The Lived Experience of Couples Navigating Borderline Personality Disorder: A Dyadic Interpretative Phenomenological Study

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ABSTRACT

Borderline personality disorder (BPD) is associated with distress in and dissolution of romantic relationships. BPD is a relational disorder. The complex interaction between BPD and romantic relationships continues to warrant further attention, as decreased BPD symptoms are associated with increased relational effectiveness. The current study was one of the first qualitative studies that used dyadic data to examine the experience and impact of BPD on couples' relationships. Semi-structured conjoint interviews were conducted with couples with a partner with BPD (N = 10) using interpretative phenomenology. This study provides a rich understanding of the experiences of couples with BPD by exploring not only how BPD impacts couples' romantic relationships, but how couples cope with BPD. Although BPD was experienced as a relational stressor, couples utilized resources to buffer against the impact of BPD in their relationship. Three superordinate themes emerged from the data that illustrate the couple experience of navigating BPD: (a) the individual lived experience of BPD, (b) the shared experience of BPD as a relational stressor, and (c) adaptive dyadic coping in the context of BPD. Dyadic coping and shared externalization emerged as key factors in adaptive couple functioning in the context of BPD. The lived experiences of these couples provide therapists and other couples with an increased understanding of the resources and skills that support successful dyadic coping with BPD.

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GENERAL AUDIENCE ABSTRACT

Borderline personality disorder (BPD) imposes significant stress on romantic relationships. BPD is associated with increased distress in and dissolution of romantic relationships. However, individuals in recovery from BPD report high relationship satisfaction. Decreased BPD symptoms are associated with increased relational effectiveness, but it is less clear whether reducing BPD symptoms leads to greater relational effectiveness or if relational effectiveness reduces symptoms of BPD. To better understand the complex relationship between BPD and romantic relationships, conjoint interviews were conducted with couples who were navigating the management of BPD. Ten semi-structured conjoint interviews were analyzed using interpretative phenomenology. Three themes emerged from the data that illustrate the couple experience of navigating BPD: (a) the individual lived experience of BPD, (b) the shared experience of BPD as a relational stressor, and (c) adaptive dyadic coping in the context of BPD. Dyadic coping and shared externalization emerged as key factors in adaptive couple functioning in the context of BPD. Couples navigating BPD benefit from many of the same couple coping strategies that other couples utilize to manage common stressors in life.

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CHAPTER I: INTRODUCTION

Interpersonal dysfunction is a key factor in all personality disorders (PDs; American Psychiatric Association, 2013; Wilson et al., 2017). Individuals diagnosed with PDs oftentimes partner with individuals that have similar personality traits and attachment styles to themselves (Beeney et al., 2019a; DeCuyper et al., 2018). These couples experience tumultuous romantic relationships characterized by chronic stress, conflict, verbal and physical aggression, instability, and decreased relationship satisfaction (Beeney et al., 2019a; Chen et al., 2004; DeCuyper et al., 2018; Gutman et al., 2006; South et al., 2008; South, 2014; South et al., 2020; Whisman et al., 2007; Whisman & Schonbrun, 2009; Wilson et al., 2017).

Across multiple studies examining the relationship between PDs and romantic relationship dysfunction, borderline personality disorder (BPD) presents as significantly associated with decreased romantic relationship quality as compared to other PDs (Bouchard et al., 2009; Chen et al., 2004; Daley et al., 2000; Javaras et al., 2017; South et al., 2008; South, 2014; South et al., 2020). BPD is characterized by interpersonal dysfunction, rejection sensitivity, and emotion dysregulation and has a population prevalence rate of 1% to 2% (American Psychiatric Association, 2013). Although the interpersonal dysfunction experienced by individuals with BPD has implications for general social functioning (Lazarus et al., 2016; Lazarus et al., 2019; Stepp et al., 2009), maladaptive interpersonal functioning is most severe in the context of close relationships (Hepp et al., 2017; Labonte & Paris, 1993; Lazarus et al., 2016; Lazarus et al., 2019).

