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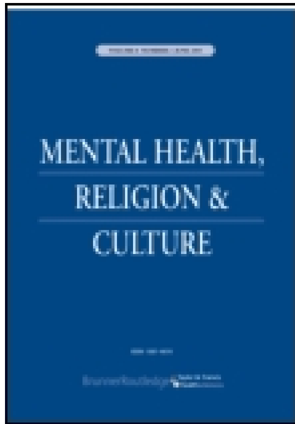

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Distancing oneself from God: relationships with borderline personality symptomatology

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Distancing oneself from God: relationships with borderline personality symptomatology

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Self-harm behaviour traditionally has been associated with borderline personality disorder. In this study, we examined the relationship between borderline personality symptomatology and intentionally distancing oneself from God as self-punishment, based on the assumption that such self-punishment may represent a form of self-harm behaviour. Data from four previous samples of primary care outpatients collected over a two-year period were combined ($N = 1511$). Borderline personality was assessed with two measures: the borderline personality scale of the Personality Diagnostic Questionnaire-4 (PDQ-4) and the Self-Harm Inventory (SHI). Point-biserial correlation coefficients revealed that those who endorsed distancing oneself from God as punishment scored relatively higher on both the PDQ-4 ($r = 0.40$, $p < 0.001$) and the SHI ($r = 0.46$, $p < 0.001$). Similarly, when compared to respondents who denied ever having distanced themselves from God as punishment, those who did were more likely to exceed the clinical cut-off score on the PDQ-4 (47.3% vs. 10.9%, $X^2 = 152.53$, $p < 0.001$) and the SHI (57.3% vs. 11.4%, $X^2 = 224.12$, $p < 0.001$). Findings support our hypothesis that distancing oneself from God as punishment may be a form of self-harm behaviour associated with borderline personality symptomatology.

Keywords: borderline personality; distancing from God; self-punishment; self-harm; self-harm behaviour; Self-Harm Inventory

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Introduction

Borderline personality disorder (BPD) is a personality dysfunction that is characterised by repetitive self-harm behaviour (R.A. Sansone & L.A. Sansone, 2007). To underscore this clinical feature, in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (American Psychiatric Association, 2000), acknowledged characteristics of BPD include self-damaging impulsivity (e.g., excessive spending, sexual promiscuity, alcohol/substance misuse/abuse, reckless driving, binge eating behaviour) as well as self-mutilation (e.g., cutting, scratching, burning oneself) and suicidal behaviour. Importantly, self-harm behaviour is not restricted to the psychiatric phenomenon of BPD (e.g., individuals suffering from depression may also engage in self-harm behaviour). However, the chronic nature of self-harm behaviour in BPD is sufficiently distinctive that Mack

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(1975) described self-destructive behaviour as the "behavioral specialty" of individuals with BPD.

The Self-Harm Inventory (SHI: R.A. Sansone, Wiederman, & L.A. Sansone, 1998) was developed as a measure of borderline personality symptomatology (BPS) that focuses on self-harm behaviour as the manifestation. One of the 22 items in the inventory refers to intentionally or purposefully distancing oneself from God. At the time of the development of this measure, this particular item was suggested by the pastor associated with our psychiatric treatment team. In initial testing of the SHI, this specific item was validated and retained in the final version of the inventory. However, larger subsequent studies have not been conducted with this particular item. In the current study, we examined whether intentionally distancing oneself from God as punishment might be associated with BPS in a large sample of primary care patients.

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Method

Participants

To maximize the size of the current sample for investigation, we compiled four datasets collected over a two-year period (2009–2011; Sansone, Farukhi, & Wiederman, 2011; Sansone, Lam, & Wiederman, 2010; Sansone, Lam, & Wiederman, 2012; Sansone, Leung, & Wiederman, in press). Participants in these four studies were males and females, ages 18 years or older, recruited from an identical outpatient primary care medical setting that is staffed predominantly by resident providers.

In each study, the recruiter informally assessed and excluded individuals with compromising conditions that would preclude the candidate's ability to successfully complete a survey. Few individuals were actually excluded, mostly because of severe illness and/or language difficulties.

Of the resulting 1511 patients who responded to the primary survey items, 496 were male, 1014 were female and one did not indicate sex. Ages ranged from 18 to 97 years ($M = 50.83$, $SD = 15.71$), and 87.6% were White/Caucasian.

Procedure

During clinic hours, each incoming patient was approached by a research assistant, who informally assessed exclusion criteria. With potential candidates, the recruiter reviewed the focus of the project and invited each to participate by completing a multi-page survey. Participants were asked to place completed surveys into sealed envelopes and then into a collection box in the lobby.

In addition to demographic queries, we examined BPS through two self-report measures – the borderline personality scale of the Personality Diagnostic Questionnaire-4 (PDQ-4: Hyler, 1994) and the SHI (Sansone et al., 1998). The PDQ-4 is a nine-item, true/false, self-report measure that consists of the diagnostic criteria for BPD that are listed in the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV: American Psychiatric Association, 1994). A score of 5 or higher is highly suggestive of BPD. Previous versions of the PDQ have been found to be useful screening tools for BPD in both clinical settings (Dubro, Wetzler, & Kahn, 1988; Hyler et al., 1990) and nonclinical settings (Johnson & Bornstein, 1992), including the use of the freestanding borderline personality subscale (Patrick, Links, Van Reekum, & Mitton, 1995).

