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The global problem of child maltreatment: Perspectives on mechanisms of influence and illness presentation

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Abstract

Child abuse and neglect negatively impact both neurological and psychological development. Patterns of abuse are learned and repeated in families. Adverse childhood experiences are a risk factor for psychopathology later in life, including borderline personality disorder (BPD). BPD is prevalent in clinical populations in the United States, but its prevalence has not been well-documented in most other parts of the world. The aim of this paper is to explore the impact of culture upon the intergenerational transmission of childhood maltreatment and the clinical presentation of abused children. To facilitate this exploration, we will consider the cases of four adolescent girls in unique socioeconomic and cultural settings around the world: Liberia, El Salvador, India, and a Congolese immigrant in France. Each of these girls endorsed some features of BPD, but only two met full criteria. In societies in which externalizing behaviors are not acceptable, children may internalize their distress or separate from their families. Defining BPD in terms of internal experience makes it more difficult to identify, but it would allow for the inclusion of cases in which symptoms may manifest differently while the underlying problem is similar.

Keywords

trauma; child maltreatment; adolescent; culture; borderline personality disorder; case report

Background

Child abuse and neglect negatively impact both neurological and psychological development. However, the effects are highly variable and difficult to predict. In a recent meta-analysis, the global prevalence of child maltreatment was estimated at 22.6%

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(Stoltenborgh, Bakermans-Kranenburg et al. 2013); the prevalence varied significantly between countries. One study compared reported rates of abuse and neglect in Kenya, Zambia, and the Netherlands and found that abuse rates were much higher in the African samples, but rates of neglect were similar (Mbagaya, Oburu et al. 2013).

While child maltreatment is a global problem, most of the research aimed at understanding and preventing it has been done in high-income countries. The aim of this paper is to explore the impact of culture on the clinical presentation of abused children. To facilitate this exploration, we will consider the cases of four adolescent girls from unique global settings. The girls had all experienced significant trauma themselves, and their families were also traumatized.

Intergenerational transmission of trauma

Research has consistently shown that patterns of abuse are learned and repeated in families (Berlin, Appleyard et al. 2011, Dayton, Huth-Bocks et al. 2015), as are patterns of attachment (Ainsworth 2015). A cycle has been described whereby women who experienced insufficient parental care, and, in some cases, abuse, become pregnant. They have doubts about their ability to parent as a result of the parenting they received. Without a healthy model, they struggle with setting limits, afraid of being too harsh, and then becoming excessively harsh when they perceive their own children as intrusive and even abusive. They also become resentful when asked to make sacrifices that were not made on their own behalf (Buist 1998). As a result, they are more likely to abuse their own children and put them in situations that make them vulnerable to abuse by others (Buist 1998).

Attachment problems are associated with behavioral disturbances and mental illness (Lyons-Ruth, Zoll et al. 1986, Lyons-Ruth 1996). Mothers who have experienced trauma and developed a disorganized attachment style relate to their children in a manner that is alternately intrusive, fearful and disengaged. Without another attachment figure who is more consistent, these children go on to develop a disorganized attachment pattern themselves (Lyons-Ruth, Bronfman et al. 1999). Disorganized attachment is associated with borderline personality disorder; it has been theorized that through the transmission of disorganized attachment, borderline personality is transmitted (Macfie and Swan 2009, Apter, Devouche et al. 2016). Studies of children in orphanages further support the significance of attachment in fostering mental health. These studies have found that without access to caring and consistent attachment figures in infancy, psychosocial, emotional and cognitive development are compromised (McLaughlin, Zeanah et al. 2012, Bick, Zhu et al. 2015).

Clinical presentation

Adverse childhood experiences (ACEs) including parental separation, unemployment, and substance use, death of a parent or child being sent away, and physical or sexual abuse or neglect have been linked with internalizing disorders like depression, as well as externalizing disorders like substance use, antisocial behavior and borderline personality disorder (BPD), later in life (Chapman, Whitfield et al. 2004, Schilling, Aseltine et al. 2007). According to the Diagnostic and Statistical Manual (DSM V), BPD is characterized by

impairments in self functioning and interpersonal functioning, negative affective states and behavioral disinhibition (APA 2013). These criteria are detailed further in Appendix 1.

