

Childhood Antecedents of Self-Destructiveness in Borderline Personality Disorder

Elyse D Dubo, MD¹, Mary C Zanarini, EdD², Ruth E Lewis, PhD³, Amy A Williams, BSc⁴

Objective: To assess the relationship between lifetime patterns of self-destructive behaviour and various parameters of childhood abuse and neglect in patients with borderline personality disorder (BPD) compared with other personality disorder (OPD) controls.

Method: The subjects were 42 inpatients with the diagnosis of BPD and 17 OPD controls. Lifetime patterns of self-destructive behaviour were assessed using the Lifetime Borderline Symptom Index. Childhood experiences were assessed using a semistructured interview by raters who were blind to diagnosis.

Results: Chronic self-destructive behaviour discriminated patients with BPD from OPD controls. In the borderline group, parental sexual abuse was significantly related to suicidal behaviour and both parental sexual abuse and emotional neglect were significantly related to self-mutilation.

Conclusion: Both parental sexual abuse and emotional neglect appear to play a role in the etiology of self-destructive behaviour in BPD. The results highlight the importance of considering the effects of sexual abuse within its environmental context and suggest that the etiology of borderline symptoms is likely multifactorial.

(Can J Psychiatry 1997;42:63–69)

Key Words: borderline personality disorder, self-destructive behaviour, self-mutilation, suicide, childhood sexual abuse, childhood neglect

Both self-mutilation and manipulative suicidal behaviour are pathognomonic symptoms of BPD (1–3). Self-destructive behaviour as a whole is poorly understood, difficult to treat, and associated with a high degree of psychosocial morbidity. The literature addressing this phenomenon is largely based on heterogeneous groups of self-injurers that include patients with psychotic disorders, mental retardation, organic mental disorders, and various personality disorders (4–13). Though the populations reported on likely encompass

large numbers of patients with BPD, surprisingly few papers and very few controlled studies have focused exclusively on self-destructive behaviour in borderline samples (14–25).

A few studies have demonstrated an association between self-mutilation and reported histories of childhood sexual abuse in patients with BPD (13,19,25–28). Only one study has looked systematically at how both childhood abuse and neglect might relate to the development of self-destructive behaviour (12). Van der Kolk and others, using both historical and prospective data for 74 subjects with personality disorders or bipolar II disorder, found that histories of childhood trauma, particularly sexual abuse, and histories of childhood neglect were highly significant predictors of chronic suicide attempts, cutting, and other self-injurious behaviour. The authors reported that chronic suicide attempts were most strongly associated with histories of childhood sexual abuse, whereas chronic cutting was most strongly associated with histories of childhood neglect. Since in their study the borderline diagnosis was the only diagnosis significantly associated with physically self-destructive behaviour, their findings may well be specifically related to patients with BPD.

The purpose of our study was to elucidate further the possible role of childhood abuse and neglect in the etiology of self-destructive behaviour in patients with BPD. It improves upon these earlier studies by defining the lifetime

Manuscript received April 1996, revised October 1996.

¹Staff Psychiatrist and Postgraduate Education Coordinator, Department of Psychiatry, Sunnybrook Health Science Centre, North York, Ontario; Assistant Professor, Department of Psychiatry, University of Toronto, Toronto, Ontario.

²Director, Laboratory for the Study of Adult Development, McLean Hospital, Belmont, Massachusetts; Assistant Professor of Psychology, Department of Psychiatry, Harvard Medical School, Cambridge, Massachusetts.

³Clinical and Research Fellow in Psychology, McLean Hospital, Belmont, Massachusetts, and Harvard Medical School, Cambridge, Massachusetts.

⁴Department of Psychology, New York University, New York, New York.

Address for correspondence: Dr ED Dubo, Department of Psychiatry, Sunnybrook Health Science Centre, F Wing, Ground Floor, 2075 Bayview Avenue, North York, ON M4N 3M5

patterns of self-destructive behaviour in criteria-defined patients with BPD compared with near-neighbour Axis II controls and by examining the relative contributions to this behaviour of a wide range of abusive and neglectful childhood experiences.

