DOWNLOAD PDF SUICIDE RISK AND SOMATIZATION DISORDER A.P. CHIOQUETA

Chapter 1 : Somatoform Disorders | Suicide: Finding Hope

The aim of the study was to assess suicide risk in psychiatric outpatients with and without Somatization disorder. A total sample of psychiatric outpatients was used in the study, 29 of whom met diagnostic criteria for Somatization disorder.

Published online Sep Cohen , 2 and Igor I. Galynker 2 Zimri S. The authors have declared that no competing interests exist. Conceived and designed the experiments: Authored the STS-3 scale: Received Apr 11; Accepted Aug This article has been corrected. This article has been cited by other articles in PMC. Methods The item STS-3 and a brief psychological test battery were administered to adult psychiatric patients with suicidal ideation or attempt in the psychiatric emergency room, and re-administered to subjects at 1 year follow up. Factor analysis, linear and logistic regressions were used to examine construct structure, divergent and convergent validity, and construct validity, respectively. Factor analysis yielded a three-factor solution, which explained Principal axis factor analysis was used to identify three reliable subscales: Suicidal subjects with suicide attempt history had mean scores 7 points higher than those without history of suicide attempts. Frantic hopelessness was a significant predictor of current suicide attempt when only attempts requiring at least some medical attention were considered. Further study is required to confirm the factor structure and better understand the nature of these relations. Introduction Suicide is estimated to be the 10th leading cause of death in the United States, and ranges between second and fourth leading cause for age groups between 10 and 54 years of age [1] , making suicide an important public health problem. While a wide body of literature exists on the chronic risk factors of suicide [2] , [3] the acute factors that lead a person to make a suicide attempt SA remain inadequately understood. Because of the difficulty in predicting imminent suicidal risk, still no instruments exist which can reliably identify persons who will make a suicide attempt in the near future [4]. A study by Deisenhammer et al. It was hypothesized that in susceptible individuals this transition from suicidal ideation to attempt may be marked by a distinct psychopathological pre-suicidal state [6] â€” [8]. Results from studies conducted by Fawcett, et al. Further, in a series of studies, Hendin and colleagues [7] , [9] â€” [11] have reported that an acute, high-intensity, negative affect state - a time-limited suicide crisis - served as a trigger for SA. In agreement with this hypothesis, a number of other reports have linked increased risk for suicide with affectively intense panic attacks [12] â€” [14] , while a recent study by Katz, et al. At present, there exist no instruments designed to capture the phenomenology of the suicide crisis â€” a suicide trigger state, indicating the risk of imminent suicide [2] , [6]. In their absence, clinicians must rely on well-known factors indicating chronic suicide risk such as suicidal ideation, history of suicide attempts, severe psychopathology, history of psychiatric hospitalization, substance abuse, and poor social supports [2] , [3]. In our previous work on defining and measuring a distinct, acute, pre-suicidal state we have identified a panic-like psychopathological state found in suicide attempters, consistent with previous findings from Fawcett and Hendin [8] , [11] , [22]. To reduce response bias by those wanting to either hide or exaggerate their suicidality, the STS-2 did not contain questions about suicidal ideation or intent. Nonetheless, STS-2 scores were significantly associated with reported lifetime history of suicide attempt. Principal component analysis of STS-2 yielded a two-component solution. The first component described a combination of near psychotic somatization and ruminative flooding, while the second described frantic hopelessness. Based on item response theory analysis of the STS-2, reverse scored items on the STS-2 were converted to equivalent non-reverse score items in its revised form, the STS-3, and one item with poor performance feeling that head or body parts had changed in size or shape was removed. In addition, based on clinical analysis and observation, four new items assessing feelings of hopeless, entrapment, and psychic pain were added. Thus in the present study we seek to replicate concurrent validity of the scale in the psychiatric emergency room setting, and refine our understanding of the scale structure by examining the revised scale on a larger sample size. Further, we hypothesize that higher scores on the STS-3 will be associated with higher rates of past, current, and future suicide attempts. Better understanding of the psychometric properties of the scale in

