

GIFTEDNESS AND PSYCHOLOGICAL ABUSE IN BORDERLINE PERSONALITY DISORDER: THEIR RELEVANCE TO GENESIS AND TREATMENT

Lee C. Park, MD, John B. Imboden, MD, Thomas J. Park, PhD,
Stewart H. Hulse, PhD, and H. Thomas Unger, MD

This clinical study of 23 borderline outpatients and 38 outpatients with other personality disorders provides evidence that individuals who become borderline frequently have a special talent or gift, namely a potential to be unusually perceptive about the feelings of others. We postulate that this talent is derived from an innate characteristic rather than simply arising from early environmental influences. We also present evidence that chronic, severe, pervasive psychological abuse, or "mind abuse," is the most frequent and significant form of caretaker abuse (vs. sexual or physical) in the childhood histories of this disorder. Our data support the hypothesis that the interaction of a child's gifted characteristics with this abuse creates a tragic drama that is etiological for BPD in a substantial number of cases. We propose that the abuse markedly perverts not only use of the perceptual talents (e.g., powerfully compelling projective identification) but overall psychological development. We discuss how these issues are relevant to the conduct of effective therapy.

Almost all clinicians who have significant experience with borderline patients are impressed at times with their exceptional ability to sense psychological characteristics of significant others in their lives, including therapists. This ability tends to be coupled with the manipulative induction

From the Johns Hopkins University, Baltimore, MD (Dr. L. Park, Associate Professor of Psychiatry; Dr. Imboden, Associate Professor of Psychiatry and Psychiatrist-in-Chief, Sinai Hospital of Baltimore; Dr. Hulse, Professor and Chairman, Department of Psychology; Dr. Unger, Instructor in Psychiatry) and the University of Texas (Dr. T. Park, Research Fellow, Department of Zoology). An earlier version of this paper was presented at the Department of Psychology, University of Texas, Austin, March 9, 1990. We thank Carol Hicks, MaryW. Park, and Stephanie S. Reynolds for critical assistance in library and data base searches, and for editorial review; and Dr. Lee Willerman and two anonymous reviewers for their pertinent advice. We wish to express profound gratitude to the patients who contributed to this study (18 of whom also reviewed the completed manuscript) and who hope their experiences will help others. Address correspondence to Dr. Lee Crandall Park, 1205 York Road, Suite 35, Lutherville, MD 21093.

of feelings like those the patients themselves experience, that is, projective identification (Kernberg, 1975; Ogden, 1982). Patients may also employ this talent in engendering strong rescue and attachment responses, as well as disagreements, quarrels, or "splits" among those who are involved in their lives, for example, between members of the family or clinic staffs, especially inpatient staffs (Adler, 1985; Gunderson, 1989; Gutheil, 1989).

It is our hypothesis that the significance of this talent goes far beyond these particular symptomatic manifestations of the disorder. We assert that there is an inborn talent and need to discern the feelings and motivations of others, and, to emphasize its positive value as well as its innateness, we choose to refer to this characteristic as a gift. Much as one would refer to the mathematically gifted person or the musically gifted person, we believe many borderline patients have a cognitive giftedness in the area of self- and other-perceptiveness called "personal intelligence" (Gardner, 1983, 1985). This talent has remained unrecognized both because it occurs in very perturbed individuals for whom it is generally unavailable in a conscious fashion, and because it is embedded in the service of self-protection, neediness, control, and rage.

Under favorable circumstances an infant born with this gift would not, of course, grow up to have borderline personality disorder (BPD). We assume that such persons, given other healthy attributes and an appropriately nurturing environment, would grow up to become particularly successful in their relationships and careers. But what of the infant whose primary caretaker has defective capacity to be empathically attuned to others, even resents or is threatened by an unusually perceptive child and responds by psychologically abusing the child?

