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To Injure Or Not To Injure: Dissecting Self-Harming Behavior in Borderline Personality Disorder

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Borderline Personality Disorder (BPD) is a mental health condition characterised by emotional dysregulation, unstable self-image, and impulsivity. Self-harming behaviours are commonly associated with BPD, but the relationship between self-harm and non-self-harm behaviours in this population remains a subject of ongoing research. This study aims to comprehensively examine the difference between self-harm and non-self-harm behaviours in individuals with BPD with respect to attachment, childhood trauma, emotional dysregulation, impulsivity and self esteem. Out of 30 BPD patients, selected using purposive sampling, 20 of them were found to be engaged in self harm (Group-1) and remaining 10 were without documented histories of self harm behaviour (Group-2). Mann Whitney U test revealed significant differences between these two groups with respect to emotional abuse, emotional dysregulation, non-acceptance of emotional responses and impulse control difficulties . Spearman coefficient of correlation revealed a significant positive correlation between anxious attachment and emotional dysregulation for group 1 and childhood trauma and self-esteem for group-2. Thematic Analysis in Group-1 revealed themes including lack of emotional support, fear of abandonment, release of suffering through self-harming, emotional sense of trauma and suffering etc.

Keywords: Borderline Personality Disorder, Self-Harm, Emotional Dysregulation, Attachment, Childhood trauma

Borderline personality disorder (BPD) is a mental health condition characterised by emotional dysregulation, impulsivity, and unstable self image. BPD affects approximately 1-2% of the general population, with a higher prevalence among individuals receiving mental health treatment (American Psychiatric Association, 2013). Self-harm is the purposive, direct alteration of bodily tissue without an intentional desire to commit suicide, leading to injuries that are severe enough to cause tissue damage. (Gratz,2004).

Despite the strong association between BPD and self-harm, not all individuals with BPD engage in self-harming. A growing body of research has suggested that BPD can be divided into two distinct subtypes: those with self-harming behaviours (BPD-SH) and those without (BPD-noSH) (Zanarini et al., 2020). These two subgroups differ in terms of clinical presentation, course of illness, and response to treatment.

In environments where caregivers are unresponsive to their children's needs within the family, the child's ability to feel safe while understanding and interpreting the emotions of close relationships is compromised. Without the necessary mental and social cognitive tools and interpersonal support,

intense emotions arising from relationship difficulties can drive individuals towards regulating their emotions through self-destructive actions focused on the body (Stagaki et al., 2021).

The physical penetration of the skin and violation of the body may be viewed as an unconscious enactment and repetition, in which the opening up of the skin and flow of blood may signal an unconscious desire to eradicate and expunge what is deemed to be unacceptable and to free the person from intolerable thoughts and feelings.(Yakaley and Jamess, 2018). This is also important because the skin is the largest organ of the body. With its multiple pores it is also the doorway or communicative opening to the world and the other.

In a study conducted by Parker (2007), an attachment trauma perspective was employed to examine various factors among BPD patients who self-harm compared to those who do not. The research involved a sample of 58 BPD patients who self-harmed and 11 BPD patients who did not, utilizing a mixed-method approach. Results indicated that BPD patients who engaged in self-harm were more prone to having a fearful forms of attachment, feeling afraid of being abandoned, and exhibiting greater degrees of dissociation. The sight of blood during self-harm was described as providing a sense of release, symbolizing the alleviation of pain.

Dubo et al. (1997) conducted a research to examine the relationship between persistent self-mutilating behaviors with various forms of childhood trauma and abandonment in 42 patients with borderline personality disorder (BPD) compared to 17 patients with other personality disorders (BPD). The results revealed that the frequency of self-harming acts was significantly linked to sexual abuse by a caregiver ($P < 0.05$). Moreover, emotional disengagement by a caregiver was found to predict the onset age of self-harming behavior ($P < 0.05$).

