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Prevalence and Severity of Childhood Adversity in Adolescents with BPD, Psychiatrically Healthy Adolescents, and Adults with BPD

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Abstract

Objective—Existing research has demonstrated that both adolescents and adults with borderline personality disorder (BPD) report higher rates of childhood adversity than their same-age peers; no studies have examined if adolescents and adults with BPD differ based on the extent of these experiences. In the present study, we compared the prevalence rates and severity of multiple forms of abuse and neglect in adolescents and adults with BPD and in psychiatrically healthy adolescents.

Methods—Participants included 104 adolescent (aged 13–17 years) inpatients with BPD, 60 age-matched, psychiatrically healthy adolescents, and 290 adult inpatients with BPD. All participants completed an interview that assessed the presence and severity of multiple forms of childhood abuse and neglect.

Results—A significantly higher percentage of adolescents with BPD reported 5 of 12 pathological childhood experiences and described more severe abusive experiences than their psychiatrically healthy peers. In comparison to adolescents with BPD, a significantly higher percentage of adults with BPD reported nearly all forms of childhood adversity and rated these experiences as more severe.

Conclusions—Taken together, these results suggest that adults with BPD report more severe profiles of abuse and neglect than adolescents with the disorder, even though adolescents with BPD differ from healthy peers.

Keywords

Adolescence; borderline personality disorder; childhood adversity

The relationship between adversity in childhood and borderline personality disorder (BPD) in adulthood has been well-documented. Studies have consistently found patients with BPD are more likely to report histories of sexual, physical, verbal, and/or emotional abuse in childhood (Herman, Perry, & van der Kolk, 1989; Ogata et al., 1990; Helgeland & Torgersen, 2004; Goldman, D'Angelo, DeMaso, & Mezzacappa, 1992; Zanarini et al., 1997; Zanarini et al., 2002). Several studies also have indicated that adult patients with BPD are more likely to have had experiences with caretakers that were characterized by experiences of emotional neglect, such as inconsistent treatment, emotional withdrawal, role reversal, denial of feelings, lack of necessary protection, and/or prolonged separations (Berziganian, Cohen, & Brook, 1993; Carlson, Egeland, & Sroufe, 2009; Crawford, Cohen, Chen, Anglin, & Ehrensaft, 2009; Zanarini et al., 1997). Further, evidence from prospective studies suggests that these early experiences of maltreatment confer a specific risk for BPD (and other personality disorders) above that observed for other psychiatric outcomes (Cohen, Crawford, Johnson, & Kasen, 2005; Cohen, 2008; Johnson et al., 1999). Additionally, the severity of these pathological childhood experiences has been linked to the severity of BPD symptomatology and functional impairment in adulthood (Silk, Lee, Hill, & Lohr, 1995; Zanarini et al., 2002).

The relatively smaller body of literature on the childhood experiences of adolescents with BPD has largely mirrored the adult literature (see Winsper, Lereya, Marwaha, Thompson, Eyden, & Singh, 2016 for a review). In particular, studies have indicated that adolescents with BPD are more likely to report experiences of various forms of abuse and neglect when compared to adolescents from non-clinical and non-BPD clinical samples (Atlas, 1995; Horesh, Ratner, Laor, & Toren, 2008; Horesh, Sever, & Apter, 2003; Infurna et al., 2016; James, Berelowitz, & Vereker, 1996; Ludolph, Westen, Misle, Jackson, Wixom, & Wiss, 1990). Adolescents with BPD are also more likely to report experiences of harsh parenting practices (e.g., harsh punishment, low warmth, etc.) than those without BPD (e.g., Ludolph et al., 1990; Stepp, Whalen, Scott, Zalewski, Loeber, & Hipwell, 2014; Zweig-Frank & Paris, 1991), and emerging evidence suggests that this relationship between adolescent BPD symptoms and parental harshness appears to be bidirectional (Stepp et al., 2014).

