Link Among Trauma Symptoms, Trauma History, and Borderline Personality Disorder in Adolescents

Amanda Venta, B.A., Robyn Kenkel-Mikelonis, B.S., & Carla Sharp, Ph.D.
University of Houston

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Background

Many studies, including Zanarini, Dubo, Lewis, and Williams (1997) suggest a strong link between borderline personality disorder (BPD) in adulthood and childhood trauma with as many as 85% of BPD patients reporting a history of trauma. For instance, Battle et al. (2004) estimated that the prevalence rate of sexual trauma in BPD diagnosed inpatient as well as outpatient samples could be as high as 75%. Rates of maltreatment have been found as high as 90% in BPD patients (Zanarini et al., 1997). Furthermore, there is a fair amount of research that suggests that sexual abuse was reported more frequently in the history of adult patients with BPD than any other disorder (Herman et al.1989; Otaga et al. 1990; Paris et al. 1994).

As such, it has been suggested that childhood trauma, particularly childhood sexual trauma, may be a factor in the development of BPD (Guzder, Paris, Zelkowitz, & Feldman, 1999; Zanarini et al., 1997). However, most studies in this area are retrospective in nature and virtually no studies have examined the concurrent link between trauma symptoms, actual trauma and BPD features in adolescents. One exception is Horesh, Sever, and Apter (2003) who demonstrated that childhood sexual abuse discriminated between BPD patients and psychiatric controls.

Aims

Despite the strong link between BPD and trauma in the existing adult literature, little is known about the link between trauma symptoms and borderline features in adolescents. Moreover, virtually nothing is known about how different aspects of trauma relate to BPD features and whether trauma symptoms relate to actual trauma history. Against this background, the first aim of this study was to determine the relation between BPD and sexual trauma among inpatient adolescents and explore which aspects of trauma pathology are uniquely associated with BPD. The second aim was to determine whether the trauma symptoms endorsed by BPD adolescents were associated with actual trauma history.

Table 1. ***Independent Sample t-tests by BPD Status***

	No BPD (n = 113) M (SD)	BPD (n = 34) M (SD)	t
Age	16.06 (1.44)	15.98 (1.48)	0.29
TSCC Anxiety	51.85 (11.36)	54.50 (19.04)	-0.77
TSCC Depression	56.11 (12.80)	60.56 (18.77)	-1.58
TSCC Anger	48.25 (8.77)	51.59 (17.21)	-1.09
TSCC Post-traumatic Stress	52.03 (10.46)	53.29 (17.35)	-0.41
TSCC Dissociation	52.75 (11.81)	56.53 (19.03)	-1.10
TSCC Sexual Concerns	56.93 (16.82)	69.23 (31.89)	-2.17*

Note. TSCC = Trauma Symptom Checklist for Children *$p < .05$.

Participants

This study explored a sample of 147 adolescents recruited from a 16-bed adolescent inpatient unit which serves adolescents with severe psychiatric disorders.

Measures

The Childhood Interview for DSM-IV Borderline Personality Disorder (CI-BPD; Zanarini, 2003) is a semi-structured interview that assesses DSM-IV BPD in children and adolescents.

The Trauma Symptom Checklist (TSCC; Briere, 1996) is a 54 item self-report measure that evaluates posttraumatic symptomatology in children and adolescents. This scale does not measure whether actual trauma occurred or not. Instead, it measures potential pathological reactions in response to trauma. It therefore includes 6 clinical subscales including anxiety, depression, posttraumatic stress, sexual concerns, dissociation, and anger.

The Computerized Diagnostic Interview Schedule for Children (C-DISC; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000) is a highly structured clinical interview used to diagnose psychiatric disorders in children and adolescents. For the purposes of this study, only the question assessing a history of sexual trauma was considered.

Results

Our first aim was to investigate the relation between trauma symptoms and BPD status. Participants were assigned to a BPD (n = 34) or No BPD (n = 113) group and a series of independent sample t-tests with BPD status as independent variable and age and trauma subscales as dependent variables were conducted. The sexual concerns subscale was the only subscale on which BPD subjects differed from psychiatric controls (t = -2.17, p = .000). To examine possible confounding variables, we computed the Pearson chi-square between sex and BPD status (X^2 = 12.06, p = .001). Because this relation proved significant, sex was controlled for in subsequent analyses. Next, both sex and TSCC Sexual Concerns were entered as predictor variables into a binary logistic regression analysis with BPD status as the outcome variable and the TSCC Sexual Concerns subscale retained significance (B = 0.022, $p < .016$) even after controlling for sex (B = -1.53, $p < .002$).

The second aim was to determine whether the trauma symptoms endorsed by BPD adolescents associate with their trauma history. 14.3% of our sample endorsed sexual trauma. The Pearson chi-square was conducted in order to determine the relation between sexual trauma and BPD status (X^2 = 9.48, p = .002). Adolescents who had experienced past sexual trauma made up 52.6% of the BPD group and 17.5% of the non-BPD group. Binary logistic regression was again conducted, this time with sex, TSCC Sexual Concerns, and the sexual trauma item as predictor variables. The TSCC Sexual Concerns subscale (B = 0.024, p = .042) and sexual trauma history item (B = 1.26, p = .039) retained significance, though sex did not.

Conclusions

Adolescents with BPD are more likely to have experienced sexual trauma than other inpatients but the higher prevalence of sexual trauma in the BPD group does not completely account for their greater endorsement of sexual concerns.

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