Chapter #11

SELF-DESTRUCTIVE BEHAVIORS IN PEOPLE WITH MOOD AND PERSONALITY DISORDERS: ITS ROLE AND IMPLICATIONS FOR FUTURE FUNCTIONING IN THE LIGHT OF REPRESSION-SENSITIZATION VARIABLE

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ABSTRACT
Personality and mood disorders influence everyday functioning throughout interference with situations and impediment of adaptive ways of coping with stress. They cause many problems relating to situations and people, and in many cases stay responsible for self-destructive behaviors. Self-injurious behaviors are related to self-esteem, social approval, and anxiety level. In the presented study the analysis of relations between data on self-destruction, self-esteem, social desirability, and anxiety level was conducted. A group of 100 respondents, including 79 women, and 21 men age 18-60 (M=31.91; SD=8.22) filled in set of questionnaires including Self-Destruction Questionnaire, Self-Esteem Scale, State Trait Anxiety Inventory, and Social Desirability Questionnaire. In the group of respondents there were 43 persons without clinical diagnosis, 22 people with mood disorders, and 35 respondents with personality disorders diagnosed by psychiatrists based on ICD-10 diagnostic criteria. A positive correlation between self-destructive behaviors and anxiety, and negative relationship with self-esteem, and social desirability were discovered. Persons diagnosed with personality disorders were more prone to high anxiety level and sensitization of emotional stimuli than were the people without such diagnosis. People without clinical diagnosis recruited quite frequently from repressors group.

Keywords: self-destructive behaviors, self-esteem, anxiety, social desirability, personality disorders.

1. INTRODUCTION

In the presented article an attention will be given to some aspects of functioning of people with mood and personality disorders. Mood disorders, also described as affective disorders, throughout the text will be understood as mental or behavioral conditions accompanied with disturbed, lowered or elevated mood. The mood itself is defined as an extensive and constant pattern of feelings that influences most of person's behaviors (Spijker & Claes, 2014). Personality disorders are defined as mental disorders expressed throughout maladaptive, inflexible, patterns of behavior incorporated with cognitive distortions and presented in many different contexts, that cause significant distress, and/ or disability (Beckwith, Moran & Reilly, 2014). Both mood disorders and personality disorders are diagnosed by mental health specialists, namely psychiatrists or clinical psychologists. In the presented paper also the terms repression and sensitization will be used. Those names are understood as labels for a defensive coping strategies characteristic for people with high need for social approval and experiencing high physiological arousal while faced with threatening or unpleasant stimuli (Myers, 2010). The diagnosis of repression-sensitization includes gathering the self-report data on the level of anxiety and

social approval, that combined together give an information on the repressive coping style (identified in people with low self-reported anxiety, and high need for social approval) or sensitization (recognized in persons with high self-reported anxiety, and high need for social approval) (Weinberger, Schwartz & Davidson, 1979). In the following sections of the article there will be given a general, theoretical information on functioning of persons with personality and mood disorders, data concerning ways of coping with relationships characteristic for this group of people, facts about emotional regulation together with strategies for dealing with unwanted emotional states throughout self-destructive behaviors observed in persons with personality disorders and mood disorders, and some information concerning the problem of repression-sensitization. Later, research data regarding self-destructive behaviors, self-esteem level, intensity of anxiety, and social desirability in people with diagnosis of personality or mood disorders or without any clinical diagnosis will be given and discussed according to the current literature.

1.1. Introduction to the Topic of Personality and Mood Disorders

Current meta analyses state that personality disorders are globally present and reach approximately 7.8% of general prevalence influencing heavily mental well being of a population (Winsper et al., 2020). Mood and anxiety disorders on the other hand are estimated for approximately 15.4% prevalence during the 12-months period (Steel et al., 2014). It is believed that both types of above mentioned disorders are very complex, hard to classify, and associated with high amount of maladaptive, severe features as well as low degree of empathetic behaviors (Kaźmierczak, Pastwa-Wojciechowska & Błażek, 2013). People diagnosed with personality disorders report problems with managing social situations, coping with stress, and experience low level of satisfaction in their lives (Błażek, 2015). Some researchers suggest they also suffer identity problems bouncing back and forth between their own perception of themselves and others' understanding of their characteristics, which leads them to unstable and inadequate self-assessment, and low level of perceived self-worth (Grabski & Gierowski, 2012). It is also believed that personality disorders impede the development of conscience, and internalization of systems of values, since individuals with personality disorders experience faulty sense of guilt or exaggerated self-punishment (Błażek, 2015). In case of mood disorders extreme emotional disturbances are observed together with cognitive impairment and difficulties with attention, executive functions and memory (Marvel & Paradiso, 2004). In people with lower mood flawed processes of attachment and affiliation are observed. People suffering mood disorders also experience deficits in social skills, and communication (Yang, Fairbairn & Cohn, 2013), accompanied with problems in fulfilling their regular social roles (Hirschfeld et al., 2000) or having difficulties engaging in regular interpersonal functioning (Hirschfeld et al., 2002).

1.2. Relationships and Attachment

Pathological relationships, and inadequate patterns of attachment in early years are believed to lead to an impaired relationships arrangements and interpersonal functioning characteristic for people with personality disorders (Millon, Grossman, Millon, Meagher & Ramnath, 2004) or mood disorders (Lee & Hankin, 2009). Destructive models of behaviors are manifested in most areas of life, including fields of cognition, and emotion. High levels of rigidness leading to problems with adaptation to various social contexts in people with personality disorders is observed from adolescence (Błażek, 2015). Many researchers underline the problem of inappropriate emotion regulation characteristic for people with personality disorders, especially in case of borderline personality disorder (Cavicchioli et al., 2021), but emotional crises are observed in other mental disorders as

well (Santangelo et al. 2016). Persons suffering from difficulties associated with personality disorders experience very complex emotional dysregulation resulting from biological and environmental causes (Grzegorzewski & Kucharska, 2018). They encounter a high level of emotional sensitivity, and a high level of emotional reactivity accompanied by a low level of agility of nervous processes. They experience low threshold of sensitivity for emotional cues, fast increase of emotional intensity in the face of affective stimuli, and slow return to emotional baseline (Crowell, Beauchaine & Linehan, 2009).