While trauma can be associated with a number of different clinical presentations, we will focus on BPD in order to consider the influence of culture upon symptom presentation. In comparison with other diagnoses, the rates of personality disorders vary significantly in different parts of the world. Responsible for a significant proportion of morbidity in the clinical population in the United States, BPD is rarely diagnosed elsewhere, particularly outside North America and Europe. One theory is that non-Western societies have close knit and hierarchical family structures that tend to repress the kind of impulsive emotional expression seen in BPD (Paris 1996). Also, in societies that place a high value on social cohesion, the antisocial behaviors characteristic of antisocial personality disorder, and self harm, a cardinal symptom of BPD, are rarely brought to clinical attention. Case reports of BPD developing following immigration to the United States lend further support to this theory (Paris 1996).

If BPD is a problem of misattunement with a primary caregiver, it may be that in these societies children do not have the same expectations of individual recognition and validation from caregivers, so they are not impacted in the same way when it is lacking. It is also possible that the core issues that underlie BPD are present in populations around the world but that the specific presentation is influenced by the cultural context. In the Gusii tribe in Kenya, mothers have shorter moments of face-to-face contact with their infants (Dixon, Tronick et al. 2014). They avert their gaze in affectively charged moments, which children learn to do themselves. This is one example of a culturally-specific norm around the communication of affect. It follows that problems with affect regulation would present differently in this context than they might in another setting.

Case examples

In order to illustrate these patterns, we will consider the cases of adolescent girls from four distinct cultural and economic settings around the world. We will describe their clinical presentations and any features of BPD that they exhibited. All minors gave their assent to be interviewed, and consent was obtained from their legal guardians.

Street child in low-income country

Between 1989 and 2003, Liberia experienced a brutal civil war characterized by ethnic killings, sexual violence and the use of child soldiers. The war displaced a huge proportion of the population, destroyed the productive capacity and physical infrastructure of the country, and eroded family and community ties (UNDP 2006). In 2008, five years after the war ended, the population was approximately 3.5 million people; there were an estimated 340,000 orphans in Liberia, 18% of the total child population of the country (Liberia Institute of Statistics and Geo-Information Services (LISGIS) 2009). It is estimated that nearly 6,000 more children were orphaned by the Ebola epidemic from 2014–2015 (Collins 2015). Many of these orphans live on the street. Some children who were not orphaned also left home after the war.

L is an18yo girl who had her first sexual experience at 10yo when she was raped by a group of soldiers during the war. “Nothing happened to [the soldiers],” she explained, intimating that the rape resulted in no consequences for them but severe ones for her. After the war ended, L left home and joined a group of children who were living on the street, using drugs and engaging in survival sex. Her parents urged her to come home, but she was not willing to live by their rules, which had failed to keep her safe. She did not express anger toward them but rather a sense of distance and disconnection. She no longer belonged at home, but she felt stuck in the life she was living because she had become addicted to drugs. She reported emotional lability, depression, hopelessness, and risky behavior.

Institutionalized children in middle-income countries

El Salvador experienced a long, brutal civil war characterized by brothers killing brothers. A children’s home on the outskirts of San Salvador took in orphans and children whose families were unable to care for them. These children had early experiences with parents who spent their childhoods in the midst of war. In addition to devastating economic consequences of war, the family ties that supported caregiving of the very young and old and disabled were disrupted. Most of the parents of these children, as well as the staff at the children’s home, witnessed violence and death, and grew up under threat of betrayal and danger. Traditional beliefs and values that gave life meaning and predictability were diminished.

