Childhood sexual abuse in adult patients with borderline personality disorder

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ABSTRACT

Background: Researchers have found elevated rates of childhood sexual abuse (CSA) in borderline personality disorder (BPD) patients. They have also implicated the role of CSA later in BPD. However, there has been a scarcity of studies regarding this in Indian population. Objectives: To profile the occurrence of CSA and its parameters in BPD patients and to document symptomatology of BPD associated with CSA. Materials and Methods: Thirty-six consecutive patients with BPD were administered with a two-staged semi-structured interview by different interviewers with the first stage for collecting sociodemographic details and confirming BPD diagnosis and the second stage for collecting information about CSA. Results: Of 36 BPD patients, 16 (44.44%) reported a history of definite CSA. The majority of CSA associated with BPD were having characteristics of onset at 7–12 years, <10 occasions of abuse, perpetrator being a close relative or a close acquaintance and genital type of CSA. Identity disturbances (P = 0.0354), recurrent suicidal/self-harm behavior (P = 0.0177), and stress-related paranoid/dissociative symptoms (P = 0.0177) were significantly associated with the presence of CSA while unstable interpersonal relationships (P = 0.001) were significantly associated with the absence of CSA. Conclusion: Significant proportion of BPD patients reported CSA. The specific symptom profile of BPD patients can be used to predict the presence of CSA in these patients, which has a direct implication in the treatment of these patients.

Keywords: Borderline personality disorder, childhood sexual abuse, parameters of childhood sexual abuse, symptomatology

Although borderline personality disorder (BPD) has been well established as a diagnostic entity, the etiopathogenesis of the disorder is still under research. Various etiological hypotheses have been proposed by researchers including genetic, neurobiological, and developmental factors. Developmental milieu suggests that some adverse childhood experiences may play an important role in the genesis of the disorder. Earlier studies concerning these formulations mostly focused on parental separation or loss[1-3] and disturbed parental involvement including parental neglect and unprotectiveness.[4-7]

However, in 1990s research related to these developmental models for the pathogenesis of BPD changed the track when some researchers found elevated rates of BPD among survivors of childhood sexual abuse (CSA). [8,9] They suggested a role of childhood trauma in the form of sexual abuse in developing borderline symptoms in adulthood and rather proposed BPD as a trauma spectrum disorder. Thereafter, many researchers have tried to explore the association between CSA and development of BPD and found significantly higher proportion of reported CSA in BPD patients.[10-14] The prevalence of reported CSA in BPD patients ranged from 16% to 71%.[11,15-19] A meta-analysis of 21 studies that reported such association found a moderate effect size (r = 0.279) between CSA and BPD concluding that a relationship does exist between CSA and development of BPD.[20]

How to cite this article: Menon P, Chaudhari B, Saldanha D, Devabhattuni S, Bhattacharya L. Childhood sexual abuse in adult patients with borderline personality disorder. Ind Psychiatry J 2016;25:101-6.

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Some researchers have explored the specific parameters of CSA and their association with BPD symptomatology. Parameters of CSA found to be associated with the development of BPD were severity of abuse, chronicity of abuse, close relation of the perpetrator with the victim, more number of perpetrators, and sexual penetration or intercourse.\textsuperscript{[11,21,22]} Attempts were also made to explore the clinical symptomatology of BPD patients with CSA, and they suggested that derealization, chronic dysphoria, and impulsivity were the best predictors of CSA.\textsuperscript{[11,22]}

However, this aspect of BPD psychopathology has been paid less attention in Indian patient population where there is a likelihood of a different culture, social environment, and familial dynamics that interact to produce a fertile ground for the development of BPD. It is in this context that the present study was conducted with the aims: (i) to study the profile of CSA in BPD patients, (ii) to determine the parameters of CSA associated with BPD, and (iii) to determine symptomatology of BPD associated with CSA.

### MATERIALS AND METHODS

The present study was conducted in the Department of Psychiatry of a Medical College in an urban area of Western Maharashtra state after approval from the Institutional Ethical Committee. The study sample consisted of 36 consecutive patients with BPD drawn from outpatient and inpatient department who were between 18 and 65 years of their age. The diagnosis of BPD was established as per the Diagnostic and Statistical Manual of Mental Disorders-IV\textsuperscript{th} Edition – Text Revision (DSM-IV-TR) criteria.\textsuperscript{[23]} The diagnosis of BPD was confirmed by two psychiatrists independently. Patients were excluded from the study if they – (a) had met criteria for schizophrenia, schizoaffective disorder, delusional disorder, or bipolar I disorder, (b) were acutely psychotic, (c) were having history or current symptoms of serious organic condition, or (d) were having cognitive decline or mental retardation.