1.3. Emotional Processing in Personality and Mood Disorders

Disturbed emotional processing usually is accompanied by extensive problems with acceptance towards one's own emotions, planning and executing goal directed behaviors, and controlling impulses. Emotional dysregulation is associated with low level of emotional awareness, poor emotion regulation strategies, and lack of emotional clarity (Gratz & Roemer, 2004). The above mentioned problems usually lead to ruminating about experienced negative emotions resulting in intensification of those feelings, and attempts for behavioral discharge including maladaptive cognitive and interpersonal emotion regulation strategies or self-harming behaviors (Selby & Joiner, 2009). People suffering from personality disorders and other mental problems endure a wide range of negative emotions including anger, anxiety, disgust, sadness, and shame that change dynamically over short periods of time (Houben, Van Den Noortgate & Kuppens, 2015). Since the above-mentioned negative emotions are very troublesome and painful, people try to engage in activities aimed at regulating of those feelings. Among strategies preferred by individuals with personality disorders, researchers identified rumination, catastrophization, and self-blame, described as cognitive ways of dealing with emotional difficulties (Kuo, Fitzpatrick, Krantz & Zeifman, 2018). People with emotional and mental problems also have a tendency to use interpersonal emotion regulation strategies. It means they stay dependent from other people's responses (response-dependent) or show a tendency to stay independent from reactions of others (response-independent). For response-dependent people regulation of emotion is possible only when others react to the actions taken by an individual. They have the tendency to please others, and engage in actions aiming at fulfilling other's needs instead of their own. Contrary, for response-independent persons self-calming behaviors are more important. Therefore they do not pay attention to others while dealing with their own emotions (Dixon-Gordon, Bernecker & Christensen, 2015).

1.4. Self-Destructive Behaviors as an Emotion Regulation Technique

Another quite important, broadly discussed problem connected to disturbed emotional processing, perceived as a maladaptive emotion regulation strategy is involvement in self-injurious behaviors (Crowell et al., 2009). There are many different types of actions that are perceived as self-harming practices, such as cutting, hair pulling, burning, substance misuse, engagement in risky or compulsive activities, eating disorders or suicidal attempts. Such behaviors result from childhood trauma assisted by insecure attachment, that lead to re-living this early abandonment and neglect in stressful situations of adulthood (van der Kolk, Perry & Herman, 1991). According to research results there is a direct connection between a tendency for self-destructive behaviors, low self-esteem, low social desirability level, and high intensity of anxiety (Cislaghi, 2020; Forrester, Slater, Jomar, Mitzman & Taylor, 2017). Self-injurious behaviors are particularly characteristic for young people (Cipriano, Cella & Cotrufo, 2017), and can be interpreted as an intrapersonal method of affect regulation or an interpersonal approach aiming at bonding and influencing others (Klonsky, Glenn, Styer, Olino & Washburn, 2015). Self-destructive behaviors result in

many negative consequences, including physical problems (e.g. injuries of tendons, muscles, nerves, blood vessels, infections) and decline in globally understood well-being connected with social isolation, feelings of shame, guilt, disgust, and low level of self-esteem. Non-suicidal self-harming behaviors usually serve certain functions connected to emotion regulation (Hetrick et al., 2020), but they do not help individuals to solve problems they are facing.

1.5. Repression and Sensitization

In the literature connected to the subject of emotion regulation one may find broadly described matters of repression and sensitization of emotional stimuli. The concept of repression originates from psychoanalysis, but since the late 1940s it is constantly present in the field of cognitive psychology, where it is perceived as a coping mechanism disclosed in difficult and threatening situations (Kleszczewska-Albińska, 2008). This modern approach to the studies of repression and sensitization was organized and re-arranged by Weinberger and colleagues (1979), who believed that in order to recognize people's true level of anxiety it is important to control the level of defensiveness they experience as well. Based on that assumption the authors introduced four independent groups that differed in subjectively declared level of anxiety and social desirability, understood as a defensiveness measure. The types that were identified were as follows: repressors with low level of anxiety and high level of social desirability, truly low anxious receiving low scores for both anxiety and social desirability, truly high anxious with high level of anxiety and low level of social desirability, and defensive high anxious obtaining high scores on both measures (Weinberger et al., 1979). Repressors have problems with identifying their true feelings, but it is not clear whether they try to deceive themselves or impress others. Truly low anxious are sincere with themselves, and present a moderate level of anxiety. Truly high anxious could be described as persons with high awareness of their elevated level of anxiety (Myers, 2010). The greatest problems are connected with the group of defensive high anxious individuals, since quite often they are not identified at all, or they are described as similar to truly high anxious (Kleszczewska-Albińska, 2008).

According to the literature published up till now both self-injurious behaviors and defensive styles of coping with emotions described by Weinberger and colleagues (1979) serve as methods for dealing with difficult emotions and regulating connections between an individual and their environment. It seems crucial to describe relationships between repression-sensitization and personality or mood disorders, since high levels of repression or sensitization might distort the perception of different situations and emotions connected with them. For that matter study in which the linkage between self-destructive behaviors and repression sensitization in people with personality disorders, mood disorders and persons without any clinical diagnosis was conducted.