Studies regarding the validity of BPD in adolescence have emphasized the importance of examining relevant clinical phenomena (e.g., comorbidity, risk factors) to assess the construct of BPD in adolescence in addition to symptoms alone (Sharp & Romero, 2007; Winsper et al., 2016). One way to assess validity is to examine a clinical correlate in adolescents believed to have BPD and in relevant comparison groups to determine the level of similarity between adult BPD vs. divergence from a normative adolescent trajectory. Given the prominence of childhood adversity as an identified risk factor for BPD, it is therefore important to examine the prevalence and severity of these experiences in multiple groups to fully assess the validity of the diagnosis in adolescence. Doing so also addresses two issues that are common in clinical care. The first is that many clinicians believe that what appears to be BPD in adolescents is just a particularly difficult phase of normal adolescence. The second is that many mental health professionals believe that adolescents can display serious traits of BPD but do not meet full criteria for the disorder. We address the first issue by comparing the childhood adversity reported by rigorously diagnosed adolescents with BPD to psychiatrically healthy adolescents in the same age range. We

address the second issue by comparing adolescents and adults with BPD concerning their reports of childhood adversity.

Method

The methodology of this study has been presented before in detail (Zanarini et al., in press). All study procedures were approved by the institutional review boards at the participating institutions. Briefly, all adults with BPD were inpatients at McLean Hospital in Belmont, Massachusetts who were admitted between June 1992 and December 1995. Each patient was initially screened to determine that he or she: 1) was between the ages of 18-35, 2) had normal or better intelligence, and 3) had no history or current symptomatology of a serious organic condition that could cause psychiatric symptoms, schizophrenia, or bipolar I disorder. Written informed consent was obtained from each patient. Three diagnostic interviews were administered by research staff blind to their clinical diagnoses. The instruments were: 1) the Structured Clinical Interview for DSM-III-R Axis I Disorders (SCID I; Spitzer, Williams, Gibbon, & First, 1992), 2) the Revised Diagnostic Interview for Borderlines (DIB-R; Zanarini, Gunderson, Frankenburg, & Chauncey, 1989), and 3) the Diagnostic Interview for DSM-III-R Personality Disorders (DIPD-R; Zanarini, Frankenburg, Chauncey, & Gunderson, 1987). The inter-rater and test-retest reliability of these measures have been found to be good-excellent (Zanarini et al, 2002; Zanarini & Frankenburg, 2001).

Adolescents (aged 13-17) with presumptive BPD were recruited from four units at McLean Hospital and one unit at the Ichan School of Medicine at Mount Sinai between the dates of August 2007 and September 2012. During the same timeframe, same-aged adolescents without a history of any psychiatric disorder were recruited using online advertisements. For adolescent participants, parents provided consent and adolescents provided assent. Adolescent participants, who all met the same exclusion criteria concerning intelligence and co-occurring disorders as adult participants, were then administered the following diagnostic assessments: 1) the Structured Clinical Interview for DSM-IV Childhood Diagnoses (KID-SCID; Matzner, Silva, Silvan, Chowdhury, & Nastari, 1997), 2) the Revised Diagnostic Interview for Borderlines (DIB-R; Zanarini et al., 1989), and 3) the Childhood Interview for DSM-IV Borderline Personality Disorder (CI-BPD; Sharp, Ha, Michonski, Venta, & Carbone, 2012).

Participants in all three groups were recruited in a consecutive manner based upon the order in which they were either admitted to the inpatient units or responded to the advertisement. In every group, **approximately** 90% of those approached agreed to participate in the study.

To assess pathological experiences reported to have occurred before age 18, all participants were administered the Revised Childhood Experiences Questionnaire (CEQ-R). The CEQ-R is a semi-structured interview whose psychometric properties have been described elsewhere (Zanarini et al., 1989). This instrument inquires about four forms of abuse and seven forms of neglect by full-time caretakers, sexual abuse by non-caretakers, three types of witnessed violence, and 12 types of separations from full-time caretakers lasting one month or more. For each type of experience, interviewers record a dichotomous rating to indicate the presence or absence of the experience during three periods in the participants' childhood: 0-5

years of age, 6-12 years of age, and 13-17 years of age. Separate ratings are provided for each caretaker on relevant items. For an item to be given a positive (present) rating, participants have to provide detailed information about the event. This instrument also yields five continuous scores representing the severity of each major type of pathological childhood experience: sexual abuse, other forms of abuse, neglect, witnessing violence, and early separations. These scores are derived by summing the total number of positive ratings for each type of experience across each age period and caretaker. For example, the maximum severity score for neglect is 42, because the presence/absence of seven different neglect experiences are assessed for three age periods and two caretakers, typically a subject's mother and father.

