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Body-related attentional biases in patients with posttraumatic stress disorder resulting from childhood sexual abuse with and without co-occurring borderline personality disorder



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ABSTRACT

Background and objectives: Disturbed body perception is a common characteristic of patients with posttraumatic stress disorder (PTSD) after childhood sexual abuse (CSA). We examined the extent to which biased information processing of body related stimuli was related to CSA.

Methods: Patients with PTSD after CSA (PTSD group; $n = 61$) were compared to healthy controls (HC group; $n = 30$). The PTSD group was subdivided into patients with comorbid Borderline Personality Disorder (BPD; PTSD+ group) and patients without BPD (PTSD-group). We used an emotional Stroop task (EST) with body-related words to assess biased information processing.

Results: Only patients in the PTSD+ group but not in the PTSD-group showed a significantly stronger attentional bias to body related words compared to the HC group ($p = .009$).

Limitations: Recruitment in in-patient setting might have led to a non-representative sample of PTSD patients. The PTSD patients were not characterized regarding anything other than the mentioned mental disorders. Potentially, the body related words may have been associated with offenders' body areas, but not with the patients.

Conclusion: We found that patients with PTSD and comorbid BPD had a stronger attentional bias towards body related stimuli in comparison to other groups. This suggests that the observed attentional bias is a product of CSA combined with the emotion regulation difficulties characteristic of BPD. Future studies should test whether directly targeting body-related abnormalities in information processing can improve existing treatments for patients with CSA and BPD.

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1. Introduction

Avoidance of trauma-associated distressing stimuli is a core feature of posttraumatic stress disorder (PTSD) (American Psychiatric Association, 2013). Confrontation with distressing stimuli has the potential to disrupt attention control mechanisms, which are responsible for orienting, maintaining, and shifting attention (Cisler et al., 2011). Distressing stimuli may originate from body related cues as indicated by previous research (Dyer et al., 2012). Results indicated that independent of eating disorder

symptomatology, patients with PTSD after CSA reported significantly more body-related avoidance behaviour (i.e., wearing wide cloths, avoiding physical intimacy) as well as negative cognitions and affects regarding their body in comparison to healthy controls. These findings are supported by numerous studies which show that body image disturbances are frequently reported in individuals with experience of CSA (Hunter, 1991; Moeller, Bachmann, & Moeller, 1993; Sack, Boroske-Leiner, & Lahmann, 2010; Simmons, 2011; Weaver, Resnick, Kokoska, & Etzel, 2007; Wenninger & Heiman, 1998).

Within a large representative US sample, high comorbidity rates (24%) of BPD were detected in PTSD patients (Pagura et al., 2010). BPD patients frequently exhibit body-related behaviour such as repetitive self-harming behaviour (Kleindienst et al., 2008). In addition, BPD patients report serious body image disturbances (Dyer et al., 2013; Haaf, Pohl, Deusinger, & Bohus, 2001; Kazuko & Inoue, 2009; Sansone, Chu, & Wiederman, 2010; Sansone,

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Wiederman, Sansone, & Monleitha, 2001). All previous studies, however are limited in that self-report instruments have primarily been used to assess body image disturbances. Experimental studies confirming subjective reportings are therefore required.

To assess biased information processing, the Stroop task and in particular, the Emotional Stroop task has been widely used with patients suffering from PTSD (Cisler et al., 2011). Results from these studies have shown that patients with PTSD show greater interference when naming colours of threatening words or PTSD-relevant words in comparison to neutral or positive words. Using this methodology, McNally, Kaspi, Riemann, and Zeitlin (1990) compared Vietnam veterans with PTSD to veterans without PTSD using positive, neutral, trauma-associated words, and words specific to obsessive-compulsive disorder. Participants with PTSD were shown to be slower in naming the colour of PTSD-specific words in comparison to the colours of other word categories. Similar results have been found among rape victims with PTSD (Cassiday, McNally, & Zeitlin, 1992; Foa, Feske, Murdock, Kozak, & McCarthy, 1991), motor vehicle accident survivors (Beck, Freeman, Shepherd, Hamblen, & Lackner, 2001; Bryant & Harvey, 1995), mixed trauma groups (McNally, Clancy, Schachter, & Pitman, 2000), and children with PTSD (Moradi, Taghavi, Neshat Doost, Yule, & Dalgleish, 1999). Among people who experienced CSA but did not necessarily receive a diagnosis of PTSD, stronger interference effects were found for words associated with sexuality, in comparison to words associated with generally threatening or neutral content (Field et al., 2001; Wingenfeld et al., 2011). Results suggested that the severity of CSA was positively correlated with increased selective attention allocation (McNally et al., 2000).