We are proposing the etiological hypothesis that BPD frequently results from the interaction of two factors (Gunderson & Zanarini, 1989), one of them biogenetic, the giftedness; and the other a disturbed parental involvement factor, severe, chronic verbal/psychological abuse by caretakers during infancy and childhood. The psychological abuse may differ in many ways from child to child, but it always includes chronic resistance to or assault on the healthy development of a child's perceptions and sense of an autonomous self. This abuse is so threatening and damaging that any intuitive talents become almost totally directed to pathological patterns of relating that are the basis for the characteristic, perhaps pathognomonic (Zanarini, Gunderson, Frankenburg, & Chauncey, 1990) interpersonal powers of these patients. Attachment theory (Bowlby, 1988) can explain the clinical manifestations of BPD as resulting from the interaction of these two factors, without assuming other biogenetic factors such as inborn abnormal personality traits or defects (Soloff & Millward, 1983). However, since there may be a number of combinations of innate and environmental factors that facilitate development of BPD, studies of borderline individuals in various populations are required to determine the validity and clinical significance of any etiological hypothesis (Millon, 1987; Stone, 1990a).

There are numerous references in the BPD literature to a skill or talent to perceive, involve, and influence people, although there has been minimal formal investigation of this characteristic. It is considered to be a man-

ifestation of pathology and/or a skill that is peculiar in some way, and/or simply a learned response to childhood stress. Adier (1985) and Gunderson (1989) discuss the tendency of borderline patients to evoke disturbing emotional conflicts between hospital staff members, as well as intense feelings of rage and helplessness in therapists. Gutheil (1989) and Averill et al. (1989) emphasize their ability to be remarkably appealing and/or compelling, and to frequently "seduce, provoke or invite" even experienced therapists into serious boundary violations, including patient-therapist sex. Numerous authors have described an "uncanny capacity" (Krohn, 1974) of many borderline patients to recognize, and often to overreact to or act manipulatively or even helpfully upon, unexpressed or private attitudes and judgments, hidden feelings, and unconscious impulses of other people (Carter & Rinsley, 1977; Gabbard, 1990; Kernberg, 1984; Kernberg, Salzer, Koenigsberg, Carr, & Applebaum, 1989; Kreisman & Straus, 1989; Masterson, 1976; Shapiro, 1978; Stone, 1985). Krohn refers to this intuitive talent as "borderline empathy." It is intriguing that there has been no consideration of a DSM-III-R criterion for this striking characteristic since it might, if proven valid, help distinguish BPD from other personality disorders such as histrionic, antisocial, and narcissistic.

There are few studies exploring psychological abuse in the histories of borderline patients. In a controlled study, Zanarini, Gunderson, Marino, Schwartz, and Frankenburg (1989) found that chronic verbal psychological abuse, defined as chronically devaluative and/or blaming statements, occurred in the childhood histories of 72% of their borderline patients. This was far more common than physical (46%) or sexual (26%) abuse and was the only form of abuse that distinguished the borderline group from each of 2 control groups. Stone (1990b) found that 73% of 15 BPD patients reported a history of intense verbal abuse, with physical and sexual abuse having occurred in 47%. Psychological abuse generally has been explored as a relatively unidimensional phenomenon. However, the psychological development of human offspring is uniquely impacted by complex and subtle verbal and nonverbal cues that deserve closer examination. In our patient review, which follows, we examined a number of categories of psychological abuse, including one that may be particularly damaging to the psychological development of a gifted child: pervasive negative feedback to a child's intuitive perceptions.

In this study we evaluated information about 23 borderline patients and 38 patients with other personality disorders, all in long-term outpatient therapy, with special reference to evidence for giftedness, for severe psychological abuse in the childhood history, and particularly for a concurrence of giftedness and psychological abuse. We also reviewed patient reports about family constellations for evidence of caretaker personality characteristics and marital patterns that were associated with psychological abuse.

METHODS

Our clinical experience with BPD comes primarily from private practice with patients of above average socioeconomic background. We reviewed the clinical records of 107 private outpatients and identified 23 (18 women) who met the