2. METHOD

2.1. Participants

A group of hundred respondents (79 women, and 21 men) aged 18-60 ($M=31.91$; $SD=8.22$) voluntarily took part in the study. There were significantly more female participants than male respondents in the researched group $\chi 2(1)=33.63$; $p<.001$. Complete group consisted of 43 people without clinical diagnosis, 22 respondents with mood disorders, and 35 people diagnosed with personality disorders. The number of people without clinical diagnosis who completed the study was significantly greater than the number of people with mood disorders and personality disorders accounted separately

$\chi 2(2)=6.740$; $p=.034$. When the comparison was done for people without clinical diagnosis and people with clinical diagnosis (including both mood disorders and personality disorders) there were no differences in the number of respondents in each group $\chi 2(1)=1.960$; $p=.162$. The clinical recognition was carried out by psychiatrists based on ICD-10 diagnostic criteria (WHO, 1998). All of the respondents were additionally classified to one out of the four groups: (1) not engaged in the therapy (23 respondents), (2) attending the therapy before the study for no longer than 6 months (26 people), (3) attending the therapy before the study for over six months (22 persons), and (4) currently attending the therapy (29 participants). There were no significant differences in the number of people in each group $\chi 2(3)=1.2$; $p=.753$ Detailed information concerning participants is given in table 1. below.

Table 1.
Detailed description of respondents according to the type of disorder and duration of therapy.

		Type of disorder			**Total**
		without diagnosis	mood disorders	personality disorders	
Therapy duration	not participating	23	0	0	23
	finished and no longer than 6 months	14	4	8	26
	finished and lasting over 6 months	5	8	9	22
	currently under therapy	1	10	18	29
Total		43	22	35	100

2.2. Materials

In order to collect data four standardized tests were used. Individual tendency for self-destructive behaviors was assessed with the Self-Destruction Questionnaire KAPiBara (Gerymski, Filipkowski & Walczak, 2016). The tool includes 45 items with 5 point Likert response scale (1-fully agree, 2-agree, 3-hard to say, 4-disagree, 5-fully disagree). Questions included in KAPiBara concern different areas of self-injurious activities, such as risky behaviors (e.g. "I do not look round at pedestrian crossing"), self-mutilation (e.g. "Purposely I was cutting my veins") or substance misuse (e.g. "I need to drink more than others in order to have fun"). The questionnaire is reliable, with Cronbach's alpha value of $\alpha=.96$ in the presented study.

The level of self-esteem of respondents was measured with the Polish adaptation of Rosenberg's Self-Esteem Scale (Dzwonkowska, Lachowicz-Tabaczek & Łaguna, 2008). It consists of 10 questions with a four point response scale (1-fully agree, 2-agree, 3-disagree, 4-fully disagree). The query has satisfactory reliability of $\alpha=.92$.

Polish adaptation of State Trait Anxiety Inventory (Wrześniewski, Sosnowski, Jaworowska, & Fecenec, 2011) was used in order to assess the level of anxiety characteristic for each respondent. The questionnaire includes 20 questions measuring anxiety understood as a temporary state, and 20 other queries for estimation of a stable trait. Each scale includes a 4 point Likert scale. In the described study only the scale assessing anxiety recognized as a trait was used, and it reached a satisfactory reliability level of Cronbach's alpha α=.95.

The last questionnaire used in the presented study was Social Desirability Questionnaire (Drwal & Wilczyńska, 1980). It was used in order to measure the level of social desirability understood as an indicator of defensiveness level. The instrument includes 29 questions with a true/false response sequence. It consist of items describing situations that are socially desirable but at the same time uncommon in society (e.g. "I am never late for my work"), and other positions applying to situations that are quite frequent and socially undesirable at the same time (e.g. "I remember I was pretending to be sick in order to avoid something"). The reliability of the test in the conducted study equals α=.84.

3. RESULTS

In order to describe the relationships between variables assessed in the study correlational analyses together with ANOVA analyses were conducted. According to the literature ANOVA analyses are appropriate for the gathered sample. The technical minimum number of subjects in each group is greater than required k+1, where k stands for number of the groups, and other assumptions for the test were met as well (Field, 2018). In the first step, links between self-destructive behaviors, anxiety, self-esteem, and social desirability in the whole group were verified. In the next stage the relationships between above-mentioned constructs separately for groups with mood disorders, personality disorders or without any clinical diagnosis were checked. Later, the differences in the mean number of self-destructive behaviors among people with personality disorders, mood disorders and without any clinical diagnosis were assessed. Also the diversity among people not engaged in therapy, and those who participated in it for six months, over six months or still are engaged in counseling were analyzed. The last stage of data verification was devoted to the exploratory analyses of connections between repression-sensitization and other constructs measured in the study.

Analyses of relationships between self-destructive behaviors, level of anxiety, self-esteem and social desirability conducted for the whole group proved that there is a strong, positive correlation between anxiety and self-harming activities. Strong, negative connection was observed for self-injurious behaviors and self-esteem, and negative, but moderate interrelationship was noticed between self-destructive behaviors and social desirability level. Detailed results are given in table 2.

Table 2.
Self-destructive behaviors, anxiety, self-esteem, and social desirability in the whole group.

		anxiety	self-esteem	social desirability
Self-destructive behaviors	Pearson r value	.732	-.701	-.485
	significance	<.001	<.001	<.001
	N = 100			

Similar as described above, pattern of results was obtained for groups identified based on the clinical description. There were significant positive, strong relationships between self-destructive behaviors and anxiety level in non-clinical and mood disorder groups, while the results observed in personality disorder group reached the statistical tendency level. All the results concerning the relationship between self-injurious behaviors and self-esteem w9ere statistically significant, negative, and strong for non-clinical group, and moderate for the mood disorders and personality disorders group. The interrelationship between self-destructive behaviors and social desirability reached the level of significance only for the mood disorders group, where negative, moderate correlation was observed. Detailed information is given in table 3 below.

