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TRANSGENERATIONAL TRANSMISSION OF BORDERLINE PERSONALITY TRAITS: A QUALITATIVE ANALYSIS OF PATIENTS' NARRATIVES

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ABSTRACT

Objectives: *This paper explores the transgenerational transmission of borderline personality traits from grandmothers to granddaughters. The study also examines the importance of early life challenges and family environment in shaping women's coping strategies and maintaining borderline personality traits across generations.*

Methodology: *This qualitative descriptive phenomenological study was conducted in Lahore, Pakistan. A sample of 15 borderline women who were the first children in their families were interviewed. A thematic analysis of these 15 semi-structured interviews revealed five main themes and related sub-themes.*

Results: *Findings focus on the role of heredity and family dynamics (such as the availability of family support and the impact of family crises) in the expression of borderline personality traits across generations. A family environment characterized by emotional neglect, inconsistent parenting, abuse, or trauma may perpetuate borderline personality in the family system. The study discusses how childhood adversity and early life challenges contribute to the risk of developing borderline personality disorder. Children, particularly first-born daughters, of mothers with borderline personality may adopt maladaptive coping mechanisms and struggle to form healthy attachments, perpetuating emotional dysregulation and relationship instability in families.*

Conclusion: *The present study will help us gain deeper insights into the transgenerational aspects of borderline personality disorder while examining the role of family environment and early life experiences in maintaining borderline traits across generations.*

Keywords: *borderline personality, family dynamics, transgenerational, BPD, emotional neglect, inconsistent parenting, abuse.*

INTRODUCTION

Borderline personality disorder (BPD) is characterized by sudden changes in mood, impulsive behaviors, and difficulty maintaining stable relationships. Other key features of BPD include distorted self-image, intense emotional reactions to perceived threats or losses, intense fear of abandonment, chronic emptiness, and non-suicidal self-injury (NSSI) to deal with internal conflicts [(1)]. The disorder is clinically diagnosed when at least five of nine specific criteria are met, with suicidal ideation or self-harm being the most indicative symptoms [(2)].

The etiology of borderline personality disorder is unclear. However, a growing body of research indicates that, like other psychiatric disorders, BPD appears as a result of genetic predispositions and environmental stressors. Family dynamics and early childhood experiences are the most prominent factors contributing to BPD traits [(3)]. According to the influential theory, BPD is a disorder of autonomy stemming from early childhood experiences where the primary caregiver is unresponsive or the home environment is invalidating or abusive [(4)]. Adverse childhood events, such as trauma and neglect, are generally more associated with BPD than with other personality disorders (Leichsenring et al., 2011).

BPD is more common in women [(5)]. This paper focuses on the transgenerational transmission of BPD from mothers to daughters. Our study hypothesizes that daughters (especially firstborns) of mothers with borderline personality traits adopt maladaptive coping mechanisms and struggle to form healthy attachments, leading to emotional dysregulation and relationship instability in families. Additionally, conflictual family dynamics and childhood adversities contribute to the development and maintenance of BPD symptoms.

Methodology

Research Design

This qualitative study used a descriptive phenomenological approach to describe the universal essence of the experience as it is lived [(6)]. According to Colaizzi (1978), seven steps guide a descriptive phenomenological study. These steps include familiarization, identifying significant statements, formulating meanings, clustering themes, developing an exhaustive description, producing the fundamental structure, and seeking verification of the fundamental structure [(7)].

Sample

Participants were selected through a purposive sampling technique. Five women (aged 25–35 years) presenting with symptoms of BPD at a tertiary care hospital were sampled. Sampling was done after ensuring that: (a) these women were the firstborn children in their families, (b) these women had mothers who had borderline personality traits and were firstborns in their families, and (c) these women had grandmothers who had borderline personality traits and were also firstborns in their families. The women, their mothers, and grandmothers were interviewed independently providing a total sample of N=15.

Data Collection

In-depth, semi-structured interviews were conducted with the sampled women, their mothers, and grandmothers (N = 15) in a private setting, either in person or through a secure online platform. After obtaining participants' consent, the interviews were audio-recorded for transcription and analysis. An interview guide was used that included open-ended questions designed to explore participants' perceptions of self, family, and childhood and a detailed family history of BPD. Questions also probed participants' coping mechanisms, interpersonal conflict, emotional regulation, impulsivity, and the impact of their mothers' borderline traits on their lives. Each interview was conducted in the native language (Urdu) to avoid linguistic barriers.

