Associations of Self-harm, Bipolar and Borderline Personality features in a student population

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CITATION
with more robust and systematic evidence with which to inform their own future treatment decisions, and potentially improve their confidence in local decision-making by making available local (rather than general) data.

2. For cases in which referral to an ERS is deemed suitable by a GP, the production of qualitative case-study data could prove invaluable in allaying patient scepticism and also patient anxiety. ‘Humanising’ the schemes through the dissemination of previous participants’ own stories, giving a voice to others ‘in the same boat’, may help form a valuable bridge between knowing about a scheme and actually feeling ready to take part in it.

Such observations further speak to the production of foundational knowledge bases upon which the grander, multi-method assessments of ERSs called for by the Department of Health (2001) can

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Abstract
This paper investigates self-harm as symptom of Bipolar Disorder (Axis I) and of Borderline Personality Disorder (Axis II Disorders). The current study assesses 260 adult students in a non-clinical sample, using the Personality Assessment Inventory for Borderline Personality Disorder (PAI-BOR, Morey, 1991), the hypomanic personality scale for bipolar and the self-harm questions on the PAI-BOR. The self-harming population scored significantly higher on the borderline personality disorder spectrum, and also higher on the hypomanic scale, than their non-self-harming counterparts.

Keywords
bipolar disorder; borderline personality disorder; self-harm; hypomania

Introduction
Borderline personality disorder (BPD) is the mental health disorder most frequently linked to self-harm (Contario & Lader, 1998). This is perhaps unsurprising since self-harm is one of the diagnostic criteria for BPD. Self-harm is neither necessary nor sufficient alone to establish a diagnosis of borderline personality disorder however, the presence of self-harm may be indicative of more severe borderline pathology (Simeon et al., 1992).

Another developmental disorder that also shows strong associations with self-harm is bipolar disorder, which is a Mood and Affective Disorder from Axis 1. Previously we have concentrated on the interface between borderline personality disorder and bipolar disorder (Nokling, 2012). However, self-harm features heavily in both disorders, despite their different placements on the Axis system of the Diagnostic and statistical manual of mental disorders, fourth edition (DSM-IV-TR) (American Psychiatric Association, 2000). Hanstock (2007) suggests that self-harm during low mood in female adolescents with bipolar disorder has led to some inpatients being mistakenly diagnosed as having borderline personality disorder traits. Misdiagnosis can cause significant problems, as it delays effective treatment for the young person and creates emotional distress due to the assignment of an incorrect label which carries considerable stigma (Kellerman, 1989).

This paper addresses the question of whether self-harm is simply an overlapping symptom between the two disorders, or whether self-harm can be present without connection to either diagnosis. It has been suggested that self-harm is actually a symptom of underlying factors that these two disorders have in common (Contario & Lader, 1998). These underlying factors, which may be expressed by self-harming behaviours, could include impulse control behaviours or affective difficulties with regard to relationships.

Hypotheses
1. The presence of self-harm in the participants will be associated with higher borderline
personality disorder scores. The presence of self-harm in the participants will be associated with significantly higher bipolar disorder scores on the hypomanic scale.

Method

Participants

The sample consisted of 260 students (115 males, 138 females, and 7 participants who choose not to disclose their gender), with a mean age of 20.4 years (age range 18–36). The most commonly occurring age was 19 for both gender groups. The majority of the sample had no history of mental illness, with 26 (10%) reporting history of mental health conditions (19 depression, 2 anxiety, 2 depression and anxiety, 1 obsessive compulsive disorder, 1 bipolar, and 1 attention-deficit hyperactivity disorder).

Measures

The PAI-BOR

All participants were tested for positioning on the borderline personality disorder spectrum using the borderline subscale of the PAI-BOR (Morey, 1991). The PAI-BOR consists of 24 items, and participants indicate their level of agreement to each item scored on a 4-point Likert-type scale; 0 for ‘False, not at all true’, 1 for ‘Sometimes true’, 2 for ‘Mainly true’ or 3 for ‘Very true’. Six items in the questionnaire are reverse scored, for example Item 7: ‘My mood is very steady’. The highest score possible is 72, although it is very unlikely for any patient to reach that score. In the literature Morey explains that a score of about 45 or above would be considered high and may indicate a borderline personality disorder, although Trull’s criteria (1995) for identifying borderline personality disorder using the PAI-BOR assigns participants with a score of greater than 38 into the borderline clinical group. However, alone this subscale has no diagnostic value, as a diagnosis can only be made by clinicians after in-depth interviews with the patient. The self-harm criteria from the PAI-BOR will be used to split the groups to allow investigation of associations with self-harm.