Table 3.
Self-destructive behaviors, anxiety, self-esteem, and social desirability in the non-clinical, mood disorders, and personality disorders group.

			anxiety	self-esteem	social desirability
self-destructive behaviors	non- clinical sample	Pearson r value	.637	-.625	-.214
		significance	<.001	<.001	.168
		N = 43			
	mood disorders	Pearson r value	.702	-.485	-.528
		significance	<.001	.022	.012
		N = 22			
	personality disorders	Pearson r value	.284	-.353	-.276
		significance	.099	.037	.109
		N = 35			

Detailed information concerning the mean level of self-destructive behaviors and self-esteem in groups identified based on the clinical affiliation, together with the results of conducted ANOVA analyses are presented in table 4. below.

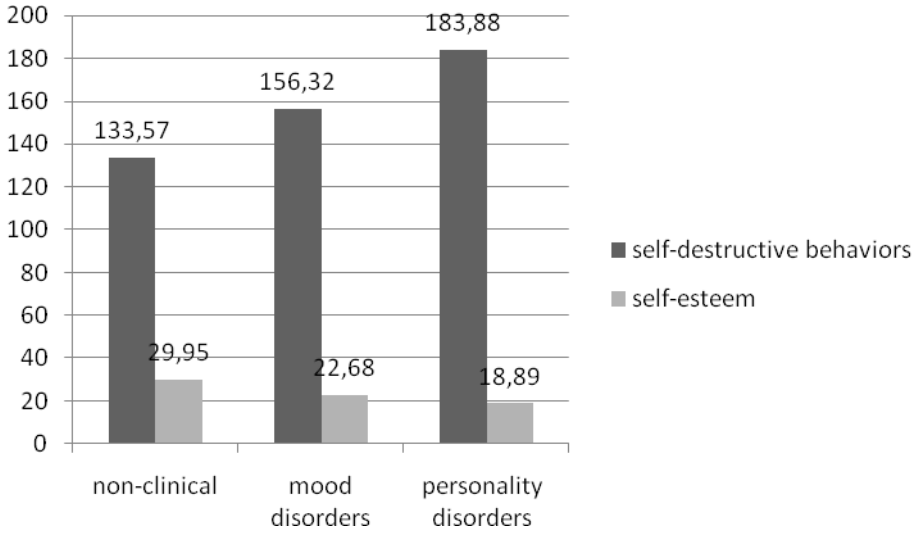
Table 4.
Results of ANOVA analyses for mean level of self-destructive behaviors and self-esteem in groups identified according to clinical affiliation.

	non-clinical group N=43		mood disorder group N=22		personality disorder group N=35		F	p	η^2
	M	SD	M	SD	M	SD			
self-destructive behaviors	133.57	27.20	156.32	39.89	183.88	26.27	27.292	<.001	.36
self-esteem	29.95	5.83	22.68	5.19	18.89	4.28	45.506	<.001	.48

ANOVA analysis showed there are significant differences in the mean number of self-destructive behaviors in different clinical groups $F_{(2,97)}$=27.292; p<.001. Post hoc analyses conducted with Bonferroni test showed all the differences reached the level of significance, with p=.001 for the difference between non-clinical group and personality disorder group, p=.002 for the difference between non-clinical group and mood disorders group, and p=.019 for the difference between mood disorders, and personality disorders groups.

There were also significant differences $F_{(2,97)}$=45.506; p<.001 in the level of self-esteem characteristic for people without clinical diagnosis, and both groups with mood and personality disorders on the level of p=.001, and the difference between respondents from the mood disorders group and personality disorders group on the level of p=.025 (differences between groups were assessed with Bonferroni test). Detailed data is presented in figure 1.

Figure 1.
The mean level of self-destructive behaviors and self-esteem in non-clinical, mood disorders and personality disorders group.



The mean level of self-destructive behaviors and self-esteem, with ANOVA analyses were also calculated in groups identified based on the duration of therapy. Detailed information is presented in table 5 below.

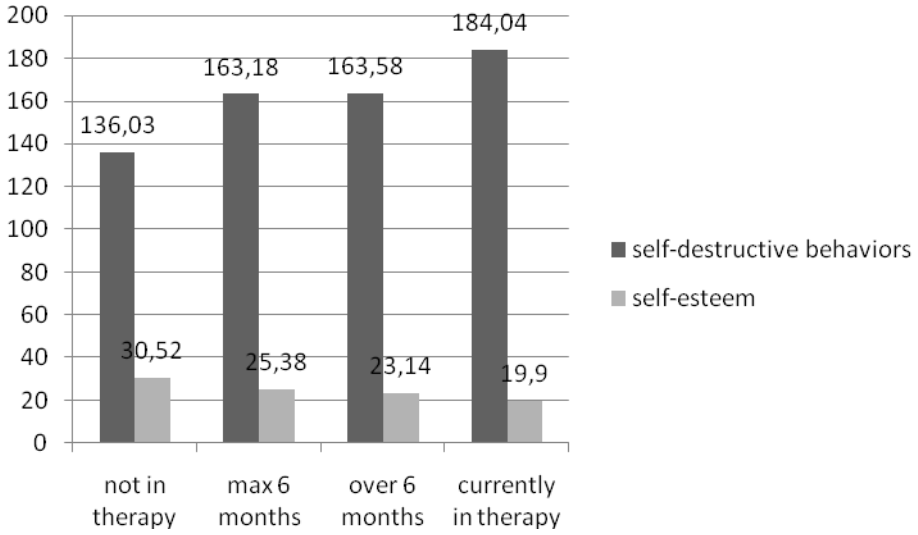
Table 5.
Results of ANOVA analyses for mean level of self-destructive behaviors and self-esteem in groups identified according to the duration of therapy.

	not in therapy N=23		max 6 months N=26		over 6 months N=22		currently in therapy N=29		F	p	η^2
	M	SD	M	SD	M	SD	M	SD			
self-destructive behaviors	136.03	35.41	163.18	30.46	163.58	33.74	184.04	32.52	9.181	<.001	.22
self-esteem	30.52	5.95	25.38	7.28	23.14	6.55	19.90	4.46	13.567	.001	.30

Statistical significance was reached for the differences between the mean number of self-destructive behaviors according to the therapy duration $F_{(3,96)}=9.181$; $p<.001$, with the differences between group not participating in therapy and the one currently in therapy on the level of $p=.001$, between group participating in therapy for the maximum of six months in comparison to the group currently in therapy on the significance level $p=.017$, and between group participating in therapy for over six months in comparison to the group currently in therapy on the significance level $p=.029$ (all the pairwise comparisons conducted with Bonferroni test).

