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PERCEIVED DIFFERENCES IN EARLY FAMILY ENVIRONMENTS AND PARENT/CHILD RELATIONSHIPS BETWEEN ADULTS DIAGNOSED AS BORDERLINE PERSONALITY OR BIPOLAR DISORDER

A Dissertation Presented

by

MARGARET L. FLAHERTY

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

February 1989

Education

PERCEIVED DIFFERENCES IN EARLY FAMILY ENVIRONMENTS AND PARENT/CHILD RELATIONSHIPS BETWEEN ADULTS DIAGNOSED AS BORDERLINE PERSONALITY OR BIPOLAR DISORDER

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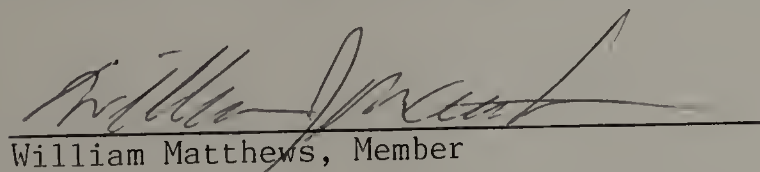
Approved as to content and style by:

Allen E. Ivey, Chairperson of Committee



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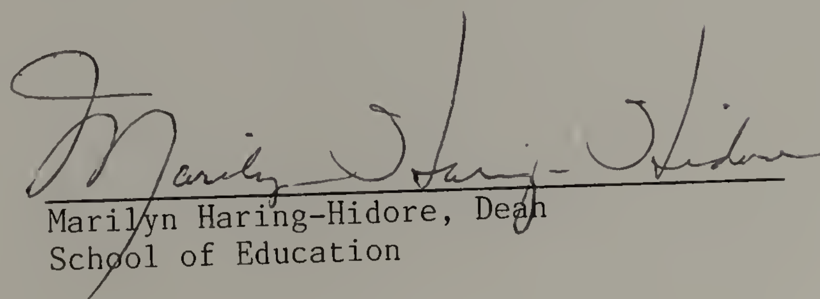

Marilyn Haring-Hidore, Dean
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ABSTRACT

PERCEIVED DIFFERENCES IN EARLY FAMILY ENVIRONMENTS AND PARENT/CHILD RELATIONSHIPS BETWEEN ADULTS DIAGNOSED AS BORDERLINE PERSONALITY OR BIPOLAR DISORDER

FEBRUARY, 1989

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The purpose of this study was to compare perceived differences in early family systems and parent/child relationships of persons diagnosed as borderline personality or bipolar disorder. Twenty-two borderlines between the ages of sixteen and forty who had no severe or continuous history of substance abuse were matched with twenty-two bipolars. Group membership was determined by interviewing each participant using Parts A through D of the Structured Clinical Interview for DSM-III-R (SCID) and the Diagnostic Interview for Borderlines (DIB). The Family Environment Scale (FES) and the Life InterPersonal History Enquiry (LIPHE) provided data about early family life. Results showed that bipolar families scored statistically higher than borderline families on cohesiveness; mothers of borderlines were perceived as more controlling than fathers; and mothers of bipolars were seen as expressing more parental disapproval than fathers. It was concluded that some support was demonstrated for the neglect hypothesis in borderline

families, and that bipolar families are characteristically more enmeshed. Aside from these differences, the samples were basically similar leading to speculation about the nature of the overlap that exists between the borderline and bipolar diagnoses.

TABLE OF CONTENTS

Page

ACKNOWLEDGMENTS iv

ABSTRACT vi

LIST OF TABLES xi

LIST OF FIGURES xii

Chapter

I. INTRODUCTION 1

Background 1

Borderline Personality Disorder: A Brief Overview . . . 3
Bipolar Disorder: A Brief Overview 6

Statement of the Problem 10
Purposes 13
Significance of the Study 15
Outline of the Remainder of the Dissertation 16

II. REVIEW OF LITERATURE 17

Introduction 17
Evolution of the Borderline Concept 18

Descriptive Approach 20

Defining characteristics for DSM-III 20
Boundaries with schizophrenic and affective disorders 31

Psychodynamic Formulations 37

Overview 37
Contributions of major theorists 38

Page

Profile of the Bipolar Patient 43

Characteristics and Hypotheses of Bipolar Disorder . . . 43

Current diagnostic issues 43
Genetic research on bipolar disorder 45
Neurobiologic hypotheses 46

Psychodynamic Formulations 48

Research on Family Systems 52

The Borderline Family 52

Familial characteristics 53
Parent/child relationships 61

The Bipolar Family 65

Familial characteristics 66
Parent/child relationships 77

Summary and Rationale for Current Research 80

III. RESEARCH METHOD 87

Introduction 87
Description of the Sample 87
Instrumentation 92
Research Design 98
Data Collection 101
Data Analysis 102

IV. RESULTS 104

Introduction 104
Descriptive Statistics 104
Data Analysis for Each Hypothesis 107

V. DISCUSSION 133

Discussion of Results 133

Summary of Findings for Borderline Family Systems 133
Summary of Findings for Bipolar Family Systems 138

Page

Conclusions and Limitations of the Investigation 141
Significance of the Research Findings 145
Suggestions for Additional Research 145

VI. SUMMARY: JOURNAL ARTICLE 147

Abstract 147
Introduction 148
Method 151

Subjects 151
Instrumentation 152
Analysis 153

Results and Discussion 153

REFERENCES 161

LIST OF TABLES

Page

1. Comparison of Borderline and Bipolar Mean Composite and Subscale Scores on the DIB 91
2. Comparison of Borderline and Bipolar Sociodemographic Characteristics 114
3. Comparison of Borderline and Bipolar Familial Characteristics 117
4. Comparison of Borderline and Bipolar Psychiatric Histories 119
5. Percentage of Borderline and Bipolar Patients Reporting Separation Experiences Prior to Age Ten 121
6. Stepwise Multiple Regression Analysis of DIB Subscales with FES and LIPHE Subscales for Borderlines and Bipolars 123
7. Comparison of Borderline and Bipolar Mean FES Subscale Scores 124
8. Comparison of Borderline and Bipolar Mean FES Subscale Scores 126
9. Comparison of Borderline and Bipolar Mean LIPHE Subscale Scores 127
10. Comparison of Mean LIPHE Subscale Scores of Mothers Versus Fathers for Borderline and Bipolar Groups 130
11. Comparison of Borderline and Bipolar Mean Composite and Subscale Scores on the DIB 154

LIST OF FIGURES

Page

1. Similarities and Differences in Borderline and Bipolar Family Systems and Parent/Child Relationships 81

2. Profile of Borderline and Bipolar Mean FES Standard Scores . . 125

3. Profile of Borderline and Bipolar Mean Raw LIPHE Scores . . . 129

CHAPTER I

INTRODUCTION

Background

At its most basic level the purpose of this thesis is to investigate the early environmental contexts within which two forms of psychopathology, borderline personality disorder and bipolar disorder, evolve. This goal will be accomplished by comparing the differences in the characteristics of early family systems and the quality of childhood parent/child relationships as perceived by adult members of each of these groups. By engaging in this research it is hoped that a more comprehensive description of the early systemic functioning of both borderline and bipolar families will be obtained, and that information will be gathered concerning the nature of the relationships of the diagnosed persons with each of their parents. In addition, it is hoped that, by comparing these particular groups, the link between borderline personality disorder and the major affective disorders can be more clearly delineated.

Psychoanalytic theorists have long suggested that there is an association between the quality of early life interaction and the subsequent development of different types of psychopathology in adulthood. Early researchers focused on the significance of the formative relationship between mother and child. They tended to attribute responsibility for adult psychopathology to the mother's lack of physical and/or emotional availability to the child during crucial times of growth.

More recently, object relations and developmental theorists have shifted the focus to an interpersonal level by stressing the importance of the roles played by the mother, the father, and the child, especially during the initial separation-individuation process which occurs during the first two years of life. They have suggested that various forms of adult psychopathology might be directly linked to a developmental arrest at one of the stages of this process, and that responsibility for the condition might now be shared by family members.

Today, systems theorists have begun to examine the contexts of family environments during different stages in the individual and family life cycles. Each stage is thought to present the family with different tasks and with the necessity for generating and negotiating new sets of rules and structures by which to function. Within this framework, accommodation to early separation-individuation issues is viewed as a task that the system as a whole needs to address. Dysfunctional behavior is thought to occur when a family is unable to mobilize its resources in order to adapt to the changing demands of its members or its environment.

Although research has acknowledged the contribution of biogenetic factors in the etiology of borderline and especially bipolar disorders, and the importance of these findings will not be overlooked, the primary goal of this research is to compare the systemic perceptions of the familial contexts within which persons with each of these disorders were raised. The rationale for comparing these particular groups was derived out of a careful review of the literature on the behavioral,

psychodynamic, and systemic research for each disorder. A discussion which reviews this literature will be presented first. Next, the methodology for the selection of the sample, a description of the instruments which were administered, and the data gathering process will be outlined. The information will then be analyzed using various statistical procedures, and finally, a discussion and interpretation of the results will be presented. Before proceeding in great detail, however, a short description of borderline personality disorder and bipolar disorder might be helpful.

Borderline Personality Disorder: A Brief Overview

The term borderline was first given formal status nearly fifty years ago by Stern who noted that there were a group of patients too ill for classical psychoanalysis (1938). He suggested ten diagnostic criteria including narcissism, psychic bleeding, inordinate hypersensitivity, psychic and body rigidity, negative therapeutic reaction, constitutional feeling of inferiority, masochism, organic insecurity, projective mechanisms, and difficulties in reality testing. Since Stern's time the term borderline has been used in a great variety of ways by theoreticians and researchers.

Prior to 1960 the focus of most researchers was on exploring the phenomenological aspects of the borderline patient. In 1953, a pivotal study by Knight popularized the notion that the borderline state existed somewhere between neurosis and psychosis. Using an ego psychological paradigm he developed extensive lists of macroscopic and

microscopic evidence of ego weakness. Some of these included a lack of concern over the situation, a lack of achievement over time, impaired integration of ideas, and peculiarities of word usage.

The first systematic, empirical study of patients diagnosed as borderline was published by Grinker, Werble, and Drye in 1968. By 1980 in the United States alone there were at least twenty empirical studies in progress. More recently there has been a plethora of investigations. Most of the focus of the current research has centered on studies which define behavioral characteristics and symptoms, studies which discriminate the borderline diagnosis from other forms of psychopathology such as the schizophrenic and affective disorders, and theoretical propositions which claim that borderline personality organization may be viewed psychoanalytically as a level of psychostructural functioning between neurosis and psychosis. Within this last context, etiology has been thought to be correlated with differing ego weaknesses or developmental arrest factors occuring in early childhood.

The evolution of the borderline concept will be presented in the next chapter. For the purposes of this thesis, however, the meaning of the term borderline will correspond to the descriptive approach of DSM-III-R (1987). From this perspective, the American Psychiatric Association (APA) has suggested that the diagnosis is appropriate when there is:

> a pervasive pattern of instability of mood, interpersonal relationships, and self-image, beginning by

early adulthood and present in a variety of contexts, as indicated by at least five of the following:

(1) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of overidealization and devaluation

(2) impulsiveness in at least two areas that are potentially self-damaging, e.g., spending, sex, substance abuse, shoplifting, wreckless driving, binge eating (Do not include suicidal or self-mutilating behavior covered in [5].)

(3) affective instability: marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days

(4) inappropriate, intense anger or lack of control of anger, e.g., frequent displays of temper, constant anger, recurrent physical fights

(5) recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior

(6) marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values

(7) chronic feelings of emptiness or boredom

(8) frantic efforts to avoid real or imagined abandonment (Do not include suicidal or self-mutilating behavior covered in [5].) (p. 347).

The clinical picture of borderlines is usually of persons who present as intensely and persistently angry. They express extreme dependence at the same time that they demonstrate hostility toward the persons with whom they have formed an attachment. They can be experienced as demanding and manipulative, and they frequently engage in impulsive behavior which usually involves self-destructive acts such as wrist-cutting. In response to stress and lack of structure they may

briefly become psychotic and exhibit dissociative states, derealization, and depersonalization. They usually have sporadic school/work histories, and often experience uncertainty about their identities and long-range goals.

It is thought that borderline personality disorder is prevalent in roughly ten to twenty percent of hospital admissions, and women are diagnosed borderline more than twice as often as men. The disorder is believed to originate in early childhood, and to continue well into adult life with somewhat of a remission after age forty. Frequent, intensive, long-term individual psychotherapy has been the treatment of choice by some psychotherapists. Others have advocated supportive therapy involving weekly individual sessions which focus on the "here-and-now" and the stabilization of the client's current living situation. Group therapy has also been advocated as an adjunct to both intensive and supportive therapy. To date, medications have shown to have minimal effectiveness in the treatment of borderline personality disorder.

Bipolar Disorder: A Brief Overview

Bipolar disorder is an illness which is manifested by two extremes of mood: elation and depression. Accurate descriptions of the disorder can be found in medical records prior to the second century. In 1851 Jules Falret, a French psychiatrist, described "la folie circulaire" after noticing that in some persons depressions and elations were cyclical. A short time later in 1863 Karl Kahlbaum coined the term

"cyclothymia", and in 1896 Kraepelin suggested the term "manic-depressive psychosis" for disorders which involve a mood disturbance (Zilboorg & Henry, 1941). Under the influence of Adolf Meyer the term was later changed to "manic-depressive reaction" to suggest that its symptoms were a reaction to events and experiences rather than representative of a specific disease process. By 1969 there was an increasing realization that organic factors played an important part in the etiology, and the disorder was renamed "manic-depressive illness".

In DSM-III (as well as DSM-III-R) all affective or mood disorders have been divided into two categories: major (episodic) and chronic. In this hierarchical schema, major affective disorders consist of bipolar disorder and major depression depending on whether or not there is a history of mania. Chronic affective disorders include cyclothymic and dysthymic disorders, both of which are considered longer-lasting but less severe than mania and major depression. Both the bipolar and major depression categories are further subdivided. The bipolar diagnosis is classified according to presenting symptoms: currently depressed, currently manic, or currently mixed. If manic, an evaluation is made as to whether or not the person is psychotic. Finally, if found to be psychotic, the nature of the psychosis is determined to be either mood congruent or mood incongruent (Andreason, 1983).

In this research participants diagnosed as bipolar met the following DSM-III-R (APA, 1987) criteria for the disorder:

A. Current (or most recent) episode involves the full symptomatic picture of both Manic and Major

Depressive Episodes (except for the duration requirement of two weeks for depressive symptoms)..., intermixed or rapidly alternating every few days.

B. Prominent depressive symptoms lasting at least a full day (p. 226).

<u>Manic</u> and <u>major depressive episodes</u> are defined as follows. A <u>manic episode</u> is characterized by:

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood.

B. During the period of mood disturbance, at least three of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity

(2) decreased need for sleep, e.g., feels rested after only three hours of sleep

(3) more talkative than usual or pressure to keep talking

(4) flight of ideas or subjective experience that thoughts are racing

(5) distractibility, i.e., attention is too easily drawn to unimportant or irrelevant external stimuli

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7) excessive involvement in pleasurable activities that have a high potential for painful consequences, e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments

C. Mood disturbance sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others.

D. At no time during the disturbance have their been delusions or hallucinations for as long as two weeks

in the absence of prominent mood symptoms (i.e., before the mood symptoms developed or after they have remitted).

E. Not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS.

F. It cannot be established that an organic factor initiated and maintained the disturbance. Note: Somatic antidepressant treatment (e.g., drugs, ECT) that apparently precipitates a mood disturbance should not be considered an etiologic organic factor (p. 217).

A major depressive episode is characterized by a two-week period in which there is depressed mood and/or loss of interest or pleasure, and significant weight loss, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness, difficulty concentrating, or suicidal ideation (APA, 1987).

The stereotypical picture of a person with bipolar disorder is one in which there are cyclical mood swings from wild mania into deep depression. In reality, a variety of clinical pictures are encompassed by the disorder. For example, Klerman (1981) has distinguished six subtypes of mania, and others believe that there are more. These will be discussed in more detail in the following chapter.

In addition to the typical symptoms already mentioned, some authors suggest that mania is also characterized by certain styles of interpersonal behavior (Davis, Noll, & Sharma, 1986). Diagnosed manics may flatter others at the same time that they attack the other's vulnerabilities. In addition, they have been found to test the limits of a situation to extreme degrees, to project responsibility for their behavior on to others, to be sensitive to others' weaknesses, to incite staff splitting over their treatment, and to evoke anger in persons who

deal with them (Janowsky, El-Yousef, & Davis, 1974). Usually, normal behavior returns once the person has begun treatment with lithium.

In bipolar illness there is a slight preponderance of women to men with the incidence of new cases each year for women being from .01 to .03 percent and for men .01 percent. The risk of developing bipolar disorder is approximately one-half to one percent (Weissman & Boyd, 1983). The first manic episode usually occurs before the age of thirty and rarely after the age of fifty. Twin studies, family studies, and surveys of the general population support the hypothesis that there is a genetic predisposition for bipolar disorder. In addition, neurophysiological studies have proposed that mania may be physiologically linked to the alteration in certain neurotransmitter substances, e.g., increased dopamine levels in the brain.

In the next section the rationale for comparing the early environments of borderlines and bipolars and the specific questions that might be answered from this comparison will be outlined.

Statement of the Problem

At first glance it would appear that there are many more differences than similarities between the borderline and bipolar diagnoses. According to DSM-III-R, the borderline diagnosis is made on Axis II, and is representative of a long-standing pattern of personality functioning. The bipolar diagnosis, on the other hand, is made on Axis I and is suggestive of recurrent symptomatic behavior; normal functioning or euthymia usually returns once the manic or

depressive episodes have been treated. Second, a strong genetic predisposition has been noted in families of patients with bipolar disorder. Research in this area with borderlines has been inconclusive thus far. Third, borderlines may exhibit brief periods of psychotic behavior particularly during times of stress or in situations which lack structure. During a full-blown manic episode, however, various types of delusions may be prominent and may last for a more sustained period of time. These delusions are usually of a grandiose nature and may be accompanied by visual and auditory hallucinations. Finally, it seems difficult to mistake a manic episode when symptoms include elation, expansiveness, flight of ideas, pressured speech, and difficulty concentrating. This behavior might be contrasted to the intense anger, manipulative suicide threats, splitting, and self-mutilation presented by borderlines.

However, even though they are currently classified as two separate forms of psychopathology, the borderline and bipolar disorders may be viewed as sharing several overlapping characteristics. First, behaviorally each patient can present with similar symptomatology making diagnostic and clinical issues confusing. These similarities are most prevalent when evaluating the affective components of each disorder. For example, not only do borderlines often exhibit symptoms of depression, they also can demonstrate behavior which, for all intents and purposes, appears to be hypomanic. In addition, borderlines can present as impulsive, distractible, and angry or irritable---behaviors associated with manic episodes.

Second, intrapsychically both groups have been described as sharing similar characteristics. As we shall see in the next chapter, psychoanalytic theorists have suggested that both borderlines and bipolars have difficulties with separation and individuation. They each seem acutely sensitive to potential abandonment experiences because neither has formed a clear representation of self and other. This leads to the postulation that members of each group have become fixated at the same early developmental level.

Third, diagnosed borderlines and bipolars share many interpersonal similarities. For example, they may each have difficulties in establishing close, meaningful interpersonal relationships; they may manipulate and devalue those to whom they feel attached; they may attempt to get others to take responsibility for their actions; and they may use the defense of splitting in order to maintain homeostasis in relationships.

Finally, and most importantly, a similarity can be noted between their family systems. Although results have been inconclusive and conflicting, both borderline and bipolar families have been described as overprotective, enmeshed systems in which boundaries are blurred and parents have difficulty being consistent. In addition, marital relationships have been seen as covertly hostile, and the mother has been perceived as dominant while the father has been seen as weak and absent.

With these similarities in mind, several questions arise as to how the diagnoses might be more clearly distinguished from one another.

The first question is whether or not any early environmental factors might be contributing to the evolution of the different forms of psychopathology. It has been shown that genetic factors contribute significantly to predisposing a person to bipolar disorder. If this be so, then early familial functioning might have only a random effect on factors contributing to development of the disorder. On the other hand, since the etiology of borderline personality disorder is thought to be primarily environmental, a specific pattern of relating might be discernable. Of special interest, then, is whether or not it is possible to delineate significant differences in the characteristics and structures of borderline and bipolar family systems during the families' early childhood years. Stated another way, how might family systemic functioning as a whole influence behavior in adult life?

A second question concerns whether significant differences can be found for borderlines and bipolars in their early relationships with either their mothers or fathers. In essence, do borderlines and bipolars view their early relationships with each of their parents differently? If so, what effect might these experiences have on the development of later relationship patterns? Investigating the answers to these questions will be the major concern of this research.

Purposes

As mentioned, the central focus of this research was the investigation of how adults diagnosed as either borderline or bipolar perceive the ways in which their families functioned during their childhood years. These family systems were compared with two general goals in mind.

The first goal was to compare the differences in perceptions of early family environments between participants of both groups. Of specific interest was the assessment and comparison of family environments along the dimensions of relationship, personal growth, and system maintenance. These three general systems' characteristics were further subdivided so that participants were able to rate their perceptions of their family systems on the variables of cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, moral-religious emphasis, organization, and control.

A second goal was to evaluate the participants' perceptions of their relationships with each of their parents during early childhood. They were asked to rate how they perceived their relationships with both their fathers and mothers on the variables of inclusion, control, and affection, and parental disapproval. Comparisons were made both within and across groups.

Drawing from the above, the major premises of this study were:

1. There are differences in the perceptions of the early family environments between diagnosed borderline and bipolar adults.
2. There are differences in the perceptions of early parent/child relationships between diagnosed borderline and bipolar adults.
3. There are differences in the perceptions of early relationships between mothers versus fathers for borderline and bipolar adults.

Having defined the major premises of the study, the following objectives were outlined for their investigation:

1. Evaluation of structured diagnostic interviews using the Diagnostic Interview for Borderlines (DIB) (Gunderson, Kolb, & Austin, 1981), and sections A through D of the Structured Clinical Interview for DSM-III-Patient Version (SCID-P) (Spitzer & Williams, 1986).

2. Administration of a retrospective version of the Family Environment Scale (FES) (Moos, 1986), a self-report measure which assesses differences in perceptions of family environments.

3. Administration of the Life InterPersonal History Enquiry (LIPHE) (Schutz, 1978), a self-report scale which assesses differences in the perceived quality of parent/child relationships during the early childhood years.

Significance of the Study

This study appeared worth pursuing for several reasons. First, although the literature suggests a correlation between early family environment and personality development, these conjectures have mostly remained theoretical. Second, very little empirical data exists concerning the characteristics of family systems and the nature of early parent/child relationships in either borderline or bipolar family systems. Third, as mentioned, there appears to be considerable overlap between the borderline and affective spectrum diagnosis yielding behavioral, intrapsychic, and interpersonal similarities between the two groups. A knowledge of early environmental differences might help to clarify confusing diagnostic and clinical issues. Finally, if systemic issues could be identified in either group, a knowledge of these early, typical patterns of relationship might assist clinicians

in identifying persons most at risk for difficulties in adult relationships.

Outline of the Remainder of the Dissertation

The remainder of this thesis will be divided into five chapters. In the next chapter the focus will be on a review of the current theoretical and empirical literature concerning borderline and bipolar psychopathology. This will include a history of the evolution of the definitions for each disorder, a discussion of psychodynamic formulations, and an evaluation of current research on the family systems of both groups. In the third chapter there will be an outline of the research methodology which was used in this study including a description of the samples under investigation and the criteria used for their selection. In addition, there will be a discussion of the content, derivation, reliability, and validity of the assessment instruments, a description of the research design, and a summary of the methods used for data collection and analysis. In the fourth chapter demographic information about the participants and results relating to each hypothesis will be presented. In the fifth chapter the data will be interpreted, conclusions will be drawn, the limitations and significance of the study will be discussed, and suggestions will be made for additional research. Finally, in the last chapter a brief overview of the entire study will be presented in the form of a publishable article. We now turn to a review of the relevant theoretical and empirical contributions as they relate to borderline and bipolar psychopathology.

CHAPTER II

REVIEW OF LITERATURE

Introduction

This chapter will be divided into four sections. The first section will focus on borderline personality disorder and will begin by tracing its emergence as a diagnostic entity in DSM-III. Its similarities and differences from the schizophrenic and affective disorders will then be addressed. The purposes of this discussion will be to summarize the current literature on defining the disorder, and to discuss its distinctiveness and similarities to other diagnoses especially bipolar disorder.

This will be followed by a description of borderline disorder from current psychoanalytic perspectives. Central to this discussion will be an examination of the borderline concept with respect to object relations and developmental theories both of which suggest that the psychopathology is a result of inappropriate early interactions between parent and child. The most noted theorists, Mahler, Kernberg, Masterson, Rinsley, and Gunderson directly or indirectly correlate the etiology of the disorder with the interpersonal context of early life experiences. A review of their contributions, therefore, are of major interest to the purposes of this thesis.

In the second section, the focus will shift to an examination of bipolar disorder. Current diagnostic issues, characteristics of the disorder, and research on the genetic and neurologic theories will be

briefly presented. This will be followed by a discussion of the relevant psychodynamic literature. Included will be the theories of manic-depressive illness suggested by Abraham, Freud, Dooley, Melanie Klein, and Cohen.

In the third section there will be a presentation of the research that has been done with bipolar and borderline family systems. Of significance will be the descriptive and empirical studies of the characteristics of borderline and bipolar families. Also included will be a summary of the nature of parent/child relationships for each disorder.

Finally, the last section will combine the discussions of diagnostic and psychodynamic issues and the literature on family systems for both disorders in order to present the rationale for this study: comparison of the early family systems and parent/child relationships of persons diagnosed as borderline or bipolar.

Evolution of the Borderline Concept

The seeds of the borderline concept find their roots in early psychoanalytic theory. As a result, different attributions for the concept's meaning have reflected the historical development and changes in the field of psychiatry itself over the last fifty years. The term borderline has been used to describe a range of forms of psychopathology with varying sources of etiological and clinical manifestations. This has lead to the evolution of a heterogeneous meaning

for the term which continues to create confusion for both researchers and clinicians.

According to Aronson (1985) four distinct themes for defining borderlines have emerged from the literature: (1) that borderline personality disorder represents a discrete, clinical entity definable by the observable, behavioral characteristics listed in DSM-III-R; (2) that borderline psychopathology should be classified on the schizophrenic spectrum of disorders; (3) that borderline psychopathology represents an Axis I affective spectrum disorder; and, (4) that borderline personality organization may be viewed psychoanalytically as a level of psychostructural functioning which is bound on one side by neurosis on the other by psychosis. Within this last framework borderline etiology has been thought to be associated with differing ego weaknesses, with developmental arrest factors, or, more recently, with familial traits and systems dynamics.

At closer examination these four definitions appear to represent two broad categories of empirical research and theoretical organization: one which is concerned with the descriptive features of borderline personality disorder, i.e., representative symptomatology which distinguishes it from other forms of psychopathology; and the other which investigates the development of life-long behavioral patterns and methods of interacting with others. A discussion of the descriptive features will be presented in the next section.

