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ARTÍCULO DE INVESTIGACIÓN

El maltrato en la infancia como condición previa para el desarrollo del trastorno límite de la personalidad en la adolescencia

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Resumen

Según un estudio de la Universidad de Manchester, las personas con trastorno límite de la personalidad son 13 veces más propensas a informar de traumas en la infancia que las personas sin ningún problema de salud mental. El presente estudio pretende revelar el estado actual de la problemática del abuso físico, mental y emocional en la infancia como posible factor de desarrollo de la sintomatología límite en la adolescencia, así como examinar las tasas de abuso físico, sexual y emocional durante la infancia entre los adolescentes con sintomatología de personalidad límite en una población clínica no psiquiátrica. Los estudios sobre la influencia de los traumas infantiles en la salud mental demuestran que se asocian con mucha más frecuencia al trastorno límite de la personalidad que a los trastornos del estado de ánimo, las psicosis y otros trastornos de la personalidad. Una de las formas de experiencia adversa más comúnmente reportada por las personas con trastorno límite de la personalidad es la negligencia física, seguida por el abuso emocional, el abuso físico, el abuso sexual y, por último, la negligencia emocional, aunque varios estudios han encontrado el patrón opuesto. Los hallazgos muestran que las experiencias traumáticas en la infancia pueden ser un predictor de la formación de los síntomas del trastorno límite de la personalidad a una edad posterior. Además, cabe destacar que el abuso y la negligencia emocional en la infancia son los que más influyen en el desarrollo del trastorno límite de la personalidad en la adolescencia.

Palabras clave: trastorno límite de la personalidad, trauma infantil, abuso físico, abuso sexual, abuso emocional.

Abstract

Abuse in childhood as a precondition for the development of borderline personality disorder in adolescence

According to a study of Manchester University, people with borderline personality disorder are 13 times more likely to report childhood trauma than people without any mental health problems. The present study aims to reveal the current state of the problem of physical, mental, and emotional abuse in childhood as a possible factor in the development of borderline symptomatology in adolescence, as well as to examine the rates of physical, sexual, and emotional abuse during childhood among adolescents with borderline personality symptomatology in a non-psychiatric clinical population. As demonstrated by the conducted analysis, traumatic experiences at the early stage of

development increase the probability of the development of the disorder at the next stages. Studies on the influence of childhood trauma on mental health demonstrate that it is much more often associated with borderline personality disorder than with mood disorders, psychoses, and other personality disorders. A widespread form of adverse experience most commonly reported by people with borderline personality disorder is physical neglect, followed by emotional abuse, physical abuse, sexual abuse, and, lastly, emotional neglect, although several studies have found the opposite pattern. The findings show that traumatic experiences in childhood may be a predictor of the formation of borderline personality disorder symptoms at a later age. Additionally, it should be noted that emotional abuse and neglect in childhood have the most significant impact on the development of borderline personality disorder in adolescence.

Keywords: borderline personality disorder, childhood trauma, physical abuse, sexual abuse, emotional abuse.

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1.- Introduction

Personality disorders are defined as "the way of thinking, feeling, and behaving, that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to suffering or impairment". It has been reported that worldwide, personality disorders have a prevalence of 3 to 10% in the population and much higher among people with other mental disorders, and are therefore considered a global mental health priority.

The goal of the present study is to disclose the present state of the problem of physical, mental, and emotional abuse in childhood as a possible factor in the development of borderline symptomatology in adolescence.

2. Methods

The study involves the analysis of publications (research reports, articles) concerning the association of physical, sexual, and emotional abuse in childhood and the development of BPD in adolescence published in the last 5 years. The study includes publications from the MEDLINE, PubMed, Google Scholar, CyberLeninka, and eLIBRARY.RU databases.

3. Results

Borderline personality disorder (BPD) is one of the most prevalent personality disorders seen in the general population. The word borderline means "on the edge". The

term was initially adopted because the disorder was originally considered "borderline" between neurosis and psychosis. Now, it is known to be a clearly distinct disorder. BPD can be thought of as a state of hyperemotionality and hypersensitivity, which occurs approximately in 1-3% of the general population, 10% of outpatients, 20% of inpatients, and 9-27% of patients in emergency departments. BPD is three to four times more common in women in a variety of clinical settings, although in the community, the distribution of prevalence by gender remains almost identical (Rosenstein et al., 2018). BPD is characterized by a pronounced overarching pattern of emotional dysregulation, impulsive behavior, personality disorder, and interpersonal conflicts. Research assessing the quality of attachment in borderline subjects, points to the predominance of insecure and disorganized attachment, which strongly correlate with chaotic and inconsistent relations. Moreover, BPD can be partly considered a severe attachment disorder of the disorganized type. Borderline personality symptoms tend to peak in intensity and frequency in young adulthood, when most people are diagnosed, and then decrease in severity with age. Many people with BPD have at some point in their life suffered from a comorbidly related mental illness, for example, depressive disorders, bipolar disorder, anxiety disorder, post-traumatic stress disorder, eating disorders, and addiction to alcohol or drugs.