Data Analysis

The researcher actively listened to the audio-recorded interviews several times and transcribed the verbatims. The study used the data analysis method outlined by Maguire and Delahunt (2017). The first phase involved reading and re-reading the transcripts and organizing the data systematically. The next step involved reducing the data into small, meaningful chunks through coding. A theoretical thematic analysis was conducted, where the researcher coded only those pieces of data relevant to our research question or something interesting about it. The study

used open coding; there were no pre-set codes and codes were developed and modified throughout the coding process. The codes were then organized into broader descriptive categories (themes). The fourth step involved reviewing and revising the initial themes. The last step involved defining each theme and identifying its essence [8].

Trustworthiness

The four principles of credibility, transferability, dependability, and conformability [9] were ensured to maintain the trustworthiness of the findings.

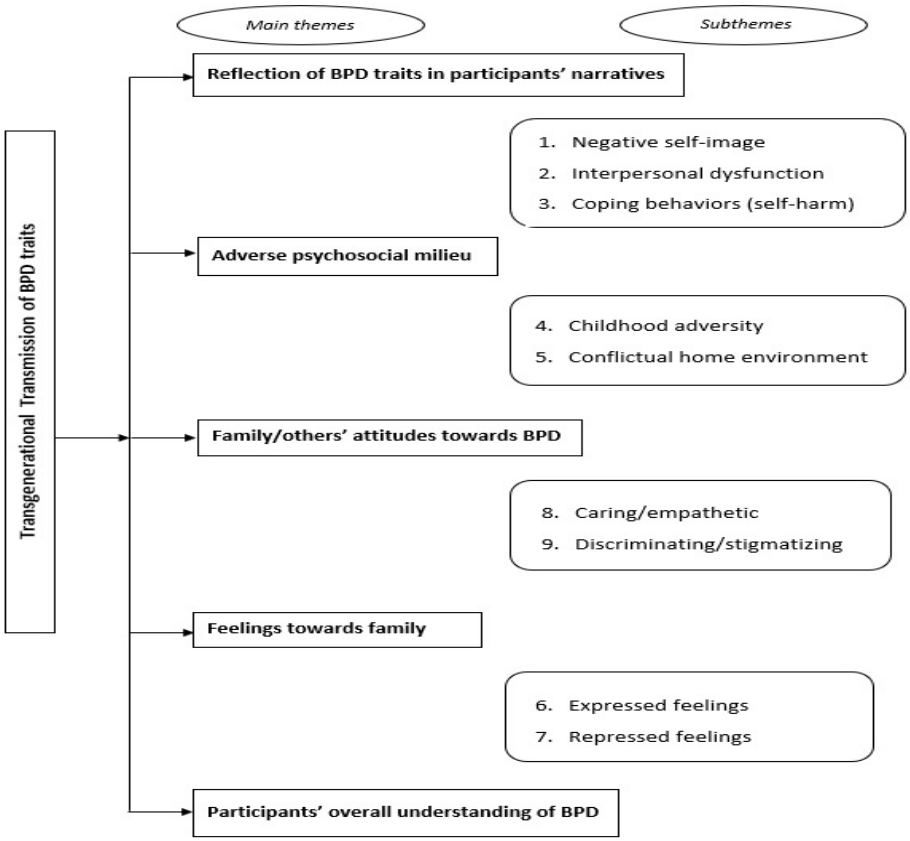
Ethical Considerations

The institutional review board (IRB) of Fountain House Institute for Mental Health, Lahore, Pakistan reviewed and approved the study (ref: PPRC 2024 / Ethics 3; 2024; dated: 28th August 2024). The procedures followed were in accordance with the Helsinki Declaration as revised in 2013. The participants provided their written informed consent to participate in this study. Note-taking and interview recording were also done after obtaining permission from the participants. Participants were guaranteed confidentiality and anonymity of information. They were also told that they could drop out of the study at any time without penalty.