Descriptive Approach

The focus of most of the current research on borderline personality disorder has centered on studies which have characterized and discriminated the borderline diagnosis from other forms of psychopathology. Some studies have sought to outline consistent diagnostic criteria, while others have attempted to draw comparisons between borderline personality disorder and differing diagnostic schemes. The research which has helped to establish the behavioral characteristics of the disorder as they are included in DSM-III (1980) will be presented in the first part of this section. Then, the investigations which have helped to differentiate it from other Axis I and II diagnoses will be discussed.

Defining characteristics for DSM-III. The search for behavioral characteristics and descriptive features of borderline personality disorder began, as mentioned, with the seminal study of Grinker et al. (1968). The goals of this study were: (1) to distinguish the attributes of borderlines from other diagnostic categories by applying the psychoanalytic concepts of ego functions (perception, language, affect and defenses, and synthetic capabilities) to behavioral observations; and, (2) to determine if the borderline grouping was composed of multiple subcategories. Fifty-one borderline patients were rated by hospital staff on 93 behavioral measures. The most common characteristics were found to be: (a) anger as a main or sole affect, (b) defect in affectional relationships, (c) absence of consistent self-identity, and

(4) depressive loneliness. Using cluster analysis, four subgroups of borderline disorder were delineated: a group on the psychotic border; the core borderline group; an affectless, adaptive, "as-if" group; and, a group bordering the neuroses.

The Grinker et al. (1968) research showed merit because it was empirically designed, based on sound statistical procedures, and because the authors attempted to validate their typological results by a follow-up study and by correlation with family dynamics (Werble, 1970). The study may be criticized, however, on several grounds: (1) the sample selection was based on the diagnostic impressions of one psychiatrist, (2) there were no control groups for comparison purposes, (3) the population selected biased the study because most of the patients included were psychotic on admission, and, (4) a structured means of data collection was not employed.

Updating the original study, Grinker and Werble (1977) used information from hospital records and research interviews to confirm their initial findings. A collective profile of the characteristics of 14 borderline patients was compiled from approximately 300 patients (excluding schizophrenics). The authors concluded that, in addition to their previous list of traits, the manipulative use of anorexia nervosa within the family system and the remembrance of early violent dreams characterized borderline psychopathology.

In another study Grinker (1979) attempted to rectify some of the methodological problems of the 1968 research by comparing samples of patients diagnosed as borderline to those diagnosed as schizophrenic. He concluded that the borderline sample represented a distinct entity,

and that psychotic episodes are more brief, ego-dystonic, and more quickly reversible in the borderline population compared to the schizophrenic group.

Gunderson, Carpenter, and Strauss (1975) reviewed the clinical characteristics and the pre-morbid and outcome functioning of matched samples of borderline and schizophrenic patients selected from 142 severely ill patients admitted to one of three hospitals. In determining the borderline sample, patients who did not demonstrate severe or continuous psychotic symptoms, or who were not diagnosed as schizophrenic, manic-depressive, or neurotic were included. Only those patients who were diagnosed with certainty as schizophrenic, and who also showed the presence of Schneiderian symptoms became part of the schizophrenic sample.

A comparison of the mean scores obtained on pre-morbid and outcome functioning rating scales showed no significant differences between the borderline and schizophrenic groups. There were, however, significant differences between the two groups in regards to symptoms: borderlines show fewer and less severe psychotic symptoms, more anger, and fewer but a relatively high amount of dissociative symptoms when compared to schizophrenics. Both groups manifest a high amount of anxiety (with borderlines less than schizophrenics), and clear evidence of depression. It was also found that over the course of time borderline patients remain unmarried, unemployed, subject to rehospitalizations, and symptomatic. They lead tumultuous lifestyles, have many somatic complaints, and experience great difficulty in their interpersonal relationships.

Using a similar methodology Willett, Jones, Morgan, and Franco (unpublished, 1973) compared a sample of male, military hospital inpatients whose behavior changed from psychotic to nonpsychotic during the course of hospitalization, to a group of patients whose behavior remained unchanged (either psychotic or nonpsychotic). They concluded that the only discriminative variable between borderlines and psychotic and nonpsychotic patients is their greater expression of anger. The procedures used to define the borderline groups in both this and the Gunderson et al. (1975) study discussed above, however, make generalizations to other borderline samples difficult.

Another difficulty of the two previous studies is that, although methodologically sound, they did not assess many areas which were considered to be diagnostically important. In 1976 Gunderson outlined a major study which compared depressive neurotics, schizophrenics, and borderlines based on characteristics ascribed to them in the literature. Diagnosis was made by the admitting physician at McLean Hospital, and subjects whose primary diagnosis was alcoholism or drug abuse and those showing signs of organicity were eliminated from the sample. All subjects were administered the Diagnostic Interview for Borderlines (DIB), a semistructured interview designed to assess areas of functioning considered characteristic of borderlines. These include social adaptation, impulse-action patterns, affects, psychotic symptoms, and interpersonal relationships.

In the area of social adaptation results showed that, like the schizophrenic group, borderlines do not exhibit a stable work history. In comparison to neurotics, however, they show a tendency to lead

active social lives. There also is a high degree of impulsive behavior when compared with other groups. This is usually manifested by self-destructive acts, habitual abuse of illicit drugs, and deviant sexual practices. In the area of major affects, borderlines most often report feeling angry, anxious, or depressed. Their psychotic experiences are not severe, and, contrary to previous studies, they rarely have dissociative experiences. Of most significance in discriminating borderlines from neurotics and schizophrenics is the manner in which they function in interpersonal relationships. They exhibit a hostile, manipulative interpersonal style, and form intense but unstable close relationships. Unlike schizophrenics, they are highly dependent, masochistic, and fear being alone.

In a follow-up to this study Gunderson (1977) used a one-way ANOVA on the 29 summary scores of the DIB for matched samples of borderline, depressed, and schizophrenic patients. Results showed that all five sections of the DIB could be used to discriminate the borderline population, and only eight of the 29 statements failed to measure significant differences with at least one control group.

Expanding again on this research Gunderson and Kolb (1978) used the same samples and performed a stepwise discriminant function analysis on the 29 summary scores and the final scores on the DIB to develop a more highly discriminating list of characteristics of borderline psychopathology. When compared to schizophrenic patients, borderlines rarely show a flat affect, are much less isolated, form intense interpersonal relationships based on devaluation and manipulation, and abuse drugs more frequently. Rather than psychosis, the

impulse/action patterns and interpersonal relations scores proved to be more useful in discriminating borderline disorder from schizophrenia. Because these latter attributes are suggestive of more enduring behavior patterns, the authors concluded that focusing on symptomatology is not useful when making a differential diagnosis.

In comparison to neurotic depressed patients, drug abuse, occasional psychotic and paranoid experiences, deviant sexual patterns, lower achievement records, and unstable interpersonal relationships are useful discriminators for borderlines. Finally, when borderlines are compared to all other patients, seven characteristics sharply discriminate them: low achievement, impulsivity, manipulative suicide attempts, heightened affectivity, mild psychotic experiences, high socialization, and disturbed close relationships.

As a result of these three studies, Gunderson and his associates concluded that their borderline sample represented a distinct entity, and concurred with Grinker et al. (1968) that the syndrome represents a definable form of personality disorder. They also reported, however, that on the section scores of the DIB, a focus on symptoms would prove less valuable diagnostically than an examination of the more enduring and consistent personality patterns.

In a replication study of Gunderson (1977) and Gunderson and Kolb (1978), Soloff and Ulrich (1981) found strong support for the reliability of the DIB and validation of the diagnostic criteria previously suggested. Their borderline sample was compared with control groups of nondelusional unipolar depressed and schizophrenic patients. Of the 29 summary statements on the DIB, borderlines significantly

differed from depressives on 16, and from schizophrenics and both groups taken together on 19. Like the McLean study, the borderline group differed most strikingly from the others in the areas of interpersonal relations and impulse action patterns. These patients did not differ from schizophrenics, however, in the occurrence of psychotic symptoms after drug use or in the frequency of brief paranoid experiences. In addition, there was no evidence for differences among groups for the dissociative experiences of depersonalization or derealization or for the compulsive need of the borderline to avoid being alone. The authors attributed these discrepancies to differences in diagnostic style and homogeneity of the groups in the two settings. They also explained that the higher level of prediction for borderline pathology that was achieved in this study compared to the Gunderson and Kolb (1978) research might be due to bias introduced by pre-interview screening by the rating psychiatrists. They suggested that a more rigorous test for the validity of the DIB, i.e., the borderline concept, would be for raters who are "blind to diagnosis and naive to theory" (p. 692) to evaluate consecutive or random admissions.

In their 1978 study Perry and Klerman performed a comparative analysis of the diagnostic criteria used by Knight (1953), Kernberg (1967), Grinker et al. (1968), and Gunderson and Singer (1975). They found an astonishing lack of overlap of the 104 total number of criteria of the four systems; half were represented in only one of the four sets. They concluded that a possibility existed for subtypes within the borderline diagnosis, and they raised doubts as to the validity of borderline as a discrete and definable diagnosis.

Results of a later study, however, contradicted these findings and offered support for the descriptive validity of the borderline concept (Perry & Klerman, 1980). On the basis of a literature review, the authors constructed a rating instrument, the Borderline Ego Functions Inventory, which was completed by mental health workers and psychiatric nurses after interviewing 18 patients diagnosed as borderline and 102 patients of other diagnoses. They found that 81 of the 129 items significantly distinguish borderlines from the other diagnoses; from these items they constructed the Borderline Personality Scale (BPS).

Using the BPS they found significantly higher mean rating scores for borderlines than for all other groups. In comparison with the research done by Gunderson et al. (1975), Carpenter, Gunderson, and Strauss (1977), and Gunderson and Kolb (1978), one variable, affective instability was more prominent in the borderline sample. For the most part, however, the same variables were found to be characteristic of borderlines in each investigation. In addition, eight of the nine criteria for borderline diagnosis suggested by the Spitzer, Endicott, and Gibbon (1979) research were upheld in this study. These were later adopted in DSM-III.

Further support for the results obtained by Gunderson and Kolb (1978) was offered by Sheehy, Goldsmith, and Charles (1980). Over a one-year period they administered a specially designed Symptom Check-list which was derived from a review of the literature. Using randomly selected groups of new patients diagnosed as borderline, schizophrenia, neurotic, and nonborderline disorders they demonstrated that there was a significant difference between the borderline and the other groups,

and that the most discriminative attributes of borderlines appear to be intense affects, impulsivity, and disturbed interpersonal relationships. They also suggested that impaired reality testing should be considered as a criterion even though it was not included in the current edition of DSM-III.

Extending the Sheehy et al. (1980) study, and using the Diagnostic Interview for Borderlines, Koenigsberg (1982) made a comparison between 24 nonhospitalized and 14 hospitalized patients diagnosed as borderline. Although the hospitalized group showed a significantly greater tendency toward self-mutilation, suicide threats, and drug abuse, he concluded that both populations represented the same diagnostic entity.

Kroll et al. (1981) also investigated the validity of the borderline concept. They compared for overlap the assigned diagnoses of 117 inpatients using DSM-III criteria, the DIB, the MMPI, and the Spitzer-Endicott-Gibbon checklist (SEG). The authors hypothesized several conclusions from the data. First, they asserted that the DIB was significantly related to all of the three other variables thus supporting the construct validity of the borderline concept. Second, they agreed with Kolb and Gunderson (1980) that difficulty arises when attempts are made to discriminate borderline from other personality disorders. Finally, they suggested that the present formulation of DSM-III criteria for borderline psychopathology may not be useful, suggesting that brief psychotic episodes, impulsiveness, and disturbed interpersonal relationships are the most important discriminators for borderlines.

Pope, Jonas, Hudson, Cohen and Gundersona (1983) attempted to test the validity of DSM-III borderline personality disorder by reviewing the cases of 33 borderline patients in the areas of phenomenology, family history, treatment response, and long-term outcome. They found that: (1) a distinction could be readily made between borderline personality disorder and schizophrenia, (2) some patients with borderline personality disorder also concurrently displayed major affective disorder and were shown to have a better prognosis and outcome, and, (3) virtually no separation could be made between borderline and histrionic and antisocial personality disorders. They concluded that borderlines represent a "stable form of serious psychopathologic disorder" (p. 30), and do not appear to lie on the "border" of affective disorders or schizophrenia.

In 1979 the Task Force on Nomenclature and Statistics sought to develop criteria for the borderline conditions for their inclusion in DSM-III. In order to clarify how the term was currently being used Spitzer, Endicott, and Gibbon (1979) constructed two item set lists from data obtained from the literature, and mailed them to 4,000 psychiatrists. The results suggested that the 18-item list could accurately discriminate borderlines from nonborderlines 88% of the time, while the 9-item list could do so 80.9% of the time. Spitzer and his associates concluded that there were two dimensions of the borderline concept: a group of stable characteristics related to the schizophrenic spectrum (Wender, Rosenthal, Zahn et al. 1971; Kety, Rosenthal, Wender et al. 1968); and, a constellation of relatively enduring personality characteristics described by Gunderson and Kernberg and related more to affective instability. In DSM-III the

schizophrenic-like group became known as schizotypal personality disorder, while the affective-like group was named borderline personality disorder. It was agreed that the schizotypal diagnosis can be made when a person exhibits four of the following behaviors: magical thinking, ideas of reference, social isolation, recurrent delusions, depersonalization and derealization, odd speech, inadequate rapport, and undue social anxiety or hypersensitivity to real or imagined criticism (APA, 1980).

Extending these results, McGlashan (1983a) applied three sets of diagnostic criteria, the DIB, and both the DSM-III criteria for borderline and schizotypal disorders, to the clinical records of 400 former inpatients. He found a strong justification for validity of the DSM-III division of borderline syndrome into two distinct entities: borderline personality and schizotypal personality disorders.

This section has been concerned with evaluating studies which have outlined characteristics of borderline psychopathology. However, one difficulty in many of the above studies rests in their methodological circularity. The same characteristics, which made differentiation between groups possible prior to administration of the rating scales or the interviews, were cited in the results. Diagnosed "certain borderlines" were observed or interviewed in order to describe borderline pathology, and then they were ascertained to be "borderline".

In the next section, the research which has assisted in differentiating the diagnosis from the schizophrenic and affective disorders will be reviewed.

<u>Boundaries with schizophrenic and affective disorders</u>. Many early researchers noted a similarity between certain borderline states and schizophrenia. They suggested a number of labels for the phenomena as well as many overlapping descriptive clinical criteria. In 1941 Zilboorg coined the term "ambulatory schizophrenia" to describe some of his patients who appeared normal, but who had difficulties with interpersonal relations, thought processes, adaptation to reality, affective stability, and impulse control. Although they did not require hospitalization, they were considered to have a mild form of schizophrenia. Other labels included "preschizophrenia" (Rapaport, Gill, & Schafer, 1945), "latent schizophrenia" (Federn, 1947), the "pseudoneurotic schizophrenic" (Hoch & Polatin, 1949), the "latent psychotic" (Bychowsky, 1953), "schizotypal" (Rado, 1956), and the "psychotic character" (Frosch, 1964, 1970).

The link between borderline personality disorder and schizophrenia evolved for several reasons (Gunderson, 1984). First, it was noticed that the behavior of borderlines became regressive, even psychotic, both on unstructured psychological tests and during unstructured treatment such as classical psychoanalysis. Second, results from adoption studies (Kety, et al., 1968) indicated a high incidence of certain types of borderline schizophrenia in the biological relatives of adoptive schizophrenics. In many person's eyes this established a direct genetic link between borderlines and the major Axis I disorder of schizophrenia. This data continued to be influential in the establishment of the schizotypal category of borderlines in DSM-III years later. Finally, Carpenter et al. (1977) and Gunderson,

Carpenter, and Strauss (1975) found similar outcomes in recidivism, symptomatology, social relations, and employment after 3 and 5 years for matched samples of borderlines and schizophrenics.

More recent research has failed to support a strong link between borderline personality disorder and schizophrenia (Aronson, 1985; Gunderson, 1984). Clearer distinctions can now be made concerning the expected pattern and quality of responses of the two groups on psychological tests (Carr, Goldstein, Hunt, & Kernberg, 1979; Singer & Larson, 1981). Descriptive differences may also be seen in the quality of interpersonal relationships and affective expression. Recent studies have also failed to demonstrate a gravitation from borderline to a schizophrenic diagnosis (Akiskal, 1981; Carpenter et al., 1977; Gunderson et al., 1983; Loranger, Oldham, & Tulis, 1982; McGlashan, 1984; Pope et al., 1983; Stone, 1980; Werble, 1970). In addition, McGlashan, (1983, 1984) has found that prognosis may be better for borderlines than for schizotypals, a diagnosis which he considers to be variant of schizophrenia. Finally, the genetic linkage suggested by Kety et al. (1968) may merely be tautological and overstated (Aronson, 1985). Research now indicates that genetic (Torgensen, 1984) and familial (Baron, 1983; Kendler, Gruenberg, & Strauss, 1981) connections may be associated between schizotypal personality disorder and schizophrenia, but not with borderline disorders.

For the last twenty years the shift of many researchers has been toward defining the affective component of borderline psychopathology. This emphasis is reflected in the current DSM-III-R nosology with five of the eight criteria highlighting affective behavior. Although most

researchers concur that the borderline diagnosis may be distinguished from schizophrenia, and some evidence has been presented for the justification of the schizotypal diagnosis, the relationship of borderline psychopathology to affective symptomatology is still much less clearly differentiated. Many recent investigations have described an overlap between depressive and borderline disorders (Akiskal, 1981; Akiskal, Khani, & Scott-Strauss, 1979; Akiskal, et al., 1980; Carroll, et al., 1981; Friedman, et al., 1982; Kroll, Carey, Sines, & Roth, 1982; Liebowitz & Klein 1981; Pope et al. 1983; Snyder, Sajadi, Pitts, & Goodpaster, 1982; Soloff, George, & Nathan, 1982).

Donald Klein (1975) was the first to hypothesize a connection between borderline and affective disorders, particularly depression. He used drug responsiveness data, family history data, and outcome study research to support his theory that many borderline syndromes are subgroups of the affective disorders. He and others have outlined subgroups of the borderline syndrome, and they have investigated their responsiveness to MAO inhibitors and lithium carbonate (Klein, 1977; Klein & Shader, 1975; Liebowitz & Klein, 1981; Rifkin, Levitan, Galewski, & Klein, 1972).

At the same time, Stone demonstrated both a very high prevalence of affective disorders in the borderline population, as well as a greater risk for affective disorder in their first-degree relatives (1977, 1979, 1980, 1981). Both he and Akiskal viewed the borderline diagnosis as a subgroup of affective disorders, while Akiskal suggested further that affective disorder is an outcome for many borderline patients (1981).

Akiskal has been the most vigorous critic of the validity of the borderline concept. He has claimed that its clinical symptomatology closely matches that of cyclothymic and dysthymic disorders, and he has questioned the strength of follow-up and familial data, some biological markers, and descriptive/phenomenologic information (1981).

Pope, et al. (1983) also found support for the overlap between borderline personality and the affective disorders. They argued, however, that rather than considering the borderline category as a subgroup of affective disorders, that both disorders are demonstrated simultaneously.

McGlashan (1983b) reached a similar conclusion in a long-term follow-up study comparing borderlines and other diagnostic groups on diagnostic overlap at admission, diagnostic change over time, and functional outcome. He found that, although the borderline and affective disorders are not similar, it is possible for depression to accompany borderline disorder without negating its validity as a diagnostic entity.

More recently, Perry (1985) compared patients diagnosed as borderline with those diagnosed as antisocial personality and bipolar II. He was interested in examining lifetime prevalence of depression at interview and longitudinal course of symptoms. He found a clear association between borderline psychopathology and depression in both the cross-sectional and longitudinal perspective. Major depressive episodes and anxiety symptoms were sometimes superimposed on underlying chronic depression in a high proportion of borderline patients. Interestingly, there was an interaction effect for depression in

subjects diagnosed as borderline and both borderline and antisocial personality disorders. Results showed that there were fewer symptoms of depression over time in subjects with both antisocial and borderline personality disorders depending on the more borderline psychopathology that was present. The author suggested that this result is consistent with the observation that the function of acting out in borderline patients is to protect against depression.

The affective overlap in the diagnoses of these two disorders has rekindled questions about the most basic assumptions on which current psychiatric nosology rests. At the heart of distinguishing between borderline and affective disorders is the issue of whether clear boundaries exist between definable diagnostic entities or whether disorders might better be considered as falling within a spectrum of heterogeneous groupings sharing some clinical similarities.

Alarcon, Walter-Ryan, and Rippetoe (1987) suggested that borderline personality disorder or some of its variants could be an integral component of almost all affective disorders. They claimed that affective disorders are inherently spectrum-oriented and may be defined as:

> "a group of conditions which do not fit the major, well-established categories, present a number of overlapping manifestations centered around affective disregulation, and are mainly characterized by depression, dysphoria, and severe 'personality' problems, or a combination of these three and other features" (1987, p. 299).

According to Alarcon and his associates, the core of the affective spectrum consists of two main vectors: depression and personality disorders most frequently of the borderline type. Superimposed along

the spectrum are the clinical entities of cyclothymic disorder, character spectrum disorder, depression spectrum disorder, bipolar affective disorder II, hysteroid dysphoria, and atypical depression.

In an attempt to summarize the literature on the intersection of borderline and affective disorders Gunderson and Elliot (1985) noted the emergence of three hypotheses: (1) that borderline disorders originate in affective disorders, (2) that affective disorders arise from borderline disorders, and, (3) that the two disorders are independent and overlap coincidentally. The authors argued, however, that none of these hypotheses sufficiently explain the current data. Based on information about the prevalence of the disorder, a description of its phenomenology, longitudinal research on its response to treatment, investigation of family prevalence in probands, biological factors, drug responsivity, and formulations from psychodynamic theory, the authors suggested that a fourth hypothesis was needed. This hypothesis recognized the heterogeneity within the borderline population, claiming that some patients have symptom clusters that fit both syndromes. They proposed that the key to overlap between the disorders may be found in a "constellation of innate and external factors that are inconsequential individually but combine to shape depression, chronic dysphoria, or borderline behavior ---alone or in any possible combination" (1985, p. 286). Thus, early psychological development may be impaired due to the presence of a biophysiological vulnerability for either disorder. The actual development of either, however, is dependent on later psychological and physiological reactions to temperament and environment.

To conclude this section it might be said that the advantage offered by the DSM-III classification is that it provides reliable diagnostic criteria composed of observable behavioral traits and symptomatology which are useful for describing subjects in research studies and clinical situations. There are several limitations to the descriptive approach, however, especially when considering borderline psychopathology. The first is that, as mentioned, considerable overlap may be found when attempting to differentiate between borderline and affective disorder diagnoses. The validity of the borderline concept might be most easily challenged in this regard. Second, many researchers view the descriptive approach as reductionistic; its focus on symptomatology detracts from dynamic understandings of defensive organization. Finally, there currently is no diagnostic criteria in DSM-III-R which allows for the vulnerability of borderlines to brief psychotic regressions under stress (Goldstein, 1984). The following section will attempt to address some of these issues by consideration of the psychodynamic perspective of borderline psychopathology.

Psychodynamic Formulations

Overview. Since the late 1960's a number of authors have written about the phenomenon of the borderline as a psychostructural concept. Derived from psychoanalytic theory, the literature reflects an amalgamation of object relations theory, ego psychology, and self psychology. In the last few years, however, a growing number of traditional psychoanalytic researchers have begun to incorporate the views of developmental psychology into their writings about the borderline patient. This interest has evolved from three sources:

recognition of the intense transference-countertransference issues evoked by the borderline patient in psychotherapy, observational research on the preverbal infant interacting with his or her mother, and study of the family in interaction (Shapiro, 1978).

Most influential to the developmental perspective have been the writings of Margaret Mahler (Mahler, 1968; Mahler, 1971; Mahler, Pine, & Bergman, 1975). Kernberg (1975), Masterson (1976), Rinsley (1978), and Gunderson (1984) have each incorporated different aspects of her writings into their own developmental models. These theorists share the belief that the development of adult borderline disorder may be related to object loss or to inappropriate early interactions between parent and child. Since each of these theorists either directly or indirectly place the etiology of the disorder within the interpersonal context of early life experiences, their contributions are of major interest to the purposes of this thesis. In the following section the theories of these authors will be reviewed with particular emphasis on how their works may be viewed through an interpersonal, systemic lens.

Contributions of major theorists. The view that the etiology of borderline pathology stems from real or threatened object loss in early life has been adopted and popularized by several prominent theorists (Gunderson, 1984 Kernberg, 1975; Mahler, 1968, 1971; Masterson, 1976). These authors agree that borderline psychopathology may be a consequence of a developmental arrest during the separation/individuation stage which occurs between the ages of 18 and 38 months. This developmental failure is the result of loss of maternal constancy by either death, separation, or more commonly, withdrawal of parental

affection. Soloff and Millward have labeled this phenomenon the separation hypothesis, and define it as "the loss of a significant love object in the earliest years of life, leading to developmental arrest and pathologic character formation" (1983, p. 580).

The research of Margaret Mahler on the separation-individuation process and its application to borderline personality disorder has been instrumental in the development of the separation hypothesis (Mahler, 1971; Mahler, Pine & Bergman, 1975). She suggested that borderline psychopathology develops as a consequence of the mother's emotional unavailability during the rapprochement subphase; this normally occurs between the sixteenth and twenty-fifth months of life. During this stage the child begins to differentiate and establish a personal identity. Growing up involves both physical and intrapsychic separation from a primary love object, namely the child's mother. The mother, not attuned to her child's needs for autonomy, responds to separation behaviors with emotional withdrawal while simultaneously rewarding clinging behavior. The child thus develops a preoccupation with fears about abandonment and engulfment and experiences a sense of identity diffusion.

According to Kernberg (1975) borderline children are unable to develop a stable ego structure due to their inability to integrate good and bad images of themselves and others. They maintain this lack of internal integration by using the primitive defenses of splitting, projective identification, devaluation, denial, idealization, and omnipotent control. Although the individual is able to establish ego boundaries and engage in reality testing, other ego functions such as

anxiety tolerance, impulse control, and the management of affect and feelings never fully mature. Thus, the individual is predisposed to an excessive amount of pregenital aggression, especially oral aggression, which tends to produce a premature development of oedipal strivings.

In his earlier writings Kernberg claimed that this predisposition to excess aggression was due to constitutional factors; he later became more equivocal (1967, 1975). From an interpersonal perspective, however, he did recognized that the child's extreme frustration was projected on to the parents, (most notably the mother), who then were viewed as dangerous and aggressive. The development of negative views of important objects is highly contradictory with positive images of those objects, and the intensity of the aggression threatens the destruction of the loving self- and object images by the hateful ones. To help the child resolve this conflict, Kernberg sees the tasks of the mother as being tolerant of the child's intense anger and repeated instinctual assaults during "excited" states, and as providing continuing love and nurturance in repeated daily interactions. This stance must be maintained throughout childhood until a stable ego identity is developed (1972).

Masterson's account of adolescent and adult borderline psychopathology (1972, 1976) has been greatly influenced by the work of Kernberg and Mahler. He believed that a splitting of the maternal and the self-representations is an intrapsychic result of maternal withdrawal during the separation/individuation process. This split object relations unit is composed of two part units: a withdrawing part unit and a rewarding part unit. In the withdrawing part unit the mother (or

object) is represented as attacking and critical when the child initiates age-appropriate separation behaviors; the self is viewed as bad, helpless, and inadequate; and the child experiences intense anger and frustration in attempting to ward off abandonment depression. In the rewarding part unit the mother (or object) is seen as approving and supportive when the child behaves in a dependent manner; the self is seen as passive and compliant; and the child experiences feelings of gratification and goodness.