DSM-III-R definition of BPD, that is, 5-8 criteria (American Psychiatric Assn., 1987; Frances, Clarkin, Gilmore, Hurt, & Brown, 1984). Treatment duration of at least 6 months was specified because brief contact may not reveal hidden intuitive talents or history of abuse, particularly psychological abuse. Twenty of these patients also had a history of Axis I, primarily affective, disorders (Fyer, Frances, Sullivan, Hurt, & Clarkin, 1988; Schwartz, Blazer, George, & Winfield, 1990; Widiger & Frances, 1989). Because only 6 patients had been hospitalized and only 7 met more than 5 diagnostic criteria, our results could differ from those of more severe cases. Furthermore, although several tended to manifest a few of the DSM criteria for antisocial personality disorder, only 1 of them satisfied enough criteria for the diagnosis, with 2 others meeting 4 adult criteria. Therefore, we may be working with a particular subset of BPD patients (Frances, Pincus, Widinger, Davis, & First, 1990; Stone, 1990a). As a control group we identified 38 (23 women) of the 107 patients as having other personality disorders and 2 or fewer DSM-III-R diagnostic criteria for BPD, with 22 controls also having a history of Axis I disorders. All but 2 of the 61 study patients were in individual therapy, the great majority seen 50 minutes once every 1 or 2 weeks. Six borderline patients and 1 control received concomitant group therapy, and 2 controls received only group therapy. Clinical judgments were made on a consensus basis but were not blind.

Currently, there is no reliable instrument that directly assesses cognitive personality features such as intuitive talents or giftedness (Costa & McCrae, 1990; Sternberg & Smith, 1985; Taylor & Cadet, 1989). For this exploratory study, we developed a rough rating scale derived from Gardner's work on the concept of "personal intelligence" (1983, 1985). Gardner has provided detailed evidence that, in humans, there are at least six relatively independent or modular (Gould, 1992) categories of intelligence: linguistic, musical, logical-mathematical, spatial, bodily-kinesthetic, and personal. Personal intelligence consists of two intimately interrelated information-processing capacities involving perception of self and others: intrapersonal intelligence, or "access to one's own feeling life"; and interpersonal, or "the ability to notice and make distinctions among other individuals and, in particular, among their moods, temperaments, motivations, and intentions" (Gardner, 1983, p. 239). Accurate labeling of the latter includes empathy, the ability of a person to "place oneself into the skin of specific other individuals" (1983, p. 250). This sophisticated form of intelligence is unique to and has been central in the evolution of primates, and its expression is markedly vulnerable to cultural and caretaker influences (Byrne, 1991; Cheney and Seyfarth, 1990; Gardner, 1983; Lieberman, 1991; Small, 1990). Gardner provides an argument that, as with other forms of intelligence, personal intelligence has a range of individual variation, including exceptional individuals.

Our scale is based on the proposal that borderline patients are such exceptional individuals. Because of additional assumptions that borderlines are largely blocked from access to this talent due to caretaker assault, but that they retain a strong innate need for such access, we included preoccupation with, as well as access to, feelings and perceptions. The preoccupation must reflect efforts to understand or resolve feelings and perceptions about self and others, rather than simply reflect a burden of symptomatic distress or strong affects.

We estimated the degree of personal intelligence or giftedness by rating patients as clearly showing the following:

1. Intense preoccupation with and/or talented access to their feelings.
2. Intense preoccupation with and/or sense of the feelings of others.
3. At least 3 perceptive intuitions or insights about others expressed during therapy.
4. (a) Capability of empathic concern for important others is clearly evident at times; and (b) grandiosity, devaluation, and envy are not pervasive.

Item 4 is added based on the commonsense assumption that perceptual giftedness generally would not be associated with absence of a capacity for genuine concern or caring for others, or with pervasive grandiosity/devaluation. Further, Perry and Cooper (1986) found that omnipotence and devaluation are characteristically narcissistic but not borderline defenses. Grandiosity, devaluation and envy were judged to be pervasive if they were detected frequently and in many contexts, and were highly resistant to change or insight.

A score of 1 to 4 was given to each patient according to how many of these criteria were met, and we arbitrarily assigned patients with scores of 3 or 4 as gifted.

We examined histories for evidence of caretaker abuse, and for patterns of parental behaviors and attitudes. This information was obtained from review of records and from direct questioning of patients, who were informed this was for research as well as for treatment purposes.