After a full explanation of the study and assuring anonymity and confidentiality of the information given by them, written informed consent was obtained from all the participants. All of the participants were administered a two-staged interview to avoid the occurrence of inherent bias creeping in the study. In the first stage of the interview, all required sociodemographic details of the patient were collected along with the confirmation of BPD diagnosis according to the DSM-IV-TR criteria by two psychiatrists independently. Information about all nine diagnostic DSM-IV-TR criteria assessing anger, mood reactivity, emptiness, identity disturbance, and stress-related paranoid ideation/dissociation, efforts to avoid abandonment, suicidal/self-harm behavior, impulsivity, and unstable relationships was collected with a semi-structured interview.

The second interview was carried out by another interviewer who was blind to the subject’s diagnosis and all other previously obtained information. In this interview, information about CSA was obtained with the help of semi-structured interview. Items which were used to assess forms of CSA were adapted from previous research.\textsuperscript{[24]} Forms of CSA were divided into three exclusive, hierarchical categories – (a) nongenital CSA (inviting or requesting to do something sexual, kissing, or hugging in a sexual way, showing perpetrator’s sex organs to victim), (b) genital CSA (touching or fondling victim’s private parts, making victim touch perpetrator in a sexual way), and (c) intercourse (attempting or having sexual intercourse). Rather than simply providing yes or no answers to questions, subjects were encouraged to describe their experiences about CSA in detail so that internal consistency of the history provided could be established. Instances of consensual sexual exploration between peers were not counted as abusive as well as equivocal situations were also not counted in the study.

The data collected were analyzed using SPSS software for Windows version 21, IBM. Chi-square test was applied to analyze the qualitative data. The two-tailed statistical significance level was set at $P \leq 0.05$.

### RESULTS

Totally, 36 BPD patients were enrolled for the study, of which 5 (13.89%) were male and 31 (86.11%) were female. The mean age of the study sample was 30.69 years $\pm$ 9.84, the range being 18–49. Of 36 BPD patients, 16 (44.44%) reported a history of definite CSA. Among these, 3 out of 5 (60%) males and 13 out of 31 (41.94%) females reported CSA. Most of these CSAs were started during latency years, i.e., 7–12 years. Eleven (68.75%) patients reported age of onset of CSA to be between 7 and 12 years while 5 (31.25%) reported age of onset of CSA during early childhood, i.e., prior to age of 6 years. Thirteen (81.25%) patients reported that they were abused for 1–10 times while 3 (18.75%) reported that they were abused for more than 10 times over a time. Twelve (75%) of the patients reported that they were abused by close relatives or close acquaintances. Of these 12 patients, 9 (56.25%) were abused by intrafamilial members while 3 (18.75%) were abused by extrafamilial but familiar persons. Nine (56.25%) were abused by a single person while 7 (43.75%) were abused by more than one perpetrator. When assessed for the type of CSA, 2 (12.5%) patients reported nongenital...
CSA, 11 (68.75%) patients reported genital CSA, and 3 (18.75%) reported completed intercourse [Table 1].

Table 2 shows a correlation of DSM-IV-TR symptom criteria for BPD and CSA. Identity disturbances ($P = 0.0354$), recurrent suicidal/self-harm behavior ($P = 0.0177$), and stress-related paranoid/dissociative symptoms ($P = 0.0177$) were significantly associated with the presence of CSA. Unstable interpersonal relationships ($P = 0.001$) were significantly associated with the absence of CSA.

**DISCUSSION**

Our study findings showed that 44.44% of our BPD patients had some form of sexual abuse in their childhood. These results are consistent with those of the earlier studies which reported the prevalence of CSA to be 40%–70% in a clinical sample of BPD patients. The slight variation in the prevalence of CSA may be attributed to selection criteria for the patients, diagnostic tools used to assess both BPD and CSA or sociocultural setting of the study sample. However, our study underlined the fact that majority, if not all, of BPD patients have CSA. Although no definite conclusion can be drawn about the etiological association of CSA with the development of BPD, it may be inferred from our findings that CSA has a major formative role in the development of BPD in later life at least in a subset of patients. Certainly, CSA is neither essential nor sufficient for the development of BPD and other factors need their due consideration.