different treatment settings may help further understanding of its best clinical application. Males and females between 18 to 65 years of age, presenting with suicidal ideation or attempt, and able to understand and willing to sign the informed consent were included in the study. Patients exhibiting mental retardation, cognitive impairment, or linguistic limitations precluding understanding of the consent or research questions, or significant medical or neurological disease or possible delirium were excluded from the study. A total of patients qualified for study inclusion, agreed to participate, signed all necessary consent and research authorization forms, and provided sufficient information to the researchers for use in the study. In addition to assessment of suicidal behavior ranging from preparatory acts to suicide attempt distinguished from aborted and interrupted attempts , the C-SSRS produces a suicidal ideation severity rating ranging from a score of 0 no ideation present to 5 active ideation with plan and intent. In our study, suicide ideation was rated according to the 0â€”5 Suicide ideation severity scale. Actual suicide attempt lethality is rated in the C-SSRS on a 0â€”5 scale, from no or very minor injury requiring no care 0 , to mild injury such as might be treated by first aid measures 1 to moderate, requiring some medical care 2 , to moderate-severe injury, requiring hospitalization 3 , to severe, requiring intensive care 4 to death 5. The actual lethality level of current attempts was assessed using the C-SSRS supplemented by information from patient charts. To avoid over-reliance on self-reported suicidal symptoms and reduce possibility of over- and underreporting of such symptoms, the scale does not contain questions overtly related to suicide. Procedure Primary contact Charts of patients currently in the BI psychiatric emergency room were reviewed for clinical records of suicidal ideation or attempt SI or SA. Those found appropriate were approached by trained research assistants, explained the purpose of the study, informed that their participation in the study would aid in the development of a questionnaire used to measure emotional states, and asked if they were willing to participate. Participants then read and signed informed consent and research authorization forms. The STS-3 was administered first because, as the scale does not contain questions overtly related to the subject of suicide, this order reduces the likelihood of biased answers commonly associated with other self-report suicide measures [25] , [26]. One-year follow-up Of subjects, 36 were reachable after 12 months. Of the that were not reachable, 18 had their telephones disconnected, 25 had wrong numbers, 41 did not answer at least 5 telephone calls and did not respond to telephone messages, 32 subjects did not provide any contact information, 14 were homeless, and 6 were either in a rehabilitation program at the time or had moved to another state. Of the 36 that were reachable, 6 refused to participate, 10 agreed to be re-interviewed but did not come for a follow-up appointment, and 20 agreed to and participated in the follow-up interview. Of these, two subjects provided demographic and clinical information that was incompatible with the initial interview and were excluded from the study. Data Analysis Reliability and internal structure As a modified version of the STS was investigated on a new sample population, an exploratory factor analysis approach was chosen. Convergent and divergent validity To control for significant intercorrelations between BDI subscales, the subscale scores of the Brief Symptom Inventory BSI were regressed against each STS-3 subscale in three multivariate regression models to identify the independent associations of STS-3 symptom domains with BSI related domains, and their lack of independent association with unrelated BSI domains. Each regression model comprised the nine BSI subscales as predictor variables regressed against each STS subscale as the outcome variable. Additionally, total and subscale score means were compared by independent groups t-test comparing subjects with and without C-SSRS defined history of actual attempt including past and current attempts. Further, in order to account for variability in the severity of actual suicidality of subjects presenting to the psychiatric emergency room, separate binary logistic regressions of total and subscale scores were performed with three levels of suicidality as outcome variables: In a secondary exploratory analysis based on the results of the preceding analysis, an alternative scoring of the STS-3 was tested using receiver operator characteristic analysis as a discriminator between subjects presenting with substantive attempts versus subjects who did not. Table 1 details the demographic and clinical characteristics of the study population. Of all subjects, All subjects had some degree of acute suicidal ideation.

Chapter 2 : Somatization Disorder by Chelsea Stoinski on Prezi

Keywords: Somatization disorder, depressive disorder, personality disorders, suicide risk, suicide attempt Somatization disorder is a chronic, distressing, disabling, and costly disorder which is characterized by a combina-.