Results

A total of 15 patients with symptoms of BPD in a tertiary care hospital in Pakistan participated in the study. Based on the data analyses, five main themes and related subthemes were extracted from the interviews. The main themes included: reflection of BPD traits in patients' narratives, adverse psychosocial milieu, family/others' attitudes towards BPD, feelings towards family, and participants' overall understanding of BPD (see Figure 1).

Figure 1: Summary of the Thematic Analysis (N=15)



Theme One: Reflection of BPD Traits in Patients' Narratives

The main theme reflection of BPD traits in patients' narratives consisted of three subthemes: negative self-image, interpersonal dysfunction, and coping behaviors.

Negative Self-image

Participants' narratives indicated dissatisfaction with self. They perceived themselves as emotionally unstable, impulsive, sensitive, and self-neglecting. One participant narrated, "In one word, I would describe my personality as unstable. I am a sensitive and emotional person who often experiences emotional ups and downs. I have poor self-confidence."

Additionally, participants' self-image was influenced by how others perceived them. Most participants considered themselves to be verbally aggressive and/or physically violent. Some participants linked this outward expression of anger to their role as mothers or wives. For example, one of the participants narrated, "I get angry easily. When I get angry, I break many things. According to my kids, I am an aggressive mother." Similarly, another one said, "According to my children, I am a strict but loving mother. I am sometimes very strict and anxious. I do not take care of my health."

Interpersonal Dysfunction

Almost all participants reported conflicts in interpersonal relationships (IPR) and difficulty trusting people. Most of them had no close friends. Those who had any close friends either reported frequent conflicts with them or the friend was submissive enough to stay through the conflict. For example, one participant narrated, "From the beginning, I had no friends, if I did, there would be fights." The participants' narratives also indicated that they faced discord in their marital life due to their unstable personalities. For example, participant XY stated, "Sometimes there are problems in our relationship, then we solve them, but my husband is always angry. Due to my unstable personality, our relationship became worse than before."

Some participants described experiencing emotional instability, reduced tolerance, and subsequent negative consequences after placing undue trust in others. For example, one participant said, "I trust almost everyone and then I suffer."

One of the participants attributed her dysfunctional IPR to her mood swings and lack of sleep, "I have problems relating to others because of my illness (BPD), and sometimes because of my mood swings and lack of sleep." One of the participants attributed her conflictual IPR to her anger issues, "After marriage, I lived with my husband at his parent's house, but our relationship did not last more than five years. My attitude towards people is not very good as I get angry easily."

One of the participants projected her interpersonal problems onto her siblings, "My brother is very good to me when he wants to be. He stays good for a long time. But then he says something wrong or does something wrong and apologizes. My little sister can't stand anything, she's a problem." This participant saw in her siblings the characteristics that were actually her personality traits.

Coping Behaviours

Most participants, when distressed, engaged in self-harm or non-suicidal self-injury (NSSI) as a coping behavior. Self-mutilating behaviors mostly cutting and intoxicating helped them suppress their emotions or internal conflicts. This reflects the use of escape coping by BPD patients. For most participants, these self-harm behaviors or NSSIs were rooted in chronic feelings of emptiness and low frustration tolerance. Furthermore, mothers and their daughters showed relatively similar coping behaviors. One of the participants described, "When I have impulsive thoughts, I harm myself (by taking pills). Most of the time, I don't intend to end my life."

Other coping behaviors included seeking treatment that is problem-focused coping, avoiding triggers or isolating self that is avoidance coping, changing or leaving conflicted environments that reflect self-distraction or escape, ventilating emotions or engaging in pleasurable activities that suggest emotion-focused coping, seeking help from a trusted family member or use of social support, crying, harming others out of frustration or aggression, and adopting a passive or submissive attitude against others to avoid conflicts.

One participant described her experience of seeking support from others as follows: "No one ever helped

me with my problems so now I don't tell anyone." Another reported, "Now I try to either stay more in my room or leave the house." On the contrary, one participant narrated, "I used medications, started therapy, increased communication with family, and focused on mental health." Another one stated, "When my condition was more serious, I used to cry and get angry, but now I don't. I try to tolerate if others do something bad to me. Once my sister slapped me which brought tears to my eyes because of the pain but I did not say anything to her so as not to aggravate the problem. I try not to use words that hurt my mother.**"**

Theme Two: Adverse Psychosocial Milieu

The second main theme adverse psychosocial milieu consisted of two subthemes: childhood adversity and conflictual home environment.