Methods

All subjects were inpatients at McLean Hospital in Belmont, Massachusetts. Patients were considered eligible for inclusion if they 1) were between the ages of 18 and 60; 2) had normal or better intelligence; 3) had no history of a clear-cut organic condition or a major psychotic disorder (that is, schizophrenia or bipolar disorder); and 4) had evidence in their hospital admission note to suggest the presence of BPD or any other Axis II disorder. Appropriate inpatients were identified by a research assistant who screened admission notes.

Written informed consent was then obtained from each patient by a trained diagnostician who was blind to the patient's clinical diagnosis and who also evaluated the phenomenological status of each patient. This was done by administering the following 4 research instruments: 1) the Revised Diagnostic Interview for Borderlines (DIB-R), a semistructured interview that can reliably distinguish clinically diagnosed borderline patients from those with other Axis II disorders (29); 2) the Revised Diagnostic Interview for Personality Disorders (DIPD-R), a semistructured interview that reliably assesses the presence of the 11 Axis II disorders described in DSM-III-R (30); 3) the McLean Hospital version of the Structured Clinical Interview for DSM-III-R, a structured interview that assesses both the current and lifetime prevalence of many of the most common Axis I disorders found in DSM-III-R (31); and 4) the Lifetime Borderline Symptom Index, a structured instrument we created, based on the symptom categories of the DIB-R, which rates the age of onset, duration, severity, and number of episodes of a variety of key borderline symptoms over a patient's lifetime. For most items in this instrument, continuous variables are generated.

Subjects who met both DIB-R and DSM-III-R criteria for BPD as assessed by the DIB-R and DIPD-R were included in the BPD group. Subjects who did not meet study criteria for BPD but who met DSM-III-R criteria for other Axis II disorders as assessed by the DIPD-R were included in the OPD control group.

Childhood experiences were assessed at a second meeting by 1 of 2 other investigators, blind to all phenomenological information. The assessments were conducted using the Childhood Experiences Questionnaire—a semistructured interview that was adapted from a review of the relevant clinical and empirical literature (29). This instrument rates the severity of a variety of childhood factors including sexual abuse, emotional abuse, verbal abuse, physical abuse, and physical and emotional neglect at each of 3 developmental stages: early childhood (0 to 5 years), latency (6 to 12 years), and

adolescence (13 to 17 years). This interview aims to obtain rich details about the patient's experience, beginning with more benign aspects of familial environment and gradually building up to more traumatic experiences. In order to establish a rapport that would facilitate disclosure, interviewers were highly sensitive to the patient's experience of the interview and often spent as much time as 2 hours collecting this information.

The means of continuous variables were compared using Student's *t* test. Categorical variables were compared using chi-square analyses with the Yates correction for continuity. Multiple regression analyses were used to assess the relationship between the various childhood factors and various aspects of self-destructive behaviour.

Results

The subjects were 42 patients who met criteria for BPD and 17 near-neighbour Axis II controls. In the borderline group, there were 30 women (71.4%) and 12 men (28.6%); the control group consisted of 10 (58.8%) women and 7 (41.2%) men. The age range for the borderline group was from 18 to 60 years of age, and the controls were 20 to 57 years of age. Mean ages were 31.7 years and 35.9 years for the 2 groups, respectively. There were no significant differences in sex distribution or mean age between the 2 groups.

Thirty-three patients (78.6%) with BPD reported histories of self-mutilation, while no controls reported this type of behaviour. Thirty-four (80.9%) of the borderline patients and 5 (29.4%) of the OPD controls reported histories of suicide attempts.

Self-Mutilation

The age of onset for self-mutilative behaviour ranged from 4 to 47 years of age. The mean age of onset was 20.7 years (± 10.1). The majority (61.9%) of patients with BPD began mutilating themselves in adolescence or adulthood. Smaller numbers began in early childhood and latency (4.8% and 11.9%, respectively).

The prevalence of self-injurious behaviour in the BPD group increased steadily from early childhood to adulthood (4.8% in early childhood; 16.7% in latency; 38.1% in adolescence; and 69.0% in adulthood). This progression is, in part, due to the increased number of subjects beginning to self-mutilate in adolescence and adulthood, but it also reflects the continuation of this behaviour in those patients who began at a young age.