None, Conflict of Interest: The aim of this study is to examine suicidality in patients with somatization and undifferentiated somatoform disorders. Suicidality was assessed among consecutive patients diagnosed with somatization disorder or undifferentiated somatoform disorder according to the ICD criteria. In the study sample, The most frequent reason for suicidal ideation was to end or stop the pain. This study had revealed that somatization and undifferentiated somatoform disorders have a high risk of self-harm. Self-harm, somatoform disorder, suicide How to cite this article: Suicidality in somatization and undifferentiated somatoform disorders: Arch Med Health Sci ;6: The risk of suicide attempt increases with increase in psychiatric morbidity. Hopelessness [19] and family support [20] are significant determinants of suicidal ideation. Factors associated with risk of completed suicide in major affective disorders are being male, living alone, hopelessness about the future, past suicide attempt, suicidal ideation, marital isolation, earlier onset of depression, comorbid alcoholism, and subjective depression. Axis I disorders, family history of psychopathology, and recent life events were risk factors. Most of these studies have concentrated on high-risk populations for suicidal acts with fatal consequences, such as patients with major depression. The literature on suicidality in patients with somatoform disorders is scarce due to its overlapping psychiatric comorbidities. We planned to look at suicidality in medically unexplained physical symptoms condition such as somatization and undifferentiated somatoform disorders without any psychiatric comorbidity. Materials and Methods A total of patients who were diagnosed with somatization disorder and undifferentiated somatoform disorder according to the ICD criteria were recruited for the study. Diagnosis of hypochondriacal disorder, body dysmorphic disorder, and pain related to psychological factors were ruled out from the study as we wanted to concentrate on cases of medically unexplained symptoms seen in a general hospital setup. The study was conducted in the out-patient and in-patient services of the Department of Psychiatry at Yenepoya Medical College Hospital, Mangalore, India over a period of 1 year from April 1, , to March 31, This was a cross-sectional design with serial sampling. All patients gave written informed consent. The study was conducted after obtaining institutional ethical clearance. Inclusion criteria were as follows: Exclusion criteria were as follows: Assessment Sociodemographic data were collected using a specially designed questionnaire. Mini-International Neuropsychiatric Interview-Plus was used to rule out psychiatric co-morbidity. Four constructs are measured. These are the severity of ideation; the intensity of ideation subscale, suicidal behavior subscale, and lethality subscale. Lethality subscale assesses actual attempts. It uses different assessment periods depending on research; the lifetime period assesses the worst-point ideation, a stronger predictor of subsequent suicide than current ideation. During the study, patients who fulfilled the inclusion criteria were approached. Twelve patients refused consent for various reasons finally leading to patients with somatization disorder and undifferentiated somatoform disorder in the study sample. Results In our study, a total of patients were included with mean age of the patients as Among the participants majority were females The sociodemographic details are described in [Table 1]. Sociodemographic data of the study population Click here to view Suicidal ideation In the study population, Frequency of suicidal ideation Click here to view Intensity of suicidal ideation of Columbia Suicide Severity Rating Scale Among all the participants those who reported any suicidal ideation, The most frequent reason for suicidal ideation was to get rid of the pain Suicidal behavior Nearly 1. Suicidal behavior Discussion Systematic data on suicidality in somatoform disorders are scarce; the study looks at suicidality in somatization and undifferentiated somatoform disorders without psychiatric co-morbidity. Clinical experience shows that prevalence of suicidal ideation in somatoform disorder is not less common than it is for other psychiatric disorders. The mean age of the study group was Although somatoform disorder generally starts an early presentation to psychiatrist is generally

late. Majority of participants were female Majority of the sample belonged to Islam religion Holy Quran prohibits suicide [37] which may be the reason for less number of suicide attempts in our study sample as majority of the participants were belonging to Islam religion. Most patients were staying with their family, and family support is identified as one of the most important determinants of suicide. Frequency and intensity of suicidal ideation were assessed, along with suicidal behavior. The first author interviewed all the patients recruited for the study. To the best of our knowledge, we have not come across a similar study in Indian culture. Limitations of the study are its cross-sectional design without a comparative group. An observational study carried out in a tertiary care hospital may not be generalized to community population. Personality factors and stressors were not assessed. Social support and life events can influence a study of this nature. Conclusion The study showed that somatization and undifferentiated somatoform disorders are associated with high suicidality and needs careful assessment of self-harm. Financial support and sponsorship.

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Chapter 3 : Somatic Symptom Disorder by Carlee Cleeland on Prezi

The aim of the study was to assess suicide risk in psychiatric outpatients with and without somatization disorder. A total sample of psychiatric outpatients was used in the study, 29 of whom.

