

## **Adult Offspring of Borderline Mothers (Excerpt)**

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The effects of maternal Borderline Personality Disorder (BPD) on her offspring has received little attention in the literature (Stepp, Whalen, Pilkonis, Hipwell & Levine, 2012). In particular, the adult offspring of such mothers have been rarely considered (Glickauf-Hughes & Mehlman, 1998; Trout, 1991). Researchers generally agree that the offspring of borderline mothers are at significant risk for developing myriad symptoms of psychopathology, (Weiss et al., 1996; Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1988; Herr, Hammen, & Brennan, 2008). The limited extant research on adults (Glickauf-Hughe & Mehlman; Trout) suggests that these individuals may present with variations of anxiety, depression, and personality deficits. However, the nature and quality of these symptoms, and the way in which the sub-syndromal adult progeny of borderline mothers function in the world is not well known.

There is great uncertainty in the literature regarding the transmission of pathology from mothers with Borderline Personality Disorder (BPD) to their offspring (Stepp, et al., 2012; Fruzzetti, 2012). Parenting behaviors that are exclusively related to BPD, have been difficult to assess due to the wide range of ages included in studies, inadequate assessment tools, and comorbidity (Lyons-Ruth, 2012). However, it is known that the prevalence of BPD in first-degree relatives of individuals with BPD is four to twenty times greater than in the general population (Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1988).

## **Behaviors of Borderline Mothers**

Based on a review of the literature, Stepp, et al (2012a) suggest that the mothers with BPD tend to invalidate the emotions of their children, particularly when they are not able to perceive them accurately. As a result, these children come to deny or misread their own emotions, which disrupts their emotional processing system. This phenomenon of emotional invalidation begins in infancy.

A recent study (2011) of borderline mothers and their infants found that clinically relevant levels of maternal Borderline Personality (BP) pathology correlated with a lower likelihood of positive affect in response to infant distress compared to low levels of maternal BP pathology (Kiel, Gratz, Moore, Lutzman, & Tull). Using the Strange Situation (Ainsworth, Blehar, Waters, & Wall, 1978, as cited in, Kiel et al.), mothers ( $n = 99$ ) categorized as high in BP ( $n = 22$ ) and low in BP ( $n = 77$ ) according to the Borderline Evaluation of Severity over Time (BEST; Pfohl et al., 2009, as cited in Kiel et al.) were rated in their interactions with their infants upon reunion. Mothers with high BP were more likely to respond to infant distress with negative affect. In addition, although they were not more likely to exhibit insensitive behavior in response to initial infant distress, they were more likely than their low BP counterparts to respond with negative affect to their infant's continuing distress. These concomitant reactions created a significant dynamic between high BP mothers and their infants: The mothers' initial negative affect in response to infant increased the infants' distress level, which in turn ignited the mothers' insensitive response:

Thus, findings suggest a transactional pattern whereby the relative absence of initial positive affect on the part of mothers with BP pathology may result in longer durations of distress in their infants, which, in turn, increases their risk for insensitive behaviors,

which lead to an increase in infant distress, which then further increases the likelihood of insensitive behaviors, and so on. (p. 917)

Infants of borderline mothers have also been shown to be less engaged with their mothers and less able to recover from negative affect (Crandell, Patrick, & Hobson, 2003). Eighty percent of these infants exhibited behavioral patterns indicative of a disorganized attachment (Hobson, Patrick, Crandell, Garcia-Perez, & Lee, 2003).

Based on their review of the research, Stepp et al. (2012a) suggest that mothers with BPD exhibit a unique pattern of rapid oscillation between over- and under-involvement with their children. Such oscillations may manifest as shifts between intrusive and avoidant or withdrawn behaviors, or between hostile control and cold, neglectful, punishment. However, they acknowledge that more research is required to determine the specific nature of these behaviors, and the mechanism of transmission (Stepp et al., 2012b)

Schore (2003a, b) seems to, in part, address an aspect of this dynamic. He posits that between 14 and 16 months of age when infants become mobile, the mother's role evolves from simply giving affection, playing and caregiving, to socialization and the curbing of unwanted behaviors. The primary mechanism by which she controls the toddler's behavior is through inducing shame by way of facial expressions that indicate disgust.

At this stage, the child is highly excited and elated by a burgeoning capacity to explore the environment (Schore, 2003a). Thus, as he or she traverses the area surrounding the mother, the child carries "an excited expectation of a psychobiologically attuned shared positive affect state with the mother and a dyadic amplification of the positive affects of excitement and joy" (2003a, p. 17). However, when the child instead encounters a facial expression of disgust, it

is experienced as a “shock-induced deflation of positive affect” (p. 17). This unexpected affective plunge constitutes the experience of shame.