Vater et al. (2008) conducted research to explore whether differences between implicit and explicit self-esteem levels are linked to the severity of symptoms in patients diagnosed with Borderline Personality Disorder (BPD). The study involved 41 women diagnosed with BPD according to DSM-IV-TR criteria. The results indicated that disparity in self-esteem, whether in a positive or negative direction, are associated with various self-reported symptoms in BPD, such as self-harm, self-perception issues, and feelings of distress.

Finally, understanding the differences between BPD-SH and BPD-noSH may help clinicians and researchers develop more targeted and effective interventions for individuals with BPD. By identifying unique characteristics of these subgroups, clinicians can tailor treatments to address the specific needs of each individual and improve outcomes for those with BPD.

Objectives

- To determine if there are any significant differences between persons with BPD with self harm and persons with BPD without self harm in terms of attachment, childhood trauma, identity and self esteem, impulsivity and emotional regulation
- To study the interrelationship between these variables

Method

Sample

Group 1: Participants were selected from the Indian adult population (18 to 40 years), consisting of 20 individuals who are diagnosed with BPD and engages in self harming, belonging to urban, rural and suburban areas in West Bengal from november 2022- may 2023.

Group 2: Participants were selected from the Indian adult population (18 - 40 years) consisting of 10 individuals who are diagnosed with BPD but do not engage in self-harming belonging to urban, rural and suburban areas in West Bengal.

Tools Used:

Adult Attachment Scale(AAS): This scale was developed by Collins and Read in 1990. The Cronbach alpha coefficients indicate clear evidence for the reliability for close(.92), depend(.75) and anxiety(.72) subscales.

Childhood Trauma Questionnaire Short Form (CTQ-SF): This scale was developed by Bernstein et al., 1994. The Cronbach alpha coefficients indicate substantial confirmation of reliability for Sexual Abuse(Range= .93-.95) Emotional Neglect(Range= .88-.92), Emotional Abuse(Range= .84-.89), Physical Abuse(.81-.86) respectively. Factor analysis assessments on the five-factor Childhood Trauma Questionnaire (CTQ) model revealed structural consistency, indicating strong validity.

UPPS-P Impulsive Behaviour Scale: The scale was developed by Dr. Donald Lynam in 2001. Test-retest correlations were also calculated for each of the five subcategories. The findings yielded evident initial indications of the consistency for negative impulsivity (.67), Perseverance Deficiency (.69), absence of premeditation (.71), desire for sensation (.69), and positive impulsivity (.80).

Difficulty in Emotion Regulation Scale(DERS): The scale was developed by Gratz and Roemer in 2004. The Cronbach alpha coefficients indicate clear evidence for the reliability for Clarity (0.78), Awareness (0.78), Strategies (0.82), Non-Acceptance (0.85), Impulse (0.89), Goals (0.91).

Self-Image Profile for Adults (SIP-AD): The self image profile for adults was developed by Butler and Gasson (2004). The Cronbach alpha coefficients indicate clear evidence for the reliability of 0.898.

Inventory of Statements about Self-Injury(ISAS): The scale was developed by Klonsky et al in 2004. The Cronbach alpha coefficients indicate clear evidence for the reliability for Affect Regulation (.69), Anti Dissociation (.50), Anti-suicide(.42), Marking Distress (.82), Self-Punishment (.84), Autonomy (.11), Interpersonal Boundaries (.26), Interpersonal Influence (.23), Peer Bonding (-.26), Revenge(.16), self-care (.33), sensation-seeking (.18) respectively. Demonstration of the scale's discriminant validity would be indicated, at least to some extent, by observing that the subcategories were unrelated to various other assessment tools.

Semi-Structured Interview: A semi-structured question set with 11 structured questions and additional (2–4) pertinent and in-depth unstructured questions that address self-harm and BPD.

Results and Discussion

A Shapiro-Wilk test was conducted to analyze normality. The results showed that the distribution of the majority of the scores departed significantly from normality.

