IMPACT OF CHILDHOOD ABUSE ON ADULT PSYCHOPATHOLOGY: A CASE REPORT

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ABSTRACT

Post-traumatic stress disorder (PTSD), borderline personality disorder (BPD) and multiple personality disorder (MPD), although categorized separately in DSM-III-R *under anxiety disorder, personality disorder, and dissociative disorder, respectively, have each been shown to be associated with early childhood abuse. Many authors have noted the importance of determining the relative impact of childhood trauma on the etiology of psychiatric illness, both from diagnostic and treatment perspectives. In this article, we will present the case of a multiply traumatized woman who satisfies criteria for all three disorders, providing support for the hypothesis that these three diagnoses may be viewed as separate phenotypic expressions of a common origin: childhood trauma. A hierarchical model of adaptation to childhood abuse is proposed to order the clinical data.*

Evidence is growing that childhood incest and abuse are implicated in the etiology of a number of adult psychopathological conditions, particularly multiple personality disorder (renamed dissociative identity disorder in *DSM-IV*), borderline personality disorder, somatoform disorder, substance abuse, and depression (Kluft, 1990). These appear to be variants on, or longstanding consequences of, what is known in adulthood as post-traumatic stress disorder, though these syndromes are not identical. The substantive question facing the field now is which factors within the domains of the victim's personality, social environment, and traumatic experience, are critical to the formation of adult disorders, and how do they interact to determine the specific form of symptomatic expression. Potentially important factors include 1) age at onset of abuse, 2) severity, 3) duration, 4) relationship to perpetrator, 5) child's constitutional resiliency, and 6) stability of and support from the family environment (Schetky, 1990). This article will contribute to this effort through the examination of one case report of a woman multiply traumatized who developed several distinct disorders as an adult. In the discussion, we will propose a framework for understanding the complex relationships among the etiological factors in her case.

CHILDHOOD ABUSE AND PSYCHOPATHOLOGY

Dissociation is widely recognized as an extreme defensive response to overwhelming psychological trauma. Hence it is not surprising that individuals with a history of childhood abuse report higher levels of dissociative symptoms than those who were not abused (Chu & Dill, 1990). Multiple personality disorder is associated with very high rates of childhood trauma (Coons, Bowman, & Milstein, 1988; Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, Norton, & Wozney, 1989; Schultz, Braun, & Kluft, 1989). Kluft (1987) reported a 90% rate of childhood physical and/or sexual abuse in subjects with multiple personality disorder, while Putnam et al. (1986) reported a 97% rate. Ross et al. (1990), in a series of multiple personality disorder cases diagnosed by structured interviews, found childhood physical and/or sexual abuse history in 95% of the cases; 50% of the subjects endorsed both physical and sexual abuse before age five, as well as abuse lasting for more than 10 years. Ross (1991), in a prevalence study of childhood abuse in various diagnostic categories, identified childhood trauma as a major factor for the development of multiple personality disorder. Rates of multiple personality disorder and dissociation were significantly higher in abused (10.5%) than non-abused (.2%) individuals.

Borderline personality disorder is also strongly associated with a history of childhood abuse (Bryer, Nelson, Miller, & Krol, 1987; Byrne, Velamoor, & Cernovsky, 1990; Herman, Perry, & van der Kolk, 1989; Ludolph et al., 1990; Ogata, Silk, Goodrich, Lohr, & Westen, 1990; Ross, 1991; Stone, 1981; Westen, Ludolph, Misle, Ruffins, & Block, 1990; Zanarini, Gunderson, Marino, Schwartz, & Frankenburg,

1989). Ross (1991) found higher rates of borderline personality disorder in an abused versus a non-abused population (61.5% vs. 1.2%). Herman et al. (1989), in their study of childhood trauma in borderline personality disorder, found borderline subjects to report high rates of childhood trauma (physical abuse 71%, sexual abuse 67%, and witness to domestic violence 62%). An abuse history was less common in subjects with only some borderline traits and least common in subjects with no borderline diagnosis. Furthermore, histories of trauma in early childhood (0-6 years) were found almost exclusively in the borderline subjects. Subjects with borderline personality disorder suffered more types of trauma, earlier in life, and for longer periods of time.