S is a 13yo girl, the third child of a single woman sex worker. When she was an infant, neighbors heard her cries and saved her from drowning in a ditch. Rescuers discovered that her 5yo sister was the primary caregiver for S and her 2yo brother. When she was 6mo, S and her siblings were placed in a small children’s home, where she was provided with a safe environment, good nutrition, and affectionate caregiving. Her mother has never visited the home and is not present in the children’s lives. Early on, S’s development flourished, and she grew to be competent and assertive, though private. At 1yo, she demonstrated initiative and persistence in her efforts to feed herself with a spoon and in learning to walk. Years later, she was described as “unmotivated” in school. She withdrew into angry isolation when she perceived a situation to be unfair. In her relationships with adults, she was tentative, as if afraid to make a commitment that could expose her to rejection or abandonment. Her only consistent trusting adult relationship was with the woman who directed the home and who had cared for her since infancy. With the other children in the home, she was a provocateur, stirring up trouble and then disavowing her involvement.

Children in an orphanage in south India came from lower-caste families, most were untouchables. In a vast country of more than a billion people, with many different languages spoken and religions practiced, the remnants of the ancient caste system have left a legacy of poverty, lack of opportunity, low self-esteem, and anger directed inward and within the family. Particularly in poor, rural settings, families are very traditional, with the father as the unquestioned authority. Violence against women and children is common. Within these families, there was a narrative that they could not manage to take care of themselves and their children and participate in society. In some cases, one or both parents were living but were unable to care for their children. Their early experiences were characterized by extreme

poverty, exposure to domestic violence, and in some cases, physical and sexual abuse. Interviews with these children indicate that those who developed externalizing behaviors were exposed to maltreatment, but most children who were maltreated did not develop these behaviors. There is some anecdotal evidence to suggest that children who experienced a long history of inconsistent parenting were more likely to externalize than those who came to the orphanage following a single dramatic loss. For those who did externalize, a common behavior was running away.

N is a 17yo girl who grew up with a father who was verbally and physically abusive; her mother died when she was young. He sent her to the street to beg. She often felt humiliated and continued to relive these experiences years later. When she was 11yo, a tourist found N and brought her to the home. She continued to sponsor her but had not visited in four years because she wanted N to learn to be more “self-reliant.” N spoke of this woman frequently. N used to run away from the home after her visits, but she had not done this for a few years. Her father had started visiting and bringing gifts in an attempt to repair their relationship. N accepted his gifts but was more interested in contact with the tourist and with her brother, who had married and moved away. She presented with impairments in self functioning and interpersonal functioning, multiple features of negative affectivity and hostility.

Child from a low-income country who immigrated to a high-income country

The Democratic Republic of Congo (DRC) has been in a state of civil war for the past 20 years, punctuated by brief, tenuous periods of peace. Many Congolese have fled to neighboring countries, and some have made it to France. Families have left behind their experiences of war and violence, as well as extended family, friends and a familiar cultural context, in the hope of finding a safer place that would also offer greater opportunities.

C is a 16yo girl from the DRC. She was raped several years ago and then entered into a forced marriage. She fled the DRC by herself, and about a year ago she arrived in France, where she was picked up as an unaccompanied minor with no legal immigration status. She was put in a home where she started to receive help and schooling. In this safe and contained environment, she became increasingly delusional. She believed that she smelled like feces and was physically rotten. She was also responding to internal stimuli and wandering off alone at night. She was then psychiatrically hospitalized, and she began sharing the story of her traumatic past. The intensity of her psychotic symptoms began to dissipate. Her presentation was characterized by impairment in identity functioning, negative affectivity and risk-taking.

Discussion

All of the cases involved a separation between the generations, either initiated by the parents or the child. It may be that a wish to avoid overt hostility was what pulled for separation in these cases. In societies in which externalizing behaviors are not acceptable, children may internalize their distress or separate from their families. The separation serves the dual functions of separating from the source of trauma and avoiding reminders of what was lost, allowing hostile feelings to be more easily hidden.