Caretaker abuse was categorized as chronic physical, sexual, and chronic, pervasive verbal/psychological. We realize that physical and sexual abuse are also forms of psychological abuse (Byers, 1987; Wolfe, 1991), but for the purposes of this study they are classified separately. Again, there is no satisfactory standardized rating scale for varieties of psychological abuse, and we devised a simple one for this study based on our clinical experience and review of the literature (Bowlby, 1984, 1988; Cicchetti & Carlson, 1989; Kohut, 1971; Miller, 1981; Shapiro, 1978; Soloff and Millward, 1983). We subcategorized chronic verbal/psychological abusive behaviors as: neglect; constant devaluation; intrusion/invasion; attack on autonomy; and attack on, depreciation of, or total nonrecognition of the child's special access to intuitive insights. We required clear reports involving incidents or behaviors that occurred on a repetitive basis. Because psychological abuse cannot be measured clearly, we did not make a rating unless we felt it should be obvious to anyone, and did not classify a patient as psychologically abused unless 2 categories were checked.

In order to investigate in more detail our findings about psychological abuse, we further categorized patients' perceptions of parental behaviors and attitudes as: psychologically dominating, controlling, warm, empathic, and hostile.

RESULTS

Seventeen of the 23 BPD patients (74%) met the definition for giftedness, meeting at least 3 personal intelligence criteria, with 11 (48%) meeting all 4 criteria. A significantly smaller proportion of the controls (34%: 13/38) met at least 3 criteria, with 6 (16%) meeting all 4 criteria ($\chi^2 = 7.52$, $df = 1$, $p < .01$). The second criterion, intense preoccupation with and/or sense of the feelings of others, was the most discriminating (96% borderlines vs. 45% controls), and the fourth, presumably an indicator of narcissistic tendencies, was the least (65% vs. 66%). (Only 2 borderlines and 4 controls met 4 or more DSM-III-R criteria for NPD.)

We reviewed these scores for gender differences and found that male borderlines received significantly higher scores than female borderlines (3.80 vs. 3.06: $t = 1.82$, $df = 21$, $p < .05$). Because there were only 5 males, this unexpected finding is suspect. However, it is in line with our clinical experience that all the male borderlines could be exquisitely sensitive to subtle cues from others, although this was not evident on casual acquaintance because they all tended to respond with male stereotypical concealment of personal feelings and/or with "antisocial" impulsive, threatening, angry, destructive, or self-destructive behaviors. For the controls, the average score was 2.00 for males and 2.13 for females ($t = .33$, $df = 36$, NS).

Examination of caretaker abuse histories for the borderline patients revealed 26% (6/23) chronic physical and 13% (3/23) sexual. Thirty percent (7/23) had sexual abuse histories if noncaretakers were included. Fewer control patients were physically or sexually abused but this was not statistically significant.

Chronic, pervasive verbal/psychological abuse had occurred in 100% of the BPD sample. Psychological abuse subcategory findings were : 30% (7/23) chronic neglect; 70% (16/23) constant devaluation; 83% (19/23) intrusion/invasion; 74% (17/23) chronic attack on autonomy; and 74% (17/23) chronic attack on, depreciation of, or total nonrecognition of the child's special access to feelings and intuitive insights. At least 2 forms of verbal/psychological abuse had occurred chronically in the lives of *all* 23 BPD patients, with 3 or more occurring in 17 cases. In comparison, 32% (12/38) of the control patients met the criteria for psychological abuse, a significant difference ($\chi^2 = 24.70$, $df = 1$, $p < .001$).

Table 1 compares BPD and control patients. There are substantial numbers of gifted and abused patients in both groups. However, 74% (17/23) of the BPD patients were rated as both gifted and psychologically abused in contrast to only 13% (5/38) of the controls ($\chi^2 = 20.38$, $df = 1$, $p < .001$).

Review of the borderline patients' perceptions about parental dominance and capacity for warmth revealed that in 91% (21/23) of the cases there was a dominant parent (see Table 1), who was also the primary psychological abuser, and a parent who played only a secondary role in the abusive pattern. The parent perceived as dominant was not always the one who might look and sound in charge but was the one whose psychological power over the patient was greatest (Byers, 1987). This sometimes became clear only later in treatment. In 18 of the 23 BPD cases (78%), the mothers were experienced by the patients (14 females, 4 males) as very dominating and controlling, and either quite limited or lacking in expression of warmth. In 3 cases (13%) the fathers were seen as very dominant and controlling,