Statistical Analyses

Between-group differences in demographic variables were assessed using Student's t-test for continuous variables and Pearson chi-square for binary variables. Most analyses of the prevalence of pathological childhood experiences were conducted using logistic regression. However, Firth penalized logit methods (Firth, 1993) were used in analyses of four variables due to sparseness of data in both adolescent groups: caretaker's physical abuse, caretaker's sexual abuse, non-caretaker's sexual abuse, and caretaker's denial of patient's feelings. Analyses of the severity of childhood adversity were conducted using linear regression.

Analyses pertaining to our two groups of adolescents were conducted controlling for age. Analyses pertaining to comparisons of adolescents and adults with BPD were conducted controlling for sex and race.

Results

Participants

One hundred and four participants were adolescents between the ages of 13 and 17 who met DIB-R and DSM-IV criteria for BPD. Sixty psychiatrically healthy comparison subjects in the same age range. Two hundred and ninety subjects were adults between the ages of 18-35 who met DIB-R and DSM-III-R criteria for BPD.

Demographic characteristics have also been described (Zanarini et al., in press). Briefly, adolescents with BPD were significantly more likely to be female than either psychiatrically healthy adolescents or adults with BPD. However, adolescents with BPD were significantly more likely to be nonwhite than adults with BPD but were very similar to psychiatrically healthy adolescents in terms of race (about a third non-white). Adolescents with BPD were significantly older than psychiatrically healthy adolescents (by about a year) but significantly younger (as expected) than adults with BPD (by about 11 years). They also came from a significantly higher socioeconomic class than adults with BPD but about the same class as psychiatrically healthy adolescents. In terms of GAF scores, adolescents with BPD had significantly lower scores than psychiatrically healthy adolescents (by almost 40 points) and significantly lower scores (by about 4 points) than adults with BPD.

Pathological Childhood Experiences

Table 1 details the prevalence rates of pathological childhood experiences of abuse and neglect reported by adolescents with BPD, psychiatrically healthy adolescents, and adults with BPD. At the Bonferroni-corrected alpha level of 0.004, a significantly higher percentage of adolescents with BPD than psychiatrically healthy adolescents reported 5 of 12 specific pathological childhood experiences. More specifically, adolescents with BPD were more likely than psychiatrically healthy adolescents to report having experienced physical abuse from a caretaker, a caretaker's emotional withdrawal, inconsistent treatment from a caretaker, lack of a real relationship with a caretaker, and the experience of a caretaker placing them in a parental role. They were also significantly more likely to report any experience of neglect when compared to psychiatrically healthy adolescents. In comparisons between adolescents with BPD and adults with BPD, a significantly higher percentage of adults with BPD reported 11 of 12 of the experiences of abuse and neglect studied. The only exception to this pattern was caretaker's emotional withdrawal; for this experience, the between-group difference in prevalence was not significant. Adults with BPD were also significantly more likely to report any experience of abuse or neglect when compared with adolescents with BPD.

Comparisons of the severity of pathological childhood experiences reported by the three groups are detailed in Table 2. At the Bonferroni-corrected alpha level of 0.01, adolescents with BPD reported significantly greater severity than psychiatrically healthy adolescents with respect to experiences of sexual abuse, other abuse, neglect, and being a witness to violence. There was not a statistically significant difference in the severity of difficulties associated with early separations. Similarly, adults with BPD reported a significantly higher level of severity of the same set of pathological childhood experiences (i.e., sexual abuse, other abuse, neglect, and being a witness to violence) when compared to adolescents with BPD. As in the first set of comparisons, there was not a significant difference in the reported severity of early separations between adults and adolescents with BPD.

