spectrum

Specialising in Personality Disorder and Complex Trauma

Prevalence of suicide and non-suicidal self-injury in people with BPD and complex trauma

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Some definitions

- NSSI involves intentionally causing physical harm to one's own body without the intent to die.
- Two key features of NSSI are (a) its association with adolescence and young adulthood (average age 16 years) and (b) the intended intra- or interpersonal function of the self-injury.
- Suicidality involves both ideation (SI) and behaviour (attempts, or SA) specifically aimed at ending one's life. SI and SA can occur at any point in the lifespan from childhood to older adulthood.
- NSSI, SI, and SA are distinct but highly interrelated.

(Ford & Gomez, 2015).

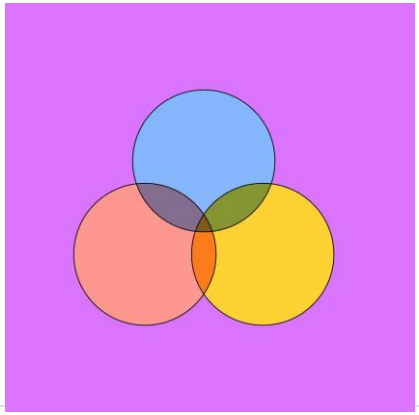
Some background

- Although suicidality and non-suicidal self-injury (NSSI) are commonly experienced by people with BPD, they are not unique to or defining of BPD
- However people with BPD are at elevated risk of engaging in NSSI and suicidal behaviours
- These may be considered as ‘observable symptoms for underlying problems of emotion regulation, impulse control, and interpersonal relations’ (Reichl & Kaess, 2021)
- A unique feature of BPD is ‘chronic suicidality’, conceptualised by Prof Joel Paris in his 2007 book ‘Half in love with death’, as a way for people to manage ongoing distress associated with their pain, emptiness, and hopelessness

Some statistics

- Prevalence rates of NSSI in the general population are estimated at 17% in adolescents (Muehlenkamp et al., 2012) and 6% in adults (Klonsky, 2011)
- In people with BPD, prevalence of 95% and 90% have been reported for adolescents and adults, respectively (Goodman et al., 2017)
- At least 75% of patients with BPD attempt suicide over their lifetime (Black et al., 2004), with up to 10% of people with BPD dying by suicide (Broadbear et al., 2020)

How does trauma fit into this picture?