The hypomanic personality scale (HPQ)

The HPQ (known in some literature as the hypomanic personality questionnaire; Eckblad & Chapman, 1986) consists of a 48-item scale in which the participant simply chooses True/False responses. Over half of the HPQ items refer to stable personality characteristics, the rest referring to recurrent experiences, and symptoms of hypomanic episodes. For example, Item 1 states, “There are so many fields I could succeed in that it seems a shame to have to pick one”, which is an item indicative of hypomania. Item 5 states, “When I go to a gathering where I don’t know anyone, it usually takes me a while to feel comfortable” which is one of 12 items that are reverse scored.

This scale had already been utilised greatly in the literature in recent years, and Rawlings et al. (1999) in conducting a factor analytic study of the hypomanic personality in non-clinical British, Spanish, and Australian samples had derived from the 48-item scale, a four-factor model. The internal reliability of the HPQ as reported by its authors is .87 and test-retest reliability is .81 (Eckblad & Chapman, 1986). Although no optimal cut-off scores have been reported by the authors of the HPQ, Mansell and Udachina (2007) note that generally 1.5 standard deviations above mean is accepted as a score strongly indicative of the hypomanic symptoms common to bipolar-II disorder.

Procedure

Participants were all presented with a participant information sheet explaining that the experiment consisted of a series of questions relating to personality characteristics with the aim of placing individuals on the spectrum of personality traits including hypomanic behaviour and impulsivity. Participants were assured that the results were completely confidential and that they had the right to withdraw at any time. Completing the scales lasted no longer than 10 minutes.

Analysis

Pearson’s correlations were used to test associations between the overall PAI-BOR and HPQ scores, and between individual factors for each scale. Means were compared using the t-test, and groups were split by gender and presence of self-harm and partial eta squared values were calculated.

Results

Using Trull’s (1995) criteria, 27 of the participants (10.4%) met above-threshold criteria indicative of the borderline personality; using Morey’s (1991) criteria only 9 did (3.5%). While Trull’s criteria is more generous – as a lower borderline score is required to reach a clinically significant research diagnosis – both of these criteria indicated a higher presence of borderline personality in the population than previous research; e.g., Torgersen et al.’s (2001) conclusion indicating that borderline personality disorder affects 1–2% of the population. Perhaps a reason for this is that this sample was derived from student populations, and that borderline personality disorder is more likely to be present among younger populations, with research indicating that the borderline personality has lower impact on people’s lives in middle age (Linehan, 1987).

Self-harm and bipolar disorder

The first hypothesis predicted that the presence of self-harm in the participants would be associated with higher borderline personality disorder scores. Those participants who expressed a history of self-harm (n=57) had significantly higher borderline personality disorder scores (t=−2.131, df=199, p = .036). Mean for self-harm group = 34.3 (SE=.061); mean for no self-harm group = 22.64 (SE=1.20). F(1, 250) = 7.383, P<.001, n²= .228. These findings support previous research into clinical populations that have reported a link between self-harm and borderline personality disorder (Klonsky et al., 2007; Gratz, 2001; American Psychiatric Association, 2000; Contario & Lader, 1998).

Figure 1 shows the association between scores on the HPQ and the PAI-BOR. Figure 1 indicates the self-harm group are all scoring above 20 points on the borderline personality disorder questionnaire, with several in the 50–60 range. However, it must be noted that there are some individuals who do not self-harm who also scored relatively high on the borderline personality disorder spectrum, indicating that the presence of self-harm does not uniquely predict high borderline personality disorder scores.

The second hypothesis was that there would be an association between hypomanic scores among populations who reported a history of self-harm (Hanstock, 2007; Clarkin et al., 1993). The self-harm group had a mean hypomania score of 23.8 (SE=1.58), the no self-harm group had a mean hypomania score of 19.2 (SE=0.58), which is a statistically significant difference (F(1, 250) = 12.65, P<.001, n²=.048). As Figure 1 demonstrates, the self-harm group scored consistently higher scores on the hypomanic scale. However, it must be noted that some individuals from the self-harm group scored within the mean range of hypomanic spectrum scores, indicating that presence of self-harm does not uniquely predict hypomania.

