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Research report

Self-injurious behaviors in posttraumatic stress disorder: An examination of potential moderators

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ABSTRACT

Background: Despite increasing evidence for a relation between posttraumatic stress disorder (PTSD) and self-injurious behaviors (SIB), limited research has examined the factors that may moderate the associations between PTSD and both nonsuicidal SIB (deliberate self-harm; DSH) and suicidal SIB (suicide attempts). Nonetheless, research suggests that characteristics of the traumatic event, co-occurring borderline personality disorder (BPD), and emotion dysregulation may influence the relations between PTSD and SIB.

Methods: Thus, the aim of this study was to examine the moderating role of these factors in the association between PTSD and SIB (including history and frequency of DSH and suicide attempts, and DSH versatility) among a sample of substance use disorder inpatients with ($n=116$) and without ($n=130$) a history of PTSD.

Results: Results from stepwise regression analyses indicate that sexual assault-related PTSD predicted suicide attempt frequency and DSH versatility among those with PTSD. Furthermore, results from hierarchical linear and logistic regression analyses suggest that co-occurring BPD moderates the relationship between PTSD and both DSH history and versatility and emotion dysregulation moderates the relationship between PTSD and DSH frequency. Specifically, the relations between PTSD and DSH outcomes were stronger among participants with co-occurring BPD and higher levels of emotion dysregulation.

Limitations: This study is limited by its reliance on cross-sectional, self-report data.

Conclusions: Despite limitations, findings suggest distinct risk factors for suicide attempts and DSH, and highlight the importance of examining characteristics of the trauma and associated BPD and emotion dysregulation in assessing risk for SIB in PTSD.

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1. Introduction

Posttraumatic stress disorder (PTSD) is a severe mental health disorder characterized by persistent reexperiencing, avoidance, hyperarousal, and cognitive or affective symptoms in response to direct or indirect exposure to a traumatic event (American Psychological Association (APA), 2013). PTSD is associated with a number of self-destructive and risky behaviors, including substance misuse (e.g., Brady et al., 2004; Kessler et al., 1995) and risky sexual behaviors (Rosenberg et al., 2001). Of particular concern, PTSD is associated with high rates of self-injurious behaviors (SIB; i.e., the deliberate destruction of body tissue with or without suicidal intent; see Tate and Baroff, 1966), both suicidal (i.e., SIB with a clear or ambivalent intent to die, or suicidal behavior; O'Carroll et al., 1996) and nonsuicidal (i.e., SIB with no intent to die, or deliberate self-harm [DSH]; Chapman et al., 2006; Fliege et al., 2006; Gratz, 2001; Pattison and Kahan, 1983). In fact, rates of DSH among individuals with PTSD often exceed 50% (Dyer et al., 2009; Sacks et al., 2008; Zlotnick et al., 1999), and PTSD symptoms have been found to predict DSH (Weierich and Nock, 2008). Furthermore, PTSD diagnoses are associated with heightened rates of suicidal behaviors, predicting higher odds of suicidal ideation and suicide attempts (Kessler et al., 1999, 1995), even when controlling for demographic, mood, and substance use variables (Sareen et al., 2005). Moreover, individuals with PTSD are at higher risk for suicidal ideation and attempts relative to other trauma-exposed individuals (Ferrada-Noli et al., 1998). Despite the clear clinical relevance of SIB among patients with PTSD, little is known about the factors that increase the risk for these behaviors among individuals with PTSD, or moderators of the association between PTSD and SIB.

In considering moderators of the association between PTSD and SIB, one population that warrants particular attention is patients

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with substance use disorders (SUD). Patients with SUD have been found to have high rates of PTSD (Brady et al., 2004), suicide attempts (Ullman and Brecklin, 2002; Wunderlich et al., 1998), and DSH (Evren and Evren, 2005; Evren et al., 2006, 2008; Gratz and Tull, 2010a; Zlotnick et al., 1999). Furthermore, evidence suggests that patients with co-occurring PTSD–SUD are at particularly heightened risk for SIB, compared with either diagnosis alone (Harned et al., 2006; Moylan et al., 2001; Najavits et al., 1999). Thus, investigating potential moderators of the PTSD–SIB relation among SUD patients is of particular clinical relevance and public health significance.

One potential moderator that warrants examination is the specific type of traumatic event experienced. In particular, there is evidence to suggest that the nature and associated features of sexual assault-related traumatic events may be qualitatively different than many other forms of traumatic exposure. Specifically, sexual assault-related traumatic events tend to be intimate in nature, often engender a sense of violation or betrayal, and may involve a known perpetrator (e.g., Goodman et al., 1993; Wiederman et al., 1998). As a result, researchers have proposed that sexual assault-related traumatic experiences may be more likely than other types of traumatic events to result in a range of negative clinical outcomes and impairments (Goodman et al., 1993; Sandberg et al., 2010), including SIB. Empirical evidence supports this proposition, finding heightened risk for SIB in sexual assault-related traumatic events. Specifically, a history of sexual abuse or assault has been associated with increased suicidal ideation and suicide attempts (Davidson et al., 1996; Kilpatrick et al., 1985; Ullman and Brecklin, 2002) and DSH (Jaquier et al., 2013; Romans et al., 1995). Furthermore, even controlling for physical and emotional forms of childhood maltreatment, childhood sexual abuse has been found to be associated with risk for suicide attempts (Wiederman et al., 1998). Moreover, evidence suggests that sexual assault-related traumas may be more strongly linked to suicide-related outcomes than other types of traumatic experiences, such as accidents, natural disasters, or combat (e.g., Belik et al., 2009; Borges et al., 2008). Finally, although no studies have examined the relative strength of the relations between sexual assault-related traumas (vs. other traumatic events) and DSH in particular, research does indicate higher rates of DSH among women with a history of sexual assault (vs. women without sexual assault; Jaquier et al., 2013; Romans et al., 1995). As such, it is possible that individuals with PTSD resulting from sexual assault-related traumatic exposure may be at particularly heightened risk for SIB.