Post-traumatic stress disorder may occur more frequently in populations that have previously experienced childhood trauma, suggesting childhood abuse may play a part in the evolution of or increased vulnerability to post-traumatic stress disorder. Coons, Bowman, Pellow, and Schneider (1989) found 57% of females with post-traumatic stress disorder from adult trauma reported childhood abuse. Several clinical studies report post-traumatic stress disorder symptoms in child victims of sexual abuse (Adams-Tucker, 1982; Goodwin, 1985). The clinical description of adult patients with a history of early sexual abuse is consistent with the symptom description of post-traumatic stress disorder (Herman, Russell, & Trocki, 1986). Bremner, Southwick, Johnson, Yehuda, and Charney (1993) found that patients seeking treatment for combat-related post-traumatic stress disorder have higher rates of childhood physical abuse than combat veterans without post-traumatic stress disorder (26% vs. 7.1%).

The concept of complex post-traumatic stress disorder (i.e., Disorder of Extreme Stress Not Otherwise Specified), offers a diagnostic formulation beyond simple post-traumatic stress disorder that encompasses the complexity of childhood trauma and its sequelae (Herman, 1992). Pre-trauma risk factors for post-traumatic stress disorder including childhood trauma, childhood behavior disorder, and parental poverty have been identified in numerous studies (Davidson & Foa, 1993). However, in a study of a community sample, Davidson et al. (1991) found that, after controlling for co-morbidity, only parental poverty was statistically significant in its continuous effect on the development of post-traumatic stress disorder.

CO-MORBIDITY

Given the strong association between each of these disorders and childhood trauma, it is not surprising to find frequent comorbidity. The *DSM-III-R* criteria for each diagnosis overlap minimally even though in the clinical setting and from a descriptive standpoint, there is a significant degree of commonality. Comorbid diagnosis of multiple personality disorder and borderline personality disorder, multiple personality disorder and post-traumatic stress disorder, and borderline personality disorder with post-traumatic stress disorder is common (Kluft, 1990). Fink (1991), in his review of comorbidity of multiple personality disorder with the personality disorders, proposed that post-traumatic personality organizations commonly coexist with multiple personality disorder. Horevitz and Braun (1984), in their analysis of 33 cases of multiple personality disorder, found 75% of these patients met *DSM-III-R* criteria for borderline personality disorder. Ross, Heber, Norton, and Anderson (1989) found that 60% of 20 multiple personality disordered patients in their sample met *DSM-III-R* criteria for borderline personality disorder. Armstrong (1991) showed all of the multiple personality disordered subjects she studied had an extensive history of childhood abuse and 86% of the subjects met *DSM-III-R* criteria for comorbid post-traumatic stress disorder. Southwick, Yehuda, and Giller (1993) demonstrated that 70% of combat-related post-traumatic stress disorder treatment seeking patients met *DSM-III-R* criteria for borderline personality disorder.

The increasing awareness that childhood trauma is associated with several psychiatric disorders has led Herman et al. (1986), Kluft (1990), Schetky (1990), and others, to suggest that childhood trauma can manifest itself in a range of disorders including borderline personality disorder, multiple personality disorder, and post-traumatic stress disorder. However, the factors responsible have not yet been empirically identified, nor has it been established whether their effects can be differentiated from one another. The following case is an illustration of how adaptation to severe trauma can present itself with the manifestations of various psychiatric disorders.

CASE REPORT

The following is a case report of a patient who meets *DSM-III-R* criteria for post-traumatic stress disorder, borderline personality disorder, and multiple personality disorder. This case illustrates that these syndromes are not independent entities, but rather are manifestations of a shared traumatic etiology. We will review the traumatic events during her life course and attempt to trace the specific symptoms to their roots in these traumas. The case is particularly illuminating, since this woman suffered traumas during several different ages of her development, allowing us to formulate hypotheses as to age-related effects of trauma. The limitation of this case lies primarily in the source of the data. We rely predominantly on the patient's retrospective report, and had minimal objective data verification of these data, though her credibility was deemed high by the clinicians who treated her. Hospital records that were available from age 19 onward corroborate her reports. Despite this limitation, the case provides additional support for the appreciation of

childhood trauma in the etiology of psychiatric illness. Consent to publish this description of her life was obtained in writing from the patient, who has also read this report.