Suicide risk in patients with somatization disorder. A total sample of psychiatric outpatients was used in the study, 29 of whom met diagnostic criteria for Somatization disorder. The results indicated that Somatization disorder was significantly associated with suicide attempts even when the effects of both a comorbid major depressive disorder and a comorbid personality disorder were statistically controlled for. The findings highlight the fact that the potential for suicide in patients with Somatization disorder should not be overlooked when a diagnosable depressive disorder or personality disorder is not present. Clinical features of body dysmorphic disorder. Psychiatric Annals, 40 7 , During this time, numerous case reports have emerged from around the world. BDD is a relatively common disorder with a long historical tradition. During the past several decades, systematic research has elucidated its clinical features, which includes very poor psychosocial functioning and quality of life. Suicide rates appear markedly high. It is hoped that future research on BDD will shed light on aspects of this disorder that remain poorly understood, which in turn is expected to improve the detection and treatment of this often-severe disorder. Increased suicide attempts in women with somatization disorder. Annals of Clinical Psychiatry, 1 4 , Purtell et al , M. Guze , and J. Herbstein see record There has been no comparable increase in women with primary affective disorder. Psychiatric diagnoses related to personality disorder may account for much of the recently noted rise in reported suicide attempts. Suicidality in body dysmorphic disorder. Primary Psychiatry, 14 12 , Suicidal ideation, suicide attempts, and completed suicide appear common in individuals with body dysmorphic disorder BDD. Although data on completed suicide are limited and preliminary, the suicide rate appears markedly high. These findings underscore the importance of recognizing and effectively treating BDD. However, BDD is underrecognized in clinical settings even though it is relatively common and often presents to psychiatrists and other mental health practitioners, dermatologists, surgeons, and other physicians. This article reviews available evidence on suicidality in BDD and discusses how to recognize and diagnose this often secret disorder. Efficacious treatments for BDD, ie, serotonin reuptake inhibitors SRIs and cognitive-behavioral therapy, are also discussed. Although data are limited, it appears that SRIs often diminish suicidality in these patients. Additional research is greatly needed on suicidality rates, characteristics, correlates, risk factors, treatment, and prevention of suicidality in BDD. Somatization and conversion disorders: Comorbidity and demographics at presentation. Acta Psychiatrica Scandinavica, 84 3 , To directly compare these disorders, we reviewed the records accrued for 2 years at a large medical center and identified 65 somatization disorder patients and 51 conversion disorder patients. Ages at onset occurred throughout the life span among conversion disorder patients but mostly before the age of 21 among the somatization disorder patients. Somatization disorder patients were more likely to have had a history of depression, attempted suicide, panic disorder and divorce.

Chapter 4 : - NLM Catalog Result

The aim of the study was to assess suicide risk in psychiatric outpatients with and without somatization disorder. A total sample of psychiatric outpatients was used in the study, 29 of whom met diagnostic criteria for somatization disorder.

References Class Summary Imipramine is a tricyclic antidepressant that has demonstrated clear superiority over the placebo in double-blind trials for treating specific symptoms of bulimia nervosa. However, SSRIs eg, fluoxetine probably should be first-line agents. SSRIs are greatly preferred over the other classes of antidepressants. Because the adverse effect profile of SSRIs is less prominent, improved compliance is promoted. SSRIs do not have the cardiac arrhythmia risk associated with tricyclic antidepressants. Arrhythmia risk is especially pertinent in overdose, and suicide risk must always be considered when treating a child or adolescent with mood disorder. Physicians are advised to be aware of the following information and use appropriate caution when considering treatment with SSRIs in the pediatric population. In October , the US Food and Drug Administration FDA issued a public health advisory regarding reports of suicidality in pediatric patients being treated with antidepressant medications for major depressive disorder. This advisory reported suicidality both ideation and attempts in clinical trials of various antidepressant drugs in pediatric patients. The FDA has asked that additional studies be performed because suicidality occurred in both treated and untreated patients with major depression and thus could not be definitively linked to drug treatment. References Further Inpatient Care Somatic symptom disorders rarely require inpatient management. Consider inpatient care if a patient appears suicidal or requires detoxification from comorbid substance dependence. Additionally, inpatient care may be needed for patients whose somatic symptom disorder is incapacitating ie, conversion disorder with motor symptoms of such severity to impair ambulation. The principles of inpatient care for somatization disorder include the following: Other complications may include 1 dependence on prescription-controlled substances and 2 development of a helpless and dependent lifestyle. References Prognosis Somatic symptom disorders can range from mild and transient to severe and chronic. Early treatment improves prognosis and limits social and occupational impairment. Patient Education The key issues of patient education are outlined Medical Care. Key patient educational issues include the following: The physician takes on the role of evaluation and monitoring of symptoms. Not all symptoms indicate evidence of a pathological disease. The patient should attempt to maintain interpersonal function despite symptoms. Physical symptoms not due to a defined disease often remit spontaneously. Identifying key life stressors and sources of anxiety can be important. Stress reduction may produce improvement in physical symptoms. Aggressive surgical approaches should be used cautiously and only with the approval of a primary care physician who knows the patient well. Family education is often crucial for the successful management of somatic symptom disorders. Discuss the somatoform diagnosis. Expect the patient to improve and return to normal function. Direct the patient to discuss any somatic symptoms with the primary care provider. Patients should not seek assistance from family members in assessing the seriousness of their symptoms or the diagnosis relating to their symptoms The primary care provider should direct any need for subspecialty evaluation. Family members should spend time with and pay attention to the patient when symptoms are absent. For the patient, this reinforces the idea that their symptoms do not bring special attention from others. Family members may help by providing distraction activities if somatic symptoms are present, eg, going for a walk or going out to a movie. Other helpful Web sites include the following: Received salary from Medscape for employment. Received salary from Amgen for employment; Received stock from Amgen for employment. References American Psychiatric Association. Diagnostic and statistical manual of mental disorders. American Psychiatric Publishing; Diagnostic and Statistical Manual of Mental Disorders. American Psychiatric Association;