Similarly, significant differences $F_{(3,96)}=13.567$; $p<.001$ were observed between the mean self-esteem level in people not attending therapy and those in therapy for the time longer than six months, and individuals currently attending therapy sessions on the level of $p=.001$. Additional difference was observed between people from the group that participated in therapy for the maximum of six months in comparison to the group currently in therapy on the level of $p=.007$ (pairwise comparisons analyzed with Bonferroni test). Graphic illustration of the results is given in figure 2.

Figure 2.
The mean level of self-destructive behaviors and self-esteem in groups according to the therapy duration time.



Additional, exploratory analyses were conducted in order to check whether there are any differences in the mean level of self-destructive behaviors and self-esteem level among people identified according to repression-sensitization. Detailed data is given in table 6.

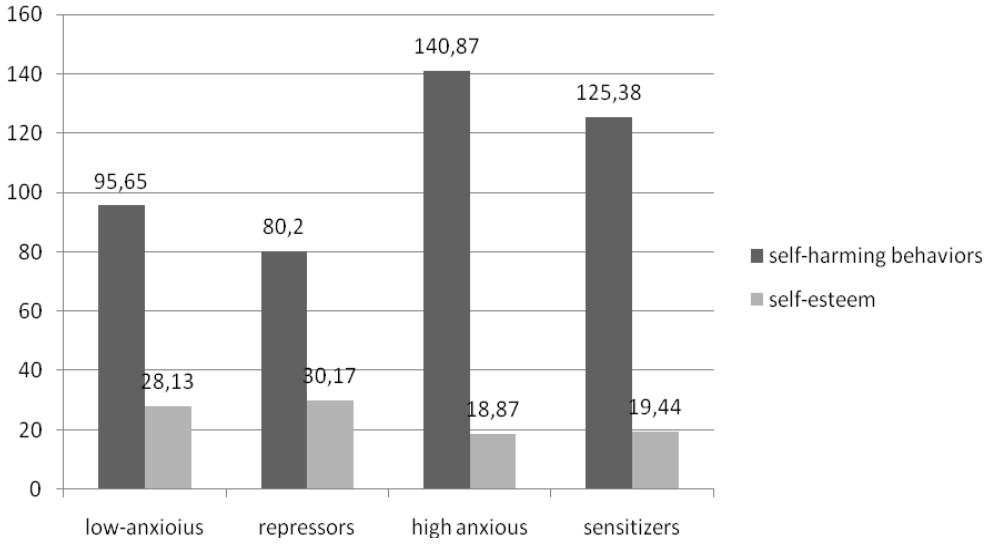
Table 6.
Results of ANOVA analyses for mean level of self-destructive behaviors and self-esteem in groups identified according to repression-sensitization affiliation.

	low anxious N=23		repressors N=30		high-anxious N=31		sensitizers N=16				
									F	p	η^2
	M	SD	M	SD	M	SD	M	SD			
self-destructive behaviors	95.65	28.39	80.20	25.22	140.87	27.11	125.38	30.44	28.704	<.001	.47
self-esteem	28.13	4.63	30.17	5.94	18.87	3.91	19.44	5.54	35.271	.001	.52

In both cases significant differences were discovered, with $F_{(3,96)}=28.704$; $p<.001$ for self-injurious behaviors, and $F_{(3,96)}=35.271$; $p<.001$ for self-esteem accordingly. It was shown that the differences between repressors, high anxious and defensive high anxious (sensitizers), and low anxious and high anxious reached the significance level of p=.001, while the differences between low anxious and sensitizers were equal p=.007 (measured with the Bonferroni test).

The level of self-esteem differed between low anxious, high anxious and defensive high anxious. Similar differences were also observed between repressors, high anxious and defensive high anxious. All the differences reached the significance level of p=.001 (assessed with Bonferroni test). Detailed information is presented in figure 3.

Figure 3.
The mean level of self-destructive behaviors and self-esteem in groups identified according to repression-sensitization affiliation.



Additional, qualitative analysis concerning the number of people from each clinical group in accordance to repression-sensitization affiliation was conducted, with detailed data given in table 7.

Table 7.
Number of people from low-anxious, high-anxious, repressors, and sensitizers types in the non-clinical, mood disorders, and personality disorders group.

	non-clinical	mood disorders	personality disorders
low-anxious	14	6	3
high-anxious	3	4	24
repressors	23	4	0
sensitizers	3	5	8

Analysis with the chi-square test proved that there are significant interconnections between analyzed variables $\chi^2_{(6)}=52.43$; p=.001. In the non-clinical group there were many low anxious respondents and repressors, while the group with personality disorders consisted mostly of high anxious persons.

Also the analysis showing the correspondence between repression sensitization and the duration of therapy was conducted, showing the significant connection between those variables $\chi^2_{(9)}=27.114$; p=.001. Details for this analysis are given in table 8.

Table 8.
Number of people from low-anxious, high-anxious, repressors, and sensitizers types according to the duration of therapy.

	not in therapy	max 6 months	over 6 months	currently in therapy
low-anxious	6	7	7	3
high-anxious	1	9	6	15
repressors	14	4	4	4
sensitizers	2	5	5	7

Most of the respondents that are not in therapy can be identified as repressors, whereas the most numerous group of study participants currently in therapy could be described as high anxious individuals. Among people who attended therapy for six months or longer there is great diversity of types identified based on the level of repression-sensitization dimension.