Each of these girls endorsed some features of BPD. Two cases in particular demonstrated overt hostility, characterized by hypersensitivity to perceived interpersonal slights, and thus displayed a full range of BPD symptoms. S, in the Salvadoran children's home, and N, in the Indian children's home, were observed to be manifestly angry. S's anger was seen occasionally in her provocative behavior with other children, though it usually stayed hidden behind her mask of self-isolation. N had also been in a safe environment for a sustained period of time, but she had ongoing contact with her father, who had been abusive. Her sociocultural context was unique in that her country had not recently experienced war. All of these factors together may explain why N had the most access to her anger and was able to express it.

The varied presentations of these girls, particularly with respect to the expression of negative affect, raise the question of how to define BPD, which has been a source of controversy. While the DSM has favored a definition based upon symptom description (APA 2013), some experts have suggested instead that the definition be rooted in internal psychological process (Higgitt and Fonagy 1992). These experts highlight the profound feeling of emptiness and lack of sense of self that these patients report (Kohut 1971, Higgitt and Fonagy 1992). A number of theories have been proposed as to how this problem develops. Kohut believed that BPD resulted from a deficit in developing a sense of self due to the lack of a reflective function provided in the primary caregiving relationship (Kohut 1971). Kernberg and others have emphasized the intensity of aggressive feelings, which the weak self struggles to manage (Klein 1950, Bion 1957, Segal 1964, Kernberg 1975). Fonagy and colleagues have further elaborated this idea, incorporating both conflict and deficit models. They suggest that the caregivers also harbor aggressive impulses toward the child, and the child's awareness of this leads her to inhibit the development of a capacity to think about the mental state of others, in order to avoid any awareness of the caregiver's hostility or disinterest (Higgitt and Fonagy 1992, Fonagy, Gergely et al. 2002).

Defining BPD in terms of internal experience makes it more difficult to identify, but it allows for the inclusion of cases in which symptoms may manifest differently while the underlying problem is similar. This is particularly important for the purpose of understanding patients who come from distinct cultural backgrounds because culture shapes behavior and thus influences symptom presentation. Further study of the ways in which borderline psychopathology is impacted by culture and the ways it remains consistent across cultures is needed. This has the potential to inform the treatment of severely traumatized patients and reduce stigma associated with BPD and other trauma-related diagnoses in settings around the world

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Appendix

Appendix 1

DSM V Criteria for Borderline Personality Disorder (APA 2013)

A. Significant impairments in **personality functioning** manifest by:

1. Impairments in **self functioning** (a or b):

- **i.** **Identity**: Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.
- **ii.** **Self-direction**: Instability in goals, aspirations, values, or career plans.

2. Impairments in **interpersonal functioning** (a or b):

- **i.** **Empathy**: Compromised ability to recognize the feelings and needs of others associated with interpersonal hypersensitivity (i.e., prone to feel slighted or insulted); perceptions of others selectively biased toward negative attributes or vulnerabilities.
- **ii.** **Intimacy**: Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes of idealization and devaluation and alternating between over involvement and withdrawal.

B. Pathological **personality traits** in the following domains:

1. **Negative Affectivity**, characterized by:

- **i.** **Emotional lability**: Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.
- **ii.** **Anxiousness**: Intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful; fears of falling apart or losing control.
- **iii.** **Separation insecurity**: Fears of rejection by – and/or separation from – significant others, associated with fears of excessive dependency and complete loss of autonomy.
- **iv.** **Depressivity**: Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feeling of inferior self-worth; thoughts of suicide and suicidal behavior.

2. **Disinhibition**, characterized by:

- **i.** **Impulsivity**: Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans; a sense of urgency and self-harming behavior under emotional distress.
- **ii.** **Risk taking**: Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one“s limitations and denial of the reality of personal danger.

3. **Antagonism**, characterized by **Hostility**: Persistent angry feelings in response to minor slights.

C. The impairments in personality functioning and the individual’s personality trait expression are relatively stable across time and consistent across situations.

D. The impairments in personality functioning and the individual’s personality trait expression are not better understood as normative for the individual’s developmental stage or socio-cultural environment.

E. The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).