) has since been developed. More recent work from Cloninger’s group has also focused on character development [11]. However the present study is restricted to the original 3 variables of the TPQ. These 3 variables are thought to account for the behavioral and interpersonal style of individuals, whereas the character variables of self-directedness, cooperativeness, and self-transcendence are seen as more determining of functional outcome (ie, whether a person develops personality disorder or not) [11]. Cloninger sees these latter variables as more closely related to longitudinal developmental/environmental conditions and as influencing “personal and social effectiveness by insight learning about self-concepts” [11].

There is little doubt that temperament makes a significant contribution to personality development. The capacity to identify temperament variables for different personality disorders will enhance our understanding of these conditions. Identifying a change in temperament variables with treatment might suggest a transformative effect on personality, a claim often made for psychotherapeutic treatment. This study makes a tentative contribution to both these matters.

2. Method

2.1. Participants

2.1.1. Tridimensional Personality Questionnaire profile

The 167 patients were drawn from consecutive referrals to the Westmead Personality Disorder Research and Treatment Program between 1990 and 2002. They were screened at an assessment interview with the Westmead severity scale (see previous publications [26–29] and the Diagnostic Interview for Borderline Personality Disorder [30]). The participants ranged in age from 18 to 57, the mean age being 28.6 (SD, 6.7), with 113 females and 54 males.

2.1.2. Treatment effect-therapy and control group

The 29 patients in the study group were in therapy for 12 months. The control group consisted of patients that waited for a period of 12 months continuing with “treatment as usual” (TAU) as carried out by the referring clinicians. This waitlist (TAU) group had evolved naturalistically. People referred to the program as well as referring clinician understood there was a waitlist because of the demand for and the limited resources of the program. The mean age of

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