Unlike Kernberg, Masterson focused more on the interactional processes between parent and child in the early years of life. He and Rinsley (1975) offered one of the most detailed theories delineating borderline family patterns. They believed that the mother of a borderline is most often a borderline herself. When her child begins to behave more autonomously, the anxiety associated with her attempts to separate from her own mother is recreated. Thus, she encourages her child's dependency in order to defend against abandonment depression and to maintain her own emotional equilibrium. The father, on the other hand, plays an important negative role. Rather than introducing the child to external reality and supporting extrication from the symbiotic maternal relationship, he encourages the mother's exclusive control of the child by his actual absence or emotional distance from the family.

The work of Gunderson (1984), in a sense, attempted a union among object relations, ego psychology, and developmental theories. He highlighted the contextual determinants of borderline psychopathology by describing three levels of psychological functioning that may be

predicted for the borderline depending on his or her current relationship with a significant, major object. Although he used the therapeutic relationship as the context for describing and predicting borderline behavior, the relationship to the systemic functioning of the family can be readily drawn; the borderline and other family members will function in an isomorphic manner with each other as they do with the therapist.

Within the first context, Level I, the primary object, the therapist, is seen as supportive and available. The borderline is able to function optimally, and may exhibit clinical signs of dysphoria, depression, and masochism because of fears of being controlled by becoming too dependent. At the second level the primary object is perceived as frustrating or in danger of being lost. The repertoire of defenses and their behavioral expression become more regressive, and the borderline usually responds with anger, devaluation, and manipulative behavior. At Level III the borderline feels totally abandoned and senses the absence or lack of any major object. Within this context the borderline can experience brief psychotic episodes, psychotic depressions, ideas of reference, and nihilistic fears. In addition, he or she may perform dangerously impulsive acts involving substance abuse, promiscuity, self-mutilation, or suicide attempts.

In this section the major psychodynamic theorists and their works have been reviewed. Although intrapsychic in nature and intent, it has been shown that each may be interpreted from an interpersonal, systemic context. In the following section the focus will shift to a brief

discussion of the characteristics and the relevant research of the bipolar disorder diagnosis.

Profile of the Bipolar Patient

Characteristics and Hypotheses of Bipolar Disorder

Unlike the borderline diagnosis which was included in DSM-III for the first time in 1980, bipolar disorder, or manic-depressive illness, has been researched for many years. It was first recognized in the writings of Aretaeus, a second-century physician who not only described the symptomatology of both mania and menancholia, but also noted a relationship between the two states (Arieti, 1974). Since the time of Aretaeus the concept of bipolar disorder has been shown to be both reliable and valid. With this established, a legion of investigators have examined its genetic, psychodynamic, familial, cultural, psychopharmacologic, and neurobiologic aspects. In this section the current theories and research about diagnostic issues will be addressed. Then, the genetic and neurobiologic hypotheses for the etiology of the disorder will be briefly examined. Finally, in the last two sections the psychodynamic and familial research will be reviewed.

Current diagnostic issues. As mentioned previously, classification of affective disorders in DSM-III-R (1987) is made on the basis of whether or not the disorder is major and episodic, or less severe and chronic. Bipolar disorder is distinguished from major depression by the presence of a current or past manic episode.

Depending on current state, it is further classified as mixed, depressed, or manic.

Closely related to bipolar disorder is cyclothymia, a disorder in which there have been numerous periods of hypomanic behavior and depressed mood for at least two years. With cyclothymia, however, there has never been a marked impairment in occupational or social functioning.

In another category, bipolar disorder not otherwise specified, manic or hypomanic features are present, but the criteria for any specific bipolar disorder are not met. For example, the individual may have experienced a major depressive episode as well as at least one hypomanic episode. This condition has been known as Bipolar II, and is generally considered to be a milder version of Bipolar I. It is possible that Bipolar II is a completely distinct entity, or it may be simply an intermediary between Bipolar I and major depression (Coryell, Endicott, Andreason, & Keller, 1985).

Klerman (1981) has suggested that there are no less than six separate subtypes of bipolar disorder. He has labeled the classic cycling type of manic-depressive disorder Bipolar I. Bipolar II is characterized by periods of depression and of hypomania (during which the person experiences talkativeness, decreased need for sleep, elation, but generally intact reality testing). This variety was first described by Dunner and his colleagues (Dunner, Dwyer, & Feive, 1976; Dunner, Gershon, & Goodwin, 1976). The third group, Bipolar III, includes patients who become manic or hypomanic when given tricyclic antidepressants; they previously had not experienced spontaneous

episodes. In the Bipolar IV group Klerman includes persons with cyclothymic personality. These persons normally experience highs and lows, and often respond well to lithium. In the Bipolar V classification are persons who have a family history of bipolar illness, but themselves do not show significant symptoms. Finally, unipolar manic patients comprise the Bipolar IV grouping. Not included in Klerman's classification are persons who undergo rapid-cycling bipolar illness, and manias which are secondary to drugs or other physical illnesses.

Genetic research on bipolar disorder. Evidence for a genetic predisposition for bipolar disorder comes from family studies, twin studies, adoption studies, and from genetic linkage studies. Leonhard, Korff and Schultz (1962) first demonstrated that bipolar illness clusters in families. They noted that bipolar patients have a greater genetic loading for affective disorders than unipolar patients. Also, compared to patients with unipolar illness, these families have a higher frequency of psychosis, suicide, and bipolar symptomatology among their relatives. Perris (1966) noted that affectively ill relatives of unipolar patients tend to have unipolar but not bipolar illness, whereas affectively ill relatives of bipolar patients normally have bipolar but not unipolar illness. In another major study done at Washington University, a high familial risk for affective disorder in relatives of bipolar patients was found (Clayton, Pitts, & Winokur, 1965).

Early research by Kallman (1954) on twin studies demonstrated very high agreement rates for bipolar illness in monozygotic versus

dizygotic twins. This work is still considered definitive. In addition, Davis et al., (1986) reviewed twin studies and found that only one-fourth of the identical twins were not concordant for affective disorder. It was also unusual to find a mix of bipolar and unipolar for those who were concordant.

The presence of a genetic component for bipolar disorder was also cited in several adoption studies. Cadoret (1978) found evidence which suggested that primary affective illness may have a familial factor. Also, Mendlewicz and Ranier (1977) concluded that a greater degree of affective pathology exists among biologic rather than adoptive parents.

Finally, investigations which have attempted to find a genetic linkage for affective disorders have been controversial. Some studies have supported the role of a major locus for bipolar disorders on the X chromosome (Goetzl, Green, Whybrow, & Jackson, 1974; Mendlewicz & Fleiss, 1974; Winokur, Clayton, & Reich, 1969; Zompo, Bocchetta, Goldin et al., 1984). In other studies these data could not be replicated, however (Gershon et al., 1979; Gershon, 1980). Recently, Kidd, Gerhard, and Kidd (1984) used recombinant DNA techniques and found evidence that a major locus for affective disorder might be located on the short arm of Chromosome 11. More research is needed to support a genetic linkage for bipolar disorder.

Neurobiologic hypotheses. Several hypotheses have evolved about the mechanisms by which therapeutic drugs produce changes in neurotransmitter substances in bipolar patients. The pioneering work of Schildkraut (1965) and Bunney and Davis (1965) has suggested a role for

catecholamines in the etiology of affective disorders. They theorized that low brain norepinephrine produced depression and high brain norepinephrine was responsible for mania. In later studies Schildkraut (1973) and Schildkraut and Kety (1967) concluded that drugs that are effective in the treatment of depression can also improve mood by increasing noradrenergic neurotransmission. They suggested that the converse might also true: drugs which are used in the treatment of manic behavior and also produce depression, often will decrease or antagonize noradrenergic activity. This theory, known as the <u>catecholamine hypothesis</u>, is incomplete, however. It fails to explain why, if norepinephrine levels return to normal within 24 hours on antidepressants, it takes 10-14 days for a patient's depression to lift (Maxmen, 1986).

Another hypothesis, the <u>seratonin theory</u>, states that depression is caused by low brain seratonin, therefore, mania must be caused by high brain seratonin (Prange, Wilson, Lynn, Alltop, & Stikeleather, 1974). To date this theory has not been supported in pharmacological studies.

Finally, Janowsky, El-Yousef, and Davis (1972) and Janowsky (1986) proposed an interactive model, the <u>adrenergic-cholinergic imbalance hypothesis</u> of affective disorders. They viewed mania as a disorder of adrenergic predominance due to increased acetylcholine activity. They suggested that mania is a syndrome of normal or increased noradrenergic or dopaminergic activity compared to relatively diminished central acetylcholine activity. To date results are still inconclusive. It can be concluded that more research is needed on each of these

hypotheses in order to establish a direct link between availability of neurotransmitter substances and manic symptoms.

Psychodynamic Formulations

Psychoanalytic literature on the etiology of manic-depressive illness demonstrates a wide divergence of opinion. In the following section, the earlier writings will be reviewed. Then the focus will shift to the work of Melanie Klein and the object relations theorists.

In 1911 Abraham made the first systematic attempt to explain manic-depressive illness in terms of psychoanalytic theory. He compared depression with normal grief and mourning, and suggested that the important difference between them was that the mourner is consciously concerned with the lost object, whereas the depressive is dominated by feelings of loss, guilt, and low self-esteem. In the latter case, unconscious hostility for the lost person is directed inward, is perceived as rejection, and confused with earlier traumatic experiences.

Abraham pointed out five factors that are basic to melancholia: (1) a constitutional tendency to oral eroticism; (2) a fixation of libido at the oral-aggressive level; (3) a successive disappointment in love objects; (4) severe disappointment in the mother before resolution of the Oedipus complex; and, (5) a repetition of this disappointment later in life, leading to the onset of melancholia (1911). Abraham thought that regression to the oral level of libido development brought out the characterological features of envy, impatience, increased

egocentricity, and intense ambivalence. In addition, the capacity to love is paralyzed by hate leading to feelings of impoverishment. He concluded in his work that depressive and manic phases are dominated by the same complexes, but the depressive is defeated by them whereas the manic ignores or denies them.

Abraham later attempted to locate specific fixation points in different phases of libidinal developments (1924). He placed the fixation point to which the bipolar regresses at the end of the second biting oral phase and the beginning of the first expelling anal stage. Fixation at this stage could explain the intrapsychic characteristics of dominating possessiveness, envy, exploitation, intense ambivalence, and exaggerated optimism or pessimism. Later object loss or frustration is an unconscious reminder of earlier maternal unavailability during the transition from the oral to the anal phase.

In 1921 Dooley studied five manic-depressive patients. She concluded that bipolar episodes are the result of deep regressions to the sadomasochistic level of the child where autoerotic wishes are satisfied by hypochondriacal complaints. She suggested that the manic attack is a defense against the realization of failure.

> "Patients who manifest frequent manic attacks are likely to be headstrong, self-sufficient, know-it-all types of person, who will get the upper hand of the analyst...The analyst is really only an appendage to a greatly inflated ego" (1921, p. 68).

Interpretation of the differences between normal mourning and melancholia, and the psychogenic nature of manic states were formulated by Freud (1917). He stated that the essential difference between grief and depression was that in the latter there is a marked loss of

self-esteem, i.e., the ego itself becomes poor and empty. In normal mourning there is an ambivalence between libido attachment and detachment which eventually results in a rechannelization of the libido toward new objects. This is not the case, however, in melancholia. The loss remains unconscious, an intensified identification develops, the ambivalent struggle is internalized, and strong resistances are built against detachment and reorientation to reality. The depressive's self-accusations may be seen as reproaches against the internalized love/hate object, and the self torture may be simultaneously seen as a form of revenge against and attempt at reconciliation with the lost object.

Freud explained mania as a result of tensions between the ego and ego ideal. The manic phase is representative of a triumphant reunion between these two contenders. Once the lost or frustrating object is re-established by identification in the ego, it is cruelly tormented by the ego ideal. The ego then rebels, and ego and ego ideal are united in a sense of expansive self-inflation.

Melanie Klein (1948) has suggested a different psychodynamic basis for the development of depression. She assumed that the ego is built up on early introjection, but it is endangered by disruptive projections and disintegration because it is still relatively weak. The basis for depression is formed during the first year of life when the mother is first recognized as a person. She is seen by the child, and the child views him/herself as "good" when she provides gratification, and "bad" when she frustrates or withholds. This splitting of internal objects becomes dangerous when the child receives an excess of

bad experience with a frustrating mother. The child becomes hateful and enraged, tries to eliminate bad feelings by denial, and becomes both guilty and anxious. Klein calls this the depressive position. The child grows helplessly dependent on the mother, idealizes her, and attempts to transform the bad into good. Resolution of the depressive position normally occurs when the infant realizes that the hated mother (the bad object) and the loved mother (the good object) are actually one (a whole object). If this resolution does not occur, however, the pathological basis is set for the development of depression in adult life.

Klein saw the manic reaction as a pseudo-repair action in which there is an attempt to reconcile frustrating objects or goals by using inadequate means of primitive defense, i.e., splitting of good and bad, overidealization of the good, and contemptuous denial of the negative.

Cohen (1954) drew heavily from Klein's work and postulated a curvilinear relationship between interpersonal relationships and maturity of object relations for schizophrenics, manic depressives, and neurotics. Initially, interpersonal closeness is great, identification is high, and dependence is intense. A fixation at this point is suggestive of schizophrenia. As relationships develop, closeness based on identification diminishes, but mature object relations based on viewing others as whole, separate persons have not yet fully developed. Cohen believed that this is the fixation point for manic-depressives, a time in development when isolation is intense because the mechanism of identification is no longer employed and more sophisticated object relations have not yet developed. As a result, the

child becomes extremely sensitive to threats of abandonment and defends against depression.

Cohen suggested that adult manic-depressives have normal infancies because the infant's dependency is pleasurable for the mother. But as the child begins to assert his or her autonomy, the mother feels threatened. She labels independent behavior as bad and punishes the child for it. Thus, the manic-depressive child is developmentally unable to mature to a full integration of whole object relations.

In the next section a review of the relevant reaearch on borderline and bipolar family systems will be presented.

Research on Family Systems

The Borderline Family

Most of the research on borderline family systems has occurred within the last ten years, and has been descriptive or anecdotal rather than empirical in nature. In addition, the sizes and characteristics of the samples and the methodologies used have rarely been specified. Moreover, the results have been varied and at times conflicting. For example, the bordeline family has been viewed as a unit which is not mutually protective, and it has been characterized as rejecting, covertly hostile, and unrelated (Frank & Paris, 1981; Grinker et al., 1968; Gunderson et al., 1980; Walsh, 1976). This may be contrasted to research which describes family members as highly overinvolved with each other and engaging in transactions which are dominated by

primitive defenses (Shapiro et al., 1975). These studies and others will be discussed in more detail in the following section. The characteristics of borderline family systems will be outlined first, then the literature on parent/child relationships will be reviewed.

Familial characteristics. The first empirical investigation concerned with the families of borderlines was conducted by Grinker et al. (1968). They attempted to describe how the family unit functions in relation to the patient's illness, how it maintains a sense of integration, and how it resists disintegration. Although they noted a wide range of family functioning, they outlined the characteristics of three distinct family types. In the first, the family is described as a non-protective unit which is incapable of resisting disintegration. There is a high amount of marital discord, family conflict, role rejection, and confusion. This contrasts with the second type of family whose members are seen as excessively protective and often smothering and suffocating. The function of this overprotectiveness is to help the family resist disintegration. Finally, in the third type of family, conflict and problems are denied. There is an absence of discordant marriages and a dominance of extremes of parental affect. The investigators concluded that borderlines come from one of these three types of pathological family systems. The exact nature of the familial pathology, however, could not be delineated.

Although seminal in nature, the Grinker study may be criticized on several grounds: (1) control group comparisons were not made, (2) preexisting records were used with roles of informants varying from

family to family, (3) the demographics of the sample were not included, and (4) subjective bias made interview reports less valid.

Wolberg (1952) suggested a theory about family dynamics in which borderline pathology can best be understood by examining the patterns of acceptance and rejection in the family unit. She noted that the borderline comes from a disorganized family in which the parents were unable to function as a unit. The patient experiences a pattern of alternating acceptance and rejection resulting in expression of aggression and sexual behavior.

In a later descriptive study of ten borderline patients Wolberg (1968) hypothesized that the parents of borderlines unwittingly sanction their children to engage in all types of anti-social, acting-out behavior in order that they might derive unconscious gratification of their own poorly integrated impulses. The sado-masochistic role that the child assumes leads to distrust in interpersonal relationships, feelings of exploitation, and eventually detachment and depression. In addition, Wolberg noted a pattern that exists in the relationships between parents and borderline children. Basically, it involves rejection of the child by the same-sex parent and encouragement of an intimate relationship with the opposite-sex parent. The result is that the child identifies with both parents, but experiences a strong reaction-formation against the opposite-sex parent. As adults, both male and female borderlines are driven toward the opposite sex, but the pattern is one of seduction then rejection.

Walsh (1976) conducted a retrospective study using the perceptions of fourteen borderline patients who were part of a previous

nonschizophrenic control group (Wolberg, 1977). Interviews, questionnaires, projective techniques, and direct observation were used to collect data on family characteristics and a family case illustration. In regards to separation stresses she found that borderlines have a significantly lower frequency of intact families than schizophrenics, and that a majority have experienced serious parental illness, parental separations, death of an important relative such as a grandparent, and marriages that end in divorce. Walsh concluded that very few interests or activities are shared as a family, parents generally give in to the patient's demands, and discipline is inconsistent. In addition, family members have difficulty understanding each others perceptions, and problems are solved by accommodation rather than by open negotiation.

Zinner and Shapiro (1975) hypothesized that adolescents' attempts to achieve separation and individuation reactivates severe childhood conflicts in borderline families. Separation is viewed as dangerous, and hate and rage are evoked. Conversely, dependence on the part of its members represents an overwhelming burden to the family unit. The family fears that if hostile feelings are expressed, however, the loved object will be destroyed. Unconsciously it uses the defenses of splitting and projective identification in the assignment of good and bad part-object roles to its members. These split off projections can take a variety of configurations, e.g., of the good/bad child, the good/bad parent, or the good family/bad community. The projections also replicate the patterns of interaction in the parents' families of origin. Parents tend to view the borderline child either as one of their own parents, or as themselves as children.

Shapiro, Zinner, and Shapiro (1975) and Shapiro (1978) used their clinical observations of fifty adolescent in-patients and their families to evaluate the contribution of the family to borderline development. They observed the parents' personalities in their families of origin, how current family relationships evolved, and how current family patterns of interacting compared with earlier behavior patterns. They concluded that there are two types of borderline families. In the first, the borderline is encouraged to remain dependent because autonomous behavior represents a hostile condemnation of the family. In the second, participation with the outside world is encouraged because parents perceive dependent needs in the patient as hostile and they react to them by withdrawing. In both of these families projective identification is part of the parent/child relationship. Communication becomes distorted, interactions are chaotic, and responses are stereotyped around issues of autonomy and dependency. The marital relationship is characterized by a complementarity of defenses, and parents are enmeshed with their own families of origin. Early interactions between parent and child are dominated by these unconscious assumptions, and these conflicts are thought to be one important basis for the borderline's internalizations (Shapiro, Shapiro, Zinner, & Berkowitz, 1977).

Mandelbaum (1977) theorized that the treatment of choice for borderline disorder should be family therapy because the borderline is caught in a system which prevents development and makes change dangerous. He noted that the family has no real sense of itself as a whole, nor do members recognize their own or others' uniqueness.

Members may be both overresponsive to each other at the same time that they may use distancing maneuvers. Communication may be hostile and volatile, and boundaries are weakly defined. Sometimes the parents may become helpless and irresponsible forcing the children to accept executive roles.

Specific characteristics of borderline family systems have been suggested by a number of authors. After a careful review of the literature, Gunderson and Englund (1981) concluded that the dynamics of borderline systems could be explained in four ways. First, there is often an intensive overinvolvement between the borderline and his or her parents. This usually occurs with the mother. Second, the personality of the growing child is greatly influenced by the degree of the parents' use of projection in order to maintain emotional equilibrium. In the third type of family, neglect is the characterizing factor. Parental deprivation, rejection, and abuse create feelings of helplessness and anger in the child. In the fourth pattern the authors describe problems of poor role modeling by the parents; this can create identification issues for the growing child.

In a more systematic study Gunderson, Kerr, and Englund (1980) compared the families of borderlines to those of diagnosed paranoid schizophrenics and neurotic personality disorders. The authors offered the following conclusions:

> "The results of this study combine to form a consistent composite picture of certain characteristics of the families of borderline patients. Both the mothers and the fathers in these families were sicker and less functional than in the comparison groups. Their marriages were marked by a relative absence of overt hostility and conflict. Their attachment to each other seemed to be at the expense of their children, either as regulators and

> monitors of their behavior or as source of gratification and support, or even as clear role models. In short, these families were best characterized by the rigid tightness of the marital bond to the exclusion of the attention, support, or protection of the children" (p 31).

Based on his observation of borderline family systems, Mandelbaum (1980) suggested seven characteristics which he viewed as typical of the patterns of interaction: (1) marital relationship are troubled and volatile and children are used as targets for projection or defenses against marital difficulties; (2) parents compete for control and have difficulty setting rules; (3) both parents are deeply enmeshed with their respective families of origin; (4) there is a high incidence of trauma experienced in early childhood caused by death, separation, divorce, physical problems, or substance abuse: (5) parental roles and marital boundaries are blurred; (6) boundaries between parents and children are blurred leading to confusion over sexual identity and independence; and, (7) there is a history of multiple generations of difficulties in interpersonal relationships.

Berkowitz (1981) noted the discrepancies in the literature concerning the different "types" of borderline systems and concluded that the common denominator among all families is the borderline's fear of abandonment and the parents' failure to support individuation. Most commonly this becomes problematic during adolescence, however, empathetic failure by the parents at an earlier stage would most likely continue and be compounded at later developmental milestones.

Some corroboration of the Gunderson et al. (1980) research on the characteristics of borderline families has been offered by Schwoeri and Schwoeri (1981). From their clinical experience they listed five

qualities: (1) the children function to divert conflict between the parents by acting out the parents' disavowed projections; (2) denial, rationalization, and minimilization are used in the face of violent or sexually aggressive behavior; (3) the marital relationship appears to function well at the expense of the children because the children become parentified and are used as sources of nurturance and support; (4) parental rules and consistent discipline are lacking; and, (5) splitting is used as a defense.

In addition to descriptive studies several researchers have attempted to take a somewhat more systemic approach. Colson (1982) suggested a different way to view the function of borderline disorder within the family system. On some level borderlines understand that their capacity for autonomy is potentially destructive to the psychological well-being of the family system. They use splitting to deal with their own rage over stifled growth and to protect the good parental and family images from destruction by aggressively cathected bad images.

Goldstein (1983) suggested an ecological approach to borderline treatment. Assessments must account for: the person, the social environment, the family life cycle, the family system, and the parental dyad. Using this system in his clinical practice, Goldstein described three patterns of borderline families: "triangulated, highly involved families, rejecting or distant families, and idealizing families" (p. 355).

Soloff and Millward (1983), compared the developmental histories of borderline, depressed, and schizophrenic patients in order to test

the separation hypothesis of borderline disorder. The separation hypothesis suggests that borderlines experience significantly more real or threatened object loss (deprivation of maternal constancy) during the separation/individuation stage of development. The authors found support for this hypothesis noting increased incidences of broken families and a greater number of problems with normal separation events.

Impressions of the adult borderline of his or her family experience during childhood and adolescence were collected by Snyder, Pitts, Goodpaster, and Gustin (1984). They used a standardized scoring instrument, the Development and Social History (DASH) questionnaire, in order to evaluate broad aspects of early family life from a predominantly male sample of rigorously diagnosed borderline patients. They concluded that both parents establish rules which are generally inflexible and rigid, but neither punishes their children excessively or often. In addition, the marital unit is described by a significant number of patients as highly conflicted.

Observation of sixteen families lead Feldman and Guttman (1984) to describe two types of borderline systems. In the first, one of the parents is literal-minded and is unable to empathetically respond to the child's feelings. In the second, one parent is borderline and uses destructive projections without empathy. In both families, the spouse fails to protect the child from the other parent. The spouse of the borderline parent will react by becoming disengaged, neutral, or passive; by forming a weak alliance with the borderline parent; or by joining the borderline parent in devaluing the child.

The role of family dynamics in borderline etiology was described in detail by Meissner (1984). He theorized that in these systems there is a lack of individuality among members as well as a lack of a sense of the family as a whole. Dependency needs are both feared and disguised by family members who are overinvolved and overresponsive toward each other. Communication becomes confused when attempts are made to resolve conflicts over autonomy and dependence. Since each member is perceived as containing parts of other members' unacceptable self-images, individuation poses a threat to the psychic economy of the system. One of two patterns evolve: either the mother ignores the child's emotional needs while imposing strict controls or she engulfs the child with nurturant attention. In each case the father is estranged from both of them.

Siever and Klar (1986) summarized the confusion which exists in the literature on borderline family systems. They state that the studies of the family dynamics of borderline patients

> "have yielded two separate patterns of family pathology (Gunderson et al., 1980; Gunderson, 1984). One type (Grinker, 1979; Soloff & Millward, 1983) is characterized by overinvolved parents who preclude the normal developmental steps toward separation to be taken by their children. The second pattern---that of parental neglect identified in the studies of Gunderson et al. (1980)---is characterized by parents' passivity regarding limit-setting and support for their children" (pp. 299-300).

Parent/child relationships. The roles of various family members have also been described in a variety of ways. The mother has been seen as being both overprotective and overinvolved in the patient's life (Grinker et al., 1968; Rinsley, 1978; Soloff & Millward, 1983) or neglecting and excluding the child in the interest of a tight marital

bond (Frank & Paris, 1981). The father has generally been characterized as disinterested (Frank & Paris, 1981) and underinvolved (Soloff & Millward, 1983).

Wolberg (1952, 1968, 1977) believed that there is a better than chance possibility that both parents of borderlines have pathological personalities. She described the mothers of borderline patients as (1) severe obsessive-compulsives; (2) narcissistic, competitive types; (3) paranoid; or (4) passive schizophrenic and childlike. Fathers, on the other hand, have been portrayed as (1) passive, irresponsible, weak, and detached persons who pit family members against one another and who allow themselves to be dominated by their wives; (2) competent, controlling, critical, manipulative persons who make all of the decisions in effort to show-up their wives' inadequacies; (3) detached, paranoid-like, grandiose individuals who compete with and belittle the children, and, (4) mildly psychopathic individuals who are disrespectful of others, who talk, eat, smoke, or lie compulsively, and who make unnecessary demands on the children.

Masterson and Rinsley (1975) viewed the mother as playing a significant role in borderline development. She does this by offering support and approval for clinging or regressive behavior and by becoming critical, hostile, angry and attacking in the face of assertive behavior.