Gender effects were also explored, and while the t-tests revealed that although males scored on average slightly lower than females on the PAI-BOR and slightly higher than HPQ, there were no statistically significant gender differences between PAI-BOR mean scores (males 24.02, females 26.02) or for HPQ mean scores (males 21.03, females 19.21).

Discussion

The associations between self-harm, borderline personality, and hypomania scores in a non-clinical sample has implications for the clinical literature; however, in order to generate more clinically useful insights, it would have been necessary to examine information regarding age of onset of the cycle of self-harm and age of cessation, and severity of the self-harm itself alongside the severity of the borderline personality disorder scores. Due to ethical constraints,

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3. Participants who express a history of self-harm (n=57) had significantly higher borderline personality disorder scores (t=−2.131, df=199, p = .036). Mean for self-harm group = 34.3 (SE=.061); mean for no self-harm group = 22.64 (SE=1.20). F(1, 250) = 7.383, P<.001, n²= .228. These findings support previous research into clinical populations that have reported a link between self-harm and borderline personality disorder (Klonsky et al., 2007; Gratz, 2001; American Psychiatric Association, 2000; Contario & Lader, 1998).

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the series of questions relating to the onset and severity of the self-harm had to be withdrawn from the current study. These observations have implications for Kellerman's (1989) description of the "self-harming borderline", as it has now been demonstrated that high borderline personality disorder scores are present in non-clinical populations among people who do not self-harm. The association of self-harm and higher hypomanic scores in this non-clinical student population also supports findings by Hanstock (2007), who observed that self-harming behaviours in female adolescents with bipolar disorder were frequent and relatively common.

Self-harm has been considered a developmental pathology commencing with a cycle of specific cognitive processes up to two years before the actual first self-harm episode takes place, leading to a cycle typically spanning seven years, indicating that for the participants who reported self-harm (n=59), this cycle is likely to have commenced far earlier in the lifespan, possibly during childhood and adolescence (Favazza & Conterio, 1988; Favazza & Rosenthal, 1990; Strong, 1990; Contario & Lader, 1998).

Conclusions
This research concludes that individuals who self-harm have significantly higher borderline personality disorder and hypomanic scores than those who do not self-harm, demonstrating high importance of prioritisation of research that focuses in on the effects of self-harm. Individuals who self-harm report far more symptoms of borderline personality disorder and hypomania than their counterparts; however, not every individual who engages in self-harm reports higher scores for borderline personality disorder or hypomania.

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References

RESEARCH ABSTRACTS
Critical review of the falls and bone health audit 2007 with a particular emphasis on medication in relation to falls risk including medicines management and polypharmacy
Lynn Sutcliffe

This is the abstract from Lynn Sutcliffe's MSc thesis. Lynn is an Advanced Physiotherapy Practitioner on the Copeland Unit. A literature review from this thesis is also published in this issue of the journal.

Background
Falls prevention came to the forefront of clinical practice with the introduction of the National service framework for older people (2001) and there was an accompanying medicines component. Secondary prevention of falls based around modification of risk factors including medication reviews remains an important aspect of evidence-based clinical practice. There is evidence to suggest medication is a risk factor for falls; however, due to the multi-factorial nature of falls prevention, this aspect appears to have been less well researched than the other risk factors.

Methods
Secondary analysis was carried out of the Falls and Bone Health Clinical Audit (Royal College of Physicians, 2007) with a specific emphasis on psychotropic and night sedation medication; the evidence of medication reviews; polypharmacy; the effectiveness of medication reconciliation and transfer of care between different settings. Comparisons were made between national and local results from the audit.

Results
There appears to be variability in prescribing practice locally and nationally in relation to the prescribing of psychotropic and night sedation medication. There was a significant increase in the number of patients on night sedation 12 weeks after the fall, i.e., 20% compared to 10% at the initial assessment following the fall. There was a significant reduction in the number of medication reviews carried out at 12-week reviews locally with only 15% of the hip fracture group and 6% of the non-hip fracture group receiving medication reviews.

Conclusion
This analysis demonstrated that there appears to be a variation in prescribing practice and medicines reconciliation in both secondary and primary care. The introduction of recent policies both nationally and locally should have an impact on current prescribing practice and may result in different outcomes if the audit (Royal College of Physicians, 2007) were repeated.

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References

Key publications