Family Relationships of Adults With Borderline Personality Disorder

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Current, ongoing interactions between adults exhibiting borderline personality disorder (BPD) traits and their families of origin may influence and maintain self-destructive behavior. Family interactions in such patients are often characterized by coexisting extremes of overinvolvement and underinvolvement by parental figures. Such parental behavior may trigger preexisting role relationship schemata in vulnerable individuals. Negative family reactions to new behavior patterns may make change difficult. A model for how present-day interpersonal patterns lead to self-destructive behavior, based on clinical observations, is proposed and case examples are presented.

MOST CONCEPTIONS of borderline personality disorder (BPD) acknowledge the effects of experiences within the patient's family of origin on the genesis of certain borderline signs and symptoms. Many biogenetic hypotheses presuppose an interaction between a vulnerable CNS and environmental traumata.[1,2] BPD has been compared with posttraumatic stress disorder resulting from physical or sexual abuse within the family[3]; such abuse is reported to be present in the past history of a significant proportion of patients with BPD.[4-6] Linehan[7] postulates that one of the major causative factors of BPD is an "invalidating environment," defined as one in which communication of private experiences is met by erratic, inappropriate, or extreme responses. That environment is usually the family.

Most clinical and theoretical literature about family-of-origin interactions of adult patients with BPD focuses on interactions that occurred in their past, particularly during early childhood and adolescence. In this report, we examine the idea that these interactions and their importance in the pathogenesis of BPD do not cease after a child grows up or leaves home, but continue well into the patient's adult life. To provide a framework that may be useful for understanding and treating self-destructive behavior in individuals with BPD, we propose a model by which ongoing, present-day interactional patterns among such individuals and members of their family of origin may influence and help maintain such behavior. A review of pertinent literature regarding the family environment of patients with BPD is presented, and case examples are described.

VIEWS OF EARLY FAMILY EXPERIENCES OF BPD PATIENTS

One prevalent theoretical view regarding the genesis of BPD behavior is that the family environment has a toxic effect on the development of the young child and leads to a developmental arrest.[8] Several investigators have suggested that although experiences at each developmental stage are important in personality formation, longer-term continuous experiences are also key to developing an understanding of adult psychopathology.[1,9] According to this view, dysfunctional family patterns expose vulnerable children to chronic rather than episodic stress and abuse and result in the continuous development of problematic behavior patterns. These patterns are then acted out in later life. Zanarini and Frankenburg[10] hypothesized that borderline pathology develops "in response to serious, chronic maladaptive behaviors on the part of immature and emotionally incompetent, but not necessarily deliberately malevolent, caregivers" (p. 26). Millon[11] observed that "the significance of early troubled relationships may inhere less in their singularity or the depth of their impact than in the fact that they are precursors of what is likely to become a recurrent pattern of subsequent parental encounters" (p. 360), and that "Early learnings fail to change, therefore, not because they have jelled

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permanently but because the same slender band of experiences which helped form them initially continue and persist as influences for years" (p. 361).

Links and Monroe-Blum[9] reviewed 10 studies on childhood environments of patients with BPD.[4,6,12-19] Although these data on early childhood are for the most part retrospective, with the resulting study limitations, several themes do recur. These seemingly dissimilar themes include a family history of neglect, abuse, loss, overprotection, overinvolvement, and biparental failure. (Biparental failure is defined as a significant impairment in both parents that leads to a failure to perform parental functions.) A unifying concept of these themes is that they reflect either the parents' overinvolvement or underinvolvement with their child. Incest, for example, may be thought of as extreme, inappropriate overinvolvement of, say, a father with his daughter.

The idea that a combination of both parental overinvolvement and underinvolvement might be present in these families, rather than just one or the other, was first suggested by Walsh.[20] Melges and Swartz[21] postulate that oscillations in attachment behavior in patients with BPD stem from patients' fears that they will be abandoned if they grow up and become independent of their families but dominated if they remain close. These investigators believe such patterns stem from ambivalent reactions of significant others. A prospective study of family interactions and the emergence of BPD[22] finds that neither maternal overinvolvement nor maternal inconsistency alone predict emergence of the disorder, but coexistence of the two factors together does.

The paradigm of Melges and Schwartz[21] described earlier receives empirical support from Shapiro[23-25] and Shapiro and Freedman.[26] Studying the families of adolescents diagnosed with BPD, they found that in families of patients with BPD both parents experience major conflicts regarding issues of autonomy that prevent them from responding to their adolescent's growing autonomy in appropriate ways. The parents angrily experience their child as clinging and demanding, resulting in defensive withdrawal. Even while neglecting the developing needs of the adolescent, the parents continue to focus much of their attention on the child.

Similar patterns have been observed in the case material described by interpersonal theorists and researchers. Benjamin[27] described an interpersonal theory of borderline behavior patterns. She views the behavior of the BPD patient as a response to other people, primarily within the patient's family of origin and spousal relationships. She observes that family backgrounds of individuals with borderline traits show four major characteristics: (1) family chaos in which the individual with BPD is subtly blamed for family problems and is expected to exert control over family misbehavior, (2) episodes of traumatic abandonment (such as being locked in a closet) interspersed with periods of traumatic overinvolvement (such as an incestual assault), (3) efforts by the individual with BPD to establish autonomy that are interpreted by the family as disloyal, and (4) parental love and concern that are elicited only when the patient presents with misery, sickness, and debilitation.

PRESENT-DAY FAMILY INTERACTIONS OF ADULTS WITH BPD

Concurrent studies of characteristics and ongoing interactions of the families of origin of adult patients with BPD have not been performed. In family systems–oriented individual psychotherapy[28,29] with adult patients diagnosed with BPD, I (D.M.A.) have observed frequent instances in which the pattern of extreme, hostile overinvolvement and underinvolvement with the family of origin seems to continue well into the patient's adulthood. This will be illustrated by case studies presented later. Furthermore, although neglect or overinvolvement may be the vastly predominant pattern in these families, eventually the other polarity manifests itself. One patient in her forties, for example, at first told me she had cut off all communication with her mother. However, it came out later in therapy that the patient was receiving monthly phone calls from her mother in the middle of the night. During these calls, the mother would at first castigate the daughter for being gay and then go into tears and say how much she loved her.

Consistent with Benjamin's[27] observation, even when these patients seem to be completely