ACADEMIA | Letters

IMPACT OF TRAUMATIC EXPERIENCES IN CHILDHOOD FOR THE DEVELOPMENT OF BORDERLINE PERSONALITY DISORDER: A CASE REPORT

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Introduction

According to the DSM – 5, a personality disorder *"is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individuals culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment"* (APA, 2013). Within this personality disorders, we can find Borderline Personality Disorder (BPD), with an estimated prevalence among general population of 1.6 – 5.9% and 10% and 20% in outpatient and hospitalized psychiatric patients, respectively (Alberdi-Paramo, Saiz-Gonzalez, Diaz-Marsa, & Carrasco-Perera, 2020).

People with borderline personality disorder (BPD) have a marked affect instability, identity pathology, chaotic relationships, and dangerous behaviors, including suicide, having a huge impact on daily life. (Porter et al., 2020). Even though BPD has a severe impact in the population, little is known about the etiology or risk factors that can contribute to this disorder, and the interventions than can be made in an early stage of life. The development of healthy affective bonds and a safe and secure environment during childhood and early adolescence,

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favors an emotional and physical development, but also the skills needed to a correct social and labor engagement. The development of appropriate affect regulation, congruent self – perception and social behavior are highly influenced by a secure attachment with trustful parents or caregivers. Traumatic experiences and difficulties in childhood have been associated with borderline personality disorder, given that individuals diagnosed with BPD have a history of severe adversities during childhood as high as 71% among this population of patients (Ibrahim, Cosgrave, & Woolgar, 2018; Llorca et al., 2018; Newnham & Janca, 2014).

Severe traumatic experiences are common among the general population; however, children are affected by multiple traumas, which includes physical, emotional, and sexual abuse, natural disasters, accidents, domestic or community violence, assaults, and terrorism. Generally, these traumatic experiences, whether being in a direct or indirect exposure, often are underestimated, and the community spends time and money aiding the physical damage cause by traumas in children, but the emotional impact of this adversities are often unappreciated, with the consequent impairment in children's development (Lubit, Rovine, Defrancisci, & Eth, 2003).

Bullying, an abuse form that has been increasing over time and can come in many ways, including physical, verbal, psychological, and, more recently, cyberbullying, can be considered a trauma that many children experience during childhood (Alberdi-Paramo et al., 2020). Given the high prevalence of divorce and the large number of families affected each year, it is important to understand how parental divorce affects children's development. There is evidence that children whose parents have divorced are at higher risk of lower academic accomplishment, more social issues, including instability on interpersonal relationships, and higher levels of behavior problems. However, the majority of these children do not experience long – term negative outcomes. (Lansford, 2009).

CASE

Identifying information – He is an 18 year old, single man from Mexico who was referred by his neurologist to the department of psychiatry due to anxiety and depressive symptoms, and increased hostility and aggressive thoughts against others with multiple fights since he was 14 years old.

Pertinent historical and traumatic information – Regarding medical records, he has a history of seizures since he was 1 year old, given the epilepsy diagnosis until he was 6 years old, moment when treatment was initiated with magnesium valproate, suspended at age 14 when the last EEG result was normal.

The patient has a history of traumatic events, beginning in childhood when bullying by

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peers started, so he had to find a way to protect himself against this bullying, so his started with physical assaults towards kids who used to bully him. Furthermore, the patient has a record of pyromania and cruelty towards animals that started in childhood and stopped when violence initiated. These physical assaults became a usual activity in the patient, that he used to seek these fights at the slightest provocation. This violence became ego – syntonic to the patient, to the extent that he had to fight to have certain sense of pleasure and these fights were something so common that he used to fight every weekend. This violence suddenly moved towards his sexual relationships, when the patient started being aggressive with his couples, creating an intense pleasure in him and making him more and more excited when him and his couple used violence or aggressive sexual acts. His sexual fantasies revolve around aggression, having control of the situation, being able to use his force to feel the rush of adrenaline of having control, in addition to getting his anger out through physical punishments towards the other person and seeing blood during sexual intercourse, the latter being the only fantasy he has not made because of fear of not being able to control himself and consider it extreme. On the contrary, when the patient was the receptor of aggression and subjected by his couple, he felt afraid of becoming even more angry and losing control.

In addition to these violence, the patient suffered the divorce of his parents, being witness of the multiple fights his fathers had, not knowing the real reason of the divorce and constantly blaming himself of being the cause of the divorce due to his epilepsy, thinking that he stole time from his parents because they had to take care of him. The divorce affected daily life activities, such as playing with friends, so the patient started to isolate from his family and started passing most of the time in his room. During the divorce process, he started writing letters to himself where he stated his emotions and having thoughts that he would be better dead, being these the only way that he could express and communicate his emotions, since he had not the confidence to express It to his parents, because they tend to underestimate and invalidate his emotions, specially his father, making comments like he had been through a lot and if he can, the patient certainly can make it through.