The reported number of lifetime instances of self-mutilative efforts ranged from 1 to 3000. Mean number of instances was 233.2 (± 548.2). Only 3 (7.1%) of the borderline patients self-mutilated once or twice; 17 (40.5%) engaged in 50 or more episodes of self-mutilative behaviour over a lifetime. Duration of self-mutilatory behaviour ranged from one month or less to 552 months (46 years). The mean duration was 107.8 months (± 123.7) or 9 years.

Table 1. Multiple regression analyses of childhood abuse variables and self-destructive behaviour (BPD group)

Outcome variable	Childhood abuse variable	P
Self-mutilation		
Age at onset	No associated variable	—
Number of instances	Sexual abuse by caregivers	< 0.05
Duration	Sexual abuse by caregivers	< 0.05
Suicide efforts		
Age at onset	No associated variable	—
Number of instances	No associated variable	—
Duration	Sexual abuse by caregivers	< 0.005

Suicide Efforts

Thirty-four (80.9%) patients with BPD and 5 (29.4%) controls engaged in suicidal behaviour. There was no significant difference in mean age of onset of suicide efforts between groups: mean age of onset was 21.4 years of age (± 9.6) for the BPD group and 22.8 years of age (± 9.0) for the OPD control group. Age of onset ranged from 6 to 48 years for the patients with BPD and 16 to 35 for the OPD controls. In the borderline group, 11.9% began their suicide efforts in latency. Onset of suicidal behaviour occurred in increasing numbers through adolescence (21.4%) and adulthood (47.6%). In contrast, patients in the control group did not begin their suicidal behaviour until adolescence (17.6%), and fewer began in adulthood (11.7%).

For the borderline group, the prevalence of suicidal behaviour during each period followed a pattern similar to that seen for self-injurious behaviour, that is, there was a steady increase in numbers over adolescence and adulthood (30.9% and 71.4%, respectively). This pattern reflects both the increasing number of subjects newly making suicide attempts as well as the tenaciousness of their suicidal behaviour. In contrast, the prevalence for the control group was the same during adolescence as adulthood (17.6%), reflecting the shorter duration of their suicidal behaviour and the decline in onset of this behaviour after adolescence.

Patients with BPD made significantly more suicide attempts over their lifetime than patients in the control group. The mean number of instances for the borderline group was 20.1 (± 46.6) compared with a mean of 2.4 instances (± 1.3) for the control group ($P = 0.03$). Patients with BPD made 1 to 200 attempts, whereas controls made only 1 to 4 attempts. Forty-four percent of the borderline group made 5 or more suicide attempts.

There was no significant difference in mean duration of suicidal behaviour between groups. Mean duration of suicidal activity for the borderline group was 102.6 months (± 121.8) or 8.6 years. Duration ranged from one month or less to 504 months (42 years). For the control group, mean duration of suicidal activity was 56.2 months (± 122.9) or 4.7 years; the duration ranged from one month or less to 276 months (23 years).

Super Self-Destructiveness

There was a subgroup of patients with BPD who engaged in extremes of self-mutilatory and/or suicidal behaviour. We have defined "super self-mutilators" as those who have made 50 or more self-mutilative efforts in their lifetime and "super suicide attempters" as those who have made 5 or more attempts in their lifetime. In this sample of borderlines, 17 (40.5%) were "super self-mutilators" and 18 (42.9%) were "super suicide attempters." All of the borderline subjects who began to self-mutilate in early childhood were in the extreme group. Similarly, the borderline subjects who made the earliest suicide attempts were in the extreme group. Sixty-five percent (11 of 17) of patients with BPD who engaged in extreme self-mutilative behaviour also engaged in extreme suicidal behaviour, clearly forming the subgroup with the highest morbidity and highest risk of mortality (26.2% of the entire BPD sample).