Recent research suggests that symptoms of BPD can worsen or improve in tandem with relationship experiences; that is, individuals with BPD react to interpersonal stress and perceived

rejection with an increase in symptoms (e.g., instability of self-image, feelings of emptiness, decreased self-esteem, impulsive behaviors such as self-harm and suicide attempts), and conversely react to perceived acceptance or re-initiation of support with a decrease in symptoms (American Psychiatric Association, 2013; Berenson et al., 2011; Bouchard & Sabourin, 2009; Brodsky et al., 2006; Hepp et al., 2017, 2018; Kuhlken et al., 2014; Lazarus et al., 2018; Sato et al., 2020; Zeigler-Hill & Abraham, 2006).

BPD is associated with increased relationship dysfunction including increased instability, decreased quality, increased dysfunction, and decreased relationship satisfaction (Bouchard et al., 2009; Hill et al., 2008; Javaras et al., 2017; South et al., 2008; South et al., 2020). Couples with a partner with BPD also display higher rates of maladaptive communication styles, decreased emotional regulation skills, and differences in cognitive perceptual functioning which impact couple dynamics during conflict and stressful conversations (Beeney et al., 2019b; Bhatia et al., 2013; Kuhlken et al., 2014; Lazarus et al., 2018; Miano et al., 2017a; Miano et al., 2017b; Miano et al., 2020). Close relationships may have the most influence on BPD symptomology (Links & Heslegrave, 2000). Although it has been established that BPD is marked by interpersonal dysfunction in close relationships, the literature on BPD and romantic relationships specifically is a newer growing body of research.

Recent research also points to the importance of conceptualizing interpersonal dysfunction in BPD as dynamic (Beeney et al., 2019b; Bouchard & Sabourin, 2009), meaning that relationship and partner factors must be integrated into the understanding of BPD relationships. Many partners of those with BPD meet criteria for PDs and exhibit insecure attachment styles (Bouchard et al., 2009). There has been a call for additional research on the influence of partners without BPD on romantic relationships with individuals with BPD (Beeney

et al., 2019b) due to the need for increased understanding of the complex dynamic between BPD symptomology and romantic relationships. Specific attention to the strengths of those BPD couples who report relational satisfaction and stability is needed to help us understand how couples with a partner with BPD successfully manage the stressors introduced by BPD (Beeney et al., 2019b; Bouchard & Sabourin, 2009).

BPD is stigmatized by clinicians who are likely to perceive clients with BPD negatively and discriminate against them in care settings, including avoiding or refusing working with them (Black et al., 2011; Markham, 2003; Markham & Trower, 2003; Nehls, 1998, 1999; Sansone & Sansone, 2013; Veysey, 2014). The stigma associated with BPD can also be seen in the research on the disorder, which largely neglects to explore the strengths of individuals and couples with BPD. The current body of research on couples with BPD primarily focuses on relationship dysfunction and instability. Although it is well established that couples consisting of a partner with BPD experience increased relationship dysfunction (Bouchard et al., 2009; Hill et al., 2008; Javaras et al., 2017; South et al., 2008; South et al., 2020), findings on relationship satisfaction are mixed. Some research suggests that the negative impact of BPD on relationship satisfaction stabilizes over time along with the stabilization of the disorder (Lavner et al., 2015; South et al., 2020; Zanarini et al., 2005). In particular, couples with a partner with BPD in remission report high levels of relationship satisfaction, despite the presence of relationship dysfunction (Bouchard & Sabourin, 2009; Zanarini et al., 2005). Still other research suggests that BPD does not always pose a threat to relationship longevity and satisfaction (Beeney et al., 2019b; Bouchard & Sabourin, 2009; Lavner et al., 2015).

Research on couples with a partner with BPD overwhelmingly focuses on relationship dysfunction rather than relationship strengths. Given that studies of couples with a partner with

BPD have also found that some of these couples experience unexpectedly high levels of relationship satisfaction, there may be relationship strengths which have not been explored in the existing literature. The oversight of strengths and primary focus on relationship dysfunction may be due to the stigma associated with BPD. Limited research has illuminated the strengths of couples with BPD thus far, but few have posited that inquiry into successful relationships among individuals with BPD may be beneficial to both couples living with BPD and therapists serving this population by identifying the tools these couples utilize in response to the stressors associated with BPD (e.g., Beeney et al., 2019b; Bouchard & Sabourin, 2009).