From a different perspective, MacMurray (1976) examined how the demographic and nosologic characteristics of borderline psychopathology is influenced by cultural changes. He agreed with Masterson (1972) that borderline disorder is being diagnosed more frequently because of

a cultural shift to a more matriarchically dominated society. He described two types of mothers of borderlines: (1) the classic matriarch who uses smothering domination, and (2) the child-wife who uses symbiotic clinging. In the early part of this century the child-wife type was dominant. She was a dependent, ineffectual person who formed a symbiotic relationship with her husband. Cultural norms dictated that she should be innocent, emotionally understanding, and able to meet his narcissistic demands. The matriarchical mother evolved with the industrial revolution and changes in women's roles. According to MacMurray, the matriarchical mother may be described in one of two ways. First, she is a very narcissistic person who vacillates between affection and aloofness; she imposes stern ideational controls on the child while ignoring the child's emotional needs and keeping it at arms length; and, she offers gratification contingent on conformity. The second type of matriarchical mother has either a low self-esteem or she received too much reinforcement for nurturant behavior as a child. In this instance her child feels overwhelmed by her nurturant attention.

Walsh (1976) noted that most borderlines characterize one or both parents as underinvolved, detached, aloof, or preoccupied. They also report feeling neglected, rejected, and belittled as children, as well as conflicted in their loyalty and often openly hostile toward their parents. In contrast, however, some borderlines feel that one of their parents had made them overly dependent. They feel as if they had been controlled and not really cared for, but made to conform to parental expectations of what "should" be.

Using the Childhood Experience Scale, perceptions of how parents responded to typical dependent and independent behaviors were assessed and compared for adult borderline patients, normal controls, and outpatients with neuroses and personality disorders (Frank & Paris, 1981). It was thought that by studying these two variables a clearer evaluation could be made of the overprotection (Bradley, 1979; Gunderson et al. 1980; Walsh, 1977) and neglect hypotheses (Levy, 1943; Masterson, 1976). The authors found that fathers of borderline patients were perceived as having been more disinterested (but not more critical) and less approving for dependent behaviors. Mothers in the three groups were not remembered differently, however. Thus, the overprotection hypothesis was not substantiated because neither parent was remembered has having acted critically toward independent behaviors and approvingly toward dependent behaviors. The neglect hypothesis, however, was supported for the behavior of fathers.

The <u>family dynamic hypothesis</u> proposed by Soloff and Millward (1983) "attributes borderline development to the structure of roles assigned within the family group" (p. 575). Investigation of five interpersonal dimensions revealed that there is usually a negative-conflictual overinvolvement between borderlines and their mothers, a distant and hostile relationship between borderlines and their fathers, and a conflictual marital relationship.

Meissner described in detail the roles of both mothers and fathers in borderline family systems (1984). He hypothesized that fathers tend to be either domineering, hypercritical, and authoritarian; or ineffectual, passive, and unable to cope with their responsibilities.

Mothers, on the other hand, are perceived as either unable to allow the child to separate, or as dependent, ineffectual, or hysterical.

Using a predominantly male borderline sample, Snyder et al. (1984) concluded that the father is perceived to be the most dominant and central family member, that parents demonstrate a high incidence of severe and chronic physical and emotional illness, and that mothers show significantly more expression of affect toward their children. Also, there generally is perceived to be more conflict between the father and borderline child with the adult either passively or actively expressing anger. On the other hand, a hostile-dependent relationship occurs most often between the mother and borderline child.

Finally, Goldberg, Mann, Wise, and Segall (1985) compared perceived parental qualities of borderlines, a psychiatric control group, and a nonclinical control group. Using the Parental Bonding Instrument, subjects were asked to reflect on their perceptions of their parents during the first sixteen years of their lives. The borderline group perceived their parents to be significantly more overprotective and less caring than either of the other groups.

The Bipolar Family

Although a number of empirical studies have been performed, much of the research on bipolar families, like borderline families, has been descriptive and anecdotal. In the following section an attempt will be made to evaluate the progress that has been achieved in understanding the environmental context in which bipolars evolve, and also in describing the specific nature of the early parent/child relationship.

Familial characteristics. One of the first studies of the family backgrounds of bipolars was made by comparing 155 bipolar and 175 dementia-praecox patients (Pollock, Maltzberg & Fuller, 1939). The investigators found that bipolar families are better off economically, that there is relatively little family dissension, that there sometimes are other adults in the household besides the parents, that mothers and fathers are both considered to be affectionate, and that most sibling relationships are harmonious.

In 1934 Witmer et al. interviewed family members of 40 manic-depressive and 68 dementia-praecox patients and concluded that, for bipolars, overprotection by parents is extreme and common. In addition, a considerable number of patients from both groups come from environments where the mother is viewed as dominant and the father as weak, and the atmosphere is described as harmonious and close-knit.

Finley and Wilson (1951) and Wilson (1951) used the Fels Rating Scale to collect data on twelve bipolar families. They concluded that individual initiative is frustrated by the walled-in existence created by either a dominant mother, dominant father, or dominant siblings. Hostility over the situation leads to depression or "an explosion outward which appears as mania" (Finley & Wilson, 1951 p.43). In addition, they found that patients feel a great deal of pressure to conform to parental attitudes and expectations (Wilson, 1951).

One of the earliest and most comprehensive studies done on the interactional aspects of bipolar disorder was completed in 1954 by Cohen, Baker, Cohen, Fromm-Reichmann, and Weigert. The authors performed an intensive investigation of twelve cases of diagnosed

manic-depressives in an attempt to describe their interpersonal environments from birth on. They focused on the personality of the parents, the quality of their parenting, and the quality of the child's response to their parent's behavior as significant factors in the formation of patterns of interaction and reactions to anxiety-arousing situations. They hypothesized that by studying the transference in each of these patients, they could make inferences about earlier relationships.

Several significant conclusions were formulated from the data. First, the authors noted that each of the families has one social, economic, ethnic, or religious characteristic which singles it out as peculiar or different from its environment. This "difference" is keenly felt by all family members. They strive to improve their acceptability by conforming to perceived norms, by attempting to better their social prestige through outstanding achievements, or by improving their economic status. The family usually evolves as an enmeshed system in which importance is placed on banning together against an adverse outer world. Children are expected to conform to their parents perceptions of their neighbors' high standards of good behavior, and they are assigned the task of improving the family's social position and reputation. As a result, they develop a strict and conventional concept of good behavior which is derived from a depersonalized authority. They also learn that parental approval is given not for "who you are" but for "what you do".

Another conclusion was that the majority of manic-depressives in the study were described as being the most talented and creative

members of their families, and, because of their abilities, are accorded a special status. As a result, they channel much of their energy into guarding this position despite its tremendous responsibility. They also become the target of envy by their siblings, and are forced into competing with one or both of their parents. They often grow up feeling very lonely in a family which fosters the myth of togetherness. To counteract their sensitivity to envy and competition, manic-depressives tend either to undersell their abilities or become exceptionally helpful toward their siblings.

In a replication study, Gibson (1958) used a specially designed questionnaire to compare the original bipolar patients from the Cohen et al. (1954) study, a newly-selected bipolar group, and a schizophrenic control group on the factors of relationship to community, envy, role of parents, authority in the home, and conventionality. The results of the previous study were validated on all but the "role of parents" and "authority in the home" scales. This lead Gibson to conclude that both bipolar groups differed significantly from the schizophrenic group in several ways: the parents use the patient as a vehicle for gaining prestige, there is competition and envy between the patient and other siblings resulting in underachievement, and there is an excessive concern for social approval.

Although Gibson confirmed Cohen's and his associate's hypothesis (1954) that parents place a high value on social approval and prestige and they use the child to achieve it, he attributed this behavior not to a sense of feeling different as a family, but rather to the personality make-up of one or both of the parents. This interpretation is

in contrast to Cohen et al. (1954), and also to Smith (1960) who claimed that the family's "differentness" is a reflection of the need of family members to rationalize the intensity of their anxiety over their isolation from others. It also contrasts with the conclusions of Brodie and Leff (1971) who found that this parental expectation for achievement is common to both unipolar and bipolar patients, and it is experienced by siblings as well.

Using global ratings of family relationships, Abrahams and Whitlock (1969) found that, when compared to unipolar endogenous and neurotic depressives, bipolars tend to report the least evidence of unsatisfactory relationships with neurotic depressives the most.

In 1975 Ablon, Davenport, Gershon and Adland used the medium of couples group psychotherapy to describe how the interpersonal relationships of married bipolar patients and their transference patterns within the group, related to the couples' ability to remain together. They also examined the significance of early object loss for these patients. They conducted two posthospitalization therapy groups with a total of eight couples who had been married between 12 and 34 years. The authors noted the emergence of five major themes in both therapy groups. First, all of the couples were preoccupied with the danger of recurring mania, however they used this focus to divert their attention away from the recognition and expression of painful affects. Second, an intense hostility existed between spouses, but the expression of anger was viewed as extremely threatening and proof that the mania still existed. Third, not able to express their feelings openly, couples relied extensively on massive denial, especially concerning

issues of loss. Fourth, the relationship between couples might best be described as symbiotic and dependent. This behavior functioned as a method of coping with grief over loss and separations. Although each spouse wished for symbiosis, each also distrusted the partner's ability to live up to the expected role and therefore was seen as not dependable. In addition, there were weak ego boundaries between parents and their children; the children became the focus of their parents' concern so that painful marital issues could be avoided. Finally, bipolar patients described experiencing their fathers as passive, weak, having a benign peripheral role, or missing from the family altogether.

The authors concluded that the same dynamics observed in group therapy i.e., the denial of rage, grief, and dependency within the context of a symbiotic relationship, also functions to keep the couples' marriages intact. In addition, they hypothesized that bipolar men have a higher incidence of intact marriages than bipolar women because they replicate their early relationship with their own mothers by choosing dominant spouses. Bipolar women, on the other hand, identify with their dominant mothers and choose weak and often absent men. Frustrated that their husbands are not strong caretakers, they become disappointed and often seek a separation or divorce.

Davenport, Ebert, Adland, and Goodwin (1977) compared twelve posthospitalization patients who had received medication management plus couples group therapy to 53 patients who were treated with medication only. Compared to the patients maintained on lithium only, the drug-plus-therapy group had better social functioning and fewer

life disruptions. The authors concluded that, while the effectiveness of group psychotherapy on bipolar couples could not be definitely established from this study, there are several advantages. First, efforts to deny or flee are counteracted by spouse involvement. In addition, the group can help the couple cope with anxiety over intimacy and fears about the genetic component of the disease, and can help support socially desirable behavior.

In a later study Davenport, Adland, Gold, and Goodwin (1979) investigated the psychodynamic features in families with multi-generational bipolar illness. Extensive clinical observations were made on six families in which an index parent and an index offspring had, at separate times, been hospitalized for an acute manic episode. Four of the same families also included an index grandparent allowing for three-generational comparisons. Several themes emerged across generations in the bipolar family. Fathers tend to be absent during critical stages of their offsprings' development contributing to unresolved dependency issues and problems of identification. Mothers, on the other hand, assume a dominant role in the family. Dependency needs are fiercely concealed, while aberrant, pathological behavior is tolerated and vehemently denied. In addition, the family is described as very tightly bound together, a condition which leaves it impervious to experiences outside of the system.

The authors further observed that in the parental/marital system, open expression of feelings occurs only during the manic phases. At other times, needs and requests are expected to be anticipated by the partner for fear of disappointment or loss of approval. In spite of

their inability to directly express feelings, however, family members generally have a great deal of affection and concern for one other. Much energy is invested by parents in their children, a factor that is seen as functioning to sustain the marriage. The enmeshment between parent and child is further exaggerated by the fact that parents fear that their offspring might have inherited the illness. Finally, since parental self-worth is experienced through the children, unrealistic expectations are placed on them to be perfect. When children fail to live up to these high standards, parents view themselves as failures.

Observations of the children in bipolar families revealed that they basically are deprived because they come from homes in which there is tension, chronic depression, stresses between parents, indecisiveness, and fear of recurring illness. They are seen by other adults as "nice", but often view themselves as "faulty" because they cannot live up to parental expectations to conform and to succeed. In addition, they often have difficulty later in life establishing a clear identity, separating from their families, and forming intimate relationships because of fears of loss and abandonment.

Waters, Marchenko-Bouer, and Offord (1981) substantiated the findings of Davenport and her colleagues (1977, 1979) by reviewing the data from an ongoing pedigree study and the work done at the Affective Disorders Clinic of the Royal Ottawa Hospital. Interviews of 20 bipolar patients and their families in the pedigree study revealed that discussion of mood with the adult offspring often causes anxiety, and that the proband is best able to distinguish between normal mood variation and affective disorder. Children of bipolars tend to either

deny or misperceive their parent's mood swings, or to initially deny mood changes and then seek reassurances from others that they are normal.

Mayo, O'Connell, and O'Brien (1979) studied the marital relations, job performance, hospitalizations, parenting skills, life change events, and communication networks of the families of twelve bipolar patients for two years before and two years during lithium treatment. The authors made several observations. First, they noted that the personality of the patients' spouses could be classified as either passive-aggressive (noninvolved, emotionally aloof, and stubborn), or rigid and controlling (aggressive, verbal, and competitive). Second, children expressing symptomatic behavior tend to be preoccupied with health, manifest characteristics of separation anxiety, and show signs of helplessness, pessimism, or overt depression. Third, patients appear ambivalent over their roles as parents and seem unable to cope when faced with the conflicting demands of spouse and children.

Results from interviews of over 150 bipolar patients at the Affective Disorders Clinic indicated that spouses tend to misattribute patients' normal adaptive responses to a return of pathological mood swings. Appropriate affective responses are restricted in the interest of maintaining the status quo, and denial is used to manage hostility and anxiety.

In a more systematic study Davenport, Zahn-Waxler, Adland, and Mayfield (1984) compared the early child-rearing practices in families with a bipolar parent to those of normal control families. Seven sets of parents in which there was a diagnosed bipolar patient and their

seven male infants were compared to a matched sample of normal parents and their infants. Mothers and their infants were observed separately in a laboratory when the infants were 12, 15, and 18 months old. In order to gather information about reactions to separation experiences the Ainsworth strange situation paradigm was used. Data about child-rearing practices was obtained by the administration of the Block Q Sort interview and a specially designed survey completed by staff during a home visit. Finally, when the proband children were four years old, all families participated in a structured interview and were rated on their global functioning.

Several conclusion were drawn from the data. First, results of the Ainsworth separation sequence showed that children with a bipolar parent showed less affective awareness of the mother's absence and more aversion to her return than children from families in the control group. This suggests that children in bipolar families learn to repress affective reaction at an early age, and consequently grow up in an atmosphere where loss is not recognized and sadness not expressed. Second, index parents differed from controls in child-rearing practices in several ways: they were less attentive to health needs, they valued achievement and performance in front of others, they were less likely to encourage risk-taking, they showed more negative affect toward their children, and they were more overprotective. Finally, raters observed less interaction with children in bipolar families, and noted more disorganization, tension, and inconsistency.

The characteristics of families with major affective disorders was more recently investigated by Stierlin, Weber, Schmidt, and Simon (1986). The authors compared 22 families in which a young adult member had been diagnosed as bipolar disorder to 4 families in which the index member had been diagnosed with bipolar disorder with psychotic features, and 7 with the diagnosis of schizoaffective disorder. The 11 comparison families were categorized into "schizo-present" (families with a schizophrenic member), and "psychosomatic" (families with serious psychosomatic diseases). Observations made during interviews with these three types of families led to several conclusions and hypotheses about their construction and negotiation of relational reality, their clarity and congruence in defining relationships, their familial value systems and ideologies, and their coalitions between members.

The most distinguishing feature of schizo-present families is the metarule that no rule is valid. Relational reality is "soft" because there are no supportive structures and no mutually-shared definitions of relationship. As a consequence, all members experience failure in their attempts to separate and individuate from the family ego mass. In addition, values are unreliable and unclear, and coalitions often change and are difficult to detect.

In contrast, psychosomatic families share a relational reality that is too "hard". Immutable values and rules are rigidly maintained and transmitted over many generations. Family loyalty is demanded by all members making individuation an act of betrayal which produces anxiety and guilt in those who attempt it. Because open confrontation

is prohibited, family members elicit guilt by appearing to be suffering or self-sacrificing. Coalitions between members are often rigidly fixed. When the stress of emotional suppression becomes too great or bodily damage too severe, the family might seek professional help to insure protection of their outward facade of harmony.

When comparing these families to bipolar systems some striking similarities and differences were noted. The relational reality could generally be described as "hard". It consists of two mutually exclusive constructions of reality that both coexist and clash with each other. Usually one of these views is held by each parent. The strength of these two rigid alternatives could alter over time: there might be a loosening-up of basic assumptions, the manic flavoring; or an excessive rigidifying of relational reality, the depressive aspect. The function of this vacillation appears to be to allow the family a safety valve for the expression of suppressed "counter-values". It is usually the responsibility of the manic member as a "bound-up delegate" to cyclically equilibrate the system by demonstrating symptomatic pathology. The index person is extremely sensitive to each parents' needs and attempts to satisfy them by behaving in a manic way for the disorderly parent and a depressive way for the orderly parent.

In a bipolar family a rigid complementarity usually develops between parents. This hampers the family in its efforts to allot tasks, to work out a balance of closeness and distance, and to negotiate new expectations, rights, and duties. In addition, all behavior is classified into mutually exclusive categories with persons viewed as responsible or irresponsible, or good or bad. Reality is

distorted so that only extremes exist. For example, one parent may be seen as adventurous, emotional, irresponsible, or generous, i.e., "manic"; and the other as conscientious, orderly, strict, or rational, i.e., "depressed". In addition, a very high demand is placed on family loyalty.

Finally, in a follow-up study, Weber, Simon, Stierlin, and Schmidt (1988) described how knowledge of the characteristics and fundamental assumptions of bipolar systems can be helpful when doing family therapy. Basically, bipolar families perceive the world in extremes of good _or_ bad or orderly _or_ disorderly. As a consequence, they are unable to alter their behavior to match different contexts. So that they may negate any uncertainty, order is their highest principle; it guarantees their cohesiveness as a unit. They operate under the premises that the family must remain intact, yet living can only take place when one is on one's own. Also, no healthy person loses control of their emotions, but once this happens one is considered ill and then free to do anything. Usually one family member is more orderly and disciplined representing the depressive end of the spectrum, while the other is footloose and easygoing representative of the manic end. Positions can change, and fluctuation is common. In the next section, the focus will shift to an examination of the relationships between bipolars and each of their parents.

Parent/child relationships. A difference has been noted in the roles of both the mothers and the fathers in bipolar families (Cohen et al., 1954; Gibson, 1958). More often than not the mother is viewed as the stronger and more determined parent who is intensely ambitious and

sometimes directly aggressive. She is considered the moral authority in the family, and is the person who is most concerned about the family's gaining prestige. The father, on the other hand, is usually portrayed as a weakling who lacks ambition. He is blamed by the mother for the family's ill fortune and lack of position. In the marital relationship, while the husband often blames his wife for being unloving and cold, he is also fearful, dependent, and desirous of her approval.

In addition, the children in a bipolar system perceive each parent differently (Cohen et al., 1954). Fathers are thought of as weak but lovable persons who generally accept the blame for the family's problems. However, they are defended for their lack of success, and are generally more warmly loved that the mothers. Mothers, on the other hand, are viewed as reliable and strong but contemptible and disliked. The child is thus caught in the dilemma of perceiving the unreliable parent as lovable and the strong parent as dislikable.

In a different study Perris and Perris (1978) compared the ratings of early life experiences of bipolar and unipolar psychotic depressives, non-psychotic depressives, and patients with cycloid psychoses (Perris & Perris, 1978). Interestingly, few differences emerged.

Parental characteristics in relation to depressive disorders were also investigated by Parker (1979). Using the Parental Bonding Instrument he compared 50 neurotic depressed patients and 50 manic-depressive with a matched control group. On the variables of parental care and overprotection there were no significant differences between

bipolars and the control group, whereas the neurotic depressed groups perceived their mothers and fathers as less caring than did the controls. The depressed group also reported experiencing greater maternal overprotection than either of the other groups.

Using 54 bipolar and 52 unipolar Italian patients plus a control group Perris, Maj, and Eisemann (1985) cross-validated results of a Swedish study (Perris, Arrindell, Eisemann, van der Ende, & von Knorring, 1985) which reported perceptions of parental behavior of patients who were diagnosed as unipolar or unspecified depression. These latter patients had rated their parents lower than healthy controls on the factor of emotional warmth. Results showed that the Italian sample showed similar trends.

In the previous two sections a review of the literature on borderline and bipolar family systems has been presented. Although in the next section the similarities and differences between them will be contrasted in greater detail, highlights of these discussions are presented in Figure 1.

To summarize this section, there has been little empirical work done to test either the theories about the etiology of either borderline or bipolar pathology or the nature of these family systems. Most studies have been descriptive in design and have focused on applying intrapsychic concepts to the family rather than investigating the qualities of these families as whole systems. Of most importance appears to be the fact that although borderline and bipolar individuals and family systems might be viewed as different from each other, there are many areas where behaviors and patterns overlap. In the next

section, the research that has been reviewed in this chapter will be summarized and contrasted. From this, the rationale for the current study will be presented.

Summary and Rationale for Current Research

The purpose of this chapter has been to review and contrast the literature on the behavioral symptomatology, and the intrapsychic, interpersonal, and familial characteristics of borderline and bipolar psychopathology. As mentioned, both similarities and differences can be noted between the two disorders. In this section an attempt will be made to summarize and integrate the material, and to demonstrate its relevance to the current investigation.

According to DSM-III-R, the behavior of borderlines and bipolars is similar in some respects and different in others. The most common characteristic shared by the two groups is their affective instability. Baseline mood can shift from normal to depressed or irritable in a short period of time. For borderlines, this shift usually lasts only a few hours, whereas bipolars, unless diagnosed "mixed", show much less lability. In addition, symptoms of both major depression and dysthymia can be present in both groups. Other commonalities include the propensity for impulsive, acting-out behavior and for periods of grandiosity. Behavior such as wreckless driving, binge eating, overspending, gambling, substance abuse, and promiscuity may be found in each sample. For the bipolar, however, impulsivity is usually associated with the manic phase, while for the borderline

Borderline family	Bipolar family
Both disengaged and enmeshed.	Tight, cohesive unit, impervious.
Mother seen as controlling, over-involved; dependent, childlike or neglectful.	Mother seen as ambitious, aggressive, moral authority, perfectionist, disapproving.
Father perceived as absent, disinterested, hypercritical, passive, weak; or dominant.	Father perceived as weak, lovable, absent.
Marital relationship covertly hostile; high conflict; no conflict--detoured through children.	Marital relationship hostile with feelings expressed only during manic phase.
Blurred parental boundaries.	Blurred parental boundaries.
Difficulty setting rules; overly strict.	Inconsistent parenting; affectionate.

Fig. 1 Similarities and Differences in Borderline and Bipolar Family Systems and Parent/Child Relationships.

self-destructive behavior is often associated with real or imagined abandonment and depression. Borderlines also seem to be characterized by more intense interpersonal relationships and tend toward manipulative suicide threats and self-mutilation, whereas it is more common for bipolars to show flight of ideas, pressured speech, and distractibility.

Although the literature suggests that each group may be distinguished fairly reliably from the disorders along the schizophrenic spectrum, there appears to be a considerable degree of overlap when they are compared with each other. This has lead researchers to hypothesize that borderline personality disorder is an outcome or a precipitant to affective disorders; that the two disorders are distinct from one another and coincide accidentally; or that there is a genetic predisposition for either disorder, and given the "proper" environmental circumstances, either disorder could develop.

Thus, it appears that both DSM-III-R nosology and the literature is far from definitive about the distinction between the diagnoses. Since clinically both borderlines and bipolars can present with similar symptomatology, the problem of making a differential diagnosis is compounded by the great degree of affective overlap between the disorders. It would seem that more research about any differences between borderlines and bipolars might be helpful in clinical decision-making and treatment planning.

In addition, research on family, twin, adoption, and genetic linkage studies has provided strong evidence for a genetic predisposition for bipolar disorder. Although inconclusive at this time,

there also appears to be some biogenetic factors operating in the case of borderline personality disorders (Siever, 1982; Siever & Gunderson, 1979). While it is not the purpose of this research to discover the extent to which genetic factors predispose persons to either disorder, or to discover if there is a genetic linkage between the two groups, it does appear worthwhile to attempt to evaluate the role of early environmental experiences in their etiologies. Coupled with continuing biogenetic research, if significant differences could be found in the early family environments and relationships of borderlines and bipolars, then the problems with diagnostic overlap would be made a little more clear.

A comparison of the literature on the intrapsychic structure of borderlines and bipolars suggests that they share similar developmental histories and issues. From a psychoanalytic perspective each group is thought to be fixated at a stage after ego boundaries have been delineated, but before whole object relations are formed leaving an excessive amount of oral aggression. Stable ego structures never fully develop because of difficulties integrating good and bad images of themselves and others. In times of stress both borderlines and bipolars can resort to primitive defenses such as projective identification, devaluation, omnipotent control, manipulation, and idealization. Bipolars, however, may become psychotic for much longer periods of time than borderlines.

Most of the psychoanalytic literature points to the importance of the early life experience of each group. When the mother (or significant caretaker) fails to provide an emotionally supportive

atmosphere which encourages and respects the child's need for separation and autonomy, the child is caught in a bind where individuation means loss of love, and closeness means engulfment. Denial, anger, guilt, and anxiety ensue. The preoccupation with fears of abandonment and engulfment which develop place children in both groups at risk for problems in adult life.

On an interpersonal level the literature suggests that both borderlines and bipolars can be experienced as demanding and manipulative. They share in common their ability to project responsibility for their behavior on to others and to engage others in limit-setting behavior. They also have been described as keenly astute to both verbal and nonverbal cues and are quickly able to discern other persons' vulnerabilities. Splitting is also common to both.

While many similarities and differences can be noted in the literature between borderlines and bipolars behaviorally, intrapsychically, and interpersonally, much of the research that has been done on the family systems of each group has been of a descriptive nature and has produced conflicting results. Bipolar families have generally been described as cohesive, overprotective, and highly organized. The mother has been viewed as strong, dominant, and dependable, and the father as weak, unlovable, and on the periphery or absent during critical stages in the child's development. This is in contrast to the borderline system which has been described as both overprotective and disengaged and rejecting. Like bipolar families, in borderline families the mother is the person who is more often

overinvolved, and the father is absent or disinterested. Unlike them, she also has been described as childlike and neglectful.

The marital relationship in borderline families has been described as covertly hostile and troubled and volatile. A rigid marital bond to the exclusion of the attention, support, and protection of the children has also been noted. On the other hand, in bipolar systems there appears to be hostility between spouses, but the expression of anger is limited only to the manic phase. Parents in this group, however, invest a great amount of energy in their children, and many times place unreasonably high expectations on them to conform and achieve. A rigid complementarity usually exists between spouses who often share two conflicting sets of rules about reality.

Researchers have noted the presence of one characteristic which singles the bipolar family out as different from its context. As a result, the bipolar child functions either to make the family more acceptable through outstanding achievements or to raise the family's status in the eyes of the community. No such expectations appear to be placed on borderline children. In fact, characteristically they are underachievers in both school and work. The function of this behavior within the family system is unclear. In both borderline and bipolar family systems, however, children are triangulated into their parents' conflicted marital relationships so that the latter can avoid painful issues especially concerning loss.

