# Childhood Experiences of Men with Borderline Personality Disorder

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# Overview

Borderline personality disorder is a severe, psychologically and socially debilitating condition that tends to develop in people who have experienced multiple forms of adversity in their early lives. For a variety of reasons, most research into the aetiology of the disorder has focused on women. This research seeks to explore potential aetiological factors among men. There is evidence that known risk factors for BPD differ in incidence between men and women, and that responses to and interpretations of such experiences may also differ by gender. It is possible, then, that BPD may develop along different pathways for men and women, or may act on different vulnerabilities. These differences may be clinically significant, and could influence the way in which therapeutic interventions are conceptualised and delivered.

The first section, a review paper, describes and critiques the existing research into risk factors for BPD, including aspects of childhood maltreatment and neurobiological markers of the disorder. It examines the literature on gender and BPD, exploring explanations for the apparent rarity of men in research and clinical settings. The review then evaluates the existing research specifically regarding men with BPD, and makes a case for a more inclusive

programme of research, incorporating a consideration of gender-specific risk factors.

The second section, an empirical paper, presents an analysis of the responses of 30 men, 19 meeting criteria for BPD and 11 forming a psychiatric control group, to questions exploring their childhood experiences of abuse, neglect and adversity, and their current symptomatology. Characteristics of the BPD group were described, and hypotheses regarding the nature and severity of experiences of maltreatment between the BPD and non-BPD group were tested. Then, the findings of this study were compared with those of two recent similar studies. Finally, the paper discusses the theoretical and clinical implications of the results, appraises their validity, and makes suggestions for further investigation.

Third, a critical appraisal reflects on several salient issues in some depth. It examines criteria for BPD in the light of gender differences and patterns of responding in this study, and explores the validity of the diagnosis for men. Methodological debates regarding the use of retrospective data collection are detailed and the decisions made in the current study discussed. Finally, some observations are made regarding the research process, noting challenges endemic in research in this area, and specific points of learning.

## Contents

**Appendices**

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# Review Paper

**Abstract**

The diagnosis of borderline personality disorder (BPD) is much more commonly given to women than men. Most of those women have suffered neglect and abuse, often sexual as well as physical and emotional, in childhood. This observation has led many prominent writers on BPD to suggest that trauma plays an integral role in the development of the disorder. A number of studies have found significant associations between specific forms of maltreatment and types of psychopathology, opening up possibilities for early detection and intervention with children at risk of developing psychological problems in adult life.

Much of the literature on BPD, and on its risk factors, has been conducted with samples that are predominantly or exclusively female. Their conclusions cannot necessarily be generalised to men. The experiences thought to be pathogenic for BPD – sexual abuse, in particular – may happen to men and women to different extents, and in different ways. They are likely to be experienced and understood differently, both between the sexes and within them. The existing literature tells us little of the paths men tread before experiencing the difficulties labelled as borderline personality disorder.

Further, some people with BPD do not report abuse or neglect. They have been conceptualised (for example, by Linehan, 1993a) as having grown up in 'invalidating' family and social environments that have more subtly undermined the developing sense of self, and the ability to manage intense emotions. If indeed traumatic experiences are an essential aetiological factor in BPD, the indices of abuse and neglect used in previous studies have not been sufficiently sensitive, specific or subtle to discern the pathogenic qualities of the environments, relationships and life events these people may have experienced.

## 1. Introduction

This review will describe what is known about adverse childhood experiences and the development of borderline personality disorder in men. It will first offer a brief sketch of BPD (in both men and women) and its multi-factorial origins, followed by a review the literature on the relationship between childhood maltreatment and adult psychopathology, and BPD in particular. The review will then examine why most research has focused on women with BPD, including discussions of diagnostic and assessment biases, and the nature and prevalence of traumatic early experiences. Finally it will cover what is known about men with BPD, and what remains to be explored.

## 2. Borderline Personality Disorder

Borderline personality disorder is the label given to a set of behaviours, emotional reactions and ways of relating to others that typically involve extreme distress and suffering. The word "borderline" signifies a conceptual space "on the border of a number of diagnoses", incorporating 'neurotic' and 'psychotic' elements (Kraus & Reynolds, 2001; p352), and people with BPD often meet criteria for a variety of Axis I and Axis II disorders[1]. A DSM-IV diagnosis (APA, 1994) of BPD requires that a person fulfil at least five of the following nine criteria: frantic efforts to avoid real or imagined abandonment; recurrent suicidal behaviour, gestures or threats; impulsivity; unstable interpersonal relationships; identity disturbance; affective instability; chronic feelings of emptiness, inappropriate anger; and transient and stress-related paranoid ideation or severe dissociative symptoms.

The diagnosis of BPD has been criticised for including overlapping symptom categories, failing to prioritise salient features, lacking agreed theoretical underpinnings, and pathologising variation on 'normal' personality

[1] Axis I refers to those conditions classified as mental disorders according to the DSM-IV (APA, 1994) system. Axis II refers to conditions classified as personality disorders. Diagnostic criteria for the Axis II disorders may be found in Appendix IX.

functioning and gender differences. However, no more satisfactory alternative has yet been proposed (Ryle, 1997).

One of the defining features of this population is risk. Between 3.0 and 9.5% of borderline personality disordered patients commit suicide (Stone, 1989). Self-harm, including cutting, banging, burning, scratching and puncturing, is found in the majority (79% in a study by Dubo, Zanarini, Lewis and Williams, 1997), and hospitalization is common. BPD is thought to involve profoundly disturbed ways of relating to self and others, reflected in self-harm, and in the complex and emotionally stressful interactions between patients with borderline personality disorder and those around them. Such interactions are commonly characterised by rapid shifts between idealization and devaluation, verbal and physical abuse and aggression, intrusions on others' boundaries, and behaviour that frequently elicits maltreatment.

Such behaviours often elicit negative reactions from health professionals and the health system more broadly, including concerns about the vast expense involved in managing 'borderline' patients, a sense of resentment at perceived manipulation, and a tendency to treat BPD with a range of medications for which there is little proven efficacy (Bornstein, 1997).

## 2.1 Prevalence

1-2% of the general population are thought to fulfil criteria for BPD, while it is typically found in 10% of out-patient and 20-25% of inpatient psychiatric populations (Kraus & Reynolds, 2001). It is likely that dimensions of 'borderline' behaviour vary along a continuum between needy and dysregulated forms of normal behaviour and violent, uncontained self-destructiveness.

## 2.2 Comorbidity

People with a diagnosis of BPD very often fulfil criteria for Axis I disorders. Zanarini *et al.* (1998a) found that people with a diagnosis of BPD are most frequently diagnosed with anxiety and mood disorders, but only the presence of mood disorders successfully discriminated those with BPD from those with other personality disorders. Complex patterns of comorbidity across the lifespan strongly predicted a diagnosis of BPD. PTSD was widely found among people diagnosed with BPD (55.9% compared with 21.6% among people with other Axis II diagnoses), and BPD has been conceptualised by some as a form of "complex PTSD" (van der Kolk, 2000).

Diagnostic criteria for BPD have historically overlapped with those of other personality disorders[2], notably anti-social, histrionic and dependent, so it is not surprising that up to 90% of patients with BPD are diagnosed with an additional personality disorder. Zanarini *et al.* (1998b) found that patients with diagnoses of BPD were significantly more likely than Axis II controls to meet DSM-III-R criteria for paranoid, avoidant, dependent and self-defeating personality disorders. Grilo, Sanislow and McGlashan (2002b) found that BPD diagnosis was strongly associated with co-morbid anti-social, avoidant and depressive personality disorders, but in men only. The overwhelming tendency for BPD to occur in combination with other mental disorders may, as Bornstein (1997) points out, imply that the BPD criteria lack discriminant validity.

### 2.3 A Multi-Factorial Aetiology

It is widely thought that the origins of BPD, in both men and women, are complex and multi-factorial. Temperamental vulnerabilities, underpinned by biological and/or genetic susceptibility, may combine with repeated early traumas and environmental reinforcement of maladaptive behaviours to create the characteristic constellation of problems.

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[2] For example, suicidal efforts and temper outbursts were criteria for histrionic personality disorder in DSM-III, but had been removed in DSM-III-R.

Biological and neurological research has identified a range of abnormalities among patients with BPD (e.g. Links, 1996), evident in EEG, MRI and PET data (Bornstein, 1997). The disorder has been linked with ADHD, developmental or acquired brain injury and cortical dysfunctions. These abnormalities may be precursors or sequelae of traumatic experiences: Soloff, Lynch and Kelly (2002) point out that childhood maltreatment is associated with "persistent biologic changes" involving the hypothalamic-pituitary axis, regulation of cortisol and catecholamines, and hippocampal structure and function. Abnormal neurological functioning, particularly in areas associated with emotion regulation (the hippocampus, the cuneus, and the frontal cortex) has consistently been found among women with BPD (Juengling *et al.*, 2003), and reduced hippocampal volume among survivors of abuse (Bremner *et al.*, 1997). Penza, Heim and Nemeroff (2003) have proposed a process by which early traumas adversely affect the central nervous system and permanently sensitize neuroendocrine systems, such as the hypothalamic-pituitary axis, to stress, as well as leading to hippocampal atrophy. These, in turn, are thought to lead to long-term vulnerability to depression, anxiety and other psychiatric problems. Zanarini *et al.* (2000b) suggest several possibilities regarding the relationship between the complex set of aetiological factors in BPD: first, that the dysphoria associated with severe and sustained trauma may affect neurological functioning "through a kindling process"; second, that innate biological vulnerabilities may be risk

factors for exposure to abusive situations, and third, that it may simply be that some individuals are unfortunately burdened with both biological and environmental disadvantages that, acting independently, raise their risk of developing BPD.

Since experiences of abuse, neglect, losses and separations are vastly over-represented among people diagnosed with BPD, a consensus has developed among clinicians regarding the importance of such traumas in the development of the disorder. Although it is problematic to infer the aetiological significance of childhood experiences from retrospective data, longitudinal research such as that carried out by the Collaborative Longitudinal Personality Disorders Study in the USA (e.g. Battle *et al.*, 2004; Johnson, Cohen, Brown, Smailes & Bernstein, 1999) has demonstrated clear links between such adverse experiences and a heightened risk of BPD in adulthood. However, a minority of individuals with BPD do not report experiences of childhood abuse or neglect. Battle *et al.* (2004), for example, found that 19% of her sample of people meeting criteria for BPD reported no abuse, and 10% reported no neglect. This might suggest several interpretations: first, that previous research methods have not tapped into some pathogenic experiences relevant to BPD; second, that a spectrum of biological vulnerability means that some people are particularly at risk even without traumatic life experiences; and third that there may be other factors

beyond those already explored that account for BPD. Gauthier, Stollak, Messé and Aronoff (1996) suggest the need "to examine the impact of 'silent' forms of maltreatment... both the quality of interactions that occur in neglectful and physically abusive families, as well as the different psychological meanings that physical abuse and neglect have for children" (p. 555).

**3. The Effects of Childhood Maltreatment**

A substantial literature has accumulated that explores and confirms the link between maltreatment in childhood and adult psychopathology. Underlying adverse experiences are further levels of the transmission of problems between parents and children, including genetic vulnerability to psychopathology, or to sensitive or difficult temperament, which might heighten the risk of eliciting hostile or abusive behaviour from caregivers and others.

The detrimental effects of experiences of poor parenting, loss, abuse and neglect in childhood have been widely documented and are described below, with particular reference to research on BPD.

### 3.1 Quality of Parenting

Poor parenting, manifested in abusive, neglectful, unavailable or intrusive behaviours, is likely to increase the risk of psychological difficulties in children. The ability to parent may be compromised by numerous factors including parental mental or physical illness, socio-economic disadvantage, lack of knowledge about child-rearing and development, and negative experiences of being parented oneself, which may be consciously or unconsciously rebelled against, replicated or both, within the next generation. The processes by which these factors may affect psychological functioning are likely to include failing to provide opportunities to learn emotional regulation and coping skills, traumatising the child through abuse, neglect and/or persistent adversity, imposing developmentally inappropriate freedoms, restrictions or responsibilities, and enabling direct social learning of behaviours likely to result in social exclusion and personal distress.

A strong body of evidence links anxiety and depression in adulthood with reported experiences of inadequate parenting in childhood (Brewin, Andrews & Gotlib, 1993). Brown and Moran (1994) found that the chronicity of depression among a community sample of women could be predicted by the experience of childhood adversity, including violence, parental indifference and sexual abuse. Women who were currently and previously depressed reported experiencing greater parental over-protection in

childhood than non-depressed women (Gotlib, Mount, Cordy & Whiffen, 1988). In a study by Gladstone *et al.* (2004), depressed female patients who had been sexually abused in childhood were more likely to rate their mothers as indifferent: "women with childhood sexual abuse held particularly strong perceptions of deprivation in maternal care" (p. 1423).

A number of early studies of the perceived quality of experiences of being parented among people with BPD (cited in Zanarini, 2000) revealed a fairly consistent constellation of attributions. Relationships with both parents appeared profoundly disturbed. Mothers were seen as uncaring, distant, lacking in affection and nurturance, or over-protective. Fathers were perceived as remote, under-involved or controlling. In particular, according to Frank and Paris (1981), "fathers of borderline patients were remembered as having been significantly less approving and more disinterested" than fathers of women without BPD, particularly "in the face of dependent behaviour" (p. 1034). Parents' relationships with each other were often violent and abusive, and this conflict also commonly characterised interactions with their children. Zanarini (1997) found that patients with BPD were significantly more likely than patients with antisocial personality disorder to report the experience of having a caregiver withdraw from them emotionally.

A low level of perceived care is highlighted by many studies of parenting experiences of people with BPD. Zweig-Frank and Paris (1991), using the Parental Bonding Instrument, found that both male and female patients with BPD described their parents as significantly less caring and more controlling compared with the recollections of non-borderline psychiatric patients. A similar perception of lack of both maternal and paternal care was found by Paris and Frank (1989), comparing female patients with and without BPD. They suggest a theory of "biparental failure" whereby "the child who becomes borderline is unable to buffer the neglect from the mother with care from the father" (p. 1499). Experiences of rejection were found by Russ, Heim and Westen (2003), who used a clinician-rated version of the Parental Bonding Instrument to discriminate participants with BPD. Berziganian, Cohen and Brook (1993) found that a combination of maternal over-involvement and inconsistency predicted a persistence or an emergence of borderline personality disorder. These were not accounted for by disturbed personality traits in mothers.

Attachment theory has provided another perspective on the pathogenic parenting context in relation to BPD. Research in this area has identified four classifications of infant behaviour evident in the context of threats to the attachment system (secure; insecure/ambivalent; insecure/avoidant; and disorganised). These have been found to correspond to a variety of styles of

parenting, and to intergenerational patterns of attachment (Steele & Steele, 1994; van Ijzendoorn, 1995). Adult patterns of attachment, matching those observed in children, have been codified in the Adult Attachment Interview (AAI; Main & Goldwyn, 1994) as Autonomous (secure), Preoccupied (insecure/ambivalent), Dismissing (insecure/avoidant) and Unresolved (disorganised). In her study of attachment experiences among 80 adults with BPD, Barone (2003) found that the Unresolved category was greatly over-represented compared with a non-clinical group. 50% of the group were classified as Unresolved, 20% Dismissing, 23% Preoccupied and 7% Autonomous. Borderline and non-clinical groups were distinguishable along the organization/disorganization dimension rather than security/insecurity dimension. An analysis of the sub-scale scores on the AAI revealed "radically impoverished" attachment experiences in the BPD group, including rejecting and neglecting experiences from both parents and role-reversal with mother during childhood. Current anger towards both parents and unresolved trauma were significantly more common in the BPD group, who scored particularly low on measures of metacognition (the ability to reflect on one's reactions and thought processes) and coherence (of the narratives and their relevance to the interviewer's questions). Barone further notes that the combination of an actively rejecting father and an unloving, neglecting mother carried the highest risk for a combination of borderline personality disorder diagnosis and insecure attachment. The tendency in the BPD group

was towards an "angry-involving relationship with the parents against the background of a role-reversing relationship with the mother" (p. 72). Such parenting might well involve the frightening behaviour and lack of responsiveness that may be characteristic of parents whose infants display disorganised attachment behaviours.

Several comprehensive surveys of childhood experiences of parenting among people with BPD have been conducted by Zanarini and her colleagues (1997, 2000a, 2000b, 2002). They found elevated rates of sexual abuse among those with BPD, compared with Axis II controls (62% vs. 32%, according to the 1997 study), and high levels of neglect (77% in the 2000b study). People with BPD consistently described parents' emotional withdrawal, neglect of their physical care, inconsistent treatment, denial of their thoughts and feelings, role-reversal, and failure to provide protection or establish a "real emotional relationship" with them (Zanarini *et al.*, 1997, p. 1104). Patients with BPD who had been sexually abused were more likely to have experienced all the types of neglect and abuse studied. The authors note a high prevalence of biparental abuse and neglect in this population, whereby the child is effectively left without a trusted, loving, safe adult in the home, and is potentially exposed to further maltreatment. Zanarini *et al.* (2000b) found that women with BPD reporting "neglect by a female caretaker and abuse by

a male caretaker were at significantly higher risk for having been sexually abused by a non-caretaker" (p. 264).

As the authors note, self-report data is subject to certain distortions which may compromise its validity. Zanarini *et al.* (2005) remark on the "hyperbolic style" that characterises the recollections of patients with BPD. However, objective evidence has been found to support such data (Chu, Frey, Ganzel & Matthews, 1999; Bifulco, Brown, Lillie & Jarvis, 1997). The procedures and methods used in the studies carried out by Zanarini's research team are also designed to minimise the risk of exaggeration or fabrication, using clinically experienced interviewers blind to diagnostic status, and interview tools which require detailed information about numerous aspects of childhood experiences, with checks on inter-rater reliability.

Recent advances in this area have focused on the processes by which these forms of maltreatment affect the development of attachment and mentalization[3] in BPD. Fonagy, Target and Gergely (2000) and others have drawn on the findings of research regarding the disorganized attachment patterns of people with BPD to describe the processes that follow from

[3] [3] 'Mentalization' is a term used by Fonagy and his colleagues to denote social cognition, as developed in a relational context, through "the understanding of one's own as well as others' behaviour in mental state terms" (Fonagy *et al.*, 2000). The concept encompasses such abilities as 'theory of mind' and 'reflective function'.

caregivers' failure to facilitate the development of the child's social, cognitive and relational capacities. Maltreatment is thought to impact on the child's reflective capacities and sense of self by trapping him in a paradoxical situation in which physical and mental proximity to a caregiver are intensely painful. A child cannot effectively learn a positive sense of self and a reflective capacity when confronted by "the hatred or murderousness implied by the parent's acts of abuse" (Fonagy *et al.*, 2000, p. 111-112), and the denial or distortion of normal feelings inculcated in abusive situations. The authors also describe the way in which the abusive parental (or other) figure is internalised and experienced as an alien, persecutory, dangerous and hateful aspect of the self. A central facet of mentalization is thought to involve a developing ability to recognise one's own emotions as well as those of others, and to be able to regulate these, following a template learned through responsive parenting. Dubo *et al.* (1997) suggest that "childhood abuse and neglect may directly interfere with the development of the capacity to modulate affects. As a result, self-destructive behaviour may emerge as a maladaptive means of regulating intolerable affects" (p. 67).

In summary, research has shown that adverse parenting experiences are significantly more frequently reported by people with psychological problems in adulthood. This trend is particularly striking among people fulfilling criteria for borderline personality disorder, who describe uncaring

parents given to emotional withdrawal and rejecting behaviour, role-reversal with their mothers, and either remoteness or over-controlling, over-protective behaviour from their fathers. Some studies report intrusive and over-involved mothering; others emphasise distance. This incoherence in the literature may reflect the fluctuating, unpredictable behaviour of caregivers, or the diversity of experiences associated with BPD. Biparental failure seems to be a key feature in the childhoods of people with BPD (Paris and Frank, 1989; Zanarini *et al.*, 2000b). Some mechanisms for the way in which these features of disturbed parenting may affect social, emotional and cognitive development, particularly where pre-existing vulnerabilities or trauma-related neurobiological damage, are increasingly being elaborated.

### 3.2 Loss

Early studies of risk factors for mental health problems, such as Bifulco, Brown and Harris (1987), found that early experiences of loss and subsequent poor parental care increased vulnerability to depression. A body of early literature on the pathogenesis of BPD identified the experience of early and profound loss as common in this group. Zanarini (2000a) cites abnormally high levels of developmentally important losses (usually of parents, through death, illness and divorce), and prolonged childhood separations from caregivers, among people with BPD. Previous findings indicated that people with BPD were significantly more likely than people

with antisocial personality disorder (ASPD) to report at least one childhood separation (Zanarini *et al.*, 1997).

Tracing this experience of loss across generations, Liotti and Pasquini (2000) found that the probability of developing BPD was increased two and a half times for a child whose mother had suffered a serious loss in the perinatal period. They argue that unresolved losses and traumas in parents are often reflected in their children's disorganized attachment behaviour: "parents with unresolved traumatic memories are prone to 'invert' the attachment relationship, and may become violent more easily than other parents when the child does not meet their unconscious hope to be soothed. Moreover, children with disorganized attachment show poor control of aggressive impulses, which makes them more likely targets of aggressive reactions from both peers and parents" (p. 287). The adult correlate of disorganized attachment status, an Unresolved classification on the Adult Attachment Interview, as described above, has been found to be associated with BPD by Barone (2003) and others, and Liotti and Pasquini describe the continuity between BPD and disorganized attachment in terms of "unintegrated representations of self-with-other", "poor control of impulses and emotions", "proneness toward dissociative experiences" and "metacognitive deficits" (p. 283). These difficulties can be seen in terms of a poorly developed or disturbed mentalizing capacity, whereby the child has not had a chance to

develop a stable sense of self, a capacity to understand others' behaviour accurately, to identify his own emotions and to manage them when they are acutely aroused.

These studies indicate that experiences of severe loss on several levels are aetiologically relevant to BPD. Loss of an attachment figure at an early age, with the attendant bereavement, might also destabilise living circumstances, lead to poverty and deprivation, and expose a child to more adverse or dangerous circumstances through lack of previous levels of protection. The damaging implications of loss also operate at an intergenerational level, with evidence that caregivers' unresolved losses affect their children's mental health. This may be through the child's vicarious exposure to trauma, or through the parent's reduced capacity to provide care and containment while in a state of distress. The link between disorganized attachment status in childhood and BPD in adulthood may reflect the aetiological significance of, among other things, severe loss and its implications for family relationships.

### 3.3 Parental mental illness

Many studies have found strong associations between mental health problems in parents and their offspring. Some of this association is likely to be explained by a common genetic vulnerability or temperament; some may reflect a common environment of disadvantage. Mental health problems may

prevent parents from adequately caring for and nurturing their children. Distressed parents may also model maladaptive behaviours and be subject to other adverse experiences (such as domestic violence, suicide attempts and social withdrawal) that may affect children's adjustment. As an example of many studies suggesting the intergenerational transmission of psychiatric illness, Andrews, Brown and Creasey (1990) found that the daughters of women who had experienced chronic or recurrent episodes of psychiatric disorder were themselves more likely to have psychiatric disorders. A detailed exploration of some of the mechanisms by which such transmission might take place, was undertaken through analysing responses to the Childhood Experiences of Care and Attachment (CECA) interview (Bifulco, Brown & Harris, 1994). Close associations were found between maternal symptomatology, poor mothering and poor fathering. Mothers were thought to be less capable of warmth and care as a result of their psychiatric problems, and to lack the "personal resources required to prevent their spouse or other family members from abusing their daughters" (Andrews *et al.*, 1990; p. 1126), in other words illustrating once again an environment of biparental failure.