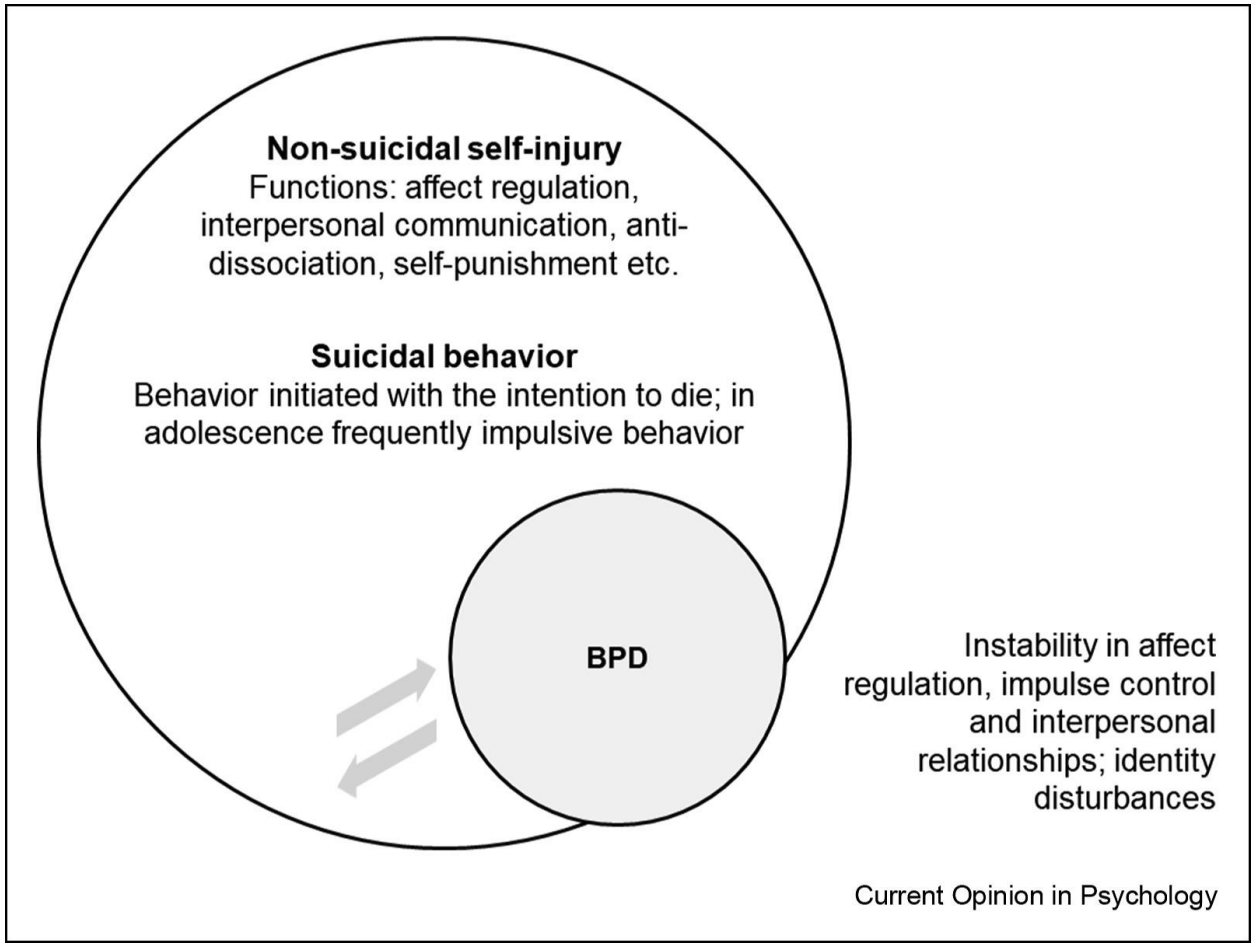
The foundational role of trauma

- A 2015 review described the relationship of (i) psychological trauma, (ii) dissociative and (iii) post-traumatic stress disorders (PTSD) with suicidal thoughts and behaviours (Ford and Gomez, 2015). Dissociative disorder (DD) and PTSD were both associated with increased incidence of suicidality and NSSI. Trauma preceded the development of both.
- From a developmental perspective, in female youth (13-21 years) with BPD, childhood abuse led to greater past NSSI and a 5-fold increase in suicide attempts. Co-occurrence of sexual and physical abuse magnified this relationship (Kaplan et al., 2016)
- Severity of clinical presentation for adolescent girls is positively associated with prolonged childhood sexual abuse, with more suicide attempts, and higher rates of severe NSSI events (Turniansky et al., 2019)

Longitudinal observations

- In a 24 year longitudinal study, deaths of patients with BPD were reported for suicide (5.9%) and non-suicide-related causes (14.0%; e.g. cardiovascular or substance-related complications, cancer, accidents), compared with 1.4% and 5.5% respectively of patients with other personality disorders (Temes et al., 2019).
- Meta-analytic findings confirm a 52-fold increase in suicide rates among individuals with BPD compared with the general population (Pompili et al., 2005).
- NSSI can be considered to be an observable risk marker for the early detection of BPD symptomatology during adolescence and is itself a symptom of BPD.
- Core features of BPD, such as affective instability, identity disturbances, or interpersonal difficulties, precede and interact with self-harm (Reichl & Kaess, 2021).

Graphical representation of core features and inter-relations between NSSI and BPD



Reichl & Kaess, 2021

Dissociative disorders (DD) – a meta-analysis

- Meta-analysis of 19 studies comparing rates of suicide attempts (SA) and non-suicidal self-injury (NSSI) in psychiatry patients with and without DD.
- Main findings:
  - DD patients were more likely to report both previous SA and NSSI in comparison to non DD patients.
  - Patients who had engaged in SA and/or NSSI reported higher Dissociative Experiences Scale (DES) scores in comparison to non SA and non NSSI patients.
- Given the presence of DD diagnosis or higher DES scores in association with both SA and NSSI in psychiatric patients, it may may be reasonable to consider the presence of a dissociative subtype as a trans-diagnostic factor.

Calati et al., 2017

Tentatively tying it all together

- Four potential functions that NSSI and suicidality may play for trauma survivors have been identified, including three that are consistent with traumatic stress disorders (re-enactments of traumatic experiences, interpersonal communication of distress and needs, and attempts to cope with disturbances in self-organization) and one that is specifically consistent with DDs (attempts to cope with dissociative symptoms).
- Preliminary cross-sectional evidence suggests that dissociation and posttraumatic stress disorders may mediate the relationship between psychological trauma and NSSI and SI/SA.
- Research also suggests that emotion dysregulation (e.g., alexithymia, shame, anger) may be a potential mechanism linking dissociation, PTSD, and self-harm.

Final thoughts

- Trauma-related dissociation and emotion dysregulation are interconnected as forms of complex self-dysregulation that may exacerbate other NSSI and SI/SA risk factors (e.g., impulsivity, negative self-perceptions, interpersonal isolation or conflict).
- Most clinical (and research) programs and practice guidelines for NSSI and SI/SA screening and assessment are insufficiently behaviourally specific or precise to accurately identify cases and at-risk persons.
- The interrelatedness of trauma exposure, dissociative and posttraumatic stress disorders, and emotion dysregulation, and their consequent association with the risk and severity of both NSSI and SI/SA risk, makes these posttraumatic constructs strong candidates for inclusion when clinically screening for or assessing NSSI and SI/SA.

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