Discussion

This study yielded several findings pertaining to the role of childhood adversity in the pathogenesis of BPD in adolescence and adulthood. The first finding is that many (but not all) pathological childhood experiences were more common in adolescents with BPD when compared to their psychiatrically healthy peers. In particular, adolescents with BPD were significantly more likely to report experiencing verbal abuse from a caretaker. Additionally, adolescents with BPD were more likely to report several forms of neglect, including caretaker's emotional withdrawal, caretaker's inconsistent treatment, lack of a real relationship with a caretaker, and a caretaker placing them in a parental role. By contrast, the prevalence rates for experiences of emotional, physical, and sexual abuse did not differentiate the two groups of adolescents. Despite this, the two groups did differ significantly with regard to the severity of reported experiences of abuse, neglect, and being a witness to violence, with adolescents with BPD reporting more severe childhood adversity.

In general, these findings are consistent with recent research, with meta-analyses indicating that experiences of verbal abuse and neglect are robustly associated with increased odds of

BPD in adolescence (Winsper et al., 2016). By contrast, we did not find differences in prevalence between healthy adolescents and those with BPD on physical, emotional, and sexual abuse, despite other studies finding that these types of abuse are more common in adolescents with BPD than comparison subjects (e.g., Horesh et al., 2003; 2008; Ludolph et al., 1990). We did, however, find that severity of the experiences of all major forms of abuse and neglect discriminated between the two groups of adolescents, suggesting that abuse that is more chronic, perpetrated by multiple people, and/or varied in form may be more predictive of BPD rather than mere presence of an abusive experience in one's history.

The second major finding was that nearly all experiences of abuse and neglect were more prevalent in adults with BPD when compared to adolescents with the disorder. The only exception to this overall pattern was for the experience of caretaker's emotional withdrawal. Likewise, the severity of reported childhood experiences of abuse, neglect, and being a witness to violence was significantly greater for adults with BPD when compared to their adolescent counterparts.

These findings build on the existing literature by providing a direct comparison of adolescents and adults with BPD. In particular, although borderline adolescents differed from their same-age peers on the basis of childhood adversity, adults with BPD were still able to be distinguished from adolescents with BPD with respect to the prevalence and severity of experiences of abuse and neglect. There are several possible explanations for the differences observed between the two groups. First, by virtue of being of older age, the adult group had more years to accumulate experiences of childhood adversity. Second, because the adult data was collected approximately 20 years prior to the adolescent data, these differences may reflect a cohort difference in terms of parenting style and degree of intervention around abuse. Third, reports by both groups could have been impacted by recall bias, which may have contributed to either over- or underreporting experiences of childhood adversity. Recent studies have found that both types of biased recall are related to psychological well-being at the time of assessment, with depression, chronic stress, and increased distress related to greater inconsistencies in reporting (Colman et al., 2016). These factors may also have impacted patients' ability to report on past events. Additionally, adults with BPD may have had more time to reflect on their experiences as being normative vs. abusive, which may have impacted reports. In contrast, adolescents with BPD might have been habituated to experiences of childhood adversity. Additionally, they may have been afraid that reporting childhood adversity could lead to disruptions in their family or even removal from their parental home.

Some limitations must be considered when interpreting these findings. First, the BPD adolescents and adults were inpatients at the time of assessment; thus, findings may not generalize to less severely ill patients with BPD. Second, information on pathological childhood experiences was collected via retrospective self-report. However, participants had to provide detailed vignettes of experiences, and ambiguous accounts were not counted. Finally, there were some issues with sparseness of data in some comparisons of pathological childhood experiences between adolescents with BPD and psychiatrically healthy adolescents (i.e., some experiences were very rare or non-existent in one or both groups). Although we accounted for this sparseness with appropriate statistical modeling techniques

(i.e., Firth penalized logit), some between-group differences in prevalence may be underestimated. Future research on this topic may benefit from examining the relationship between severity of childhood adversity and severity of BPD symptoms and impairment in psychosocial functioning.

Taken together, these results suggest that adults with BPD report more severe profiles of abuse and neglect than adolescents with the disorder, even though adolescents with BPD differ from healthy peers on the basis of childhood adversity.

