CHAPTER ONE

INTRODUCTION

Whilst it has been known for over a century that trauma can cause psychopathology and that developmental trauma can determine a later psychopathological outcome (Charcot, Janet & Freud in Herman, 1998), there is something about subtle and chronic trauma that places it in the shadow of acute and violent trauma. War and rape easily displace consistent teasing or unpredictable but harsh criticism. We recall the acute events of our lives, both painful and pleasurable, more easily than the mundane actions and reactions of child and parent, child and teacher or children with each other. It is in this shadow of acute and dramatic trauma, however, that much knowledge of developmental psychopathology is to be found; and it is in these mundanities that we have failed to search for increased understanding.

One's sense of self is dependent upon a continuous consciousness that turns upon crucial, consistently available, attentional processes (William James in Stevens, 1996). Children who suffer from deficient attention (some of whom are labelled as having Attention Deficit/Hyperactivity Disorder or ADHD) both attract less-than-optimal parenting, and are oversensitive to less-than-optimal parenting. In addition to this, there is an implication that deficits of both parenting and disorder are exacerbated over time. If this is so, the sense of forming identity, interrupted by deficits in attention and their attendant lapses in consciousness, encounters increasing obstacles as it proceeds. This provides an ideal setting for the study of chronic, subtle effects of trauma. In such a setting, the accuracy and veracity of the memories are of less importance than the

overall impression that an individual has of growing up; they are less important than a life history of minute Chinese water torture than they are of a life history of harmonious family life marred by the ordinary, if painful, loss of loved ones, and they are just as important as war and rape.

In this chapter, I deal with the framework upon which my study rests. I begin with how I became interested in borderline psychopathology (one conceptualisation of which is Borderline Personality Disorder or BPD), its development and the possible contribution of deficient attention. I note the gap in the literature with respect to dealing with both psychopathologies in relation to each other and in the studies undertaken from a qualitative perspective. I then clarify my research aim and question.

My interest in borderline psychopathology and its development arose from a puzzle, which confronted me in 1990, when doing a psychometric internship in the psychiatric ward of the Johannesburg Hospital. During this internship, I was required to assess many new admissions. I was struck by the fact that, in the histories of many of those who came to be diagnosed as having a personality disorder, there were deficits of attention, learning disabilities, attendance at remedial or special schools, or early dropout from the schooling system, but not necessarily an acute traumatic event.

There are many types of learning disabilities with associated deficits in attention and several personality disorders, however. Over the years, I refined this problem from thoughts about a connection of some kind between learning disabilities and personality disorders in general to an exploration of the experiential development of borderline psychopathology and an experiential link between deficient attention and borderline

psychopathology. This refinement seems to be supported indirectly by the association and comorbid presentation of BPD and ADHD in the DSM IV.

I have chosen to focus on the developmental issues in borderline psychopathology in depth for several reasons. I am interested in this psychopathology from a professional point of view, as it is very difficult, but intriguing, to treat. The topic further interests me because BPD is written about extensively in the literature, as an unending source of fascination for both psychoanalysts and neuropsychologists, amongst others, as well as an increasingly fashionable psychodynamic diagnosis. In addition, I believe it presents a particular challenge because it appears to represent a crossing over of many known psychopathologies. For example, behaviours such as self-mutilation, binge-eating and periods of dissociation are all diagnostic criteria of BPD, while the latter two can constitute disorders in their own right (Eating Disorders and Dissociative Identity Disorders, respectively).

For these reasons, BPD presents a general challenge to the profession, a challenge increased by the fact that its treatment both in theory (related to its complexity as a psychopathology) and in practice remains problematic. The treatment of BPD is avoided in private practice as it is felt that institutional settings are better equipped to deal with its multiple presentations. However, the institutional settings I explored during this research do not report better results, other than the containment of the psychopathology while the patient is institutionalised. Nevertheless, treatment in institutions is not always effective or lasting and patients presenting with BPD often display a distinct ‘revolving door’ syndrome. The same patients can be found in private practice, or at a half-way house such as Walberton Manor, Sterkfontein and other

psychiatric hospitals, at various times, depending on the severity of the psychopathology being displayed at that moment.