Table 1. Giftedness and Histories of Abuse for BPD vs. Controls

Dependent variable	Personality disorder		χ^2	<i>p</i>
	BPD (<i>n</i> = 23)	CONTROLS (<i>n</i> = 38)		
Gifted + psychological abuse	17 (74%)	5 (13%)	20.38	<.001
Gifted	17 (74%)	13 (34%)	7.52	<.01
Psychological abuse	23 (100%)	12 (32%)	24.70	<.001
Sexual abuse	7 (30%)	3 (8%)	3.79	<.10, NS
Physical abuse	6 (26%)	4 (11%)	1.52	<.30, NS
Posthoc comparisons				
D/U parent ^a	21 (91%)	14 (37%)	15.22	<.001
Gifted + D/U parent	15 (65%)	7 (18%)	11.65	<.001
Gifted + psychological abuse + D/U parent	15 (65%)	5 (13%)	15.34	<.001

^aD/U parent = dominant, unempathic parent.

usurping the parenting role and overattached to their children (in all 3 cases, daughters) in ways that had sexual overtones. In 1 case the parents as a rigid unit were very dominating to the patient; and in 1 case a judgment about dominance could not be made.

Patients frequently described the 21 dominant parents in ways that fit DSM-III-R criteria for narcissistic personality disorder (NPD). For instance, they *invariably* were described, particularly later in treatment, as very limited in empathy and as having a controlling sense of entitlement, the latter often expressed as parental wisdom. At least seven (33%) were frequently or chronically profoundly hostile to the child, and in all but one of the other cases (62%:13/21), the patients felt they avoided rage and abandonment only through skillful submission, sometimes with subtle or disguised manipulation of vulnerabilities of the parent.

The nondominant parents (21/23), usually fathers (18/23), were generally experienced as not intrusive and as somewhat warmer as a group, but in all cases not able, unavailable, too dependent, and/or too symptomatic to influence their abusing partners. In a number of cases (6/23) psychologically dominant mothers facilitated the perception that the fathers were dominant because of the male role and/or intimidating temper and/or physically abusive behaviors, a perception that tended to conceal or blur the mother's primary psychic power until after childhood. One of the dominant fathers functioned analogously, blaming the mother's dramatic emotionality. The finding of 30% neglect took into account only the dominant caretakers, but if the partner's behavior is also considered, there was a pervasive atmosphere of emotional neglect playing a background accompaniment to the active abuse. The most frequent family pattern, occurring in 61% (14/23) of the cases, consisted of a dominant, unempathic mother, an emotionally neglectful father, and a borderline daughter.

In summary, for our group of borderline patients, there was major biparental psychological failure, by combined commission and omission, throughout childhood and adolescence. In addition to the categories of psychological abuse already described, there was in every case a chronic family atmosphere of morbid, disturbing dramas between parents, and/or between one or both parents and the child, usually involving strong negative affects. One of the few softening notes was that the dominant parents generally had grandiose ideas of competence, with malevolence demonstrated in tactics of control rather than in long-term designs of deliberate harm. The children frequently had strong feelings of love and concern (also rage, hate, fear, and so forth) for one or the other, sometimes both, parents, and at times were burdened by a painful wish to take care of and protect these parents. In addition, in a number of cases the dominant parents were appreciated for their intense attention to education and social development, although this was experienced later as for the parent rather than for the child.

Review of family constellations in the control group revealed that significantly fewer patients (37%: 14/38) had dominant, controlling, unempathic parents, all mothers, who were also reported to be quite lacking or limited in expression of warmth ($\chi^2 = 15.22$, $df = 1$, $p < .001$). Only 1 of these parents was profoundly hostile to the child, with just 8 other control patients reporting that they avoided rage and abandonment through skillful submis-

sion. There was not a general background atmosphere of neglect, disturbing family dramas, and negative affects, with only 6 spouses of dominant parents experienced as markedly unavailable.

Links and Blum (1990) recently speculated that intrusive overinvolvement associated with criticism, abuse, and a highly malevolent parental attitude may be particularly characteristic of the borderline's childhood caretaker environment. With regard to this scenario, 78% (18/23) of the borderline patients and 29% (11/38) of the controls experienced chronic intrusion/invasion along with constant devaluation and/or chronic attack on autonomy, ($\chi^2 = 13.65$, $df = 1$, $p < .001$). In line with this, Reiser (1986) distinguishes intuitively gifted, depressed, but not borderline individuals who apparently experienced intrusive overinvolvement without conspicuous threat or hostility from caretakers (Miller, 1981), from borderline individuals who were subjected to severe hostility.