Another factor that may increase the risk for SIB among those with PTSD is the presence of co-occurring borderline personality disorder (BPD) pathology, which co-occurs frequently with PTSD (at rates of 10–76%; Pagura et al., 2010; Shea et al., 1999; Zlotnick et al., 2002) and has been found to be associated with worse clinical severity among those with PTSD (Feeny et al., 2002; Zlotnick et al., 2003). Of particular relevance to this study, patients with co-occurring BPD and PTSD have been found to have higher rates of suicide attempts than patients with PTSD alone (Connor et al., 2002; Heffernan and Cloitre, 2000). Moreover, SIB are a hallmark feature of BPD (American Psychiatric Association (APA), 2013), with up to 75% of individuals with BPD endorsing a history of DSH (Gunderson, 2001) and up to 84% attempting suicide (Soloff et al., 2002). Notably, although a recent study of substance-dependent patients failed to find support for the moderating role of BPD in the relation between PTSD and DSH frequency (Gratz and Tull, 2012), this study did not examine other aspects of DSH (i.e., DSH history or versatility) or suicidal behaviors. However, given previous literature underscoring the relevance of co-occurring BPD to suicide attempts among patients with PTSD (e.g., Connor et al., 2002), the examination of suicide-related outcomes is particularly important in this context.

A final factor that may moderate the association between PTSD and SIB is emotion dysregulation. As defined here, emotion dysregulation is a multidimensional construct involving a lack of awareness, clarity or acceptance of emotions, difficulties controlling behaviors when distressed, limited access to effective emotion modulation strategies, and an unwillingness to experience distress in order to pursue meaningful activities in life (Gratz and Roemer, 2004; Gratz and Tull, 2010b). In addition to evidencing strong relations with PTSD pathology in both clinical (McDermott et al., 2009; Weiss et al., 2013, 2012) and nonclinical (e.g., Tull et al., 2007) samples, emotion dysregulation has been implicated as a risk factor for SIB. In particular, DSH has been conceptualized as serving an emotion regulatory function (Chapman et al., 2006; Gratz, 2001; Suyemoto, 1998), and emotion dysregulation has demonstrated robust associations with DSH in nonclinical (Gratz and Chapman, 2007; Gratz and Roemer, 2008; Heath et al., 2008) and clinical (Gratz and Tull, 2010a; Slee et al., 2008) samples. Given that PTSD is associated with heightened emotional arousal, the presence of emotion regulation difficulties among individuals with this disorder may prompt the use of maladaptive strategies to avoid or escape emotional distress (e.g., Weiss et al., 2012), including DSH. Notably, although heightened levels of emotion dysregulation among individuals with PTSD may increase the risk for DSH, the relation of emotion dysregulation to suicidal behaviors has been theorized to be more complex (Anestis et al., 2011), and there is evidence to suggest that emotion dysregulation may not increase the risk for suicidal behaviors in this population. Specifically, despite early evidence for an association between emotion dysregulation and suicide attempt frequency (Zlotnick et al., 1997), recent evidence (Anestis et al., 2011) suggests that emotion dysregulation may be positively associated with suicidal desire but negatively associated with the acquired capability for suicide (i.e., the habituation to physiological pain and the fear of death and bodily harm that permits individuals to enact serious and lethal self-injury; Joiner, 2005). These researchers have suggested that although individuals with high levels of emotion dysregulation may be more likely to desire suicide, they may be less inherently capable of enacting potentially lethal self-injury (which requires the ability to persist in the face of emotional and physical distress associated with serious suicidal behaviors; see Anestis et al., 2011, 2012). Thus, emotion dysregulation may moderate the relation of PTSD with some forms of SIB (e.g., DSH), but not others (e.g., suicidal behaviors).

The aim of the present study was to examine moderators of the association between PTSD and SIB in a high-risk sample of SUD patients. Despite research and theory underscoring the need to distinguish between DSH and suicidal outcomes (Chapman and Dixon-Gordon, 2007; Gratz, 2003), and evidence of divergent associations between these forms of SIB and risk factors (e.g., emotion dysregulation; Anestis et al., 2012; Gratz and Chapman, 2007), there is little research examining the associations with risk factors across various forms of SIB. Taking an initial step in this line of research, we examined a range of SIB in the present study. Consistent with past research (Harned et al., 2006; Moylan et al., 2001), we hypothesized that PTSD would be associated with a history of DSH and suicide attempts, frequency of DSH and suicide attempts, and DSH versatility (i.e., use of multiple methods of DSH; Turner et al., 2013). We also hypothesized that sexual assault-related traumas and co-occurring BPD would moderate the relationship between PTSD and SIB, such that the presence of these factors would be associated with a stronger relation between PTSD and SIB. Finally, we hypothesized that overall emotion dysregulation would moderate the relationship between PTSD and DSH (but not suicide attempts; consistent with Anestis et al., 2012), such that the association between PTSD and DSH would be stronger at high (vs. low) levels of emotion dysregulation. Given the limited

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