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References

- Atlas JA. Association between history of abuse and borderline personality disorder for hospitalized adolescent girls. *Psychological Reports*. 1995; 77:1346.doi: 10.2466/pr0.1995.77.3f.1346 [PubMed: 8643803]
- Bezirgianian S, Cohen P, Brook JS. The impact of mother-child interaction on the development of borderline personality disorder. *American Journal of Psychiatry*. 1993; 150:1836–1842. DOI: 10.1176/ajp.150.12.1836 [PubMed: 8238639]
- Carlson EA, Egeland B, Sroufe LA. A prospective investigation of the development of borderline personality symptoms. *Development and Psychopathology*. 2009; 21:1311–1334. DOI: 10.1017/S0954579409990174 [PubMed: 19825270]
- Chanen AM, Jackson HJ, McGorry PD, Allot KA, Clarkson V, Yuen HP. Two-year stability of personality disorder in older adolescent outpatients. *Journal of Personality Disorders*. 2004; 18:526–541. DOI: 10.1521/pedi.18.6.526.54798 [PubMed: 15615665]
- Cohen P, Crawford TN, Johnson JG, Kasen S. The children in the community study of developmental course of personality disorder. *Journal of Personality Disorders*. 2005; 19:466–486. DOI: 10.1521/pedi.2005.19.5.466 [PubMed: 16274277]
- Cohen P. Child development and personality disorder. *Psychiatric Clinics of North America*. 2008; 31:477–493. DOI: 10.1016/j.psc.2008.03.005 [PubMed: 18638647]
- Colman I, Kingsbury M, Garad Y, Zeng Y, Naicker K, Patten S, Jones PB, et al. Thompson AH. Consistency in adult reporting of adverse childhood experiences. *Psychological Medicine*. 2016; 46:543–549. DOI: 10.1017/S0033291715002032 [PubMed: 26511669]
- Crawford TN, Cohen PR, Chen H, Anglin DM, Ehrensaft M. Early maternal separation and the trajectory of borderline personality disorder symptoms. *Development and Psychopathology*. 2009; 21:1013–1030. DOI: 10.1017/S0954579409000546 [PubMed: 19583895]
- Firth D. Bias reduction of maximum likelihood estimates. *Biometrika*. 1993; 80:27–38.
- Goldman SJ, D'Angelo EJ, DeMaso DR, Mezzacappa E. Physical and sexual abuse histories among children with borderline personality disorder. *The American Journal of Psychiatry*. 1992; 149:1723–1726. DOI: 10.1176/ajp.149.12.1723 [PubMed: 1443251]
- Helgeland M, Torgersen S. Developmental antecedents of borderline personality disorder. *Comprehensive Psychiatry*. 2004; 45:138–147. DOI: 10.1016/j.comppsy.2003.09.001 [PubMed: 14999665]
- Herman JL, Perry JC, van der Kolk BA. Childhood trauma in borderline personality disorder. *American Journal of Psychiatry*. 1989; 146:490–495. DOI: 10.1176/ajp.146.4.490 [PubMed: 2929750]
- Horesh N, Ratner S, Laor N, Toren P. A comparison of life events in adolescents with major depression, borderline personality disorder and matched controls: A pilot study. *Psychopathology*. 2008; 41:300–306. DOI: 10.1159/000141925 [PubMed: 18594165]