4. DISCUSSION

Results presented above are consistent with data showing connections between self-harming behaviors and high anxiety level (Chartrand, Sareen, Toews & Bolton, 2012), low self-esteem (Forrester et al., 2017), and low social desirability (Cislaghi, 2020). Interesting are the differences observed in the level of significance obtained for each correlation when the whole group was analyzed in comparison to the analyses conducted separately for non-clinical group, mood disorders and personality disorders. This result stays in agreement with the assumption that mood disorders are rather patterns of people's dysfunctional emotions while personality disorders are more stable dispositions. On the other hand, it is a bit surprising, that the connections between self-injurious behaviors and social desirability in individuals with personality disorders weren't significant, since this type of dysfunction is strictly connected to ways people relate to others (Skodol, Shea, Yen, White & Gunderson, 2010). It is said that self-harming behaviors serve two important functions connected to intrapersonal affect regulation, and interpersonal bonding (Klonsky et al., 2015). According to the results presented above it might be hypothesized that the non-clinical and mood disorders groups are more focused on intrapersonal functions of self-destructive behaviors while personality disorders group is more prone to interpersonal role of such activities. This assumption needs to be further empirically investigated even though there is some evidence for its validity (Guénolé et al., 2021; Colle, Hilviu, Rossi, Garbarini & Fossataro, 2020). The group mostly involved in long term therapy are persons with personality disorders. It is possible that individuals suffering with personality disorders undergo changes resulting in modification of their own perception of self-harm,

and see more interpersonal aspects of this type of behavior (Cipriano et al., 2017). More research in that area is therefore needed in order to better understand the function of self-destructive activities.

Negative correlations obtained for self-harming behaviors and self-esteem, beside its concurrence with previous research (Hetrick et al., 2020; Forrester, et al., 2017), should be analyzed very carefully in face of the needs of people engaged in it. It is possible that improvement of self-esteem throughout psychotherapeutic methods may serve as a way for reducing the intensity and frequency of self-harming behaviors (Clarke, Allerhand & Berk, 2019). This hypothesis needs additional, more explicit, empirical verification. Data proving the negative correlations between self-harm and social desirability are also in congruence with results already published in the literature (Cislaghi, 2020). On the other hand, this result may serve as an important suggestion for specialists working with individuals involved in self-injurious behaviors (Wijana, Enebrink, Liljedahl & Ghaderi, 2018). It might be crucial to direct patients towards better understanding and acceptance of their problem in order to reduce the risk of therapy dropout (Brophy & Holmstrom, 2006). It seems possible to encourage self-harming people in helping others with the same problem. This could be the best improvement method for persons with self-injurious tendencies, and their progress in therapy. This assumption needs to be further empirically investigated.

There are not so many studies describing the connections between repression-sensitization and self-injurious behaviors. Therefore, additional studies in this area are needed. Interestingly, a lot of persons participating in the study and describing themselves as non-clinical group were identified as repressors. More studies concerning this data are needed. Especially in the light of previous results showing problems connected with repression (Myers, 2010). It is said that repressors underestimate their inner emotional and mental conditions, and are more prone to experience physical health problems. It is therefore needed to look at their conditions and to identify their features. The same is needed for patients with personality disorders since most of this group consisted of high anxious individuals. More specific data on that issue might be helpful also for planning therapeutic interventions especially for hospitalized individuals.

There are certain limitations that should be taken into consideration, starting with a relatively small, and mostly female sample. Also, most of the analyses were based on correlations, that preclude cause and effects investigation. More data on interrelationships between self-harming behaviors and repression-sensitization construct are needed. On the other hand, it is important to underline that the results obtained in the study described above are consistent with previous results. They underline the role of self-injurious behaviors in affect regulation. Obtained outcomes may serve as a foundation for further studies aiming at reducing the amount and intensity of self-destructive behaviors, increase of social acceptance for people engaged in such behaviors, and techniques focused on improvement in therapy.

5. CONCLUSION

The main aim of the conducted research was to explore the connections between self-harming behaviors, self-esteem, and repression-sensitization coping style in people suffering with personality disorders and mood disorders, and in people without clinical diagnosis. The results relative to the first two variables are congruent with data already published in the literature. It was proved that the highest mean level of self-destructive behaviors was characteristic for people with personality disorders, and the lowest for

persons from non-clinical sample. Conversely, the highest level of self-esteem was observed in non-clinical sample, while the lowest it was for people with personality disorders. It was also confirmed that people still undergoing therapy have the highest level of self-harming behaviors, and the lowest level of self-esteem, while for people not engaged in the therapy, and not involved in it in previous time in their life the results are reversed. The evidence concerning functioning of low anxious, repressors, high anxious, and sensitizers were not analyzed in previous studies, and they might constitute new lines of research in the field of clinical studies. The results obtained for those coping styles have to be taken into consideration with caution, and need to be verified throughout additional research. Nevertheless, it was discovered that self destructive behaviors were the most frequent for high anxious individuals and sensitizers. The smallest amount of such activities was declared by repressors. The opposite pattern of results was observed for self-esteem, with the highest results gained by repressors, then low anxious group, sensitizers, and the lowest results characteristic for high anxious. It is also crucial to observe the frequency of respondents from each of the four groups while conducting clinical studies. The results obtained in the study described above showed that in the personality disorder group there were many people disclosed as high anxious, while the non-clinical sample consisted in large part from repressors.

REFERENCES

Beckwith, H., Moran, P.F., & Reilly, J. (2014). Personality disorder prevalence in psychiatric outpatients: a systematic literature review. *Personal Mental Health, 8*(2), 91-101.