Even though BPD is well established as a diagnostic entity, the etiopathogenesis of this disorder is still not quite clear and remains under active investigation. Researchers have proposed various etiological hypotheses, including genetic, neurobiological, and developmental factors. The most recognized among the various etiopathological theories is the theory proposed by M. Linen, which suggests that BPD may result from a combination of biological and psychosocial factors.

C.H. Hughes et al. (2005) proposed integration with the etiopathogenetic model of BPD, emphasizing the role that lack of social closeness or responsiveness on the part of appropriate caregivers plays in the development of BPD symptoms, which, in turn, impairs the individual's emotion regulation. Difficulties in affect regulation have also been suggested as key mediators in the relationship between childhood trauma and BPD.

The role of childhood trauma in the etiology of BPD has been the subject of research for over 30 years. The word "trauma" is used these days in the context of various situations where it is easy to lose its actual psychological-diagnostic meaning. The definition of a traumatic event refers to the very fact of the occurrence of a particular event in a person's life rather than their reaction to that situation.

The definition of trauma presented in the literature on mental disorders reads that it refers to the immediate and personal experience of an event involving death or serious injury, or the threat of death or serious injury, or other threat to the physical integrity of that person; witnessing the death, injury or threat to the physical integrity of another person, or reporting a sudden or violent death or serious injury or threatened death, or serious injury to a family member or other loved one. It also involves the person's reaction to the event, which is manifested by intense fear, feelings of helplessness or terror (in the case of a child, it must involve disorganized behavior or agitation).

In modern psychotherapy and psychiatry, experts increasingly cite early experiences of developmental trauma among the etiologies of mental disorders. The DSM classifies as potentially traumatic events the following: war, physical and sexual assault, kidnapping, terrorism, torture, disasters, serious car accidents and life-threatening illness, witnessing someone die or being seriously injured after an accident, war, or disaster. In addition, the DSM-V classification considers a traumatic event to be a threat to mental integrity. The DSM-V does not mention any kind of traumatic event as a diagnostic criterion for BPD despite the inextricable link between BPD and trauma.

BPD is described as having "serious consequences in interpersonal relationships". Interpersonal relationships are essentially children's relationships with their caregivers, those who care for them and raise them. Children are dependent on parents and other reliable caregivers to provide a safe, loving, and supportive environment. When this is not the case, the long-term effects can be devastating. In a borderline structuring problem, when attachment remains unreliable or even disorganized, aggressive action will be codependent on the experience of dependence on the object. An aggressive act becomes symptomatic, an impulsive response to anxiety, turning into a source of direct instinctive gratification. There is a nonspecific weakness of the ego linked to the inability to cope with aggression, intolerance to the frustration caused by anxiety and insufficient development of sublimation skills. In addition, there is an inability of the subject to regulate and neutralize their own aggression. Because of the failure of symbolization, an attempt is made to eliminate the intrapsychic conflict of thoughts through acting it out, which is a consequence of primitive anxiety of abandonment. The risk of early distortions or even deficits and/or abuse, which is common in family dynamics, makes the study of family relationships in cases of BPD a subject not only of clinical research but also of public health.

According to the World Health Organization (WHO), more than 1 billion children between the ages of 2 and 17 are physically, sexually, and emotionally abused each year. Retrospective studies show that about 25-35% of women and 10-20% of men confirm that they were victims of childhood sexual abuse, and about 10-20% of men and women's descriptions of these experiences meet the criteria for physical abuse (Zarrati et al., 2019).

Studies around the world provide ample evidence of multiple intrafamilial pathological experiences in childhood, such as histories of physical, emotional, sexual abuse, and neglect, commonly reported by patients with BPD. The consequences of child abuse are nothing short of traumatic, as abused children often struggle with the consequences long into adulthood.