In relation to BPD, Fonagy *et al.* (2000) remark that "as children [people with BPD] frequently had caregivers who were themselves within the so-called *borderline spectrum* of severe BPD" (p. 106). An adult perception of

interpersonal relationships as intrusive, overwhelming or neglectful might be traced to childhood experiences of being attacked, abandoned or threatened by caregivers who were themselves distressed and hostile. A further dimension is supplied by Zanarini *et al.* (1999), who suggest that parents' reported abusive and neglectful behaviours "are manifestations of a shared biologically based impulsivity" (p. 70). This impulsivity may be linked to substance abuse, suicidality and self-harm, and – in the original instance – may have put the BPD patients at risk of physical or sexual assault. Goldman, D'Angelo and DeMaso (1993) found that rates of psychopathology, particularly depression, substance abuse and antisocial disorders, were significantly higher in the families of children and adolescents with diagnoses of BPD. Trull (2001) found that parental mental illness was a significant predictor of scores on measures of BPD, even when controlling for the variance accounted for by other aetiological factors (childhood abuse and comorbid Axis I disorders).

In summary, parental mental health problems are associated with psychopathology in their offspring, and BPD in particular, whether through genetic vulnerability, for instance to a trait such as impulsivity; modelling of maladaptive behaviours; traumatisation through maltreatment, or neglectful exposure to damaging environmental influences. However, hypotheses regarding genetic transmission of traits or psychological vulnerabilities are

as yet speculative. The multiple pathways through which such influences might operate also make it difficult to construct coherent aetiological models, or to disentangle risk factors. For example, as Mullen, Martin, Anderson, Romans and Herbison (1996) point out, while it is tempting to attribute particular aetiological prominence to specific factors, this may be misplaced if they operate as markers "for a range of co-existing deleterious influences" (p. 8) such as socio-economic disadvantage, domestic violence, parental mental illness or separation.

### 3.4 Abuse

The experience of abuse is known to raise the risk of psychological damage, evident in the form of psychosocial impairment and psychiatric disorder (Zanarini *et al.*, 2002). Violence or neglect, particularly from a caregiver, sends messages to a child that he or she is fundamentally unacceptable, worthless, deserving of punishment, shameful, disgusting or hated. These messages damage a child's self-esteem and set him or her apart from others. In the absence of support and other protective factors, the risk of psychological maladjustment rises. Abuse of various kinds has been associated with personality disorder, substance abuse, depression, anxiety, self-harm and suicide. Experiencing abuse or neglect in childhood raises the likelihood of being diagnosed with a personality disorder fourfold, even when the effects of age, parental education and parental psychiatric disorder

are taken into account (Johnson *et al.*, 1999). In Spataro, Mullen, Burgess, Wells and Moss's (2002) sample, the risk of personality disorder was increased fivefold among those who had experienced abuse. Victims of child sexual abuse were significantly more likely to receive treatment for affective disorders, anxiety disorders and personality disorders in adulthood.

A substantial body of research has confirmed the links between childhood sexual abuse (CSA) and adult psychopathology. In a twin study with a female sample, Bulik, Prescott and Kendler (2001) found CSA to be associated with a heightened risk of psychiatric disorder. This risk increased with the severity of the abuse, defined in this study as attempted/completed intercourse, intra-familial abuse, the use of force or threats, and others' denial, lack of support, or punishment of the victim for disclosure. Although in this study, CSA was not linked with any specific disorders in adulthood, the authors noted that "both the nature and impact of child sexual abuse vary along several continua... the long-term impact of child sexual abuse-related events is affected both by the characteristics of the child sexual abuse as well as the presence of protective events" (p. 447). Similarly, Mullen, Martin, Anderson, Romans and Herbison (1993) found that the presence and severity of CSA were significantly correlated with greater levels of psychopathology in a random community sample of women. In particular, the experience of sexual abuse in childhood was associated with substance

abuse and suicidal behaviour in adulthood. Notably, sexual abuse often occurred in conjunction with physical and emotional abuse.

Specific effects of sexual abuse were also found by Bifulco, Brown and Adler (1991): severe CSA was associated with an increased risk of depression, and to relationship difficulties in adulthood. These results were echoed by a community study of the relationship between childhood sexual abuse and adult depression (Cheasty, Clare & Collins, 1998), which found a highly significant relationship between severe abuse (defined as penetration) and adult depression, and heightened levels of relationship breakdown, sexual problems, housing difficulties, and problems with their children at school among women who had been sexually abused. Gladstone *et al.* (2004) found that women who had been sexually abused in childhood were more likely to have self-harmed and attempted suicide. They were also at heightened risk of depression early in life, panic disorder and victimization through interpersonal violence. Although resources such as good love relationships in adulthood have been found to protect against the risk of depression among people who had experienced poor parental care in childhood, they did not ameliorate this risk among people who were sexually abused (Hill *et al.*, 2001). This indicates that while diverse childhood experiences are associated with apparently similar long-term outcomes (depression), the effects of protective factors may be influenced by the specific nature of those

experiences. Some forms of sexual abuse are perhaps so devastating and destructive to a child's emerging concept of self that no environmental resources can compensate. In the case of Hill *et al.* (2001), it may be that the love relationships which supported vulnerable people who had not been sexually abused were not helpful to those who had, because they required exactly the kinds of abilities that were damaged by that early intrusion. Considering Cheasty *et al.*'s (1998) finding regarding the raised risk of relationship breakdown among people who have been sexually abused, and the centrality of the disturbed relationships criterion for BPD, it may be that the interpersonal relatedness, sexual contact and emotional intimacy required by a good love relationship are particularly difficult for people who have endured sexual abuse, and not necessarily experienced as supportive.

Sexual abuse is often seen as a hallmark of those patients showing borderline features although, notably, a minority do not report this. Silk, Lee, Hill and Lohr (1995) found that 75% of their mixed-gender sample of inpatients with borderline diagnoses had experienced sexual abuse in childhood. 32% had been abused by a parent. Zanarini *et al.* (2002) found that 62.4% of her predominantly female sample of inpatients with borderline personality disorder diagnoses had experienced childhood sexual abuse. This was often severe, frequent, of long duration, and perpetrated by multiple and familiar adults, a finding that differs from Paris, Zweig-Frank and Guzder (1994a),

who found a greater proportion of single-incident sexual abuse among female patients with BPD. Like Silk *et al.* (1995), who found a significant relationship between severity of reported abuse and overall borderline psychopathology, Zanarini *et al.* (2002) found severity of childhood abuse or neglect to be significantly correlated with measures of symptomatic and psychosocial impairment. Differential effects of types and combinations of abuse and neglect were evident: severe sexual abuse and neglect were related to cognitive, interpersonal and dissociative symptoms, and to severity of borderline psychopathology. A combination of multiple types of maltreatment, including sexual abuse, was related to psychosocial impairment and the severity of BPD-specific dysphoric affects and cognitions. Severity of childhood sexual abuse was significantly related to severity of parasuicidal behaviour.

These findings underline a strong relationship between the severity of childhood sexual abuse and borderline symptomatology: in particular, cognitive, interpersonal and parasuicidal symptoms, as well as broader psychosocial impairment. A recurring tendency in this body of research, and one requiring some examination, is the implicit privileging of sexual abuse as a cardinal feature of BPD. Many research studies, including those of Zanarini (2000b, 2002), set out to map numerous forms of maltreatment but focus their discussion on the aetiological significance of CSA, despite the fact that a

sizeable proportion of men and women with BPD do not report it (Paris, Zweig-Frank & Guzder, 1994a, 1994b). This focus is at the expense of exploring the specific pathogenic effects of psychological and physical abuse, which the same studies find are also highly prevalent in this population. Considering the lower rates of sexual abuse reported by men, including men with BPD (bearing in mind the possibility that men may be less likely to report sexual abuse than women), it may be that physical and psychological abuse play a more important part in the development of the disorder, at least in men.

Other forms of abuse have certainly been shown to relate to impairments common to BPD. Zanarini *et al.* (2002) found that combinations of multiple forms of abuse were associated with the severity of BPD symptoms, and noted that "the etiology of BPD is complex, involving a number of pathological childhood experiences as well as aspects of personality or temperament and subtle forms of biological dysfunction" (p. 386). Psychological abuse, for instance, involving calculated cruelty, controlling, humiliating, rejecting and denigrating behaviour, particularly if continuous over time, is associated with signs of emotional dysregulation and self-destructiveness characteristic of BPD. Bifulco and Moran (1998) found that 27% of the women they interviewed who had been psychologically abused had been depressed in the previous year; 33% had self-harmed in childhood,

53% had made a suicide attempt in early adulthood and 40% admitted previous substance abuse. Physical abuse, similarly, was associated with high levels of depression among the women interviewed by Bifulco and Moran (1998), with 41% of those who had experienced severe abuse reporting depression in the preceding year.

Abuse in childhood, it seems, can foster the development of personality traits and forms of behaviour that are judged by society as maladaptive and pathological, and labelled "personality disorder" and "borderline" in particular. This raises further questions: why, for instance, do people develop these particular constellations of difficulties following abusive experiences in childhood? And for those who do not, why not? The existing body of research has not fully addressed the specificity of childhood experiences in relation to borderline symptoms, nor elucidated how BPD develops in the absence of obvious childhood maltreatment. Further, it has not explained why or how people may experience similar forms of maltreatment and go on to develop less severe or different psychological problems. For example, numerous studies (e.g. Bifulco, Brown & Adler, 1991; Gibb, Butler & Beck, 2003) have found links between childhood abuse and adult depression and anxiety, but have not explored the possibility of personality disorder. Gibb *et al.*'s (2003) sample, for example, was selected on the basis of depressive and anxiety disorders, and was not screened for Axis II. Since depression and

BPD are known to co-exist in many cases (e.g. Zanarini *et al.*, 1998a), it is certainly possible that some of these participants might have met criteria for a personality disorder. Another possibility is that certain factors may lessen or change the impact of childhood trauma in later life. Hill *et al.* (2001) describe the protective nature of a good love relationship in adulthood, in relation to the risk of depression for women who have been sexually abused. Whiffen, Judd and Aube (1999) echoed this, finding that the perceived quality of an intimate relationship in adulthood influenced the extent to which it protected a person who had been sexually abused from experiencing depression. Again, these studies have not explored Axis II disorders, instead tending to address the severity of depressive symptoms.

The repeated findings regarding links between childhood abuse and adult depression, and between childhood abuse and adult personality disorder, may imply several options. First, that studies of depression do not assess personality disorder which may be present (and vice versa). Second, that people who show the severe psychological problems characteristic of a personality disorder have experienced more traumatic, severe or extensive abuse than those who become depressed. This assumption implies a continuum between depression and personality disorder, and between mild and severe trauma (and that the concepts themselves are unitary conditions rather than complex and multi-dimensional). This may be an inaccurate and

simplistic view of the development of mental disorder. A third possibility is that in some cases, certain factors (such as a supportive relationship during the period of abuse, or later in life) moderate the impact of childhood abuse and play a role in determining the severity of adult psychopathological sequelae. It seems likely that patterns of risk and protective factors, moderators of various kinds, individual resilience and genetic, temperamental and physiological vulnerabilities may affect the severity and nature of the effects of childhood trauma. However, these processes have yet to be delineated clearly, and we are still far from understanding the specificity of the relationships between forms of childhood maltreatment and adult mental disorder.

### 3.5 Neglect

In contrast to sexual, physical or emotional abuse, which may be considered attacking or intrusive and certainly necessitate some involvement between parent and child, neglect may be experienced as "complete psychological abandonment" (Gauthier *et al.*,1996; p. 551). Certainly, it precludes physical or emotional contact (even if this would have been harmful) and thereby has the potential to affect further areas of development. For example, language development is often delayed in neglected children, but is less so in those who have been physically abused. Neglect also blocks important life lessons, such as the contingency between behaviour and consequences. Bifulco and

Moran (1998) remark that neglected children tend to develop "various psychological handicaps, particularly those involving a sense of identity, worth and mastery" (p. 19). This form of maltreatment, perhaps unlike some other forms of abuse, has the potential to go unnoticed by those who might otherwise intervene, and as such may form a backdrop for the perpetration of further abuse. Several parameters of neglect may also be differentially important: physical neglect, with its corollaries of malnutrition, poor hygiene and consequent social rejection, may mean something quite different from psychological neglect, involving implicit rejection through disinterest, lack of protection or encouragement.

Gauthier *et al.* hypothesised that neglect would have the most damaging effects of any sort of childhood adversity, and would predispose a person to global psychiatric symptomatology and grossly disturbed attachment styles. In their study of college students, using measures of attachment, childhood abuse, neglect and psychiatric symptomatology, they found that neglect was strongly associated with general psychological problems, resistant and avoidant attachment, whereas physical abuse was significantly related to avoidant attachment only. Adults who were neglected in childhood were more likely to report current anxiety, depression, somatization, paranoia and hostility than those who had experienced only physical abuse. However, a sample composed of individuals who could function well enough to be

engaged in further education does not represent the same sets of vulnerabilities, experiences and responses one might expect to find in a clinical population.

There is also evidence that emotional neglect may be a significant predictor of deliberate self-harm (Gratz, 2003); Gratz, Conrad and Roemer (2002) found that maternal emotional neglect was a significant positive predictor of self-harm behaviour among female college students while paternal emotional neglect was negatively associated with self-harm. The authors speculate that the lack of opportunities to learn affective and behavioural regulation that may arise in the context of neglectful parenting may leave children vulnerable to using such extreme and maladaptive strategies for self-regulation. A related possibility might be a genetic predisposition to impulsivity, which could go some way towards explaining both neglectful parenting and impulsive self-harming behaviour. Parents whose impulsive behaviour limits their responsiveness and sensitivity might be less able to foster the skills needed for emotional self-regulation in their children, as well as passing on some predisposition to impulsivity; self-harm and other extreme attempts to cope with emotions may then become habitual, particularly where temperamental impulsivity already exists.

Zanarini *et al.* (2002) extended these findings to BPD, showing that severity of childhood neglect was significantly related to the severity of affective symptoms (including depression, anxiety, hopelessness and loneliness) in a predominantly female sample, and to all aspects of BPD symptomatology measured. This contrasts with her findings regarding other types of childhood abuse, which were significantly related to the dysphoric affects and cognitions characteristic of BPD and to the severity of psychosocial impairment, but not, like neglect, to the whole range of BPD symptoms.

### 3.6 Differential effects of childhood maltreatment

Disentangling specific childhood experiences and their effects on adult functioning is a complex task. In many cases it is intuitively and logically unwise to look at specific types of abuse out of context. As Gladstone *et al.* (2004) point out, "different forms of child abuse commonly co-occur" with "adverse family conditions" and key risk factors, including high stress, parental conflict and domestic violence (p. 1417). One form of child abuse is likely to raise the risks of others: for instance, as described above with reference to the theory of biparental failure (Paris and Frank, 1989; Zanarini, 2000a, 2000b), neglectful parenting may leave children vulnerable to sexual abuse by extrafamilial perpetrators. The overlapping characteristics of various forms of abuse and the wide variety of associated psychological problems make it difficult to conceptualise "specific post-abuse syndromes"

(Mullen *et al.*, 1996; p. 18). There is a clear need to be able to identify specific risk factors and trace their possible consequences, despite the complexity of this endeavour. As Battle *et al.* (2004) remark: "a better understanding of the childhood events linked with specific forms of personality pathology may contribute to more effective treatments or early interventions to help prevent these disorders" (p. 194).

Indeed, as mentioned above with reference to sexual abuse, there is evidence that different types of childhood maltreatment may be uniquely related to forms of adult psychopathology. Mullen *et al.* (1996) report that relationships between three different forms of abuse (physical, emotional and sexual), and specific problems in adult life remained independent of the potentially confounding effects of environmental adversity. For example, when controlling for those factors connected with increased risk of abuse (in this study, parental separation, violence between parents, parental mental illness, drug and alcohol abuse), sexual abuse heightened the risk of suicidal behaviour threefold.

Emotional abuse is consistently associated with low self-esteem and suicidal behaviour (Briere & Runtz, 1990; Mullen *et al.*, 1996) and depression (Gibb *et al.*, 2003) in adulthood. The experience of early physical abuse has been found to relate to adult aggressiveness and antisocial behaviour (Pollock *et*

*al.*, 1990; Briere & Runtz, 1990), anxiety (Gibb *et al.*, 2003) and marital breakdown (Mullen *et al.*, 1996), among others. Sequelae of childhood sexual abuse commonly include sexual and relationship problems (Briere & Runtz, 1990; Mullen *et al.*, 1996; Cheasty *et al.*, 1998), depression, self-harm and suicidality (van der Kolk, Perry and Herman, 1991; Mullen *et al.* 1996). Neglect, though less heavily researched than other forms of childhood maltreatment, is thought to lead to psychosocial problems, depression and self-harm and specifically to the affective symptoms evident in BPD (Gauthier *et al.*, 1996; Gratz *et al.*, 2003; Zanarini *et al.*, 2002). Combinations of multiple forms of abuse are associated with even more severe psychological outcomes (Briere & Runtz, 1990; Zanarini *et al.*, 2002).

Most of these studies examined relationships between specific forms of abuse and single psychological outcomes (such as depression or maladaptive sexual behaviour). Few have focused on broader psychological categories such as personality disorders, or on some of their defining characteristics. An attempt to do so was made by Johnson *et al.* (1999), who found that, in a mixed gender sample, childhood physical abuse, sexual abuse and neglect were differentially associated with different diagnoses. When they controlled for the symptoms of other personality disorders, they found that sexual abuse was associated with elevated symptom levels of BPD, and that neglect remained associated with BPD after co-occurring personality disorder

symptoms were statistically controlled. Antisocial and depressive personality disorder symptoms remained significantly associated with physical abuse after symptoms of other personality disorders were statistically controlled. The authors noted that it would be worth investigating the unique associations between types of childhood maltreatment and specific personality disorder symptoms, rather than broader Axis II diagnoses. While looking at the personality disorders as distinct entities is necessary if the aim is to construct an aetiological model, problems are posed by the overlap of symptoms between disorders, and the heterogeneous range of BPD presentations within the range of available criteria. A more refined approach, examining each criterion in relation to potential aetiological factors, might be more ecologically valid.

In any case, experiences of maltreatment may not be distinctive purely on the basis of 'type', as described above. The context of the abuse, its frequency, duration and severity are all measurable and important indices that may affect the way in which the abuse is processed and understood. Mullen *et al.* (1996) investigated the relevance of the perpetrator's gender, finding that emotional abuse by a male caregiver was associated with difficulties with sexuality in adulthood, whereas emotional abuse by a female caregiver left victims at greater risk of psychiatric problems (as measured by scores on the Present State Examination). Other aspects of the perpetrator beyond gender,

such as whether the abuser is intra- or extra-familial, or the quality of the relationship between abuser and abused, are also likely to affect the way in which the abuse is experienced. However, relationship quality is difficult to measure and to compare across cases, and is not, of course, separable, from the experience of abuse. Qualitative research methods, or highly detailed interviews producing quantitative methods, may be necessary to illuminate the finer points of these complex relationships.

In summary, there are grounds for further examination of the links between childhood experiences and features of BPD. Many studies have found specific psychopathological effects of abuse, particularly where it is severe and sexual in nature. Others have found more generalised psychopathology and no links to specific disorders. This difference might reflect sampling characteristics of the different studies: for instance, drawing on in-patient populations might find more severe and specific forms of psychopathology than those found in community samples. Methodological features, such as the sensitivity and reliability of the instruments used to screen for psychiatric disorder, are also likely to affect the chances of investigators finding specific links. From another angle, personality disorder criteria overlap considerably, and the disorders also occur in combination, which again affects the chances of making connections between childhood events and specific disorders in adulthood. Different ways of measuring the various indices of child abuse

across studies, and the variety of techniques for eliciting that kind of information (whether through interview or questionnaire) are likely to produce different results for the same people. Finally, as mentioned above, the common co-occurrence of multiple risk factors for mental disorder means that it is difficult to make reliable inferences as to the significance of individual aetiological factors. While as Mullen *et al.* (1996) point out, the similarity between the effects of different forms of abuse is usually more striking than the differences between them, it remains vital to uncover the specificity and subtlety of pathogenic experiences, towards the aim of constructing useful aetiological models and informing therapeutic interventions.

### 3.7 Implications of aetiological models for clinical practice

In current clinical practice, a variety of models are employed to explain the relationship between abuse and psychopathology. The psychoanalytic model of BPD proposes that the relationships between the child and his or her primary caregiver becomes distorted at an early point (according to some theorists, during the phase of separation and individuation at around 18-36 months of age), with the parent unable or unwilling to set safe and clear boundaries between herself and the child. Silverstein (1993) describes this in terms of the mother "withdrawing her love from the child if the child attempts to separate, or by overgratification at the symbiotic stage. This

withdrawal produces an abandonment depression in the child" which "will be experienced throughout the child's life" (p. 117). Developments of the psychoanalytic model, through attachment theory and, most recently, Fonagy's theory of mentalization (Fonagy *et al.*, 2000; Bateman & Fonagy, 2004), have seen the emotional dysregulation and relationship instability characteristic of BPD in terms of disturbed and abusive attachment relationships that have failed to foster a reflective and positive self-concept in the developing child, instead instilling basic mistrust and a hostile, alien sense of self. This perspective proposes a modified form of dynamic psychotherapy to address these fundamental relational problems, focusing on enabling the patient to develop a reflective capacity.

Theorists in cognitive-behavioural traditions, notably Linehan (1993a, 1993b) have conceptualised BPD as a biopsychosocial problem in which a biological disposition towards high arousal, emotional sensitivity and reactiveness coincides with experiences of a chaotic, abusive and/or invalidating environment. The result is a set of maladaptive behaviours, aimed at managing intense emotions and an interpersonal world experienced as dangerous and harmful. In terms of clinical practice, this theory specifically proposes that people with BPD require a new set of skills in order to tolerate distress, regulate their emotions, and manage interpersonal situations effectively. These are taught through a programme Linehan has labelled

'Dialectical Behavior Therapy', involving individual and group therapy with cognitive and behavioural dimensions as well as the incorporation of mindfulness, and, like most therapies for BPD, an emphasis on the importance of a consistent and supportive therapeutic relationship.

Neurobiological findings regarding BPD – notably, atrophy of the areas of the brain thought to be involved in emotion regulation (such as the hippocampus, amygdala, and frontal cortices), and stress-induced sensitivity of neuroendocrine stress response symptoms – have indicated the presence of serious vulnerabilities that persist over the life-span. Clinical implications of such findings emphasise the importance of early intervention. Neuronal plasticity in the early years may mean that identifying children at risk of abuse, and working to improve family relationships and to alleviate other stressors, may affect brain development and minimise the long-term effects of maltreatment. However, clinicians are more likely to encounter people who are already adversely affected, and an awareness of the existence of such deficits and the need to develop compensatory strategies becomes more relevant.

Clarifying the relationships between features of childhood experience and adult psychopathology enriches the aetiological models evident in the main therapeutic approaches to BPD by providing greater clarity as to specific risk

and protective factors. This is even more valuable in the case of men with BPD, who represent a complex, under-researched and little-understood group.