The literature on borderline psychopathology, which will be dealt with in a subsequent chapter, is predominantly quantitative, or descriptively rich, portraying both external symptoms and putative internal dynamics in detail. However, it does not enquire into the experience of sufferers of borderline psychopathology themselves, nor focus on their voices. Until now, the questions that have been asked deal with description of disparate aspects of the disorder from different approaches (psychoanalytic, psychodynamic, self psychology, object relations, psychiatry and neuropsychology). These questions have dealt with labelling the entity as a whole; noting its heterogeneity of presentation; and specifying structural defectiveness with increasing refinements, and have been dependent upon school of thought. Other questions deal with placing the disorder on a spectrum (affective/impulsive/trauma); the repeated difficulties with rule governance; triggering aspects of the environment; increasingly refined dynamic aspects, both intrapsychic and interpersonal; increasingly refined specifications of defence mechanisms; the time the pathology begins and the developmental pathway it follows. At this point object relations views contrast with those of self-psychology, particularly in the role of the drives.

Currently there is clear specification of symptoms and the environments in which they are likely to appear, together with further specifications of structural considerations, identification of the rules and processes of the self along a developmental pathway, specific inclusion and exclusion criteria for DSM IV and subsequent research into these criteria as well as into comorbidities, course and prognosis. Aetiology has come back into favour as a subject of enquiry but in a non-integrative manner, without consideration of

neuropsychology (for example), the specific potential antecedent condition of Attention Deficit Hyperactivity nor the developmental experiences of sufferers as they perceive them. This latter knowledge is gleaned from the sufferers themselves, in the course of this study.

At present, it is suggested, we have moved from the nominative level to several different levels of integrative understanding of borderline phenomena, i.e. physiological, emotional, and cognitive, to varying degrees (Clarkson & Lapworth, 1992). Other integrative levels have yet to be addressed when understanding both the broad-ranging external manifestations and the problematic internal overdeterminations that constitute borderline phenomena. It is towards such integration that this study is intended to contribute. Furthermore, the integration of these integrative levels in themselves is still a work-in-progress, although a start has been made (Millon, 1996; Paris, 1993). There is insufficient reference in the current literature, it is suggested, to diverse theories, whether they are integrated or not. Allusions to the feelings of sufferers remain at that level. The question I ask, i.e. what the developmental issues of borderline psychopathology are from the participants' points of view, has, therefore, no substantial history in its own right.

Inattention refers to failures of working memory, deficient attention and variable levels of consciousness, together with their behavioural manifestations such as impulsivity and hyperactivity. The issue of deficient attention has not been comprehensively treated as a precipitating factor in the abundant literature (covered in Chapter Three) on borderline psychopathology.

There is one relevant ongoing study being conducted in Milwaukee (in Barkley, 1998).

In the Milwaukee follow-up study, 14% of individuals diagnosed with ADHD receive an additional BPD diagnosis in young adulthood. While this may be no more than chance, 75% of ADHD individuals report interpersonal problems (versus 54% of controls) and 79% present with neurotic symptoms, such as anxiety, sadness, and somatic complaints (versus 51% of controls) (G.Weiss & Hechtmann, 1993). These latter are suggestive of milder borderline pathology.

In general, the literature on ADHD is even more quantitative and experience-distant than that pertaining to borderline psychopathology. In a manner similar to that of borderline psychopathology, the research questions are based on attempts at identification and then aetiology from an etic (outside observer) point of view. Children with deficient attentional processes have been described historically in various ways (impulsive, defiant, immoral, hyperactive, unable to sustain attention, impervious to pain) in the literature. The current DSM IV criteria focus on the predominance of inattention or of hyperactivity or on a combination of both.

There is still much grappling with the issue of identification of the phenomenon, much like the blind men attempting to conceive of an elephant when presented with only a leg each for inspection. At the moment investigations of aetiology emphasise which brain networks are responsible for wreaking the behavioural havoc of ADHD. There is little in the literature that notes what it was or is like from the point of view of afflicted children, and very little from adult retrospective accountings, which in any event were taken from otherwise highly functional adults (Ratey & Johnston, 1997).

The available literature does not emphasise a link between BPD and ADHD disorders on

any level. Even in this study, at first, the literature on each is treated separately and in depth. (See Chapters Two and Three.) The literature dealing with both disorders separately has been predominantly quantitative, e.g. correlating two or more facets or demonstrating various points, within a particular model of the psyche. Another variety of the quantitative approach has been adopted by the field of neuropsychology, which has attempted to explain both disorders in terms of underlying biological and chemical components of the brain. Similarly, most of the literature on ADHD hones the quantitative aspects, particularly biological and genetic origins.