Exposure to trauma is a common experience for children and adolescents, and the prevalence of post-traumatic stress disorder (PTSD) in this population is underestimated. Although most of them demonstrate potential for recovery, giving the child the ability to overcome these experiences, a certain portion of this population will, nevertheless, present very diverse reactions, ranging from minimal impairment in the child's life to patterns of severe clinical symptoms that heavily interfere with the psychoaffective

development of their personality. Meanwhile, the long-term consequences of early childhood trauma are tricky to estimate and are contingent on a wide range of variables. Among these are the nature, duration, number of instances, and frequency of recurrence of the trauma, its intensity, and the subject's age, pre-existing medical condition, and personality. To this list also belong collateral events, such as illnesses, accidents, or losses that precede or follow the trauma(s) (Godbout et al., 2019).

BPD and complex post-traumatic stress disorder have a number of common characteristics and symptoms, such as impaired emotional regulation and altered self-image. The thoughts, feelings, and behaviors observed in BPD often result from childhood trauma. These childhood traumas can also put a person at risk for developing PTSD. In fact, people with BPD and PTSD report prior trauma experiences more often compared to people with PTSD alone. Yet there is a key difference: complex PTSD clearly defines a person's state as a response to trauma – old or recent, long-term or short-term – while BPD does not. Nevertheless, many people meet the diagnostic criteria for both disorders simultaneously. Despite this, the role trauma plays in the onset of BPD was and remains a topic of heated debates between psychiatrists and psychologists.

An analysis of data from 42 international studies involving more than 5,000 people finds that 71.1% of people with personality disorders report experiencing at least one trauma in childhood. In the latter, in a series of meta-analyses of the impact of childhood trauma on adult mental health, it is demonstrated that these traumas are much more often associated with BPD than with mood disorders, psychoses, and other personality disorders (Winter et al., 2017).

A large number of empirical studies, both cross-sectional and longitudinal, have shown that 30% to 90% of patients diagnosed with BPD report a history of child abuse. Specifically, 40-86% of subjects with BPD report childhood sexual abuse. In addition, 10-73% report physical abuse by parents or adult caregivers, and 17-25% report neglect. Three-quarters of patients with BPD report emotional abuse and 70% report emotional detachment during childhood. People with BPD are also significantly more likely to have witnessed domestic violence (54%) than people with other personality disorders (20.5%) (Porter et al., 2019). This association has been noted in a variety of samples, including inpatient psychiatric patients and outpatients, substance users, and adolescents. At the same time, other authors suggest that a history of trauma is neither necessary nor sufficient for the development of BPD, and studies have been unable to empirically demonstrate strong direct causal associations between these variables.

P. Bozzatello et al. review studies published on PubMed over the past 20 years to assess whether different types of childhood trauma serve as a risk factor and form the clinical picture of BPD. It is found that compared to subjects with other personality disorders, patients with BPD are more likely to have been abused in childhood (Bozzatello et al., 2021).

Following a search of five electronic databases, M. Girard has selected 22 articles examining the relationship between child maltreatment (e.g., physical, sexual, and emotional abuse; physical and emotional neglect) and BPD (i.e., the diagnosis, severity,

assessment of related personality traits). Overall, the results partially support the hypothesis that early maltreatment is a risk factor for BPD. Evidence for a perceived link between child maltreatment and BPD is more common when using a symptom scale compared to a categorical diagnosis (Girard, 2020).

An article entitled "Childhood Adversity and Borderline Personality Disorder: A Meta-Analysis" was published in the journal Acta Psychiatrica Scandinavia. F. Varese, along with his colleagues, found patients with BPD to be 13.91 times more likely to experience childhood abuse trauma compared to people with no mental health problems. When compared with epidemiological and prospective cohort studies, the odds drop tenfold. According to the revised calculations, people with BPD are found to be 3.15 times more likely to report childhood trauma than people with other psychiatric disorders.

M. Solmi et al. review combined data from five meta-analyses on personality disorder risk factors. The results show that of 56 associations between 26 potential environmental factors and the antisocial, dependent, and borderline personality disorders, despite 62.5% of the associations being nominally significant, only 8.92% of the associations meet Class II evidence for BPD, including emotional abuse, emotional neglect, physical abuse, sexual abuse, and physical neglect in childhood. All other significant associations are classified as weak (Class IV evidence) (Solmi et al., 2021).

Experiencing such events early on in development often results in substantial and persistent dysfunction, mental impairment, and personality development disorders.