Chapter 5 : Somatic Symptom Disorders

Suicide in psychiatric disorders during adolescence / Alan Apter and Danuta Wasserman --Beneficial and adverse effects of antidepressants on suicide mortality in individuals with major depression / Corrado Barbui, Andrea Cipriani and Michele Tansella --Suicide risk and somatization disorder / A.P. Chioqueta --Acute risk factors for suicide.

This study was concerned with correlates of measures, their dissociative disorder was more severe suicidal ideation among patients with chronic than that of the patients with no suicidal ideation. They had elevated scores for childhood emotional abuse, physical abuse and emotional neglect. Participants were 40 patients diagnosed as current somatization disorder diagnosis was the having either dissociative identity disorder or disso- only predictor of suicidal ideation when childhood ciative disorder not otherwise specified according trauma scores and borderline personality disorder to the DSM-IV. The Dissociative Disorders Inter- diagnosis were controlled. Among dissociative patients, there is an Trauma Questionnaires, the Spielberger Trait Anger association between somatization and suicidal ide- Inventory, the Beck Suicidal Ideation Scale, and the ation. Disorders were administered to all patients. Having significantly high scores on both trait and state dissociation HISTORY OF attempted suicide is frequent constitute a principal group in emergency psychiatric A among patients with dissociative disorders1 and they may present to psychiatric treatment facilities wards due to intermittent crisis episodes. Participants had these syndromes, item self-report instrument developed by Bern- however, in the context of their complex dis- stein and Putnam. The Turkish version of the scale has good reli- ability and validity. All patients had a diagnosis of interviewer-rated measure used to evaluate the dissociative disorder according to the DSM-IV. They were between iors and plans to complete suicide. The total score probands was The male subjects can range from 0 to Two patients were onstrated good psychometric properties for psychiat- below 18 years of age. The patients had a mean of ric outpatients. The Somatoform Dissociation Questionnaire is a The patients who agreed to participate provided item self-report instrument that evaluates the written informed consent after the study procedures severity of somatoform dissociation. It was devel- had been fully explained. For two patients between oped by Nijenhuis et al. A obtained from their parents as legally authorized rep- cut-off point of 35 yielded a sensitivity of 0. All interviews were conducted by one specificity of 0. The interviewer had extensive in a Turkish clinical sample. The Spielberger Stateâ€”Trait Anger Expression Inventory assesses the intensity of feelings of anger state anger in seven items, the disposition to expe- Instruments rience anger trait anger in six items, behaviorally The Dissociative Disorders Interview Schedule expressed anger anger-out in six items, suppressed DDIS is a structured clinical interview consisting of anger anger-in in six items, and self-control of anger items. It was designed by Ross et al. Sar Psychiatry and Clinical Neurosciences ; The mean BSI score of Personality Disorders is a semi-structured interview the suicidal group was Gender distribution was administered in the present study. The Turkish did not differ between the two groups either: The sum of the current somatization disorder and a history of scores derived from each trauma type provides the childhood physical abuse more frequently than the total score, ranging from 5 to The suicidal group had a higher for the factors related to each trauma type ranges mean number of somatoform and Schneiderian from 0. Sar secondary symptoms of dissociative identity disor- was used in the present study. Previous studies in der, and previous suicide attempts. They also had Turkey supported the validity of this instrument. The suicidal Statistical analysis mean, The sui- to compare the dissociative and non-dissociative cidal group had elevated scores on childhood physi- groups on continuously distributed variables. Bonfer- cal abuse, emotional abuse and emotional neglect as roni correction was used to minimize type I statistical well as total childhood trauma. Logistic regression was performed using sui- neglect did not differ between two groups. On logis- cidal ideation as the dependent variable and six clini- tic regression using suicidal ideation as the depen- cal items as independent variables. All patients had the lifetime diagnosis of childhood trauma history and borderline personality major depressive disorder while Seventeen somatization disorder was the only significant predic- patients In the present study