Self-Destructive Behaviour and Childhood Factors

The relationship between self-destructive behaviour and 12 childhood factors was examined in multiple regression format. These childhood factors are: caregiver emotional, verbal, physical, and sexual abuse; sexual abuse by non-caregivers; caregiver physical neglect; emotional withdrawal, inconsistent treatment, emotional denial, and lack of a real relationship with a caregiver; parentification of the patient by a caregiver; and failure to protect by a caregiver. Chi-square analyses revealed that when viewed as a categorical variable, no childhood factor is more frequently associated with the BPD than with the OPD group.

Self-Destructiveness and Childhood Abuse. Abusive childhood experiences were considered first. Multiple regressions were performed to determine the influence of childhood verbal, emotional, physical, and sexual abuse on the onset, lifetime number of episodes, and duration of self-mutilative and suicidal efforts in patients with BPD. Subject's sex was also controlled for. The significant findings can be seen in Table 1.

For subjects with BPD, age of onset of self-mutilative behaviour was not related to any of the abuse variables. Lifetime number of self-mutilative efforts was significantly related to caregiver sexual abuse ($P < 0.05$). Lifetime duration of self-mutilative behaviour was also significantly associated with sexual abuse by caregivers ($P < 0.05$). In the same group, subject's sex predicted age of onset of suicidal behaviour, that is, female subjects began to make suicide efforts at an earlier age than their male counterparts ($P < 0.05$). There was no relationship between any of the abuse variables and number of suicide efforts. Lifetime duration of suicidal behaviour, however, was strongly associated with caregiver sexual abuse ($P < 0.005$).

Self-Destructiveness, Childhood Abuse, and Neglect. Table 2 shows the significant results of the childhood abuse and neglect variables considered together in multiple regression format for the borderline group. For self-mutilative

Table 2. Multiple regression analyses of childhood abuse/neglect variables and self-destructive behaviour (BPD group)

Outcome variable	Childhood abuse/neglect variable	<i>P</i>
Self-mutilation		
Age at onset	Caregiver emotional withdrawal	< 0.05
Number of instances	Sexual abuse by caregiver	< 0.05
Duration	1. Failure to protect by caregiver	< 0.05
	2. Inconsistent treatment by caregiver	< 0.005
Suicide efforts		
Age at onset	No associated variable	—
Number of instances	No associated variable	—
Duration	Sexual abuse by caregiver	< 0.005

behaviour, childhood sexual abuse no longer appeared to be the most important factor, and several aspects of childhood neglect gained significance. Emotional withdrawal by a caregiver predicted age at onset of self-mutilative behaviour ($P < 0.05$). There remained a weaker but significant relationship between lifetime number of instances of self-mutilation and caregiver sexual abuse ($P < 0.05$). Duration of self-injurious behaviour was significantly related to failure to protect by a caregiver ($P < 0.05$) and inconsistent treatment by a caregiver ($P < 0.005$).

Age at onset of suicidal behaviour in subjects with BPD remained associated with subject's sex. Lifetime number of suicidal efforts was not related to any of the abuse or neglect variables. Lifetime duration of suicidal behaviour continued to be significantly related to sexual abuse by caregivers.

The childhood experiences of the controls were also explored using a multiple regression format, and the significant findings are presented in Table 3. In contrast to the borderline group, the abuse variables were not significantly related to suicidality. Three neglect variables, however, were significantly related to suicidal behaviour in the OPD control group: emotional withdrawal and emotional denial by a caregiver were associated with lifetime number of suicide efforts ($P < 0.05$ and $P < 0.001$, respectively), and lack of a real relationship with a caregiver was associated with lifetime duration of suicidal behaviour ($P < 0.001$).

Discussion

This study revealed several significant findings regarding the lifetime patterns of self-destructive behaviour in patients with BPD, and the role of childhood sexual abuse and neglect in its development.