## 4. Gender and Borderline Personality Disorder

### 4.1 Why so little research with men?

The statistics listed in Table 1 show the preponderance of women in BPD samples in major non-epidemiological studies over the last decade, and reflect the prevalence described in DSM-IV-TR (APA, 2000). The authors note that approximately 75% of those diagnosed with BPD are female, a 3:1 gender ratio equalled only by ASPD (in the opposite direction).

TABLE 1

*Percentages of male and female participants in samples used in recent studies of BPD*

| Study | % Male in sample | % Female in sample |
|---|---|---|
| Dubo *et al.* (1997) | 28.6% | 71.4% |
| Zanarini *et al.* (1998a,b) | 23.0% | 77.0% |
| Zanarini *et al.* (1999) | 19.7% | 80.3% |
| Liotti and Pasquini (2000) | 29.3% | 70.7% |
| Trull (2001) | 48.0% | 52.0% |
| Zlotnick *et al.* (2002) | 29.5% | 70.5% |
| Zanarini *et al.* (2002) | 23.0% | 77.0% |
| Soloff *et al.* (2002) | 19.0% | 81.0% |
| Zanarini *et al.* (2005) | 22.9% | 77.1% |

A small number of epidemiological studies, however, have not found that rates of BPD vary by gender. Golomb, Fava, Abraham and Rosenbaum (1995) found a higher prevalence of narcissistic, antisocial and obsessive-compulsive disorders in male depressed patients. Women, in this sample, were no more likely than men to meet criteria for any personality disorder, including BPD. Grilo (2002c) found no association between personality disorder diagnosis and gender in a sample of out-patients with binge-eating disorder, and notes that "these empirical findings are somewhat at odds with DSM-IV estimates and prevailing clinical lore" (p. 429). It is possible that the populations from which Golomb *et al.*'s (1995) and Grilo's (2002c) samples were drawn (patients seeking treatment for Axis I disorders) were ones in which men with BPD were more likely to be found than those from which other studies have drawn (for example, patients seeking treatment for Axis II disorders). It is possible that men who display Axis I disorders in addition to personality problems might be more likely to access mental health services than men who show the features of an Axis II disorder (and who might therefore not be deemed suitable for treatment, or might present in different settings such as drug and alcohol or forensic services). Carter, Joyce, Mulder, Sullivan and Luty (1999), for example, found a higher prevalence of BPD in men among a sample of depressed out-patients. Alternatively, the incentives for taking part in these studies, or the way in which they was presented to participants, might have appealed to a different cross-section of people.

Several epidemiological studies (such as Torgersen, Kringlen & Cramer, 2001) have found no relationship between BPD and gender, but another (Maier, Lichtermann, Klinger, Heun & Hallmayer, 1992) found women significantly more likely to have BPD than men. Skodol and Bender (2003) argue that more research is required to clarify the true prevalence of BPD by gender.

These findings, while inconclusive, suggest that while women with BPD are strongly over-represented in most study populations, BPD is not necessarily less prevalent among men. Why, then, are more women than men diagnosed with BPD?

### 4.1.1 Biases in the diagnosis of BPD

In their examination of accusations of sex bias levelled at the DSM system for classifying personality disorder, Widiger and Spitzer (1991) noted that it was impossible to determine the presence of bias without being able to ascertain the true expected gender distribution of BPD. Indeed, the prevalence of BPD in men as compared with women, as described above, has not yet been clearly established. In spite of this, a body of research has suggested the potential for several separate forms of bias relevant to personality disorder diagnosis.

Biased sampling methods may be a source of sex bias in research on BPD. For example, more women than men may be seen in the settings in which research customarily takes place. Skodol and Bender (2003) point out that women are in general more likely to seek help for psychological problems than men. It is also possible that many men with behaviours that would be labelled as borderline in a mental health setting are detained in prison or are homeless, and are therefore less likely to be included in studies of the kind usually carried out in psychiatric hospitals or personality disorder services.

The DSM-IV criteria for certain personality disorders, and BPD in particular, have been seen as biased diagnostic constructs that involve "sexist characterizations or stereotyping of women's behaviour patterns as pathological" (Skodol & Bender, 2003; p. 351) to a greater extent than other mental disorders. For instance, emotional lability is a quality traditionally associated with women, and is enshrined in the BPD criteria as "affective instability due to a marked reactivity of mood". A dependent attitude to interpersonal relationships is also an attribute commonly associated with women in European and American cultures, and is taken to an extreme level in the DSM-IV criteria with the criterion: "Frantic efforts to avoid real or imagined abandonment" (APA, 1994). This argument was powerfully made by Kaplan (1983) in relation to borderline, dependent and histrionic personality disorders, which she argued represented extreme versions of

traits and behaviours traditionally ascribed to women. Klonsky, Jane, Turkheimer and Oltmanns (2002) point out that traits on which women tend to score more highly (extroversion, agreeableness and neuroticism) also feature in those personality disorders more frequently found in women (histrionic and dependent), as do those for men (low agreeableness being characteristic of antisocial personality disorder).

In contrast, some authors (such as Henry and Cohen, 1983) have argued that BPD is diagnosed more frequently in women than men because some of its core symptoms are inconsistent with traditionally female traits and behaviours. As Sprock (1996) speculates, it may be that when women behave in a way considered inappropriate to their gender, they might be more likely to be considered "ill" or "disturbed" than men who show the same behaviours (in their case, more gender-role-congruent). It may be that the diagnostic threshold, as well or instead of the actual criteria, may represent a source of bias, shifting according to gendered expectations of male and female behaviour. Indeed, in a study designed to assess gender bias, Sprock (1996) found that symptoms of personality disorders, and inappropriate anger in particular, were more likely to be rated as abnormal if an unknown patient was female, rather than male. Participants rated symptoms similarly for women and a baseline gender-unspecified condition. Sprock suggests that this "points more to the possibility of underdiagnosis of personality

disorders in men rather than overdiagnosis in women" (p. 316). Klonsky *et al.* (2002) found that female college students who endorsed more BPD criteria also regarded themselves as comparatively masculine. Male participants in the same study showed a moderate association between self- and peer-reported femininity and BPD. The authors report that self- and peer-reported feminine-acting men also exhibited more severe personality pathology. Klonsky *et al.* (2002) suggest that "it may be that participants who considered themselves unlike their gender also considered themselves dysfunctional... men who do not behave in a manner consistent with their gender role are perceived as having pathological personality traits" (p. 475), implying a possible interaction between gender, sense of self, and personality dysfunction. In terms of the proposition that core criteria of BPD represent an exaggeration of feminine gender characteristics, Klonsky *et al.* argue that this may indeed be the case in men, but not in women.

Diagnostic criteria might also be biased in their application, for instance by clinicians whose assumptions and prejudices lead them to misdiagnose certain personality disorders in one gender more than in another. Morey and Ochoa (1989) found that, in a test of clinicians' adherence to DSM criteria, female clinicians were more likely to propose unwarranted diagnoses of BPD for female patients. Given the preponderance of women with BPD in the research literature, and perhaps the consequent development of a stereotype

of a female patient with BPD, such a bias might develop through a process of inadvertent reinforcement, though it is not clear why it would not also apply to male clinicians. In contrast, a later study by Morey, Warner and Boggs (2002) showed that students did not discriminate by gender in attributing BPD criteria to themselves or rating their adverse effects on functioning. However, self-rating according to specific criteria in a population untrained as clinicians is likely to draw on more specific, detailed self-knowledge, and to be less susceptible to reinforcement from sources of information about BPD. As such, it is likely to reflect private and personal self-attributions, or broader social representations of gender and psychiatric disorder, rather than reflections of clinical stereotypes.

Several sources of bias may, then, contribute towards an over-diagnosis of BPD in women, or an under-diagnosis of BPD in men. However, as Widiger and Spitzer (1991) point out, "in the absence of a comprehensive model of personality disorder pathology it is difficult to determine whether there should be an equal proportion of males and females receiving a personality disorder diagnosis, and whether there is an imbalance in the current system" (p. 18). Sampling, diagnostic and criterion biases are, as Skodol and Bender (2003) remark, unlikely to account for the magnitude of a 3:1 ratio in the prevalence of BPD by gender. It may, of course, be the case that fewer men do meet criteria for BPD. The 3:1 ratio, however, closely reflects the

proportions of men and women participating in recent studies of BPD, and therefore the proportions of men and women present in treatment settings at the time of research and willing to participate.

### 4.2 Different pathways for men and women?

As described above, various biases affecting the prevalence by gender of BPD in clinical and research settings have meant that studies have largely focused on women's experiences and clinical presentations. There are several reasons why it might be worthwhile to devote research efforts to men and women with BPD separately. Biological, individual, family and social differences between men and women may affect the risk of developing these kinds of difficulties, as well as affecting the chance of receiving a diagnosis.

Biological differences between men and women may influence their comparative likelihood of displaying the behaviours that characterise BPD. Skodol and Bender (2003) argue that girls are more likely, for biological reasons such as higher levels of autonomic arousal, serotonin responsivity and frontal activity in the brain, to develop internalising problems. These would contribute "an affective component to any impulse-control problem" (p. 357). Here, there is an assumption that BPD involves a primary difficulty with impulse-control, and that the sensitivity of women's particular physical make-up may interact with that impulsivity to produce the characteristic

features of BPD. This theory implicitly attempts to account for the 3:1 ratios of BPD and ASPD in (respectively) women and men, suggesting that impulsive men would be more likely to externalise distress (through damaging property or other people, rather than themselves). The fact remains that some men do internalise, however. This prompts us to ask whether these men are socialised in particular ways that over-ride the expectations of their gender and/or whether aspects of their physiology represent the end of a continuum at which they are biologically more similar to women. Research exploring the ways in which men with BPD are socialised into particular gender roles or behaviour, and measuring the neurochemical markers of gender described above, might provide some clarity.

Trait differences between men and women, at least in European and American cultures where studies have been undertaken, may also have some bearing on the pathway to diagnosis with BPD. As Widiger and Spitzer (1991) point out: "Personality disorders are to a large extent maladaptive variants of personality traits that are observed in normal men and women. Research has indicated differential sex prevalence in many personality traits seen in normal populations, including dominance, submissiveness, aggression, deference, nurturance, caring, compliance, emotionality, and many others" (p. 4). Systematic trait differences between men and women

are likely to have some effect on the way in which they experience and interpret abuse, neglect and adversity in general. While one would expect population gender differences in trait to be replicated in sub-samples (such as people with BPD), Johnson *et al.* (2003) found no differences in trait or temperament between men and women with BPD. An earlier study with the same population had found men to be more mistrustful, manipulative, aggressive, entitled, detached and disinhibited, and women more negative and dependent. The authors suggest that "BPD pathology attenuates usual gender differences... typically found in clinical presentations, trauma history, temperament and personality traits", perhaps through "comorbid disorders and/or etiological pathways" (p. 290). This finding is supported by Klonsky *et al.* (2002), as described above, with the finding that both male college students rating themselves as feminine, and female students rating themselves as masculine, endorsed more borderline personality features. Klonsky *et al.* (2002) add: "participants who considered themselves unlike their gender also considered themselves dysfunctional. Borderline personality traits are particularly maladaptive compared to other kinds of personality pathology" (p. 473).

It is not clear whether non-typical traits for male gender might predispose someone to the experiences or biological vulnerabilities associated with BPD, or whether the reporting styles or self-identifications measured by the

instrument used by Johnson *et al.* (2003) (the Schedule for Non-Adaptive and Adaptive Personality – SNAP) and Klonsky *et al.* (2002) (the Bem Sex Role Inventory – BSRI) developed in response to experiences associated with BPD (or neither). For example, a feminine man might be more likely to be mistreated or abused, and thereby to develop BPD; alternatively, the femininity such men report may reflect other biological differences from more masculine men that in some way predispose them towards BPD. Another possibility might be that specific forms of maltreatment and oppression in childhood might foster the development of atypical gendered personality traits in men, abuse perhaps leaving a man confused about his gender identity, or drawn to ways of behaving and feeling more characteristic of women in this society. In any case, as Johnson *et al.* (2003) remark, the muting of gender differences in BPD deserves further investigation.

If we assume a major role of trauma, and particularly sexual abuse, in the genesis of BPD, it might be reasonable to assume that women would be more likely to develop BPD on account of statistically greater odds of exposure to trauma. A review by Dhaliwal, Gauzas, Antonowicz and Ross (1996) found prevalence rates of 2.5-36.9% for male sexual abuse and 6.8%-53.5% for female, in the general population. These results are likely to underestimate the prevalence of male sexual abuse as it is thought more likely to be

concealed (through repression and/or fear of stigma) or not viewed as abuse by those who have experienced it or those to whom it has been reported. A significant gender difference in the prevalence of sexual abuse is also found among people with BPD, with approximately 70% of women reporting sexual abuse compared with 50% of men (Paris *et al.*, 1994a; 1994b). Several studies (including Russ *et al.*, 2003) have found that sexual and physical abuse were significant predictors for BPD *in women only*. So even those men who are sexually abused are not necessarily at heightened risk for BPD. However, as King, Coxell and Mezey (2002) note, experiences of childhood sexual molestation in men are associated with a significantly greater risk of psychological disturbance in adulthood.

Various studies have explored the differences between male and female experiences of sexual abuse. Some (including Hunter, 1991) have found that sexual abuse of men is on average of shorter duration than that of women, perhaps because men are more able or likely to refuse or physically resist, which might be expected to have less severe effects. It is also the case that people who abuse girls are more often family members, and are therefore able to continue abusing them over years, whereas people who abuse boys are more likely to be friends or strangers who have more limited opportunities for contact with their victims (Dhaliwal *et al.*, 1996). There is an assumption in the literature that incestuous sexual abuse may be more

psychologically harmful than that perpetrated by an extrafamilial person (Browne & Finkelhor, 1986). Studies of the sexual abuse of women have indicated that perpetrators are usually male, whereas some studies of male childhood sexual abuse have shown larger proportions of female perpetrators (Dhaliwal *et al.*, 1996). The implications of this are not clear, although it may suggest differences in the nature of the abuse according to the gender of the perpetrator and the victim. Other differences between male and female experiences of sexual abuse – for example, that women are more likely to be victimized by a much older family member, whereas perpetrators of sexual abuse on men are more often cousins or siblings – may also be significant in terms of their psychological sequelae. Notably, men who have been sexually abused are more likely than women to rate their experience of childhood sexual abuse in positive terms, and to cite a positive impact on their sexuality in adulthood (Fromuth and Burkhart, 1987; cited in Dhaliwal *et al.*, 1996).

Studies that have compared the sequelae of sexual abuse for men and women have found intriguing gender differences. Among the first studies to extend findings of a positive association between psychopathology and abuse to male populations was Spataro *et al.* (2004), who found that male victims of childhood sexual abuse were significantly more likely than population controls to receive treatment for anxiety disorders, personality

disorders, organic disorders, childhood mental disorders and conduct disorders. Sequelae of sexual abuse were subtly different for men and women, with men more likely to have had contact with mental health services, and to show conduct disorders and other childhood mental disorders. Interestingly, abused men were at a lower risk of major affective disorder than abused women. The authors speculate that women might be more likely to respond to childhood sexual abuse by developing a depressive disorder than men, perhaps reflecting the traditionally assumed gender split between internalising and externalising responses. Gratz *et al.* (2002) found that sexual abuse was not related to self-harm behaviour in men, in their sample of college graduates. Although the size of the sample precluded firm conclusions ($n = 44$), they suggest that no relationship existed only because most of the sexually abused men reported only one incident of sexual abuse (whereas sexually abused women, for whom a relationship between sexual abuse and self-harm did exist, usually reported multiple incidents). The implication here may be that the experience of extensive or sustained periods of sexual abuse may be more likely to produce the desire to damage oneself evident in self-harm, irrespective of gender, although the nature of the data did not permit this to be tested. Other studies have suggested that duration of sexual abuse is one of many features of the experience which may lead to a more negative outcome in psychological terms. King *et al.* (2003) supported the expected relationship between sexual abuse and self-harm among men,

finding that molestation in childhood significantly raised the risk of deliberate self-harm in adulthood. However, their study did not ask men to specify the nature, duration or severity of the sexual abuse they experienced.

Other experiences may be more common among men, notably physical abuse and bullying by peers. For example, Gauthier *et al.* (1996) found no differences in the rates of neglect experienced by male and female college students in her sample, but found that significantly more men had experienced physical abuse. Zanarini *et al.* (2005) similarly found that while women with BPD were more likely than men with BPD to report a history of emotional and sexual abuse occurring in adulthood, verbal and physical abuse occurred at similar levels or were more common among men than women.

Men may be encouraged to cope differently with the same kinds of violent or traumatic experiences, for instance using less verbalisation of feelings and more diversion of painful emotions into an anaesthetising or power-reclaiming activity (such as drinking, drug-taking or committing acts of violence). Studies of coping strategies (for example, Rew, Esparza and Sands, 1991), have indicated that sexually abused men predominantly use avoidant, externalising coping strategies, whereas sexually abused women use more emotive, internalising coping strategies. This process may underlie some of

the similarities between BPD and antisocial personality disorder (ASPD), and perhaps the gender distribution in the prevalence of each. Known risk factors for ASPD include physical abuse (Pollock *et al.*, 1990) and having a criminal or absent father (Robins, 1966; West & Farrington, 1973). Skodol and Bender (2003) remark that investigating risk factors for ASPD "may provide fruitful leads for the study of BPD" (p. 356).

In summary, men and women may experience the traumas associated with BPD differently, and may respond in contrasting ways. Broadly speaking, men and women are sexually abused to differing extents, in different ways, by different people. A significant proportion of both men and women who are sexually abused in childhood go on to experience psychological disturbance later in life; notably, these sequelae are not identical between the sexes. Furthermore, not everyone with BPD has been sexually abused (Johnson *et al.*, 2003) – in fact, a smaller proportion of men than women with BPD – and other forms of abuse, neglect or maltreatment may be highly significant in the development of the disorder. Indeed, men may be at a greater risk of physical abuse than women. The identity and gender of the abuser may have different meanings for men and women. As abusers or caregivers, the roles of mothers and fathers may be differentially significant for men and women in developing mental health. As Frank and Paris (1981) point out, "the family experience of male and female borderline patients

could be quite different, particularly in relation to the importance of the responses of mothers and fathers" (p. 1034). Findings such as those of Russ *et al.* (2003) – that strong correlations exist between BPD and maternal rejection for male patients, and between BPD and both maternal and paternal rejection for female patients – underline the fact that different sets of childhood experiences between men and women may lead to similar adverse outcomes. Men and women differ systematically in terms of biology, and to some extent, in terms of culturally-defined personality traits; they also differ in terms of habitual or socially acceptable methods of coping. All of these differences may mediate the links between pathogenic early experiences and later psychological disturbance. Until recent studies by Paris *et al.* (e.g. 1994b), the relevance of such differences has largely been ignored in the literature.

## 5. Borderline Personality Disorder in men

The following section will summarise what is currently known about men with BPD, beyond the research described above on BPD in general. It will include relevant findings regarding the clinical presentation of men with BPD, after which it will review the research on their childhood experiences.

There are various indications that men and women with BPD might present differently. Notably, considering the theory that men typically externalise emotion while women tend to internalise (if valid in BPD), some gender differences in certain symptoms, such as impulsivity, reactivity of mood and outbursts of anger, might be evident. Similarly, if it proves to be the case that BPD is prevalent among men in non-psychiatric settings such as the forensic system, or substance abuse treatment, one might expect a greater degree of antisocial behaviour among men. However, such gender differences in clinical presentation have not been found. As described above, Johnson *et al.* (2003) and Klonsky *et al.* (2002) both describe a trait femininity in men meeting or endorsing BPD criteria which might make expected gender differences less evident. Trull (2001) also found that gender was not significantly related to BPD symptomatology. Male and female participants' scores on the DSM-IV Global Assessment of Functioning Scale, on other measures of psychosocial functioning, and on personality variables, did not differ significantly. Men and women reported similar levels of childhood physical abuse, sexual abuse and witnessing of abuse. Some subtle differences, picked up by other studies, may be significant: for instance, Dubo *et al.* (1997) found that men with BPD started to make attempts at suicide significantly later than their female counterparts. Johnson *et al.* (2003) found that the patterns and frequencies of endorsement of BPD diagnostic criteria did not differ between men and women, except for the identity

disturbance criterion, which was endorsed by significantly more women (67.4% *vs.* 47.7%). As mentioned previously, Zanarini *et al.* (2005) found that men with BPD were less likely than women to report ongoing emotional and sexual abuse, but the difference was not evident for verbal and physical abuse in adulthood.

Patterns of comorbidity, however, show striking gender differences. Like Zanarini *et al.* (1998a) and Zlotnick, Rothschild and Zimmerman (2002), Johnson *et al.* (2003) found that men with BPD were significantly more likely to fulfil criteria for substance use disorders (84.6% of men *vs.* 58.3% of women), while women with BPD were more likely to show symptoms of PTSD (50.9% of women *vs.* 30.8% of men) and eating disorders (41.7% of women *vs.* 18.5% of men). Men with BPD were more likely to meet criteria for one or more other personality disorders, notably antisocial, narcissistic and schizotypal (a finding similar to Zanarini *et al.*, 1998b and Grilo *et al.*, 2002b, 2002c, who found the same elevated risk of comorbid Axis II diagnoses in men only, but a more varied range). Similarly, Dulit, Fyer, Miller, Sacks and Frances (1993) found that men with BPD were significantly more likely than women with BPD to abuse multiple substances. They speculate that substance abuse "may be a primary cause of psychopathology for a subgroup of males who fulfil borderline criteria", and note its association with a poorer long-term treatment outcome (p. 184). Johnson *et al.*

(2003) assume that these contrasting comorbidities reflect a socio-cultural difference in the expression of trait impulsivity, describing such patterns in terms of male externalising and female internalising tendencies. This explanation does not fully account for the comorbidity of non-externalising personality disorders such as the depressive, avoidant, schizotypal and narcissistic types often seen in men diagnosed with BPD.

Challenging the idea that a 'normative' gender difference in the tendency to externalise or internalise emotion holds for BPD, Hatzitaskos, Soldatos, Sakkas and Stefanis (1997) found that men with BPD tend to internalise hostility and anger, in contrast to men with ASPD. While achieving high scores on Total Hostility, men with BPD also scored highly on a measure of introverted hostility and self-criticism (subscales of the Hostility and Direction of Hostility Questionnaire – HDHQ; Caine, Foulds & Hope, 1967), and showed comparatively lower levels of "acting-out hostility". High scores on the introverted hostility scale were found in participants who also reported high levels of depression, anxiety and psychopathology. The authors state that BPD can be distinguished from ASPD by the direction of hostility, and that such high levels of introverted hostility may intensify depression and anxiety. The origins of such hostility, they remark, are likely to be in an early learning environment characterised by violence and abuse. The authors did not compare the direction of hostility evident between men

and women, which might have cast some light on the presence or absence of gender differences in the presentation of BPD. However, this was an important piece of research in the sense that it effectively distinguished BPD from ASPD. The aetiological significance of this difference is not yet clear, but it might give rise to some hypotheses regarding the nature of childhood maltreatment experienced by men with BPD that might foster a tendency to internalise hostility.