Our first encounter with W. was in the spring of 1992 when she was hospitalized for inpatient treatment. At the time of her inpatient admission she carried the diagnoses of borderline personality disorder, alcohol abuse in remission, and rule-out post-traumatic stress disorder. During the hospital course she was evaluated extensively and was additionally diagnosed with post-traumatic stress disorder and multiple personality disorder. During that admission seven alters were identified (a total of 26 alters were reported by the patient in subsequent outpatient therapy).

The following instruments were employed in addition to the clinical diagnostic assessment: PTSD-SCID (Spitzer et al., 1990), Clinician Administered PTSD Scale (Blake et al., 1990; scores= B-4, C-7, D-6), Impact of Events Scale (Horowitz et al., 1979; total score of 75, Intrusion=35, Avoidance=40), DIB (Gunderson et al., 1981; score=10), and Dissociative Experiences Scale (Bernstein & Putnam, 1986; score= 46.6; Ross et al., 1988). All scores met respective criteria for diagnosing the relevant clinical conditions.

W. is a 34-year-old white female who was adopted at three months of age by an alcoholic couple who raised her as an only child until age 18. During childhood she was repeatedly traumatized by her mother, father, and uncle. During adulthood she was traumatized by lovers and other men. Traumas included frequent physical, sexual, and verbal abuse as well as neglect and abandonment.

W. characterized her childhood household environment as chaotic and unpredictable. Her parents were intoxicated much of the time and she witnessed domestic violence on a regular basis. Physical abuse was primarily directed from her mother to her father. "I grew up too afraid to confront my mother and found myself doing much the same thing as my father and allowing her to dominate and control situations regardless of whether or not she was right or wrong."

The earliest abuse W. recalls is by her father when she was four years old. Sexual abuse began with masturbation and led to intercourse, persisting for approximately one year. W. has no recollection of and cannot account for the next four years. At nine years of age, she remembers sexual abuse (insertion of objects into vagina and anus) and physical abuse (hitting, spanking, throwing objects at her head) by her mother. The abuse was characterized as random and violent. At one point she sustained second and third degree burns on her hands when her mother disciplined her by burning her with an iron. Other injuries included a broken arm, a dislocated shoulder, a broken collar bone, and vaginal trauma leading to hemorrhage. At ten years of age she recalls being hospitalized for a period of one year on a locked psychiatric unit and reportedly received a course of electroconvulsive therapy. We have no records or reports regarding this (or other) hospitalizations.

Approximately at the age of ten, W. recalls the onset of sexual abuse by her uncle. Her uncle took her to an abandoned building where she was restrained to a bed in a room full of camera equipment. She describes the abusive routine as follows, "My uncle and three other men removed my clothing as I tried to escape and they forced me onto the bed and placed me in restraints. I watched as each of the men exchanged money with my uncle and he stood there counting all of it. They then turned off the lights and watched pornographic films while drinking..." "They then took turns with me, forcing me to perform all types of sexual acts before they were finally through. After they were through and had left, my uncle also sexually abused me, then physically beat me, telling me that I had not performed adequately enough and because of this fact that I needed to be punished." These encounters continued until she turned 18. "As I entered my teenage years, I carried with me feelings of anger, betrayal, disgust, fear, sadness, shame, guilt and remorse, in addition to no self-esteem or hope for the future. The only way I expected to resolve any of these feelings was through death."