There are a number of weaknesses in this study that are often present in long-term clinical research, including small sample size, limited testing instruments, and lack of blind evaluation (Frances, 1990). Data are derived retrospectively from subjective reports and are potentially biased by both observers and patients. On the other hand, some of the results are very strong statistically. Also, self-reports of childhood trauma and abuse have been quite similar throughout a number of studies (Briere & Zaidi, 1989; Herman & Schatzow, 1987; Jacobson, 1989).

DISCUSSION

For clinicians who treat borderline patients, the most striking personality feature is the "flavor" of their involvement in the treatment relationship, particularly their ability both to access and then to strongly influence our private emotions, engendering the classical "countertransference problems/'special' treatment relationships" that Zanarini et al. (1990) found to be one of seven "more specific or even pathognomonic features" (p. 166) of BPD. We have presented evidence compatible with the hypothesis that this unusual ability to access private emotions reflects a healthy innate intuitive talent or gift, and that the highly developed skill to influence detected emotional vulnerabilities reflects a learned capability that could develop only through years (Millon, 1987) of constant, often subtle (to an observer), interactions with caretakers who relate to the child in a severely controlling, threatening fashion, and in a biparental situation that isolates the child from significant empathic support or validation (Gunderson & Zanarini, 1989; Kohut, 1971; Links & Blum, 1990).

We propose that this explanation for the interpersonal characteristics of BPD can also provide an understanding of other clinical manifestations of the syndrome. The interactive combination of giftedness and psychological abuse in the genesis of borderline symptomatology is elucidated by attachment theory, which proposes that when there are incompetent, abusive caretakers, the child blames himself or herself and absolves the caretaker in order to maintain a "secure base" (Bowlby, 1988; Crittenden & Ainsworth, 1989; van der Kolk, 1987), that is, in order to maintain the perception that the caretaker is at least "good enough" (Winnicott, 1960) for basic psycho-

logical survival. This scenario would be especially significant and complex if the child were intuitively brilliant, and the interaction would be particularly destructive if the parent rejected and assaulted the child for its very perceptions, because the child must then experience himself or herself as profoundly bad for having core mental processes that cannot be stifled. After a childhood of such pervasive requirement to experience black as white and vice versa (Gantt, 1944; Shengold, 1989), the only behavioral clue to giftedness in the adult is a defensive pattern suggesting a very complex yet provocative confusion about self and others. This formulation accounts for the paradoxical combination in the borderline patient of cognitive and affective disarray, enormous distress, and helplessness, coexisting with surprisingly persuasive interpersonal powers (Gutheil, 1989). It also accounts for the observation that intuitive borderlines paradoxically can frequently be perceptively dense, since healthy perceptiveness can be overwhelmed by biases and introjections resulting from parental intrusive intents and behaviors.

The concept of a crucial interaction between social perceptivity and the quality of child-rearing receives support from recent primate and pediatric research. Suomi (1991) found that rhesus monkeys selectively bred to be "high reactive" (i.e., very fearful and anxious in new or challenging situations) and who are highly aware of their environment from birth (i.e., possibly gifted) (Suomi, personal communication, 1991) tend to maintain this anxious pattern to reach a relatively marginal adult adjustment. However, when raised by unusually nurturing foster mothers, such monkeys become the most socially skilled and dominant members of their peer groups. Boyce, Chesney, Kaiser, Alkon-Leonard, and Tschann (1991) report findings suggesting that there is a subset of children with a "heightened sensitivity to the social world" (gifted?) whose developmental and emotional outcomes, ranging from unusually successful to unusually poor, are critically dependent upon the character of early child-rearing conditions (Boyce, personal communication, 1991). It appears that an apparent biogenetic vulnerability may actually reflect an advanced social potential that requires special nurturing (i.e., an appropriate parental "fit") for the proper development of this potential (Brazelton & Cramer, 1990; Thomas & Chess, 1984). It can be extremely important to distinguish a talent requiring such special care from a defect. For instance, we do not say the human infant is defective because it requires very attentive and sensitive care for many more years than any other creature. These issues may be relevant not only to BPD but also to other psychiatric disorders, particularly those involving affects.