Finally, the literature suggests that the boundaries between parent/child and husband/wife are blurred for both groups. This leads to inconsistency in rule setting and poor role modeling.

This research will be an empirical attempt to gain more information about systemic characteristics and functioning in borderline and bipolar family systems. Its purposes are to investigate the early family environments and parent/child relationships between members of each group. It has been shown that making distinctions between these diagnoses might be helpful to both researchers and clinicians. With this in mind, analysis of the data obtained from these goals will either support or reject the following hypotheses:

H_1

There will be no relationship for borderline and bipolar groups between composite and section scores on the DIB and the mean subscale scores on the FES and LIPHE.

H_2

There will be no significant differences in perceptions of early family environments on each of the subscales of the FES between diagnosed borderline and bipolar participants.

H_3

There will be no significant differences in perceptions of early parent/child relationships on each of the subscales of the LIPHE between diagnosed borderline and bipolar participants.

H_4

There will be no significant differences in the perceptions of early parent/child relationships with mothers versus fathers between members in either the borderline or bipolar groups.

CHAPTER III

RESEARCH METHOD

Introduction

This chapter will be divided into five sections, and its purpose will be to acquaint the reader with the criteria and procedures which were used for gathering and analyzing data. In the first section the focus will be on a discussion of the study's participants. This will include a description of the sample, the methods employed in recruiting members, and the criteria for their inclusion. Following this, there will be a comprehensive description of the instruments which were used to assess the variables under investigation. Next, there will be a description of the research design used in this study. Finally, in the fourth and fifth sections, an outline of how the data was collected and analyzed will be presented.

Description of the Sample

Target participants for this study were 42 males and females between the ages of 19 and 40 years old each of whom had been diagnosed as either borderline personality disorder or bipolar disorder. The sample was divided on the basis of their diagnoses into two matched groups. The borderline group consisted of 18 females and 4 males, and the bipolar groups consisted of 19 females and 3 males.

In selecting participants for each group, primary attention was directed toward matching the following two demographic characteristics: age and sex. The participants' race, marital status, education, income, religion, birth order, number of siblings, psychiatric history, number of hospitalizations, and current medications were also acknowledged. An in-depth profile comparing the demographic characteristics of the participants in each group will be presented in the next chapter.

Participants were selected from two private inpatient hospital settings: the Institute of Living in Hartford, CT, and Elmcrest Psychiatric Institute in Portland, CT. The Institute of Living, founded in 1822, is the largest, private psychiatric hospital in the country. It is a fully accredited, 400-bed teaching hospital with residency programs for psychiatrists and an APA approved internship program for psychologists. The hospital is divided into five clinical divisions which encompass 14 inpatient units, a research department, adult and adolescent day treatment and outpatient clinics, consultation services, psychiatric education, and geriatric services.

Elmcrest Psychiatric Institute is also a fully accredited inpatient, teaching hospital. It provides beds for 129 inpatients including units for children, adolescents, and adults. In addition, there are child, adolescent, and adult day treatment hospitals, a behavioral medicine clinic, substance abuse units for both adolescents and adults, an outpatient clinic, and employee assistance program services. It offers a fully accredited APA internship program for training psychologists.

At both facilities teams of psychiatrists, psychologists, social workers, nurses, and mental health workers develop specific patient treatment plans which best utilize the hospital milieus. Treatment modalities include individual psychotherapy, and group, family, occupational, and multiple family group therapy.

The method for recruiting participants will be described more fully in the research design section of this chapter. In order to be included in the study, however, each patient needed to meet the following criteria:

(1) no evidence of:
   (a) organic central nervous system disorder (e.g., organic brain syndrome, epilepsy).

   (b) severe and habitual alcohol or drug abuse in six months prior to inclusion in the study.

   (c) mental retardation (i.e., I.Q. not less than 70).

   (d) severe or continuous psychotic symptoms.

   (e) conjointly sharing both a borderline and bipolar diagnosis.

(2) fulfill a minimum of five of the eight DSM-III-R criteria for borderline personality disorder, or three of the seven criteria for bipolar disorder as diagnosed by the unit psychiatrist and treatment team responsible for the case.

(3) obtain either a scaled composite score of "7" or greater on the DIB, and "0" under bipolar disorder on the SCID if diagnosed as borderline; and a score of "3" under bipolar disorder on the SCID, and less than "7" on the DIB if diagnosed as bipolar disorder.

(4) be between the ages of 16 and 40 years old.

(5) if diagnosed borderline, that must be the primary diagnosis with no other Axis II personality disorder

as well as no Axis I diagnosis of cyclothymia or schizoaffective disorder; if diagnosed bipolar, must show no Axis II personality disorder.

The selection of participants lasted about a year and a half from August, 1986 to February, 1988. Criteria for selection was extremely stringent, and many cases were eliminated from the study. For example, during the time period of September, 1986 through December, 1987 there were 2,091 admissions to the Institute of Living. Of those 324 were diagnosed as borderline and 262 as bipolar. When criteria such as age, substance abuse, ECT, IQ, organic factors, and proper diagnosis were considered, the number of appropriate borderline candidates was reduced to 21, and the number of bipolar participants to 53. Of the 21 borderlines, only 2 were males, 3 had a length of stay less than 3 weeks, and 2 were discharged AMA. On the other hand, 23 of the 53 bipolars were males, however, 21 had lengths of stay less than 3 weeks, and 6 were discharged AMA. Throughout the course of the study 10 patients refused to participate, and 8 dropped out before completion of data collection.

Given the difficulty in sample selection, it is necessary to speculate on whether the two groups are, in fact, significantly different from each other. To determine this, the mean composite and subscale scores on the DIB were compared. Table 1 summarizes the results.

Obviously there is overlap between the two diagnostic categories, but once separated carefully, it was possible to identify two precise groups. Not surprisingly, the major differences between borderlines and bipolars as revealed by the data are on the DIB composite scores,

and on interpersonal relations and affects subscales. In fact all scores were significant at $p < .01$ except for social adaptation. It is possible that this variable did not reach significance because all members of the sample were currently hospitalized, and most had required multiple hospitalizations in the last few years.

Table 1

Comparison of Borderline and Bipolar Mean Composite and Subscale Scores on the DIB

	Patient group				
	Borderline (n=22)		Bipolar (n=22)		
DIB subscale	M	SD	M	SD	t
Social adaptation	5.46	1.50	4.64	1.81	1.63
Impulse action	7.05	1.84	3.27	2.41	5.83 **
Affects	7.23	1.11	1.68	1.59	13.44 **
Psychosis	4.14	3.26	-.364	2.22	5.36 **
Interpersonal rel.	10.09	1.88	1.96	1.79	14.74 **
DIB composite	8.91	.81	3.23	1.31	17.33 **

** $p < .01$, two-tailed.

Instrumentation

In the following section there will be a brief description of the purposes and type of data obtained by each of measurements listed above. As mentioned previously, all target participants underwent a diagnostic interview using the Diagnostic Interview for Borderlines (DIB), and sections A through D of the Structured Clinical Interview for DSM-III (SCID-P). These interviews were chosen because, in combination, they confirm the presence (or absence) of borderline and bipolar characteristics.

The major emphasis of the DIB is on providing historical information about enduring behavior patterns. It was devised by Gunderson and his colleagues (Gunderson & Kolb, 1978; Gunderson, Kolb, & Austin, 1981; Kolb & Gunderson, 1980) to provide a way of distinguishing borderline personality from other major disorders. The DIB consists of 123 questions which provide data for 29 summary scores. These summary scores are in turn converted into a scale of 0.0 to 2.0 for each of the five sections of the interview. They are reflective of the following areas of functioning: social adaptation, impulsivity, major affects, evidence of psychosis, and style of interpersonal relationships. When tallied, the statement scores yield a total score of 0.0 to 10.0 points. A score of 7 or higher is considered sufficient to determine a diagnosis of borderline personality disorder.

The DIB has proven to be a valid instrument for discriminating borderline patients from patients with schizophrenia, neurotic depression, and mixed diagnoses (Gunderson & Kolb, 1978); and from

nondelusional unipolar depressives (Soloff & Ulrich, 1981). It also correlates significantly with the DSM-III definition of borderline personality disorder (Kroll et al., 1981), and the structural interview developed by Kernberg et al. (1981).

Interrater reliability using concurrent observers showed an overall agreement of borderline vs. nonborderline between 85-92% (Cornell, Silk, Ludolph, & Kohr, 1983; Gunderson et al., 1981; Kroll et al., 1981). Also, when paired clinicians administered the DIB to the same patient over a one week interval, diagnostic agreement was 87.5%. (Cornell et al., 1983).

In order to become proficient in administering the DIB, the researcher went to McLean Hospital in Belmont, MA where she independently scored several videotapes of Dr. Gunderson conducting the diagnostic interview. In addition, the researcher conducted five practice interviews prior to beginning data collection.

The SCID-P (patient version) (Spitzer & Williams, 1986) is a structured interview which enables a clinician to make DSM-III-R Axis I and II diagnoses. Each major diagnostic class is a separate module allowing the interviewer to focus on the diagnosis in question. Inquiries are arranged in a sequence which approximates the differential diagnostic process of an experienced clinician. Assessment of current episode plus lifetime prevalence of the disorder may be determined. At the end of each module there are also a series of questions evaluating the chronology and severity of the illness. At the completion of the interview the Diagnostic Index for each disorder

is determined. This measure indicates the extent to which the criteria for the SCID disorders have been met.

Two separate instruments were used to gather information about early family characteristics and relationships: the Family Environment Scale (FES) Form R, (Moos, 1986) and the Life InterPersonal History Inquiry (LIPHE) (Schutz, 1976). These measurements yielded a total of twenty-two variables. Ten of these were used to evaluate early family environments and were derived from the FES, while the other twelve were used to investigate perceptions of early parental relationships and were taken from scores on the LIPHE. In the course of the study the number of variables of the LIPHE was collapsed across groups yielding a total of eight. A detailed description of each follows.

Characteristics of family environments were compared using a retrospective version of the Family Environment Scale (FES). This instrument was selected because it allows one member of a system to describe his or her perceptions of the characteristics of the system as whole. The retrospective version evaluates participants' perceptions of their family environments during earlier stages of their lives. Results from this scale were used to evaluate the first major premise of this research: that there are differences in the early family environments of persons diagnosed as borderline compared to bipolar.

The FES is a 90-item true-false instrument which assesses the differences of perceptions of family members along the three general systems' characteristics of relationship, personal growth, and system maintenance. These underlying domains of family life have been further divided into ten subscales which measure degrees of cohesion,

expressiveness, conflict, independence, achievement orientation, intellectual and cultural orientation, active and recreational orientation, moral and religious orientation, organization, and control.

The assumptions of the FES are that environments have unique "personalities" in the same ways that people do, and that these can be measured as accurately as individual personality assessments (Busch-Rossnagel, 1985). Normative data for the Form R subscales were collected from 1,125 normal and 500 distressed families. Families included in the normal sample were drawn from all areas of the country, a variety of ethnic minority groups, all age groups, and included both single-parent and multigenerational families. Participants in the distressed families were selected from general psychiatric patients, families of alcohol abusers, and families in which a younger child or adolescent was in a crisis situation.

Internal consistencies (Cronbach's Alpha) for each of the ten subscales of the FES are all in an acceptable range, while inter-correlations among subscales show that they are measuring distinct though somewhat related domains of family environments. Test-retest reliabilities vary from a low of .68 for independence to a high of .86 for cohesion (Moos, 1986).

The FES has been described as having robust face and content validity because each item seems relevant, is expressed clearly, and appears reasonable. Construct validity has been supported by comparison of the FES with other scales, by the development of indices of family role and functioning, and by linking individuals' perceptions of

their families' to trained raters' judgements of them (Moos, 1986). In addition, a comprehensive review is presented on

> "how the FES discriminates among families, the associations between the family climate and life transitions and crises, the impact of the family environment on children and adults, and the connections between characteristics of the family and treatment processes and outcomes" (Moos, 1986, p 20).

Those variables which were used to describe perceptions of early family environments may be defined as follows:

> "1. Cohesion (Ch): the degree of commitment, help, and support family members provide for one another.
>
> 2. Expressiveness (E): the extent to which family members are encouraged to act openly and to express their feelings directly.
>
> 3. Conflict (Cft): the amount of openly expressed anger, aggression, and conflict among family members.
>
> 4. Independence (I): the extent to which family members are assertive, are self-sufficient, and make their own decisions.
>
> 5. Achievement Orientation (AO): the extent to which activities (such as school and work) are cast into an achievement-oriented or competitive framework.
>
> 6. Intellectual/Cultural Orientation (ICO): the degree of interest in political, social, intellectual, and cultural activities.
>
> 7. Active/Recreational Orientation (ARO): the extent of participation is social and recreational activities.
>
> 8. Moral/Religious Emphasis (MR): the degree of emphasis on ethical and religious issues and values.
>
> 9. Organization (O): the degree of importance of clear organization and structure in planning family activities and responsibilities.
>
> 10. Control (C): the extent to which set rules and procedures are used to run family life" (Moos & Moos, 1986, p. 2).

The Life InterPersonal History Enquiry (LIPHE) (Schutz, 1978) is a retrospective assessment of the respondent's relations with his or her parents during early childhood. Its selection allowed for evaluation of the second major premise of this study: that there are differences in the perceived quality of early parent/child relationships between diagnosed borderline and bipolar participants.

The LIPHE has separate scales for the perceptions of relations with the person's father and mother measured in the areas of inclusion, control, and affection. Inclusion is defined as the need to establish and maintain a satisfactory relationship with others with respect to association and interaction. It refers to one's general social orientation. Control is the need to establish and maintain power especially in the decision-making process with others; it pertains to leadership behavior. Finally, affection is the need to be emotionally close or distant to others, or the need to establish deep rather than superficial relationships. Both the inclusion and control subscales are broken down into measures for behavior and feelings. The affection subscale also includes a scale which measures parental disapproval.

The specific variables which were used in conjunction with investigating the quality of early parent/child relationships may be defined as follows:

1. Inclusion Behavior (Ib): the amount of parental attention believed to have been received.

2. Inclusion Feeling (If): the amount of dissatisfaction perceived about how important parents felt participant was.

3. Control Behavior (Cb): the degree to which the participant felt allowed and encouraged to develop independence and personal abilities.

4. Control Feelings (Cf): the measure of dissatisfaction perceived by subject with parents' feelings about his/her abilities.

5. Affection (A): the measure of the satisfaction with the quality of the love received from parents.

6. Parental Disapproval (PD): the measure of the perception of how much parents wanted subject to be better than he/she was.

The LIPHE was normed on a sample of 5,847 persons. Internal consistency scores are comparable to other scales of this type, and scale intercorrelations are fairly high. Means, standard deviations, and distributions are also presented (Schultz, 1978).

Research Design

In this section a description of how the study was conducted will be outlined. This will include a discussion of how target participants were recruited, the procedure for administering each of the instruments, and how the data was analyzed.

As mentioned, participants in this study were selected from two, private, psychiatric hospitals in Connecticut. Depending on the setting, referrals of appropriate candidates were made in one of two ways. At one of the hospitals the researcher was provided with bi-weekly computer print-outs of case numbers of currently hospitalized patients who met the diagnostic and demographic criteria for the study. At the other facility the researcher received referrals from a

psychologist designated as the contact person. On each of the 15 units from which candidates were selected, the researcher made presentations which summarized the purpose and procedures of the project to the chief psychiatrists and clinical and nursing staffs.

Once a patient was deemed an appropriate candidate, contact was made with the doctor or clinician in charge of the case. The study was detailed to him or her, and the candidate was assessed for current mental state, degree of cooperativeness, and possible benefit to be derived from participation. At this point, the clinician presented the Informed Consent Form to the patient for consideration. Once signed, the researcher was informed of the participant's name and contacted the unit in order to schedule a meeting time.

At this preliminary meeting the researcher thoroughly reviewed the Informed Consent Form explaining the type of involvement requested, (i.e., time commitment, procedure, and the nature of the material to be discussed), the possible risks and benefits involved, how confidentiality would be maintained, and rights of the patient to withdraw from the study at any time. Participants were also made aware of the researcher's request for access to their hospital records. (One borderline patient agreed to participate in the study, but refused to allow a chart review. The researcher accommodated to her request.) Given these constraints, if the patient agreed to participate, two sessions were scheduled.

In the first session all target participants underwent a combination of the two diagnostic interviews, the DIB and the SCID. Before beginning, patients were told that they were free to decline to answer

any questions about material which they felt uncomfortable discussing. They also were instructed to inform the researcher if they were feeling fatigued and wished to discontinue the session. The combined interviews took approximately one to two hours. At the end of the DIB the interviewer also spent a fair amount of time gathering information about specific demographic material as well as a detailed family genogram. Most were completed in one session, however, about a third of the persons from both samples required more time. Sometimes the demographic and family information was taken at the beginning of the second session.

At the next meeting the researcher administered the Family Environments Scale and the Life InterPersonal History Inquiry. On average the FES took 15 to 20 minutes to administer, while the LIPHE required about 10 to 15 minutes to complete. This time frame varied from subject to subject, however, depending on how the patient was feeling. Two bipolar subjects requested that the inventories be read to them because of blurry eyesight caused by their medication. This was done while the patients recorded the responses on their own.

Prior to administering the scales, the researcher emphasized several points. First, it was emphatically stressed that participants recall perceptions of early life experiences. In addition, it was emphasized that there could be no incorrect responses, and that different family members would probably have different ideas of what the family was like. Second, the directions for each of the scales were explained. Then, patients were asked to take a moment to think back to ages seven or eight to recall where they were living, who lived

with them, the occupations of their parents, how the family was getting along in a general sense, and the quality of their relationships with their parents and siblings. After the scales were administered, the researcher reviewed the participants' records for further information about behavior during course of treatment, current medication if unknown to the patient, and results from psychological or neurological assessments.

Data Collection

The data for this research were collected in the following manner. Scaled scores for each of the five sections of the DIB were obtained for all participants through analysis of the diagnostic interview. These were then added together to obtain the composite score of seven or greater for the confirmation borderline personality disorder. The presence or absence of bipolar disorder was determined by evaluating the results of the SCID. The raw FES and the LIPHE subscale scores were then calculated for each participant. After the final meeting, each participant's chart was reviewed in order to obtain information on the patient's marital status, educational level, occupation, yearly income, race, parental occupations, number and birth order of siblings, psychiatric history, additional DSM-III diagnoses, psychiatric history of parents, and current medications. In addition, a brief summary of each of the participant's major separation experiences from birth to 10 years old was obtained. Information collected from all participants was kept in coded form in order to protect their rights to confidentiality.

Data Analysis

A description of how the data was analyzed will be presented in this section. Before proceeding to that discussion, however, it seems appropriate to list the major hypotheses of this research once again. They are as follows:

H_1

There will be no relationship for borderlines and bipolars between the composite and section scores on the DIB and the mean subscale scores on the FES and LIPHE.

H_2

There will be no significant differences in perceptions of early family environments on each of the subscales of the FES between diagnosed borderline and bipolar participants.

H_3

There will be no significant differences in perceptions of early parent/child relationships on each of the subscales of the LIPHE between diagnosed borderline and bipolar participants.

H_4

There will be no significant differences in the perceptions of early parent/child relationships with mothers versus fathers between members in either the borderline or bipolar groups.

Prior to testing any of these hypotheses, descriptive statistics were computed from the raw scores. Means and standard deviations were derived for all variables. In addition, also computed were statistics on patient demographic, familial, and psychiatric information and on types of separation experiences. Significanc of these variables were tested using chi-square statistics.

Data analysis of the major hypotheses proceeded as follows. A stepwise multiple regression analysis was performed to find associations between the DIB, and FES and LIPHE scores. Next, borderline and bipolar mean scores on the FES variables were compared using t-tests. Then, in order to maximally differentiate between borderline and bipolar groups on the FES, a discriminant function analyses was performed. It was thought that useful information might be obtained by performing this procedure even though the subject to variable ratio was only 4.4:1. This is slightly less than the 5:1 ratio considered risky but permissible, and far from the 10:1 ratio used as a rule of thumb for multivariate statistics. Interpretation of any results from this procedure, therefore, were considered with extreme skepticism.

Next, mean scores for borderlines and bipolars on the LIPHE were compared using t-tests. Again, bearing in mind that caution is needed to interpret the results, another discriminant function analysis was performed. A correlation matrix was generated first, however, to determine if variables could be collapsed across groups.

Finally, significance of the means of scores on the LIPHE for borderline and bipolar mothers versus fathers were determined using t-tests. This information, plus the descriptive statistics will be presented in the following chapter.

CHAPTER IV

RESULTS

Introduction

The following chapter will be divided into two sections. In the first there will be a summary of descriptive data which were collected on all participants. Included will be comparisons between the two groups on sociodemographic characteristics, familial information, psychiatric history, and relevant early separation experiences. In the second section there will be a discussion of results obtained through analysis of the major hypotheses. For the sake of convenience all tables and figures will be located at the end of this chapter.

Descriptive Statistics

As mentioned earlier, the criterion of matched groups was critical to the design of this study. Therefore, information such as age, sex, education, income, race, religion, and marital status were considered when assessing the appropriateness of each candidate for participation. Since most of these variables are categorical, frequencies and percentages for each category were calculated. Chi-squared analyses were then performed on each of the variables to determine their statistical significance. Results of these computations are summarized in Table 2 on page 114.

It may be noted that none of the variables tested to be statistically significant indicating that, for these characteristics, the groups may be considered to be matching. In addition, a t-test analysis of the age variable revealed no significant difference in age between borderlines (M=28.09, SD=5.68) and bipolars (M=29.55, SD=6.08), $t(42)=-.8198$, $p < .01$.)

Since this investigation focused on comparing the early family experiences and parent/child relationships of the participants, data were also collected for variables such as birth order, number of siblings, and whether or not the person was currently living with his or her parents. A summary of these statistics are presented in Table 3 on page 117.

Again it may be noted that none of the chi square statistics reached significance at $p < .05$, therefore the groups can be considered to be matching on familial variables.

Two other common characteristics of all participants were that they were hospitalized at the time of the interview, and that they had all sought some form of outpatient therapy prior to admission. Therefore, a set of variables comparing the psychiatric histories of each group was generated. These variables included: the age of onset of emotional difficulties, the age when the person first sought professional help, the number of years of both inpatient and outpatient treatment, and number of hospitalizations. These data are summarized in Table 4 on page 119.

Since no statistical differences were found, the groups may be considered to be matching on these variables.

Two other aspects of psychiatric history were also examined: current medications and additional diagnoses of each patient. Half of the borderline patients were receiving a combination of medications including neuroleptics, tricyclics and anti-anxiolitics, 36% percent the borderline patients were receiving some type of tricyclic anti-depressant only, and 13% were on no medication. This can be compared to 37% of the bipolar patients who were maintained on lithium, and the rest who were prescribed a combination of medications.

Criteria for diagnoses of participants was stringently defined. All borderlines in the sample had borderline personality disorder as their primary diagnosis. None had an Axis I of bipolar disorder, cyclothymia, or schizoaffective disorder. Additional diagnoses for borderlines on Axis I were as follows: dysthymia=16, major depression=4, other, mixed or unspecified substance abuse=6, alcohol abuse=4, alcohol dependence=2, cocaine abuse=2, identity disorder=1, bulimia=2, atypical depression=1, schizophreniform disorder=1, generalized anxiety disorder=1, and no Axis I diagnoses=1.

In the bipolar group the additional Axis I diagnoses were as follows: dysthymia=1, panic disorder=1, bulimia=1, alcohol abuse=4, cocaine abuse=3, and cannabis abuse=2. Ten bipolar patients were diagnosed as currently manic, four as depressed, and eight as mixed. No bipolar participant had any personality disorder on Axis II. Also,

participants in both groups were accepted only if their substance abuse diagnoses were considered either episodic or in remission.

Finally, the literature suggests that persons with borderline personality disorder may often have experienced some form of separation experience prior to adolescence especially during the separation/ individuation stage of development at around age two. Table 5 on page 121 summarizes the percentage of subjects who have experienced the death of a family member, loss of a parent through separation or divorce, problems of chemical dependency for each parent, critical hospitalizations and chronic illness of family members, and frequent or traumatic changes of residence prior to age ten.

It has generally been assumed that borderlines have experienced a higher incidence of critical separations and trauma in early childhood. Contrary to reports by Walsh (1976), Mandelbaum (1980), and Soloff and Millward (1983), when borderlines were compared to bipolars, data for separation experiences did not reach significance.

In the next section an analysis of each of the hypotheses of the study will be presented.

Data Analysis for Each Hypothesis

The basic questions of this research were concerned with the ways in which borderline and bipolar participants differed on their perceptions of their early family systems and their relationships with each of their parents. Another interest focused on assessment of any

associations between perceptions of earlier family systems and interactions and later adult psychopathology. In the following section, the second issue will be addressed first. Next, there will be an analyses of the two central hypotheses: that there would be no significant differences between the groups on either their perceptions of their early family environments as assessed by the FES, or their perceptions of individual parent/child relationships as measured by the LIPHE. Finally, the question of how borderlines or bipolars perceived each of their parents will be investigated.

The first hypothesis stated, "There will be no relationship for borderlines or bipolars between composite and section scores on the DIB, and mean subscale scores on the FES and LIPHE." Its purpose was to assess the association between early environment and later behavior. To test this hypothesis two stepwise multiple regressions were performed, one for borderlines and the other for bipolars. FES and LIPHE scores were considered as independent variables, while the DIB composite and section scores served as the dependent variables. Table 6 on page 123 summarizes the findings for both borderlines and bipolars for the FES and LIPHE scores.

For both borderlines and bipolars, then, it would appear that there is some association between perceptions of early interactions and adult behavior. Therefore, since significant differences were found between the DIB and FES and LIPHE variables, Hypothesis 1 may be rejected at $\underline{p} < .01$. Extreme care must be taken not to overinterpret the results, however, as spurious Multiple R's usually occur when there are a large number of variables and a small number of subjects.

The second and third hypotheses were concerned with perceptions of early family environments and parent/child relationships. Specifically, Hypothesis 2 said that, "There will be no significant differences in perceptions of early family environments on each of the subscales of the FES between diagnosed borderline and bipolar participants," and Hypothesis 3 stated, "There will be no significant differences in perceptions of early parent/child relationships on each of the subscales of the LIPHE between diagnosed borderline and bipolar participants". Both of these hypotheses were analyzed using similar procedures.

In testing Hypothesis 2, t-tests were performed which compared the differences of the means for each variable. Table 7 on page 124 summarizes these statistics, while Figure 2 on page 125 presents them in graphic form. It can be noted that the cohesion variable was the only one which reached statistical significance.

In further testing a discriminant function analysis was performed to identify those FES variables which maximally discriminated between members of the criterion groups. With 63.6% of the "grouped" cases classified correctly, three variables contributed to the variability in the equation due to group differences. They are:

Cohesion	29%
Control	22%
Intell/Cult	21%

Although the cohesion variable again appears discriminative, it is important to remember that the subject to variables ratio is very low (4.4:1). Therefore, much caution must be exercised in not overstating the results. This caution is further justified when considering that the Wilks' Lambda (.752) failed to reach the .05 level of significance (p=.392, X=10.57, df=10).

As noted, results of the t-tests showed that the only variable which significantly distinguished borderline from bipolar groups was cohesion. The intellectual/cultural and control variables, however, approached significance at $p < .05$. Therefore, a post-hoc analysis was performed on the data.