The meta-analysis conducted by N. Cattane et al. presents proof of the role of changes in the hypothalamic-pituitary-adrenal (HPA) axis, in neurotransmission, in the endogenous opioid system, and in neuroplasticity in childhood trauma vulnerability to developing BPD; the authors also confirm the presence of morphological changes in several brain regions in patients with BPD, particularly in those involved in the stress response. This is presumably due to the fact that memory consolidation occurs during the first night of sleep after trauma. Conversely, an adequate capacity for resistance, that is, the ability to adapt to an adverse situation, is shown to be a crucial protective factor against trauma-related disorders. In response to childhood stressors, there occurs a cascade of neuromorphological and epigenetic changes that may have a strong link with the development of BPD (Cattane et al., 2017). Many researchers point to one of the consequences of trauma – the inability to modulate emotions, which, in turn, is one of the typical indicators of BPD.

For about 60% of patients with BPD, childhood sexual abuse appears to be an important etiological factor. A systematic review by L.F. de Aquino Ferreira et al. focuses on sexual abuse as a predictor of the diagnosis, clinical picture, and prognosis of BPD. Overall, sexual violence is found to play an important role in BPD, especially in women. The rate of adult sexual violence is significantly higher in patients with BPD compared to other personality disorders. A history of sexual abuse predicts a more severe clinical picture and a worse prognosis.

The strongest evidence is suicidality, followed by self-harm, post-traumatic stress disorder, dissociation, and the chronic form of BPD. Years of sexual abuse can have a

detrimental effect on the child's achievement of age-appropriate developmental goals, reduce their self-esteem, interfere with the development of a sense of identity, and impair the ability to establish and build interpersonal relationships and achieve their goals (De Aquino Ferreira et al., 2018). However, maltreatment tends to seem embedded in an atmosphere of general chaos and neglect on the part of both parents. For other patients, other forms of maltreatment combined with various forms of neglect probably play a more important etiological role.

Physical abuse has been widely researched as a predisposing condition for the development of BPD. Abuse and inherited susceptibility essentially play a synergistic role in the development of borderline personality traits. Physically abused children develop more BPD symptoms by age 12 than their nonabused peers, and they are particularly vulnerable if they have relatives with psychiatric disorders. Abuse and inherited susceptibility appear to play a synergistic role in the development of borderline personality traits. Not only family medical history, but also children's temperament characteristics may contribute to BPD symptoms if they were physically abused: children with low temperament and relatedness who were physically abused exhibit earlier onset and higher severity of BPD symptoms.

The relationship between maltreatment and temperament is complex and debated: maltreatment can contribute to BPD in patients with biological susceptibility (specific temperament traits). However, it is also possible that premature and repeated maltreatment in the family influences at least some of the temperament traits associated with BPD. The timing of temperament traits assessment poses a limitation, as it is difficult to distinguish temperament traits in the personalities of adult patients. The effects of physical trauma extend to many areas of personality, such as affective dysregulation, identity dissemination, disturbed relationships, and self-harm. Children who were physically abused score higher on each parameter compared to a control group of children who were not abused. Moreover, they have higher overall borderline trait scores and are more likely to be identified as high risk for BPD (Bozzatello et al., 2021).

A link is discovered between neglect and the early development of BPD. In the context of child care, neglect is a type of abuse characterized by "failure to properly care for a child, resulting in physical or emotional harm". The concept of neglect includes physical neglect, which refers to the failure to adequately meet children's physical needs, and emotional neglect, which is expressed by caregivers' emotional disconnect from children's requests for attention and care. The most important findings suggest that: adolescents with BPD and concomitant depression have had significantly higher levels of neglect than healthy control subjects; physical neglect is associated with the onset of the signs of BPD at an earlier age; the combination of specific temperament traits and physical/emotional neglect may precipitate the onset of BPD and the symptoms of antisocial personality disorder; neglect by both parents is reported more frequently by adolescents with BPD compared with other clinical groups (Solmi et al., 2021).

Attachment to the primary caregiver, the controlling figure, serves as the basis of security for the child in exploring the environment. The accessibility of the adult, the

quality of assistance provided, and the appropriateness and adjustment of responses to the child's cues contribute to the emergence of a progressive sense of security and self-confidence in the child, as they see their needs being met. The longer the period spent without stable and adequate attachment, the more limited the opportunities to catch up. The effects of specific types of neglect (e.g., childhood neglect and maternal detachment) have been studied. Neglect of child supervision, including failure to set limits, monitor inappropriate behavior, and know the whereabouts of the child and their friends, is associated with a higher risk of Cluster B personality disorders in adolescence and early adulthood. Maternal detachment in infancy, a kind of neglect in which the mother creates a physical and verbal distance from her child, is found to be a reliable predictor of both BPD symptoms and self-harm or suicidality in adolescence (Godbout et al., 2019).

Studies confirm that among the variety of childhood maltreatment, only emotional abuse acts as a unique predictor of the features of BPD (Rosenstein et al., 2018).