In order to objectively assess preferred attention allocation to body-related cues that might be associated with the symptom strengths and avoidance behaviour of patients suffering from PTSD and CSA, we compared participants with PTSD after CSA to healthy control (HC) participants using the Emotional Stroop Task. Because body-related information processing might be influenced by a comorbid BPD we subdivided the PTSD group into participants with comorbid BPD (PTSD+) and participants without co-occurring BPD (PTSD-).

Specifically, we phrased the following research questions: 1) Participants with CSA-related PTSD show a stronger attentional bias (i.e., stronger interference) for body-related words in the emotional Stroop Task (EST) than healthy controls. 2) PTSD participants with comorbid BPD symptomatology (PTSD+) show a stronger attentional bias for body-related words than individuals with PTSD but without comorbid BPD (PTSD-). 3) Severity of CSA, symptomatology of PTSD, and symptomatology of BPD correlate positively with the attentional bias for body-related words in the EST.

2. Method

2.1. Participants

Participants were recruited at the Department of Psychosomatic Medicine and Psychotherapy at the Central Institute of Mental Health, Mannheim, Germany. Healthy controls were recruited via newspaper ads. In total, 241 candidates registered to participate. After screening and a subsequent diagnostic interview, we finally included 128 candidates. A sample of 37 participants did fulfil the diagnosis of BPD but not of PTSD and were therefore excluded. Of the remaining 113 candidates that were excluded, 86 did not fulfil inclusion criteria and 27 refused further participation. To be included, participants had to be female, over the age of 18, and fluent in German.

Exclusion criteria for healthy controls were mental disorders of any kind assessed via the Structured Clinical Interview for DSM-IV (SCID-I; First, Spitzer, Gibbon, Williams, & Benjamin, 1997; Wittchen, Zaudig, & Fydrich, 1997) and the International Personality Disorder Examination (IPDE; Loranger et al., 1994). We also excluded participants who reported a sexual abuse defined by a score higher than five points on the corresponding subscale of Childhood Trauma Questionnaire (CTQ; Bernstein et al., 1994). The healthy control group consisted of 30 healthy participants without any current mental disorder or lifetime eating disorder.

We included 61 female participants with PTSD after CSA diagnosed via the SCID-I. The sexual abuse was verified via a score higher than five points on the corresponding subscale of Childhood Trauma Questionnaire (CTQ; Bernstein et al., 1994). Within this group, 29 participants fulfilled criteria for comorbid BPD according to the IPDE. We did not exclude patients with additional comorbid disorders (i.e., Eating Disorder, Body Dysmorphic Disorders). Written informed consent was obtained from all participants. The local ethics committee approved the study. Patients and controls received €20 payment for participation in the study.

2.2. Assessments

2.2.1. Structured Clinical Interview for DSM-IV (SCID-I)

The SCID-I (First et al., 1997; Wittchen et al., 1997) is a semi-structured clinical interview for the diagnostic of mental disorders according to the DSM-IV. We used part I of the SCID-I which assesses only axis I disorders.

2.2.2. International Personality Disorder Examination (IPDE)

The semistructured diagnostic interview for personality disorders (Loranger et al., 1994) was developed by order of the World Health Organization. Therefore it primarily assesses personality disorders according to ICD-10. Nevertheless, criteria according to DSM-IV were considered as well. Both diagnostic interviews proved to be reliable and valid instruments.

2.2.3. Posttraumatic Disorder Scale (PDS)

The PDS (Griesel, Wessa, & Flor, 2006) assessed the specific symptomatology of PTSD. The questionnaire was used as a screening instrument and to assess severity. In the current study, the internal consistency of the mean value displaying the severity of PTSD symptomatology was .96 (Cronbach's α).

2.2.4. Childhood Trauma Questionnaire (CTQ)

Experience and extent of childhood sexual abuse was assessed with CTQ (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997; Bernstein et al., 1994). The CTQ is a 28-item questionnaire, containing the following subscales: Physical Abuse, Sexual Abuse, Emotional Abuse, Physical Neglect, Emotional Neglect, Experiences of Inconsistencies, and Minimization. The cut-off within the Sexual Abuse scale was set at five points (Bernstein et al., 1994), higher scores indicated the experience of childhood sexual abuse. In the current study, the internal consistency of the CTQ subscales ranged from .72 to .97 (Cronbach's α). The internal consistency of the subscale Sexual Abuse was very high (Cronbach α : .97).

2.2.5. Borderline Symptom List (BSL-23)

The Borderline Symptom List (Bohus et al., 2009) is a self-rating instrument for specific assessment of borderline-typical symptomatology. It contains 23 items using a Likert-type rating format (0–4). The scale evaluates symptoms experienced during the previous week. Internal consistency was high within the current study (Cronbach's α of .97).

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