Since there appeared to be a high degree of overlap between the two samples, and given the difficulty in obtaining distinguishable, non-overlapping groups, the criteria for group membership was more stringently redefined. Scores on the DIB for both groups were plotted on a scatter diagram, and the cut-off score for group membership was raised from ≥ 7 to ≥ 9 for borderlines and lowered from ≤ 7 to ≤ 3 for bipolars. Two new samples, each with n=14, were formed. Table 8 on page 126 summarizes the results.

With more stringent criteria no other variables became significant. The cohesion variable changed, however, from $p < .05$ to $p < .01$. Therefore, since t=-2.02 with df=42 at .05 is equal to the computed t=2.02, Hypothesis 2 may be rejected indicating that there is a significant difference in the means of the two groups.

The test for Hypothesis 3, that there were no differences between the groups on the LIPHE subscales, was conducted in a similar manner as for Hypothesis 2.

T-tests were performed to see if there were any differences in the means of the two groups. Results of t-tests are presented in Table 9 on page 127, while Figure 3 on page 129 shows them in graphic form.

Although none of the variables reached significance at $p < .05$ for two-tailed analysis, father inclusion behavior was extremely close ($p=.051$). In addition, father inclusion feelings and affection behavior plus mother control behavior and feelings approached that level of significance.

A discriminant function analysis was then performed in order to maximally distinguish between the two groups. In an attempt to reduce the number of LIPHE subscales prior to analysis, a Pearson product-moment correlation matrix was generated. In both borderline and bipolar groups scores for inclusion feeling and behavior, and control feeling and behavior for both fathers and mothers were significantly correlated (borderline FIB/F=.4297, FAB/F=.7571, MIB/F=.6731, MCB/F=.4630; bipolar FIB/F=.6910, FCB/F=.6749, MIB/F=.7106, MCB/ F=.5805) at ($p < .01$), allowing these scores to be collapsed across groups.

With 68.18% of "grouped" cases classified correctly, three variables contributed to the variability in the equation due to group differences. They were:

Father Affection Behavior	33.5%
Father Inclusion Feelings/Behavior	31.8%
Mother Control Feelings/Behavior	20.3%

No definitive conclusions can be drawn from these results, however, because of the low subject to variable ratio (5.5:1), and because the Wilks' Lambda (.80) failed to reach the .05 level of significance (p=.399, X=8.37, df=8).

Applying more stringent criteria for group membership, and performing t-tests on a reduced sample size (n=28) again failed to produce any significant differences. Therefore, Hypothesis 3 must be retained at $p < .05$, and it may be concluded that there were no significant differences in the ways that borderlines and bipolars perceived their relationships with each of their parents.

Hypothesis 4 stated, "There will be no significant differences in the perceptions of early parent/child relationships with mothers versus fathers between members in either the borderline or bipolar groups". T-tests were used to compare the means of mother versus father for each variable. Results for the borderline and bipolar groups are presented in Table 10 on page 130.

Since two t values were significant $p < .05$, Hypothesis 4 may be rejected indicating that the means of the groups are significantly different. Results indicate that mothers were perceived as more controlling than fathers by borderlines and more disapproving than fathers by bipolars.

The purpose of this chapter was to outline the results of the analyses of the major hypotheses of this study. Following is a summary:

1. Hypothesis 1: (association between DIB scores and FES and LIPHE scores for borderlines and bipolars) was rejected because significant correlations were found for borderlines between social adaptation and father parental disapproval and mother inclusion feelings; between impulse action patterns and active/recreational orientation; and between psychosis and mother parental disapproval and father affection behavior. For bipolars relationships were found between affects and cohesion, and interpersonal relations and father control feelings.

2. Hypothesis 2: (differences in family environments between borderlines and bipolars) was rejected because a significant difference was found for the cohesion variable. Weak evidence was also found for the intellectual/cultural orientation and control variables.

3. Hypothesis 3: (differences in early parent/child relationships between borderlines and bipolars) was retained because no significant differences in the means were found.

4. Hypothesis 4: (differences in perceptions of mothers versus fathers for borderlines and bipolars) was rejected. Borderlines perceived their mothers as more controlling than their fathers, and bipolars saw their mothers as more disapproving than their fathers.

It may be noted that only three variables attained significance: cohesion for both groups, mother control behavior and feelings for borderlines, and mother parental disapproval for bipolars. Although disappointingly thin, the importance and interpretation of these results in relation to the literature will be discussed in the next chapter.

Table 2

Comparison of Borderline and Bipolar Sociodemographic Characteristics

Socio-demographic variables	Patient group: Borderline (n=22) %	Patient group: Bipolar (n=22) %	df	χ^2
Age (years)			3	1.43
19-25	31.7	27.2		
26-30	36.4	38.8		
31-35	27.1	36.3		
36-40	4.5	4.5		
Sex			1	.17
Male	18.2	13.6		
Female	81.8	86.4		
Marital Status			3	2.50
Single	31.8	22.7		
Married	18.2	36.4		
Divorced	13.6	18.2		
Never Married	36.4	22.7		

Continued Next Page

Table 2 Continued

Race			1	1.02
White	95.5	100.0		
Hispanic	4.5	0.0		
Religion			4	4.67
Catholic	22.7	45.5		
Protestant	22.7	22.7		
Jewish	9.1	13.6		
Other	27.3	13.6		
None	18.2	4.5		
Education			4	2.68
9th Grade	4.5	0.0		
High School	27.3	27.3		
Some College	31.8	45.5		
Bachelors	4.5	9.1		
Grad Degree	31.8	18.2		
Employment			2	1.10
Unemployed	54.5	50.0		
Public Assist	4.5	13.6		
Employed	40.9	36.4		
Yearly Income			4	2.22
< $5,000	22.7	22.7		
$5-10,000	18.2	13.6		
$10-20,000	31.8	27.3		
$20-30,000	18.2	18.2		

Continued Next Page

Table 2 Continued

$30-40,000	9.1	9.1
> $40,000	0.0	9.1

*$p < .05$.

Table 3

Comparison of Borderline and Bipolar Familial Characteristics

	Patient group			
Family variable	Borderline (n=22) %	Bipolar (n=22) %	df	χ^2
Number of siblings			5	3.01
0	0.0	9.1		
1	13.6	18.2		
2	45.5	36.4		
3	22.7	18.2		
4	9.1	4.5		
> 4	9.1	13.6		
Birth order			3	3.05
First born	31.8	27.3		
Middle born	27.3	36.4		
Youngest born	45.5	27.3		
Only child	0.0	9.1		

Continued Next Page

Table 3 Continued

Living with parents			1	.46
Yes	22.7	31.8		
No	77.3	68.2		

*$p < .05$.

Table 4

Comparison of Borderline and Bipolar Psychiatric Histories

Psychiatric variable	Patient group: Borderline (n=22) %	Patient group: Bipolar (n=22) %	df	χ^2
Age of onset (yrs.)			3	6.88
5 to 10	31.8	9.1		
11 to 20	45.3	31.8		
21 to 30	22.6	45.5		
31 to 40	0.0	13.6		
Age 1st therapy			3	1.09
5 to 10	9.1	4.5		
11 to 20	45.4	36.3		
21 to 30	40.8	50.0		
31 to 40	4.5	9.1		
Years in therapy			3	.59
< 1 year	4.5	9.1		
1 to 3 years	50.0	45.4		

Continued Next Page

Table 4 Continued

4 to 6 years	22.6	18.2		
> 7 years	22.6	27.3		
Hospitalizations			3	1.70
1 to 3	45.4	59.0		
4 to 6	31.8	18.2		
7 to 9	9.1	4.5		
> 10	13.6	18.2		

*$p < .05$.

Table 5

Percentage of Borderline and Bipolar Patients Reporting Separation Experiences Prior to Age Ten

Separation experiences	Patient group: Borderline (n=22) %	Bipolar (n=22) %	df	χ^2
Death of family member				
Mother	0.0	4.5	1	1.02
Father	4.5	13.6	1	1.10
Sibling	4.5	4.5	1	0.00
Grandmother	27.3	40.9	1	.91
Grandfather	45.5	22.7	1	2.53
Friend	18.2	18.2	1	.23
Other	9.1	13.6	1	.22
Parental separation	22.7	22.7	1	0.00
Parental divorce	18.2	13.6	1	.17

Continued Next Page

Table 5 Continued

Hospitalizations				
Mother	45.5	36.4	1	.38
Father	13.6	31.8	1	2.08
Patient	50.0	36.4	1	.83
Chronic illness				
Mother	27.3	9.1	1	2.22
Father	13.6	9.1	1	.23
Alcohol/drug depend.				
Mother	27.3	18.2	1	.52
Father	27.3	9.1	1	2.54
Family moved	40.9	18.2	1	2.73

** $p < .01$.

Table 6

Stepwise Multiple Regression Analysis of DIB Subscales with FES and LIPHE Subscales for Borderlines and Bipolars

DIB scales	R	Percent of variance	Strongest regression weights of FES and LIPHE with DIB scales
		Borderlines	
Social adaptation	.664	.441	FPD (.884), MIF (-.513)**
Impulse action	.507	.257	ARO (.507)*
Psychosis	.637	.406	MPD (-.477), FAB (.388)**
		Bipolars	
Affects	.523	.273	C (-.523)*
Interpersonal relations	.537	.289	FCF (-537)**

*p < .05, **p < .01.

Table 7

Comparison of Borderline and Bipolar Mean FES Subscale Scores

FES subscales	Patient group: Borderlines (n=22) M	SD	Bipolars (n=22) M	SD	t(df=42)
Cohesion	3.36	2.57	5.05	2.94	-2.02 *
Expressiveness	2.55	2.04	2.77	1.88	-0.38
Conflict	4.45	2.74	4.23	2.47	0.29
Independence	5.05	1.96	5.27	1.91	-0.39
Achievement	6.55	1.68	6.27	1.78	0.52
Intell/cultural	3.45	2.30	4.73	2.68	-1.69
Active/rec.	4.32	2.72	5.32	2.32	-1.31
Moral/religious	4.55	2.54	5.14	2.53	-0.77
Organization	5.68	2.40	6.23	2.45	-0.75
Control	7.23	1.72	6.05	2.65	1.76

*$p < .05$, two-tailed.

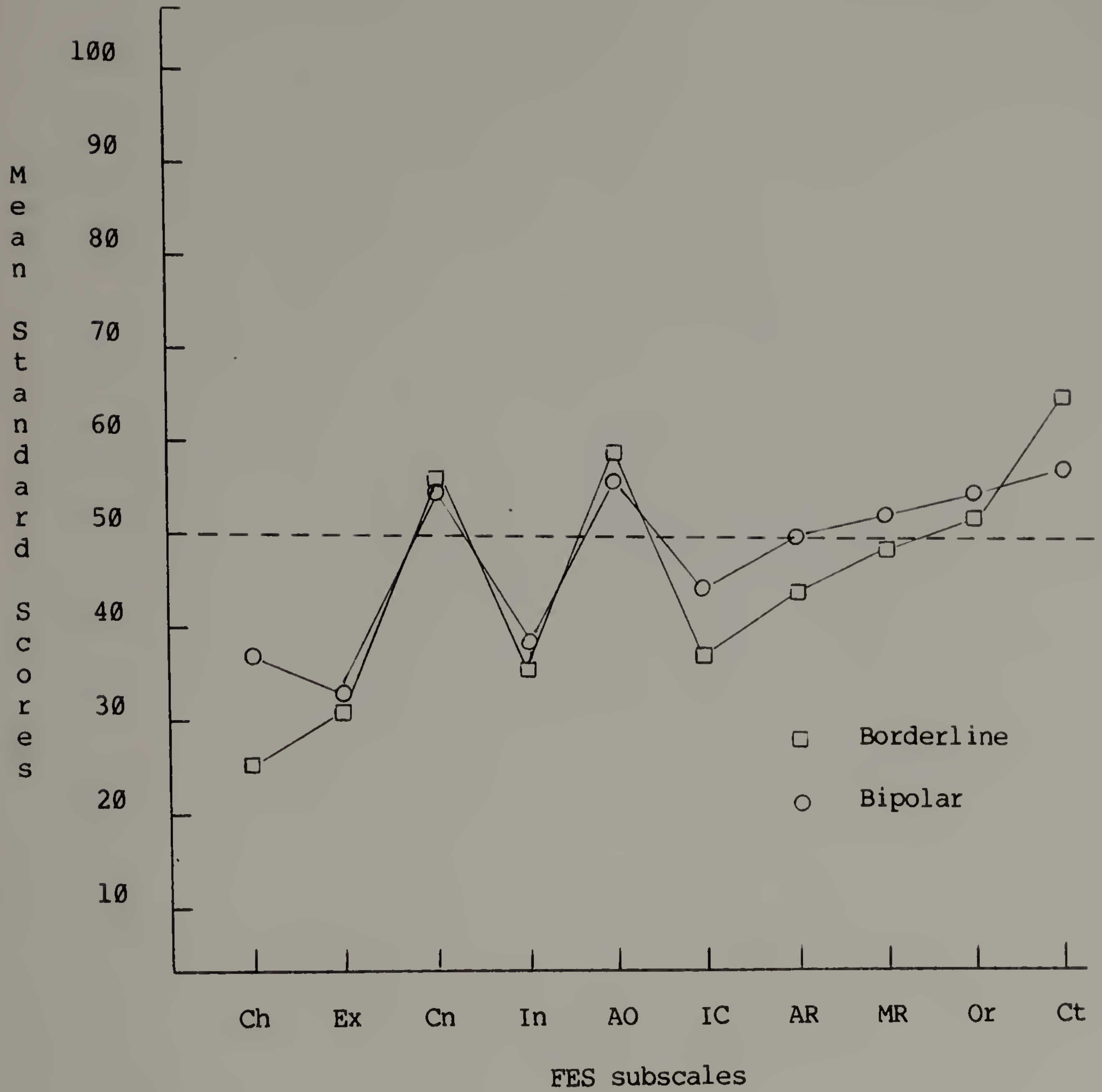

Fig. 2 Profile of Borderline and Bipolar Mean FES Standard Scores

Table 8

Comparison of Borderline and Bipolar Mean FES Subscale Scores Using Reduced Sample Size

FES subscales	Patient group: Borderlines (n=14) M	SD	Bipolars (n=14) M	SD	t(df=12)
Cohesion	3.07	2.13	5.79	2.55	-3.06**
Expressiveness	2.36	1.98	2.36	1.86	0.00
Conflict	4.43	3.06	4.29	2.37	0.14
Independence	4.71	2.16	5.36	1.65	-0.88
Achievement	6.43	1.74	6.86	1.46	0.71
Intell/cultural	3.71	2.30	4.86	2.68	1.21
Active/rec	4.36	2.76	5.93	1.94	-1.74
Moral/religious	4.57	2.65	5.50	2.53	-0.95
Organization	5.50	2.59	6.43	2.31	-1.00
Control	6.86	1.83	6.29	2.55	1.68

**p < .01, two-tailed.

Table 9

Comparison of Borderline and Bipolar Mean LIPHE Subscale Scores

LIPHE subscales	Patient group				
	Borderlines (n=22)		Bipolars (n=22)		
	M	SD	M	SD	t(df=42)
			Father		
Inclusion					
Behavior	6.73	1.49	5.27	3.01	2.03
Feelings	6.41	1.89	5.50	3.02	1.20
Control					
Behavior	5.09	1.86	4.41	2.77	0.96
Feelings	8.18	2.40	6.27	2.87	-0.11
Affection	6.91	2.54	5.36	2.95	1.86
Disapproval	5.55	1.90	4.91	3.05	0.83

Continued Next Page

Table 9 Continued

			Mother		
Inclusion					
Behavior	6.14	2.57	5.91	3.28	0.26
Feelings	6.14	2.66	6.22	3.05	-0.11
Control					
Behavior	5.86	1.70	5.00	3.01	1.17
Feelings	7.31	2.06	6.36	2.54	1.37
Affection behavior	6.68	2.52	6.36	2.72	0.40
Parental disapproval	5.41	2.16	5.77	2.33	-0.54

*$p < .05$, two-tailed.

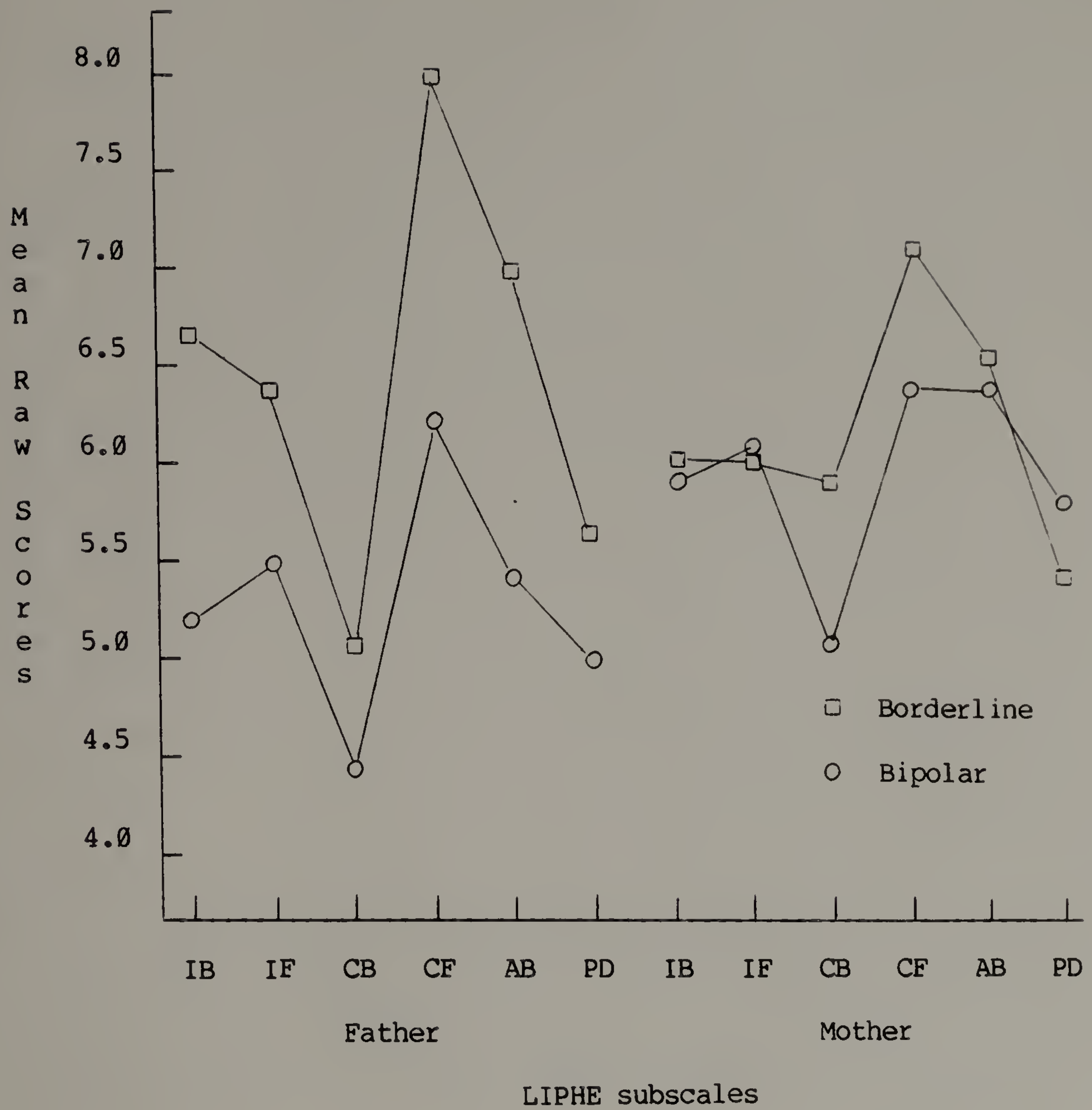

Fig. 3 Profile of Borderline and Bipolar Mean Raw LIPHE Scores

Table 10

Comparison of Mean LIPHE Subscale Scores of Mothers Versus Fathers for Borderline and Bipolar Groups

LIPHE variables	M	SD	t(df=21)
	Borderline group (n=22)		
Inclusion behavior			1.08
Father	6.73	1.49	
Mother	6.14	2.57	
Inclusion feeling			0.41
Father	6.41	1.89	
Mother	6.14	2.66	
Control behavior			-1.52
Father	5.09	1.88	
Mother	5.86	1.70	
Control feelings			-2.28 *
Father	6.18	2.40	
Mother	7.32	2.06	

Continued Next Page

Table 10 Continued

Affection behavior			0.31
Father	6.90	2.54	
Mother	6.68	2.53	
Parental disapproval			0.36
Father	5.55	1.90	
Mother	5.41	2.18	
	Bipolar group (n=22)		
Inclusion behavior			-0.89
Father	5.27	3.01	
Mother	5.91	3.28	
Inclusion feeling			-1.39
Father	5.50	3.02	
Mother	6.23	3.05	
Control behavior			-1.11
Father	4.41	2.77	
Mother	5.00	3.01	
Control feeling			-0.14
Father	6.27	2.87	
Mother	6.36	2.54	

Continued Next Page

Table 10 Continued

Affection behavior			-1.51
Father	5.35	2.95	
Mother	6.36	2.72	
Parental disapproval			-2.31 *
Father	4.91	3.05	
Mother	5.77	2.33	

*$p < .05$, two-tailed.

CHAPTER V

DISCUSSION

Discussion of Results

In this chapter the findings of the study will be evaluated and interpreted. It will begin with separate discussions of the results for borderline and bipolar family systems. This will be followed by a summary of the conclusions, limitations, and significance of the research findings. Finally, suggestions will be made for further research.

Summary of Findings for Borderline Family Systems

As mentioned, the literature on borderline family systems presented two patterns of interactional behavior, the neglect and the overinvolvement hypotheses. In this study, when borderlines and bipolars were compared on their perceptions of their early family environments, results showed that borderline families were less cohesive than bipolar. This data tends to support the neglect hypothesis, and is in agreement with several authors, most notably Gunderson et al. (1980), who described the predominance of parental neglect and abuse to the exclusion of attention, support, and protection of the children. The data also concur with Grinker et al. (1968) who described some borderline families as non-protective; Walsh (1976) who saw them as sharing few interests; Mandelbaum (1977, 1980) and Meissner (1984) who viewed them as having weak boundaries and no

real sense of themselves as a whole; and, Shapiro et al. (1975) who described a type of family who responds to dependency needs by withdrawing.

Many theorists have reported, however, that there are some borderline families who can best be described as overinvolved. Among them are Grinker et al. (1968) who noted some families who are excessively protective, smothering, or suffocating; Gunderson et al. (1981) and Soloff and Millward (1983) who described an intense over-involvement of the borderline with his or her parents; Shapiro et al. (1977) who claimed that sometimes the borderline is encouraged to remain dependent because autonomous behavior represents a condemnation of the family; Snyder et al. (1984) who noted that parents of borderlines establish rigid, inflexible rules but fail to enforce them; and, Goldberg et al. (1985) who claimed that borderlines perceive their parents to be overprotective and less caring.

The question of how to account for these discrepancies might be explained by re-evaluating the significance of the control variable in discriminating between borderline and bipolar groups on the FES. It may be noted that in subsequent t-tests, the control variable approached statistical significance, with borderline families appearing more controlling than bipolar. Also, the discriminant function analysis of borderline and bipolar scores on the LIPHE showed some support for perceptions of control by mothers; significance was not obtained, however. Although highly speculative at this point, an argument could be made for the overinvolvement hypothesis by saying that there is some

evidence that a group of families exists where an overly strict set of rules and procedures are used to run family life.

In addition, while no differences in perceptions were obtained across borderline and bipolar groups, significant differences were found when examining borderline perceptions of mother versus father on the LIPHE. Borderlines perceived feeling that their mothers were significantly more controlling ($t=-2.28$, $df=21$, $p < .05$) than their fathers suggesting that, by and large, their mothers are overinvolved. This data is supported in the literature by Meissner (1984) who claimed that the mother of the borderline ignores the child while imposing strict controls; by Soloff and Millward (1983) who noted a negative-conflictual overinvolvement in the mother/child relationship; by MacMurray (1976) who described some borderline mothers as imposing stern ideational controls while ignoring the child's emotional needs; and, by Masterson and Rinsley (1975) who saw the mother as rewarding clinging behavior and withdrawing from assertive behavior.

Finally, in families which might be described as overinvolved, the scores for independence and expressiveness might be predicted to be low as well. Although no statistically significant differences were found between borderlines and bipolars across groups or between borderline mothers versus fathers, these variables were both statistically lower than the FES normed average (for expressiveness $t=-5.15$, $df=21$, $p < .01$, and for independence $t=-2.80$, $df=21$, $p < .05$).

Investigation of perceived differences of early parent/child relationships on the LIPHE failed to produce any significant differences between the borderline and bipolar groups. The fact that no

results were obtained may reflect some of the confusion that is present in the literature. As mentioned, mothers generally have been viewed as overprotective and overinvolved suggesting that they should score higher on control and inclusion. They also have been described, however, as passive and childlike persons who use symbiotic clinging and dependency (MacMurray, 1976; Meissner, 1984; Wolberg, 1968, 1977) indicating that scores on these variables might be lower rather than higher.

Likewise, the behavior of fathers in borderline family systems has also been viewed in conflicting ways. By some researchers (Frank & Paris, 1981; Meissner, 1984; Soloff & Millward, 1984; Wolberg, 1968, 1977) fathers have been described at times as weak, passive, uninvolved, disinterested, while by others (Meissner, 1984; Snyder et al., 1984; Wolberg, 1968, 1977) they have been viewed as sometimes domineering, hypercritical, and authoritarian. Scores on inclusion, control, affection, and parental disapproval for fathers might be difficult to predict because they encompass a wide range of variability in the literature. Discriminant function analysis on the LIPHE scores suggested that affection and inclusion behavior by fathers might account for some of the differences between the groups. None of the results attained statistical significance, however, so no conclusions may be drawn on how borderlines might differ from bipolars on perceptions of early parent/child relationships on any of the LIPHE variables.

Finally, if parents are united at the expense of the children's welfare as suggested by Gunderson et al. (1980), then inclusion scores

on the LIPHE for both mothers and fathers should be significantly lower for borderlines than bipolars. This did not prove to be the case, and explanation for why this was not is uncertain.

To summarize it might be said that, while support has been found for the neglect hypothesis, it might also be speculated that some borderline families are overinvolved. This suggests that, when compared to bipolars, perhaps borderline families can be placed on a spectrum between disengaged at one end, and enmeshed at the other. While the data suggests that the majority of families might be located at the disengaged end, and exhibit behavior that is neglectful, some families might also be found toward the enmeshed side. It is also possible that either of these types of families shift to the polar opposite during different stages in their family life cycle. Finally, there may exist a group of families who continuously vacillate between these poles.

The concept of fluidity in borderline families is similar to Meissner's (1982) discussion of countertransference with borderline patients. Reflecting the push/pull dynamics associated with separation and attachment, Meissner claimed that borderlines can operate within three basic configurations, the aggressive, the narcissistic, and the erotic. Each configuration is composed of polar opposites, one which is introjected and the other which is projected. It is highly characteristic of borderlines to shift not only within a configuration from one polar opposite to another, but also to shift to a different configuration. For example, a patient presenting as helpless can easily shift to being aggressive, inferior, or seductive.