Childhood Adversity

Some participants experienced parental separation or parental divorce, resulting in the emotional and/or physical unavailability of their father. Moreover, parental fights and financial limitations during the participants' childhoods added to their psychological burden. Participants also experienced multiple childhood deprivations and unfulfilled aspirations. They also reported experiencing physical abuse at the hands of their mothers. The most prominent personality traits in childhood included being short-tempered, mischievous or serious, and sensitive.

One participant reported a childhood history of sexual abuse, "My uncle sexually assaulted me. My brother also tried. At that time, I was six or seven years old." One of the participants who experienced the accidental death of her father at the age of 17 described her experience, "I was sensitive and serious as a child. My father's personality and then his death influenced me a lot because I used to get help from him. I was 17 years old when my father died and almost five years passed when my mother fell ill. Then my uncle and aunt abandoned us." Her daughter narrated, "As a child, the economic conditions were not stable. We faced many difficulties. There were mostly fights in the house. Sometimes I felt love for them and sometimes there was hate. I was a sensitive and naughty child. My parents' fighting and not getting along bothered me for a long time. As a child, I wanted to ask my grandmother for a doll, but my mother did not like it and the economic conditions at home were not good. There was no way I was going to get what I needed. Also, I wanted to be a doctor. That wish also remained unfulfilled."

Conflictual Home Environment

The mother-daughter relationship seemed particularly volatile. Their overlapping BPD traits (emotional instability, sensitivity, aggression, and fear of abandonment) led to frequent clashes and misunderstandings, creating a tense and uncongenial home environment. Daughters with BPD traits viewed their mothers' aggression and emotionality as problematic, while mothers with BPD traits identified their daughters' impulsivity as a source of conflict. Additionally, participants with BPD appeared emotionally distant from their mothers. For example, a daughter stated, "My mother gets angry easily. She is a very religious woman, however, when she gets angry she beats me." Similarly, one of the mothers narrated, "Because of my daughter, my house system is conflicted, there is always a fight."

Some participants also reported financial constraints and a lack of family tolerance. In addition to mother-daughter conflict, participants reported their conflictual relationships with other family members and conflicts between family members (especially parents). Apart from their mothers, participants perceived at least one other family member or in-law (e.g., spouse, mother-in-law, brother) as aggressive and impulsive. One participant stated, "My brother used to beat my mother, and when I came forward to save my mother, he would beat me too… The torture by my mother was physical. But there was emotional torture from my husband." In contrast, the family member who was usually engaged in the care of patients after self-harm was perceived to be supportive, kind, and caring. If this support figure is separated for any reason, the problems would aggravate.

Theme Three: Family/Others' Attitudes Towards BPD

The third main theme family/others' attitudes towards BPD consisted of two subthemes: caring/empathetic attitude and discriminating/stigmatizing attitude.

Caring/Empathetic Attitude

Most of the participants' families showed concern, care, attention, and support towards them. In some cases, family members were hypervigilant about symptoms and ensured the participant's safety in case of self-harm. One of the participants stated, "My son notices my emotional swings; he listens to everything I say and tries to keep me happy." Another one reported, "When I am unwell, everyone gets worried and sometimes scared. They don't let me make decisions. They hide every pointed object in the house from me. My mother-in-law also keeps my medicines in a locker. When I engage in harmful behaviors, my family immediately medicates or restrains me so that I do not harm myself."

Discriminating/Stigmatizing Attitude

Some participants reported occasional teasing and discrimination from people other than family. However, one participant described constant teasing, discrimination, fluctuations in family support, abandonment, and stigmatization by her husband and father in the following words: "My family was shocked and worried at first (when BPD was diagnosed). Then they understood and supported me. My brothers played a very positive role in this. But my father usually says I am tired of this mother and daughter (mother also had BPD). Now the same statement my husband says…My husband once said I would either leave her or admit her to a mental hospital."

Theme Four: Feelings Towards Family

The fourth main theme feelings towards family consisted of two subthemes: expressed feelings towards family and repressed feelings towards family.