Some qualitative attempts have been made in terms of the family dynamics of both disorders and the behavioural circumstances that exacerbate or moderate them (Barkely, 1998, Giovaccini, 1993). In psychodynamic models of the psyche, much rich description has been provided, but quite separately from quantitative information or in opposition to it, and primarily from the distance of the describer. Approaches to both disorders are characterised by varieties of research clustered in terms of model building, for purposes of intervention or to instantiate and develop theory. Most do not look in detail at the experiences of borderline psychopathology from the sufferer's point of view, and in particular do not look at the connection between ADHD and BPD, at the level of experience, or at the impact of chronic, subtle trauma. Furthermore, the available literature does not treat any link between these disorders firstly as experiential, and, secondly, as a basis for subsequent causality.

Nevertheless, *prima facie*, the symptom profiles of BPD and ADHD, as described in the DSM IV (APA, 1994), resemble each other. Across contexts, self-destructive impulsivity, disruption, poor frustration tolerance, and variable, extreme cognitions and

affects mark both deficient attention and borderline psychopathologies. Boredom and chaos in work or relationships plague both. In both, there is a notable tendency for aspects of the self to be absent from current reality through inattention and a distractibility fostered by an affectively distorted inability to distinguish and prioritise sources of stimuli. Both syndromes are characterised by inconsistent experiences of self and others. Both syndromes evidence an inability to persevere and the relationships of those experiencing these disorders are fraught with conflict.

Paulina Kernberg (1983) also notes that Minimal Brain Dysfunction (MBD – former broad terminology for ADHD and learning disabled) in children with affected spatial orientation, memory and verbal abilities, *inter alia*, are more prone to problems in the separation-individuation phase, placing them at high risk for borderline pathology. Outcome studies of ADHD children indicate that "the overlap between MBD and borderline symptomatology is great; and in fact, follow-up studies of MBD children indicate that a significant number in late adolescence and adulthood are diagnosed borderline" (Marcus *et al.*, 1983:174-175).

From these descriptions, it is conceivable that the symptoms of borderline pathology could develop at least in part from the affective and cognitive *sequelae* of attention deficits, and from the responses that these *sequelae* frequently generate.

Despite these scattered and relatively early references, the factors that may be implicated in this phenomenon have yet to be identified clearly in the literature. A conceptualisation of borderline pathology founded on deficits in attention has not yet been explored from an experiential, subjective perspective. The research problem is

both a developmental dilemma (how does borderline psychopathology develop from the sufferer's point of view?) and a causal quandary (does deficient attention contribute to the development of this pathology?).

This study has sought to address the deficit in the literature, through establishing an experiential link between the two syndromes first, with causality as a secondary concern in order to meet (to some extent) the unmet challenge posed by Cohen *et al* (1983):

> ...ADD may be but one facet or determinant of a more ominous disorder, such as borderline syndrome. To explore this hypothesis ... will require systematic research [and] may suggest new approaches to the treatment of the perplexing borderline syndromes ... The extension of these concepts ... remains an unmet empirical challenge (Cohen *et al*, 1983:19).

Against this general background, I decided to explore the developmental issues of sufferers of borderline psychopathology. In doing so, I raised the question of the putative "link" between deficient attention and borderline psychopathology in a specific form: it might be possible that deficits in attention and subsequent lapses in consciousness constitute subtle but chronic traumatogenic factors, predisposing vulnerable individuals in adverse circumstances to serious adult pathology, in this case borderline psychopathology.

In order to assess whether this conjunction could in fact be substantiated, the research took the form of an exploration of the experiences of self, along a developmental trajectory, and an identification of what, in lived experience, led these particular people away from success in dealing with the issues of life towards succumbing to them; away from coherence towards unravelling. The purpose of this assessment is to contribute to the understanding of these psychopathologies and thus, perhaps, to their different treatment.

This study does not only adopt the type of qualitative approach that concentrates exclusively on the actual experiences of participants diagnosed as having BPD. This research is also about the characteristics of the relationships between the two disorders, as expressed by the participants, and about possible correlations between the two disorders brought about by chronic and subtle trauma.