Following on from these findings, Paris, Zweig-Frank, Bond and Guzder (1996) compared the levels of hostility and defence styles of male patients across a range of personality disorders. They found that those with BPD exhibited more "primitive" maladaptive and image-distorting defences (such as omnipotence, splitting, primitive idealization, regression, acting out, projection, withdrawal and inhibition) than patients with other personality disorders. A previous study (Bond, Paris & Zweig-Frank, 1994) found similar results for women with BPD. However, women with BPD used fewer "adaptive" defences (such as suppression, sublimation and humour) compared with women with other personality disorders. Paris *et al.* (1996) also found that men with BPD scored more highly on an inventory of hostility than other male personality disordered patients. Both hostility and defence styles were significantly related to diagnosis, and more weakly to a range of childhood risk factors such as abuse and neglect. In a previous

study (Zweig-Frank, Paris & Guzder, 1994), the authors found a similar weak relationship linking behaviours such as self-mutilation and dissociation with childhood experiences and a stronger connection between these and a diagnosis of BPD. Paris *et al.* (1996) raise the possibility that hostility, defence style, dissociation and self-mutilation may be heritable personality traits that form part of a constellation of constitutional aspects of BPD rather than direct consequences of adverse childhood experiences. This implies that such symptoms might not be responses to or learned from a harsh and adverse environment, but instead, or additionally, transmitted biologically as maladaptive predispositions. These might include impulsivity (as proposed by researchers such as Zanarini and Johnson), aggression, and some predisposition to depression.

Research on experiences of violence shows that men with BPD are less likely to have been victims of violence in adulthood than their female counterparts (Zanarini *et al.*, 1999), but that a sub-group of perpetrators of domestic violence exhibit borderline features. 50% of women in Zanarini's sample of patients with BPD had experienced physical and sexual assault in adulthood, whereas only 26% of men had. Women were also more likely to have been raped by a known perpetrator. 25% of men with BPD reported physical abuse by a partner and/or rape, compared with none of the Axis II control group having had these experiences. Experiences of violence in adulthood

were strongly associated with childhood maltreatment. However, 50% of those maltreated in childhood reported no violence in adulthood. This indicates that a sub-group of people who were abused in their early years continue to suffer physical and sexual abuse throughout their lives. The risk of being in this high-abuse subgroup was higher in association with several types of childhood maltreatment: from a caretaker who emotionally withdrew, from one who failed to provide needed protection and/or physically neglected the child, from one who perpetrated sexual abuse, and in particular, in the case of sexual abuse by a non-caretaker.

Examining perpetrators of domestic violence, Holzworth-Munroe (2000) identified a sub-group of violent men who exhibit borderline and dysphoric features. She found that these men tend to perpetrate a moderate to severe level of marital violence and were characterised by fears of abandonment, preoccupied or fearful attachment, and dependency.

Femininity in men with BPD has been highlighted by the two studies described above (Klonsky *et al.*, 2002 and Johnson *et al.*, 2003), although this phenomenon is, as yet, little understood and barely researched. Sexuality in men with BPD has attracted more attention. A study of in-patients diagnosed with BPD found that 48% of men described themselves as homosexual or bisexual, compared with 14% in the general population (Dulit *et al.*, 1993).

This rate also differs from that found among women with BPD, 14% of whom rated themselves as homosexual or bisexual. These findings reflect those of Zubenko, George, Soloff and Schulz (1987), who recorded a rate of homosexuality among men with BPD that was ten times that of the general population. A more recent study by Paris, Zweig-Frank and Guzder (1995) found that 16.7% of their group of men with diagnoses of BPD classed themselves as homosexual, compared with 1.7% of men with other Axis II diagnoses. 100% of the homosexual men with BPD had been sexually abused in childhood (compared with 37.3% of heterosexual men with BPD in the same sample). Homosexual men with BPD rated themselves as having experienced less maternal affection and more controlling behaviour from both parents than heterosexual men with BPD. 30% of homosexual men with BPD reported that the abuse they suffered was incestuous, at the hands of their fathers. This form of abuse is thought to be especially damaging to psychological wellbeing (Paris, Zweig-Frank & Guzder, 1995). The authors suggest that early experiences of sexual abuse may have a formative influence on the developing sexuality of the child; if not a causal relationship, then an association in some form. Alternatively, they propose, children with an early homosexual orientation may be more vulnerable to sexual abuse. This body of research indicates that homosexuality is strongly over-represented among men with BPD, compared with rates of homosexuality among women with BPD, men with other personality disorders, and the

general population. Moreover, as Dulit *et al.* (1993) point out, the co-occurrence of substance abuse, self-destructive and impulsive behaviour among men who are homosexual bears serious implications for public health, in terms of a raised risk of HIV infection. Certainly, issues of identity and stigma often prove a source of distress and confusion for homosexual men in this society (Silverstein, 1993). Such difficulties are likely to exacerbate the problems of identity and social relatedness that may have developed through biological vulnerability and family dysfunction among men with BPD.

Although clearly a heterogeneous group, men who come to receive a diagnosis of BPD are, according to the available literature, likely to present with a range of characteristic difficulties. Symptom presentations similar to those experienced by women with the same diagnosis would be expected if the diagnostic criteria are valid, and indeed this is largely the case (with the exception of identity disturbance, seen more frequently in women, and differing patterns of co-morbidity). Unusually similar personality traits between men and women with BPD, as observed by Johnson *et al.* (2003) and Klonsky *et al.* (2002), may signal an attenuation of normal gender differences which deserves further investigation. Sexual preference among men with BPD is significantly more likely to be in the direction of other men, compared with the general population. In the one study that addressed this question,

homosexual men with BPD were, without exception, sexually abused as children. Men with BPD are also more likely to abuse substances and to behave in ways that lead clinicians to diagnose them with many additional personality disorders. High levels of impulsivity, similar to those shown by women with BPD, are likely to be expressed in ways that are culturally acceptable for men in this society (such as violence or substance abuse), in contrast to the more internalised impulsive gestures found in women with BPD (though this is somewhat at odds with observations of the 'feminisation' of men with BPD, and may relate to possible diagnostic confusion between ASPD and BPD). Intense hostility, often focused on the self, has been observed in several studies. An elevated risk of exposure to violence in adulthood, though to a lesser degree than among women with BPD, has been found in men, and it is possible that some men who perpetrate acts of domestic violence also exhibit 'borderline' features.

### 5.1 Childhood experiences of men with diagnoses of BPD

As with women, high proportions of men with psychiatric problems have experienced abuse and maltreatment in childhood. Swett, Surrey and Cohen (1990) studied the sexual and physical abuse histories of male psychiatric outpatients and found that 48% reported abusive childhood experiences. Those who reported abuse also had high levels of psychiatric symptomatology. King *et al.* (2002) found that men who had been sexually

molested in childhood were 2.4 times more likely than those who had not to report psychological disturbance, and 3.7 times more likely to report deliberate self-harm. Men who had been sexually molested in childhood reported more psychological problems than those who were molested in adulthood only. Gratz (2003) found that self-harm in the men in their sample of college students was strongly related to a history of childhood separation, usually from their fathers. Such findings raise the question of the potential psychological damage associated with the absence of a safe attachment relationship.

With reference to BPD in particular, Paris *et al.* (1994b) carried out parallel investigations of risk factors for BPD in men and women, focusing on various parameters of childhood sexual abuse and physical abuse, separation, loss, and parental bonding. They found that 47.5% of men in their sample with BPD had been sexually abused, compared with 25% in an Axis II control group. Penetration was reported by 18% (compared to 2% among controls). They note that CSA as a strong risk factor for BPD in men as well as women is surprising "in view of the relatively lower prevalence of sexual abuse in males in community studies... it appears that even though there are fewer boys who are sexually abused during childhood, they may be at greater risk for borderline psychopathology" (p. 378). This might not be unexpected finding, considering the lower prevalence of BPD in men: if

fewer men are abused, and fewer men show symptoms of BPD, we should not necessarily be surprised. However, as Paris *et al.* (1994b) note, over half their sample of men with BPD had not been sexually abused. Among those who had, comparatively few had experienced incestuous sexual abuse: 12% of men, compared with 29% of women (in Paris *et al.*, 1994a). Paris *et al.* also note that the childhood sexual abuse described by their male BPD participants was not of greater frequency or duration than that described by their non-BPD patients, and that most men with BPD did not report significantly more severe abuse than non-BPD patients, apart from a specific subgroup who had been particularly severely abused. In terms of physical, rather than sexual abuse, Paris *et al.* (1994b) found similar levels among men with and without BPD, but interestingly those with BPD were more likely to have been abused by their father, and for a longer duration. Other paternal relationship problems emerged from the data; men with BPD were more likely to have experienced excessive control, physical or sexual abuse from their fathers, or to have had fathers who were absent during their childhood. Finally, separation or loss before the age of 16 was a significant factor in discriminating men with BPD from those without.

Drawing on this body of research, a psychological model of BPD in men might involve a set of inherited predispositions (such as impulsivity and aggression), with the violent and maladaptive behavioural manifestations of

such traits modelled by their parents and inflicted on them throughout childhood. In the context of harsh and deprived social circumstances, and in the absence of protective factors for children living in these conditions (such as the lack of a confidant, poor intellectual ability, and a deviant peer group), and particularly when early experiences of abuse and neglect leave them vulnerable to abuse by others and 're-set' their expectations of the world in distorted and fearful ways, an individual might resort to self-destructive and self-anaesthetising activities in order to experience relief and emotional safety. Experiences of abuse by fathers, separations from fathers, and excessive paternal control, may have particular salience for men, as they frequently reappear as risk factors for BPD and associated problems such as self-harm. If early relationships have not provided the context for learning to understand and control strong impulses such as aggression and distress, violence to the self and others, and the use of substances, might become habitual outlets for aggression and distress.

**6. Summary**

Developing a model of BPD in men is a complex task. The links between childhood maltreatment and adult psychopathology are evident but difficult to bind together in a coherent predictive matrix, since factors such as genetic

and biological vulnerability (themselves little understood), resilience and positive environmental influences are also essential parts of the picture.

There is a dearth of research into BPD in men, with only a handful of studies addressing their particular concerns and the main body of literature subsuming small numbers of male participants in larger mixed-gender groups. This apparent neglect may partly reflect a wider problem in finding and identifying men with BPD in the contexts in which this research has usually taken place. Whether the actual prevalence of BPD among men is lower than that among women (and why this might be), whether the apparent rarity of men with BPD is a factor of the research setting, whether men with BPD are less likely to seek treatment, or participate in research, than women, and whether there are gender biases in the criteria and application of BPD diagnoses that discriminate against men or in favour of women, are questions for which the answers are not yet clear. Various suggestions as to the nature of BPD being more 'female' than 'male' (by virtue of the centrality of internalising problems in the diagnostic criteria, and in recognition of the link between BPD and sexual abuse, which occurs more often to women) further highlight questions regarding the particular aetiological factors that mark the pathway towards BPD for men, in comparison to women.

The evidence suggests that such factors as childhood maltreatment, particularly in relation to fathers; homosexuality; substance abuse; internalised hostility and complex co-morbid mental health problems (often involving impulsive externalising behaviours) are defining features of BPD in men. Research examining these factors in close detail is needed in order to enable us to develop therapeutic interventions that are gender-appropriate and to acknowledge the specific experiences that men suffering these difficulties may have undergone.

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# Empirical Paper

**Abstract**

This study seeks to cast light on some of the experiences reported by an under-researched population, men with borderline personality disorder (BPD), and to investigate the links between their current symptomatology and specific experiences of maltreatment in childhood. A detailed semi-structured interview was used to assess the nature and severity of a range of childhood experiences of care and abuse amongst 30 men. 19 of these met criteria for borderline personality disorder as assessed by a screening measure of demonstrated reliability and validity. The borderline personality disorder group was compared with a non-borderline psychiatric control group (n=11) in order to test the specificity of potential risk factors for BPD. Measures of childhood maltreatment and borderline symptoms were supplemented by a test of autobiographical memory, and inventories of depressive symptoms and experiences of shame, which were considered to be potentially confounding variables. A significant proportion of the study population reported experiences of physical, psychological and sexual abuse, as well as parental antipathy, neglect and bullying by peers. Men with BPD reported significantly more severe psychological and physical abuse, and greater paternal antipathy. Severity of borderline symptoms, and in particular, cognitive and affective disturbance, was significantly related to neglect, physical and psychological abuse in childhood. Multiple forms of maltreatment were found to be correlated with each other, suggesting

characteristic matrices of abuse and neglect associated with BPD. The findings of this study were compared with those of similar research studies, and similarities and differences explored. These results suggested that specific forms of abuse are likely to affect the symptomatology of BPD, and that maltreatment at the hands of fathers may render men particularly vulnerable.

**Introduction**

Borderline personality disorder is usually characterised as a 'female' disorder. It is thought to occur far more frequently among women than men (Skodol and Bender, 2003); its criteria have been criticised for pathologising characteristically female traits (Kaplan, 1983); and the vast proportion of research into BPD has used exclusively or predominantly female samples. The evidence for associations between traumatic and invalidating experiences in childhood and a later diagnosis of BPD, specifically emotional and physical neglect, psychological, physical and sexual abuse, often at the hands of caregivers (Ogata *et al.*, 1990; Shearer, Peters, Quaytman and Ogden, 1990; Zanarini *et al.*, 2002), may not, therefore be generalisable to male populations.

These potentially pathogenic experiences may occur in different ways, and to different extents, among men and women. The way such experiences are

constructed intrapsychically, and informed by social representations of gender, childhood, abuse and neglect, may vary according to gender. For instance, Herman, Perry and van der Kolk (1989) found that women with BPD reported higher levels of sexual abuse, but that both men and women with BPD reported similar levels of physical abuse and witnessing domestic violence. Zanarini *et al.* (2000b) demonstrated that the relationship between biparental abuse and neglect, and sexual abuse by a non-caretaker, held only for women with BPD and not for men. Indeed, the adverse experience most commonly linked with BPD, sexual abuse in childhood, is, broadly speaking, thought to differ in terms of type, relationship of victim to perpetrator, duration, and self-perceived impact on adult sexuality, between men and women (Hunter, 1991; Dhaliwal, Gauzas, Antonowicz and Ross, 1996). Certainly the incidence of childhood sexual abuse appears to differ between men and women with BPD, occurring in approximately 70% of women, and 50% of men (Paris, Zweig-Frank and Guzder, 1994a; 1994b). Paris *et al.* (1994b) have also suggested that maltreatment at the hands of fathers may be particularly pathogenic for men with BPD, in contrast to women.

As well as experiencing and understanding events differently, men and women are also likely to express distress in different ways, according to cultural expectations and, possibly, biological imperatives. The little research conducted solely with men with BPD has indicated several noteworthy

gender differences, giving us further cause to explore the possibility of different pathways to BPD for men and women. First, the co-morbid disorders with which men with BPD present systematically differ from those observed among women with BPD. Men are more likely to abuse substances, and to show symptoms of several other Axis II disorders, while women more often meet co-morbid criteria for PTSD and eating disorders (Zanarini *et al.*,1998a; Zanarini *et al.*,1998b; Grilo, Sanislow and McGlashan, 2002; Zlotnick, Rothschild and Zimmerman, 2002; Johnson *et al.*, 2003). Second, men with BPD report being a victim of violence in adulthood less frequently than women with BPD, and may be more likely to commit acts of domestic violence (Zanarini, Frankenburg, Reich, Marino, Haynes and Gunderson, 1999; Holzworth-Munroe, 2000). Third, men with BPD are significantly more likely to be homosexual than women with BPD, and much more likely than men in the general population (Dulit, Fyer, Miller, Sacks and Frances, 1993; Zubenko, George, Soloff and Schulz, 1987). Further, studies of personality traits among men and women with BPD have indicated that gender differences appear somewhat attenuated (Johnson *et al.*, 2003) with expected trait differences between the sexes not found to the same extent in this population. In a study of masculinity, femininity and personality disorder, Klonsky, Jane, Turkheimer and Oltmanns (2002) found that both male and female college students endorsing BPD traits were significantly more likely to endorse traits characteristic of the opposite sex.

In summary, striking and clinically relevant differences are evident between men and women with BPD. Some of these may reflect gender differences apparent in the general population; others point to unusual similarities between the sexes. These observations might imply that steps along the pathway to BPD may also differ for men and women, and that we need to supplement existing research focused on women with a perspective informed by the experiences of men. The theoretical basis of our understanding of BPD requires the integration of gender-specific risk factors, in order to educate clinicians about specific vulnerabilities and to enable the development of sensitive and informed interventions.

The marginalisation of men with BPD evident in existing research stems from their under-representation in study samples. This reflects the comparative rarity of men in clinical and research settings, and may or may not indicate an actual difference in prevalence by gender (Widiger and Spitzer, 1991). Various theories attempting to account for the preponderance of women with BPD have been advanced, including criticism of the diagnostic criteria and of clinicians' prejudicial diagnostic practices. Others have attempted to explain the gender difference in terms of differential exposure to risk factors. For instance, Herman *et al.* (1989) suggest, that girls "may be more frequently exposed to conditions favouring the development

of borderline personality disorder" (p. 494), having found high rates of sexual abuse in the histories of female study participants with BPD compared with males. Epidemiological studies have suggested a variety of prevalence rates, some equal across the sexes (for example, Torgersen, Kringlen and Cramer, 2001), others favouring women (for example, Maier, Lichtermann, Klinger, Heun and Hallmayer, 1992). As a result, there is an argument for some caution generalising from aetiological data collected from female samples, and further research focused on men alone.

In constructing a framework for such a programme, the findings of the aetiological literature on BPD should be outlined and the gaps identified. It is widely thought that the origins of BPD, in both men and women, are complex and multi-factorial. Temperamental vulnerabilities, underpinned by biological and/or genetic susceptibility, may combine with repeated early traumas and environmental reinforcement of maladaptive behaviours to create the characteristic constellation of problems (Linehan, 1993).

Biological and neurological research has identified a range of abnormalities among patients with BPD (e.g. Links, 1996), evident in EEG, MRI and PET data (Bornstein, 1997). The disorder has been linked with ADHD, developmental or acquired brain injury, and cortical dysfunctions. These abnormalities may be precursors or sequelae of traumatic experiences: Soloff,

Lynch and Kelly (2002) point out that childhood maltreatment is associated with enduring changes to the functioning of the hypothalamic-pituitary axis, regulation of cortisol and catecholamines, and hippocampal structure and function. Abnormal neurological functioning, particularly in areas associated with emotion regulation (the hippocampus, the cuneus, and the frontal cortex) has consistently been found among women with BPD (Juengling *et al.*, 2003), and reduced hippocampal volume among survivors of abuse (Bremner *et al.*, 1997). Penza, Heim and Nemeroff (2003) have proposed a process by which early traumas adversely affect the central nervous system and permanently sensitize neuroendocrine systems, such as the hypothalamic-pituitary axis, to stress, as well as leading to hippocampal atrophy. These, in turn, are thought to lead to long-term vulnerability to depression, anxiety and other psychiatric problems. Zanarini *et al.* (2000b) suggest several possibilities regarding the relationship between the complex set of aetiological factors in BPD: first, that the dysphoria associated with severe and sustained trauma may affect neurological functioning "through a kindling process"; second, that innate biological vulnerabilities may be risk factors for exposure to abusive situations, and third, that it may simply be that some individuals are unfortunately burdened with both biological and environmental disadvantages that, acting independently, raise their risk of developing BPD.

Certainly, the consensus in the research points to an inseparable relationship between biological abnormalities and experiences of abuse, neglect, loss and separation, which appear to be vastly over-represented among people diagnosed with BPD. Importantly, as Shearer, Peters, Quaytman and Ogden (1990) point out, "abuse usually occurs in the context of other family problems, including parental alcoholism or affective disorder, physical impairment or death of a parent, and fragmentation of the family. Hence, abuse victims are also burdened with the legacy of genetic predisposition or multiple developmental traumas, which compound the specific effects of victimization" (p. 216). Although it is problematic to infer the aetiological significance of childhood experiences from retrospective data, longitudinal research such as that carried out by the Collaborative Longitudinal Personality Disorders Study in the USA (e.g. Battle *et al.*, 2004; Johnson, Cohen, Brown, Smailes and Bernstein, 1999), has demonstrated clear links between such adverse experiences and a heightened risk of BPD in adulthood. Associations between BPD and several forms of childhood abuse and neglect have been replicated by a number of studies (for example, Zanarini, 2000b; Zanarini *et al.*, 2002). One example in which male participants, unusually, formed the majority (73%) of the sample, was Goldman, D'Angelo, DeMaso and Mezzacappa (1992), who found that BPD in adolescence was associated with both sexual and physical abuse. Finer links, between specific experiences and certain symptoms, have also been

made. For example, severity of sexual abuse has been found to be associated with severity of borderline symptomatology (Silk *et al.*, 1995) and parasuicidal behaviour (Zanarini *et al.*, 2002). Herman *et al.* (1989) found that participants with BPD had experienced more varied trauma, starting earlier in life and lasting longer, than non-borderline psychiatric controls. Incestuous abuse has been associated with lethality of self-destructive behaviour among women with BPD (Shearer *et al.*, 1990). Recollections of their parents among people with BPD are characterised by attributions of lack of care and over-protection (compared with recollections of people without BPD), with parents, in effect, "both failing to provide basic emotional support and preventing them from separating" (Zweig-Frank and Paris, 1991; p650). Zanarini *et al.* (1997, 2000a, 2000b) showed that patients with borderline personality disorder were significantly more likely than other personality disorder controls to have experienced "biparental failure", i.e. neglectful or abusive parenting in which neither parent could be relied upon to provide care or protection, thereby potentially leaving the child vulnerable to abuse from multiple sources. Bifulco and Moran (1998), similarly, found that parental antipathy related to adult psychopathology only when experienced from both parents. Recent theoretical advances suggest a mechanism by which these experiences might lead to the behaviours and feelings characteristic of BPD. As Dubo, Zanarini, Lewis and Williams (1997) suggest, "childhood abuse and neglect may directly interfere

with the development of the capacity to modulate affects. As a result, self-destructive behaviour may emerge as a maladaptive means of regulating intolerable affects" (p. 67). The model suggested by Bateman and Fonagy (2005) proposes that non-contingent, abusive and neglectful parenting, combined with early traumas, may prevent the child developing a full capacity to mentalise under stress, and internalising a hostile, alien view of the self that is a product of the parent's unmodulated, projected anxieties, rather than a positive, healthy, independent reflection of the child's own behaviour and feelings. The resultant internal source of persecution, combined with a hypervigilant attachment system, gives rise to the oscillating, dysregulated emotions evident in BPD.

However, a minority of individuals with BPD do not report experiences of childhood abuse or neglect. Battle *et al.* (2004) found that 19% of those meeting criteria for BPD reported no abuse, and 10% reported no neglect. This might suggest several interpretations: first, that previous research methods have not tapped into some pathogenic experiences relevant to BPD; second, that a spectrum of biological vulnerability means that some people are particularly at risk even without traumatic life experiences; and third that there may be other factors beyond those already explored that account for BPD. Linehan (1993), for instance, suggests that a consistently invalidating family or social environment may produce the same effects in biologically

vulnerable individuals, subtly undermining the developing sense of self, and the ability to manage intense emotions. Gauthier, Stollak, Messé and Aronoff (1996) suggest the need "to examine the impact of 'silent' forms of maltreatment... both the quality of interactions that occur in neglectful and physically abusive families, as well as the different psychological meanings that physical abuse and neglect have for children" (p. 555).