At age twelve W. became pregnant by her uncle. She moved to a maternity home where she completed her pregnancy (five months on) and gave birth to her only son. W. returned home to live with her mother who took care of the baby while she attended school. When her son was two years old (as she approached her 15th birthday), she recalls the following event: "As I arrived from school...suddenly my mother grabbed me by the back of my neck and began to beat my head against the wall until I was nearly unconscious. Then she grabbed my hand and held it over a boiling pot of water with one hand and with her other hand attempted to stab me with one of the carving knives which had been lying on top of the counter...I tried to escape from her, but I was too weak to fight her off very long and eventually she managed to drag me into my son's bedroom where she first sexually assaulted me right in front of my screaming son, then... (she cries)... forced me to abuse him. From that time on until I left and enlisted in the army, there were many such occasions." She refused to give details of the "abuse" of her son.

During her teenage years W. describes her behavior as rebellious. "I disobeyed curfews, got intoxicated and high in front of them (parents) and fought with my father constantly." I came and went as I pleased and often didn't come home for three or four days at a time. I ran away from home several times and was picked up three times out of state for hitch-hiking on the interstate highway."

Throughout her high school years W. describes gradual deterioration of her academic performance (from an A to a D average), in addition to increased disciplinary problems at school. She also became aware of her homosexual longings, and established a lesbian identity by the age of 17. "By the time I reached my 18th birthday I had become an extremely angry young woman who only wanted to die. I did not care about anyone or anything and that included myself

and my son. I believed that I had failed as a daughter, a student, and as a mother and the only recourse I have was to leave and go some place far away to eventually die."

At 18 she joined the army and was honorably discharged after three months and 21 days. She claims she was found physically unfit to finish the basic training. During her military service she learned her son was diagnosed with chronic lymphatic leukemia and was very ill. Her mother continued to be the primary caregiver of her son.

At 19, she entered the VA for treatment for the first time after a suicide attempt (an overdose with librium and ETOH) when a relationship with a female lover ended. W. proceeded for the next two years to travel around the country, held multiple jobs (longest six months) and used alcohol heavily. She reports being violently raped by a stranger while intoxicated during that period. She was severely beaten and required two months hospitalization after this incident.

At 21, she returned to her home state. During the next four years she became involved in a relationship with a female lover who was both sexually and physically abusive.

At 25, her son died after lying in a coma for three weeks. Several months later her father died of pancreatic cancer. After the death of her son and father she could not hold a steady job, her relationship fell apart, and she became socially isolated. At 30, she became sober for the first time with the help of AA, went back to school, and then returned to the workforce as a medical assistant for the next four and a half years.

At 34, she located her biological father and learned that her biological mother died ten years earlier. Her biological father returned home with her. However, shortly afterward he abandoned her and she never saw him again. After this event she became depressed and relapsed into alcohol abuse, leading to her current admission at the VA Medical Center. She presented with chief complaints of nightmares, flashbacks, depressed mood and active suicidal ideation. She was an inpatient for four months and then entered outpatient treatment.

Currently W. is pursuing her college degree. She attends a local university part-time and she volunteers at the VA hospital. She successfully completed a rehabilitation program that helped her attain subsidized housing. She lives independently and attends regular outpatient appointments. She has continued to maintain her sobriety.

DISCUSSION

This case illustrates the potential relationship between childhood trauma and the subsequent development of multiple personality disorder, borderline personality disorder, and post-traumatic stress disorder within the same patient. The patient's three adult diagnoses appear to share a common etiology: child abuse. Factors such as age, duration, severity, and form of abuse, as well as constitutional factors, may determine whether multiple personality disorder, borderline personality disorder, or post-traumatic stress disorder will dominate the clinical picture (Herman, 1992; Kluft, 1990). If a child is abused over the course of different ages and in different ways, as was true in W.'s case report, then multiple diagnoses may co-exist.

We propose to order this clinical data through an adaptational, rather than diagnostic, framework consisting of a hierarchical series of adaptational strategies that are hypothesized to be employed by the abused/traumatized individual. Depending largely upon the age of onset and duration of the abuse, and the subsequent need to utilize adaptational defenses due to an unsupportive interpersonal environment, these adaptations to trauma may result in progressively greater damage to personality, interpersonal relatedness, and behavior. Conceivably, specific psychopathological disorders will manifest themselves at different points along this continuum.