We found that as a group the borderline patients reported a tremendous amount of self-harm. Self-mutilation was seen exclusively in the borderline subjects, reflecting the discriminating power of this symptom. Approximately 79% of subjects with BPD reported a history of self-mutilative behaviour, which was typically chronic and highly repetitious. About the same percentage (81%) gave a history

Table 3. Multiple regression analyses of childhood abuse/neglect variables and self-destructive behaviour (OPD group)

Outcome variable	Childhood abuse/neglect variable	<i>P</i>
Suicide efforts		
Age at onset	No associated variable	—
Number of instances	1. Caregiver emotional withdrawal	< 0.05
	2. Caregiver emotional denial	< 0.001
Duration	Lack of a real relationship with caregiver	< 0.001

of suicide attempts, compared with only 29% of the OPD controls. Borderline subjects characteristically made repeated suicide attempts and reported a significantly greater number of suicide efforts over their lifetime than the controls. Our results confirm previous reports that self-destructive behaviour is highly discriminative of BPD (1–3) and demonstrate empirically that this behaviour is characteristically severe and enduring.

The results of this study also illustrate that there is a subgroup of patients with BPD who begin to injure themselves and/or attempt suicide at a very young age. Consistent with previous reports, we found that onset of self-destructive acts most commonly occurred in late adolescence and early adulthood (6–8). Approximately 5% of borderline subjects, however, began to self-mutilate in early childhood (0 to 5 years), and nearly 12% began to make suicide attempts as early as latency (6 to 12 years). In all cases, those who started very young continued their self-injurious behaviour into adulthood. This group deserves further study in order to elucidate what factors are specifically related to childhood onset of self-destructive behaviour.

Our findings also bring to light that within the BPD population there is a subgroup of patients who are extraordinarily self-destructive. Those subjects who began to self-harm at the earliest ages tended to fall into this category, but it also included subjects who became self-destructive in adolescence and adulthood.

While previous studies have rated the presence or absence of self-injurious behaviour, we used an instrument that rated, albeit retrospectively, lifetime number of self-destructive episodes. We found that 41.5% of our subjects with BPD were extreme self-mutilators, having engaged in 50 or more episodes of self-mutilation in their lifetime. We also identified a subgroup of extreme suicide attempters. Fully 44% of the BPD group had made 5 or more suicide attempts in their lifetime.

There was significant overlap between these 2 subgroups: 65% of patients with BPD who engaged in extreme self-mutilative behaviour also engaged in extreme suicidal behaviour. More than one-quarter of the entire borderline sample met criteria for this "super destructive" subgroup. This likely reflects the overall high acuity of our inpatient sample and may be an overestimate for less disturbed populations of patients with BPD. Nonetheless, this group presents a serious

clinical problem associated with severe morbidity and greatly increased risk of mortality.

One of the main purposes of our study was to examine the role of childhood factors in the development of self-destructive behaviour in patients with BPD. Our results lend additional support to previous observations that both caregiver sexual abuse and caregiver emotional neglect play an important role in the etiology of self-harm. Our findings demonstrate that when the influence of childhood abuse is examined separately from neglect, its role in the etiology of self-destructive behaviour in BPD appears of singular importance. When the effects of childhood sexual abuse are viewed within the context of the emotionally detached and nonprotective relationships in which it typically occurs, however, the neglectful features of the borderline patient's familial environment gain etiologic importance.

When we looked first at the effects of various types of childhood abuse on the development of self-destructive behaviour, we found that sexual abuse by caregivers was highly predictive of both self-mutilative and suicidal behaviour. This is consistent with the numerous reports in the literature that have cited the high incidence of suicide attempts and other forms of self-destructive behaviour among victims of incest (32).

When we considered the effects of childhood abuse and neglect together, a more complex picture developed. While parental sexual abuse continued strongly to predict suicidal behaviour, parental emotional neglect emerged as the strongest predictor of self-mutilative behaviour. These findings confirm the observations of van der Kolk and others (12) and suggest that lack of early parental emotional responsiveness and protection play an important role in the failure of people with BPD to develop affective modulation, which can lead to chronic self-mutilation in such patients. It appears that parental sexual abuse may increase the severity of self-mutilation and drive chronic suicidal behaviour. Overall, our results underscore the role of both parental sexual abuse and emotional neglect in the etiology of self-destructive behaviour in patients with BPD and highlight the importance of considering the effects of sexual abuse within its environmental context.