In the transference with borderline patients, if therapists experience affective instability as well as intense, interpersonal relationships which alternate between devaluation and idealization, it follows that this fluid pattern of interaction should reflect and be isomorphic to patterns exhibited in the patient's family. Based on our knowledge of the individual psychopathology of the borderline patient, we can infer as to possible family patterns of interaction. If one of the hallmarks of borderlines is unpredictability in relationships, then it would seem that the borderline family system would by necessity have to be dynamic in order to initiate or accommodate to that behavior. A conclusion of this sort, however, would be an overstatement of the results found in this investigation.

Summary of Findings for Bipolar Family Systems

The finding that bipolar families were significantly more cohesive than borderline families on the FES is congruent with other research outcomes. Cohen et al. (1954) described the bipolar family as banning together against an outside world which is different from and socially disapproving of them. They also described the family as harmonious and close knit. Davenport et al. (1979) concurred, saying that the family is very tightly bound together, a condition which leaves it impervious to experiences outside of the system. Within the family, members usually have a great deal of affection and concern for one another even though they are not allowed to directly express it. Steirlin et al. (1986) claimed that there is a high demand placed on family loyalty, and both Abrahams and Whitlock (1969) and Frank et al. (1980) agreed

that bipolar marriage and family life is generally satisfactory and stable. Most recently, Weber et al. (1988) claimed that bipolar families are highly organized in order that they guarantee "the cohesion they consider imperative for survival" (p. 34).

Although the cohesion variable proved significant, it is interesting that several other variables did not. Many researchers have mentioned the restricted affect in bipolar families. For example, Abland et al. (1979) said that feelings are expressed only on the manic phase; Waters et al. (1981) found that discussion of mood by adult of bipolars causes anxiety; Mayo et al. (1979) noted that affective responses are restricted because spouses misattribute normal expression of feelings as pathological; and Davenport et al. (1984) demonstrated that affective reactions are repressed by children of bipolar parents at an early age. Finally, Weber et al. (1988) stated that one of the major premises of bipolar families is that a person who "loses control" is not healthy; once lost, however, the person is seen as ill and can do anything he or she likes. The closest evidence for the validity of this variable for bipolar families was found when testing the first hypothesis. Expression of affects on the DIB was negatively correlated with cohesion on the FES. Much caution must be exercised in interpretation, however, because of the high subject to variable ratio.

Another prediction that might have been made from the FES scores was that achievement for bipolars would be higher than borderlines. Several authors mentioned the high expectations of parents that children be perfect and that they raise the status of the family in the

community (Cohen et al., 1954: Davenport et al., 1979). Although both borderline and bipolar scores were above the norm, no significance was found between the groups.

When borderline and bipolar scores were compared on the LIPHE no significant differences were found. However, when bipolar perceptions of mothers versus fathers were evaluated, it was found that bipolar mothers were perceived as expressing significantly more parental disapproval than fathers (t=-2.31, df=21, $p < .05$). This is supported in the literature by Cohen et al. (1954) who described the mother as the moral authority of the family and a person who was more ambitious, aggressive, unloving, and cold. Davenport et al. (1979) saw mothers as more dominant. Also, when children failed to live up to unrealistic standards, they were disapproved of by one or both parents. In a later study, Davenport et al. (1984) discussed how bipolar parents show more negative affect toward their children.

To summarize, it appears that the hallmark of bipolar families is their sense of cohesiveness. When compared to borderline families, members provide a higher degree of commitment, support, and help to one another. In addition, mothers show more parental disapproval than fathers suggesting that they may often take the "depressive position" (Weber et al., 1988) in the family. They appear more orderly, organized, and disciplined. The "manic position" might be filled by fathers who are seen by their offspring as footloose, loving, but irresponsible. It is possible that the reason that borderlines and bipolars did not differ significantly on the expressiveness variable is because both groups have such difficulty with regulating affect.

Conclusions and Limitations of the Investigation

From the literature on family systems one might expect to find differences between the two groups on the FES possibly in the areas of cohesion (borderlines lower); expressiveness (borderlines higher); conflict (borderlines higher); achievement (borderlines lower); organization (borderlines lower); and control (borderlines higher). On the LIPHE one might predict that scores for father on affection might be lower for borderlines; and scores for mother on inclusion, and control would be higher for borderlines. Finally, parental disapproval might be higher for bipolar mothers.

In essence, when comparing scores across groups only one variable attained statistical significance, cohesion. The overall similarity between borderline and bipolar family systems and parent/child relationships is cause for speculation. The first question that must be asked is if, in fact, the two groups were significantly different from each other. As mentioned in the section on Description of the Sample, borderlines could be statistically differentiated from bipolars not only on the DIB composite, but also on the section scores for impulse action patterns, affects, psychosis, and interpersonal relations ($p < .01$). Social adaptation was the only section score that did not reach significance; this may be due to the fact that nearly all participants were hospitalized on several occasions in the last few years. It appears, then, that relatively pure groups of borderlines and bipolars were selected.

It would seem, however, that even after using the most stringent criteria for group membership, there still appears to be a great deal

of overlap between the two groups. What factors might account for their overall similarities? As mentioned previously, borderlines and bipolars share some behavioral, intrapsychic, interpersonal, and familial similarities. Most simply some of these include: affective instability, impulsivity and irritability; developmental arrest prior to integration of whole object relations resulting in the use of splitting, projective identification, devaluation, etc. during times of stress; use of dependency and manipulation in interpersonal relationships; family systems which have been described as enmeshed; and, perceptions of mothers as dominant and fathers as weak and disinterested. Therefore, the assumption that there is a high degree of overlap between the two groups does not appear unfounded.

Kroll (1988), in fact, has challenged the DSM-III-R Axis II diagnostic schema. He questioned the validity of personality disorders as they are currently defined. His criticisms include: the use of categories rather than dimensions, the establishment of criteria for personality disorders based on insufficient research, the inability to objectively define and measure personality traits, and the lack of weighting of criteria.

Kroll also claimed that the borderline diagnosis is a political concept which evolved from historical, economic, and ideological factors; its overlap with the affective disorders has arisen as a result of these factors. First, although established as a discrete category as early as 1968 by the Grinker et al. research, the psychoanalytic community has been reluctant to relinquish its definition of borderline as a disorder which lies on a continuum linking neurosis

and psychosis. The paradox in DSM-III-R appears to be that borderline personality disorder is categorized as a discrete entity on Axis II, while at the same time it is heavily loaded with Axis I affective characteristics thus supporting the continuum concept. In addition, the link with affective disorders has been reinforced by the creation of the schizotypal diagnosis. Cognitive disturbances such as depersonalization and derealization, which are characteristic of some borderlines, have been disassociated from the borderline diagnosis and included as criteria for the schizotypal disorder. Finally, the link to affective disorders was strengthened by omission of the characteristic of brief psychotic episodes from the borderline criteria.

A second reason for the overlap, according to Kroll, has been economic. After 80 years of Freudian influence, biological psychiatrists have again become influential, and the explanation for human behavior has shifted back to physiological, genetic, and biochemical causes. Medication for physical and psychological symptoms has become more prevalent. More importantly, reimbursements have favored short-term rather than long-term treatment. If borderline disorders, then, are linked diagnostically with affective disorders, they fall in the domain of biological psychiatrists who can recommend medication and short-term treatment. Not surprisingly, it is these same people who profit economically from those recommendations.

Finally, Kroll claims that there are ideological reasons which contribute to the overlap dilemma. A faction of psychiatrists, whom he refers to as "affectophiles", have successfully redefined a variety of conditions as affective disorders which should be treated with

antidepressant medication. This group is in conflict with others who view borderline personality disorder as a discrete entity. The opinion of the affectophiles was carried in DSM-III, but with each new edition of the manual, the battle for ideological recognition begins again.

To summarize, diagnostic limitations may have contributed to the paucity of significant differences between the two groups.

In addition to these diagnostic limitations, this study has both methodological and theoretical limitations which could have influenced the results obtained. First, results might have been greatly enhanced with a larger number of participants in both samples. Second, even after collapsing across groups, the number of variables for each instrument was large. Third, it is possible that either the measuring instruments were imprecise in their definitions of the variables, or that systemic functioning is too complex to be assessed by paper and pencil scales. Fourth, the study may be criticized on the fact that nearly all of the participants were female leaving the question of gender differences still unresolved. Fifth, all participants were psychiatrically hospitalized at the time of the interview thus omitting a large number of borderlines who function on the outside either with or without outpatient therapy. Sixth, memories recalled from childhood are usually selective and distorted. They also may be biased depending on the participant's current mental state or the current status of his or her relationships with family members. Major intervening life events such as death of a parent also bias current perceptions. Seventh, borderlines, especially, have difficulty with evocative memory, recalling events which are highly affectively charged. The

fact that part of their cognitive style involves the acquisition of global, impressionistic perceptions (Kroll, 1988) may have been helpful, however, in their recall of their family as a whole. Eighth, a clearer understanding of the "reality" of borderline and bipolar family life would have been obtained had all family members been included in the study.

Significance of the Research Findings

The link between borderline personality disorder and the affective disorders is far from resolved. In this study only one difference between them was found: that bipolar families tended to be significantly more cohesive than borderline. In general, their overall similarities prevailed. More research is needed to determine exactly how they overlap and exactly how they may be differentiated from one another.

Suggestions for Additional Research

Several suggestions may be offered for additional research. One is that the study be repeated with an increased sample size. A second is to compare borderlines or bipolars with other diagnostic categories. Finally, it might be interesting to investigate family environments of borderlines who have reported sexual abuse to those for

whom it has never been a problem. This data might help to further substantiate or nullify the neglect hypothesis.

CHAPTER VI

SUMMARY: JOURNAL ARTICLE

Abstract

The purpose of this study was to compare the early family environments and parent/child relationships between adults who have been diagnosed as either borderline personality or bipolar disorder. Twenty-two borderlines between the ages of nineteen and forty who had no severe or continuous history of substance abuse were matched with 22 bipolars. Participants were stringently evaluated for group membership using the Structured Clinical Interview for DSM-III-R (SCID) and the Diagnostic Interview for Borderlines (DIB). The Family Environment Scale (FES) and the Life InterPersonal History Enquiry (LIPHE) provided data about early family life. Results showed that bipolar families scored statistically higher than borderlines on cohesiveness; mothers of borderlines were perceived as more controlling than fathers; and, mothers of bipolars were seen as expressing more parental disapproval. It was concluded that some support was demonstrated for the neglect hypothesis in borderline families, and that bipolar families are characteristically more enmeshed. Aside from these differences, the samples were basically similar leading to speculation about the nature of the overlap between the diagnoses.

Introduction

The central purpose of this research was to investigate how diagnosed borderlines and bipolars might differ in their perceptions of their early family systems and their relationships with each of their parents. These diagnoses were chosen for comparison because of the confusion that exists about their relationship to each other. Even though differentiation is possible, there appears to be considerable diagnostic overlap. It was hoped that an examination of environmental factors might help to clarify how they interface.

Borderlines and bipolars share similarities in behavior, intrapsychic structures, and interpersonal and familial relationships. First, it is difficult to mistake a manic episode when behavior includes elation, flight of ideas, pressured speech, and grandiosity. However, bipolars may also present as depressed, irritable, angry, and impulsive---affects which are many times displayed by borderlines.

Second, both have been described intrapsychically as having difficulty with separation/individuation and abandonment issues. To some this would suggest a developmental arrest during the rapprochement stage. In addition, they both may use primitive defenses such as projective identification and splitting (Cohen, Baker, Cohen, Fromm-Reichmann, & Weigert, 1954; Kernberg, 1975; Klein, 1948; Mahler, 1968; Mahler, Pine & Bergman, 1975; Masterson, 1972, 1976).

Third, interpersonally both may be experienced as manipulative, demanding, devaluing and idealizing; they are able to project responsibility for their behavior on to others, and they may test limits

to the extreme (Davis, Noll, & Sharma, 1986; Gunderson & Kolb; Gunderson, Carpenter, & Strauss, 1975; Kernberg, 1975).

Finally, similarities may be noted in their family systems. Borderline and bipolar families have been described as enmeshed, cohesive units where the mother is perceived as overinvolved and controlling and the father as weak, disinterested, or passive. Thus, investigation of differences in early family environments of these groups was chosen because of their behavioral, intrapsychic, interpersonal, and systemic similarities.

Research on borderline family systems and parent/child interactions has produced varied and at times conflicting results. For example, the borderline family has been described as non-protective (Grinker, Werble, & Drye, 1968); sharing few interests (Walsh, 1976); showing a predominance of parental neglect to the exclusion of support and protection of the children (Gunderson, Kerr, & Englund, 1980), having weak boundaries and no real sense of themselves as a whole (Mandelbaum, 1977, 1980; Meissner, 1984); and as a family who responds to dependency needs by withdrawing (Shapiro, Zinner, Shapiro, & Berkowitz, 1975). These behaviors have been labeled the <u>neglect hypothesis</u>.

In contrast, Grinker et al. (1968) noted families who are excessively protective or suffocating; Gunderson and Englund (1981) and Soloff and Millward (1983) described an intense overinvolvement of the borderline with his or her parents; Shapiro, Shapiro, Zinner, and Berkowitz (1977) claimed that dependency is encouraged because separation represents a condemnation of the family; and, Goldberg, Mann,

Wise, and Segall (1985) stated that borderlines perceive their parents as overprotective. These behaviors have been labeled the overinvolvement hypothesis.

Parental behavior in borderline family systems has also been viewed in conflicting ways. Mothers have been seen either as ignoring the child while imposing strict controls (MacMurray, 1976; Meissner, 1984), or they have been viewed as passive, dependent, and childlike (MacMurray, 1976; Wolberg, 1968, 1977). Fathers, on the other hand, have been perceived as neglectful, disinterested, and underinvolved (Frank & Paris, 1981; Soloff & Millward, 1983).

The literature on bipolar family systems and parent/child relationships has shown fewer discrepancies. Bipolar families have been described as cohesive, overprotective, affectionate, impervious to outside experiences, and highly organized (Davenport, Adland, Gold, & Goodwin, 1979; Stierlin, Weber, Schmidt, & Simon, 1986; Weber, Simon, Stierlin, & Schmidt, 1988). Mothers have been characterized as showing more negative affect, and as being dominant, dependable, and ambitious. Fathers have been thought of as weak but lovable (Cohen, et al., 1954). Usually one parent is described as orderly and disciplined (representing the depressive end of the spectrum), while the other is easygoing and irresponsible (representing the manic end) (Weber et al., 1988)

In an attempt to gain more information about the differences in systemic functioning and parent/child relationships in borderline and bipolar families the following hypotheses were generated:

1. There will be no significant differences in the perceptions of early family environments on each of the subscales of the FES between diagnosed borderline and bipolar participants.

2. There will be no significant differences in the perceptions of early parent/child relationships on each of the subscales of the LIPHE between diagnosed borderline and bipolar participants.

3. There will be no significant differences in perceptions of early parent/child relationships with mothers versus fathers between members in either the borderline or bipolar groups.

Method

Subjects

Forty-four adults between the ages of 19 and 40 were seleted from two private psychiatric hospitals in Connecticut. The sample was divided on the basis of diagnosis into two matched groups with the borderline group consisting of 18 females and 4 males, and the bipolar group composed of 19 females and 3 males.

Participants were screened for the following criteria: appropriate age; no evidence of organicity; non-overlapping diagnoses; no severe or continuous substance abuse problems; average intelligence (I.Q. of not less than 70); no history of ECT; and, a score of 7 or greater on the DIB for borderlines, and a score of 3 on the SCID for bipolars.

Data were collected during over the course of a year and a half. Criteria for group membership was most stringent, and many cases were

eliminated. For example, during the period of September, 1986 through December, 1987, there were 2,091 admissions to one of the hospitals; 324 were diagnosed as borderline and 262 as bipolar. After screening, only 21 borderlines and 53 bipolars were considered appropriate.

Instrumentation

Prior to inclusion, all participants underwent the Structured Clinical Interview for DSM-III-R (SCID) (Spitzer & Williams, 1986) and the Diagnostic Interview for Borderlines (DIB) (Gunderson, Kolb, Madow, & Zanarini, 1982). These semi-structured interviews were chosen because they confirm the presence (or absence) of borderline and bipolar characteristics. All interviews were conducted by the chief investigator, and lasted about 1 to 2 hours. During the interview data were also gathered on psychiatric history, separation experiences, and family genograms.

At a second meeting information on early family life was obtained by administration of a retrospective version of the Family Environment Scale (FES) (Moos, 1986), and the Life InterPersonal History Enquiry (LIPHE) (Schutz, 1978). The FES is a 90-item, true-false instrument which assesses family systems on ten variables: cohesion, expressiveness, conflict, independence, achievement, intellectual and cultural orientation, active and recreational orientation, moral and religious emphasis, organization, and control. The LIPHE evaluates the respondent's relations with each of his or her parents during early

childhood on the variables of inclusion, control, affection behavior, and parental disapproval.

Analysis

In order to test Hypothesis 1 (differences between the groups on perceptions of early family environments), multiple independent t-tests were performed on each of the FES variables. In a post-hoc analysis, a discriminant function was also done because it was thought that data derived from this analysis might be useful for speculative purposes. Due to the low subject to variable ratio, however, extreme caution was necessary when interpreting the results.

Next, Hypothesis 2 (differences in borderlines versus bipolar perceptions of their early relationships with each parent) was tested by comparing mean scores on the LIPHE using t-tests. A discriminant function was again performed for the same reasons and mindful of the same limitations.

Finally, scores on the LIPHE for mothers versus fathers for borderlines then bipolars (Hypothesis 3) were evaluated. Analysis again was made using multiple independent t-tests.

Results and Discussion

Given the difficulty in obtaining pure samples of borderlines and bipolars, the first issue that needed to be addressed was whether or

not the groups were indeed different from one another. To determine this, the mean composite and subscale scores on the DIB for both groups were compared. Table 1 summarizes these results.

Table 11

Comparison of Borderline and Bipolar Mean Composite and Subscale Scores on the DIB

	Patient group				
	Borderline (n=22)		Bipolar (n=22)		
DIB subscale	M	SD	M	SD	t
Social adaptation	5.46	1.50	4.64	1.81	1.63
Impulse action	7.05	1.84	3.27	2.41	5.83 **
Affects	7.23	1.11	1.68	1.59	13.44 **
Psychosis	4.14	3.26	-.364	2.22	5.36 **
Interpersonal rel.	10.09	1.88	1.96	1.79	14.74 **
DIB composite	8.91	.81	3.23	1.31	17.33 **

** $p < .01$, two-tailed.

Obviously there was overlap between the two diagnostic categories, but, once carefully separated, it was possible to identify two distinct

groups. Interestingly, all scores for borderlines were significantly higher ($p < .01$) than bipolars except for social adaptation. One explanation for this might be the fact that the majority of bipolar participants had undergone multiple hospitalizations within the last few years.

When mean FES subscale scores were compared for both groups a significant difference was noted for the cohesion variable ($t=-2.02$, $df=42$, $p < .05$) indicating that borderline families were less cohesive than bipolar. In addition, two other variables, intellectual/cultural orientation and control approached but did not reach significance. The discriminant function also noted these three variables as contributing to the variability in the equation due to group differences, however only 63.6% of the "grouped" cases were classified correctly and the Wilks' Lambda failed to reach significance ($X=10.57$, $df=10$, $p=.392$).

The fact that borderlines scored significantly lower than bipolars on cohesion allows for rejection of Hypothesis 1. These results appear to support the neglect hypothesis. From this it might be concluded that borderlines come from families systems in which parental neglect and abuse is predominant to the exclusion of the attention, support, and protection of the children. Few interests are shared, and there is no real sense of the family as a whole.

Interpretation of the significance of these results for bipolar families is less clear. When compared to borderline, bipolar families are more cohesive. This result supports the literature which describes bipolar families as tightly bound, cohesive units which are generally impervious to the outside world. When compared to the normal

popularion, however, bipolar families are significantly less cohesive (t=-2.494, p < .05). One explanation might be that a "pseudo-cohesiveness" exists, and it is present only as a defense against the manic phase. This interpretation is supported by observations made by Stierlin et al. (1986) and Weber et al. (1988) that bipolar families alter their behavior to match different contexts. One of the premises under which they operate is that the family must remain intact; yet, living can only take place when one is on one's own. The manic member functions to occasionally loosen up the excessively rigid relational reality, and to provide an opportunity for individual expression of feelings and opinions.

Since no significant differences were found between borderlines' and bipolars' perceptions of early parent/child relationships on the LIPHE, Hypothesis 2 must be retained. The possiblility that the two groups are actually similar in the ways that they perceive each parent is cause for speculation.

Hypothesis 3 may be rejected for two reasons. First, when comparing perceptions of fathers versus mothers on the LIPHE for borderlines, a significant difference was found for the control variable (t=-2.28, df=21, p=.033). Mothers were perceived as more controlling than fathers indicating that they are overinvolved.

The fact that the control variable approached significance on the FES for borderlines, and was reported as contributing 22% to group differences on the discriminant function might be interpreted as support for the overinvolvement hypothesis which has been reported by many researchers. Mindful of the extreme skepticism needed to

interpret these data, an argument could be made that there are also some borderline families in which an overly strict set of rules and procedures are used to run family life.

If this be the case, then it is possible that both types of borderline families exist: neglectful or disengaged, and overinvolved. This suggests that, when compared to bipolars, perhaps borderline families can be placed on a continuum with disengaged at one end and enmeshed at the other. While the data suggests that the majority of families might be located at the disengaged end, and exhibit behavior that is neglectful, some families might also be found toward the enmeshed side. It is also possible that either of these types of families shifts to the polar opposite in differing contexts and stages in their life cycles. Finally, there may be a group of families which vacillate between these poles.

The concept of fluidity in borderline families is similar to Meissner's (1982) discussion of countertransference with borderline patients. Reflecting the push/pull dynamics associated with separation and attachment, Meissner claimed that borderlines operate within three basic configurations: the aggressive, the narcissistic, and the erotic. Each configuration is composed of polar opposites, one which is introjected and the other which is projected. It is highly characteristic of borderlines to shift not only within a configuration from one polar opposite to another, but also to shift to a different configuration. For example, a patient presenting as helpless can shift to being aggressive, inferior, or seductive.

In the transference with borderline patients, if therapists experience affective instability as well as intense interpersonal relationships alternating between devaluation and idealization, it follows that this fluid pattern of interaction should reflect and be isomorphic to patterns exhibited in the patient's family. Based on our knowledge of individual psychopathology of the borderline patient, we can infer familial patterns of interaction. If one of the hallmarks is unpredictability in relationships, then it would seem that the borderline family system would, by necessity, have to be dynamic in order to initiate or accommodate to that behavior. A conclusion of this sort, however, would be an overstatement of the results found in this investigation.

The second reason for rejecting Hypothesis 3 was because, when bipolars perceptions of father versus mother were compared, bipolar mothers were seen as expressing more parental disapproval ($t=-2.31$, $df=21$, $p < .05$). These data support the findings of Cohen et al. (1954) who described mothers of bipolars as aggressive, unloving, and cold; and Davenport et al. (1984) who saw them as showing more negative affect toward their children.

To summarize, only one variable, cohesion, significantly distinguished borderline from bipolar family systems. Even after using the most stringent criteria for group membership, there still appeared to be a great deal of overlap between the two groups on their perceptions of their families. What factors might account for the paucity of results? It is possible that their family environments,

like their behavioral, intrapsychic, and interpersonal characteristics, are indeed quite similar.

It is also possible that diagnostic issues clouded the results. Kroll (1988) has challenged the DSM-III-R Axis II schema claiming that the borderline diagnosis is a political concept. Its overlap with the affective disorders has evolved for three reasons. First, historically it has been defined by the psychoanalytic community as a link between neurosis and psychosis. The paradox in DSM-III-R appears to be that borderline personality disorder is represented as a discrete entity on Axis II, while at the same time it is heavily loaded with Axis I affective characteristics thus supporting the continuum concept.

According to Kroll, a second reason for overlap has been the increasing dominance of the view of biological psychiatrists that human behavior can be best explained in physiological and biochemical terms. Medication for physical and psychological symptoms has become more common. More importantly, reimbursements have favored short-term treatment. Therefore, economic factors are creating pressure to diagnostically link borderline with the affective disorders. Short-term treatment utilizing a regimen of medications is seen by some as the treatment of choice.

Finally, Kroll claims that there are ideological reasons which contribute to the overlap dilemma. A faction of psychiatrists, whom he calls "affectophiles", have successfully redefined a variety of conditions as affective disorders. This group conflicts with others who view borderline personality disorder as a discrete entity. Interestingly, the splitting that has occurred in the field over

theoretical issues appears to be isomorphic to the nature of the psychopathology itself.

In addition to diagnostic issues, the study had several other limitations. Results could have been strengthened with a larger number of subjects. Even after collapsing across groups, the number of variables was large. Also, memories recalled from childhood tend to be selective and distorted; they may be biased depending on current mental state and status of current parental relationships. In addition, borderlines, especially, have difficulty with evocative memory, the recalling events which are highly affectively charged. Finally, it is possible that family systemic functioning, which is fluid by nature, is too complex to be assessed by paper and pencil scales.

Since borderlines families were found to be less cohesive than bipolar, it might be useful in future research to compare both of these groups to other diagnostic categories, and to further examine the commonalities. In addition, since some support was found for the neglect hypothesis in borderline families, it might be interesting to compare family environments of borderlines who have reported substantial sexual or physical abuse to borderlines for whom abuse was never an issue.

REFERENCES

Ablon, S., Davenport, Y., Gershon, E., & Adland, M. (1975). The married manic. American Journal of Orthopsychiatry, 45, 854-866.

Abraham, K. (1911). Notes on the psycho-analytical investigation and treatment of manic-depressive insanity and allied conditions. In E. Wolpert (Ed.), Manic-depressive illness: History of a syndrome (pp. 115-129). New York: International Universities Press, Inc.

Abraham, K. (1924). A short study of the development of the libido, viewed in the light of mental disorders. In E. Wolpert (Ed.), Manic-depressive illness: History of a syndrome (pp. 131-177). New York: International Universities Press, Inc.

Abrahams, M., & Whitlock, F. (1969). Childhood experience and depression. British Journal of Psychiatry, 115, 883-888.

Akiskal, H. (1981). Subaffective disorders, dysthymic, cyclothymic, and bipolar II disorders in the borderline realm. Psychiatric Clinics of North America, 4, 25-46.

Akiskal, M., Khani, M., & Scott-Strauss, A. (1979). Cyclothymic temperamental disorders. Psychiatric Clinics of North America, 2, 527-554.

Akiskal, M., Rosenthal, T., Haykal, R., Lemmi, H., Rosenthal, R., & Scott-Strauss, A. (1980). Characterologic depressions: Clinical and sleep EEG findings separating "subaffective dysthymia" from "character spectrum disorders". Archives of General Psychiatry, 37, 777-783.

Alarcon, R., Walter-Ryan, W., & Rippetoe, P. (1987). Affective spectrum disorders. Comprehensive Psychiatry, 28, 292-308.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (1987). Diagnostic and statistical manual of the mental disorders (rev. 3rd ed.). Washington, DC: American Psychiatric Association.

Andreason, N. (1983). The diagnosis and classification of affective disorders. In J. Davis and J. Maas (Eds.), The affective disorders (pp. 135-149). Washington, DC: American Psychiatric Press, Inc.