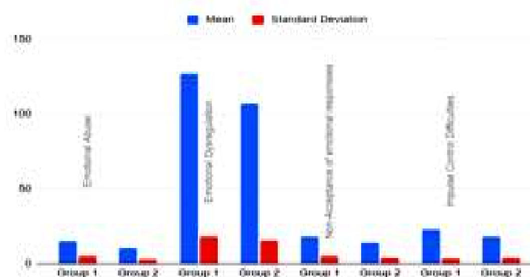

Fig-1: Graphical Representation of Mean and SD of Group 1 and Group 2

A Mann-Whitney U test revealed that Emotional Abuse (U = 2.563, p = .010), Difficulty in Emotion Regulation (U = 2.554, p = .011), Non Acceptance of Emotional Responses (U = 2.073, p = .038) and

Impulse control Difficulties (U = 2.671, p = .008) scores were significantly higher in Group 1 as compared to Group 2.

Spearman's rank order correlation was computed to examine the relations between the scores of variables for Group 1 (n = 20) and Group 2 (n = 10)

Table 1: Thematic Analysis for group 1 and group 2

Group 1	Group 2
Lack of emotional support	Lack of emotional support
Unable to express emotion to parents	Mother sometimes provide love and care
Lack of being understood	Absence from mother's love
Strong need of emotional support	Distant and Unsupportive parental figure
Emotional distancing from parent	Conditional acceptance from parents
Difficulty in emotion regulation	Intentional emotional control
Intentional emotional control	Father is perceived as indifferent
Unable to regulate emotion into adaptive Ways	Feeling of unwantedness is present
Realization regarding immature	
expression of emotion in childhood	Minimal expectation from parents
Failing to suppress emotions	Ambivalent attitude of parents
Distant, punitive and Unsupportive Parental Figure	Revenge taking attitude
Lack of acceptantance from Father's side	Adaptive emotional regulation
Perceived feeling of rejection	Mature emotional coping
Father is perceived as punitive and abusive	Able to express emotion more outwardly
Unavailability of parental love and care	Trying to handle emotions into more adaptive,creative way
Lack of encouragement	Attitude toward self harming
Self -Blaming due to sense of unwanted child is evident	Self harming is perceived as meaningless
Worry related to separation	Attention-seeking non-suicidal manipulation
Sense of vacuum	Outburst anger to gain attention
Fear of abandonment	
Unbearable pain due to distance from closed ones	
Strong belief against separation	
Functions of self-harming	

Release of suffering through self harm Emotional pain get reduced after seeing the blood Create fear and inflict mental pain to closed Ones A way to gain love and seeking attention Momentary Satisfaction Emotional sense of trauma and suffering Momentary depersonalization Self-Punishment A way to seek autonomy Protest against physical abuse	

The objective of this research is to investigate potential disparities between individuals diagnosed with Borderline Personality Disorder (BPD) who engage in self-mutilation and those who do not, focusing on attachment patterns, childhood trauma experiences, emotional regulation difficulties, impulsivity, and the interactions among these factors. Notably, concerning childhood trauma, the study reveals that emotional abuse is significantly more prevalent among individuals in Group 1 (mean = 15.10) in contrast to those in Group 2 (mean = 10.40). This suggests a heightened susceptibility to negative affectivity which refers to a predisposition to be deeply impacted by emotionally provocative situations and to feel more intense negative emotions as a result, which is consistent with findings from prior research (Rosenthal et al., 2005). It is proposed that to alleviate heightened negative affectivity, individuals may turn to maladaptive coping mechanisms such as self-harm. Additionally, qualitative data further support this hypothesis.

(“I harm myself without thinking about what will happen in the future, this suffering has to be freed from it.”When I see my scars, I remember everything, it’s like an album for me, each one has a different story”)

This idea is supported by Nock and Prinstein’s “four function model” (2004, 2005) which suggests that self-harm acts as an automatic negative reinforcement to regulate negative affective states which is unfortunately found to be an effective emotional regulation tool.