Current Study

The current study was an interpretative phenomenological analysis of couples' experiences in navigating their relationship while at least one partner was diagnosed with BPD. This research expands our understanding of BPD and its impact on romantic relationships. In an effort to counter stigma associated with the disorder, the current study explored couples' struggles *and* strengths , as well as the impact that BPD had on their partnering and relationship experiences. In response to the need for dyadic and dynamic research on couples with a partner with BPD (Beeney et al., 2019a, 2019b; Bouchard & Sabourin, 2009), conjoint interviews were conducted that allowed for the exploration of facets of both individual and shared experiences. The aims of the current study were as follows: (a) gain a rich understanding of the experiences of couples with BPD, (b) explore not only *what* relationship factors were impacted by BPD but *how* those factors were experienced by the couple, and (c) investigate the protective and resiliency factors that promoted adaptive couple functioning in the context of BPD.

CHAPTER II: LITERATURE REVIEW

The Impact of Personality Disorders on Interpersonal Functioning

Personality Disorders and General Interpersonal Dysfunction

Personality disorders (PDs) are defined by interpersonal dysfunctions including difficulties in maintaining stable, healthy, adaptive, and satisfying interpersonal relationships (American Psychiatric Association, 2013; South, 2014; Wilson et al., 2017). Each PD consists of criteria related to interpersonal dysfunction, yet recent findings suggest that PDs may not be as pervasive in the relationships of diagnosed individuals as previously thought (Wilson et al., 2017). PDs may impact varying types of relationships, but not necessarily all interpersonal contexts, depending on the severity of the personality pathology of the individual (Wilson et al., 2017). This finding suggests the need for contextual inquiry; that is, although we recognize that individuals with PD diagnoses are prone to experience interpersonal dysfunction, much less is known about how, when, and with whom these difficulties present. This is important given that much of the literature exploring the impact of PDs on interpersonal functioning groups multiple types of PDs together and measures their impact on interpersonal relationships generally rather than differentiating between separate interpersonal contexts (Bouchard & Sabourin, 2009). Assessing the impact of PDs on different types of interpersonal relationships may help us to better understand these disorders (Bouchard & Sabourin, 2009).

Personality Disorders and Romantic Relationship Dysfunction

Understanding both the impact of PDs on romantic relationships and the role of partners of individuals diagnosed with PDs is valuable and necessary given the importance of romantic relationships for well-being and the impact that partners have on self-rated PD severity and relationship satisfaction (Beeney et al., 2019a; DeCuyper et al., 2018; South et al., 2008; South,

2014). PD symptoms impact couples' daily conflict, interactions, and relationship sentiment (South, 2014). Individuals with PDs tend to have relationships that are unstable, unsupportive, chronically stressful, and even violent (Beeney et al., 2017; South, 2014). High severity PD individuals often select partners with insecure attachment styles, interpersonal dysfunction, and PD presentations similar to their own, which is associated with decreased relationship satisfaction (Beeney et al., 2019a; DeCuyper et al., 2018; Lavner et al., 2015). Individuals with PD pathology are more likely to experience relationship distress, conflict, physical and verbal aggression, separation, and divorce, as well as decreased relationship satisfaction (Chen et al., 2004; Gutman et al., 2006; South et al., 2008; South et al., 2020; Whisman et al., 2007; Whisman & Schonbrun, 2009).

PD severity has been found to predict the severity of couple dysfunction (DeCuyper et al., 2018; Gutman et al., 2006; Miller et al., 2000). Other factors contributing to decreased relationship satisfaction for both partners include perception of one's partner, one's partner's perception of one's own maladaptive PD characteristics, inhibition in the relationship, emotional dysregulation, and attachment styles (Beeney et al., 2019a; DeCuyper et al., 2018; South, 2014). Perceiving one's partner as having similar PD traits and other personality characteristics to the self was associated with increased relationship satisfaction in couples with a PD diagnosis (DeCuyper et al., 2018; South et al., 2020).

Although couples with PDs experience decreased relationship satisfaction compared to the general population, their relationship satisfaction does not seem to decrease over time (South et al., 2020). This finding suggests the possibility that couples with PDs have some resilience or protective factors in their relationships. Given that romantic relationship quality is meaningful for individual mental health outcomes (DeCuyper et al., 2018; Kamp et al., 2008; Proulx et al.,

2007), South and colleagues' findings (2020) point to the importance of exploring the experiences of couples living with personality disorders in order to learn more about their strengths and any existing protective factors.