Expressed Feelings Toward Family

Most of the participants showed ambivalence toward their families. They showed a mixture of anger and love toward their family members. One participant narrated, "When I think of my family, at first, I feel intense anger, but then I feel deep love." Another one stated, "When I think about my family, I feel love and hatred at the same time."

Participants expressed anger and frustration toward their daughters having BPD traits while expressing more positive feelings toward their support figures. For example, one participant stated, "My relationship with my son is good but my daughter causes problems… I am very angry with my daughter… My feelings towards my son have always been positive as he has always supported me." One of the participants expressed resentment toward her parents by stating**,** "I think parents should leave each other if they don't get along, they cause their children pain. If given the chance, I would have taught my father to respect women. I would have taught him loyalty."

Repressed Feelings Toward Family

The participants' narratives indicated mothers' repressed compassion and love for their daughters and vice versa. One participant narrated, "Maybe one day, I will start loving my mother or perhaps she will show compassion towards me." Participants also confessed unexpressed love and affection for their family members, especially for parents or spouses. For example, one of the participants said, "I want to tell my parents that I love them both very much and I need them both to stay together and be there for each other."

Theme Five: Participants' Overall Understanding of BPD

The majority of participants had a clear understanding of their borderline personality and the resulting emotional and behavioral consequences. They had insight into the transgenerational transmission of BPD traits. They were able to trace the role of their childhood and family dynamics in the formation and maintenance of their BPD symptoms. One of the participants described her overall understanding of BPD as follows: "Mental health has always been a challenge in our family. Some people have problems like depression, anxiety, and borderline personality disorder. These complications have led to instability in our family. Problems arose in our relationship. The mental health of my family members affected me emotionally, causing me to suffer from anxiety, depression, and more. Over time, the understanding and awareness of mental health improved in our family. We tried to strategize together, engaged in talk therapy, started communicating and understanding each other, took medicine, and kept ourselves happy."

Another participant explained, "It is said that Abu had a lot of mental health problems. Dada had treated him a lot, and after Dada, Abu threw the medicines away. My Dadi also used to take medications during Dada's life. She was much better at that time. They had problems like paranoia and aggression. Later these problems were transferred to my mother. These problems have destroyed our home. My two brothers also use drugs."

Discussion

Unlike most research on BPD conducted in High-Income Countries (HICs), this is the first study from a low-middle-income country like Pakistan that offers a phenomenological exploration of BPD by examining the lived experiences of mothers and daughters with BPD traits. Narratives of all participants indicated core BPD features of negative self-image, interpersonal dysfunction, and maladaptive coping behaviors, particularly self-harm. Mothers and daughters with BPD showed relatively similar traits and coping behaviors indicating transgenerational transmission of BPD features along with the transgenerational transmission of childhood adversity. These findings support Masterson's (1976) comment "The mother of any borderline is herself a borderline" [10].

The overlapping BPD characteristics of mothers and daughters i.e., emotional instability, sensitivity, aggression, and fear of abandonment often lead to conflicts and misunderstandings, creating a tense and uncongenial home environment. Parental fights and other factors also contribute to conflictual home environments [11, 12]. Our findings are consistent with many previous studies examining the role of genetics and environmental factors in determining and maintaining the characteristics of BPD [13, 14, 15].

All participants experienced an adverse psychosocial milieu, particularly childhood adversity such as parental separation, emotional neglect, inconsistent parenting, physical abuse by their mothers, sexual abuse by a family member or relative, etc. This aligns with many previous studies [16]. One study asserted that mothers with BPD were less likely to be sensitive and provide autonomy and support and were more likely to be hostile and display fearful/disoriented behavior and higher levels of parent-child role reversal [17].

Attitudes of family or other people toward BPD were found to be mixed. Some family members or friends were found to have a caring and empathetic attitude, while others adopted a discriminatory or stigmatizing attitude. As found, a history of self-harm was associated with an increased number of discrimination experiences [18].

Similar to a previous study examining perceptions that BPD patients have of their families, our study indicated that almost all participants reported unexpressed love or gratitude towards their families and had an insecure attachment to their mothers [19]. Additionally, most participants expressed ambivalence towards their family members.

Implications of the Study for Policy and Practice

Our findings can help understand the unique challenges and experiences of people with BPD to promote the delivery of effective mental health services and the development of national/international policies or support programs. This study may also fill a gap in the prevailing literature on BPD as it looks at the disorder in its unique cultural context.