In the literature on borderline psychopathology and deficient attention, questions about the aetiology of borderline psychopathology at the experiential level and about an experiential link between deficits in attention and borderline psychopathology have not yet been asked. The nature of my research problem and the open-ended research question it generated represents a movement away from descriptions of these psychopathologies at the quantitative, experience-distant, descriptive level towards an experience-near, and possibly linked, questioning of aetiology. Although there have been a few narrative approaches to this question, I do not believe that there have been attempts to investigate the developmental issues of sufferers, as reported by them, in opposition to (or in agreement with) existing constructions of such suffering in the literature.

Unlike many authors of previous literature on borderline psychopathology and deficient attention, I do not think that quantitative measures such as those of self-esteem and measures of parental pathology can convey the multiple and non-linear processes contained in the research question about qualities and textures of experience in a substantially meaningful way. From time to time lay texts and media have treated the subjects of borderline psychopathology and deficient attention from an experiential perspective, such as in *Girl, Interrupted* (Kaysen, 1993, and the film based on it) or in the

most extreme form of BPD in *Fatal Attraction*; and even more so in narratives such as *I Never Promised You a Rose Garden* (Hannah Green, 1964); and *Borderliners* (Peter Hoag, 1994), *Smart but feeling Dumb* (Levinson, 1994) and *Woman with Attention Deficit Disorder – Embracing disorganization at home and in the workplace* (Solden, 1995), which keep the viewer/reader engaged long enough to begin deliberation of their own. However, what the lay accounts do not do is effectively extend academic knowledge.

The intention here is to probe a syndrome now considered to be genetic-biological in origin (Ratey, 1995), universal (encountered across cultures) and affecting 3-5% of all school-age children, predominantly male (DSM IV, 1994). The intention of such probing is to examine the interplay between this syndrome and environmental factors in the production of borderline states, focusing on how this interplay is recounted retrospectively by adult sufferers of borderline psychopathology, and teasing out the chronic and subtle nature of potential trauma.

The thrust of this research is individual and emic (i.e. from the perspective of the participants), directed at the specifics of particular cases and what these participants have to say about their experiences of growing up. The number of such people reporting poor self-esteem is less meaningful to this enquiry than the processes flowing into and from poor self-esteem. It is suggested that the playing out of attention deficits in the interpersonal space creates disparate feedback from the environment as well as contradictions in self-image.

My aim, then, is:

To understand the development of borderline psychopathology.

My research question is:

What are the developmental issues in borderline psychopathology; and is deficient attention contributory on the experiential level?

The research question asks: firstly, about the developmental issues in borderline psychopathology and, secondly, whether there is a particular experiential link between earlier ADHD and the later manifestation of BPD.

It became important to address the developmental issues in borderline psychopathology (rather than BPD) and similarly deficient attention (rather than ADHD). A subsidiary question arose of how these individuals reference themselves in terms of marginalisation in relation to siblings, peers, and people in positions of structural authority over them, inside and outside the family. The apparent contradiction of a female-dominated psychopathology arising from a male-dominated psychopathology will be addressed in the literature survey and other chapters. The rationale for studying these areas of psychopathology is to make a contribution to the understanding of them and thus to the prevention and treatment of them.

The originality of the study rests not only in the investigation of these psychopathologies as possibly being experientially linked, but also in the strategy of inquiry into suffering itself (Chapter Four). Moving from within a qualitative paradigm, data was purposively gathered in three settings. The question I asked of the data and of the participants was what growing up was like for them, in the specific contexts of home and school, in

relation to authority figures, peers and siblings, as well as how they came to think of themselves. The data was subjected to extensive qualitative analysis, during which each transcribed interview was treated as a life history and coded using purposive sampling to create a thematic content analysis.

The data analysis produced seven themes set in an overall context of trauma, namely: incoherence, inattention, incompetence, dispossession, persecution, discord, and refraction, all of which are clearly defined in the body of the text (Chapter Five). I used these to build a model of developmental psychopathology, which is intended to be of pragmatic value to fellow mental health professionals and to educationalists (Chapter Seven).

Chapters Two and Three review the existing literature on borderline psychopathology and deficient attention, respectively. Following this literature review are the chapters on my methodological orientation and the research procedures I carried out. Most of the remainder of this study is taken up by the data presentation and the concluding model derived from its systematic analysis. The effect of this study will hopefully be to contribute to placing the effects of subtle and chronic trauma alongside, and not in the shadow of, war and rape.