In Schore’s (2003a) words, shame is the “reaction to an important other’s unexpected refusal to enter into a dyadic system that can recreate an attachment bond” (p. 18). Although this maternal reaction is often spontaneous and non-conscious, it is significant because the toddler’s affect is physiologically regulated by the mother’s facial expression. The toddler is not yet able to autoregulate himself or herself out of this intensely distressful state. Hence, there is no relief without the mother’s reattunement (2003b, p. 19).

As Schore (2003a) explains, “prolonged states of shame are too toxic for older infants to sustain for very long, and although infants possess some capacity to modulate low-intensity negative affect states, these states continue to escalate in intensity and duration” (p. 19). Therefore, it is incumbent on the mother to recognize the nonverbal signals of shame (facial expression, blushing, collapsed posture, averted gaze) and to reengage and re-regulate the toddler, primarily through synchronized eye-contact and facial expression.

In the event the mother does not timely repair these misattunements, the child learns to expect these insufferable states to endure, and is forced to adapt by over-engaging the parasympathetic nervous system (Schore, 2003a). This process stimulates excessive stress hormone secretion, which induces over-pruning of the neurons connecting the amygdala to the orbitofrontal cortex. As a result, initial autonomic fear reactions generated in the amygdala become inhibited from integrating with the higher, more conscious, processes in the orbitofrontal cortex that are central to the regulation of emotion (Schore, 2003a).

According to Schore (2003a), individuals with these structural impairments typically suffer from a disorganized/disoriented attachment pattern, since they exhibit “fragile regulatory capacities, [that] even under moderate stress, . . . [are] vulnerable to disorganization and to affect shifts that are extremely discontinuous and labile” (p. 119). To the extent the borderline mother oscillates toward hostility and neglect during occasions that require her dyadic re-attunement, her child experiences intolerable levels of shame and emotional dysregulation (Schore, 2003a).

### **Research on Offspring of Borderline Mothers**

Not all, or even most, of the offspring of borderline mothers contract borderline personality disorder, although they are up to five times more likely to contract the disorder than the general public (DSM-IV-TR, American Psychiatric Association, 1994). However, studies of these probands generally apply the categorical approach to BPD, applying threshold scores on various measures to determine its presence or absence (e.g. Kiel, Gratz, Moore, Lutzman, & Tull, 2011; Trull, 1995) rather than a dimensional approach, which looks at the aggregation of symptoms (Silverman et al., 1991). Consequently, subclinical individuals are typically excluded from studies (Trull, 1995).

Research has not determined which features of BPD are transmitted to offspring (Stepp, et al, 2012). The uncertainty may be attributable to the myriad phenotypes of the disorder itself (DSM-IV-TR, American Psychiatric Association, 1994; Fruzzetti, 2012). As Fruzzetti (2012) explains, there is little consistency among borderline presentations: some people with BPD are extremely angry, while others are not; some experience other emotions, such as intense shame.

Some, but not all, BP sufferers commit impulsive, self-destructive acts, such as self-injury and suicide attempts.

Macfee and Swan (2009) describe the disagreement in the literature regarding the essence of BPD:

First, BPD has been characterized as a disorder of attachment (Fonagy, Target, & Gergely, 2000; Gunderson, 1996; Liotti & Pasquini, 2000), with symptoms including fear of abandonment, volatile relationships, and inappropriate angry outbursts. Second, BPD has been characterized as a disorder of self-development (Westen & Cohen, 1993), with symptoms including an unstable sense of identity, feelings of emptiness, and brief paranoid or dissociative states. Third, BPD has been characterized as a disorder of emotion regulation (Posner et al., 2003), with symptoms including self-damaging impulsivity, suicidal behaviors and/or self-injury, emotional reactivity, and inappropriate displays of anger. (p. 1005)

With so little agreement as to the nature of BPD, it is naturally difficult to unravel the nature of its heritability.

Heterotypic transmission of features may contribute to the confusion. Certain characteristics, such as affect instability and impulsivity, have been found to be more likely to transmit to offspring independently of other symptoms (Silverman, et al., 1991). Also, symptoms which appear to carry the same meaning may present differently at various stages of development (Macfee & Swan, 2009). For example, a young child who expresses expectations of negative relationships with both mother and father in narrative story-stem completion measures (Scarlett & Wolf, 1979, as cited in MacFee & Swan), may experience anger and lack of trust in later relationships, and develop adult relationships marked by angry outbursts and mistrust (MacFee & Swan). However, as a child, he or she would not have demonstrated such inappropriate expressions of anger.