W. appeared to utilize different types of adaptation to her various traumatic experience and their sequelae. What might be called the primary adaptation to the trauma was dissociation. The child's novice biological and psychological coping mechanisms are completely overwhelmed by the trauma, as memory traces of the trauma are encapsulated and split off from representations of the self. If particularly severe or early, then the dissociation may succeed in creating two or more autonomous self-representations. If less severe or later in age, then transient dissociative experiences such as flashbacks or nightmares may develop. For example, in our case, the ages of the three most significant alters correspond to traumatic events in W.'s early life: Betty (four years old – onset of physical and sexual abuse by father); Susie (nine years old – onset of physical and sexual abuse by mother and uncle); and Ann (a few months old – age of adoption). "The only thing Ann is able to do is cry." Ann is assumed to have been created at a later age than the age attributed to her.

In contrast, the content of both the nightmares and the flashbacks associated with PTSD appear to be related to the sexual abuse by her uncle and mother from her teenage years. Most of the intrusive thoughts pertain to the verbal abuse from her mother (e.g.,"you deserve to die," "you are a piece of shit"). W. reports frequent avoidance of anything that reminds her of family, family activities, music (which reminds her of her father who liked music), and children (which reminds her of the abuse of her son). Her hyperarousal symptoms also emerged in late adolescence.

A secondary adaptation to the trauma may be manifested in the form of various defense mechanisms that serve to dampen, avoid, and contain the disturbing experiences, such as projection, reaction formation, and denial, obsessive, and avoidant defenses and behaviors. Employment of these defenses over many years shapes personality development, and may result in permanently altering one's personality style

(Putnam, 1990; Schultz, 1990). Secondary adaptations may affect the interpersonal relationships of the developing child, eventually being incorporated as traits of mistrust, withdrawal, paranoia, self-defeating behavior, or acting out. In some individuals, these alterations may become autonomous from the original trauma, in the form of a personality disorder, often of the borderline or antisocial type. In W.'s case, several of the borderline personality disorder symptoms can be associated with traumatic experiences. For example, she remembers the onset of self-mutilation at the age of ten, after her mother started sexually and physically abusing her. She often spoke about her sexual identity confusion as stemming from the abuse by both her mother and her father. She referred to the constant fear of being abandoned and rejected despite her ongoing wishes to run away from home. Her first suicide attempt, at age twelve, was triggered by the abuse by her uncle.

Tertiary adaptations are the most generalized effects of trauma, resulting from the constriction of the individual's sense of self caused by primary and secondary adaptations. They include impairments in the person's regulatory functions (e.g., arousal, mood, cognition), characterizing what has been called the general stress response (Selye, 1956; Horowitz, 1986). Examples of these general stress symptoms are poor impulse control, anger, dysphoria, anhedonia, anxiety, hopelessness, cognitive distortions, and existential fatigue (Coons et al., 1989). These symptom constellations affect how the adult individual interacts with the world. Over time, it is these symptoms that become more and more prominent in the life course of traumatized individuals, and may lead to what Titchener has called post-traumatic decline (Titchener, 1986). For example, W.'s deteriorating academic performance, sense of worthlessness and failure, and suicidal ideation beginning at the age of 18, and culminating in her thirties, may be experiences of this level of adaptation to traumatic stress.

SUMMARY

The case of W. illustrates what we propose as primary, secondary and tertiary adaptations to her severe and long-standing experience with trauma, expressing themselves as dissociative experiences, personality alteration, and generalized stress responses. Patients such as W. challenge our notions of the independence of multiple personality disorder, borderline personality disorder, and post-traumatic stress disorder. Empirical studies are needed to examine the specific effects of the major hypothesized factors in childhood abuse on the development of adult psychopathology. This case contributes to the rapidly growing evidence that symptomatic expression in the adult is a highly complex, multiply-determined process. Though treatment implications are beyond the scope of this article, it is clear that taking a comprehensive trauma history on our patients is essential. The profound and widespread effects of childhood trauma on the development of psychiatric illness cannot be underestimated, and are only now being charted. ■

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