G.D. Xie et al. (2021) also find that resilience and self-worth mediate all three types of childhood maltreatment (emotional abuse, physical abuse, and sexual abuse) when these types are considered separately; however, when all three types of childhood maltreatment are entered into the model simultaneously, neither the indirect nor the direct effects of physical abuse or sexual abuse are significant, only the relationship between emotional abuse and BPD characteristics is partially mediated by resilience and self-worth. Nevertheless, the risk of developing BPD in an emotionally abused child may be higher only when one or more risk personality traits are already present: rejection sensitivity, the tendency to frequently expect and experience interpersonal rejection, and negative affectivity, the tendency to experience large amounts of strong negative emotions. However, there is a limited body of research explaining how rejection sensitivity and negative affectivity are related to childhood emotional abuse and the subsequent development of BPD (Winter et al., 2017).

The parent’s lack of affective accessibility and unpredictable responses to the child’s needs have serious consequences for the development of the child’s ability to manage emotions and the maturation of their defense mechanisms.

Studies reveal that children with higher rejection sensitivity are significantly more likely to develop BPD traits after emotional abuse. With high rejection sensitivity, children often misinterpret ambiguous social situations as rejecting when the actual rejection is very mild or non-existent; they often perceive social situations as more emotionally upsetting than their peers. To protect themselves from rejection, children with high rejection sensitivity often develop two coping mechanisms over time: avoidance and excessive attachment. Both coping mechanisms are common among the behavioral symptoms of patients with BPD, and they are often both present in the same person.

Higher negative affectivity is characterized by a tendency to be easily disturbed by emotionally triggering events and to experience greater negative emotions from these triggers. Compared to rejection sensitivity, which causes children to subjectively

experience only rejection as more intense, negative affectivity reinforces all of their negative emotions. Consequently, emotionally distressing experiences can cause much greater trauma in children with higher negative affectivity than in those with lower negative affectivity, and this trauma often interferes with their emotional and social development. Not only has the high prevalence of exposure to childhood trauma in people with psychotic disorders been proven, but also that such events have a very significant impact on the course of the illness and the chances of recovery (Kim et al., 2018).

The results of the study by N. Godbout et al. provide further evidence that a history of childhood abuse may be directly related to symptoms commonly associated with BPD, such as anger, stress-reducing behavior, suicidality, dysfunctional sexual behavior, and self-esteem disorders, and also indirectly related through its effects on insecure attachment. These findings have important implications for psychological treatment, including the possibility that trauma and attachment-focused interventions, such as phased cognitive behavioral therapy for complex trauma, teach affective and interpersonal skills. Regulation and emotionally oriented therapy for complex trauma, along with dialectical behavioral therapy known to be effective, may be helpful in treating BPD. These findings also suggest that men and women may experience parental maltreatment differently, resulting in gender differences in attachment patterns and psychosocial symptoms (Godbout et al., 2019). Such findings emphasize the possible importance of developing and offering gender-specific interventions for men and women with BPD.

4. Conclusion

Understanding the impact of negative life stressors in early life on adulthood requires serious attention to early diagnosis and intervention. The multifactorial model suggests that the development of BPD is largely the end product of childhood trauma, such as emotional abuse, physical abuse, and sexual abuse. In addition, researchers have found that childhood maltreatment is an important predictor of BPD in adolescence and adulthood.

Individuals who experienced childhood maltreatment tend to score higher on BPD traits than those who did not. However, examining the effect of a particular subtype of childhood maltreatment on BPD traits without considering the overlap of childhood maltreatment subtypes does not provide accurate results because most maltreated children have experienced multiple forms of maltreatment that exhibit high rates of concurrent acts of abuse or neglect. Therefore, more research is needed to assess the exact relationship between childhood maltreatment and BPD, and if maltreatment is a cause, what types of child maltreatment are most closely associated with the development of BPD.

Additional research is needed on patients with BPD that have or have not had traumatic experiences in childhood, as well as on the changes that occur in response to trauma. A detailed study of the influence of the nature and severity of trauma in children of different age groups can give a better understanding of how to modulate treatment

based on individual needs. Research also shows that post-trauma patients diagnosed with BPD tend to report chaotic early environments that may also include sexual, physical, emotional, or verbal abuse and chronic neglect, and that more severe and extensive child maltreatment tends to be associated with higher levels of BPD symptomatology. However, more research is needed to specifically identify the individual and cumulative effects of different types of child maltreatment and their characteristics, including the relative contribution of caregiver maltreatment on BPD.

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