A study by Paris, Zweig-Frank and Guzder (1994b) is the only one, to date, to investigate specific risk factors for BPD in the childhood histories of men. Their findings indicated that men with BPD were more likely than a non-BPD control group to have experienced childhood sexual abuse, severe abuse, early separation and loss, and experiences of rigid and controlling paternal relationships. Notably, Paris *et al.* (1994b) interviewed a Canadian sample of current and former out-patients with BPD. The generalisability of their findings to UK populations may be limited by different treatment protocols and cultural attitudes to BPD; certainly, the present study is the first to address the abuse histories of men in the United Kingdom. Paris *et al.* (1994b) used the Parental Bonding Instrument (a 25-item self-report measure of recollections of affection and control from each parent) and a developmental interview to measure indices of abuse. The self-report nature of the Parental Bonding Instrument lays it open to a variety of response biases, and it arguably lacks the breadth, descriptiveness and 'objectiveness'

enabled by a clinician-rated interview about the same experiences. It also lacks any consideration of various indices of the child's environment including parental antipathy, discord and tension between parents, and violence between family members (including or excluding the participant), and relies on abstract retrospective judgements by the participant rather than specific memories of events. Interviews such as the M-CECA (used in this study) are specifically designed to address the problems of retrospective memory biases that compromise other methods in this area.

Indeed, the role of memory biases in the retrospective recall of abuse and neglect has rarely been examined or controlled for in studies of childhood experiences in BPD, though it is often acknowledged (Zanarini *et al.*, 2002). The growing literature on autobiographical memory biases indicates that people with depression have difficulty retrieving specific memories (Williams & Scott, 1988), as do those who have attempted suicide (Evans, Williams, O'Loughlin and Howells, 1992), those who have survived childhood sexual abuse (Kuyken & Brewin, 1995), and people with BPD (Jones *et al.*, 1999). It is also intuitively likely that a sense of shame associated with sexual abuse or other traumatic childhood events may inhibit disclosure to an interviewer. In response to these concerns, this study has sought to measure the specificity of autobiographical memory, depressive symptomatology and self-reported experiences of shame in men with and

without BPD, to check for any systematic biases that might influence their retrospective recall.

A number of studies, therefore, have found significant associations between specific forms of maltreatment and types of psychopathology. At the same time, theories exploring the mechanisms by which such experiences may affect people on many levels – the neurobiological, the intrapsychic, the cognitive, the social – are developing, opening up possibilities for early detection and intervention with children at risk of developing psychological problems in adult life. However, the existing literature, with its focus on women, tells us little of the paths men tread as they develop borderline personality disorder. Furthermore, it may be that the indices of abuse and neglect used in previous studies have not been sufficiently sensitive, specific or subtle to discern the pathogenic qualities of the environments, relationships and life events people may have experienced.

This study sought to explore the childhood experiences of men with BPD, to test the relationships between specific aspects of maltreatment and borderline symptoms, and to trace any similarities and differences with previous research in the area, as well as tracking the role of potential memory biases on retrospective recall. The exploratory nature of the study reflects its position in an early phase of a process of gradually illuminating

the male experience of BPD and its possible precursors, within a broader programme of developing a framework for understanding the aetiology of BPD with a consideration of gender as a potentially important factor.

**Method**

Participants were initially identified by keyworkers and other clinicians. They were recruited for the study if they were male patients between the ages of 18 and 65 with a diagnosis of either borderline personality disorder or depression. Recruitment initially took place through presentations to Community Mental Health Teams and meetings with local clinicians. When this method failed to provide sufficient referrals for the study, the investigator cultivated relationships with the ward managers of local in-patient units, and spent time on the wards discussing the study with potential participants. Referrals were also obtained through contact with a specialist personality disorder team, and with clinicians running a weekly psychotherapy group for men with personality difficulties. In-patient units and specialist out-patient services proved the most efficient and productive sources of participants, with 40% (n = 12) of participants found in in-patient treatment and 23% (n = 7) through specialist out-patient services. The recruitment process aimed to attain as many participants as possible within the time frame; the final sample size of 30 was thought to provide sufficient

power for a preliminary study in this field[4]. Participants were screened for BPD using the Zanarini Rating Scale for Borderline Personality Disorder (Zanarini, 2003). This procedure obtained 19 subjects who met the diagnostic criteria for BPD and 11 who were assigned to a non-borderline psychiatric control group. Patients with brain injuries, psychotic disorders, known learning disabilities and extensive forensic histories were excluded from the study. Full information was provided, and written informed consent obtained from each participant. Participants were advised that they would remain anonymous, and could receive a summary of the results on request. Contact details of the researchers and the participant's keyworker were provided, and each participant offered after-care in the form of telephone support on request.

## Measures

### *Borderline Personality Disorder*

Participants' borderline symptomatology, and their assignment to the BPD or non-BPD groups, was assessed using the Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD), a well-validated semi-structured interview

[4] Using the power calculations of Aleong and Bartlett (1979), assuming a base rate of 25% people with or without BPD being sexually abused (using the Paris *et al.* (1994b) study for a baseline figure) a sample size of 30 would allow for 80% power to detect a 35% difference in childhood experiences.

covering the DSM-IV criteria for BPD (Zanarini, 2003). The measure is clinician-administered and rated. In this study, transcripts of responses to the interview questions were rated consensually by two raters. The ZAN-BPD has been found to have very good convergent and discriminant validity, and high internal consistency (Cronbach's $\alpha$=0.85), inter-rater and test-retest reliability (Zanarini, 2003). The ZAN-BPD gives a total score of overall severity of borderline symptomatology (ranging from 0-36, with 18 as the cut-off), as well as four sub-scale scores: affective disturbance, cognitive disturbance, relationship disturbance and impulsivity. These are composed of scores for individual criteria (which match those of DSM-IV).

*Childhood Experiences*

A retrospective, semi-structured developmental interview, the Menninger Childhood Experiences of Care and Abuse (M-CECA; Bifulco, Brown & Harris, 1994), was administered to all participants. It was used to measure adversity in childhood and adolescence, occurring at the hands of parents and alternative caregivers. Scales include: (1) antipathy, including rejection, differential treatment of siblings, hostility and dislike; (2) psychological neglect, including mis-attunement and indifference to emotional, social and educational needs; (3) physical neglect, including lack of attention to the child's hygiene, nutrition and medical welfare, and lack of appropriate supervision; (4) physical abuse of the child by any perpetrator; (5) sexual

abuse of the child by any perpetrator; (6) psychological abuse, including mental cruelty and sadism, humiliation, extreme rejection and terrorizing; (7) discord and tension in the home, including arguments and physical violence between parents and other family members, (8) exposure to violence, non-personal and inter-personal; and (8) role reversal: taking a major role in caring, emotionally or physically, for parents and other siblings. The M-CECA is a clinician-rated instrument and ratings were made consensually with a trained rater, according to a detailed, manualized scoring system (see Fonagy, Stein, Allen and Vrouva, in press, and Smith, Lam, Bifulco and Checkley, 2002, for further discussions of the validity of the measure, and the reliability of consensus ratings). The severity of each participant's experience of adversity in each of the domains listed above was rated on four-point scales (1 – Marked; 2 – Moderate; 3 – Some; 4 – Little/None), with more specific information (such as frequency, age at time of abuse and number of perpetrators) scored separately.

*Depression*

Severity of self-reported depressive symptomatology was assessed with the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock and Erbaugh, 1961), a 21-item questionnaire measuring cognitive and somatic aspects of depression. Although the BDI was not designed to be a diagnostic instrument, scores above 20 have been taken to indicate moderate

depression, and above 30, to indicate severe depression (Kendall, Hollon, Beck, Hammen and Ingram, 1987). It was hypothesised that severity of depression might be relevant to some of the same factors as would borderline symptomatology, so it was necessary to measure depression in order to check any differences between the BPD and non-BPD groups.

*Autobiographical Memory*

Previous research (e.g. Williams & Scott, 1988; Kuyken & Brewin, 1995) has indicated that depressed and parasuicidal participants tend to retrieve over-generalised memories. Autobiographical memory accuracy was assessed using the Autobiographical Memory Test (AMT; Williams and Broadbent, 1986), in order to provide a check on memory biases between the two groups that might affect the quality of their recall of childhood experiences. The process of the AMT involves the experimenter prompting participants' spontaneous memories using emotional cue words (such as "happy", "angry", "insecure" and "excited"). The task was explained according to standard instructions; practice items were administered until the experimenter was satisfied that the participant understood that he had to provide a specific memory. Alternating positive and negative words were then read to each participant by the researcher. Responses were recorded and timed. Each participant was given 60 seconds to produce a specific memory, and if initially responding with an over-general response, they were asked

for something more specific. The specificity of each memory was determined by consensus ratings of transcripts according to the procedures defined by Williams and Broadbent (1986).

*Shame*

Inhibition of responses or personal information in response to feelings of shame was also considered to be a factor that could potentially confound results, particularly if found to differing extents in the BPD and non-BPD groups. The Experience of Shame Scale (ESS; Andrews, Qian and Valentine, 2002) was used to gain measures of characterological, bodily and behavioural shame, as well as a total score for current experiences of shame, for each participant. The ESS is a 25-item questionnaire pertaining to experiences over the past year. Each item is rated from Very Much to Not At All, on a four-point scale. Scores can range from 25 to 100, with the mean total scare being 55.56 (std. dev. = 13.95; range = 29-95). The scale has been shown to be internally consistent for the three subscales (Cronbach's $\alpha$=0.90, 0.87 and 0.86, respectively) and to show good test-retest reliability ($r$ (90-93) = 0.78, 0.74 and 0.82, respectively, over two time points 11 weeks apart), according to Andrews *et al.*, 2002. Participants were asked to fill in this questionnaire privately, without assistance from the researcher, in order to minimise any inhibitions that might arise in answering questions about shame-inducing experiences.

*Procedure*

After initial consent had been given, either by phone or in person, the interviewer met the participant in a local mental health facility. The interviewer gave the participant a second copy of the information sheet, checked his understanding of its terms and elicited further questions. The participant then filled in a consent form. The interview began with the Autobiographical Memory Test, followed by the Zanarini Rating Scale for BPD. The participant was offered a break and refreshments at this point (or before if it seemed appropriate) and at several further junctures in the interview. Participants then filled in the Beck Depression Inventory and the Experience of Shame Scale. At this point, the interviewer and the participant co-constructed a genogram of the family in which the participant had grown up, and completed a brief chronology of major family events and household arrangements. The participant was then interviewed using the Menninger Childhood Experiences of Care and Abuse interview. Following this, the participant and interviewer discussed the interview process. Participants were offered a relaxation task if desired. They were then given contact numbers for the interviewer, a senior clinician, and their keyworker (should they wish to discuss the study or any relevant concerns), as well as the £10 incentive payment.

*Analysis*

Interviews were transcribed verbatim, and the transcripts coded by two raters according to the published criteria for the AMT, the ZAN-BPD and the M-CECA. Codes were entered into an SPSS database. Measures of overall severity for the indices of child abuse were constructed according to the system described by Zanarini (2002), in which points are scored according to age at the time of abuse, its frequency, duration, relationship to perpetrator, number of perpetrators, and the nature of the abuse. The measure of severity of neglect was constructed by adding the total scores on the M-CECA for maternal and paternal psychological and physical neglect. A limited set of comparisons were made between the demographic, psychometric and maltreatment scores for the BPD and non-BPD groups, using Chi-Square, Mann-Whitney and T-test analyses as appropriate. The severity of neglect, physical, sexual and psychological abuse were correlated with severity of BPD symptoms, as a total score, and with each sub-scale of the ZAN-BPD, using Spearman's rho. A composite score of total severity of abuse and neglect, using the Zanarini schedule, was also correlated with severity of BPD. Finally, the findings of previous studies were compared with the present results, using descriptive statistics and further correlations.

## Results

Table 1 shows the demographic information for participants in the two groups, those with BPD and those without. All participants were male. The mean age for participants across the whole sample was 41.0 years. 96.7% of participants were of White UK origins, with 3.3% defining themselves as Black UK. With respect to marital status, exactly a third of participants were married or cohabiting, a third were divorced or separated, and the final third were single. Mann-Whitney and Chi-Square tests indicated that differences between groups on these indices were not significant.

TABLE 1
*Demographic Information*

| | BPD (*N*=19) | Non-BPD (*N*=11) |
|---|---|---|
| Age (years) (M/SD)[a] | 38.47 (9.81) | 45.36 (10.76) |
| Ethnicity n (%) | | |
| White | 19 (100.00) | 10 (90.91) |
| Black UK | 0 (0.00) | 1 (9.09) |
| Marital status n (%)[b] | | |
| Married/cohabiting | 7 (36.80) | 3 (27.30) |
| Separated/divorced | 7 (36.80) | 3 (27.30) |
| Single | 5 (26.30) | 5 (45.50) |

[a] U = 67.00, $N_2$ = 30, $p$ = 0.112 (median = 40.00, range = 36.00)
[b] Two cells had an expected count less than 5, so an exact significance test was selected for Pearson's chi-square. There was no significant relationship between meeting criteria for BPD and marital status ($X^2$ = 1.148, df = 2, exact $p$ = 0.709).

As seen in Table 2, the BPD and non-BPD groups rated similar scores on the Beck Depression Inventory, the Experience of Shame Scale, and the

Autobiographical Memory Test. Differences between groups on these factors were not significant.

TABLE 2
*Comparison of BPD and non-BPD groups on the Beck Depression Inventory, Experience of Shame Scale and Autobiographical Memory Test*

| | BPD (*N*=19) | Non-BPD (*N*=11) |
|---|---|---|
| Beck Depression Inventory score M (SD)[a] | 30.74 (13.49) | 25.00 (12.76) |
| BDI mini-suicide score M (SD)[b] | 4.84 (2.48) | 3.91 (2.91) |
| Experience of Shame Scale score M (SD) | | |
| Character[c] | 30.68 (8.22) | 31.91 (11.62) |
| Behaviour[d] | 22.47 (7.36) | 23.36 (7.84) |
| Bodily[e] | 10.94 (3.70) | 9.91 (4.37) |
| Total[f] | 64.11 (14.32) | 64.81 (19.93) |
| Autobiographical Memory Test score M (SD)[g] | 5.37 (1.92) | 5.45 (2.54) |

[a] U = 75.50, $N_2$ = 30, $p$ = 0.216 (median = 26.00, range = 45.00)
[b] U = 80.50, $N_2$ = 30, $p$ = 0.307 (median = 4.50, range = 9.00)
[c] U = 92.00, $N_2$ = 30, $p$ = 0.611 (median = 32.50, range = 35.00)
[d] U = 94.00, $N_2$ = 30, $p$ = 0.651 (median = 23.00, range = 24.00)
[e] U = 89.00, $N_2$ = 30, $p$ = 0.503 (median = 10.50, range = 12.00)
[f] t (df = 28) = -0.114, $p$ = 0.262
[g] t (df = 28) = -0.105, $p$ = 0.917

*Childhood experiences of men with BPD*

Men who met criteria for BPD tended to describe childhoods characterised by emotional deprivation, cruelty and abuse. 47.4% described being sexually abused. 66.7% of this was intrafamilial abuse. This finding is comparable with reports of abuse among men with BPD in other studies, notably Paris *et al.* (1994b), who reported a rate of 47.5%. However, sexual abuse was also highly prevalent in the non-BPD group, at a rate of 44.5%, though none of this was abuse by a caregiver. Physical and psychological abuse were also

highly prevalent among men with BPD, as were parental separation and mental illness. These results are summarised in Table 3. It is also noteworthy that 73.7% of men with BPD reported being bullied in childhood, compared with 45.5% of men in the non-BPD group. Limited comparisons were tested for significance in order to minimise the risk of Type I error.

TABLE 3
*Comparison of incidence of childhood adversity between BPD and non-BPD groups*

| | BPD (*N*=19) | Non-BPD (*N*=11) |
|---|---|---|
| Sexual Abuse n(%) | 9 (47.4) | 5 (45.5) |
| Physical Abuse n(%)** | 16 (84.2) | 4 (36.4) |
| Psychological Abuse n(%) | 16 (84.2) | 6 (54.5) |
| Parental separation n(%) | 10 (52.6) | 3 (27.3) |
| Known parental mental illness n(%) | 6 (31.6) | 4 (36.4) |
| Maternal Antipathy n(%) | 8 (42.1) | 2 (18.2) |
| Paternal Antipathy n(%)*** | 12 (63.2) | 1 (9.1) |
| Maternal Psychological Neglect n(%) | 11 (57.9) | 3 (27.3) |
| Paternal Psychological Neglect n(%) | 14 (73.7) | 4 (36.4) |
| Role Reversal n(%) | 3 (15.8) | 2 (18.2) |
| Discord/Tension n(%)*** | 11 (57.9) | 1 (9.1) |
| Interpersonal Violence n(%)*** | 13 (68.4) | 1 (9.1) |

* $p < .05$, ** $p < .02$, *** $p < .01$

Severity, as well as incidence, of different forms of childhood maltreatment were also compared between the groups. Mann-Whitney tests were used to show that those with BPD were significantly more likely to have suffered severe physical abuse ($U = 48.000$, $N_2 = 30$, $p = 0.014$, two-tailed; median = 14.5; range = 19) and severe psychological abuse ($U = 43.500$, $N_2 = 30$, $p = 0.007$, two-tailed; median = 21, range = 29). Men with BPD were no more

likely to have suffered severe sexual abuse than men without (U = 92.500, $N_2$ = 30, $p$ = 0.611, two-tailed; median = 0.00, range = 19).

TABLE 4
*Mean scores on severity of forms of abuse and neglect*

| | BPD (*N*=19) | Non-BPD (*N*=11) |
|---|---|---|
| Sexual Abuse | 6.37 | 4.72 |
| Physical Abuse | 13.26 | 5.54 |
| Psychological Abuse | 13.89 | 7.81 |
| Neglect | 4.62 | 3.09 |

*Severity of borderline symptomatology in relation to abuse and neglect*

Correlations between the severity of BPD symptomatology (both the total score and scores for each sub-scale of the ZAN-BPD) and the severity of each form of abuse and neglect indicated a series of significant positive relationships. Mean scores for each group on the indices of severity for each form of abuse and neglect are summarised in Table 4. Table 5 displays the correlations between BPD symptomatology and each form of maltreatment. Physical and psychological abuse were both associated with affective disturbance, cognitive disturbance, and overall severity of BPD. The composite score for the severity of neglect, derived from M-CECA scores for psychological and physical neglect, was also associated significantly with affective disturbance, cognitive disturbance, and overall BPD severity.

*The role of paternal maltreatment*

Men with BPD were significantly more likely to have been physically abused by their fathers, or by a father figure (defined as a partner of the participant's mother who took some care-taking role or lived in the family home) than men without BPD ($X^2 = 5.662$, df = 1, exact $p = 0.021$, 1-sided). They were also more likely to have suffered psychological abuse from fathers or father figures ($X^2 = 6.914$, df = 1, exact $p = 0.010$, 1-sided). As noted above, the severity of reported paternal antipathy was significantly greater among men with BPD ($U = 40.000$, $N_2 = 30$, $p = 0.005$, 2-tailed; median = 3.00, range = 3.00). Sexual abuse by a father or father figure was reported by 21.1% of men who met criteria for BPD, and by none of those who did not, but this relationship was not shown to be statistically significant ($X^2 = 3.111$, df = 1, exact $p =$ 0.221).

TABLE 5

*Correlations between severity of each form of abuse/neglect and ZAN-BPD severity scores*

| | Sexual abuse severity | Physical abuse severity | Psychological abuse severity | Neglect severity |
|---|---|---|---|---|
| ZAN-BPD Affective Disturbance | 0.070 | 0.366* | 0.605** | 0.445* |
| ZAN-BPD Cognitive Disturbance | 0.309 | 0.487** | 0.530** | 0.488** |
| ZAN-BPD Impulsivity/Suicidality | 0.208 | 0.237 | 0.285 | 0.078 |
| ZAN-BPD Disturbed Relationships | -0.033 | 0.075 | 0.065 | 0.092 |
| ZAN-BPD Total Score | 0.239 | 0.390* | 0.527** | 0.389* |

*Spearman's rho: *=0.05, **=0.01*

*Comparisons with previous studies*

Two main studies have investigated similar parameters of childhood experience in relation to BPD: Paris *et al.* (1994b), who used an all-male study population, and Zanarini *et al.* (2002), of whose sample 19.7% were men. Systematic comparisons of findings between these studies and our own are listed in Table 6.

The current findings broadly replicated those of Zanarini *et al.*, in particular showing that all forms of abuse and neglect were correlated, implying the characteristic matrix of multiple forms of co-occurring maltreatment among families of people with BPD. The two studies concurred, also, on many of the significant correlations between measures of symptomatic impairment and of severity of forms of childhood maltreatment.

Although some of Paris *et al.*'s findings could not be directly compared with the current study owing to the limited size of this sample, similar trends regarding paternal abuse were evident between the studies. Paris *et al.* found that sexual abuse by fathers was significantly more common among men with BPD than men without (8.2% of men with BPD compared with none without). In the present study, 21.1% of men with BPD were abused by fathers or male caretakers, compared with no one in the non-BPD group suffering sexual abuse at the hands of a father figure. Physical abuse by fathers of men with

BPD was found at similar rates by this and Paris *et al.*'s study, in both cases markedly more common than paternal physical abuse among men without BPD.

Paris *et al.* found a high rate of sexual abuse in the BPD group (nearly identical to that found in the current study), and a significantly lower rate in the non-BPD control group. This study, surprisingly, found a slightly higher rate of sexual abuse in the non-BPD group. This may be a reflection of sampling error due to a small sample size; alternatively it may reflect the severity of psychosocial problems evident in much of the sample, who were predominantly interviewed during in-patient treatment. It may also signal that while sexual abuse may be aetiologically significant in BPD, it is also not specific to this disorder.