When characteristics of CSA associated with the development of BPD were analyzed, we found that majority of these CSAs (68.75%) were started during latency years of children and remaining CSAs (31.25%) were started in early childhood. No CSA associated with BPD was started in adolescence. This is in accordance with the previous findings. The particular prominence of CSA in latency years compared to early childhood can be justified because of reporting bias due to difficulty in remembering early childhood events. However, it can be concluded that CSA in earlier years of life is specifically associated with BPD compared to CSA in later years. CSA in earlier years of life is associated with BPD because traumatic experiences in this phase result in changes in neural networks and formation of traits resulting in a persistent and pervasive pattern of personality disorder. Most of these CSAs (75%) were done by close relatives or close acquaintances; especially 56.25% of CSAs were intrafamilial. Previous researchers have also confirmed this fact. Insecure or disoriented/disorganized attachment pattern and shattered family support resulting from intrafamilial abuse may likely increase the vulnerability of child for later development of pathology including BPD. When analyzed for the type of CSA, genital CSA (68.75%) was most commonly associated with BPD. Nongenital type of CSA was reported by very few patients (12.5%). It has been stressed by previous researchers also that the development of BPD is associated with the severe type of CSA.

However, two of our findings about parameters of CSA did not match with those of previous researchers. First, most of our patients have <10 occasions of abuse (81.25%), and second, most of them were abused by a single perpetrator (56.25%). Where most of the previous researchers, mostly western world, have shown a chronic pattern of abuse and multiple perpetrators are associated with BPD, our findings were divergent with them. This difference may be particularly attributed to different family and social structure of Indian population which restricts the occasions of CSA. Certainly, in this respect, the differential perception of trauma by Indian people depending on the sociocultural background cannot be overlooked.

CSA may particularly give rise to some specific BPD symptoms clusters in adulthood. Our study findings underlined this fact and showed that the patients who have CSA are more likely to present with symptoms of identity disturbances, recurrent suicidal or self-harm behavior, and stress-related paranoid or dissociative symptoms while unstable interpersonal relationships are more significantly

**Table 1: Parameters of childhood sexual abuse associated with borderline personality disorder**

| Parameter of CSA | Number of patients (%) |
|------------------|------------------------|
| Gender           |                        |
| Males (n=5)      | 3 (60)                 |
| Females (n=31)   | 13 (41.94)             |
| Age at which CSA started (n=16), years |             |
| <6 (early childhood) | 5 (31.25)             |
| 7-12 (latency years) | 11 (68.75)            |
| 13-18 (adolescence) | 0                     |
| Chronicity of CSA (n=16) |             |
| 1-10 occasions | 13 (81.25)             |
| >10 occasions | 3 (18.75)              |
| Relation to perpetrator (n=16) |             |
| Intrafamilial | 9 (56.25)              |
| Extrafamilial familiar | 3 (18.75)         |
| Unfamiliar | 4 (25)                 |
| Number of perpetrators (n=16) |             |
| 1 | 9 (56.25)             |
| 2 | 4 (25)                |
| 3 | 3 (18.75)             |
| Type of CSA (n=16) |             |
| Nongenital | 2 (12.5)              |
| Genital | 11 (68.75)            |
| Intercourse | 3 (18.75)              |

CSA – Childhood sexual abuse

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associated with patients without CSA. Identity disturbance is a core feature of BPD and childhood abuse has been shown to affect the complex process of identity formation by many researchers\cite{24,26} by affecting the development of core values, stable self-image, objective views, and feelings toward others. Wilkinson-Ryan and Westen\cite{27} particularly studied the effect of CSA on identity disturbances in BPD patients and found out that CSA was significantly correlated to the sense of painful incoherence affecting mainly the dissociative aspects of identity disturbance. Likewise, suicidal ideation, suicidal attempts, and self-harm behaviors have been commonly reported by patients with CSA in the previous literature.\cite{9,28-30} Soloff et al.,\cite{13} when studied the role of CSA in suicidal behavior of BPD patients and found that CSA and its severity were predictive of adult suicidal behavior independent of other known risk factors and the odds of a sexually abused patient attempting suicide in adulthood was over 10 times that of a patient who was never sexually abused. Dissociative symptoms have been commonly reported by patients with CSA in the previous literature.\cite{9,28-30} Soloff et al.,\cite{13} when studied the role of CSA in suicidal behavior of BPD patients, found that CSA and its severity were predictive of adult suicidal behavior independent of other known risk factors and the odds of a sexually abused patient attempting suicide in adulthood was over 10 times that of a patient who was never sexually abused. Dissociative symptoms are also commonly reported in patients with sexual abuse histories.\cite{31-33} Dissociative symptoms may develop as a way to cognitively disengage from aversive stimuli during abusive episodes, especially when there is the inability to escape from the situation, which in later life becomes a trait to be elicited in a variety of stressful situations.\cite{34} However in other stressful instances, if a person uses projection and distortion as a defense mechanism, instead of dissociation, it may lead to paranoid symptoms which are not uncommon in BPD. Finally, in our sample, we found unstable interpersonal relationships to be associated significantly with patients without abuse history. Such association has been reported by previous researchers too.\cite{35} This differential symptomatic profile of BPD patients with and without CSA may help the clinician in predicting childhood abuse in patients which in turn has its own implications in the management of patients.