One personality disorder exceptionally marked by interpersonal dysfunction is borderline personality disorder (BPD). Many studies exploring the impact of PDs on interpersonal functioning find that BPD characteristics are associated with exceptionally severe interpersonal dysfunction, specifically in romantic relationships (Chen et al., 2004; Daley et al., 2000; Labonte & Paris, 1993; South, 2014; South et al., 2008). Individuals diagnosed with BPD are more likely to have cut-offs in significant relationships than individuals with other psychiatric diagnoses and individuals in the general population (Labonte & Paris, 1993). BPD has a negative impact on the quality, stability, and outcomes of romantic relationships (Daley et al., 2000; Labonte & Paris, 1993; South et al., 2008; Whisman & Schonbrun, 2009), as BPD pathology is significantly related to both partner's self-reported relationship dissatisfaction in couples (South et al., 2020). Interpersonal dysfunction and instability in relationships is the cornerstone of the BPD diagnosis (American Psychiatric Association, 2013). This suggests that inquiry into the romantic relationships of those with borderline personality disorder is worthwhile, given that romantic relationships are amongst the most significant adult relationships (DeCuyper et al., 2018; Kamp et al., 2008; Proulx et al., 2007).

Borderline Personality Disorder: An Overview of Experiences and Symptomology

Lived Experiences of Individuals with Borderline Personality Disorder

Phenomenological studies of BPD have explored the experiences of those living with the disorder, describing their experiences in mental health settings (Lawn & McMahon, 2015; Miller, 1994; Myburgh et al., 2016; Perseius et al., 2005; Veysey, 2014) as well as their general

experiences of having BPD and the meaning they attribute to the disorder (Black et al., 2014; Nehls, 1999; Myburgh et al., 2016; Rivera-Segarra et al., 2014). Studies pertaining to the general life experiences and meaning making of individuals with BPD report themes including the experiences of stigma with family and friends, complicated family relationships and traumatic early life experiences which contribute to the disorder, and experiences of intense emotional suffering and self-hatred paired with impulsivity and self-harming behavior (Black et al., 2014; Nehls, 1999; Myburgh et al., 2016; Perseius et al., 2005; Rivera-Segarra et al., 2014). Studies exploring experiences of individuals with BPD in mental health settings report themes including feeling labeled and stigmatized, being perceived as manipulative, and an overall appraisal of mental health care as being inadequate (Black et al., 2014; Lawn & McMahon, 2015; Nehls, 1999; Myburgh et al, 2016; Miller, 1994; Perseius et al., 2005; Veysey, 2014).

Borderline personality disorder (BPD) has a population prevalence percentage of 1-2% while occurring amongst 20% of individuals in psychiatric in-patient care (American Psychiatric Association, 2013). As such, clinicians might encounter individuals living with BPD often, especially in inpatient psychiatric work. Therapists and other clinicians largely view individuals with BPD more negatively than individuals with other psychopathology (Markham, 2003; Markham & Trower, 2003; Nehls, 1998, 1999; Sansone & Sansone, 2013). These discriminatory attitudes are felt by those with BPD that seek care (Lawn & McMahon, 2015; Veysey, 2014). Individuals diagnosed with BPD feel judged and labeled by clinicians (Nehls, 1999). They experience psychiatric and mental health care as limited and experience discrimination when seeking care in public and private mental health settings (Lawn & McMahon, 2015; Veysey, 2014). They believe that clinicians perceive them as hopeless, manipulative, and at-fault for their psychopathology (Nehls, 1999; Veysey, 2014). The discrimination and marginalization against

individuals with BPD in mental health settings has been found to contribute to their negative self-image and self-harm behaviors (Veysey, 2014). Given the high levels of rejection sensitivity experienced by those with BPD (Brodsky et al., 2006; Lazarus et al., 2016; Sato et al., 2020; Zeigler-Hill & Abraham, 2006), it is reasonable to expect that the experience of rejection in terms of the denial of care and the lack of empathy expressed for clients with BPD would contribute greatly to their suffering and dysfunction (Aviram et al., 2006). Given that those with BPD fare better when experiencing acceptance from others (Lazarus et al., 2018), it is unsurprising that these individuals wish clinicians would evaluate them more holistically and see them as more than just a diagnosis (Veysey, 2014).