While for the patients with BPD, an admixture of sexual abuse and emotional neglect was related to suicidality, we found that for the OPD control subjects, only neglect was significantly associated with a history of suicide attempts. This further supports the notion that parental validation of feelings and experiences is critical for the development of affective self-regulation.

A surprising finding was that when we viewed the childhood experiences of our subjects as categorical variables, the subjects in the BPD group did not appear to have more trauma or neglect in their histories than those in the control group. This is inconsistent with previous studies reporting a higher prevalence of childhood histories of sexual abuse and neglect in BPD cohorts compared with other populations (33). A

possible explanation is that our control group was largely comprised of patients from the dramatic cluster, including many with antisocial personality disorder and many who just missed meeting our research criteria for BPD.

This finding suggests that it may be the interaction of particular childhood variables or their additive effect that is important for the development of certain types of borderline symptoms. In addition, it may be that because of constitutional factors, patients with BPD respond to their experiences differently than other persons who have endured similar circumstances.

How sexual abuse and emotional neglect might relate to causality of self-destructive behaviour in these patients is uncertain. Some authors suggest that childhood abuse and neglect may directly interfere with the development of the capacity to modulate affects (34,35). As a result, self-destructive behaviour may emerge as a maladaptive means of regulating intolerable affects (36). There is evidence that biochemical abnormalities, such as low levels of serotonin (37) and/or subtle underlying neurological abnormalities (38) may mediate this behaviour. These biological abnormalities may be sequelae of childhood abuse and neglect, or they may be innate vulnerabilities. The etiology of self-destructive behaviour in patients with BPD is most likely multifactorial, involving the interaction of predisposing biological vulnerabilities and deleterious childhood experiences.

Our study was limited by the retrospective nature of the data, the relatively small sample size, and the possibility that findings based on an inpatient BPD population may not be generalizable to a less disturbed outpatient population. Our results, however, suggest that there may be subgroups of patients with BPD who differ in symptom presentation and course and that these differences may, at least in part, be related to their childhood experiences. Because of our small sample size, we could not meaningfully make separate comparisons of these groups. Clearly, large, prospective studies are needed to clarify further which environmental, constitutional, and/or biological factors account for subsyndromal differences and to determine the most effective early interventions for at-risk children.

Conclusions

By assessing lifetime patterns of self-harm, our study revealed 3 significant findings related to the phenomenology of this behaviour in patients with BPD. Our results confirm previous reports that chronic, repetitive, self-destructive behaviour discriminates BPD from other disorders, even very near neighbours. We also identified a subgroup of patients who report childhood onset of self-harm, and we described a subgroup of "super-destructive" patients with BPD, who accounted for nearly half of our sample. Differences between subgroups are likely multifactorial, reflecting constitutional, psychological, and early environmental influences.

Most importantly, our findings provide further confirmation of the strong association between chronic self-destructive

behaviour and childhood histories of both parental sexual abuse and emotional neglect in patients with BPD. Awareness of the possible role of childhood abuse and neglect in the etiology of self-destructive behaviour in these patients can help treaters to be more empathic and to have greater understanding of patients' desperate, ill-fated attempts to manage their feelings and experiences.

Clinical Implications

- There may be subgroups of patients with BPD who develop early and/or extreme self-destructiveness.
- Differences in BPD symptom presentation and course may be related to childhood experiences.
- Large prospective studies are needed to clarify the etiology of self-harm in BPD and determine early interventions.

Limitations

- Retrospective nature of data.
- Relatively small sample size.
- Findings based on inpatient BPD population may not be generalizable to outpatients.