There are two published controlled studies that support our findings of intuitive capacities in borderline patients. In the first, Ladisich and Fell (1988) evaluated empathy in 20 borderline, 20 neurotic, and 19 patients with a history of schizophrenia, all in inpatient group therapy. Patients and group therapists evaluated themselves and other group members using personality trait and social attitude tests, with empathy assessed by calculating how accurately a person could rate other persons' ratings of themselves. The borderline patients scored significantly better than both the neurotic and schizophrenic groups and, in fact, were as good as the therapists, who presumably had more knowledge of the patients. The authors suggested that high empathy (i.e., personal intelligence) in borderline patients might reflect a vulnerability for psychosis.

In the second study, Frank and Hoffman (1986) compared two groups of patients, borderline and neurotic, employing the Brief Exposure Profile of Nonverbal Sensitivity. They demonstrated significantly higher nonverbal sensitivity in the borderline group, which they felt provided empirical confirmation of a "borderline" or symptomatic type of empathy in BPD that developed as a way of contending with maternal emotional neglect. They also found (Hoffman & Frank, 1987) correlations consistent with the hypothesis that a constitutional vulnerability contributes to the nonverbal sensitivity. However, the scientific literature supports the concept that the capacity for empathy is a healthy inborn trait (Brothers, 1989; Neubauer & Neubauer, 1990) rather than an inborn weakness or vulnerability, a susceptibility for psychosis, or a manifestation of childhood stress per se (Cicchetti & Carlson, 1989).

Because there has been no prior consideration of giftedness as having major relevance for etiology and clinical manifestations of BPD, there are no published estimates of its prevalence. The Zanarini et al. (1990) report that 63% of 120 borderline patients engendered countertransference problems and special treatment relationships, and our finding of 74% gifted individuals, suggest the possibility that as many as two thirds to three fourths of borderline individuals have unusually high levels of personal intelligence. In line with this, Bond (1990) reported a pilot study in which two thirds of a small borderline group scored significantly higher for defense mechanisms that included projective identification than a control group of other personality disorders.

Our findings about patterns of parenting behaviors are in line with a preliminary report from Zanarini and Gunderson (1987), who found evidence for chronic verbal abuse by female caretakers, along with inconsistency and physical neglect by male caretakers. Similarly, Soloff and Millward (1983), in a controlled study of 45 BPD inpatients, found a significant pattern of intrusive, controlling, overinvolved mothers, along with underinvolved or absent fathers and a conflictual marital relationship.

It appears that different patterns of caretaker abuse tend to be etiological for differing clinical syndromes, with terrorizing and dramatic abuse, particularly sexual and physical, predominant in the history of multiple personality disorder (Putnam, 1989), and severe psychological abuse that pervasively and insidiously affects routine workings of the mind predominant in the history of BPD. The finding of 100% psychological abuse suggests that this is a necessary etiological factor for BPD, and that giftedness is frequently present but not essential. Although an emotionally gifted child would be uniquely vulnerable to, and characteristically responsive to, such caretaker behaviors and attitudes, severely abusive and chaotic family environments could be expected to elicit significant borderline characteristics in almost anyone, with and without clinical manifestations of intuitive talents. The literature also suggests that borderline characteristics can be engendered by reasonably well-meaning, even generally empathic, parents who have very strongly held but very faulty and severe child-raising concepts, or who respond very negatively or inappropriately to certain highly stressful phenomena such as difficult temperaments, significantly defective impulse, attention or affect regulation, severe learning disabilities, and marked hyperactivity (Feldman & Guttman, 1984; Gunderson & Zanarini,

1989; Kernberg, 1975; Linehan, 1989; Miller, 1983). In all these scenarios, the essential factor in the development of borderline symptomatology is severely defective caretaker empathy for, and response to, the child's psychological state, that is, broadly speaking, psychological abuse. Biogenetic factors such as a child's physical appearance and behaviors would not be a major antecedent for BPD per se, as the development of such psychopathology would not be expected with appropriate parenting (Brazelton & Cramer, 1990; Miller, 1981; Werner, 1989).

