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Commentary - Borderline personality disorder and sexual abuse: A systematic review

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Although sexual abuse (SA) is known to be frequent among borderline personality disorder (BPD) patients, few reviews or meta-analysis examining that topic have been published. The aim of our study[1] was to investigate SA history (including adulthood) as a predictor of BPD diagnosis, clinical presentation and prognosis. I will comment on our most relevant results.

We analyzed 40 papers. Eligibility criteria were described in the manuscript. Overall, SA played a major role in BPD, particularly in women. Childhood sexual abuse (CSA) was a relevant risk factor. To our knowledge, this is the first systematic review that showed higher rates of adult sexual abuse (ASA) in BPD compared with other personality disorders (PDs). Our review is also the first one to demonstrate the negative impact of CSA and ASA on BPD clinical presentation and prognosis.

Two longitudinal studies with sexually abused children presented mixed outcomes. WIDOM et al.[2] described possible explanations for the absence of significant association between CSA and BPD in their article: court cases may differ from CSA reported by BPD patients (usually minor or single incidents), women who seek treatment may have more CSA, and the relatively lower proportion of SA victims compared to other trauma may have led to limited power. CUTAJAR et al.[3] found statistical significance only in the female sex, which represented 80.1% of the sample and was 7.62 times more likely to develop BPD than healthy controls. On the other hand, BIERER et al.[4], in their cross-sectional paper, reported a statistical trend between BPD and CSA only in males, which represented 64.9% of the sample.

Analyzing the relationship between BPD and type of CSA, MERZA et al.[5] concluded that genital fondling and penetration were strong predictors of BPD, but not oral sex or anal penetration. This finding resembles that of the meta-analysis of FOSSATI et al.[6], in which BPD was associated with genital fondling and penetration, but not with oral sex. One possible explanation for these findings is that our sexuality is culturally linked to the genitalia, so acts involving oral or anal regions are less likely to be interpreted by the children as sexual abuse and causes less impact on mental health.

By relating BPD to the age of occurrence of CSA and the profile of the abuser, articles showed divergent results. ZANARINI et al.[7] compared BPD with other PDs and found an association between

BPD and CSA by non-caregiver, but not between BPD and CSA by the caregiver. On the other hand, LAPORTE and GUTTMAN[8], when comparing BPD, anorexia nervosa and healthy controls, revealed a correlation between BPD and CSA at an earlier age and BPD and intrafamilial CSA, but not between BPD and extrafamilial CSA. These findings differ from those of the meta-analysis of FOSSATI et al.[6], who reported a statistically more significant relationship between BPD and adolescence/extrafamilial SA than between BPD and childhood/intrafamilial SA.

Among clinical presentation or prognosis variables, suicidality was the most studied. BPD patients with CSA had a 10-fold increased risk of a history of suicide attempt than BPD patients without CSA[9,10]. Several papers have described statistical significance between suicide ideation or attempts and CSA in BPD[10,11,12,13,14,15,16]. Many researchers have found the correlation between CSA and suicidal behavior in adulthood[17,18,19,20].

Some results from the included articles suggest a dose-response relationship between CSA and clinical presentation of BPD. The severity of CSA or the co-occurrence of physical and SA in childhood were related to self-mutilation episodes[14,15] and suicide attempts[10,13,14,15]. Other authors have already revealed a dose-response effect of childhood trauma on self-injurious or suicidal behaviors in adulthood[21,22].

Previous studies reporting lower CSA rates in samples with less BPD traits or milder symptoms raise the hypothesis that there may also be a directly proportional relationship between BPD severity and positive history of CSA[23,24]. Another paper demonstrated a directly proportional relationship between the number of types of childhood trauma and the number of BPD symptoms[25].

Although CSA has been consistently associated with BPD, CSA rates in individuals with BPD may be overestimated, possibly because false memories and misinterpretations are more common in this population[26]. The scientific literature lacks more prospective articles about the prevalence and course and management effect for documented or corroborated SA cohorts. Future research also needs to further study prognosis variables and ASA, and include more men and milder BPD patients. It is also essential to clarify the clinical repercussions of CSA in the various presentations (e.g., intrafamilial versus extrafamilial) and age groups (childhood, latency, adolescence), as well as to investigate whether differences in CSA management (e.g., validate versus invalidate victim report) influence the association with BPD. The impact of other traumatic experiences, such as emotional abuse, should also be systematically reviewed.

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