References

- Barrash J, Kroll J, Carey K, and others. Discriminating borderline personality disorder from other personality disorders: cluster analyses of the Diagnostic Interview for Borderlines. *Arch Gen Psychiatry* 1983;40:1297-302.
- Frances A, Clarkin JF, Gilmore M, and others. Reliability of criteria for borderline personality disorder: a comparison of DSM-III and the Diagnostic Interview for Borderline Patients. *Am J Psychiatry* 1984;141:1080-4.
- Zanarini MC, Gunderson JG, Frankenburg FR, Chauncey DL. Discriminating borderline personality disorder from other Axis II disorders. *Am J Psychiatry* 1990;147:161-7.
- de Wilde EJ, Kienhorst CW, Diekstra RF, Wolters WH. The relationship between adolescent suicidal behavior and life events in childhood and adolescence. *Am J Psychiatry* 1992;149:45-51.
- Favazza AR. Why patients mutilate themselves. *Hospital and Community Psychiatry* 1989;40:137-45.
- Favazza AR, Conterio K. The plight of chronic self-mutilators. *Community Ment Health J* 1988;24:22-30.
- Favazza AR, Conterio K. Female habitual self-mutilators. *Acta Psychiatr Scand* 1989;79:283-9.
- Pattison EM, Kahan J. The deliberate self-harm syndrome. *Am J Psychiatry* 1983;140:867-72.
- Rosenthal RJ, Rinzler C, Wallsh R, Klausner E. Wrist cutting syndrome: the meaning of a gesture. *Am J Psychiatry* 1972;128:1363-8.
- Simeon D, Stanley B, Frances A, Mann JJ, Winchel R, Stanley M. Self-mutilation in personality disorders: psychological and biological correlates. *Am J Psychiatry* 1992;149:221-6.
- Simpson CA, Porter GL. Self-mutilation in children and adolescents. *Bull Menninger Clin* 1981;45:428-38.
- van der Kolk BA, Perry JC, Herman JL. Childhood origins of self-destructive behavior. *Am J Psychiatry* 1991;148:1665-71.
- Zlotnick CM, Shea T, Pearlstein T, Simpson E, Costello E, Begin A. The relationship between dissociative symptoms, alexithymia, impulsivity, sexual abuse, and self-mutilation. *Compr Psychiatry* 1996;37:12-6.
- Brodsky BS, Cloitre M, Dulit RA. Relationship of dissociation to self-mutilation and childhood abuse in borderline personality disorder. *Am J Psychiatry* 1995;152:1788-92.
- Dulit RA, Fyer MR, Leon AC, Brodsky BS, Frances AJ. Clinical correlates of self-mutilation in borderline personality disorder. *Am J Psychiatry* 1994;151:1305-11.
- Gardner DL, Cowdry RW. Suicidal and parasuicidal behavior in borderline personality disorder. *Psychiatr Clin North Am* 1985;8:389-403.
- Leibluft E, Gardner DL, Cowdry RW. The inner experience of the borderline self-mutilator. *Journal of Personality Disorders* 1987;1:317-24.
- Perry JC. Personality disorders, suicide, and self-destructive behavior. In: Jacobs D, Brown H, editors. *Suicide: understanding and responding*: Harvard Medical School perspectives. Madison (CT): International Universities Press; 1989. p 157-69.
- Russ MJ, Shearin EN, Clarkin JF, Harrison K, Hull JW. Subtypes of self-injurious patients with borderline personality disorder. *Am J Psychiatry* 1993;150:1869-71.
- Schaffer CB, Carroll J, Abramowitz SI. Self-mutilation and the borderline personality. *J Nerv Ment Dis* 1982;170:468-73.
- Shearer SL, Peters CP, Quaytman MS, Wadman BE. Intent and lethality of suicide attempts among female borderline inpatients. *Am J Psychiatry* 1988;145:1424-7.
- Simpson MA. Self-mutilation and the borderline syndrome. *Dynamische Psychiatrie* 1977;10:42-8.
- Soloff PH, Lis JA, Kelly T, Cornelius J, Ulrich R. Risk factors for suicidal behavior in borderline personality disorder. *Am J Psychiatry* 1994;151:1316-23.
- Stone MH. A psychodynamic approach: some thoughts on the dynamics and therapy of self-mutilating borderline patients. *Journal of Personality Disorders* 1987;1:347-9.
- Zweig-Frank H, Paris J, Guzder J. Psychological risk factors for dissociation and self-mutilation in female patients with borderline personality disorder. *Can J Psychiatry* 1994;39:259-64.
- Bryer JB, Nelson BA, Miller JB, Krol PA. Childhood sexual and physical abuse as factors in adult psychiatric illness. *Am J Psychiatry* 1987;144:1426-30.
- Links PS, Boiago I, Huxley G, Steiner M, Mitton JE. Sexual abuse and biparental failure as etiologic models in borderline personality disorder. In: Links PS, editor. *Family environment and borderline personality disorder*. Washington (DC): American Psychiatric Press; 1990. p 107-20.
- Westen D, Ludolph P, Mistle B, Ruffins S, Block J. Physical and sexual abuse in adolescent girls with borderline personality disorder. *Am J Orthopsychiatry* 1990;60:55-66.
- Zanarini MC, Gunderson JG, Frankenburg FR, Chauncey DL. The revised diagnostic interview for borderlines: discriminating BPD from other Axis II disorders. *Journal of Personality Disorders* 1989;3:10-8.
- Zanarini MC, Frankenburg FR, Chauncey DL, Gunderson G. The diagnostic interview for personality disorders: interrater and test-retest reliability. *Compr Psychiatry* 1987;28:467-80.
- Spitzer RL, Williams JBW, Gibbon M, and others. *Structured clinical interview for DSM-III-R Axis I disorders*. Washington (DC): American Psychiatric Press; 1990.
- Browne A, Finkelhor D. Impact of child sexual abuse: a review of the research. *Psychol Bull* 1986;99:66-77.
- Zanarini MC, editor. *The role of sexual abuse in the etiology of borderline personality disorder*. Washington (DC): American Psychiatric Press; 1996.
- van der Kolk BA, Greenberg MS. The psychobiology of the trauma response: hyperarousal, constriction, and addiction to traumatic reexposure. In: van der Kolk BA, editor. *Psychological trauma*. Washington (DC), American University Press; 1987. p 63-87.
- Cicchetti D. How research on child maltreatment has informed the study of child development: perspectives from developmental psychology. In: Cicchetti D, Carlson V, editors. *Child maltreatment*. Cambridge: Cambridge University Press; 1989. p 377-431.
- Linehan MM, Heard HL. Dialectical behavior therapy for borderline personality disorder. In: Clarkin J, Marziali E, Munroe-Blum H, editors. *Borderline personality disorder*. New York: The Guilford Press; 1992.
- Coccaro EF, Siever LJ, Klar HM, and others. Serotonergic studies in patients with affective and personality disorders. *Arch Gen Psychiatry* 1989;46:587-99.
- Zanarini MC, Kimble CR, Williams AA. Neurological dysfunction in borderline patients and Axis II control subjects. In: Silk KR, editor. *Biological and neurobehavioral studies of borderline personality disorder*. Washington (DC): American Psychiatric Press; 1994. p 159-75.

