

Developmental Antecedents of Borderline Personality Disorder

Margareth I. Helgeland and Sverre Torgersen

Developmental antecedents of borderline personality disorders (BPDs) were examined in 25 DSM-IV–diagnosed subjects with BPD and 107 non-borderline control subjects on the basis of medical records and 28 years follow-up. Abuse, neglect, environmental instability, paternal psychopathology, and lower score on protective factors differentiated significantly between the groups. Environmental instability and lower score on protective factors such as artistic talents, superior school performance, above average intellectual skills, and talents in other areas were found to be indepen-

dent predictors of BPD diagnosis. The results of this study suggest that both abuse and neglect, unpredictable and unstable early environment, as well as deficit in protective factors may substantially contribute to the development of BPD in persons constitutionally predisposed for the disorder. The results of the study also suggest that future research should address the impact of social and cultural context, as well as the absence of protective factors, on the development of the BPD.

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THE ETIOLOGY of borderline personality disorder (BPD) has been a focus of research for more than 25 years. The first attempts to explain its pathogenesis were offered by the psychoanalytic theories of Kernberg,¹ Masterson and Rinsley,² and Adler and Buie.³ The authors respectively suggested excessive aggression, either inborn or caused by frustration, parental hindrance of child's strivings for independence and separation, and parental lack of empathy as factors substantially contributing to the development of borderline pathology.

A vast number of empirical studies that followed described a fairly consistent picture of several developmental antecedents of the disorder. These include traumatic experiences, such as sexual abuse⁴⁻¹² and physical abuse,^{9,13} and histories of prolonged early separation and loss through parental divorce and illness.^{4,11-16} Other studies have also described borderlines having been exposed to domineering, cold, and sadistic parental attitudes,¹⁷ and to emotionally neglecting, overprotective, and controlling parenting.^{11-13,18,19}

Several studies delineate parental psychopathology as another antecedent of BPD. BPD itself, antisocial personality disorder, substance abuse,

depression, and anxiety have been found to be over-represented in parents of borderlines.²⁰⁻²⁵ Trull²⁶ reported that parental mental illness and lifetime axis I disorders were in fact significant and unique predictors of BPD. However, several studies emphasize not only the relevance of traumatic and adverse life events in the development of BPD, but also the importance of a broader family context in which the traumatic events take place. They report on borderlines being raised in extremely chaotic families and chronically disturbed households where they often live with caretakers trying to cope with multiple hardships. In addition, they report that borderlines often experience physical and sexual abuse occurring in a context of grossly inappropriate parental behavior, disrupted attachments, neglect and rejection.^{4,27,28} Zanarini et al.⁵ emphasized that traumatic experiences in childhood and adolescence of borderlines often occur in a context of an extensive family dysfunction where parents with significant psychopathology fail to establish secure and predictable family context by not protecting children against trauma, or by being themselves the perpetrators. Thus, the accounts of the etiology of BPD need to be embedded in an understanding of a larger context of the borderline's family conditions.

It is essential, however, to keep in mind that the studies of developmental antecedents of BPD are almost solely based on the childhood recollections of adults with BPD. Obviously, the validity of such data is problematic due to retrospective bias.

Paris²⁹ claimed that prospective longitudinal follow-up studies are required in order to determine the true relationship between developmental antecedents and BPD, but such studies are both expensive and time-consuming.

From the Department of Psychology, University of Oslo, Oslo; and the Sogn Center for Child and Adolescent Psychiatry, Oslo, Norway.

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Address reprint requests to Margareth I. Helgeland, Ph.D., Department of Psychology, University of Oslo, PO Box 1094, Blindern, 0317 Oslo, Norway.

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Our study, which compares developmental antecedents in a sample of reliably diagnosed BPD subjects and non-borderline controls on the basis of medical records and 28 years follow-up, offers an approach that may fill the void between these two methodologies. The fact that information on our subjects was gathered 21 to 40 years ago, near in time to actual events or at the time of the actual events, reduces substantially the problems of the retrospective methodology.