Błażek, M. (2015). Structural aspects of self in personality disorders and the quality of life. *Current Issues in Personality Psychology*, 3(1), 42-50. doi: 10.5114/cipp.2015.50174

Brophy, M., & Holmstrom, R. (2006). *Truth hurts: Report of the National Inquiry into Self-Harm Among Young People: Fact or Fiction?* Mental Health Foundation. Retrieved June 22 2022, from https://www.mentalhealth.org.uk/publications/truth-hurts-report1

Cavicchioli, M., Barone, L., Fiore, D., Marchini, M., Pazzano, P., Ramella, P., Riccardi, I., Sanza, M., & Maffei, C. (2021). Emotion regulation, physical diseases, and borderline personality disorders: Conceptual and clinical considerations. *Frontiers in Psychology, 12*. doi: 10.3389/fpsyg.2021.567671

Chartrand, H., Sareen, J., Toews, M., & Bolton, J.M. (2012). Suicide attempts versus nonsuicidal self-injury among individuals with anxiety disorders in a nationally representative sample. *Depression and Anxiety, 29*(3), 172-179. doi: 10.1002/da.20882

Cipriano, A., Cella, S., & Cotrufo, P. (2017). Nonsuicidal self-injury: A systematic review. *Frontiers in Psychology, 8*. doi: 10.3389/fpsyg.2017.01946

Cislaghi, B. (2020). *Attitudes toward self-harm* (Master's thesis, Murray State University). Retrieved from https://digitalcommons.murraystate.edu/etd/178

Clarke, S., Allerhand, L.A., & Berk, M.S. (2019). Recent advances in understanding and managing self-harm in adolescents. *F1000 Research, 8*. doi: 10.12688/f1000research.19868.1

Colle, L., Hilviu1, D., Rossi, R., Garbarini, F., & Fossataro, C. (2020). Self-harming and sense of agency in patients with borderline personality disorder. *Frontiers in Psychiatry, 11*. doi: 10.3389/fpsyt.2020.00449

Crowell, S.E., Beauchaine, T.P., & Linehan, M.M. (2009). A biosocial developmental model of borderline personality: Elaborating and extending Linehan's theory. *Psychological Bulletin, 135*(3), 495-510. doi: 10.1037/a0015616

Dixon-Gordon, K.L., Bernecker, S., & Christensen, K. (2015). Recent innovations in the field of interpersonal emotion regulation. *Current Opinion in Psychology, 3*, 36-42. doi: 10.1016/j.copsyc.2015.02.001

Drwal, R.Ł., & Wilczyńska, J.T. (1980). Opracowanie kwestionariusza aprobaty społecznej [Elaboration of the social desirability questionnaire]. *Przegląd Psychologiczny, 23*(3), 569-583.

Dzwonkowska, I., Lachowicz-Tabaczek, K., & Łaguna, M. (2008). *Samoocena i jej pomiar. Polska adaptacja skali SES M. Rosenberga* [Self-esteem and it's measurement. Polish adaptation of M. Rosenberg's SES scale]. Warszawa, Poland: Pracownia Testów Psychologicznych.

Field, A. (2018). *Discovering statistics using IBM SPSS Statistics*. London: Sage edge.

Forrester, R.L., Slater, H., Jomar, K., Mitzman, S., & Taylor P.J. (2017). Self-esteem and non-suicidal self-injury in adulthood: A systematic review. *Journal of Affective Disorders, 221*, 172-183. doi: 10.1016/j.jad.2017.06.027

Gerymski, R., Filipkowski, J., & Walczak, R. (2016). *Kwestionariusz KAPiBara* [Questionnaire KAPiBara]. Opole, Poland: Uniwersytet Opolski.

Grabski, B., & Gierowski, J.K. (2012). Zaburzenia osobowości – różne spojrzenia i próby ich integracji [Personality disorders – different outlooks and an attempt to integrate them]. *Psychiatria Polska, 5*, 829-844.

Gratz, K.L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 26*(1), 41-54. doi: 10.1023/B:JOBA.0000007455.08539.94

Grzegorzewski, P., & Kucharska, K. (2018). Components of emotion dysregulation in borderline personality disorder: a review of recent research. *Advances in Psychiatry & Neurology, 27*(2), 120-134. doi: 10.5114/ppn.2018.77033

Guénolé, F., Spiers, S., Gicquel, L., Delvenne, V., Robin, M., Corcos, M., Pham-Scottez, A., & Speranza, M. (2021). Interpersonal relatedness and non-suicidal self-injurious behaviors in female adolescents with borderline personality disorder. Frontiers in Psychiatry, 15. doi: 10.3389/fpsyt.2021.731629

Hetrick, S.E., Subasinghe, A., Anglin, K., Hart, L., Morgan, A., & Robinson, J. (2020). Understanding the needs of young people who engage in self-harm: a qualitative investigation. *Frontiers in Psychology, 10*. doi: 10.3389/fpsyg.2019.02916

Hirschfeld, R.M.A., Dunner, D.L., Keitner, G., Klein, D.N., Koran, L.M., Kornstein, S.G., Markowitz, J.C., Miller, I., Nemeroff, C.B., Ninan, P.T., Rush, A.J., Schatzberg, A.F., Thase, M.E., Trivedi, M.H., Borian, F.E., Crits-Christoph, P., Keller, M.B. (2002). Does psychosocial functioning improve independent of depressive symptoms? A comparison of nefazodone, psychotherapy, and their combination. *Biological Psychiatry, 51*(2), 123-133.

Hirschfeld, R.M., Montgomery, S.A., Keller, M.B., Kasper, S., Schatzberg, A.F., Möller, H.J., Healy, D., Baldwin, D., Humble, M., Versiani, M., Montenegro, R., Bourgeois, M. (2000). Social functioning in depression: a review. *Journal of Clinical Psychiatry, 61*(4), 268-275.