Résumé

Objectif : Évaluer le rapport entre des profils de comportement autodestructeur au cours de la vie et divers paramètres de mauvais traitements et de négligence au cours de l'enfance chez des malades qui présentent des troubles limites de la personnalité (TLP) en comparaison de sujets témoins ayant d'autres troubles de la personnalité (ATP).

Méthode : L'étude a porté sur 42 malades hospitalisés ayant un diagnostic de TLP et 17 sujets témoins ATP. À l'aide de l'Indice de symptômes limites au cours de la vie (ISLV), on a évalué des profils de comportement autodestructeur au cours de la vie. Des évaluateurs qui ignoraient le diagnostic ont évalué les expériences de l'enfance au moyen d'une entrevue partiellement structurée.

Résultats : Un comportement autodestructeur chronique a distingué les TLP de sujets témoins ATP. Dans le groupe limite, une agression sexuelle parentale était reliée de façon significative à un comportement suicidaire alors qu'aussi bien l'agression sexuelle parentale que la négligence affective étaient reliées de façon significative à une automutilation.

Conclusion : Dans les TLP, aussi bien l'agression sexuelle parentale que la négligence affective semblent jouer un rôle dans l'étiologie du comportement autodestructeur. Les résultats démontrent l'importance de tenir compte des effets de l'agression sexuelle dans son contexte environnemental et font penser que l'étiologie de symptômes limites est probablement multifactorielle.