The aim of this study was to investigate which developmental factors in childhood and adolescence were antecedent to the development of BPD in adulthood. Based on existing research, we expected the following hypotheses to be confirmed: (1) subjects with BPD would have developmental histories characterized by a significantly higher incidence of traumatic factors like neglect, abuse, loss, rejection, and separation than subjects with no BPD diagnosis; (2) a history of family conflict, parental overprotection and control, and parental psychopathology would be significantly more common in the histories of BPD subjects than it would be in histories of subjects with no BPD diagnosis; and (3) subjects with BPD would be significantly more likely than non-borderline controls to have had histories of growing up in chaotic and unstable family contexts. In addition, we intended to examine whether BPD subjects would differ from controls on other developmental variables such as physical dysfunctions, neurological dysfunctions, and obstetric factors.

As our study also includes a small subsample of recovered BPD subjects, an investigation of differences between the recovered and nonrecovered BPD patients on variables addressed by the study is also offered.

METHOD

Subjects and Procedures

The subjects were recruited from a population of 1,018 adolescent patients consecutively admitted to the adolescent unit at The National Center for Child and Adolescent Psychiatry (NCCAP) in Oslo, Norway, from 1963 to 1978. The population consisted of 553 men (54.3%) and 465 women (45.7%).

On the basis of examination of the NCCAP's register of diagnoses, 93 patients with a diagnosis of organic brain syndrome and 35 patients with no diagnosis due to short stay were excluded from the study.

At the time of follow-up (1998 to 2000), 143 subjects were identified as deceased, 59 had immigrated, 17 could not be identified, and 24 had untraceable addresses according to the Norwegian Central Register of Persons.

In all, 371 subjects were initially excluded from the study. The remaining 647 subjects were approached by mailed request and asked to voluntarily participate in a follow-up study. The subjects were asked to sign a written informed consent and to return it by mail together with an address and a telephone number where they would be available for an interview appointment. The subjects were assured that their anonymity and confidentiality would be upheld. They were also informed about their right to withdraw from participation in the study at any time.

The study had been approved by the institutional Ethics Review Committee.

Four hundred forty-five subjects did not respond to the request, while eight subjects expressed, either by letter or phone, their disapproval of being contacted.

One hundred ninety-four (30%) subjects agreed to participate in the study. Of these, 33 cancelled the interview appointment. For unknown reasons, seven subjects did not show up for the interview. Fourteen subjects were unavailable at the address or the phone number stated in the written informed consent and were further impossible to localize. Two subjects were too disturbed to be interviewed. Finally, 148 subjects, 77 men and 71 women, were interviewed. Judged from the diagnoses in the NCCAP's register of diagnoses, these 148 subjects were diagnostically representative of the original sample. Only the diagnostic groups defined as "Neuroses" and "Psychoses" were over-represented (57.8% in the interviewed group compared to 41.3% in the not-interviewed group, $\chi^2 = 15.11$, $P = .0001$), and adolescents from the diagnostic group defined as "Drug abusers" were slightly under-represented in the final sample (2.0% compared to 9.6%, $\chi^2 = 9.45$, $P = .002$).

For the purpose of this study, 13 subjects with diagnosis of schizophrenia at the follow-up were excluded from the total sample. Assessment of personality disorders in a person with schizophrenia is difficult, if not impossible, since the diagnoses of personality disorders are based on the person's usual way of behaving, independent of symptom disorders, medication, medical illness, or other confounding factors. Three subjects whose hospital records could not be traced were also excluded from the study.

The final sample consisted of 132 subjects, 62 (47%) men and 70 (53%) women, with a mean age of 14.5 years (SD 1.3) at admission and 43.2 years (SD 4.2) at the follow-up. The mean length of stay during the index hospitalization was 29 weeks (SD 28; range, 2 to 136). The mean interval between admission and follow-up was 27.9 years (SD 3.8; range, 21 to 38).

The follow-up interviews were performed by the first author. All interviews were conducted in person except for two, which were completed by phone. The interviewer was blind to subjects' diagnoses from the NCCAP. According to the subjects' preferences, the interviews were conducted at their homes, at the University of Oslo, at mental health care institutions, or in prison. The average duration of each interview was 4.5 hours. Each follow-up interview consisted of administration of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)³⁰ and the Structured Interview for DSM-IV Personality (SIDP-IV).³¹ Thirty interviews were recorded on audiotape for an assessment of inter-rater reliability of the diagnoses.

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