TABLE 6

*Comparison of the results of this study with two similar previous studies*

| Study | Original study | Present study |
|---|---|---|
| **Zanarini *et al.*, 2002** (mixed sample) | 62.4% of BPD group reported CSA<br>86.2% of BPD group reported other abuse<br><br>92.1% of BPD group reported neglect | 47.4% of BPD group reported CSA<br>84.2% of BPD group reported psychological abuse<br>84.2% of BPD group reported physical abuse<br>89.5% of BPD group reported neglect |
| | Severity of CSA sig. correlated with severity of other forms of abuse (Spearman's rho = 0.390, $p < 0.001$) | Severity of CSA significantly correlated with severity of both physical (Spearman's rho = 0.430, $p = 0.017$) and psychological abuse (Spearman's rho = 0.460, $p = 0.011$). |
| | Severity of CSA sig. correlated with severity of neglect (Spearman's rho = 0.500, $p < 0.001$) | Severity of CSA significantly correlated with severity of neglect (Spearman's rho = 0.505, $p = 0.004$) |
| | Severity of other forms of abuse and neglect significantly correlated with one another (Spearman's rho = 0.710, $p < 0.001$) | Physical abuse significantly correlated with psychological abuse (Spearman's rho = 0.658, $p < 0.001$)<br>Physical abuse significantly correlated with neglect (Spearman's rho = 0.399, $p = 0.029$)<br>Psychological abuse correlated with neglect (Spearman's rho = 0.410, $p = 0.025$). |
| | Severity of each form of abuse and neglect correlated at $p < 0.005$ level with each measure of symptomatic impairment except impulsivity. | Severity of each form of abuse and neglect correlated at $p < 0.05$ or 0.01 level with each measure of symptomatic impairment, except impulsivity/suicidality and disturbed relationships. |

| | | |
|---|---|---|
| **Paris *et al.*, 1994** (men only) | 47.5% experienced CSA in BPD group, 25% in non-BPD group. | 47.4% experienced CSA in BPD group, 54.5% in non-BPD group. |
| | CSA sig. more common in BPD group ($X^2 = 6.6$, df = 1, $p < 0.01$) | No significant difference found between BPD and non-BPD groups in CSA ($X^2 = 0.010$, df = 1, $p = 0.919$) |
| | 18% of BPD reported extra-familial CSA | 15.9% of BPD reported extra-familial CSA |
| | 8.2% of BPD group abused by fathers; 0% non-BPD ($X^2 = 5.1$, df = 1, $p < 0.03$) | 21.1% of BPD group reported CSA from father figures; 0% of non-BPD group ($X^2 = 3.111$, df = 1, exact $p = 0.221$) |
| | 23% of BPD group abused by a stranger; 8.3% non-BPD ($X^2 = 4.9$, df = 1, $p < 0.03$) | 5.2% of BPD group abused by a stranger (n = 1); 0% of non-BPD group. |
| | No difference in severity of CSA between groups, except penetration among 18% BPD and 1.7% of non-BPD ($X^2 = 9.1$, df = 1, $p < 0.003$) | No difference in severity of CSA between BPD and non-BPD groups (U = 92.500, $N_2 = 30$, $p = 0.611$, 1-tailed; median = 0.00, range = 19.00). |
| | Rate of physical abuse different at trend level (65.6% vs. 50%) ($X^2 = 3.0$, df = 1, $p < 0.10$) between BPD and non-BPD groups. | BPD group suffered significantly more physical abuse in childhood than non-BPD group (84.2% vs. 57.1%) ($X^2 = 7.177$, df = 1, exact $p = 0.012$, 1-sided) |
| | Father as perpetrator of physical abuse among 47.5% of BPD, 26.7% of non-BPD group ($X^2 = 5.6$, df = 1, $p < 0.02$). | Father as perpetrator of physical abuse among 47.4% of BPD group, and among 9.1% non-BPD group (n=1). Father figure significantly more likely to have physically abused men in BPD group than in non-BPD group ($X^2 = 5.662$, df = 1, exact $p = 0.26$, 2-sided). |
| | Severity and frequency of physical abuse was the same for the BPD and non-BPD groups. | Significant difference between BPD and non-BPD groups on severity of physical abuse (U = 48.000, $N_2 = 30$, $p = 0.014$, 2-tailed; median = 14.5, range = 19). |

**Discussion**

This study suggests several findings that reflect and extend the conclusions of previous work in the area. First, it confirms the frequently found phenomenon of multiple, co-occurring forms of abuse, deprivation and adversity within the same families, particularly for men with BPD. Within this sample, neglect, sexual, physical and psychological abuse were all significantly correlated. Zanarini *et al.*'s (2000b) finding that biparental failure is associated with a heightened risk of extra-familial sexual abuse for pre-borderline girls highlights the process by which an inadequately caring home situation may expose children to further maltreatment elsewhere. In illustration of this, several men in the sample described situations in which their parents' physical absence from the home in the after-school, early evening period each day, enabled neighbours or family friends to abuse them; then perceived emotional unavailability of parents or the expectation of punishment or disbelief prevented them from disclosing these experiences. The high proportions of parental mental illness, parental separation (whereby the absence of a parent extinguished a possible source of support or protection, and their replacement frequently provided a new source of abuse), and co-occurring bullying at school (experienced by 73.7% of the BPD group), further add to a picture of an ecology of risk with few evident protective factors. While men in the non-BPD group largely experienced a similar matrix of adversity, in almost every factor studied,

men with BPD experienced more severe and more varied forms of maltreatment.

Second, these findings illustrated some noteworthy correlations between specific childhood experiences and borderline personality disorder symptoms. Cognitive disturbance, a sub-scale of the ZAN-BPD composed of items regarding identity disturbance and transient symptoms of dissociation and paranoia, was significantly correlated with neglect, psychological and physical abuse. A clear and coherent sense of identity, and the ability to tolerate distress and interpret others' intentions accurately, depends on the experience of contingent, meaningful and positive treatment by parents or other major caregivers, given certain biological conditions. In these cases, mental cruelty and physical violence, usually at the hands of caregivers, is associated with a failure to develop such qualities. Psychological abuse, as specified in the M-CECA, may include persistent humiliation, terrorizing, emotional blackmail, cognitive disorientation, the infliction of distress or pain, exploitation and extreme rejection. According to the models advanced by the major psychological theories in the area (for example, the cognitive models specified by Beck and Freeman, 1990; Young, 1989; Linehan, 1993, and Ryle, 1997; and evident in Bateman and Fonagy's model of mentalization in BPD, 2004), these experiences are likely to undermine or distort a child's developing sense of self, and to promote a fearful and avoidant style of

emotional regulation as seen in the capacity to dissociate. Neglect, as Gauthier, Stollak, Messé and Aronoff (1996) have pointed out, prevents even the most basic learning about the self and about others, implying a direct relationship between the absence of opportunities to develop a sense of self, and the symptoms of identity disturbance evident among the men in this study. The trauma literature has repeatedly demonstrated links between severely frightening or life-threatening experiences, particularly at an early age, and the tendency to dissociate (e.g. Chu & Dill, 1990; Anderson, Yasenik & Ross, 1993). While initially a way of coping in the original abusive situation, this later becomes generalised as an automatic response to emotionally stressful situations. This association is apparent here in the correlation noted between physical abuse and cognitive disturbance evident in transient dissociative episodes. However, it is likely that cognitive functioning may also be disturbed by numerous factors more specific than and not necessarily related to physical abuse, psychological abuse or neglect. For example, it may be that children with poor cognitive skills in some way elicit abusive or neglectful treatment in certain adverse environments. Certain neurobiological abnormalities (pre-dating trauma or not) may increase the risk of dissociative episodes or other aspects of cognitive disturbance. Intergenerational transmission of styles of coping, whether through temperamental, genetic or behavioural means, may also play a role in shaping the ways in which children learn to think under stress. Quite

apart from early childhood experiences, dissociative thinking and identity disturbance may also reflect the effects of contemporaneous influences in the person's life such as substance abuse. Paranoid ideation, similarly, may be a realistic and adaptive cognitive strategy in the context of the hostile environments participants in this study described in their current lives. Many had spent periods homeless, in prison, and in chaotic psychiatric wards in which they frequently experienced threatening behaviour from others. In consideration of the small sample size and the tentative nature of any statistical findings, and multiple possible influences on psychological experiences, no clear conclusions can be drawn from the correlations described. It is, however, important to note that they replicate major findings from previous studies: in particular, those of Zanarini *et al.* (2002).

Zanarini's results are further replicated in our finding that affective disturbance was, like cognitive disturbance, correlated with neglect, psychological and physical abuse in this sample. The criterion is made up of three aspects of BPD symptomatology: rapid shifts in mood, chronic feelings of emptiness, and inappropriate and intense anger. Again, such experiences are likely to be over-determined by a range of influences ranging from temperamental vulnerability to parental modelling of poor emotion regulation strategies, neurobiological dysregulation or reactivity, and current factors such as substance abuse and experiences in hostile and traumatising

environments. However, certain features of each of the forms of maltreatment associated with affective disturbance in this study may also be hypothesised, according to current theories, to make a potential contribution. For example, research has indicated that BPD in adulthood is associated with disorganized attachment status in childhood – in other words, the experience of a non-contingent relationship with a caregiver who is likely to be traumatised themselves or frightening to the child (Barone, 2003; Fonagy, Target & Gergely, 2000; Liotti & Pasquini, 2000). A fundamental cornerstone of secure attachment is the transmission of emotion regulation skills through responsive caregiving, whereby the parent is able to represent the child's affect accurately and sensitively and to scaffold the child's developing ability to recognise and soothe his or her emotions. A disorganised attachment relationship, by definition, does not enable the child to develop these skills. The anger and mood shifts experienced by people with BPD as uncontrollable and extremely intense may represent the adult manifestation of a failure to learn to modulate emotions. Thus, the abusive and neglectful behaviour implicated in the parenting of children whose attachment is disorganised, and described by men with BPD, may bear some relation to the affective disturbance they reported.

This study found non-significant relationships between the impulsivity/ suicidality and unstable relationships sub-scales of the ZAN-BPD, and any of

the forms of maltreatment measured by the M-CECA. However, Zanarini *et al.* (2002) similarly found no relationship between impulsivity and childhood abuse or neglect. The small sample size here means that all findings, significant or not, are to be treated with caution. However, this replication bears some examination. Impulsivity, according to a number of theorists of BPD, may reflect a temperamental vulnerability rather than a specific effect of childhood maltreatment, which nevertheless contributes to the clinical presentation of the disorder (Zanarini *et al.*, 1999). As such, one might not expect it to be aetiologically related to environmental factors. However, it is also possible that impulsive behaviours, such as substance abuse, law-breaking, promiscuity, destroying property and outbursts of physical violence, may represent attempts at emotion regulation, which itself may be determined by neurobiological, attachment-related and environmental factors.

The overall severity of BPD symptomatology was significantly correlated with the severity of each index of abuse and neglect except for that of sexual abuse. This finding implies that the more severe the neglect, the psychological abuse and the physical abuse experienced by a person, the more globally severe their BPD symptomatology is likely to be. Similar conclusions were reached by numerous previous studies including Briere and Runtz (1990) and Zanarini *et al.* (2002). The current results, while

tentative, question the assumption that sexual abuse is a necessary or sufficient contributing factor to BPD: the non-BPD group actually had a marginally higher rate of sexual abuse than the BPD group, and there was no significant difference in the severity of the sexual abuse reported by the two groups. It may be that specific indices of sexual abuse, for instance, the duration or the perpetrator, may have greater relevance in terms of BPD (although the overall severity score used in this study, following Zanarini *et al.*'s (2002) schedule, attempted to incorporate these factors). Other studies, for example, Silk, Lee, Hill and Lohr (1995), have found significant relationships between the severity of reported sexual abuse and overall borderline symptomatology. Zanarini *et al.* (2002) similarly found correlations between the severity of CSA and cognitive, interpersonal and self-destructive symptoms of BPD. Severity of sexual abuse, in this study, was correlated with the severity of one measure of BPD symptomatology alone, cognitive disturbance (Spearman's rho = 0.464, $p = 0.045$), and then only within the BPD group rather than the wider sample. This finding may reflect the consensus in much previous research (such as Chu, Frey, Ganzel and Matthews, 1999) that sexual and other forms of abuse are associated with elevated levels of dissociative symptoms.

The fact that the incidence of sexual abuse was not related to BPD diagnosis in the present sample may reflect a sampling bias in that those men in the

non-BPD group were also experiencing a range of particularly severe mental health problems, over which the parameters of this study did not allow statistical control. These mental health problems may themselves be independently related to a history of sexual abuse. Studies of the long-term psychological sequelae of sexual abuse in men (i.e. Spataro, Mullen, Burgess, Wells & Moss, 2004) have indicated a range of adverse psychiatric outcomes in addition to a raised risk of personality disorder. The incidence of sexual abuse in the current sample of men with BPD almost exactly replicated the findings of Paris *et al.* (1994b), at 47.4% (compared with 47.5%), demonstrating that, among men, it may be equally possible to develop BPD whether one has been sexually abused or not. While the difference between rates of sexual abuse in the BPD and non-BPD groups in this study was minimal, it is worth noting that the difference from the rates reported in the general population was sizeable (estimated at between 2.5% and 36.9% by Dhaliwal *et al.*(1996).

Maltreatment by paternal figures emerged as an important factor distinguishing men with BPD from the psychiatric control group. Men with BPD were significantly more likely to have been psychologically and physically abused by fathers or father figures (defined as a partner of the participant's mother who took some care-taking role or lived in the family home) than men without, and while 21.1% of the BPD group were sexually

abused by paternal figures, none of the non-BPD group were. Men with BPD also remembered more severe levels of paternal antipathy than men without. This leads to the speculation that maltreatment by fathers may leave men particularly vulnerable to developing borderline personality disorder, a suggestion also made by Paris *et al.* (1994b). Certainly this pattern has not been specifically traced among women with BPD. These results tell us little about why, or how, men are affected in this way by paternal maltreatment. It may be, for instance, that fathers are capable of exerting particularly severe levels of violence, or that witnessing and experiencing cruelty at the hands of a primary role model and example of adult masculinity is fundamentally undermining to the development of a sense of identity among men, within the context of an otherwise invalidating and adverse environment. It may be that findings of gender-incongruent personality traits among men with BPD (Johnson *et al.*, 2003; Klonsky *et al.*, 2002) might relate to core difficulties constructing a masculine identity in the aftermath of paternal abuse. An exploratory qualitative study of perceptions of paternal relationships among men with BPD might reveal more about the salience and meaning of these experiences.

The present findings raise some potential implications for clinical practice. First, depending on the therapeutic model in question, it might be useful for clinicians to be aware and curious about male clients' experiences of being

fathered. This might afford an opportunity to process possible trauma and to examine the impact of these experiences on the development of self and identity. A further implication might be to remind clinicians that sexual abuse may be an important risk factor but is not essential to a borderline personality disorder diagnosis. Perhaps because it is so common among women with BPD, sexual abuse is often strongly identified with the disorder, and this runs the risk of devaluing the impact of other traumatic experiences that men with BPD might have undergone. These results also indicated, not surprisingly, that the severity of certain forms of maltreatment in childhood is positively related to the severity of BPD symptomatology. People with BPD often present major interpersonal challenges, in terms of their dramatic clinical presentations and their core difficulties in managing relationships, and where services are under pressure, the space and time to think about what might help such patients may be limited. Research that clarifies the incidence, nature and severity of the experiences common to people with BPD may be used to train staff to recognise, tolerate and work with their feelings and behaviour in a sympathetic and constructive way.

The conclusions of this study are partly limited by the caution required in dealing with a small sample. A larger sample would permit more complex statistical procedures, including controlling for certain factors, and would enhance the reliability and validity of the results. Additionally, the study

population was composed of patients from both in- and out-patient settings, which may have implications for the severity of their difficulties and possibly for the way in which they were reported. Zanarini *et al.* (2002) point out, however, that "the line between outpatient and inpatient borderlines is fluid" (p. 386) as they commonly undergo one or more psychiatric hospitalisations, so the difference may be more apparent than real. The reliance on retrospectively recalled, self-reported memories also compromises the reliability of this study, leaving the data vulnerable to distortion by a variety of memory and other biases. However, the practical and ethical problems involved in prospective studies of the effects of childhood maltreatment effectively preclude such an endeavour. Furthermore, there are solid reasons to employ a retrospective methodology with certain safeguards. Brewin, Andrews and Gotlib (1993), in a review of the literature on the use of methods relying on retrospective recall, conclude that "adults asked to recall salient factual details of their own childhoods are generally accurate, especially concerning experiences that fulfil the criteria of having been unique, consequential and unexpected" (p. 87). The methods employed in this study, including supplementing the interview with a genogram and a family chronology, and requesting specific memories and examples, have sought to mitigate some of the problems associated with retrospective recall. This study, unlike others, has considered the role of memory biases by providing checks in the form of measures of depressive

symptomatology, shame, and autobiographical memory. It is also the case that several studies (Herman & Schatzow, 1987; Bifulco, Brown, Lillie & Jarvis, 1997) have shown high levels of reliability for memories of childhood abuse through verification with siblings' accounts.

In future, the programme of elucidating the complex risk factors underlying BPD in both genders could be enhanced by carrying out studies with sample sizes that permit more informative and reliable data analysis. Studies that specifically compare the patterns of experiences that systematically differ between men and women with BPD will allow us to understand more about patterns of vulnerability by gender. The clinical implications of such understandings might permit modifications and elaborations to therapies for BPD as appropriate. The measures used in research in this field should aim to examine the subtler aspects of family interaction as well as the more concrete indices of abuse and neglect. Regarding men in particular, further attempts to understand gender-specific risk factors, such as maltreatment by male caregivers, would be of use in constructing aetiological models of BPD and developing treatments accordingly, as well as providing specific targets for early intervention in families.

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# Critical Appraisal

Undertaking this piece of research has raised a number of issues worth consideration and reflection. Accordingly this appraisal will be divided into three parts. First, it will examine the validity of the construct of Borderline Personality Disorder in relation to men, with particular reference to the experiences and presentations of the current study population. Second, the appraisal will focus on the use of research methods that depend on retrospective memory. Concerns regarding the utility of such methods, with a traumatised, dysphoric population being asked for detailed recollections of distant events, will be identified and discussed. Third, some observations will be made regarding the research process, and recommendations made for future work in this area.

**1. Borderline Personality Disorder in men**

The comparative rarity of men with BPD, as we have seen, has raised a variety of hypotheses, most assuming that the gender balance should be equal. Widiger and Spitzer (1991) have pointed out that until the true prevalence of a disorder is known, it may not be useful to speculate about over- or under-representation of one gender with a particular disorder. Partly because epidemiological studies have not produced a consensus on the true prevalence of BPD by gender, some uncertainty remains regarding the possibility that men may be under-diagnosed (or women over-diagnosed) with the disorder. Some have argued that the diagnostic criteria

favour women for reasons such as clinician prejudice, and a tendency to pathologise traditionally female forms of behaviour. It has been suggested that men with BPD may not come to the attention of mental health services, either because they are less likely to seek treatment than women, or because other problems potentially associated with BPD such as alcohol or drug misuse, and impulsive behaviour, have steered them towards non-psychiatric settings such as prisons or drug rehabilitation.

Certainly, in the current study, major difficulties arose around recruitment. In CMHTs, clinicians were at a loss for potential participants, in some cases claiming never to have seen a man with BPD; in in-patient units, it often transpired that a participant who potentially matched the study criteria had been admitted and discharged within a space of 24 hours (preventing an interview taking place) due to the person "just wanting somewhere to stay", being "a troublemaker", "manipulative", or "not being mentally ill". Participants were routinely referred who did not fulfil the criteria, being in a severely psychotic state or as one clinician memorably described her referrals, "any old PD".

The combination of these various factors – apparently low prevalence (particularly compared with BPD in women), presence in non-psychiatric settings, under-diagnosis, non-referral to community teams and a poor

standard of knowledge regarding BPD among workers in the mental health services – are likely to have affected the quantity of men available and suitable for participation in this study. However, in the process of the research, it became increasingly clear that the problems described by participants diagnosed with BPD did not reflect the breadth and nature of the diagnostic criteria.

I will take, as examples, three of the nine DSM-IV criteria for BPD (APA, 1994), and will examine their application with particular reference to this study population. Each criterion was assessed individually according to the Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD; Zanarini, 2003).

### 1.1 *Frantic efforts to avoid real or imagined abandonment*

Participants with BPD routinely scored at floor level on the criterion representing 'frantic efforts to avoid abandonment', as seen in Table 1, below. While their mean score on this item was considerably lower than their mean scores on other items in the ZAN-BPD, men with BPD did score, on average, significantly higher than those of the non-BPD group[5]. Those who

[5] The mean score for this item among the BPD group was 1.42 (out of a possible score of 4), with a standard deviation of 1.39. The mean score for the non-BPD group was 0.27 (with a standard deviation 0.65). A t-test confirmed a significant difference between the groups (t (df=27.161) = 3.077, p=.005).

did score above zero rarely endorsed the question directly, instead giving the interviewer behavioural clues as to its accuracy in describing them.

TABLE 1
*Scores on DSM-IV Frantic efforts to avoid abandonment criterion within BPD Group*

| Score | Number of participants | Percent |
|---|---|---|
| 0 | 8 | 42.1 |
| 1 | 1 | 5.3 |
| 2 | 5 | 26.3 |
| 3 | 4 | 21.1 |
| 4 | 1 | 5.3 |

Interestingly, participants tended to deny any emotional experience of abandonment completely. Instead, they described efforts to *avoid situations* in which they might be abandoned, in a sense pre-empting the possibility of this experience:

> I could always walk away at any moment, and it wouldn't bother me, I wouldn't get emotional about it....Just literally, just cut it off and walk away.

> If they want to go, they can go. If they're not happy with what I'm saying, if they don't like it, they can get up and walk away.

> There's times where I'll just leave, if I'm not welcome – "Bye bye, Adios – I'm not going to lose any sleep over you", know what I mean.

Several other men in the BPD group described reclusive lives in which they specifically avoided close relationships in order to escape potential emotional pain. It might well be argued that these responses show a profound fear of abandonment; however, such assumptions are not evident in the scoring criteria, and cannot therefore be made in scoring the item. In consequence, the results may underestimate the salience of this aspect of BPD in men. This pattern of emotional disengagement is reminiscent of that described in the attachment literature with reference to insecure/avoidant and disorganized attachment styles. Disturbed attachment is a key feature of many models of borderline personality disorder (Fonagy, Target & Gergely, 2000, Barone, 2003), in line with the numerous findings of inconsistent, neglectful and abusive parenting (Zanarini *et al.*, 2000b). As such, it is not surprising that men with BPD should show similarly disturbed patterns of interaction in significant adult relationships. Hazan and Shaver (1987) attempted to demonstrate that styles of early attachment are reflected in the ways in which adults approach romantic love situations, and found some evidence to support their hypotheses. However, methodological criticisms aside, their study pre-dated much of the research into disorganized attachment and did not investigate this category.

This strategy of pre-emptively 'cutting off' may reflect a broader gender difference in conflict behaviour, perhaps exacerbated by the emotional

sensitivity and poor problem-solving skills characteristic in BPD. Hinde (1997) remarks that "a common pattern is for one (often the woman in a heterosexual relationship) to make emotional demands and complaints, while the other (often the man) withdraws or behaves passively" (p. 179). This may reflect a socially or biologically-driven affiliative tendency on the part of women, in contrast to a greater desire for autonomy in men. Hinde also suggests that men's greater physiological reactivity to stress may lead them to withdraw from emotionally demanding situations. A theory on the level of socio-political dynamics (Christensen & Heavey, 1990) proposes that men, as holders of power in Western societies, have a greater interest in preserving the status quo, even in terms of personal relationships, and therefore behave in ways that prevent or stifle demands for change. They interpret attempts to 'cut off' or 'exit' from conflict with partners as functioning to maintain a situation in which they hold power. As men with borderline personality disorder may experience heightened physiological reactivity, poor emotion regulation, and dysfunctional working models of close relationships in which they are likely to expect abusive or neglectful treatment, it is not, perhaps, surprising, that the cognitions and behaviours enacted under pressure may be an exaggerated form of those apparent among 'normal' men. Alternatively, such behaviours may represent a culturally-sanctioned channel for a fearful and defensive approach to interpersonal conflict, or an inability to tolerate emotional pain. In any case,

they potentially pose a problem for the assessment of this aspect of BPD in men, as the unconscious motivation for the avoidance of abandonment situations cannot easily be examined, and the expected endorsement of fears of abandonment is unlikely to be forthcoming.