## Studies of Children of Borderline Mothers

The children of borderline mothers have been repeatedly found to suffer from more psychiatric diagnoses, and lower functioning than children whose mothers have other personality disorders (Weiss et al., 1996). Weiss and colleagues studied adolescent children ( $n = 44$ ) of former psychiatric patients who had participated in a previous study of borderline versus non-borderline women. The children of mothers with BPD exhibited a higher prevalence of childhood BPD, ADHD and disruptive behavior disorders that could not be accounted for by trauma alone. Small sample size and possible comorbidity limited the results of this study.

Adolescent offspring of borderline mothers have been found to suffer from interpersonal and family relationship difficulties as well as fearful attachment (Herr, Hammen, & Brennan, 2008). Specifically, in a community-based sample of mother-child (15 year old) pairs ( $n = 815$ ), higher maternal BPD symptoms independently correlated with the following offspring symptoms:

- (1) impairment in child's self-reported ability to make close friends and attain social acceptance,
- (2) child's self-reported cognitions related to fearful attachment,
- (3) chronic stress in parent-child relationship according to interviewer ratings of mother, and
- (4) child perception of mother's hostility.

These results remained when maternal major depression, dysthymia as well as youth depressive symptoms were controlled for (Herr et al., 2008).

Danti, Adams and Morrison (1985) studied nine children (of five mothers) ages 5 to 17, whose mothers were in a day treatment program for BPD. Through observation and Rorschach data, they found that all of them experienced serious emotional regression. Each had great difficulty getting his or her emotional needs met. In lieu of verbal expression, they relied on mechanisms of denial, aggression, self-harm, role-reversal, fantasy and withdrawal. They often revealed fears of abandonment and engulfment. All of their mothers split each child into all good or all bad, but alternated their appraisals based on circumstance. The children tended to internalize their mother's defensive splitting, by viewing themselves as either all good, when they satisfied her needs, or all bad when either they felt resentful and angry towards her, or failed to meet her, often unreasonable, demands. They also exhibited disorganized affect in response to the Rorschach protocol. The authors expressed concern that many of them were at high risk for personality pathology.

### **Research on Adults**

Glickauf-Hughes and Mehlman (1998) reported their observations of nine adult patients (ages 23 to 51) in long-term psychoanalytic psychotherapy. All of the patients described being neglected or abused since infancy by mothers with borderline characteristics, including defensive splitting, clinging and dependency, unpredictable rage and punishing withdrawal and rejection for failure to meet her emotional needs. However, in spite of being raised in pathological environments, these patients did not develop personality disorders. They suffered from low self-esteem and depressive symptoms. However, they exhibited a secure sense of self, demonstrated empathy, tolerated frustration and achieved a therapeutic alliance. They also infrequently relied on primitive defenses such as splitting and projective identification.



The authors (Glickauf-Hughes & Mehlman, 1998) theorized that several adaptive features contributed to the resilience of these patients. Each of them were eldest children, and the birth of a sibling may have interrupted the mother-child symbiosis, permitting room for separation-individuation. All of them generally maintained a negative identification with their mother, leading them to develop opposite traits and make “reactionary choices” (p. 298) in order to differentiate from her, such as choosing highly professional careers, which had survival value. Negative identification also allowed these patients to fantasize about the type of non-borderline object they wished to have, and to aspire to be that type of person. They also looked to other objects, such as a father or scout leader, who served, at least in part, as an alternative role model. Notably, each patient sublimated anger and frustration through exercise or art.

Despite the sub-syndromal nature of their symptoms, these individuals entered long-term psychoanalysis for relief of several intrapsychic and interpersonal issues, which the authors posit were the direct consequence of their maternal environments (Glickauf-Hughes & Mehlman, 1998). These included anxious attachment patterns. Although they often engaged in relationships with relatively trustworthy individuals, they had great difficulty overcoming the ambient sense that no one is completely trustworthy, and the fear that the significant individuals in their lives (including the therapist) would suddenly stop caring for them.