Limitations

The present study has a few limitations. First, the small sample of 15 individuals makes it difficult to generalize the findings to a larger population. Additionally, focusing on specific geographical or cultural dynamics limits the generalizability of the findings to other cultures and populations. Although the study acknowledges that family dynamics can contribute to BPD, it does not consider, in detail, other factors like environmental influences outside the family unit. Moreover, relying solely on interviews might introduce bias, as participants' responses could be influenced by recall bias or social desirability. Therefore, further research in this domain is required.

Conclusion

The present study has helped us gain deeper insights into the transgenerational aspects of BPD while examining the role of family environment and early life experiences in maintaining BPD features.

REFERENCES

Mishra S, Rawekar A, Sapkale B. A Comprehensive Literature Review of Borderline Personality Disorder: Unraveling Complexity From Diagnosis to Treatment. Cureus. 2023.

Leichsenring F, Leibing E, Kruse J, New AS, Leweke F. Borderline personality disorder. Lancet. 2011;377(9759):74-84.

Ansari D, Lakkimsetti M, Olaleye KT, Bhullar JVK, Shah RZ, Arisoyin AE, et al. Genetic Influences on Outcomes of Psychotherapy in Borderline Personality Disorder: A Narrative Review of Implications for Personalized Treatment. Cureus. 2023.

Ryan RM. The developmental line of autonomy in the etiology, dynamics, and treatment of borderline personality disorders. Dev Psychopathol. 2005;17(4):987-1006.

American Psychiatric Association. Diagnostic and statistical manual of mental disorders: DSM-5: American psychiatric association Washington, DC; 2013.

Shorey S, Ng ED. Examining characteristics of descriptive phenomenological nursing studies: A scoping review. J Adv Nurs. 2022;78(7):1968-79.

Morrow R, Rodriguez A, King N. Colaizzi's descriptive phenomenological method. The psychologist. 2015;28(8):643-4.

Maguire M, Delahunt B. Doing a Thematic Analysis: A Practical, Step-by-Step Guide. 2017;9.

Lincoln YS, Guba EG. Naturalistic inquiry. Beverly Hills, Calif.: Sage Publications; 1985.

Lamont A. Mothers with Borderline Personality Disorder. Graduate Student Journal of Psychology. 2006;8.

Giffin J. Family experience of borderline personality disorder. ANZJFT Australian and New Zealand Journal of Family Therapy. 2008;29(3):133-8.

Golomb A, Ludolph P, Westen D, Block MJ, Maurer P, Wiss FC. Maternal empathy, family chaos, and the etiology of borderline personality disorder. J Am Psychoanal Assoc. 1994;42(2):525-48.

Distel MA, Rebollo-Mesa I, Willemsen G, Derom CA, Trull TJ, Martin NG, et al. Familial resemblance of borderline personality disorder features: genetic or cultural transmission? PLoS One. 2009;4(4):e5334.

Torgersen S. Genetics of patients with borderline personality disorder. Psychiatr Clin North Am. 2000;23(1):1-9.

White CN, Gunderson JG, Zanarini MC, Hudson JI. Family studies of borderline personality disorder: a review. Harv Rev Psychiatry. 2003;11(1):8-19.

Belsky DW, Caspi A, Arseneault L, Bleidorn W, Fonagy P, Goodman M, et al. Etiological features of borderline personality related characteristics in a birth cohort of 12-year-old children. Dev Psychopathol. 2012;24(1):251-65.

Macfie J, Kurdziel G, Mahan RM, Kors S. A Mother's Borderline Personality Disorder and Her Sensitivity, Autonomy Support, Hostility, Fearful/Disoriented Behavior, and Role Reversal With Her Young Child. J Pers Disord. 2017;31(6):721-37.

Veysey S. People with a borderline personality disorder diagnosis describe discriminatory experiences. Kōtuitui: New Zealand Journal of Social Sciences Online. 2014;9(1):20-35.

Kirsten DK, van Lellyveld V, Venter CA. Perceptions That Patients Diagnosed with Borderline Personality Disorder Have of Their Families. South African Journal of Psychology. 2006;36(2):319-39.

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