- Horesh N, Sever J, Apter A. A comparison of life events between suicidal adolescents with major depression and borderline personality disorder. *Comprehensive Psychiatry*. 2003; 44:277–283. DOI: 10.1016/S0010-440X(03)00091-9 [PubMed: 12923705]
- Infurna MR, Brunner R, Holz B, Parzer P, Giannone F, Reichl C, et al. Kaess M. The specific role of childhood abuse, parental bonding, and family functioning in female adolescents with borderline personality disorder. *Journal of Personality Disorders*. 2015; 30:177–192. DOI: 10.1521/pedi_2015_29_186 [PubMed: 25905734]
- James A, Berelowitz M, Vereker M. Borderline personality disorder: A study in adolescence. *European Child & Adolescent Psychiatry*. 1996; 5:11–17.
- Johnson JG, Cohen P, Brown J, Smailes E, Bernstein DP. Childhood maltreatment increases risk for personality disorders during early adulthood. *Archives of General Psychiatry*. 1999; 56:600–606. [PubMed: 10401504]
- Ludolph PS, Westen D, Mistle B, Jackson A, Wixom J, Wiss FC. The borderline diagnosis in adolescents: Symptoms and developmental history. *American Journal of Psychiatry*. 1990; 147:470–476. DOI: 10.1176/ajp.147.4.470 [PubMed: 2316734]
- Matzner F, Silva R, Silvan M, Chowdhury M, Nastari L. Preliminary Test-retest Reliability of the KID-SCID. Paper presented at the annual meeting of the American Psychiatric Association. 1997
- Ogata SN, Silk KR, Goodrich S, Lohr NE, Westen D, Hill EM. Childhood sexual and physical abuse in adult patients with borderline personality disorder. *American Journal of Psychiatry*. 1990; 147:1008–1013. DOI: 10.1176/ajp.147.8.1008 [PubMed: 2375434]
- Sharp C, Romero C. Borderline personality disorder: A comparison between children and adults. *Bulletin of the Menninger Clinic*. 2007; 71:85–114. [PubMed: 17666001]
- Silk KR, Lee S, Hill EM, Lohr NE. Borderline personality disorder and severity of sexual abuse. *American Journal of Psychiatry*. 1995; 152:1059–1064. DOI: 10.1176/ajp.152.7.1059 [PubMed: 7793443]
- Spitzer RL, Williams JB, Gibbon M, First MB. The Structured Clinical Interview for DSM-III-R (SCID). I: History, rationale, and description. *Archives of General Psychiatry*. 1992; 49:624–629. [PubMed: 1637252]
- Steff S, Whalen D, Scott L, Zalewski M, Loeber R, Hipwell A. Reciprocal effects of parenting and borderline personality disorder symptoms in adolescent girls. *Development and Psychopathology*. 2014; 26:361–378. DOI: 10.1017/S0954579413001041 [PubMed: 24443951]
- Winsper C, Lereya ST, Marwaha S, Thompson A, Eyden J, Singh SP. The aetiological and psychopathological validity of borderline personality disorder in youth: A systematic review and meta-analysis. *Clinical Psychology Review*. 2016; 44:13–24. DOI: 10.1016/j.cpr.2015.12.001 [PubMed: 26709502]
- Zanarini MC, Frankenburg FR. Attainment and maintenance of reliability of axis I and II disorders over the course of a longitudinal study. *Comprehensive Psychiatry*. 2001; 42:369–374. [PubMed: 11559863]
- Zanarini MC, Frankenburg FR, Chauncey DL, Gunderson JG. The Diagnostic Interview for Personality Disorders: interrater and test-retest reliability. *Comprehensive Psychiatry*. 1987; 28:467–480. [PubMed: 3691072]
- Zanarini MC, Frankenburg FR, Vujanovic AA. Interrater and test-retest reliability of the Revised Diagnostic Interview for Borderlines (DIB-R). *Journal of Personality Disorders*. 2002; 16:270–276. [PubMed: 12136682]
- Zanarini MC, Gunderson JG, Frankenburg FR, Chauncey DL. The Revised Diagnostic Interview for Borderlines: discriminating BPD from other Axis II disorders. *Journal of Personality Disorders*. 1989; 3:10–18.
- Zanarini MC, Gunderson JG, Marino MF, Schwartz EO, Frankenburg FR. Childhood experiences of borderline patients. *Comprehensive psychiatry*. 1989; 30:18–25. [PubMed: 2924564]
- Zanarini MC, Williams AA, Lewis RE, Reich RB, Vera SC, Marino MF, Levin A, et al. Frankenburg FR. Reported pathological childhood experiences associated with the development of borderline personality disorder. *American Journal of Psychiatry*. 1997; 154:1101–1106. [PubMed: 9247396]
- Zanarini MC, Yong L, Frankenburg FR, Hennen J, Reich DB, Marino MF, Vujanovic AA. Severity of reported childhood sexual abuse and its relationship to severity of borderline psychopathology and

psychosocial impairment among borderline inpatients. *Journal of Nervous and Mental Disease*. 2002; 190:381–387. [PubMed: 12080208]