Childhood emotional abuse is also a significant predictor of high rejection sensitivity. High rejection sensitivity is described as having consistently heightened and unfounded expectations of rejection, leading to a tendency to perceive social interactions as rejecting. (Chesin et al., 2015) which is clearly reflected in the verbatim of one patient: “I wanted someone to love and understand me, but no one in the family ever understood my pain”.

This idea can be verified from the self-image profile score of the two groups as the self-esteem was observed to be remarkably lower in group 1 as compared to group 2. As they view self-esteem, as a measure of belongingness, rejection communicates a lowered relational value and undermines the feelings of self-worth (Wood et al.2009). This

may be due to the fact that in Indian subculture, attachment style is different as it does not promote autonomy and independence, the child perceives the separation-individuation phase as challenging. Some of them adopt maladaptive cognitive affective reactions as reflected in the qualitative interview, like forming negative inferences about themselves; and viewing rejection as deliberate and personal. Thus, in conclusion, they deserve to suffer or to be punished for perceived inadequacy. This theme is also reflected in the qualitative interview ("Cutting hands is a kind of self-punishment; I think I'm such a bad girl that nothing good will happen in life.").

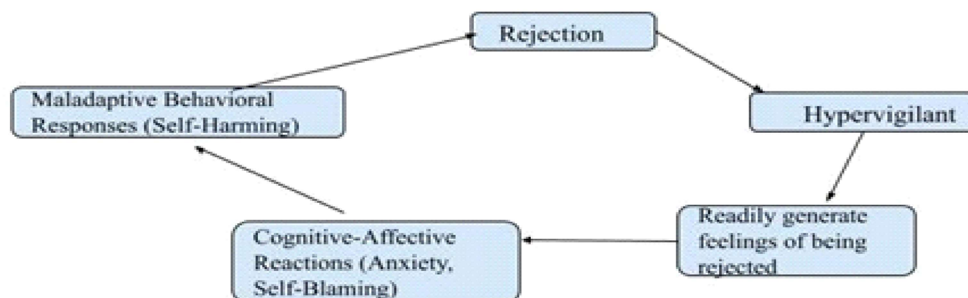

Fig 2: Schematic diagram of the relationship between rejection sensitivity and self-harm

As revealed from Mann Whitney U test, Emotional Dysregulation was significantly higher in Group 1(M= 125.95) as compared to Group 2(M=106.70).This is probably an indication that they may have elevated emotional sensitivity, difficulty managing intense emotional reactions and a prolonged return to emotional stability. Studies indicate that difficulty in emotional regulation serves as a maintaining factor in the frequency of self-harming behaviour (Stepp et al., 2013). Two key theoretical perspectives offer insights into this discovery. Firstly, the outcome aligns with Linehan's biosocial theory of Borderline Personality Disorder (BPD) (1993), proposing that BPD primarily stems from challenges in regulating emotions and arises from interactions between individuals with biological susceptibilities and particular environmental factors. This can be supported by higher mean scores in the domain of non-acceptance of emotional responses of Group 1 (Mean=17.85) as compared to Group 2 (Mean=14).Thus self-injury is served as a survival mechanisms with temporary success in handling different external but mainly internal problems (Moorey, S. 2010) as evidenced by higher mean scores in the domain of impulse control difficulties of Group 1 (Mean= 23) as compared to Group 2 (Mean= 17.90).

Secondly, this phenomenon can also be understood through the Experiential Avoidance Model (EAM), which posits that experiential avoidance encompasses any actions aimed at evading or alleviating unwanted internal experiences or the external stimuli that trigger them. Examples include avoidant coping strategies, suppressing thoughts, using drugs or alcohol to escape unpleasant emotions, and avoiding feared stimuli. These behaviors are primarily sustained through negative reinforcement (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996)..("When the sensation of pain increases from the sensation of anger, the anger will decrease, the pain that was congested in the chest will come out")