NARCISSISTIC CHARACTERISTICS IN PARENTS

Of special interest to us was the high occurrence of a dominating, unempathic parent who exhibited impressive narcissistic characteristics and who appeared to have low or defective (Gardner, 1983; Gould, 1991; Mountcastle, 1975) innate personal intelligence, an exceptionally poor fit (Thomas & Chess, 1984) for an emotionally gifted child. The very nature of pathological narcissism (Kernberg, 1975; Kohut, 1971) includes primitive defenses that would be very disturbing such as splitting with alternating mental states, exploitativeness and intimidating rage in response to envied qualities and autonomous strivings of significant others. Possibly contributing to the relative scarcity of speculation about parental narcissism in the genesis of BPD is the skewing of criteria for NPD toward identifying relatively overt exploitative behaviors seen in stereotypical male roles rather than in subtle, disguised, or concealed behaviors (Gunderson, Ronningstam, & Bodkin, 1990) common in parenting.

The domain of NPD as it relates to BPD requires a great deal of study, considering that there may be very different forms and expressions of narcissism, such as states versus traits, and including individuals with varying potentials to experience empathy and caring. Widiger and Frances (1988) point out that psychodiagnostic research has not demonstrated a substantial overlap of these two disorders. We are investigating the possibility that individuals who develop these conditions tend to be at extremes of personal intelligence, with psychopathology often reflecting complex interactions of caretakers at one extreme with offspring at the other.

THERAPEUTIC APPROACHES

Validation of the etiology we have proposed may lead to new therapeutic strategies for BPD that will have significant consequence both for rate of improvement and for decrease in the high suicide rate early in treatment when hope is most often abandoned (Frances, 1990). We believe that the current average of 15 or more years before recovery (Gunderson & Zanarini, 1989) may well reflect, in part, negative or devaluative formulations about these individuals, their histories, and prognosis.

We are currently investigating the effect of validating, when appropriate, six major characteristics of borderline patients that are either positive or encouragingly explanatory: exceptional personal intelligence; history of severe psychological abuse/neglect with concomitant enormous suffering; compulsive self-blame and self-devaluation as attachment characteristics;

"staying power"; "real self versus introjected narcissistic characteristics of abusers; and the absolute right to experience their innate capacity for freely enjoying their feelings, their perceptions, and thoughts. We are also informing patients of recent hard data that the natural, long-term course for most borderline individuals is improvement to essentially normal functioning, which means we are able to communicate optimism that is sincere, is confidently based on knowledge, and carries no false bravado that an intuitive patient might detect (Frances. 1990; Perry, Herman, van der Kolk. & Hoke. 1990; Stone, 1990a).

By validating personal intelligence or giftedness as an innate characteristic, we can provide a therapeutic "mirroring" or "holding environment" (Kohut. 1971; Lear. 1990; Warnes, 1981) in which the borderline individual experiences an unconditionally and inherently good quality. Krohn (1974) grasped the importance of recognizing and validating occasional penetrating perceptions by borderline patients, but he did not remark on the possibility of an underlying talent. Similarly, Frank and Hoffman (1986) recommended giving more credence to perceptions of borderline patients and helping them learn to modulate an abnormal sensitivity to nonverbal cues. Carter and Rinsley (1977) commented on the value of recognizing that the borderline patient's intuitive perceptions can be accurate but did not consider the therapeutic benefit of verbalizing this to the patient.

Validation of chronic physical, sexual, and psychological caretaker abuse is essential for the gradual dissolution of profound shame, self-blame, self-hate, and self-loathing (Miller, 1983; Perry et al., 1990). We find that it is absolutely necessary for Intuitive patients to understand relevant moment-to-moment behaviors, intents, and even dynamics of their parents and others. "Staying power" refers to the relentless urgency and effort to survive destructive childhoods and endless suffering, and to be complete persons.

CONCLUSIONS

The etiology of BPD remains one of the significant challenges for psychiatry. more so now that it has been established as a clearly defined syndrome not specifically related to schizophrenia or to depression. We have presented evidence that an understanding of BPD may be found by investigating the Interaction of a child's healthy intuitive talents and developmental requirements with severe psychological abuse from caretakers. The concept of giftedness in borderline individuals may have important implications for an Improved psychotherapeutic environment, which in turn may significantly alter the prognosis, suicide rate, and length of treatment for patients who are generally viewed in a rather negative conceptual framework.

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