the majority The mean suicide attempt. Thus, for most of the patients, the DES score was It is well known that a high proportion of dis- tization disorder had the lifetime diagnosis of a sociative patients have concurrent somatization dissociative disorder. In a follow-up study on a disorder. Thus, these studies Table 2. DSM-IV borderline personality disorder criteria endorsed 5. After Bonferroni correction, significance level is set up at 0. In adult suicidal and self-destructive behavior. The difficult-to-treat patient with dissociative associated with suicide attempts when the effects of disorder. The Difficult-to- both a comorbid major depressive disorder and a Treat Psychiatric Patient. American Psychiatric Publishing, comorbid personality disorder were statistically con- Washington, DC, ; â€" Risk of repetition of suicide trolled for. A register-based survival analysis. Psy- sociative disorders are frequently observed among chiatry ; Chronic suicidality and borderline personality. Prevalence of dissociative disor- In a study on patients with borderline personality ders among women in the general population. Dissociative disorders among inpatients with significantly associated with suicide attempts. Diese- drug or alcohol dependency. Diagnostic and Statistical solving capacity and general self-efficacy predicted Manual of Mental Disorders, 4th edn. American Psychiatric repetition of suicide attempt. They retained their predictive power even Barchet P. The Dissociative Disorders Interview Schedule: A when controlling for age, sex, previous suicide structured interview. Comparison of dis- Recent studies suggest that both somatization and sociative identity disorder with other diagnostic groups suicidality are independently associated with inse- using a structured interview in Turkey. Psychiatry cure attachment style originating from developmen- ; Development, reliability and validity of a dissociation scale. The reliability and validity of the attachment theoretical perspective, suicide attempts Turkish version of the Dissociative Experiences Scale. Measurement of considered by others as much as needed. This may be dissociative states with the Clinician-Administered Dissocia- also valid for persistent somatic complaints. Assessment of suicidal treatment in patients with dissociative disorders. The Scale for Suicide Ideation. Psychometric characteristics tive disorder in patients with severe and persistent of the Scale for Suicide Ideation in psychiatric outpatients. Differ- ders and suicidality in psychiatric outpatients. Dissociative disorders in Trauma Dissoc. The state trait anger scale. Six completed suicides in dissociative identity CD eds. Advances of Personality Assessment Vol. Hillsdale, NJ, ; â€" Childhood origins of anger expression style. Initial reliability chiatry ; Clinical correlates of and neglect. Reported childhood patients with conversion disorder. Psychiatry ; trauma, attempted suicide and self-mutilative behavior Psychiatry Habitual self-mutilation in Japan. Psychiatry ; K, Hirayasu Y. Characteristics of self-cutters among male Prevalence of conver- Oldham JM. Borderline personality disorder and suicidality. Suicide risk in patients with soma- 28 Guze SB. The validity and significance of the clinical diag- tization disorder. Borderline personality ; Predicting repetition of suicide attempt: A pro- Vanderlinden J. Degree of somatoform and psychological spective study of 50 suicide attempters. Application of adult attachment theory to treat- Guze SB. Clinical study of the relation of borderline person- ment of chronically suicidal, traumatized women. Mapping the abuse disorders. Is there a spe- of attachment. Attachment, Intimacy and Autonomy: