CHAPTER TWO

ON BORDERLINE PSYCHOPATHOLOGY

2.1 INTRODUCTION

Thus far, I have presented an overview of this study. In this chapter, I consider certain theoretical positions on borderline psychopathology that may be of use when attempting to make meaning of participants' stories. In this attempt, I have utilised available conceptualisations of Borderline Personality Disorder (BPD) or Borderline Personality Organisation (BPO), or 'borderline psychopathology'. I have sought to employ these contrasting points of view, in the promotion of understanding my analysis of the data, rather than remain caught within their (at times) conflicting positions.

In this chapter, I discuss borderline psychopathology in terms of its historical as well as current psychodynamic, psychiatric and neuropsychological perspectives, all of which I find useful to a potentially comprehensive understanding of the data generated in this study. However, commentary is reserved for after the data that has been presented and analysed (see Chapter Nine), although where pertinent, consideration is given to the implications that deficient attention may have in the development and functioning of the borderline individual.

2.2 HISTORICAL PERSPECTIVES

There has been considerable difficulty in understanding precisely what borderline psychopathology constitutes, with various terms all applying to it. This difficulty is apparent in the many names previously applied to those who did not fit neatly into neurotic or psychotic categories but seemed nearer the latter than the former. Such terms included 'ambulatory schizophrenia', 'latent schizophrenia', 'preschizophrenia', 'schizophrenic character', 'abortive schizophrenia', 'pseudo-psychopathic schizophrenia', 'psychotic character', 'subclinical schizophrenia', and 'occult schizophrenia' (Gunderson & Singer, in Stone, 1986). Deutsch (in Stone, 1986) introduced the notion of the "as-if" personality, one form of borderline psychopathology, which presents as an individual who is superficially appropriate, but masks serious disturbance, a refrain recently taken up by Sherwood and Cohen (1994). As late as 1986, Gunderson and Singer point to disagreement over definition, although the term 'borderline' had by then become commonplace.

Millon (1996) provides a comprehensive historical review of both divergent labels and heated debates about the nature of borderline psychopathology, highlighting depth and variability of mood as the most salient characteristic the pathology. Millon (1996) also emphasises the divergent backgrounds and the heterogeneity of presentation, which can nevertheless be grouped by structural defectiveness and recognised as a durable pattern of disturbed behaviour. It is clear that borderline psychopathology is no longer a category representing clinical indecision or a transitory state between levels of severity, following DSM IV (1994). However, there are several other syndromes that are clinically similar to the DSM IV's (1994) description of borderline.

There is also ongoing disagreement about the prime attributes of borderline psychopathology. The current focus is on whether borderline psychopathology is a structural configuration, an affective disorder, an impulse-spectrum disorder, a precursor to schizophrenia or whether it can be seen as an umbrella term for a variety of disorders (Millon, 1996). Zanarini (1993) begins with classifying it as an impulse-spectrum disorder but later Zanarini and Frankenburg (1997) propose that BPD is a trauma-spectrum disorder. This particular point will be dealt with below, in order to clarify which point of view I have found most useful in the analysis of data.

Stone (1986) provides the most useful summary of historical conceptualisations of borderline psychopathology for this study. He begins with the descriptions of Falret, Pritchard and Reich; and continues with the later writings of Stern, Knight, Hoch and Palatin, Deutsch, Schmiddeberg, Little, Balint and Jacobson. The contributions of all these writers, in terms of relevance to the analysis of the domains of experience elicited by analysis of data in the current study, are discussed below.

Despite the consensus on the term 'borderline', it is remarkable that Falret, in 1890, and Pritchard, at a similar time, (Stone, 1986) described the 'hysteric' in terms similar to the BPD and BPO criteria of today, as set out in the DSM IV (1994), Kernberg (1984, 1985a, 1985b) and other current studies detailed below:

> To begin with, one notices a great lability in all their emotional dispositions, which fluctuate according to the moment one is observing them. They alternate, and at very brief intervals, from excitement to depression, in the same manner that they change abruptly, from the standpoint of physical expression, between an outbreak of laughter and an outbreak of tears. They wax enthusiastically with ardour, and with passion, for any person or object they wish to possess at all costs. They shrink before no effort or sacrifice to attain their goal. But once obtained – or even before their goal is achieved – they swing suddenly to the other extreme. Their love transforms itself into hatred; their sympathy into disdain; their desire into repulsion – and they bend as much effort into rejection and avoidance of the object they had just been

> pursuing as they had expended the moment before in winning it. They are thus, and in everything, fanciful and capricious, presenting an extreme of changeability in either ideas or feelings. (Falret, 1890, translated by Stone, in Stone, 1986:7)

The essence of what Falret observed in 1890 seems to be akin to the current notion that one aspect of borderline psychopathology is sudden variability of affect, impulse and behaviour, without apparent reason across both internal and external contexts. Pritchard emphasises that

> the power of self-government is lost or greatly impaired; [there is] insanity of conduct, feeling or impulse or all combined without appreciable intellectual derangement…expressing itself in action rather than speech although it may occur in both (in Stone, 1986:23).

Wilhelm Reich's 'impulse-ridden character' similarly has "ungovernable propensities to act out…just to act impulsively, irrationally, precipitously and often enough, meanly, as a general habit" (1925 in Stone, 1986:12). Recent literature reinstates the centrality of impulsivity to borderline psychopathology (Paris, 1997; Zanarini, 1993; Stone, 1986), implying that it is primarily a disorder of behavioural disinhibition with underlying neurological dysfunction.

Interestingly, the features of BPD display much that relates to the ADHD child. Taken together, Falret, Pritchard and Reich come remarkably close to Barkley's (1998) description of the ADHD child (presented at the end of the next chapter). Children with ADHD also swing wildly about, are incessantly demanding and self-centred, respond too quickly without appreciation of consequences, are heedless and careless of themselves and others, unable to delay gratification and have been termed ungovernable and insensitive as well as lacking in the essentials of appropriate judgement.

One of the first authors on borderline psychopathology, whose work seems particularly

relevant to the data analysis here, was Stern (in Stone, 1986). Writing in the 1930s within a classical psychoanalytic framework, Stern referred to the 'stable instability' of borderline psychopathology, describing it as a series of character traits and reaction formations. His work remains significant, as it is clear that current Object Relations, Self-psychology and even Cognitive Behaviour schools find some of their roots here. According to Stern, the historical external world of the adult borderline comprised a neurotic or psychotic mother, who injured the child through deficient spontaneous maternal affection, either neglectful or over-solicitous. The histories of those who become borderline are characterised by high levels of family conflict, parent-child separation, chronic cruelty, neglect, and brutality by parents, all of which leave a hunger for affect, a state of 'psychic starvation'. Borderlines suffer then "from affective (narcissistic) malnutrition" (in Stone, 1986:56), which leads to intolerable distress.

It is noteworthy that these descriptions of both the individual sufferers and the context in which they found themselves match the description Barkley (1998) provides in his summary of studies regarding the ADHD child. Frequently, these children are also 'injured', and family dynamics are manifestly the same as those in the histories of borderline individuals.

In moving from the description to the dynamics of borderline psychopathology, Stern (in Stone, 1986) notes several features of borderline psychic structure pertinent to this study. Stern writes of "psychic bleeding and rigidity" (in Stone, 1986:58), which dictate, similarly to the ADHD child (Barkley, 1998; Woods & Ploof, 1997), a paralysed response to trauma, where fight or flight questions are posed rapidly by the victim and yet remain unanswered, leaving the victim in a paralysed position. There is a constant

reflexive, hypersensitive, protective stance, visible in defence mechanisms and indicative of “an exquisite receptive apparatus or instrument to detect danger readily and to take appropriate precautions” (in Stone, 1986:58). The difficulty experienced by those in borderline states and those suffering from deficient attention, centres around the word ‘appropriate’ – the apparatus is exquisitely sensitive to danger but not necessarily to the reality of the situation. A recuperative survival reflex is seemingly not possible.

With regard to this study, a similar situation is characteristic of the ADHD child, the difference residing only in the perception and reality of the external world. The borderline stance, like that of ADHD children, is apparent before age four or five and precipitates a maturation process fraught with anxiety and danger. The experience of danger extends to the level of the body: in difficult situations, somatic insecurity is apparent, only partially concealed by a pseudo-equanimity maintained by massive defensive operations. Stern (in Stone, 1986) continues: lack of real self-confidence is ongoing and there are never periods of confidence unless derived from the environment, temporarily. Instead, there is inordinate hypersensitivity, without a reality function, which results in injury by innocuous remarks, amongst other apparently non-injurious experiences.

Uses of projective mechanisms are plentiful, implying “the existence of a piece of defective judgment” (in Stone, 1986:64). This is particularly important to this study as, following Barkley’s (1998) model and earlier conceptualisations of ADHD, deficient attention is broadly equivalent to defective judgement. In Stern’s terms, this leads to anxiety being projected onto the outside world, a defence employed at the expense of insight. The environment is perceived as hostile, rather than the self as insecure, because

such knowledge of self, rather than presumed knowledge of others, would lead to maturity. Relationships are difficult, particularly with authority figures. Similarly, the literature on ADHD is replete with the child, in conflict with authority figures, employing similar defence mechanisms and with the same perceptions of the environment (Barkley, 1998), as will be detailed in the next chapter.

Borderline dependency needs are heightened because relationship to authority is determined by the need for love and affection; and this need is approached through infantile methods "especially obedience, compliance and insistent demands for tender, gentle handling" (in Stone, 1986:60). Such infantile methods can also be seen in the child with attention deficits, although only in short and unsustained bursts. The sense of inferiority in both is based on experienced immaturity: the individual feels "young, weak, timid, unworthy, never loved" (Stone, 1986:61) and adult expectations overwhelm them with anxiety. I suggest that this anxiety is based in reality in that the child does not have the wherewithal to take on adult responsibilities, whether it is consciously or unconsciously aware of this.

Anxiety, following Stern (in Stone, 1986), and heightened awareness of this anxiety, is experienced at the expense of awareness of other things, i.e. attention is paid to the anxiety, and is sufficient to cause recoil into both inactivity and further inferiority. Inactivity, consolation, pity, and self-pity masochistically contain the anxiety itself. These defences and behavioural manifestations are in contradiction of apparently intact intellectual capacity and even knowledge of the defence mechanisms. Stern (in Stone, 1986) interprets the dreadful fear of becoming an adult as a fantasy of perfection, which is why the task is impossible. If adulthood is achieved, there is an underlying belief that it

is not real and may be easily unmasked. Success means suppression of inferiority and assumption of the role of the envied omnipotent imago. The imago itself is overvalued and identified with, an illusory identification; insight is equally illusory, and the concept of reality is based on *wishing* to do what adults do.

Difficulties in reality testing manifest in many ways, maintains Stern (in Stone, 1986). The analyst (or other object) is initially experienced as omnipotent because of extreme dependency needs. The object then seemingly becomes hostile, causing confusion and attempts to recapture the illusion of the perfect, omnipotent object. Self-esteem rises based on perceived approval, commendation or preference; and falls just as easily in the face of perceived criticism. Old information is reacted to as if it is new and as painful as the first presentation, following Stern (in Stone, 1986). This is startlingly similar to the case of the ADHD child, as a 'prisoner of the present', following the model set out by Barkley (1998) and supported by Woods and Ploof (1997), because of dysfunction of the pain and pleasure centres in the brain.

Deutsch (in Stone, 1986), writing in the 1940s on borderline psychopathology, points to the lack of object love in the "as-if" personality, one form of borderline psychopathology. Apparent adaptation is empty because there is gross identification with multiple external objects, without internalisation. An inner experience of warmth and emotion is missing even if these are displayed by these personalities in behaviour and speech; it is merely evidence of pseudo-affectivity. Again, this is similar to the truncated experiences of pain and pleasure, which Woods and Ploof (1997) place at the centre of ADHD problems.

Deutsch (in Stone, 1986) maintains that these "as-if" individuals are characterised by

submission, suggestibility and plasticity. Beneath the passivity and its denial, however, lies aggression. Deutsch (in Stone, 1986) further points to the contradictory expressions of these aspects of self and the denial of one aspect while the other is fore-grounded, an idea taken up later by Kernberg (1984) as well as in Kohut's (1977) notion of a self vertically split by pathological dynamics. What is important for the current study is the suggestion that only one aspect of self can be held in mind, by working memory, at a time, without reality-based shifting or focusing, again linking a central problem of deficient attention to borderline psychopathology.

At a similar point in history as Deutsch, i.e. the 1940s, Schmiddeberg (in Stone, 1986) noted another essential: "Such patients are unable to stand routine and regularity". With regard to the present study, this description of those with borderline psychopathology is similar to the ADHD child (Hyperactive Type). "Both ADHD and BPD's transgress every rule…even when they try to co-operate, they cannot sustain the effort" (in Stone, 1986:92).

Hoch and Palatin (in Stone, 1986), also writing in the 1940s, identify eleven criteria denoting borderline states. These criteria include depressive, angry and impulsive elements, which are marked by diffusion of aims, sexual adaptation and polyvalence, i.e. "many constantly shifting notions in the approach to reality" (in Stone.1986:121). Other symptoms are anxiety, depression, and neurotic symptoms. Additional symptoms include confusion of both affect and of thought. Affect is inappropriate; there is overreaction to trivia; and cold, or controlled under-reaction to significant events. In different terms, over-inhibition swings to lack of inhibition, a function of the systems controlling self-monitoring, also present in ADHD. Indiscriminate expression of hatred is evidenced,

particularly against family members.

Thought is specifically disordered, taking the form of “condensations and concept displacement” (in Stone, 1986:122); omnipotence of the patient or of the environment towards the patient; magical thought; some concreteness, and confusion between foreground and background. Rorschach responses include attention to insignificant details, a “lack of constructive planfulness [and] marked variability of…performance” (in Stone, 1986:126), a definition that can be equally applied to the ADHD child. Thought disorder can be severe: short-lived periods of psychosis are evident, which Hoch and Palatin name “zigzagging” (in Stone, 1986:124) across the reality line. These periods contain hypochondriacal ideas, ideas of reference and feelings of depersonalisation. Symptoms remain unexplained to the self and are usually left unreconciled with logic.

In the 1950s, the focus in the study of borderline psychopathology became Knight’s thoughts on primitive defence mechanisms, object relations and reality testing, identity diffusion and individuation issues. Knight (in Stone, 1986) disputed the various labels referred to at the beginning of the section and settled for ‘Borderline States’. Knight pointed to severely weakened ego functions, particularly the inability to integrate or plan realistically, rigid defences, poor concept formation and judgement. This again echoes some of the ways in which ADHD children are described and the usual dysfunctions based on inadequate frontal systems, which underlie both disorders. These dysfunctions lie beneath superficial adaptation to reality and very superficial maintenance of object relations, which vary in amount of adaptation. Knight (in Stone 1986) notes that individuals in borderline states can appear seemingly unimpaired, with memory, calculation and habitual performances carried through without indication of the internal

chaos. Structured situations may conceal avoidance, denial, and peculiarities of expression and lost affect, as these situations inherently balance impulse and control.

Knight further proposes that if symptoms are ego-syntonic, this is an indication that the ego is overwhelmed. On the other hand, if there are apologies about these peculiarities, there is a degree of ego-dystonia, preservation of the critical ego; and thus a degree of self-monitoring capacity is retained. Such capacity is significantly absent in the case of deficient attention. Knight continues: ego-syntonic presentation indicates "lack of concern about the realities of his life predicament, usually associated with low voltage wishes for help or grossly inappropriate treatment proposals of his own" (in Stone, 1986:166).

Also in the 1950s, ways of understanding borderline psychopathology assumed different forms in the United Kingdom and United States. The British Object Relations School represented by Fairbairn, Balint, Winnicott and Guntripp almost never mention the term 'borderline'. Nevertheless, Balint arrived at the notion of a 'Basic Fault', which described a tension and strangeness that appeared in the therapeutic context "…and because the trouble stems from the preverbal period, language fails as the vehicle of communication – which takes place instead via the borderline's peculiar behaviour" (in Stone, 1986:156).

In the United States, psychosomatic theories abounded, which Giovacchini (1993) has taken up more recently; Rado investigated the schizotypal character and Erikson the formation of identity and major life tasks. Erikson concluded that borderlines have not negotiated the initial tasks, leaving these individuals with mistrust, shame, self-doubt, guilt, and inferiority. Also in this period, Little contributed the crucial notion that

experience for borderlines is life-and-death; and all-or-none thinking (in Stone, 1986). When examining either the UK or US trends, it is noteworthy that studies pointing to poor self-esteem in ADHD children abound, as will be seen in the next chapter.

Jacobson, also a major forerunner of both current Object Relations and Self Psychology approaches to the study of borderline psychopathology, investigates the borderline-affective boundary, concluding, *inter alia*, that

> to the extent which the child begins to cathect and employ the executive organs of his own body and to acquire the physical and mental functions that will turn him into an autonomous, independent human being in his own right, he will be ready to develop the outlines of his future identity and, concomitantly, to build up advanced forms of personal interrelations and identifications (in Stone, 1986:195).

In the case of the nascent borderline, the child is unable to carry out the fundamentals of becoming an autonomous, independent human being in his or her own right. In the case of the ADHD child, the executive functions are similarly unavailable (Barkley, 1998).

2.3 CURRENT PSYCHODYNAMIC PERSPECTIVES

2.3.1 The Object Relations Point of View

Kernberg (1984, 1985a, 1985b), who began his writings in the 1960s, is still considered a primary authority on borderline psychopathology (Arntz, Dietzel & Dreessen, 1999), from an Object Relations and developmental point of view. Kernberg's (1985a) 'Borderline Personality Organisation' (BPO) delineates clear inclusion and exclusion criteria, thus demonstrating his own psychiatric manner of thinking (Akhtar, 1989), as well as clarifying issues for practitioners in a pragmatic manner.

Borderline Personality Organisation refers to a specific and stable but pathological psychic structure, more severe than neuroses and less severe than psychoses. Inclusion criteria encompass, firstly, the different and largely intact capacity to test reality, as opposed to psychotic incapacity. Secondly, the sense of diffuse identity distinguishes this from a neurotic organisation. Thirdly, there is the possibility of testing innate aggression through neurotransmitters and pathways in borderline patients, rather than relying on intuition. Kernberg (1985a) paints BPO in broader strokes than the DSM IV (1994) criteria (although his influence on these latter is manifest), ascribing an underlying borderline organisation to other disorders such as narcissistic personalities. Kernberg (1985) draws attention to the specific clustering of these symptoms, and suggests the co-occurrence of at least two as pointers for diagnostic purposes. Diagnosis, however depends on "characteristic ego pathology and not on the descriptive symptoms" (Kernberg, 1985:9).

2.3.2 Kernberg's symptoms of borderline presentation

Firstly, chronic and diffuse anxiety is manifest. Secondly, there is 'polysymptomatic neurosis': at least two of these six anxiety symptoms are considered presumptive of BPO. This neurosis is visible in multiple phobias, particularly those that relate to the body or social life, as well as paranoid and hypochondriacal trends, which may occur with any other symptom. Less pathognomic are obsessive-compulsive symptoms, particularly of a paranoid or hypochondriacal nature, which are over-valued and ego-syntonic. As part of the neurosis, there may be multiple elaborate and bizarre conversion symptoms of a chronic nature, and dissociative reactions. Less frequent is hypochondriasis itself with chronic symptoms and social withdrawal specifically directed at preoccupation with health.

Thirdly, polymorphously perverse sexual trends prevail, either manifest or in fantasy. Fourthly, classical pre-psychotic personality structures are in evidence, i.e. paranoid, schizoid, hypomanic, and cyclothymic with strong hypomanic trends. Fifthly, there are impulse neurosis and addictions; i.e. chronic repetitive eruption of instinct-gratifying impulses, experienced as pleasurable during the episode and ego-dystonic or rejected outside of the episode. Kernberg (like Jacobson before him) notes a "selective impulsivity shown by many borderline patients" (1984:19), i.e. only in one, compartmentalised, aspect do their behaviour and inner dynamics manifest as contradictory and disinhibited. Lack of impulse control is more generalised in the 'acting out' disorders with which borderline overlaps, and is central to the manifestation of ADHD.

Finally, there are lower-level character disorders and structures, i.e. infantile, narcissistic, as-if and anti-social, in their severe manifestations. Kernberg (1985) includes here sado-masochistic personalities and masochistic characters given to primitive self-destructiveness such as self-mutilation or impulsive suicidal gestures marked by rage rather than depression. The severe infantile personality is given to generalised and diffuse emotional lability, childlike overidentifications of a desperate and inappropriate nature based on gross misreadings of the inner life of others, a helpless-toned need to be the centre of attention and cold-toned exhibitionism. Sexual provocativeness of a crude and socially inappropriate kind is linked with promiscuity of a drifting quality. There is rapid shifting between submission and imitation, on one hand, and "stubborn, pouting oppositionalism of short duration, on the other" (Kernberg, 1985:15) and between intense positive and negative feelings. This description comes closer to the abilities of the child

with attention deficits, in that rapid shifting is more likely than sustained attention, with consequent variable presentations. Masochistic traits, interpenetrated by sadistic traits, without guilt, prevail.

2.3.3 Kernberg's structural considerations

In Kernberg's understanding of Object Relations, BPO is characterised by four structural considerations: non-specific manifestations of ego weakness; a shift towards primary process thinking; specific defensive operations and pathology of internalised object relationships.

Firstly, there are non-specific manifestations of ego weakness. Here, Kernberg (1985a) refers to specific weaknesses without specific contexts of their manifestations. Lack of anxiety tolerance manifests in reaction to frustration in terms of additional symptomatology. Even minor frustrations can be experienced as intolerable. Lack of impulse control is marked by its ego-syntonicity during the expression of the impulse, by the repetitive nature of its expression, its dissociation from the rest of the experience of the self, and its denial, just as in the case of ADHD. Underachievement (compared to individual intellectual capability) and creative incapacity, characteristic also of ADHD, indicate this lack of developed sublimatory channels.

Secondly, a shift towards primary process thinking occurs. This type of thinking is elicited by projective techniques or in unstructured contexts and manifests in primitive fantasies, inability to adapt to formalities of a testing situation and "peculiar verbalizations" (Kernberg, 1985a: 24). Kernberg suspects that these contexts reactivate pathological and primitive internalised object relations and facilitate the regression of the

individual to early defensive operations, especially splitting, partial refusion of early self and object images and consequent destabilising of ego boundaries and primitive cognitive structures.

Thirdly, Kernberg (1985a) specifies defensive operations characteristic of BPO. Defensive operations are characterised by "vicious circles involving projection of aggression and reintrojection of aggressively determined object and self images" (Kernberg, 1985a: 27). In borderline pathology, regression does not extend to psychotic refusion of the images but to the unintegrated stage of fixation, i.e. images of opposite valence are split defensively apart (and only one can be held in mind at a time, in the case of deficient attention) but reality testing is retained. The drive derivative attains consciousness as an emotion, an idea, and motor activity but this psychic component is "completely separated from other segments of the conscious psychic experience" (Kernberg, 1985:26). *Attention is paid to one sector or the other but never to the whole.*

The primary defensive operation in borderline psychopathology is splitting. Kernberg uses splitting only in the sense of actively keeping apart introjections and identifications of opposite affective valence, when their integration would neutralise aggression and provide energy for ego growth. The excessive, age-inappropriate use of splitting is the essential failure in BPO, manifested as "alternative expression of complementary sides of a conflict…combined with bland denial and lack of concern over the contradiction in his behaviour and internal experience" (Kernberg, 1985:29). Further manifestations are the selective lack of impulse control referred to above, the division of external objects into all good and all bad, sudden movement of objects from one category to the other, and extreme, repetitive fluctuation between contradictory self-concepts. The

problem is that the intensity of the aggression with which the mental representations are imbued and the intensity with which the all-good mental representations are defensively idealised make integration impossible (Kernberg, 1985b:12). Several of these symptoms are also characteristic of the child with deficient attention, viz. splitting, lack of impulse control, rapid shifting, and, after a period of reactivity to an invalidating environment, intense aggression.

Splitting occurs together with other primitive defences: primitive idealisation, projection, projective identification, denial, omnipotence and devaluation, following Kernberg (1984, 1985a, 1985b). Primitive idealisation inflates external objects to all-good and omnipotent proportions to protect them both from internally and externally experienced aggression, the latter a consequence of projection. The omnipotence of the object is identified with and basked in, experienced as sharing his or her greatness protectively, thus gratifying narcissistic needs. No regard for the reality of the idealised object is entertained.

The second specified defensive operation is projection. In its early forms, projection externalises all-bad self and object images resulting in a dangerous, potentially retaliatory, world that requires further defence, setting in motion projective identification, as defined by Kernberg (1985). In the case of the ADHD child, his or her behaviour may precipitate a retaliatory world. Ego boundaries are weakened specifically in the area of aggression so that the projection is incomplete and identification with the projected aggression is possible. The aggressive impulse is both experienced through identification and feared through projection. This manifests as a superficial capacity for empathy but the now threatening object must be controlled in defence before it can attack and destroy.

This may account for the frequent complaint that ADHD children are bossy or domineering, engendering poor relationships with peers and authority figures.

The third defensive operation is denial in its early forms, of the type implicated in splitting. Contradictory states of the individual are entertained in consciousness but the memory of one state whilst in another has no emotional salience, *implying a weakness in working memory of which attention is an essential part.* Both a specific subjective experience and a sector of the external world can be denied. When the emotion is strongly experienced, denial can take the form of an extreme, opposite affect.

Fourthly, there are the ambivalent defences of omnipotence and devaluation. These enable shifting between the need for protection from the idealised object and the need to devalue it in order to experience the individual's own omnipotence. In both states, the object is idealised but the purpose differs. There is no love and concern defining dependence on the object, rather a ruthless need to control it so that it can destroy potential enemies, and share omnipotence, thus giving the individual a sense of pride in possessing such a perfect object. I suggest that the shifting quality is provided by the inability to sustain attention, particularly automatic attention, to one entity long enough to provide an holistic experience of it.

Kernberg (1984) suggests that grandiose and omnipotent trends underlie borderline feelings of inferiority and fuel unconscious, narcissistic, entitlement. If the object frustrates the individual's needs, it is devalued, in proportion to the individual's need for omnipotence. This action is defensive, to prevent the object from assuming a persecutory position. Devaluation of early significant objects obstructs an integrated ego and

superego. Devaluation continues until a paranoid distortion of early objects, particularly mother, results. This distortion extends to hatred of both parents, who are experienced as a dangerous unit by the child. Realistic parental injunctions cannot be appreciated, protectively, and sexual relationships are later approached as aggressively infiltrated. The resolution of the positive Oedipus complexes in both sexes is obstructed (Chessick, 1993). In an attempt to escape the earlier rage and fears, premature genital strivings occur but are distorted by the intensity of aggression.

The final structural consideration of borderline personality organisation is termed 'pathology of internalised object relationships'. In this configuration, splitting leads to the persistence of early, non-metabolised object relations. Ego boundaries fail specifically where projective identification and fusion with idealised objects take place. Aggression, unneutralised by libido through integration (or limbic override of dysfunctional frontal, executive systems), predisposes the individual to the eruption of primitive affect states and obstructs the capacity to experience real and substantial depression, guilt and concern. This is not to be confused with the apparent guilt and shame mentioned in the DSM IV (1994), detailed below, and lacking in substance. That type of guilt is contingent upon potential loss of nurturing behaviour, rather than true remorse.

Pathology of the internal world is visible in interpersonal relationships, which are characterised by a protective emotional shallowness that defends the individual against the activation of primitive defences, particularly projective identification and fears of attack by the potentially important object. Lack of superego development contributes to a misreading of the other as this deficit facilitates further ego splitting, and immature

feelings, aims and interests. This relates directly to a failure of internalised non-verbal and verbal executive functions, specified by Barkley (1998) as characteristic of deficient attention. These contradictory introjections and internalisations imbue the borderline with an 'as-if' quality as they permit the expedient re-enactment of partial identifications, dissociated from each other.

Only aspects of self are exchanged with others because of emergent non-metabolised units, which are partly projected, partly enacted, but never merged as in psychosis. Superficial adaptation to reality is achieved but "what they pretend to be is really the empty dressing of what at other moments they have to be in a more primitive way. This is quite confusing to the patients themselves" (Kernberg, 1985:39), a confusion of who the self is, is characteristic also of the ADHD child. This identity diffusion (unintegrated self-concept and total object-concept) is characteristic of both BPO and of the inability to hold the whole self and other in mind of the ADHD child. Splitting-induced identity diffusion during the rapprochement phase results in poorly integrated concepts of self and significant others. This manifests as a chronic, subjective, sense of emptiness, shallow, flat and impoverished perceptions of others, contradictory self-perceptions, and contradictory behaviours. Essentially, in these latter contradictions, there is a lack of temporal continuity, visible in the behavioural manifestations of deficient attention.

Kernberg's (1984) point of view is held as important for theories of borderline because, amongst other things, he specifies these clear inclusion/exclusion criteria. However, there are some difficulties with the Object Relations point of view as put forward by Kernberg (1985) despite support for many, but isolated, aspects of his theory (Leichsenring, 1999; Devens & Erickson, 1998; Stern, Herron, Primavera & Kakuma, 1997). Fundamentally,

Kernberg (1984, 1985a, 1985b) remains rooted in a model of self, loyal to classical analysis and therefore characterised by conflicting drives. In the light of this, it is suggested that alternatives to this view of borderline psychopathology, potentially useful to the data analysis, are considered.

2.3.4 Self Psychology

Whereas Kernberg (1984) sees the borderline state as a stable pathological organisation, Kohut (1971, 1977, 1978, 1984) and subsequent proponents of Self Psychology view borderline psychopathology as a deficiency of functions necessary for survival, which the self normally acquires in the course of development. Specifically, borderline psychopathology is construed as the need for specific archaic selfobject ties and the disturbance of these ties (Stolorow & Lachman, 1984). Because of historical unempathic attunement by the caretakers, the self is insecurely established. When this weak self is threatened by fragmentation, the attempt to maintain cohesion (and existence) leads to the manifestation of the drives as products of disintegration.

In the case of the ADHD child, it is likely that the need for specific self-object ties is disturbed, attunement is unempathic, and the self insecurely established. The self, weakly formed in the first instance, is always on the verge of fragmentation, and attempts to maintain cohesion become visible in the manifestation of the aggressive drive in particular. These inferences are supported by studies quoted in Barkley (1998), clearly indicating the poor self-esteem and tendencies to acting out aggression of the ADHD child.

The demand for absolute control over reactions and absolute identification rather than empathy, characteristic of borderline psychopathology, is seen by Self Psychologists as

a heightening of the experience of faulty, unempathic reactions of both historical and current selfobjects. The self, which experiences itself as still-unresponded-to, operates with unmoderated archaic grandiosity and an unmoderated, archaic wish to merge with an omnipotent selfobject. Reliable self-esteem, realistic ambitions, and attainable ideals belong to a moderated and transformed self, which is experienced as fundamentally alien.

The extent of disintegration dictates the formation of a primary defect concealed by defensive and/or compensatory structures, the latter indicative of less pathology. *Compensatory* structures can serve to shore up a weakened self-pole or sector by strengthening the other pole or sector. However, the primary defect of an incoherent nuclear self is concealed by *defensive* structures in borderline psychopathology. What are seen, following Self Psychologists, are not the conflicts engendered by splitting, projection and projective identification, but developmental arrests, deficits that result from psychic trauma and from the inability of an immature nervous system to integrate powerful affects.

Pathological symptoms are explained in Self Psychological terms as symbols of catastrophes and dilemmas in various intersubjective fields, an explanation that will be taken up in detail in Chapter Four, when I deal with development. The nature of these encapsulations gives rise to the different typologies of the self in disequilibrium: the fragmented, empty, overloaded or overstimulated selves (Wolf, in Lee & Martin, 1991).

Disorders of the self are 'faulty' (Kohut, 1978) attempts to control excitement and to avoid depletion and collapse of the self through defensive splitting and displacing. These faulty attempts can be seen as frontal system dysfunction, it is suggested. Although Kohut (1978) categorises the primary self disorders as ranging from narcissistic behaviour disorders, through narcissistic personality disorders, to the borderline states and psychosis, an examination of his taxonomy indicates that the borderline psychopathology under scrutiny in this study overlaps into the first three categories.

The essential difference, in Kohut's view, is that the damage to the self in borderline states is permanent but covered by effective defensive structures, whereas the damage in narcissistic disorder, marked by apparently less serious compensatory structures, is reversible, to an extent (Elson & Kohut, 1987). The permanence Kohut refers to may very well be a function of the intractable effects of frontal system deficiencies and limbic override, characteristic of both deficient attention and borderline psychopathology.

2.3.5 Cognitive Analysis as an Integrative Extension of Object Relations and Self Psychology

Ryle (1997) extends the theory of cognitive analytic therapy (CAT) to offer an additional useful and pragmatic understanding of borderline personality disorder, a putative aetiological link with deficient attention, and a manner of approaching analysis of the data in this study. The CAT approach is close to that of Linehan's (1993) dialectical dilemmas and emotional dysregulation, but accounts for dissociation at increasingly sophisticated levels, which Linehan (1993) does not. Ryle (1997)

describes structure in terms of dissociated selves rather than in terms of intrapsychic conflict or deficit. He proposes a “multiple self states model” of the structure of BPD and classifies the different levels of developmental damage consequent upon such a structure.

Procedural repertoires (the rules and processes of the self) are arranged hierarchically and Ryle (1997) describes three levels pertinent to borderline states, and by inference to deficient attention. At the first and lowest level, repertoires become restricted and distorted by genetic and biological damage, such as ADHD. In terms of the environment, the repertoires are restricted and distorted primarily by abusive and neglectful relationships experienced in early life. These types of relationships are easily precipitated by ADHD behaviour and the parental psychopathology often associated with it, following Barkley (1998).

Internalisation of the harsh attitudes of the perpetrators of such relationships, as is likely when deficient attention is present, contributes to both learned damaging patterns and intrapsychic conflict. Internalised damaging patterns dictate not only that the individual is predisposed to receiving and inflicting abuse on others and the self, but also is restricted in his or her capacity to receive or give care.

Following Ryle (1997), these Level One problems include a variety of Axis I pathologies (DSM IV, 1994), such as eating disorders, depression, anxiety and somatisation, all notable in borderline psychopathology. It is suggested that ADHD is added to this list, as damage to procedural repertoires in the presence of deficient attention appears to follow almost exactly the restrictions and distortions present in

Level One problems.

Level Two procedures mobilise, sequence, and integrate Level One procedures. “Their development can be impaired by contradictory, incoherent or disrupted parenting. Once developed, they may be disrupted by trauma-induced dissociation” (Ryle, 1997:83). Both types of disruption are commonly found in borderline and ADHD backgrounds. Ryle (1997) asserts that “dissociation occurs initially in response to unmanageable external threat, and recurs in response to reminders, memories of repetitions of the threat” (Ryle, 1997:85). The persistence of dissociation is attributed, in this model, not only to internally and externally generated contradictions and incoherence, but also to real threats, real trauma and actual experience, of the sort that the ADHD child is likely to encounter.

At Level Three, self-reflection is both deficient and disrupted, which is clear in borderline psychopathology and in the model of behavioural disinhibition proposed by Barkley of deficient attention. Functional consciousness allows attention to be focused on what is new or problematic in the world or on one’s own behaviour. ADHD children and borderline patients, however, seem only partially or irregularly capable of self-reflection. This is understood, in CAT terms, to result from two factors. Self-reflection is itself a procedure and, in common with other procedures, originates in interaction with others. Parents whose concern is with appearance, obedience or performance rather than with the child’s subjective experience, or who lack interest in, or a vocabulary with which to describe, emotional experience, do not equip the child with a basis for self-reflection. These two factors – narrow attention and deficient emotional vocabulary – frequently coexist in the parents of borderline subjects and children with

deficient attention. A third factor is the disruption of self-reflection caused by state shifts. Borderline subjects may be sensitively aware of the feelings of others and of themselves when they are in certain states. However, such awareness is discontinuous and is liable to interruption by state shifts, often at the precise moment when it could be of value in reviewing and revising problematic procedural repertoires (Ryle, 1997:83). Disruption of self-monitoring capacity is the very essence of ADHD, following Barkley (1998).

Cognitive analytic theory defines a state as the subjective experience of enacting a particular role, where role includes action, and expectation, together with associated affects and memories. A role implies the existence of a reciprocal role. Therefore, in describing a self state, both poles of the reciprocal pattern require elucidation. Frightened and threatening poles would be an example of a full description. Ryle (1997) elevates the importance of the abrupt shifts between different and partially dissociated states of the self, thus accounting for the variability encountered in borderline states and in deficient attention. States are in flux and disconnected because of disruptions on all three procedural levels in the course of development, perpetuated in the present by the compromised procedures themselves.

Ryle (1997) further places state shifting on a continuum of severity, ranging from normal mood fluctuations through state-dependent memory to dissociative identity disorder. Dissociation, asserts Ryle (1997), is typical, and is marked by “alternating dominance of one or other of a small range of partially dissociated ‘self states’” (Ryle, 1997:82). This is in contrast to placing it last on the list of DSM IV (1994) diagnostic criterion of BPD. Viewing dissociation as central to borderline psychopathology has

found some support (Herman, 1994, Paris & Zweig-Frank, 1997). In common with the contradictory self states proposed by both Kernberg and Kohut above, it is as if only one state can be held in mind, by working memory, at a time.

2.4 PSYCHIATRIC PERSPECTIVES

The DSM IV (1994) describes the essential feature of Borderline Personality Disorder as "a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts" (DSM IV, 1994:650). A parallel presentation of the DSM IV (1994) on ADHD will be made in the following chapter. Individuals with BPD are noted for undermining themselves just short of attaining a goal, feeling more secure with a transitional object such as a pet rather than in an interpersonal relationship and sometimes suffering physical handicap following failed suicide attempts or self mutilation.

Also associated with the disorder are failed relationships and occupational defeat or non-engagement, and interrupted education. Abuse, neglect, conflict and early parental loss in the childhood history are common. The disorder frequently co-occurs with other personality disorders and Axis I disorders, including ADHD (DSM IV, 1994). The implications of this comorbidity of BPD and ADHD lends emphatic support for this study, in which a link between borderline psychopathology and deficient attention is postulated. Furthermore, it is possible that the comorbidity is not a parallel occurrence but rather a feature of BPD itself, when it assumes a milder form.

The pattern of behaviour characteristic of BPD "has been identified in many settings

around the world" (DSM IV, 1994:652) and 75% receiving a diagnosis are female. Borderline Personality Disorder occurs in an estimated 2% of the general population; 10% of outpatient mental health patients; 20% of psychiatric patients and makes up anything from 30% to 60% of clinical populations with personality disorders. These figures are substantial and imply that mental health professionals, amongst others, spend a good deal of time and money on the disorder. Early adulthood is described as the most volatile of periods with "episodes of serious affective and impulsive dyscontrol and high levels of use of health and mental health resources" (DSM IV, 1994:653). Greater stability is achieved as the thirties and forties are approached.

Following DSM IV (1994), nine diagnostic criteria for BPD are listed, of which at least five are required to make a diagnosis. The first criterion states that these individuals make *frantic efforts to avoid real or imagined abandonment*, which can take the form of a specific perception of separation, rejection or loss of external structure. This is evident in extreme changes of self-image and in affect.

The second criterion states that these individuals have *unstable relationships, characterised by alternately idealising and devaluing the potential caretaker or lover*, inappropriate sharing of intimate information and being demanding. Devaluing is concurrent with an experience of the other as insufficiently available. Shifts from idealising to devaluing are rapid and result from disillusionment with the idealised nurturing functions of the caretaker or in anticipation of rejection or abandonment. A limited capacity for empathy and nurturing is present, but only with an expectation of something in return, such as 'being there' on demand for the individual if she makes herself available.

The third criterion notes the possibility of an *identity disturbance characterised by marked and persistent instability of self-image*, evident in sudden and dramatic changes in opinion, values, occupational plans, sexual identity and types of friend, exacerbated in unstructured work/school situations. The individual shifts rapidly from "needy supplicant for help to righteous avenger of past mistreatment" (DSM IV, 1994:651). DSM IV (1994) notes a change from a sense of self as evil to one that does not exist when external bolstering in the form of nurturing relationships is unavailable.

The fourth criterion is the display of *impulsivity* in at least two areas that are potentially self-damaging: gambling, irresponsible spending of money, binge eating, substance abuse, unsafe sex, reckless driving.

Fifth, there are *recurrent suicidal behaviours, gestures or threats*. Self-mutilation in the form of cutting or burning (for example) is common and 8% to 10% of those receiving the diagnosis complete suicide. Self-mutilation may occur during dissociative episodes "and often brings relief by reaffirming the ability to feel, or by expiating the individual's sense of being evil" (DSM IV, 1994:651). Such behaviours frequently follow separation, rejection, or the expectation by other people that increased responsibility should be assumed by the borderline individual.

The sixth criterion is the possible display of *affective instability*, evident in brief but intense episodes of dysphoria, irritability or anxiety. DSM IV (1994) also describes a chronic state of dysphoria interrupted only by periods of anger, panic or despair in response to interpersonal stressors.

The seventh criterion describes a *chronic sense of emptiness in individuals, who are easily bored and constantly seeking activity*.

Criterion eight points to the *frequent expression of inappropriate, intense anger or difficulties with anger-control*, evident in characteristic sarcasm, verbal outbursts and bitterness, in response to perceptions of the caretaker as unavailable. These expressions are often followed by (a superficial form of) guilt and shame, which exacerbate "the feeling they have of being evil" (DSM IV, 1994:651).

The ninth, and last, criterion refers to *brief (minutes or hours) and transient periods of paranoid ideation or dissociative symptoms* such as depersonalisation, which may occur during extremely stressful times, defined as real or imagined abandonment. These symptoms remit when the caretaker's nurturance returns.

Recent studies provide evidence for the existence of the DSM IV (1994) criteria, showing that borderline states are more likely to occur when there are associated Axis I and II diagnoses, particularly of mood, anxiety and stimulant substance abuse (Zanarini, Frankenburg, Dubo, Sickel, Trikha, Levin & Reynolds, 1998; James, Berelowitz & Vereker, 1996); or bipolar disorder (Carver, 1997). Lower social class and poor academic achievement (Taub, 1996) and the use of transitional objects such as stuffed animals in adulthood (Cardasis, Hochman & Silk, 1997) are associated features. Kapadia (1998) and Van Reekum (1993) point to specific use of language, and Carver (1997) highlights self-injurious behaviour as well as high rates of interpersonal psychopathology, specifying manipulation and devaluation. James, Berelowitz and

Vereker (1996) point to a pervasive sense of boredom; in adolescents Gunderson and Lyoo (1997) support the presence of eating pathology, as well as significantly negative perceptions of family environment and relationships.

Research into the DSM IV (1994) criteria is ongoing. Modestin, Oberson and Erni (1998) do not find supporting evidence for the proposition that identity diffusion is an essential feature of BPD, nor that it is confined to BPD. The study by Modestin *et al* (1998) contrasts with Frommer and Reissner's (1997) view of Borderline Personality Disorders as disturbances of personal identity. Frommer and Reissner (1997) maintain, instead that patients fail when attempting to overcome the tension between being a person and being a subject in their interpretation of the world and themselves.

There is some debate about the course that BPD takes. Carver (1997) notes that although early follow-up studies on patients with BPD led to the belief that the lifetime course of BPD was as gloomy as schizophrenia, these studies were methodologically unsound. Results from the 'methodologically sound' PI-500 study have led researchers to uniformly conclude that the majority of patients with BPD show improvement at follow-up, although more in the sphere of their professional and career activities than in their social relationships and interactions.

From a study of BPD patients, Stone (in Carver, 1997) has compiled a list of factors that can be used to predict how BPD patients will fare. Patients with BPD whose outcomes were distinctly better than average tended to show: (1) high intelligence (IQ higher than 130); (2) unusual artistic talent; (3) physical attractiveness (women only); and (4) obsessive-compulsive features that enhance self-discipline, work-orientation, and the

ability to structure leisure time. BPD patients who were also substance abusers had better outcomes if they maintained participation in groups such as Alcoholics Anonymous.

BPD patients whose outcomes are "distinctly worse" than average also share common features. These patients are more likely to have a history of (1) transgenerational incest and (2) parental brutality. Moreover, they tend to have (3) schizotypal or antisocial features and (4) untreated substance-abuse problems. BPD patients who have "poor" outcomes can be divided into two broad categories: patients who have chronic impairment and patients who complete suicide. The suicide rate in the PI-500 study was 8.5% in an average sixteen-year follow-up period. Of the nineteen patients in the PI-500 study who completed suicide, thirteen had a history of affective illness, seven had a history of alcohol abuse, five had a history of incest, and eight had at least one first-degree relative with a diagnosed psychiatric illness (primarily substance abuse or affective illness).

This study shows that although patients with BPD may not routinely recover, most do improve in time with appropriate treatment (Carver, 1997). In contrast, Links, Helsegrave and van Reekum (1998, 1999) have found that almost 50% of former inpatients with BPD continue to test positive for BPD at a seven-year follow-up examination, and that these persistent BPD patients also have significantly more comorbid personality psychopathology. In Links, Helsegrave and van Reekum's (1998, 1999) study, the level of borderline psychopathology recorded at the initial assessment primarily predicted borderline psychopathology at follow-up.

Zanarini and Frankenburg (1997) review the literature on the pathogenesis of BPD,

develop their own model, and conclude: “Each pathway is poignant in its uniqueness and agonizing in its similarity. Each is a painful variation on an unfortunate but familiar theme” (ibid:100). The authors note Masterson’s contribution that fear of abandonment is central to BPD. Pre-existing studies on parental loss or separation, disturbed parental involvement and childhood experience of abuse provide the environmental components in the development of BPD; those examining family histories of psychiatric disorder, temperament and neurological and/or biochemical dysfunction (such as ADHD) provide the constitutional components. The model that Zanarini and Frankenburg (1997) arrive at has three elements: a vulnerable (hyperbolic) temperament, a triggering event or series of events and a traumatic childhood (broadly defined).

Zanarini and Frankenburg assert that ‘emotional hypochondriasis’ is the primary defence of borderline patients, and a ‘hyperbolic stance’ is the behavioural manifestation of this defence.

> In this view, emotional hypochondriasis is defined as the transformation of unbearable feelings of rage, sorrow, shame, and/or terror into unremitting attempts to get others to pay attention to the enormity of the emotional pain that one feels. These attempts are usually indirect, and involve a covert reproach of what is perceived as the listener’s ‘insensitivity’, ‘stupidity’ or ‘malevolence’ (Zanarini & Frankenburg, 1997:98).

A hyperbolic stance is defined in the following terms:

> nothing that can be stated dramatically is said simply, and nothing that can be stated once goes unrepeated…borderline patients insist that attention must be paid to the enormity of their subjective pain – pain that is often consciously perceived and openly discussed as ‘the worst pain anyone has felt since the history of the world began’. Perhaps most prototypic of this behaviour is the deliberately physically self-mutilative acts and manipulative (help-seeking) suicide efforts engaged in by borderline patients when under interpersonal stress and feeling alone. While anyone would be in pain, given the traumatic childhood typical of borderline patients, the manner in which borderline patients handle their pain is both characteristic and distinguishing. They insist that their pain be recognized and they present it in a difficult-to-identify manner, due to a combination of habituation and shame (Zanarini & Frankenburg, 1997:98-99).

Zanarini and Frankenburg (1997) specify that triggering events

> can be normative in nature, such as moving away from home to attend college or starting an intimate relationship. They can also be traumatic in nature, such as being injured in a car crash or being date raped…The role of this triggering event seems to be that of a bridge between the intense dysphoria and frustration resulting from traumatic childhood experiences and the preborderline person's innate vulnerability…Without such an event or series of events, which remind the preborderline person of old feelings of rageful despair, and may represent the final degree of frustration that he or she can bear, such a person might be viewed as intense and demanding but not clearly ill or impaired (Zanarini & Frankenburg, 1997:99).

Three types of environmental trauma are specified. Type I Trauma is a home environment, which the authors describe (rather peculiarly) as providing "the types of childhood experiences that can be categorized as unfortunate but not totally unexpectable" (Zanarini & Frankenburg, 1997: 98). This type of trauma is characterised by "prolonged early separations, chronic insensitivity to the preborderline child's feelings and needs, and serious emotional discord in the family, perhaps leading to separation or divorce" (ibid:98).

While considering Type I trauma, it is worth noting that chronic insensitivity is inherent to the ADHD child's experience of his or her world (Barkley, 1998). Therefore, it could be said that ADHD and its consequences could constitute Type I trauma, at the very least.

Type II Trauma includes verbal and emotional abuse, neglect of the age-appropriate physical needs of the child, and periods of caretaker psychiatric illness.

On this level of Type II trauma, ADHD behaviour and the parental psychopathology that frequently accompanies an ADHD child, either through provocation or inherence, could constitute this type of trauma.

Type III Trauma is brought about by physical or sexual abuse, chronic caretaker psychiatric illness (especially Axis II disorders and substance abuse) and "a generally chaotic and dysfunctional home environment (e.g. parents repeatedly engage in shouting matches, the children physically assault one another, no one abides by family rules or honours other family members' personal boundaries)" (ibid:98).

Again, the family profiles of ADHD children are not dissimilar to Type III environments (Barkley, 1998), and, therefore, it is suggested, ADHD predisposes the child to the experience of Type III trauma as well.

Types I, II and III occur sequentially or co-occur in the histories of borderline patients, and, it is submitted, in the childhoods of ADHD individuals.

In a different study, (Zanarini, Williams, Lewis, Reich, Vera, Marino, Levin, Yong & Frankenburg, 1997), which investigated a full range of pathological childhood experiences reported by patients with criteria-defined BPD and comparison patients with other personality disorders, 92% reported having been neglected, before the age of eighteen. They were also significantly more likely to report having a caretaker withdraw from them emotionally, treat them inconsistently, deny their thoughts and feelings, place them in the role of a parent, and fail to provide them with needed protection. In the case of ADHD, the increased demand upon the parents frequently provokes withdrawal and inconsistent treatment from these parents (Barkley, 1998), again precipitating a traumatic environment.

Childhood trauma is considered to be the main aetiology of borderline states (Zanarini, Williams *et al*, 1997), particularly the cumulative effects of sexual abuse, physical abuse, severe neglect, and parental substance abuse or criminality (Guzder, Paris, Zelkowitz & Feldman, 1999; Dubo, Zanarini, Lewis & Williams, 1997).

Parental sexual abuse has been significantly related to suicidal behaviour and both parental sexual abuse and emotional neglect have been significantly related to self-mutilation (Dubo *et al*, 1997). In Dubo *et al*'s, (1997) study, risk factors include female gender, sexual abuse by a male non-caretaker, emotional denial by a male caretaker, and inconsistent treatment by a female caretaker. However, sexual abuse is neither necessary nor sufficient for the development of BPD, and other childhood experiences, particularly neglect by caretakers of both genders, represent significant risk factors (Zanarini & Frankenburg, 1997).

Sexual abuse may not be the major factor, but there does seem to be agreement that abuse or neglect of any kind is predictive of risk for borderline psychopathology (Bailey & Schriver, 1999; Guzder *et al*, 1999), particularly the non-affective criteria, taking into account the interaction of gene and environment (Paris, 1997, 1998). Although the study by Paris (1997, 1998) writes of genetic predispositions in BPD, there is little to support this, and certainly not to the extent that ADHD is established as a genetic or biologically based disorder. Instead, support for neglect as causative of BPD is found in the enormous prevalence of childhood maltreatment and borderline outcomes.

In the United States, reports of such maltreatment of children in general have reached more than 1.6 million new cases per year. A breakdown of the cases reveals 52% from neglect, 25% from physical abuse, 13% related to sexual abuse, and 10% from other sources. The number of children seriously injured because of abuse has quadrupled from 1986 to 1993. Characteristically, sexual abuse of girls begins at age 7.9 years and persists for 26.3 months. Physical violence frequently accompanies sexual abuse (51.9%). Also characteristically, perpetrators are father-figures (58.4%), biological fathers (23.4%) or other family members (18.2%), (Taub, 1996; Zanarini, Williams *et al*, 1997; Paris, 1993).

Amongst other things, abused girls are significantly more physically active, more resistant to co-operation, more impulsive and more anxious (just as ADHD children are). They score high on acting out behaviours, shy and anxious behaviour, and learning problems (just as ADHD children do). Following such abuse, children score very low on frustration tolerance, good social skills, task orientation, or sociability. Poor frustration tolerance, impaired social skills, distracted task orientation and deficits in sociability are hallmarks, too, of ADHD children.

Adults, abused children and, it would seem, ADHD children have substantially greater likelihood of being in an abusive relationship and being the victim of violence, including rape (Bailey & Schriver, 1999; Zanarini, Frankenburg, Dubo *et al*, 1998; Zanarini, Frankenburg, Reich *et al*, 1998.) The results of this latter study suggest that both male and female borderline patients are at substantial risk of being physically and/or sexually victimised as adults.

Bailey and Shriver (1999) capture the attitude beneath the psychiatric position in a study that found that, relative to patients with other personality disorders and to the typical outpatient, patients with BPD were rated as especially likely to misinterpret or misremember social interactions, to lie manipulatively and convincingly, and to have voluntarily entered destructive sexual relationships, possibly even at young ages.

Questions remain, however: how and why would they misinterpret, misremember, lie, and voluntarily enter destructive sexual relationships? What are the roots of their emotional hypochondriasis and ensuing hyperbolic stance?

2.5 NEUROPSYCHOLOGICAL PERSPECTIVES

Neuropsychologically, borderline pathology can be seen in terms of the concerted malfunctioning of the frontal and limbic systems, manifesting phenomenologically as impulsivity and affective instability respectively, corresponding almost isomorphically to the neuropsychology of ADHD.

2.5.1 Frontal System Dysfunction

Changes in personality following insult to the frontal systems have been written about ever since the case of Phineas Gage (Damasio, 1995). Recently these changes, which form a heterogeneous group, are being parcelled out and attributed to different subsystems within the frontal system. Stuss (in Beaumont, Kenealy & Rogers, 1999) suggests reframing these disparate changes in terms of altered drive, altered mood and altered affect. Altered drive is attributed to impairment of the anterior convex, which, with or without the involvement of the medial frontal regions, can produce changes in

different directions – either apathy with difficulty initiating behaviour, or disinhibition if orbitofrontal areas are involved. Changes in mood (defined as subjective feeling tone) and affect (defined as the overt expression of emotion) also result from dysfunctional frontal systems.

This neuropsychological reframing of disorders in personality permits further understanding of phenomena such as the ability to experience emotion when it is dissociated from or incongruent with the ability to control the expression of emotion. Additional neuropsychological disturbances are most apparent in a social context, where the demand, constantly, is for controlled expression of emotion. Perceptual, motor, attentional, memory, learning, and executive disruptions act to divert the individual's ability to

> establish appropriate goals or responses; to organize and integrate behaviours in time and space; to monitor and verify the veracity and appropriateness of a percept of action; to show adequate concern about the implications of actions; and to alter behaviours after feedback (Stuss, in Beaumont *et al*, 1999:351ff).

The possibility of frontal system cognitive dysfunction in adult BPD was investigated by Van Reekum, Links, Mitton, Fedorov and Patrick (1996). They found significant correlations between borderline pathology and neurodevelopmental/acquired brain injury, as well as between borderline pathology and frontal system cognitive functioning. Neurocognitive testing and comparison with a cohort of subjects with traumatic brain injury showed a pattern of similar cognitive functioning between the two groups, with the only differences on individual tests being in the direction of worse functioning in the group with BPD on two of the tasks.

The first MRI study, which evaluated the structural abnormalities of the brain in

subjects with the sole diagnosis of BPD, found that subjects had significantly smaller frontal lobes compared to comparison subjects. This has the implication that there are global and diffuse deficits in the executive, self-monitoring functions of subjects. There were, however, no significant differences in volumes of the temporal lobes, the lateral ventricles, and the cerebral hemispheres between subjects with and without BPD, which means that BPD subjects can appear 'normal'. In terms of EEG readings and drug effects, 58 electroencephalograms were conducted on 20 borderline patients under carbamazepine or placebo double-blind treatment. Taking into account only definite abnormal tracings, there was a 40% incidence of abnormal diffuse slow activity and no incidence of focal or epileptiform EEG features (in Beaumont, Kenealy & Rogers, 1999), again leading to an apparently 'normal' appearance.

It has been suggested that impulsivity, which is related to serotonergic mechanisms, is the major constitutional predisposition to BPD, regardless of whether or not there is a subsequent history of trauma. The trauma, I suggest, is necessary for these latent tendencies to manifest. Combining environmental hyperactivity with impulsivity may lead to a clinical picture, often seen in BPD, where impulsivity and self-destructive behaviour are employed in order to deal with the stress, distress, and dysphoria of being hypersensitive to interpersonal and other environmental stimuli.

Several studies support the hypothesis of a 5-HT dysfunction in BPD, as a latent predisposition. When given Selective Serotonin Reuptake Inhibitors (SSRIs), symptomatic relief was seen in measures of general functioning, depression, impulsivity, sensation-seeking and chronic feelings of emptiness. However, these findings do not reduce borderline psychopathology to an entity treatable by a drug for

impulsivity, but do provide direction and highlight the significance of impulsivity, which, up to a point, can be controlled by SSRIs. Although this aspect of BPD may be alleviated by drug therapy, BPD is a multifaceted disorder and thus only the biological facets are open to such treatment.

A prospective follow-up study conducted by Links, Helsegrave and van Reekum (1999) found that impulsivity as a central issue of borderline psychopathology was stable over a seven-year follow-up period and able to predict the persistence versus remittance of BPD over seven years of follow-up. It was also more predictive of the severity of borderline psychopathology on follow-up than other aspects of the disorder. It is noted again that impulsivity is a central characteristic of ADHD.

Furthermore, male and female borderline patients were found to differ in the type of disorder of impulse in which they 'specialised'. More specifically, substance abuse disorders were significantly more common among male borderline patients, while eating disorders were significantly more common among female borderline patients (Zanarini *et al*, 1998).

From these studies, it is suggested that, neuropsychologically, borderline psychopathology is a function of insufficient control by dysfunctional frontal networks, specifically undercontrol of the limbic structures. A parallel situation exists in the case of deficient attention, which will be clarified in the next chapter.

2.5.2 Limbic Dysfunction

Limbic structures are crucial in motivational, emotional and social behaviours, modulated and integrated by the mesial temporal and prefrontal areas (Beaumont, Kenealy & Rogers, 1999). The limbic system refers to both cortical and subcortical structures linked by functionality, EEG studies and biochemical evidence into a fifth 'lobe'. The limbic cortex receives information not only from exteroceptive systems (somatic, auditory, visual), but also from the olfactory, gustatory, and visceroceptive systems. Notably, all these systems coalesce in and diverge from the hippocampus (MacLean in Beaumont *et al*, 1999). The hippocampus is responsible, furthermore, for the registration and retention of ongoing experience and, in the case of its dysfunction,

> without a sense of personal identity there is, so to speak, no place to deposit a memory. Through introspection, there results the realization that a sense of personal identity depends upon an integration of externally and internally derived experience (ibid).

The limbic system both affects and modulates "the intensity and amplitude of feelings and perceptions" (ibid: 457). MacLean defines three emotional functions of the limbic system, all directed at self-preservation. Where "emotion" refers to the outward manifestation of feelings identified in the self and others, "affect" refers to the subjective experience of these. Affects may be pleasurable or painful, and three main affects are generated by the limbic system: basic, specific, and general. Respectively, these refer to feelings of hunger or thirst; pleasurable and painful feelings associated with specific sensory systems; and feelings that are specific to individuals, situations or things rather than neuronal pathways. General affects take six forms: desire, fear, anger, dejection, self-congratulation, and affection, and are not attached to the truth or falsity of a particular situation. To this tripartite system of emotions, MacLean (ibid) adds feelings of familiarity or strangeness, and feelings associated with time and space. The impact of dysfunction in these areas will become clearer in Chapter Four, where

development is discussed.

Le Doux (1998) proposes that there are many emotional systems in the brain. Separate neural pathways (from each other and from cognitions) mediate various classes of emotions. When the brain systems that generate emotional behaviours function in the presence of a capacity for awareness, conscious emotional feelings can occur, whereas most emotional experiences and responses are unconscious. The relationship between conscious and unconscious is not reciprocal, however: “While conscious control over emotions is weak, emotions can flood consciousness” (Le Doux, 1998:19) as the neural connections from emotional systems to the cortex are stronger than vice versa. Further, once an emotion has occurred, it motivates future responses or behaviours. Apart from basic emotions and blends, which are largely universal, there are also “display rules” (Eckman in Le Doux, 1998:117), i.e. learned, socially appropriate, expression of emotions, which become unconscious over time.

Le Doux (1998) examines the fear system in detail, as fear is intrinsic to psychopathology and may be said to characterise the defensive, angry, hypervigilance of the borderline individual. “Feelings of fear…occur as part of the overall reaction to danger and are no more or less central to the reaction than the behavioural and physiological responses that also occur, such as trembling, running away, sweating and heart palpitations” (Le Doux, 1998:18).

Crucial to this study is the understanding that fearful, traumatic situations activate both the implicit emotional memory system of the amygdala; and the explicit memory of emotional situations mediated by the hippocampal system. “The outcome of activity in

the explicit memory system of the hippocampus is a conscious awareness of stored knowledge or personal experience. The outcome of activity in the amygdala is the expression of emotional (defensive) responses" (Le Doux, 1998:204). Explicit memories and immediate arousal combine through the function of working memory to allow formation of new explicit memories. *Disordered personalities are a function of "a deficit in the functional system regulating experiential learning"* (Gualtieri, 1995:167), i.e. a derangement of the system that regulates integration and assimilation of reinforcement. This "neocortical system exists to guide the development of social integration through reinforcement, empathy and attachment" (Gualtieri, 1995:166).

In addition to the structural considerations described above, noradrenergic mechanisms have been identified, in the literature, as the mediator of the hyperreactivity to the environment, characteristic of borderline psychopathology (Van Reekum, 1993). This often manifests itself as hypersensitivity in interpersonal situations, and these processes may be most closely related to, and exaggerated by, a history of childhood sexual abuse.

Linehan (1993) and Linehan and Kourner (1993) characterise borderline pathology in terms of dysregulation of emotions, interpersonal relationships, behaviour, cognition and the sense of self. The fundamental rupture is emotional dysregulation, which is a function of both biological make-up, and interacting and transacting with a dysfunctional, invalidating environment to produce inadequate learning experiences. Borderline pathology is a breakdown in the regulation of the states of self, i.e. arousal, attention, sleep, wakefulness, self-esteem, affects and needs, compounded by the *sequelae* of the breakdown itself.

Linehan (1993) makes the comment that

> A number of investigations have found that increases in emotional arousal and intensity narrow attention, so that emotion-relevant stimuli become more salient and more closely attended to...The stronger the arousal and the greater the intensity, the narrower attention becomes (Linehan, 1993:44, emphasis mine).

Emotion is the antecedent and consequent condition, enclosing cognitions that activate and re-activate emotional states. Linehan (1993) refers to research, furthermore, which indicates that emotional states bias recall of affect-toned material such that superior memory is in evidence when recall emotional states match learning emotional states. Emotions thus enhance learning of mood-congruent material and "can bias interpretations, fantasies, projection, free associations, personal forecasts, and social judgements in a fashion congruent with current mood" (Linehan, 1993:44). Emotions override cognitions because they are "full-system responses" (Linehan, 1993:45), integrating the entire system in favour of a current emotion and complicated by reactivation through cognitions and a slow return to emotional baseline in individuals vulnerable to borderline pathology.

2.6 CONCLUDING COMMENT

In this chapter, I have investigated both historical and current conceptualisations of borderline psychopathology, which will assist in my analysis of the data collected in this study. In this regard, historical and current conceptualisations, psychiatric, psychodynamic and neuropsychological will be utilised in data analysis.

It is striking that descriptions of the disorder first made by Falret in 1890 (in Stone, 1986) have not changed in any substantive manner between then and the current DSM IV (1994) criteria. Based on this overlap in description, I examined several historical positions taken on borderline psychopathology, and found that many, as presented by Stone (1986), have current applications. In particular, the characteristics of lability and 'ungovernability' are a clear link to the processes of deficient attention, which may be their precursor.

Furthermore, affective and impulsive conceptualisations of borderline psychopathology may be summarised, rather than displaced, by viewing the disorder as placed at the severe end of a traumatic spectrum. This would lend credence to the historical terms of narcissistic malnutrition, which leads to intolerable distress, as well as psychic bleeding and rigidity (Stern in Stone, 1986). It would also integrate confluently with the latest literature on trauma as an overriding factor in BPD (Bailey & Schriver, 1999; Zanarini, Frankenburg, Dubo *et al*, 199; Zanarini, Frankenburg, Reich *et al*, 1998).

Significantly, trauma leads to a paralysed response, heightened dependency needs, and significant amounts of underlying anger, a description that characterises recent psychiatric conceptualisations. Authority figures are feared, in both past and present conceptualisations, acting as the repository for projections of hatred and then for the experience of these projections as hostile; combined with real hostility, whether provoked by the *sequelae* of ADHD behaviour or unprovoked in the case of parental pathology (Barkley, 1998).

This description and many others are startlingly analogous to those of ADHD, as will be clarified in the next chapter. Switches from being one type of individual to another, denial of one aspect while foregrounding another can be seen as the inability to hold the whole self in mind, an inability characteristic of ADHD. Affect is inappropriate in whichever domain of self predominates. There is a tendency to express the self through a hypochondriacal preoccupation with the body, as if attention cannot be shifted from this aspect. Primitive defence mechanisms, predominantly splitting and projection, abound and are congruent with an inability to hold the self in mind, a logical inference from the mechanisms of deficient attention and lapses in consciousness. It is no wonder then, with the dysfunctional frontal systems of both BPD and ADHD, that there are severely weakened ego functions, particularly rigid defences, poor concept formation and judgement and the inability to integrate or plan realistically.

It is possible, I suggest, that the literature surveyed here implies four routes to adult borderline pathology: an acquired dysfunction, e.g. head injury, or series of triggering events (Zanarini *et al*, 1997); a developmental process stemming from a genetic-biological source such as Attention Deficit/Hyperactivity Disorder; chronic trauma registering on the level of the brain; or all three of the previous factors interactively.

These four main conceptualisations (historical, and current psychiatric, psychodynamic, represented by Kernberg, Kohut and Ryle, amongst others, and neuropsychological) will inform the analysis of data gathered in this study (see Chapters Eight, Nine and Ten) by drawing on analogous processes in the action of deficient attention in relation to normal development. (See Chapters Three and Four.) In the next chapter, I explore the literature on consciousness, attention, and deficient attention. My purpose is to

enhance the understanding of the neuropsychological problems identified in borderline psychopathology and their action in its development, and to understand the “piece of defective judgement” (Stern, in Stone, 1986) operating in a subtle, traumatic context, which may lead from deficient attention to borderline psychopathology.