Zweig-Frank H, Paris J. Parents' emotional neglect and overprotection according to the recollections of patients with borderline personality disorder. *American Journal of Psychiatry*. 1991; 148:649–651. DOI: 10.1176/ajp.148.5.648

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Pathological Childhood Experiences Reported by Adolescents with BPD, Psychiatrically Healthy Adolescents, and Adults with BPD

Table 1

Childhood Experience	Adolescent BPD		Psychiatrically Healthy Adolescents		Adult BPD		Adolescent BPD vs. Healthy Adolescents		Adult BPD vs. Adolescent BPD	
	%	N	%	N	%	N	OR	P-value	OR	p-value
Any abuse	85.5	91	8.3	5	97.3	282	2.07	0.111	5.21	0.001 *
Caretaker's emotional abuse	26.9	28	6.7	4	71.4	207	5.20	0.005	7.11	<0.001 *
Caretaker's verbal abuse	41.3	43	5.0	3	75.6	220	12.71	<0.001 *	4.29	<0.001 *
Caretaker's physical abuse	26.0	27	0	0	58.6	170	3.74	0.010	4.70	<0.001 *
Caretaker's sexual abuse	2.9	3	0	0	28.6	83	1.43	0.366	16.30	<0.001 *
Noncaretaker's sexual abuse	20.2	21	0	0	56.9	165	3.35	0.021	5.96	<0.001 *
Any neglect	74.0	77	15.0	9	90.7	263	13.19	<0.001 *	4.15	<0.001 *
Caretaker's physical neglect	12.5	13	5.0	3	27.2	79	3.04	0.109	2.88	0.001 *
Caretaker's emotional withdrawal	36.5	38	6.7	4	53.1	154	8.99	<0.001 *	1.96	0.006
Caretaker's inconsistent treatment	28.9	30	1.7	1	53.1	154	25.54	0.002 *	2.65	<0.001 *
Caretaker's denial of patient's feelings	36.5	38	0	0	71.4	207	4.16	0.004	4.25	<0.001 *
Lack of real relationship with caretaker	29.8	31	3.3	2	66.6	193	12.89	0.001 *	4.66	<0.001 *
Caretaker's placing patients in parental role	37.5	39	6.7	4	61.7	179	7.56	<0.001 *	2.85	<0.001 *
Caretaker's failure to protect patient	19.2	20	1.7	1	59.3	172	13.49	0.013	6.97	<0.001 *

Note: Logistic regression analyses were adjusted for age for comparisons of BPD adolescents vs. healthy adolescents and were adjusted for sex and race for comparison between BPD adults vs. BPD adolescents. Firth logit method was used for analyses of caretaker's physical abuse, caretaker's sexual abuse, non-caretaker's sexual abuse, and caretaker's denial of patients feelings.

* Bonferroni Correction for multiple comparison: $p < 0.004$, OR = odds ratio.

Table 2
Severity of Childhood Experiences Reported by Adolescents with BPD, Psychiatrically Healthy Adolescents, and Adults with BPD

Severity of Childhood Experience	Adolescent BPD		Psychiatrically Healthy Adolescents		Adult BPD		Adolescent BPD vs. Healthy Adolescents		Adult BPD vs. Adolescent BPD	
	Mean	SD	Mean	SD	Mean	SD	t	P-value	t	p-value
Sexual Abuse	0.3	0.7	0	0	1.8	2.1	2.97	0.003 *	7.23	<0.001 *
Other Abuse	2.1	3.1	0.2	0.7	7.2	0.3	4.24	<0.001 *	9.03	<0.001 *
Neglect	5.6	6.7	0.4	1.3	14.6	10.7	5.09	<0.001 *	3.72	<0.001 *
Witness to violence	1.7	2.0	0.4	0.8	3.4	2.5	4.56	<0.001 *	6.65	<0.001 *
Early Separation	1.0	3.6	0.5	1.1	0.9	2.8	1.03	0.306	0.44	0.658

Note: Linear regression analyses were adjusted for age for comparison between BPD adolescents vs. healthy adolescents and were adjusted for sex and race for comparison between BPD adults vs. BPD adolescents.

* Bonferroni Correction for multiple comparison: $p < 0.01$.