## References

- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. text revision). Washington, DC: Author.
- Barnow, S., Spitzer, C., Grabe, H. J., Kessler, C., & Freyberger, H. J. (2006). Individual characteristics, familial experience, and psychopathology in children of mothers with borderline personality disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*, 965-972.
- Crandell, L. E., Patrick, M. P. H., & Hobson, R. P. (2003). "Still-face" interactions between mothers with borderline personality disorder and their 2-month-old infants. *British Journal of Psychiatry, 183*, 239-247.
- Danti, J., Adams, C., & Morrison, T. L. (1985). Children of mothers with borderline personality disorder: A multimodal clinical study. *Psychotherapy, 22*(1), 28-35.
- Fruzetti, A. E. (2010). Risk factors affecting children of mothers with Borderline Personality Disorder: Comment on Stepp et al. (2011). *Personality Disorders: Theory, Research and Treatment, 3*(1), 92-94.
- Glickaug-Hughes, C. & Mehlman, E. (1998). Non-borderline patients with mothers who manifest borderline pathology. *British Journal of Psychotherapy, 14*(3), 294-302.
- Herr, N. R., Hammen, C., & Brennan, P. A. (2008). Maternal borderline personality disorder symptoms and adolescent psychological functioning. *Journal of Personality Disorders, 22*(5), 451-465.
- Hobson, P. R., Patrick, M. Crandell, L., Garcia-Perez, R., & Lee, A. (2005). Personal relatedness and attachment in infants of mothers with borderline personality disorder. *Development and Psychopathology, 17*, 329-347.
- Kiel, E. J., Gratz, K. L., Moore, S., Lutzman, R. D., & Tull, M. T. (2001). The impact of borderling personality disorder on mother's responses to infant distress. *Journal of Family Psychology, 25*(6), 907-918. doi:10.1037/a0025474.
- Lyons-Ruth, K. (2010). Methodological challenges in identifying parenting behaviors as potential targets for intervention: Commentary on Stepp et al. (2011). *Personality Disorders: Theory, Research and Treatment, 3*(1), 95-97.
- Macfie, J., & Swan, S. A. (2009). Representations of the caregiver-child relationship and of the self, and emotion regulation in the narratives of young children whose mothers have borderline personality disorder. *Development and Psychopathology, 21*, 993-1011.

- Nickell, A. D., Waudby, C. G., & Trull, T. J. (2002). Attachment, parental bonding and borderline personality disorder features in young adults. *Journal of Personality Disorders, 16*(2), 148-159.
- Schore, A. N. (2003a). *Affect Dysregulation and Disorders of the Self*. New York, NY: W. W. Norton.
- Schore, A. N. (2003b). *Affect Regulation and the Repair of the Self*. New York, NY: W. W. Norton.
- Silverman, J. M., Pinkham, L., Horvath, T. B., Coccaro, E. F., Klar, H., Scheer, S. . . . Siever, L. J. (1991). Affective and impulsive personality disorder traits in the relatives of patients with borderline personality disorder. *American Journal of Psychiatry, 148*, 1378-1385.
- Stepp, S. D., Whalen, D. J., Pilkonis, P. A, Hipwell, A. E, & Levine, M. D. (2012a). Children of mothers with borderline personality disorder: Identifying parenting behaviors as potential targets for intervention. *Personality Disorders: Theory, Research, and Treatment, 3*(1), 76-91.
- Stepp, S. D., Whalen, D. J., Pilkonis, P. A, Hipwell, A. E, & Levine, M. D. (2012b). Parenting behaviors of mothers with Borderline Personality Disorder: A call to action. *Personality Disorders: Theory, Research, and Treatment, 3*(1), 104-106.
- Trout, M. (1991). Perinatal depression in four women reared by borderline mothers. *Journal of Prenatal & Perinatal Psychology & Health, 5*(4), 297-325.
- Trull, T. J. (2001). Relationships of borderline features to parental mental illness, childhood abuse, axis I disorder, and current functioning. *Journal of Personality Disorders, 15*(1), 19-32.
- Webster, L. & Mertova, P. (2007). *Using Narrative Inquiry as a Research Method*. New York, NY: Routledge.
- Weiss, M., Zelkowitz, P., Feldman, R. B., Vogel, J., Heyman, M. & Paris, J. (1996). Psychopathology in offspring of mothers with borderline personality disorder: A pilot study. *Canadian Journal of Psychiatry, 41*, 285-290.
- White, C. N., Gunderson, J. G., Zanarini, M. C., & Hudson, J. I. (2003). Family studies of borderline personality disorder: A review. *Harvard Review of Psychiatry, 11*, 8-19.

Zanarini, M. C., Frankenburg, F. R., Hennen, J. & Silk, K. R. (2003). The longitudinal course of borderline psychopathology: 6-year prospective follow-up of the phenomenology of borderline personality disorder. *American Journal of Psychiatry*, *160*, 274-283.