Assessment – During the assessment, we used the Structured Interview of Personality Organization – Revised (STIPO – R) and contains 55 items divided in 5 domains: identity, object relations, Defensive mechanisms, aggression, and moral values. In the identity domain, we found that the patient has a poor integrated identity of himself and others, with superficiality, instability, and distortion, evident in the way the patient see himself, mostly negative with few adjectives and finding difficult to express about himself and others, with a moderate capacity to invest in academics and job options not congruent with his studies. Concerning the object relations domain, affective bonds are few and very superficial, he sees relationships in terms of fulfillment of personal needs, low capacity for empathy, he can show efforts to seek

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intimacy, but has developed few or nonintimate relationships. He also is unable to associate sex, tenderness, and love. Regarding defensive mechanisms, he has a consistent use of split base defenses, with changes in self – perception and others. In the aggression domain, he evidenced poor control of aggression towards others, with verbal and physical threats of harming himself or others, and pleasure in hurting or controlling others in a hostile way. With respect to moral domain, he has been involved in some unethical activities such as fights. Given this assessment, we concluded that the patient is in a Middle level of Borderline Personality Organization (BPO).

According to DSM – 5, the patient fulfills the criteria for Borderline personality disorder, since he shows a pattern of instability in relationships, characterized by shifts between idealization and devaluation, in addition to superficial bonds characterized by the necessity of fulfilment of personal need, showing also fear of abandonment, affective dysregulation (dysphoria and occasional anxiety), identity pathology, inappropriate anger with difficulty controlling it, paranoid ideation made evident by distrust in others, with chronic ideas of death.

Discussion

There are different theories about the possible etiologies of BPD, which suggest that BPD may be the outcome of multiple interactions between biological, especially temperamental vulnerabilities and traumas or adverse situations in childhood, and psychosocial factors. Another important factor is when children develop in an invalidating environment, where there is a trend to private from emotions expression during this stage. Therefore, children that are constantly exposed to this kind of adverse experiences show difficulties in learning how to manage emotional responses such as identify, control, or understand emotions, which leads children to show either emotional inhibition or extreme lability (Cattane, Rossi, Lanfredi, & Cattaneo, 2017).

Childhood traumas and adversities were highly related to a diagnosis of BPD and a predictor of multiple abuse types, including emotional abuse, withdrawal and denial, domestic violence and parental conflicts, divorce and early losses. Therefore, etiologies for BPD must center in multiple ways in the same direction, a confluence of neurobiological factors, environmental and social stressors, and family conflicts, and not focus on a single event or risk factor for the development of BPD (Battle et al., 2004; Weaver & Clum, 1993).

Affective dysregulation may be a primordial aspect in the association between childhood adversities and BPD. In addition, a lack of social support and affective bonds from the principal caregivers may contribute to the development of symptoms of BPD (Cattane et al., 2017). Children are prone to multiple effects of trauma and violence exposure. Among the most

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common symptoms that children manifest are fear, anhedonia, and attention and learning impairments, and may vary according to the developmental stage, in adolescence, they have similar reactions to adults, and include numbing and withdrawal, and hyperarousal (Lubit et al., 2003).

Suicide attempts and completed suicide are highly prevalent among psychiatric patients and is very common among patients with BPD. Adversities in early stages of life are related to suicidal risk. In the development of suicidal ideation among adults who had adversities and traumatic experiences during childhood, BPD has a mediating role, which has a strong relationship between emotional neglect or abuse and suicide potential. Therefore, a combination of affective dysregulation and impair cognitions may contribute to the link between suicide and childhood maltreatment (Bach & Fjeldsted, 2017; Newnham & Janca, 2014).

Conclusion

In conclusion, traumatic experiences such as physical, sexual, or emotional abuse, parental conflicts and divorce, bullying, among others, are common among psychiatric patients, especially in patients with Borderline Personality Disorder, and may play a role in the development of this disorder. Trauma can express in a variety of forms and symptoms depending of the developmental stage, including fear or anhedonia, and may have an impact on the development of identity and self – perception, as well as in social skills and stability of interpersonal relationships and affective regulation. Suicide is another major aspect in Borderline Personality Disorder and is one of the principal causes of death among adolescents and early adulthood, where BPD is more prevalent. There is a possible association between suicide potential and emotional neglect and withdrawal. However, literature related to trauma and borderline personality disorder and etiology are scarce, and the confluence of multiple risk factors (trauma, environment, social, neurobiological) need to be taken into account for the development of this disorder.

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