Arieti S. (1974). Affective disorders. In S. Arieti (Ed.), American handbook of psychiatry. New York: Basic Books.

Aronson, T. (1985). Historical perspectives on the borderline concept: A review and critique, Psychiatry, 48, 209-222.

Baron, M. (1983, May). Scizotypal personality disorder: Family study. Unpublished paper presented at the 136th Annual Meeting of the American Psychiatric Association, New York.

Berkowitz, D. (1981). The borderline adolescent and the family. in M.R. Lansky (Ed.), Family therapy and major psychopathology (pp. 183-201). New York: Grune & Stratton.

Borg, W., & Gall, M. (1983). Educational research: An introduction. New York: Longman, Inc.

Bradley, S. (1979). The relationship of early maternal separation to borderline personality in children and adolescents: A pilot study. American Journal of Psychiatry, 136, 424-426.

Brodie, K., & Leff, M. (1971). Bipolar depression: A comparative study of patient characteristics. American Journal of Psychiatry, 127, 1086-1090.

Bunney, W., & Davis, J. (1965). Norepinephrine in depressive reactions. Archives of General Psychiatry, 13, 483-494.

Busch-Rossnagel, M. (1985). Family Environment Scale. In J. Mitchell (Ed.), The Ninth Mental Measurement Yearbook (Vol. 1, pp. 573-575). Lincoln, NE: The University of Nebraska Press.

Bychowsky, G. (1953). The problem of latent psychosis. Journal of the American Psychoanalytic Association, 4, 484-503.

Cadoret, R. (1978). Evidence for genetic inheritance of primary affective disorder in adoptees. American Journal of Psychiatry, 135, 463-466.

Carpenter, W., Gunderson, J., & Strauss, J. (1977). Considerations of the borderline syndrome: A longitudinal comparative study of borderline and schizophrenic patients. In P. Hartocollis (Ed.), Borderline personality disorders: The concept, the syndrome, the patient (pp. 231-253). New York: International Universities Press, Inc.

Carr, A., Goldstein, E., Hunt, H., & Kernberg, O. (1979). Psychological tests and borderline patients. Journal of Personality Assessment, 43, 582-590.

Carroll, B., Greden, J., Feinberg, M., Lohr, N., James, N., Steiner, M., Haskett, R., Albala, A., deVigne, J., & Tarika, J. (1981). Neuroendocrine evaluation of depression in borderline patients. Psychiatric Clinics of North America, 4, 89-99.

Clayton, P., Pitts, F., & Winokur, G. (1965). Affective disorder: IV Mania. Comprehensive Psychiatry, 6, 313-322.

Cohen, M., Baker, G., Cohen, R., Fromm-Reichmann, F., & Weigert, E. (1954). An intensive study of twelve cases of manic-depressive psychosis. Psychiatry, 17, 103-137.

Colson, D. (1982). Protectiveness in borderline states. Bulletin of the Menninger Clinic, 46, 305-320.

Cornell, D., Silk, K., Ludolph, P., & Lohr, N. (1983). Test-retest reliability of the diagnostic interview for borderlines. Archives of General Psychiatry, 40, 1307-1310.

Coryell, W., Endicott, J., Andreason, N., & Keller, M. (1985). Bipolar I, bipolar II, and non-bipolar major depression among the relatives of affectively ill probands. American Journal of Psychiatry, 142, 817-821.

Davenport, Y., Adland, M., Gold, P., & Goodwin, F. (1979). Manic-depressive illness: Psychodynamic features of multigenerational families. American Journal of Orthopsychiatry, 49, 24-35.

Davenport, Y., Ebert, M., Adland, M., & Goodwin, F. (1977). Couples group therapy as an adjunct to lithium maintenance of the manic patient. American Journal of Orthopsychiatry, 47, 495-502.

Davenport, Y., Zahn-Waxler, C., Adland, M., & Mayfield, A. (1984). Early child-rearing practices in families with a manic-depressive parent. Journal of Orthopsychiatry, 141, 230-235.

Davis, J., Noll, K., & Sharma, R. (1986). Differential diagnosis and treatment of mania. In A. Swann (Ed.), Mania: New research and treatment (pp. 2-58). Washington, DC: American Psychiatric Press, Inc.

Dooley, I. (1921). A psychoanalytic study of manic-depressive psychosis. Psychoanalytic Review, 8, 37-72.

Dunner, D., Dwyer, T., & Feive, R. (1976). Depressive symptoms in patients with unipolar and bipolar affective disorder. Comprehensive Psychiatry, 17, 447-451.

Dunner, D., Gershon, G., & Goodwin, F. (1976). Heritable factors in the severity of affective illness. Biological Psychiatry, 11, 31-42.

Federn, P. (1947). Principles of psychotherapy in latent schizophrenia. American Journal of Psychiatry, 1, 129-139.

Feldman, R., & Guttman, H. (1984). Families of borderline patients: Literal-minded parents, borderline parents, and parental overprotectiveness. American Journal of Psychiatry, 141, 1392-1396.

Finley, C., & Wilson, D. (1951). The relation of the family to manic-depressive psychosis. Diseases of the Nervous System, 12, 39-43.

Frank, H., & Paris, J. (1981). Recollections of family experience in borderline patients. Archives of General Psychiatry, 38, 1031-1034.

Freud, S. (1917). Mourning and melancholia. In J. Strachey (Ed.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 14, pp. 243-258). London: The Hogarth Press.

Friedman, R., Clarkin, J., Corn, R., Aranoff, M., Hurt, S., & Murphy, M. (1982). DSM-III and affective pathology in hospitalized adolescents. Journal of Nervous and Mental Disease, 170, 511-521.

Frosch, J. (1964). The psychotic character: Clinical psychiatric considerations. Psychiatric Quarterly, 38, 81-96.

Frosch, J. (1970). Psychoanalytic considerations of the psychotic character. Journal of the American Psychoanalytic Association, 18, 24-50.

Gershon, E. (1980). Nonreplication of linkage to X-chromosome markers in bipolar illness. Archives of General Psychiatry, 37, 1200.

Gershon, E., Targum, S. Matthysse, S., & Bunney, W. (1979). Color-blindness not closely linked to bipolar illness: Report of a new pedigree series. Archives of General Psychiatry, 36, 1423-1430.

Gibson, R. (1958). The family background and early life experience of the manic-depressive patient. Psychiatry, 21, 71-90.

Gibson, R., Cohen, M., & Cohen, R. (1959). On the dynamics of the manic-depressive personality. American Journal of Psychiatry, 115, 1101-1107.

Goetzl, U., Green, R., Whybrow, P., & Jackson, R. (1974). X-linkage revisited (A further family study of manic-depressive illness). Archives of General Psychiatry, 31, 665-672.

Goldberg, R., Mann, L., Wise, T., & Segall, E. (1985). Parental qualities as perceived by borderline personality disorders. Hillside Journal of Clinical Psychiatry, 7, 134-140.

Goldstein, E. (1983). Clinical and ecological approaches to the borderline client. Social Casework: The Journal of Contemporary Social Work, 3, 353-362.

Goldstein, W. (1984). Confirmation of borderline personality within a psychodynamic framework. Psychopathology: International Journal of Descriptive Psychopathology and Clinical Diagnosis, 17, 59-66.

Grinker, R. (1979). Diagnosis of borderlines: A discussion. Schizophrenia Bulletin, 5, 47-52.

Grinker, R., & Werble, B. (1977). The borderline patient. New York: Jason Aronson.

Grinker, R., Werble, B., & Drye, R. (1968). The borderline syndrome: A behavioral study of ego functions. New York: Basic Books.

Gunderson, J. (1976, March 18-21). Discriminating characteristics of borderlines. Paper presented at the International Conference of Borderline Disorders, The Menninger Clinic, Topeka, KS.

Gunderson, J. (1977). Characteristics of borderlines. In P. Hartocollis (Ed.), Borderline personality disorders: The concept, the syndrome, the patient (pp. 173-192). New York: International Universities Press, Inc.

Gunderson, J. (1984). Borderline personality disorder. Washington, DC: American Psychiatric Press.

Gunderson, J., Carpenter, W., & Strauss, J. (1975). Borderline and schizophrenic patients: A comparative study. American Journal of Psychiatry, 132, 1257-1264.

Gunderson, J., & Elliot, G. (1985). The interface between borderline personality disorders and affective disorders. American Journal of Psychiatry, 142, 277-288.

Gunderson, J., & Englund, D. (1981). Characterizing the families of borderlines. Psychiatric Clinics of North America, 4, 159-168.

Gunderson, J., Kerr, J., & Englund, D. (1980). The families of borderlines: A comparative study. Archives of General Psychiatry, 37, 27-33.

Gunderson, J., & Kolb, J. (1978). Descriminating features of borderline patients. American Journal of Psychiatry, 135, 792-796.

Gunderson, J., Kolb, J., Madow, M., & Zanarini, M. (1982). Diagnostic interview for borderline patients. New York: Pfizer Pharmaceuticals.

Gunderson, J., Kolb, J., & Austin, V. (1981). The diagnostic interview for borderline patients. American Journal of Psychiatry, 138, 896-903.

Gunderson, J., Siever, L., & Spaulding, E. (1983). The search for a schizotype: Crossing the border again. Archives of General Psychiatry, 40, 15-22.

Gunderson, J., & Singer, M. (1975). Defining borderline patients: An overview. American Journal of Psychiatry, 132, 1-10.

Hoch, P., & Polatin, P. (1949). Pseudoneurotic forms of schizophrenia. Psychiatric Quarterly, 33, 248-276.

Janowsky, D. (1986). A role for acetylcholine in mania. In A. Swann (Ed.), Mania: New research and treatment (pp. 60-77). Washington, DC: American Psychiatric Press, Inc.

Janowsky, D., El-Yousef, M., & Davis, J. (1974). Interpersonal maneuvers of manic patients. American Journal of Psychiatry, 131, 250-254.

Janowsky, D., El-Yousef, M., Davis, J., & Sekerke, H. (1972). A cholinergic-adrenergic hypothesis of mania and depression. Lancet, 2, 632-635.

Janowsky, D., Leff, M., & Epstein, R. (1970). Playing the manic game. Archives of General Psychiatry, 22, 252-261.

Kallmann, F. (1954). Genetic principles in manic-depressive psychosis. In J. Zubin and P. Hoch (Eds.); Proceedings of the American Psychopathological Association (pp. 1-24). New York: Grune and Stratton.

Kendler, K., Gruenberg, A., & Strauss, J. (1981). An independent analysis of the Copenhagen sample of the Danish adoption study of schizophrenia: The relationship between schizotypal personality disorder and schizophrenia. Archives of General Psychiatry, 38, 962-977.

Kernberg, O. (1967). Borderline personality organization. Journal of the American Psychoanalytic Association, 15, 641-685.

Kernberg, O. (1972). Early ego integration and object relations. Annals of the New York Academy of Science, 193, 233-247.

Kernberg, O. (1975). Borderline conditions and pathological narcissism. New York: Jason Aronson.

Kernberg, O., Goldstein, E., Carr, A., Hunt, H., Bauer, S., & Blumenthal, R. (1981). Diagnosing borderline personality disorder: A pilot study using multiple diagnostic methods. The Journal of Nervous and Mental Disease, 169, 225-232.

Kety, S., Rosenthal, D., Wender, P., & Schulsinger, F. (1971). Mental illness in the biological and adoptive families of adopted schizophrenics. American Journal of Psychiatry, 128, 302-306.

Kidd, K., Gerhard, D., & Kidd, J. (1984). Recombinant DNA methods in genetic studies of affective disorders. Clinical Neuropharmacology, 7(Suppl. 1), 198.

Klein, D. (1975). Psychopharmacology and the borderline patient. In J. E. Mack (Ed.), Borderline states in psychiatry (pp. 75-91). New York: Grune & Stratton.

Klein, D. (1977). Psychopharmocological treatment and delineation of borderline disorders. In P. Hartocollis (Ed.), Borderline personality disorders: The concept, the syndrome, the patient (pp. 365-383). New York: International Universities Press, Inc.

Klein, D., & Shader, R. (1975). The borderline state: Psychopharmacologic treatment approaches to the undiagnosed case. In R. I. Shader (Ed.), Manual of psychiatric therapeutics: Practical psychopharmacology and psychiatry. New York: Little, Brown.

Klein, M. (1973). Contributions to the psycho-genesis of the manic-depressive states. In E. Jones (Ed.), Contributions to psychoanalysis, 1921-1945 (pp. 282-310). London: Hogarth Press. (Original work published in 1934)

Klerman, G. (1981). The spectrum of mania. Comprehensive Psychiatry, 22, 11-20.

Knight, R. (1953). Borderline patients. Bulletin of the Menninger Clinic, 17, 1-12.

Koenigsberg, H., Kernberg, O., Haas, G., Lotterman, A., Rockland, L., & Selzer, M. (1982). A comparison of hospitalized and nonhospitalized borderline patients. American Journal of Psychiatry, 139, 1292-1297.

Kolb, J., & Gunderson, J. (1980). Diagnosing borderline patients with a semistructured interview. Archives of General Psychiatry, 37, 37-41.

Kroll, J. (1988). The challenge of the borderline patient. New York: W. W. Norton & Co.

Kroll, J., Carey, K., Sines, L., & Roth, M. (1982). Are there borderlines in Britain? A cross-validation study. Archives of General Psychiatry, 39, 60-63.

Kroll, J., Pyle, R., Zander, J., Martin, K., Lari, S., & Sines, L. (1981). Borderline personality disorder: Interrater reliability of the Diagnostic Interview for Borderlines. Schizophrenia Bulletin, 7, 269-272.

Kroll, J., Sines, L., Martin, K., Lari, S., Pyle, R., & Zander, J. (1981). Borderline personality disorder: Construct validity of the concept. Archives of General Psychiatry, 38, 1021-1026.

Leonhard, K., Korff, I., & Schulz, H. (1962). Temperament in families with unipolar and bipolar phases psychosis. Psychiatric Neurology, 143, 416-434.

Liebowitz, M., & Klein, D. (1981). Interrelationship of hysteroid dysphoria and borderline personality disorder. Psychiatric Clinics of North America, 4, 67-87.

Loranger, A., Oldham, J., & Tulis, E. (1982). Familial transmission of DSM-III borderline personality disorder. Archives of General Psychiatry, 39, 795-799.

MacMurray, J. (1976). Mothering and the borderline patient. Psychiatric Annals, 6, 75-92.

Mahler, M. (1968). On human symbiosis and the vicissitudes of individuation. New York: International Universities Press.

Mahler, M. (1971). A study of the separation-individuation process and its possible application to borderline phenomena in the psychoanalytic situation. The Psychoanalytic Study of the Child (Vol. 26, pp. 403-424). New York: Quadrangle.

Mahler, M., Pine, F., & Bergman, A. (1975). The psychological birth of the human infant, symbiosis and individuation. New York: Basic Books, Inc.

Mandelbaum, A. (1977). The family treatment of the borderline patient. In P. Hartocollis (Ed.), Borderline personality disorders: The concept, the syndrome, the patient (pp. 423-438). New York: International Universities Press, Inc.

Mandelbaum, A. (1980). Family characteristics of patients with borderline and narcissistic disorders. Bulletin of the Menninger Clinic, 44, 201-211.

Masterson, J. (1972). Treatment of the borderline adolescent: A developmental approach. New York: Wiley-Interscience.

Masterson, J. (1976). Psychotherapy of the borderline adult: A developmental approach. New York: Bruner/Mazel.

Masterson, J., & Rinsley, D. (1975). The borderline syndrome: The role of the mother in the genesis and psychic structure of the borderline personality. International Journal of Psycho-Analysis, 56, 163-177.

Mayo, J. (1979). Families of manic-depressive patients: Effect of treatment. American Journal of Psychiatry, 136, 1535-1539.

Maxmen, J. (1986). Essential psychopathology. New York: W. W. Norton and Company.

McGlashan, T. (1983a). The borderline syndrome, I: Testing three diagnostic systems for borderlines. Archives of General Psychiatry, 40, 1311-1318.

McGlashan, T. (1983b). The borderline syndrome, II: Is borderline a variant of schizophrenia or affective disorder? Archives of General Psychiatry, 40, 1319-1323.

McGlashan, T. (1984a). The Chestnut Lodge follow-up study, I: Follow-up methodology and study sample. Archives of General Psychiatry, 41, 573-585.

McGlashan, T. (1984b). The Chestnut Lodge follow-up study, II: Long-term outcome of borderline personalities. Archives of General Psychiatry, 41, 586-601.

Meissner, W. (1982). Notes on countertransference in borderline conditions. International Journal of Psychoanalysis, 9, 89-124.

Meissner, W. (1984). The borderline spectrum: Differential diagnosis and developmental issues. New York: Jason Aronson, Inc.

Mendlewicz, J., & Fleiss, J. (1974). Linkage studies with X-chromosome markers in bipolar (manic depressive and unipolar depressive) illness. Biological Psychiatry, 9, 261-294.

Mendlewicz, J., & Rainer, J. (1977). Adoption study supporting genetic transmission in manic-depressive illness. Nature, 268, 327-329.

Moos, R. (1986). Family Environment Scale Manual. Palo Alto, CA: Consulting Psychologists Press, Inc.

Parker, G. (1979). Parental characteristics in relation to depressive disorders. British Journal of Psychiatry, 134, 138-147.

Perris, C. (1966). A study of bipolar (manic-depressive) and unipolar recurrent depressive psychosis. Acta Psychiatrica Scandinavica, 42(Suppl, 194), 1-188.

Perris, C., Arrindell, W., Eisemann, M., van der Ende, J., & von Knorring, L. (1986). Perceived depriving parental rearing and depression. British Journal of Psychiatry, 148, 170-175.

Perris, C., Maj, M., Perris H., & Eisemann, M. (1985). Perceived parental rearing behaviour in unipolar and bipolar depressed patients. Acta Psychiatrica Scandinavica, 72, 172-175.

Perry, J. (1985). Depression in borderline personality disorder: Lifetime prevalence at interview and longitudinal course of symptoms. American Journal of Psychiatry, 142, 15-21.

Perry, J., & Klerman, G. (1978). The borderline patient: A comparative analysis of four sets of diagnostic criteria. Archives of General Psychiatry, 35, 141-150.

Perry, J., & Klerman, G. (1980). Clinical features of the borderline personality disorder. American Journal of Psychiatry, 137, 165-173.

Pollock, H., Malzberg, B., & Fuller, R. (1939). Hereditary and environmental factors in the causation of manic-depressive psychoses and dementia praecox. New York: State Hospitals Press.

Pope, H., Jonas, J., Hudson, J., Cohen, B., & Gunderson, J. (1983). The validity of DSM-III borderline personality disorder: A phenomenologic, family history, treatment response, and long-term follow-up study. Archives of General Psychiatry, 40, 23-30.

Prange, A., Wilson, I., Lynn, C., Alltop, L., & Stikeleather, R. (1974). L-tryptophan in mania. Contributions to a permissive hypothesis of affective disorders. Archives of General Psychiatry, 30, 56-62.

Rado, S. (1956). Psychoanalysis of behavior: Collected papers. New York: Grune and Stratton.

Rappaport, D., Gill, M., & Schafer, R. (1945). Diagnostic psychological testing. Chicago : Year Book Publishers.

Rifkin, A., Levitan, S., Galewski, J., & Klein, D. (1972a). Emotionally unstable character disorder. A follow-up study: I. Description of patients and outcome. Biological Psychiatry, 4, 65-79.

Rifkin, A., Levitan, S., Galewski, J., & Klein, D. (1972b). Emotionally unstable character disorder. A follow-up study: II. Prediction of outcome. Biological Psychiatry, 4, 81-88.

Rinsley, D. (1978). Borderline psychopathology: A review of etiology, dynamics and treatment. International Review of Psychoanalysis, 5, 45-54.

Schildkraut, J. (1965). The catecholamine hypothesis of affective disorders: A review of the supporting evidence. American Journal of Psychiatry, 122, 509-522.

Schildkraut, J. (1973). Norepinephrine metabolism in the pathophysiology and classification of depressive and manic disorders. In J. Cole, A. Freeman, & A. Freidhoff (Eds.), Psychopathology and pharmacology. Baltimore, MD: Johns Hopkins University Press.

Schildkraut, J., & Kety, S. (1967). Biogenic amines and emotion. Science, 156, 21-30.

Schutz, W. (1978). FIRO Awareness scales manual. Palo Alto, CA: Consulting Psychologists Press, Inc.

Schwoeri, L., & Schwoeri, F. (1981). Family therapy of borderline patients: Diagnostic and treatment issues. International Journal of Family Psychiatry, 2 237-250.

Shapiro, E. R. (1978). Research on family dynamics: Clinical implications for the family of the borderline adolescent. Adolescent Psychiatry, 6, 360-376.

Shapiro, E. R., Shapiro, R. L., Zinner, J., & Berkowitz, D. (1977). The borderline ego and the working alliance: Indications for family and individual treatment in adolescence. The International Journal of Psycho-Analysis, 58, 77-87.

Shapiro, E. R., Zinner, J., Shapiro, R. L, & Berkowitz, D. (1975). The influence of family experience on borderline personality development. International Review of Psychoanalysis, 2, 399-412.

Sheehy, M., Goldsmith, L., & Charles, E. (1980). A comparative study of borderline patients in a psychiatric outpatient clinic. American Journal of Psychiatry, 137, 1374-1379.

Siever, L. (1982). Genetic factors in borderline personalities. In L. Grinspoon (Ed.), American psychiatric review (pp. 437-456). Washington, DC: American Psychiatric Press.

Siever, L., & Gunderson, J. (1979). Genetic determinants of borderline conditions. Schizophrenia Bulletin, 5, 59-86.

Siever, L., & Klar, H. (1986). A review of DSM-III criteria for the personality disorders. In A. J. Frances and R. E. Hales (Eds.), American Psychiatric Annual Review (Vol. 5). Washington, DC: American Psychiatric Press.

Singer, M., & Larson, D. (1981). Borderline personality and the Rorschach test: A comparison with acute and chronic schizophrenics, normals, and neurotics. Archives of General Psychiatry, 38, 693-698.

Smith, J. (1960). The metaphor of the manic-depressive. Psychiatry, 23, 375-383.

Snyder, S., Pitts, W., Goodpaster, W., & Gustin, Q. (1984). Family structure as recalled by borderline patients. Psychopathology, 17, 90-97.

Snyder, S., Sajadi, C., Pitts, W., & Goodpaster, W. (1982). Identifying the depressive border of the borderline personality disorder. American Journal of Psychiatry, 139, 814-817.

Soloff, P., George, A., & Nathan, R. (1982). The dexamethasone suppression test in patients with borderline personality disorders. American Journal of Psychiatry 139, 1621-1623.

Soloff, P., & Millward, J. (1983a). Psychiatric disorders in the families of borderline patients. Archives of General Psychiatry, 40, 37-44.

Soloff, P., & Millward, J. (1983b). Developmental histories of borderline patients. Comprehensive Psychiatry, 24, 574-588.

Soloff, P. & Ulrich, R. (1981). Diagnostic interview for borderline patients: A replication study. Archives of General Psychiatry, 38, 686-692.

Spitzer, R., Endicott, J., & Gibbon, M. (1979). Crossing the border into borderline personality and borderline schizophrenia. Archives of General Psychiatry, 36, 17-24.

Spitzer, R., & Williams, J. (1986). Structured Clinical Interview for DSM-III-R: Patient Version (SCID-P, 5/1.86). New York: New York State Psychiatric Institute.

Stern, A. (1938). Psychoanalytic investigation and therapy in the borderline group of neurosis. Psychoanalytic Quarterly. 7, 467-489.

Stierlin, H., Weber, G., Schmidt, G., & Simon, F. (1986). Features of families with major affective disorders. Family Process, 25, 325-336.

Stone, M. (1977). The borderline syndrome: Evolution of the term, genetic aspects, and prognosis. American Journal of Psychotherapy, 31, 345-365.

Stone, M. (1979a). Contemporary shift of the borderline concept from a subschizophrenic disorder to a subaffective disorder. Psychiatric Clinics of North America, 2, 577-594.

Stone, M. (1979b). Genetic aspects of borderline syndromes. Schizophrenia Bulletin, 5, 105-110.

Stone, M. (1979c). Assessing vulnerability to schizophrenia or manic-depression in borderline states. Schizophrenia Bulletin, 5, 105-110.

Stone, M. (1980). The borderline syndromes: Constitution, personality, and adaptation. New York: McGraw-Hill Book Co.

Stone, M. (Ed.). (1981). The psychiatric clinics of North America: Symposium on borderline disorders. Philadelphia: W. B. Saunders.

Torgensen, S. (1984). Genetic and nosologic aspects of schizotypal and borderline disorders: A twin study. Archives of General Psychiatry, 41, 546-554.

Walsh, F. (1977). Family study 1976: 14 new borderline cases. In A. Wolberg (Ed.), The borderline patient (pp. 158-177). New York: Jason Aronson.

Waters, B., Marchenko-Bouer, I., & Offord, D. (1981). The perception of mood and affect in families of bipolar manic-depressives. International Journal of Family Psychiatry, 2, 65-74.

Weber, G., Simon, F., Stierlin, H., & Schmidt, G. (1988). Therapy for families manifesting manic-depressive behavior. Family Process, 27, 33-49.

Weissman, M., & Boyd, J. (1983). The epidemiology of affective disorders: Rate and risk factor. Psychiatric Update, 2, 406-426.

Werble, B. (1970). Second follow-up of borderline patients. Archives of General Psychiatry, 23, 3-7.

Willett, A., Jones, A., Morgan, D., & Franco, S. (1973, May). The borderline syndrome: An operational definition. Unpublished paper presented at the 20th Annual Meeting of the American Psychiatric Association, Honolulu, HI.

Wilson, D. (1951). Families of manic-depressives. Diseases of the Nervous System, 12, 362-369.

Winokur, G., Clayton, J., & Reich, T. (1969). Manic-depressive illness. St. Louis: C. V. Mosby Co.

Witmer, H. (1934). The childhood personality and parent-child relationship of dementia praecox and manic-depressive patients. Smith College Studies in Social Work, 4, 289-377.

Wolberg, A. (1952). The borderline patient. American Journal of Psychotherapy, 6, 694-710.

Wolberg, A. (1968). Patterns of interaction in families of borderline patients. In B. Reiss (Ed.), New directions in mental health (pp. 100-115). New York: Grune & Stratton.

Wolberg, A. (1973). The borderline patient. New York: Intercontinental Medical Book Corporation.

Wolberg, A. (1977). The borderline patient. New York: Jason Aronson.

Zilboorg, G. (1941). Ambulatory schizophrenia. Psychiatry, 4, 149-155.

Zilboorg, G., & Henry, G. W. (1941). A history of medical psychology. New York: Norton.

Zinner, J., & Shapiro, E. (1975). Splitting in families of borderline adolescents. In J. E. Mack (Ed.), Borderline states in psychiatry (pp. 103-122). New York: Grune & Stratton.

Zinner, J., & Shapiro, R. (1972). Projective identification as a mode of perception and behavior in families of adolescents. International Journal of Psychoanalysis, 53, 523-530.

Zompo, M., Bocchetta, A., Goldin, L., & Corsini, G. (1984). Linkage between X-chromosome markers and manic-depressive illness. Acta Psychiatrica Scandinavica, 70, 282-287.