### 1.2 *Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour*

The debate over the gender split of externalising and internalising styles of behaviour has been raised in relation to BPD as part of the argument that BPD and Anti-Social Personality Disorder represent two aspects of the same core set of difficulties. It is noteworthy that Hatzitaskos, Soldatos, Sakkas and Stefanis (1997) found that men with BPD tend to internalise hostile feelings, compared with men with ASPD. Others, such as Johnson *et al.* (2003), have pointed out that men with BPD show some trait femininity on personality tests. While self-harm and suicidal behaviours are usually seen as intrinsically 'internalising', it is possible that their prevalence, and, by extension, the prevalence of BPD, is under-estimated in male populations because of the methods men may use to harm themselves. In the study population, several men with BPD described methods of self-harm that might have been seen as 'externalising' or 'anti-social' behaviours, or even socially desirable 'risk-taking', rather than specifically self-destructive, as

intended. The following quotations, elicited by questions regarding attempts at self-harm, illustrate this point:

> I was intending to get run over, so I sat in the middle of a main road for ten minutes and only about one car came along.

> I was using excessively, just really mental amounts of drugs and drink. Absolutely crazy amounts.

> I have put myself needlessly in dangerous situations – better to let someone else do it. Suicide is the way of a coward. If you go down fighting, you're a hero, as opposed to going out as a coward.

When asked about the emotional experiences and intentions underlying these actions, these participants were clear that their actions were intended to block out painful emotions, to punish themselves, and to elicit help from others: all functions commonly associated with methods of self-harm common among women with BPD (such as cutting, burning and overdosing). Accordingly, the existing criteria and methods of assessment may not adequately capture the gendered presentation of self-harm that may characterise men with BPD. Such actions may easily be mistaken for anti-social, reckless and even psychotic behaviours and treated accordingly.

### 1.3 *Inappropriate or intense anger or difficulty controlling anger*

The above criterion presents many problems in terms of its equal and fair application to women and men in this society. Public expressions of anger such as road rage and street fights are more often seen among men than women[6], and may even, in some cases, come to represent socially valued traits such as dominance and power within a peer group. Similar behaviours among women may be considered unusual and potentially pathological. As a result, when men display such behaviours, the underlying emotional disorder may go unnoticed or even be reinforced (for instance, enabling membership of a violent sub-culture) or punished by environmental contingencies. Many of the study participants mentioned regular nights spent in police station cells after violent altercations.

Again, real caution must be exercised with the application of this criterion to men. The difficulty lies in finding the balance between culturally acceptable (and the culture concerned is unlikely to be that experienced daily by the clinician assessing the patient) angry actions, and pathological, uncontrollable, irrational anger. The item runs the risk of excessive sensitivity, including many 'normal' men, and simultaneously of excessive

[6] For example, Home Office statistics (Home Office, 2003) show that c. 51,800 male offenders were found guilty of or cautioned for acts of violence against the person in 2002, compared with c. 9,500 women in the same time period.

specificity, failing to include many men whose anger may fit cultural patterns but is unusually reactive or pervasive.

### 1.4 Is BPD a valid label for men?

Various pieces of evidence – the difficulty applying certain criteria, and the apparently low incidence of diagnosis – imply that BPD is not a label which is easily given to men. Of course, apparently low prevalence in clinical and research settings is no reason to question its existence. However, despite their scores on the ZAN-BPD defining them as 'borderline', the feelings and experiences described by men interviewed in this study did not seem to match the typical profile enshrined in the diagnostic criteria. In particular, efforts to avoid abandonment and oscillations of attachment evident in disturbed relationships were described by very few men, at least in the terms ("clingy", "dependent") used in the ZAN-BPD to signify these characteristics. High levels of irrational, uncontrollable anger and impulsive behaviour were much more commonly reported, as is evident in Table 2, below.

TABLE 2

*Percentage of men with BPD achieving the highest score on each DSM-IV criterion*

| DSM-IV criterion | % achieving highest score | Mean (std. dev.) |
|---|---|---|
| Frantic efforts to avoid abandonment | 5.3% | 1.42 (1.39) |
| Unstable relationships | 10.5% | 2.11 (1.33) |
| Irrational, uncontrollable anger | 73.7% | 3.63 (0.68) |
| Impulsivity | 57.9% | 2.95 (1.43) |
| Suicide/self-harm | 52.6% | 3.36 (0.83) |
| Affective instability | 73.7% | 3.52 (0.84) |
| Chronic feelings of emptiness | 26.3% | 2.42 (1.26) |
| Identity disturbance | 26.3% | 2.37 (1.42) |
| Transient paranoia/dissociation | 26.3% | 2.42 (1.39) |

Since co-morbidity between ASPD and BPD is so prevalent (Grilo, Sanislow & McGlashan, 2002a; Zanarini *et al.*, 1998b), it may be more useful to consider integrating the two categories in some form, at least as regards men. Personality disorders, after all, are not 'disease entities' with clear-cut profiles, but more collections of maladaptive characteristics that often co-occur in the same people. Perhaps the future development of the ASPD diagnostic criteria could involve the inclusion of additional criteria that allow for the internalising and self-harming aspects of BPD. However, this tentative suggestion is based on the presentation of the small sample (n=19) interviewed here, who may not adequately represent men with BPD. Furthermore, it is not clear that such a modification would necessarily be useful to either patients or clinicians, despite the conceptual utility of breaking down a potentially artificial division between ASPD and BPD. Classing men with BPD as having a modified form of ASPD might in fact

further limit the chances of their receiving caring and thoughtful treatment from services. It may be that the relevance of gender simply needs to be considered more closely in the diagnostic process, and allowances made for the natural variation in expressions of distress according to biological imperatives, trait differences and social and cultural influences.

## 2. Methodological issues in the study of childhood experiences

While the veracity of a person's retrospective recall may be of less concern in therapy, where perceptions may be important than reality, as Brewin, Andrews and Gotlib (1993) point out, "the issue of accuracy versus distortion is central to the evaluation of many current models of psychopathology" (p. 84). An aetiological model of BPD which proposes that childhood maltreatment is in some way linked to the clinical presentation of the disorder can only be tested if that maltreatment is accurately described.

Research methods in which participants are required to recall events from the distant past have been criticised on several fronts. First, psychological research has questioned the concept of memory as an unchanging, detailed body of concrete knowledge, and has shown how context-dependent, malleable and fragmentary it can be (Halverson, 1988). If memory is so open

to modification in the light of subsequent experience, how can we rely on it to develop and test our theories? Second, as with non-retrospective research, we know that the ways in which people report events are influenced by numerous factors. Response biases, in this case particularly in relation to events experienced as traumatic and shameful, may affect what information is communicated and how. Third, debates over the recall of childhood memory have, in recent years, focused on the possibility that clinicians or interviewers can affect, and even create, memories, leading to a 'false memory syndrome'. If this can happen, it clearly has the capacity to undermine the integrity of retrospective research methods. Lastly, theorists have argued over the relative merits of different methods of retrospective life-history research. Some have proposed that questionnaire-based designs minimise shame and other response biases; others have championed the depth and clarity offered by face-to-face interview designs. Both methods are likely to affect the quality, quantity and nature of information given. These four issues will be considered with particular attention to their relevance to research participants with psychological problems and to the recall of personal, often traumatic, memories.

### 2.1 Memory and its biases

A pervasive trend in the psychological literature identifies memory as persistently unreliable, particularly in relation to personal events. Loftus and

Palmer (1974) argue that memory is perpetually reconstructed in the context of later experience. There is also evidence that large portions of life-history are forgotten. These difficulties apply particularly to memories of childhood events, which have been consigned to a dust-heap of fantasy, imagination and fabrication by theorists such as Halverson (1988), who argues that children's ability to encode memory about their experience of being parented is limited by the lack of information-integrating schemas relevant to parenting, and by few contemporaneous experiences of comparison with other parents. Childhood memories are thus reconstructed across the life-span as schemas of parenting develop. This theory depends on a schema-based view of memory which is disputed by various theorists. For example, Brewin *et al.* (1993) remark on the capacity for individuals to remember large quantities of seemingly trivial and irrelevant information, not easily categorised in terms of schemas.

As evidence that memories of past events, particularly those regarding parenting, are unreliable, Halverson cites a study by Yarrow, Campbell and Burton (1970) which showed parents to be inconsistent in their retrospective accounts of their children's early years (overly positive regarding developmental progress and the quality of the relationship) at interviews between three and thirty years later than original records were collected. As Brewin *et al.*(1993) point out, the quality of parents' memories of their own

children "may not be a good guide to the accuracy of recall in general" (p. 85). A significant body of evidence demonstrates that siblings largely agree with each others' assessments of childhood events and parental behaviour (Bifulco, Brown, Lillie and Jarvis, 1997; McCrae and Costa, 1988). Even where recall of childhood events differs between siblings, or between parents and children, several studies have shown that the same events and experiences can be consistently recalled over extended time periods (e.g. Parker, 1989), particularly in response to specific questions. Agreement with original records is likely to be higher for factual information than value judgements, and accuracy is enhanced if the information required is likely to have been known by the child at the time. Questions referring to events and experiences before the child was five years old are not likely to elicit accurate answers: it is widely thought that memories encoded earlier may be lacking in the specificity afforded by more sophisticated verbal encoding. This phenomenon has been termed 'infantile amnesia' (Williams, 1994).

Further debate has focused on the extent to which recall is affected by psychopathological conditions, and little consensus has emerged. Cognitive impairment may be evident in some mental disorders, and is listed as a core criterion of depression in DSM-IV (APA, 1994). Flattening and slowing of affect, reactions, intelligence and memory may also be a side-effect of psychotropic medications. Specific and replicable effects of depression on

memory functioning have not been identified, with the possible exception of some short-term memory deficits in delayed free and cued recall (Watts & Sharrock, 1987). An alternative explanation for the occasional and slight memory deficits observed in patients with depression is a difficulty with effort, rather than impaired ability. Depressed patients also tend to report memory problems; on testing, these are not usually evident. In anxiety disorders, little evidence exists for systematic memory impairment – instead, individuals appear to be hyper-vigilant for stimuli related to the sources of their anxiety, with no major effects on memory.

Numerous studies have examined the specific effects of mood on memory retrieval. Findings include a tendency for depressed people to take comparatively longer to recall pleasant memories, though no differences exist between depressed and non-depressed people in recalling unpleasant memories. Studies using mood induction techniques have shown that participants in whom a state of depression is induced by experimenters recall equal numbers of positive and negative memories, while elation-induced participants recall more positive events. This would imply that depressed patients' memories are possibly *less* open to bias. Interestingly, as Brewin *et al.* (1993) point out, anxious patients (for whom memory biases have not been consistently shown) also report adverse childhood experiences. It is also highly possible that depressed patients have a greater store of adverse

experiences on which to draw, which means that enhanced or more frequent recall of negative memories is not necessarily a bias but a true reflection of experience. Recall of parenting in depressed and psychiatrically ill patients has been found to be corroborated by siblings' accounts (Robins *et al.*, 1985) and to be stable over time and mood state (Gerlsma, Kramer, Scholing & Emmelkamp, 1991, cited by Brewin *et al.*, 1993). There is no convincing evidence that depressed people are biased in their memories of childhood, nor that variations in mood affect their recall.

In general, Brewin *et al.* (1993) conclude that "adults asked to recall salient factual details of their own childhoods are generally accurate, especially concerning experiences that fulfil the criteria of having been unique, consequential and unexpected" (p. 87). The current study has operated under this assumption, and has employed specific techniques to manage other challenges to the validity of methods relying on retrospective memory, as described below.

### 2.2 Influences on reporting

An individual's inclination to describe traumatic childhood experiences will be influenced by numerous factors. These will almost certainly include the interviewer's manner, the way in which the interview has been introduced and set up, the immediate environment, their degree of physical comfort, the

way in which questions are phrased, and the order in which they are asked. Many factors will be beyond the interviewer's control. Social desirability and acquiescence biases come into play, the latter even more so among vulnerable populations. Some individuals may have certain agendas, depending on what they understand the research to be for, or who will read it.

In reporting abuse, in particular, the very complex and difficult feelings around such trauma are likely to affect the way a person will talk about it. Feelings of shame and intense distress may lead to self-censorship, or, conversely, unburdening. Under-reporting may result from amnesia, as described above, unwillingness to open up old wounds, or a consciousness of stigma around some experiences. Over-reporting, as Williams (1994) remarks, may be used to justify or explain current difficulties and/or psychiatric problems. The experience of previous therapy may enable some objectivity when discussing some experiences. As Durrett, Trull and Silk (2004) point out, "information about abuse history can be forgotten, withheld, or redefined as abusive or nonabusive at different points in an individual's life" (p. 179).

A variety of reporting styles have been codified in the development of the Adult Attachment Interview (Main, Kaplan & Cassidy, 1985), including a

tendency to minimise the impact of experiences (Dismissing), an emotive, entangled style (Preoccupied), and a chaotic and incoherent response (Disorganised). Attempts to extract specific examples and factual information may be compromised by these tendencies, but they provide crucial clues to the individual's attachment status.

In the case of abuse, some memories may not be tolerable. There is strong evidence that memories of childhood abuse can be selectively "forgotten" for long periods. Briere and Conte (1993) found that 59% of 450 people in treatment for sexual abuse reported that they had previously forgotten abusive events from childhood. Similarly, Herman and Schatzow (1987) reported that 28% of women who had suffered incest had severe memory deficits, and 64% had some amnesia for these experiences. Both studies found associations between age at the time of abuse, particularly violent episodes, and forgetting; this is attributed to the use of dissociation as a defensive resource. In the current study, two of the thirty participants remarked that they had only remembered certain events from childhood in recent years, prompted by other life events. For example, one participant said, regarding memories of his father's abusive behaviour:

**Participant:** I feel guilty ever since my memories started coming back. Strong, strong guilt feelings, really.

**Interviewer:** How long ago was that?

**Participant:** Two years ago. After the death of my grandson.

Another participant described an intense and pervasive feeling that he had experienced some sort of trauma in early childhood, but was unable to remember almost anything specific about his life before his late teens:

**Interviewer:** Did your parents ever severely deprive you of your basic needs, such as food, water or light?

**Participant:** I think, I think that she did, but I don't know. That's possibly part of what I'm thinking now but I don't know. I've got no – it's just my perception, I don't know.

**Interviewer:** Do you have particular memories of it?

**Participant:** I don't. All I have... apparently, when I was first unwell, I was very very frightened of the loft in my mum's house. Wouldn't go there, wouldn't go anywhere near it. That was when I would go into the house. I wouldn't even go into the house now.

Williams (1994) suggests that experiencing abuse at a pre-verbal stage of development may mean that "the memory for these events was laid down or constructed in a way that was not verbally mediated, but was based on images, actions or feelings... evoked only when those images are encountered again or if they are revived as may be the case in some therapeutic interventions" (p. 1168). A prospective study by Williams (1994)

examined factors affecting recall of childhood sexual abuse in women who had been seen in a hospital Emergency Room 17 years previously. Of 129 women who had previously been examined and interviewed after allegations of childhood sexual abuse, 38% had no memory of any abuse. Others had remembered the abuse previously after having forgotten for several years. Women who were very young at the time of the abuse (under four years old), and those who were abused by a familiar adult (such as a parent) were less likely to remember being abused. Interestingly, however, Williams found that many of those who had no memory of the events described in hospital records did remember experiences of abuse, but not by the perpetrators named in the records, and at a different time in their lives. Full or partial amnesia for abuse memories in people for whom abuse was independently corroborated was also reported by Chu, Frey, Ganzel and Matthews (1999), who similarly noted that those who experienced physical and sexual abuse at an earlier age showed greater levels of amnesia.

Serious methodological criticisms can be levelled at these studies. For instance, it is thought that a proportion of reports of CSA – between 4% and 8% - are fictitious, motivated by secondary gain of some sort (Everson and Boat, 1989). Even if validated by cast-iron corroborative sources, as Williams herself points out, "some of the 'memories' may be attributable to information they received from others later in life" (1994; p. 1171). Further,

the experience of being involved in a study of memories of child abuse, and asked detailed questions about such memories, when one is aware of a previously documented history, is likely to elicit a range of ideas in acquiescence to the interviewer's perceived interests. While, no doubt, steps are taken to minimise this bias, it is unlikely that it could be eradicated entirely. Risks with such research therefore include the possibility that true abuse is remembered differently over time or via suggestion, or forgotten through trauma; or that fictitious abuse becomes reified, both for the individual concerned and later researchers, through the assumption that it must be true if corroborated by original sources, and is then elaborated via iatrogenesis or responses to researchers' questions.

For a study such as our own, serious challenges are presented by the problem of forgetting, particularly if motivated by a conscious or unconscious desire not to remember trauma, as the true incidence of abuse may be under-reported: in Chu *et al.*'s (1999) study, 58.6% of those who had been physically abused and 59.5% of those who had been sexually abused had suffered partial or complete amnesia for these events. In the current study, the setting conditions and structure of our interview were specifically designed to mitigate such problems: in particular, attempts to make the interviewee comfortable and relaxed, 'warm-up' tasks such as the Autobiographical Memory Test (which inadvertently had a free-associative

function, in many cases eliciting surprisingly vivid and salient memories of childhood), and the use of memory aids such as a genogram and a chronology in concert with the M-CECA interview.

### 2.3 'False Memory' and retrospective recall

Experiments demonstrating the malleability and indeterminacy of certain kinds of memory, and the publicity generated by admissions of long-forgotten abuse in criminal trials, civil lawsuits, memoirs and popular books, have led to claims that memories of childhood abuse may in some cases be false. Williams (1994) notes that "some have suggested that the recovered memories are fabricated by disturbed or vindictive adults or fostered by overzealous or poorly trained therapists who use aggressive memory recovery techniques" (p. 1167).

In a research context, this is less of a concern, as there is no therapeutic agenda that might encourage 'reliving' traumas or coming to terms with childhood experiences. However, as Timmerman and Emmelkamp (2001) point out, "because borderline patients are highly suggestible, retrospective studies on traumatic experiences in these subjects might enhance the induction of false memories of traumatic events" (p. 137). In this case, the interviewer explained in advance that she was not expecting or hoping that participants would provide any particular kinds of information, but was just

generally interested in childhood experiences. The absence of any incentive for reporting abuse, the use of open-ended, non-leading questions, and specific requests for examples of behaviours (rather than relying on vague statements or value judgements), were intended to reduce the risk of false reporting or false memories. The awareness that some individuals may be highly suggestible, and likely to provide information that they perceive the researcher may wish to hear, should inform the development of safeguards on research design in this area.

### 2.4 Methodological debates

Where the topics of research are sensitive – involving traumatic or personal experiences – there is some question over the comparative value of different methods of information gathering. Abuse cannot be studied prospectively without involving the collusion of researchers; retrospective studies raise fewer ethical concerns. This places certain limits on what can be studied, however, and leaves retrospective research open to the criticisms described above. A further debate involves the method of data collection. Interviews may carry the advantage of enabling rapport, which in turn may facilitate disclosure. Finkelhor (1986) published evidence that interviews could reveal higher rates of abuse than questionnaires, and Gauthier, Stollak, Messé and Aronoff (1996) remark that "it is probable that subjects deny, distort and/or unconsciously forget painful experiences when responding to

questionnaires" (p. 555). However, confidential or anonymous self-report questionnaires may lessen the inhibiting effects of shame on the disclosure of sensitive information, and Gauthier *et al.*'s questionnaire produced levels of disclosure at comparable levels to other studies with similar populations. For example, in a study by Dill, Chu, Grob and Eisen (1991), female inpatients were twice as likely to report experiences of abuse on a survey than on a psychiatric intake interview. Durrett, Trull and Silk (2004), however, found a high level of agreement between parallel questionnaire and interview-based measures of childhood sexual abuse on all dimensions measured. In this study, a combination of interview and questionnaire methods were employed. Participants were interviewed about their childhood experiences, but privately completed questionnaires relating to experiences of shame and symptoms of depression.

Brewin *et al.* (1993) recommend a range of safeguards for accurate retrospective data collection, and suggest that other informants' accounts should be used for corroboration of the validity of data. Research suggests that siblings provide the most reliable and valid corroborative data, although it is worth remembering that in some cases they might have been perpetrators of the abuse, or for other reasons may not wish to confirm that it occurred. Independent records held by external agencies are also a valuable source of corroboration, as used by Williams (1994) – though they may be

difficult to obtain, and may provide only sparse information. In many cases childhood maltreatment will have been a private, secret matter and will not have been reported to such agencies. The time and resource limitations on the current study did not allow for such rigorous procedures.

A second recommendation for accurate retrospective data collection concerns the use of methods that enhance recall. Several studies highlight the importance of using specific, factual questions (Durrett *et al.*, 2004; Gauthier *et al.*, 1996). These improve accuracy and allay the value-judgements and global statements that prove unreliable over time. Gauthier *et al.* (1996) remark: "asking subjects to report about the occurrence of specific behaviors may provide a more accurate index of the quality of interactions in families than global descriptions of parenting styles that have been used in other studies" (p. 555). The M-CECA interview used in the current study is characterised by its specificity and reliance on concrete examples, which are then consensually rated by clinicians according to a closely defined rating scale. The M-CECA also employs techniques such as chronological anchoring, and a semi-structured format that allows the interviewer to elicit particular memories in relation to global statements and to check and expand when further detail is necessary. The interviewer furthermore incorporated the collaborative construction of a genogram, initially intended to clarify the family structure, but in fact providing rich insights into the family's history and opening up a new source of memories. In accordance with Brewin *et al.*'s

(1993) suggestion, interviews were all conducted in clinical settings, in order to alleviate some of the feelings of shame and self-censorship that might be more salient in a public or non-clinical context.

## 3. The process of research

As the research process progressed, it became increasingly clear that certain aspects of the research design would compromise the validity of the final product. Some of these difficulties, notably the limitations imposed by the use of self-report data and a retrospective method, and the conceptual and practical difficulty of disentangling risk factors, are endemic to research in this field. Others, such as the relative inaccessibility of the study population, could be tackled more easily, and benefited from hindsight over the period of research.

### *The use of self-report data*

As described above, relying on people to give an accurate and representative picture of their general mental state, childhood history and performance on a memory task, is risky and prone to bias from many sources; and yet, the accuracy of the measures depends entirely on the accuracy of the participant's self-report. The conditions of the research setting; the expectations they may perceive (rightly or wrongly); their ideas about the

purpose and use of the research; their mood and physical state; the interviewer's manner; the time pressure they might be under: all of these factors, and many more, are likely to affect the content and style of self-report. While steps were taken to keep all manipulable conditions as consistent as possible, it is inevitable that some interviewees felt more at ease than others, and this is, of course, likely to have affected the nature of their disclosures.

In this context, it is also important to reflect on the interviewer's gender (female) and age (mid-20s) in relation to the nature and content of the interviews, which were predominantly with middle-aged men and involved the disclosure of deeply personal experiences. The power dynamics in this situation were complex: often participants were in-patients who appeared oppressed and compliant, perhaps seeing the interviewer as a powerful figure who could command their time and demand responses. The interviewer attempted to make the voluntary nature of the interview clear, and encouraged the participants to ask questions, to let her know if they had concerns or needed a break, and, at the end, to offer their thoughts on the experience of the interview. The payment of a £10 incentive, the provision of refreshments, and expressing appreciation for the participants' time and effort, further affected the power dynamics of the interview situation.