The SHI (Sansone et al., 1998) is a 22-item, yes/no, self-report inventory for BPD that explores participants' histories of self-harm behaviour. Each item in the inventory is preceded by the statement, ''Have you ever intentionally, or on purpose, . . .'' and items include, ''overdosed,'' ''cut yourself on purpose,'' ''burned yourself on purpose,'' and ''hit yourself.'' Each endorsement is in the pathological direction and the SHI total score is the summation of ''yes'' responses. SHI total scores of 5 or higher are highly suggestive of the diagnosis of BPD. Indeed, in comparison with the Diagnostic Interview for Borderlines (Kolb & Gunderson, 1980), the gold standard for the diagnosis of BPD in research settings, the SHI demonstrates accuracy in diagnosis of 84%. Item 14 of the SHI queries, ''Have you ever intentionally, or on purpose, distanced yourself from God as punishment?'' As the focus of the current investigation, this item was not included in the total SHI score.

These various projects were reviewed and exempted by the institutional review boards of both the community hospital as well as the university. Completion of the survey was assumed to function as implied consent, which was explicitly clarified on the cover page of the booklet.

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Results

Of the 1511 respondents, 165 (10.9%) indicated having intentionally distanced themselves from God as a form of self-punishment, and this rate did not differ significantly between males and females ($X^2 = 2.07$, $p < 0.17$). Point-biserial correlation coefficients revealed that those who endorsed the item tended to be younger ($r = -0.15$, $p < 0.001$), and scored higher on both the PDQ-4 ($r = 0.40$, $p < 0.001$) and the SHI ($r = 0.46$, $p < 0.001$). Similarly, when compared to respondents who denied ever having distanced themselves from God as punishment, those who did were more likely to exceed the clinical cut-off score on the PDQ-4 (47.3% vs. 10.9%, $X^2 = 152.53$, $p < 0.001$) and the SHI (57.3% vs. 11.4%, $X^2 = 224.12$, $p < 0.001$). Findings indicate associations between distancing oneself from God as punishment and BPS.

Discussion

In this study, we found that intentionally or purposefully distancing oneself from God was associated with BPS – a personality disorder associated with ongoing self-harm behaviour. Importantly, this empirical relationship supports the general contention that self-harm behaviour may manifest in an endless number of ways, including religious/spiritual conflict. That intentionally distancing oneself from God may be associated with personality pathology is a finding that may be particularly important to clinicians and pastoral counsellors who are working with clients who may be conflicted about religious/spiritual issues. On one level, the conflict may appear to be genuinely religious in nature and truly reflect internal tension with regard to religious/spiritual beliefs, creeds and/or doctrines. On another level, the conflict may have very little to do with religious/spiritual ideology, and may be intimately related to a dysfunctional personality structure.

Regardless of type, self-harm behaviour may serve a number of psychological purposes (e.g., regulating strong affective states, consolidating a self-destructive identity, displacing anger towards others to oneself, organising oneself from a quasi-psychotic episode; Gunderson, 1984). An additional and common psychological theme in self-harm behaviour associated with BPD is the engagement of others for support and nurturance

(i.e., eliciting caring responses from others; Gunderson, 1984). In this particular case, it may be that generating continuing conflicts over one's relationship with God provides a practical venue for repetitively engaging pastoral and/or other counsellors into frequent and regular contact – in an effort to generate ongoing support.

We are not aware of any cases of BPD in which the individual demonstrated one exclusive form of self-harm behaviour. This pivotal feature may assist pastoral and other professional counsellors in differentiating the genuine clinical issue – valid religious/spiritual concerns versus characterologically related self-harm behaviour. In other words, the presence of distancing oneself from God in the context of adjunctive self-harm behaviours (e.g., self-destructive interpersonal relationships, self-cutting, suicide attempts, eating pathology) is highly suggestive of underlying character pathology as opposed to religious/spiritual conflict. When BPS is suspected, affected individuals should be referred to mental health professionals who are experienced in treating this particular personality dysfunction. In mental health settings, there are a number of ways to therapeutically approach self-harm behaviour (Sansone & Sansone, 2006), but this complex discussion is beyond the scope of this paper.

As an alternative explanation for these findings, it may be that self-harm behaviour induces guilt in the affected individual, with the result being that one feels unworthy of a connection with God. Again, while a possibility, this interpretation does not exclude the additional possibility of underlying BPS, particularly when there is evidence that the individual is engaging in various other self-harm behaviours.

This study has a number of potential limitations. First, all data are self-report in nature and therefore subject to recollection, misinterpretation, denial, repression and suppression. Second, there is the possibility of repeat patients in the database; however, this is less likely due to the two-year time span over which the four initial studies were conducted. Third, self-report measures for BPD are known to be over-inclusive (i.e., they run the risk of generating false positives). Because of this, we have avoided the term BPD, and alternatively used the term BPS. Overall, these self-report measures are best viewed as screening tools. Fourth, from these data, we do not have any information on participants' religious histories, affiliations or practices – all factors that may temper one's relationship with God. However, to our knowledge, this is the first report to associate distancing oneself from God as punishment and BPS – a seemingly relevant finding for all professionals involved in spiritual/religious issues.

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