Houben, M., Van Den Noortgate, W., & Kuppens, P. (2015). The relation between short-term emotion dynamics and psychological well-being: A meta-analysis. *Psychological Bulletin, 141*(4), 901-930. doi: 10.1037/a0038822

Kaźmierczak, M., Pastwa-Wojciechowska, B., & Błażek, M. (2013). A multidimensional model of empathy and the occurrence of personality disorders and stress in social settings. *Acta Neuropsychologica, 11*(2), 113-125.

Kleszczewska-Albińska, A. (2008). Tłumienie i wyolbrzymianie bodźców emocjonalnych - próba systematyzacji badań [Repression and sensitization of emotional stimuli – systematical review]. *Studia Psychologiczne, 46*(3), 5-16.

Klonsky, E.D., Glenn, C.R., Styer, D.M., Olino, T.M., & Washburn, J.J. (2015). The functions of nonsuicidal self-injury: converging evidence for a two-factor structure. *Child and Adolescent Psychiatry and Mental Health 9*, Article 44. doi: 10.1186/s13034-015-0073-4

Kuo, J.R., Fitzpatrick, S., Krantz, L.H., & Zeifman, R.J. (2018). How do you choose and how well does it work? The selection and effectiveness of emotion regulation strategies and their relationship with borderline personality disorder feature severity. *Cognition and Emotion, 32*(3), 632-640, doi: 10.1080/02699931.2017.1330254

Lee, A., & Hankin, B.L. (2009). Insecure attachment, dysfunctional attitudes, and low self-esteem predicting prospective symptoms of depression and anxiety during adolescence. *Journal of Clinical Child & Adolescent Psychology*, *38*(2), 219-231.

Marvel, C.L., & Paradiso, S. (2004). Cognitive and neurological impairment in mood disorders. *Psychiatric Clinics of North America*, *27*(1), 19-36.

Millon, T., Grossman, S., Millon, C., Meagher, S., & Ramnath, R. (2004). *Personality disorders in modern life*. New York: John Wiley & Sons, Inc.

Myers, L.B. (2010). The importance of the repressive coping style: findings from 30 years of research. *Anxiety Stress & Coping*, *23*(1), 3-17. doi: 10.1080/10615800903366945

Santangelo, P.S., Limberger, M.F., Stiglmayr, C. Houben, M. Coosemans J., Verleysen G., Kuppens P., Tuerlinckx F., Vanpaemel W., & Ebner-Priemer U.W. (2016). Analyzing subcomponents of affective dysregulation in borderline personality disorder in comparison to other clinical groups using multiple e-diary datasets. *Borderline Personality Disorder and Emotion Dysregulation, 3*, 5. doi: 10.1186/s40479-016-0039-z

Selby, E.A., & Joiner, T.E., Jr. (2009). Cascades of emotion: The emergence of borderline personality disorder from emotional and behavioral dysregulation. *Review of General Psychology, 13*(3), 219-229. doi: 10.1037/a0015687

Skodol, A.E., Shea, M.T., Yen, S., White, C.N., & Gunderson, J.G. (2010). Personality disorders and mood disorders: Perspectives on diagnosis and classification from studies of longitudinal course and familial associations. *Journal of Personality Disorders, 24*(1), 83-108. doi: 10.1521/pedi.2010.24.1.83

Spijker, J., & Claes, S. (2014). Mood disorders in the DSM-5. *Tijdschrift voor psychiatrie, 56*, 173-176.

Steel, Z., Marnane, C., Iranpour, C., Chey, T., Jackson, J.W., Patel, V., & Silove, D. (2014). The global prevalence of common mental disorders: a systematic review and meta-analysis 1980-2013. *International Journal of Epidemiology, 43*(2), 476–493.

van der Kolk, B. A., Perry, J.C., & Herman, J. L. (1991). Childhood origins of self-destructive behavior. *American Journal of Psychiatry, 148*(12), 1665-1671. doi: 10.1176/ajp.148.12.1665

Weinberger, D.A., Schwartz, G.E., & Davidson, R.J. (1979). Low-anxious, high-anxious, and repressive coping styles: psychometric patterns and behavioral and physiological responses to stress. *Journal of Abnormal Psychology, 88*(4), 369-380. doi: 10.1037//0021-843x.88.4.369

WHO. (1998). ICD-10. *Klasyfikacja zaburzeń psychicznych i zaburzeń zachowania w ICD-10. Badawcze kryteria diagnostyczne* [International Statistical Classification of Diseases and Health Related Problems – Tenth revision]. Kraków-Warszawa, Poland: Uniwersyteckie Wydawnictwo Medyczne "Vesalius". Instytut Psychiatrii i Neurologii.

Wijana, M. B., Enebrink, P., Liljedahl, S. I., & Ghaderi, A. (2018). Preliminary evaluation of an intensive integrated individual and family therapy model for self-harming adolescents. *BMC Psychiatry, 18*(1), 371. doi: 10.1186/s12888-018-1947-9

Winsper, C., Bilgin, A., Thompson, A., Marwaha, S., Chanen, A.M., Singh, S.P., Wang, A., & Furtado, V. (2020). The prevalence of personality disorders in the community: A global systematic review and meta-analysis. *British Journal of Psychiatry, 216*(2), 69-78. doi: 10.1192/bjp.2019.166

Wrześniewski, K., Sosnowski, T., Jaworowska, A., & Fecenec, D. (2011). *Inwentarz Stanu i Cechy Lęku. Polska adaptacja STAI* [State Trait Anxiety Inventory. Polish adaptation of STAI]. Warszawa, Poland: Pracownia Testów Psychologicznych.

Yang, Y., Fairbairn, C., & Cohn, J.F. (2013). Detecting depression severity from vocal prosody. *IEEE Transactions on Affective Computing, 4*(2), 142-150.

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