Certain observations relevant to the nature and quality of self-report data, in the context of these factors, may be made. First, very few participants challenged the interviewer in any way. Some inquired as to the confidentiality of the data, but many seemed to regard the interviewer as equivalent to the psychiatrists they regularly met, and as such, someone to whom they could freely impart personal information. Second, some participants, realising that the interviewer was not involved in their care, nor bound to disclose any details beyond those related to risk, seemed to enter into a somewhat conspiratorial mode of relating; for example, informing the interviewer of details that they had not disclosed to professionals involved in their care (such as benefit fraud, drug-taking and shoplifting). Third, many participants saw the research as exceptionally valuable and important, even declining payment and, typically, saying that they hoped the research could do some good for people like themselves[7].

To have approached this research question with methods that avoided the use of self-report data would have involved an analysis of case notes or interviews with keyworkers. These methods are also subject to numerous biases and are unlikely to reflect the nuances of a person's current mental state or the fine details of their past experiences.

[7] In these cases, the interviewer continued to offer the incentive payment, and gave the option for the participant to donate it to charity if he did not personally wish to accept it.

*Retrospective design*

Retrospective methods, as discussed above, are unlikely to provide information as precise and reliable as that available from prospective studies. However, no other approach to the research question was possible within the time frame and scope of this study. Quite apart from the fuzziness of memory and its susceptibility to suggestion, particular concerns with this client group (many of whom had spent years in consultation with mental health professionals) were the effects of "efforts after meaning" (Zanarini *et al.*, 2002). Narratives of childhood experiences and their relevance to distress and dysfunction in adulthood, developed through therapy or through personal attempts to make sense of events, may have led participants to construct their memories in particularly meaningful sequences, or to remember selectively. Although merely a subjective impression, the interviewer was not aware of experiencing a situation in which a participant appeared to be fabricating details of past experiences. The M-CECA interview schedule requires the examination of a breadth of memories, very much at the behest of the interviewer, rather than the interviewee: while the authors of the interview (Bifulco, Brown & Harris, 1994) describe it as "semi-structured", the only way in which its structure is slightly loosened is that it permits a flexible order of questioning. Thus, the participant does not lead or direct the flow of memories, but is subject to a standardized interview format

(see Appendix VIII). This, along with specific instructions to obtain descriptions of actual incidents, should enable the interviewer to act against the tendency for participants to tell familiar stories shaped by later experience, instead – ideally – tapping into more unprocessed and potentially more accurate material. Even so, retrospective interviews are by nature inexact and subject to interpretation, as are the phenomena they tend to explore.

*The tools of research*

Each of the measures selected performed adequately in terms of the research question, with some minor exceptions. The ZAN-BPD (Zanarini, 2003) specifies a two-week time-scale of symptom self-report, which is problematic when assessing patients who, for instance, have a long history of severe self-harm but, partly owing to their confinement in in-patient treatment, are not currently self-harming. This posed some difficulties in the scoring process which were resolved through discussion and consensual rating. However, it might lead to problems of reliability between studies, where the criteria might be applied differently. The M-CECA proved an excellent and comprehensive instrument, worded and structured in an engaging way. However, it failed to incorporate any detailed questioning or standard criteria in the scoring process for experiences of loss and separation. A reliable way of defining and assessing such experiences should be

constructed in future studies, as a number of studies (summarised by Zanarini, 2000a) have noted the significance of loss among people with BPD.

*The research question*

The research question - an exploration of the relationship between childhood experiences and adult symptomatology in borderline personality disorder - assumes that the two might be in some way associated. It further assumes, on the basis of recent literature (e.g. Mullen, Martin, Anderson, Romans & Herbison, 1996; Zanarini *et al.*, 2002), that people might respond to certain experiences and traumas with specific psychopathological sequelae. These are fair assumptions: they form the basis of many schools of psychotherapy and of a vast body of literature in psychology and popular discourse. However, any attempt to trace specific relationships is ultimately undone by the complexity of human nature and the enormous number of factors that affect people as they move through life and make sense of their experiences. Genetic and biological predispositions, social and cultural influences, protective factors, resilience and entirely random events all intervene, and the role of one particular trauma cannot, therefore, be untangled from the greater whole. Even that trauma - for example, an incident of childhood physical abuse - will have numerous dimensions that determine its meaning and significance for a person, including the quality of the relationship with the perpetrator, before, during and since the event, the context of the abuse,

its duration, its nature, the way it was explained or dealt with afterwards, the presence of a protective adult, the age at which it occurred, and opportunities since to process and understand it.

An acknowledgement of this complexity raises two important points. First, any methods used to explore specific risk factors must produce, rich, detailed, naturalistic data, and must be interpreted finely and closely by more than one individual, in order to capture the real meaning implicit in the account. Even then, any attempt to standardise, rate or compare experiences will inevitably be reductive. Second, any conclusions reached from such an exploration must be tentative, in respect to the myriad influences acting on any experience and any interpretation.

*The Sample*

Finding men with BPD was extremely problematic. Their apparent rarity aside, the difficulty lay, in fact, in persuading clinicians to spend the time necessary to identify and recommend potential participants, and to allow the researcher access to patients considered highly vulnerable. In retrospect, at least as far as the researcher was aware, the participants largely appreciated an opportunity to speak to someone not involved in their lives or their treatment, who had an interest in understanding exactly what they had experienced and how it might have affected them. Many expressed pleasure

and enjoyment in the interview, and enthusiasm for the endeavour. Others saw it as a welcome distraction from the monotony of an in-patient ward setting.

A total sample of 30, 19 of whom met criteria for BPD, is not sufficient for anything more than an exploratory study, however, and the small sample size is regrettable. To recruit even that number required concessions that may also have compromised the validity of the study. For example, the sample was largely composed of people who were specifically seeking treatment. While it may be the case that people with BPD are often closely engaged with services, this factor may limit the generalizability of our findings: participants were typically functioning poorly with serious psychosocial impairments and high levels of symptoms. This may mean they represent a particularly severe sub-group of patients with BPD, who may have experienced higher rates of abuse, neglect and other forms of adversity. Eagle (1995; cited by Salzman, 1998) has argued that using retrospective data to explore the aetiology of BPD with a sample of hospitalized borderline patients would run the risk of "seriously distorting and exaggerating the nature and strength of the relationship between childhood sexual abuse and adult personality disorder" (p. 1626). However, as Zanarini and Frankenburg (1998c) have pointed out, "the boundary between outpatients and inpatients with borderline personality disorder is quite permeable with today's

outpatient being tomorrow's inpatient" (p. 1626). Most borderline patients, they note, have histories of prior hospitalization. This problem may be endemic to research with this client group: Trull (2001) notes that the clinical settings in which research into BPD normally takes place tends to produce a sample that is skewed towards representing the "most dysfunctional or severe cases" (p. 20). Paris *et al.* (1994) and Zanarini (2003) have tackled this problem by recruiting participants through newspaper advertisements, in the latter case calling for people who see themselves as "extremely moody", "distrustful of others", "out of control" and experiencing "painful and difficult" relationships (p. 236). Even so, Zanarini (2003) found that 47% of those recruited in this fashion had experienced at least one prior psychiatric hospitalization.

A further compromise imposed by the small sample size and the limited scope of the study was our decision not to screen for co-morbid Axis I and II disorders. The interview, as described in the empirical paper, lasted at least three hours as it was; using further screening instruments would probably have necessitated a further meeting. This would have risked the attrition of some participants and possibly affected their willingness to participate. Given the high levels of co-morbidity with Axis I and II disorders noted by several previous studies (Grilo *et al.*, 2002a; Grilo, Anez & McGlashan, 2002b; Zanarini *et al.*, 1998a, 1998b), it would have been useful to collect this data.

Controlling for co-morbid disorders in statistical tests might have enabled us to separate out the specific effects of childhood experiences on adult functioning more effectively.

*Clinical implications*

On a personal level, the experience of undertaking this study has afforded the researcher with an opportunity to develop a range of clinical skills. In particular, simply helping people to feel at ease in an unusual and challenging situation, and working to create an atmosphere in which they can freely discuss experiences they have seen as shameful or traumatic, have been the most significant points of learning.

In broader terms, the experience has highlighted service user perspectives. Many of the men interviewed took the meeting as a chance to explain what was frustrating and inadequate about the care they received. Often, they described ward staff as intolerant and punitive in relation to their self-harm, and hospital life as frightening, exhausting and monotonous. Many participants, particularly those in in-patient care, spontaneously asked the interviewer whether she could arrange for them to see a 'counsellor', a 'psychologist' or a 'therapist', as they had not had access to such services.

Other participants described being profoundly grateful for certain kinds of help, especially when provided by a service that was set up to cater specifically for their difficulties. In particular, several men described a long-term weekly out-patient group for men with BPD as a powerful and profound experience that had allowed them to make major changes in their lives. Certainly, considering the experiences of social alienation, stigmatisation and disturbed identity described by many men in the study, it seemed that constructive, contained contact with others in similar situations might be extremely valuable.

The relevance of our findings to future clinical practice are described in some detail in the Empirical Paper (p. 132, p. 134). However, it is worth noting here that certain results have direct implications for the identification of children at risk of developing serious mental health problems in adulthood. In particular, as noted by many previous studies (e.g. Zanarini, 2000), multiple co-occurring forms of abuse and deprivation appear to be a hallmark of the histories of many men with BPD. Particularly conflictual and violent paternal relationships may also be regarded as a risk factor for later distress. Professionals who come into contact with young children (for example, teachers and GPs) need to be trained to notice and act appropriately when children evidence signs of emotional or physical damage. Interventions with such families need to address the multiple forms of disadvantage they suffer.

In adulthood, men with BPD (almost by definition) pose a serious risk to themselves, and may often need containment and safe outlets for the emotions they experience so intensely. The continuing development of therapies designed to address this dysregulation and to help people access and use meta-cognitive skills (for example, Dialectical Behaviour Therapy and Mentalization-Based Therapy) offer some hope. This study illuminated a population of men who felt that many of the services they were offered (or not offered) had failed them, or left them feeling alienated and hopeless. The difference between those who languished in in-patient wards, or who were allowed only brief stays following major crises, and those who had been able to make use of DBT and other specifically tailored psychotherapeutic interventions in the community, was striking. It points towards a pressing need for greater awareness of BPD and its treatment among professionals, and, of course, more investment, enabling greater and faster access to such services.

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# Appendix I:

# Ethical approval

NHS

Barking and Havering Local Research Ethics Committee

14 September 2004

[redacted]

University College London
Sub Department of Clinical
Health Psychology
Gower Street
London
WC1E 6BT

[redacted]

***Full title of study: Can aspects of childhood maltreatment predict borderline symptomatology in men? A comparative study of the trauma histories of men with BPD or depression.***
***REC reference number: LREC (B&H) 2004/233***
***Protocol number: 1***

The Research Ethics Committee reviewed the above application at the meeting held on 04 August 2004.

**Ethical opinion**

The members of the Committee present gave a favourable ethical opinion to the above research on the basis described in the application form, protocol and supporting documentation.

*The favourable opinion applies to the following research site:*

Site: University College London.

Principal Investigator: [redacted]

**Conditions of approval**

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

**Approved documents**

The additional documents reviewed and approved at the meeting were:

Document Type: Response to further information: Patient Information Sheet
Version: 2
Dated: 16/06/2004
Date Received: 16/06/2004

**Management approval**

The study may not commence until final management approval has been confirmed by the organisation hosting the research.

All researchers and research collaborators who will be participating in the research must obtain management approval from the relevant host organisation before commencing any research procedures. Where a substantive contract is not held with the host organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

**Membership of the Committee**

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

**Notification of other bodies**

We shall notify the research sponsor, University College of London that the study has a favourable ethical opinion. Please notify your local R&D Department of this outcome by forwarding a copy of this letter.

**Statement of compliance *(from 1 May 2004)***

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**REC reference number:** 04/Q0602/9 **Please quote this number on all correspondence**

Yours sincerely,

**Chairman**
Barking & Havering Research Ethics Committee

*Enclosures* *List of names and professions of members who were present at the meeting and those who submitted written comments*

*Standard approval conditions SL-AC2*

# Appendix II:

# Information sheet

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

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# Information Sheet

## "A comparative study of childhood trauma experiences in men with severe emotional distress or depression"

Investigators: Celia Sadie, Dr Janet Feigenbaum, Professor Peter Fonagy

*You are being invited to take part in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.*

- We are conducting a study to learn about the childhood experiences of men who are severely emotionally distressed and/or depressed, and are hoping to interview about 50 people over the next year. The results of this study will, we hope, add to our knowledge and understanding of the severe emotional distress some people experience. It may also help us with the development of new treatment techniques, and could help us identify problems early on.

- If you decide to take part, you will be asked to complete an interview and questionnaires about your symptoms, your memories of childhood and relationships with your parents and siblings, your feelings about yourself, and a brief memory task.

- The interview will be recorded onto tape. The tapes will be labelled with a number (and not your name) and will be erased once the study is completed. All information you provide will be kept strictly confidential and will not be shared with others unless you request that it is. Your GP will be notified that you are participating in a research study but will not be given any further details.

- We hope you will not find any of the tasks distressing. However, if you do, we can stop at any time, and if you want, the researcher/clinician will spend time talking to you about what has upset you. You will have the choice of withdrawing from the study, resuming the interview after a break, or continuing at a later date.

- We hope to publish our findings in a journal. We can assure you that individuals will not be identified in any way in any published material. We are happy to send you copies of any publications from this study if you wish.

- **Participants will be paid £10**. We can meet for the interview in a range of places including your local Community Mental Health Centre. The session will last two to three hours, and will include breaks for refreshments.

***This study is not part of normal treatment. You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason. Your decision to take part or not will not affect your care, nor any decisions subsequently made by any service. This project was approved by Barking and Havering and Camden and Islington Local Research Ethics Committees.***

**If you would like further information about this study, or are interested in participating, please contact Celia Sadie on 07779 580 179.**

# Appendix III:

# Consent form

Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
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## Consent Form

**"A comparative study of childhood trauma experiences in men with severe emotional distress or depression"**

Celia Sadie, Dr Janet Feigenbaum, Professor Peter Fonagy

Sub-Department of Clinical Health Psychology, University College London

To be completed by the participant:

1. I have read the information sheet about this study YES / NO
2. I consent to the researcher recording interviews with me YES / NO
3. I have had the opportunity to ask questions and discuss the study YES / NO
4. I have received satisfactory answers to all my questions YES / NO
5. I have received sufficient information about this study YES / NO
6. Which health professional have you spoken to about this study?

   .....
7. I understand that I am free to withdraw from this study at any time without giving a reason and without it affecting my future care

   YES / NO
8. Do you agree to take part in this study? YES / NO

Signed .....

Date .....

Name in block letters .....

Signature of investigator.....

# Appendix IV:

# Autobiographical Memory Test

## Autobiographical Memory Test (AMT)

(Williams & Broadbent, 1986)

***I am interested in your memory for events that have happened in your life. I am going to read to you some words. For each word, I want you to think of an event that has happened to you that the word reminds you of.***

***The event could have happened recently (yesterday or last week) or a long time ago. It might be an important event or a trivial event.***

***Just one more thing – the memory you tell me about should be of a specific event. So if I said the word 'good', it would not be OK to say "I always enjoy a good party", because that does not mention a specific event. But it would be OK to say "I had a good time at Jane's party" because that is a specific event.***

***Let's try some words for practice:***

***'Enjoy'***
***'Friendly'***
***'Bold'***

Participant should be given prompts and feedback until he/she produces a specific memory detailing a single event which could be located in time and place.

12 cue words are then presented in randomised order, 6 positive and 6 negative, both verbally and visually on cue cards, and asked for each one:

***Can you tell me of something that's happened to you that you are reminded of when you see the word...."***

| | |
|---|---|
| ***'Happy'*** | ***'Miserable'*** |
| ***'Proud'*** | ***'Guilty'*** |
| ***'Relieved'*** | ***'Angry'*** |
| ***'Pleased'*** | ***'Insecure'*** |
| ***'Excited'*** | ***'Lazy'*** |
| ***'Hopeful'*** | ***'Uncomfortable'*** |

***Can you tell me when this happened?***

# Appendix V:

# Beck Depression Inventory

# Appendix VI:

# Experience of Shame Scale

# Appendix VII:

# Zanarini Rating Scale for

# Borderline Personality Disorder

# Appendix VIII:

# Menninger – Childhood Experiences of Care and Abuse

# Interview Schedule

# Appendix IX:

# Diagnostic Criteria for DSM-IV personality disorders

**Paranoid personality disorder**

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by at least four of the following:

A1. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her.

A2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.

A3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.

A4. Reads hidden demeaning or threatening messages into benign remarks or events.

A5. Persistently bears grudges, i.e., unforgiving of insults, injuries, or slights.

A6. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or counter-attack.

A7. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.

B. Exclude the diagnosis if the features only occurred during the course of schizophrenia, a mood disorder with psychotic features, or another psychotic disorder, and are not due to the direct physiological effects of a general medical condition.

**Schizoid personality disorder**

A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by at least four of the following:

A1. Neither desires nor enjoys close relationships, including being part of a family.

A2. Almost always chooses solitary activities.

A3. Has little, if any, interest in having sexual experiences with another person.

A4. Takes pleasure in few, if any, activities.

A5. Lacks close friends or confidants other than first-degree relatives.

A6. Appears indifferent to the praise or criticism of others.

A7. Shows emotional coldness, detachment, or flattened affectivity.

B. Exclude the diagnosis if the features only occurred during the course of schizophrenia, a mood disorder with psychotic features, or another psychotic disorder, and are not due to the direct physiological effects of a general medical condition.

**Schizotypal personality disorder**

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behaviour, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

A1. Ideas of reference (excluding delusions of reference)

A2. Odd beliefs or magical thinking, that influence behaviour and are inconsistent with subcultural norms, (e.g., superstitiousness, belief in clairvoyance, telepathy or 'sixth sense'; in children and adolescents, bizarre fantasies or preoccupations).

A3. Unusual perceptual experiences, including bodily illusions.

A4. Odd thinking and speech (e.g. vague, circumstantial, metaphorical, over-elaborate, or stereotyped).

A5. Suspiciousness or paranoid ideation.

A6. Inappropriate or constricted affect.

A7. Behaviour or appearance that is odd, eccentric or peculiar.

A8. Lacks close friends or confidants other than first-degree relatives.

A9. Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgements about self.

B. Exclude the diagnosis if the features only occurred during the course of schizophrenia, a mood disorder with psychotic features, or another psychotic disorder.

**Borderline personality disorder**

A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

1. Frantic efforts to avoid real or imagined abandonment (not including suicidal or self-mutilating behaviour).

2. A pattern of unstable and intense interpersonal relationships characterized by alternative between extremes of idealization and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating, not including suicidal or self-mutilating behaviour).

5. Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour.

6. Affective instability due to a marked reactivity of mood.

7. Chronic feelings of emptiness.

8. Inappropriate intense anger or difficulty controlling anger

9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

**Antisocial personality disorder**

A. Current age at least 18 years

B. Evidence of conduct disorder with onset before age 15 and demonstrated by at least three of the following:

B1. Often bullies, threatens or intimidates others.

B2. Often initiates physical fights.

B3. Has used a weapon that can cause serious physical harm to others

B4. Has stolen with confrontation with a victim.

B5. Has been physically cruel to people.

B6. Has been physically cruel to animals.

B7. Has forced someone into sexual activity.

B8. Often lies or breaks promises to obtain goods or favours or to avoid obligations.

B9. Often stays out at night despite parental prohibitions, beginning before 13 years of age.

B10. Has stolen items of nontrivial value without confrontation with the victim either within the home or outside the home.

B11. Has deliberately engaged in fire-setting, with the intention of causing serious damage.

B12. Has deliberately destroyed others' property (other than by fire-setting).

B13. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period).

B14. Often truant from school, beginning before 13 years of age (for employed person, often absent from work).

B15. Has broken into someone else's home, building or car.

C. A pervasive pattern of disregard for and violation of the rights of others occurring since age 15, as indicated by at least three of the following:

C1. Failure to conform to social norms with respect to lawful behaviour as indicated by repeatedly performing acts that are grounds for arrest.

C2. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.

C3. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations.

C4. Impulsivity or failure to plan ahead.

C5. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.

C6. Reckless disregard for safety of self or others.

C7. Lack of remorse, as indicated by being indifferent to, or rationalizing having hurt, mistreated, or stolen from another.

D. Exclude the diagnosis if the occurrence of antisocial behaviour is exclusively during the course of schizophrenia or a manic episode.

**Narcissistic personality disorder**

A pervasive pattern of grandiosity (in fantasy or behaviour), need for admiration and lack of empathy, beginning by early adulthood and present in a variety of contexts as indicated by at least five of the following:

1. Has a grandiose sense of self-importance

2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty or ideal love.

3. Believes that he or she is 'special' and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).

4. Requires excessive admiration.

5. Has a sense of entitlement (i.e. unreasonable expectations of especially favourable treatment or automatic compliance with his or her expectations).

6. Is interpersonally exploitative (i.e. takes advantage of others to achieve his or her own ends).

7. Lacks empathy: is unwilling to recognise or identify with the feelings and needs of others.

8. Is often envious of others or believes that others are envious of him or her.

9. Shows arrogant, haughty behaviours or attitudes.

**Histrionic personality disorder**

A pervasive pattern of excessive emotionality and attention-seeking, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

1. Is uncomfortable in situations in which he or she is not the centre of attention.

2. Interaction with others is often characterized by inappropriate sexually seductive or provocative behaviour.

3. Displays rapidly shifting and shallow expressions of emotions.

4. Consistently uses physical appearance to draw attention to self.

5. Has a style of speech that is excessively impressionistic and lacking in detail.

6. Shows self-dramatization, theatricality and exaggerated expression of emotions.

7. Is suggestible (i.e. easily influenced by others or circumstances).

8. Considers relationships to be more intimate than they actually are.

**Obsessive-compulsive personality disorder.**

A pervasive pattern of preoccupation with orderliness, perfectionisms and mental and interpersonal control, at the expense of flexibility, openness and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by at least four of the following:

1. Is preoccupied with details, rules, lists, order, organization, or schedules, to the extent that the major point of the activity is lost.

2. Shows perfectionism that interferes with task completion.

3. Excessive devotion to work and productivity to the exclusion of leisure activities and friendships.

4. Overconscientiousness, scrupulousness, and inflexibility about matters of morality, ethics or values.

5. Is unable to discard worn-out or worthless objects even when the have no sentimental value.

6. Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.

7. Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.

8. Shows rigidity and stubbornness.

**Avoidant personality disorder**

A pervasive pattern of social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by at least four of the following:

1. Avoids occupational activities that involves significant interpersonal contact, because of fears of criticism, disapproval, or rejection.

2. Is unwilling to get involved with people unless certain of being liked.

3. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed.

4. Is preoccupied with being criticised or rejected in social situations.

5. Is inhibited in new interpersonal situations because of feelings of inadequacy.

6. Views self as socially inept, personally unappealing, or inferior to others.

7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

**Dependent personality disorder**

A pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.

2. Needs others to assume responsibility for most major areas of his or her life.

3. Has difficulty expressing disagreement with others because of fear of loss of support or approval.

4. Has difficulty initiating projects or doing things on his or her own, because of a lack of self-confidence in judgement or abilities rather than a lack of motivation or energy.

5. Goes to excessive lengths to obtain nurturance and support form others, to the point of volunteering to do things that are unpleasant.

6. Feel uncomfortable or helpless when alone, because of exaggerated fears of being unable to care for himself or herself.

7. Urgently seeks another relationship as a source of care and support when a close relationship ends.

8. Is unrealistically preoccupied with fears of being left to take care of himself or herself.