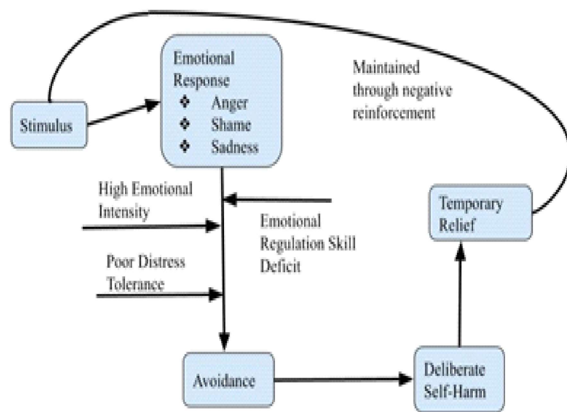

Fig 3: Schematic diagram of how EAM works

Whereas for Group 2, adaptive emotional reaction in terms of mature emotional coping and able to express emotion more outwardly contributed to non-self-harming.

Furthermore, Anxious attachment was found to be positively correlated with limited access to emotion regulation strategies in Group 1 just like other studies(Dijke et al., 2015). This could stem from the anticipation that individuals are erratic and unreliable, leading to a fear of abandonment during times of vulnerability. Consequently, there is a drive to seek closeness when experiencing distress, and individuals tend to adopt hypervigilant approaches, relying on close relationships for coping while devaluing their own capacity to manage due to the absence of functional strategies for regulating emotions as reflected in the qualitative interview ("I actually never expressed my pains to my parents. But I never got that emotional need").

Childhood Trauma was found to be positively correlated with autonomy as a function of self-harming. Experiencing trauma during childhood can interfere with the formation of a stable representation of self , adversely affecting self-esteem (Liu et al., 2018). Furthermore, they tend to seek validation and reassurance from others, indicating a deficiency in self-reliance (Buchheim, A., & GeorGe, C. 2011). Thus the desire to seek autonomy escalates and can be obtained through self-harming. Self-harm extends beyond mere communication; it is an act of self-formation and self-definition. Motz (2010) proposes that self-harm is an effort to occupy a shared mental space, beginning with one aspect of the self-focusing on another, where emotional states are maintained rather than being lost or separated by language.. ("I want to prove to others that I can bear the pain;I'm not weak").

In case of Group 2, childhood trauma was found to be positively correlated with ideal self image profile score which indicates that as childhood trauma is associated with shame and self-blaming, it leads to poor self-functioning and low self-worth. As a result, the longing to appear ideal arises as a means to conceal the wounded and diminished self from the judgment of others. (Elzy, M. B. 2011).

Difficulty in emotion regulation was found to be negatively correlated with actual self-image profile score. This could be attributed to strong negative emotional responses, which include adverse self-evaluations, potentially impeding individuals' capacity to regulate their emotions, as observed in similar research. (Trull.,2015).

Finally a partial correlation was carried out to partial rule out the effects of BDI scores on emotional dysregulation and results indicate that BDI scores are positively correlated with restricted availability of strategies for regulating emotions and challenges in controlling impulses in Group1. Thus we can say that except these two, emotional dysregulation solely contribute to self-harming in group 1.

Implications

By illuminating the shared underlying factors and functions, it emphasizes the need for tailored interventions that address how these two groups are different that will further enhance therapy planning.

Limitations

The sample size was very small due to unavailability and thus limits the generalizability of the findings, gender related differences are not included, retrospective bias are included in the study and lack of longitudinal prospective study limits the findings of the study

Conclusion

Therefore the study concludes that although BPD is present among both groups, these two groups differ significantly with respect to attachment styles, childhood trauma, emotional dysregulation. Emotional abuse is found to be higher in BPD with self harm, contributing to their high negative affectivity which exacerbates self-harming frequency, as evident in thematic analysis too. Emotional dysregulation in terms of non-acceptance of emotional responses and impulse control difficulties are also higher among BPD with self harm groups. In the case of non self harm BPD, childhood trauma is positively correlated with ideal self-image.

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