There are few limitations to our study. First, our findings are based on retrospective self-reported childhood sexual adverse events. Reporting biases due to repressed memories, willful forgetting, denial due to shame or guilt, or even false reporting may not be overruled. Second, our study sample consisted of BPD patients who visit the hospital for their ailments. Hence, it will be difficult to generalize our findings to all BPD patients who are less severely disturbed. And third, apart from CSA, we did

| DSM-IV-TR symptom criteria for BPD | CSA present (%) | CSA absent (%) | P (Chi-square test) |
|-----------------------------------|----------------|---------------|--------------------|
| Efforts to avoid abandonment      |                |               |                    |
| Present                           | 12 (75)        | 16 (80)       | 0.72               |
| Absent                            | 4 (25)         | 4 (20)        |                    |
| Unstable interpersonal relationship|                |               |                    |
| Present                           | 9 (56.25)      | 20 (100)      | 0.001              |
| Absent                            | 7 (43.75)      | 0             |                    |
| Identity disturbances             |                |               |                    |
| Present                           | 14 (87.5)      | 11 (55)       | 0.0354             |
| Absent                            | 2 (12.5)       | 9 (45)        |                    |
| Impulsivity                       |                |               |                    |
| Present                           | 14 (87.5)      | 16 (80)       | 0.549              |
| Absent                            | 2 (12.5)       | 4 (20)        |                    |
| Recurrent suicidal/self-harm behavior|              |               |                    |
| Present                           | 14 (87.5)      | 10 (50)       | 0.0177             |
| Absent                            | 2 (12.5)       | 10 (50)       |                    |
| Affective instability             |                |               |                    |
| Present                           | 16 (100)       | 20 (100)      | -                  |
| Absent                            | 0              | 0             |                    |
| Chronic feeling of emptiness      |                |               |                    |
| Present                           | 10 (62.5)      | 6 (30)        | 0.0512             |
| Absent                            | 6 (37.5)       | 14 (70)       |                    |
| Inappropriate intense anger       |                |               |                    |
| Present                           | 14 (87.5)      | 20 (100)      | 0.104              |
| Absent                            | 2 (12.5)       | 0             |                    |
| Stress-related paranoid/dissociative symptoms | | | |
| Present                           | 14 (87.5)      | 10 (50)       | 0.0177             |
| Absent                            | 2 (12.5)       | 10 (50)       |                    |

DSM-IV-TR – Diagnostic and Statistical Manual of Mental Disorders-IVth Edition, Text Revision; CSA – Childhood sexual abuse; BPD – Borderline personality disorder
not consider other adverse childhood events including physical abuse, neglect, disturbed family environment which may have their contribution to the development of BPD in adulthood. Further research including all the above limitations will help in consolidating the gains achieved, and a full range of pathological and protective childhood experiences to which they are exposed can be outlined. A longitudinal prospective case–control study can also explore the effects of CSA on the long-term adult functioning of BPD patients.

CONCLUSION

The present study highlights the fact that CSA is reported by a significant proportion of BPD patients and this fact is sustained beyond sociocultural boundaries even in Indian population. However, detection of CSA is quite a difficult task because of secrecy, stigma, and shame associated with the incidence. Therefore, high index of suspicion about CSA should be kept in mind by clinician while dealing with BPD patients. The specific symptom profile of BPD including identity disturbances, recurrent suicidal or self-harm behavior, and stress-related paranoid or dissociative symptoms can be used to predict the possible occurrence of CSA in these patients. Moreover, once the history of CSA is revealed, its specific parameters can be used to predict their association with the development of BPD. This recognition of CSA in the childhood histories of BPD patients and resolution of long lingering psychological conflicts associated with it has direct implications in the treatment of these patients.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

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