Borderline Personality Disorder Symptoms and Contributing Factors

Symptomology overview. Borderline personality disorder (BPD) is characterized by interpersonal dysfunction and intrapersonal suffering. The hallmark of BPD is the experience of interpersonal relationships that are characterized by their lack of stability and heightened intensity (American Psychiatric Association, 2013). Those diagnosed with BPD typically have strong fears of abandonment or separation from close others (American Psychiatric Association, 2013). Their perception of important others fluctuates from idealization to devaluation, as they typically feel close to others quickly and later shift to devaluing them due to perceived withdrawal of support or care (American Psychiatric Association, 2013; Gunderson & Lyons-Ruth, 2008). These individuals tend to lack emotion regulation skills and have low self-esteem, unstable self-image, internal working models of the self as bad or even unlovable, as well as recurrent feelings of disconnection and emptiness (American Psychiatric Association, 2013). BPD is also characterized by self-damaging behaviors and impulsivity, including self-harm and suicide attempts and completion (American Psychiatric Association, 2013). Individuals with

BPD experience more severe rejection sensitivity than healthy comparisons and those with social anxiety (Staebler et al., 2011). Individuals with BPD features are more likely to appraise neutral facial expressions as untrustworthy, and this relationship is mediated by rejection sensitivity (Miano et al., 2013). Rejection sensitivity and longing for connection are associated with the fear of abandonment that is central to the BPD diagnosis (American Psychiatric Association, 2013; Brodsky et al., 2006; Lazarus et al., 2016).

Key contributing factors. Recent research has found that intrapersonal features of BPD, such as low self-esteem, unstable self-image, low affect, and emotion dysregulation, are exacerbated in the context of interpersonal dysfunction, specifically interpersonal stressors which are related to the symptomology of the disorder, such as rejection, rescinded support or nurturance, and abandonment (American Psychiatric Association, 2013; Brodsky et al., 2006; Coifman et al., 2012; Lazarus et al., 2016; Sato et al., 2020; Zeigler-Hill & Abraham, 2006). This may be because those diagnosed with BPD fear social rejection and long for love and connection with others while characterizing themselves as evil and unlovable, thus pushing others away in attempts to test the safety of their relationships, or whether their unlovable nature will bring the rejection they fear in their relationships (American Psychiatric Association, 2013; Holm & Severinsson, 2008; Perseius et al., 2005; Sato et al., 2020).

Rejection sensitivity is a key factor in the experiences of those with BPD. Those diagnosed with BPD react to perceived rejection and abandonment with heightened emotional reactivity and corresponding extremity in behavior to avoid being left, including threats or actions of self-harm and suicide (American Psychiatric Association, 2013; Brodsky et al., 2006). Their low self-esteem and affect are worsened by disruptions in interpersonal relationships, specifically experiences of social rejection (Brodsky et al., 2006; Lazarus et al., 2016; Sato et al.,

2020; Zeigler-Hill & Abraham, 2006). Interpersonal stress and experiences of rejection also lead to self-criticism and decreased self-esteem, both of which contribute to the overall self-image of being evil or unlovable that is characteristic of those with BPD features (American Psychiatric Association, 2013; Sato et al., 2020; Zeigler-Hill & Abraham, 2006). Perceived rejection, decreased support, or abandonment in close relationships can worsen the instability of self-image and the feelings of emptiness experienced by those diagnosed with BPD (American Psychiatric Association, 2013). Additionally, the most recent edition of the Diagnostic and Statistical Manual states that individuals with BPD experience dissociative episodes in response to perceived abandonment or rejection, and that these episodes typically subside with the re-engagement and nurturance of the previously rejecting other (American Psychiatric Association, 2013). Individuals with BPD may experience rage, suicide attempts, and self-harm as a result of interpersonal stress, specifically rejection (Brodsky et al., 2006). As Sato and colleagues (2020) found, "attachment anxiety, need to belong, and self-criticism mediate the relationship between rejection sensitivity and BPD features" (p. 273). Interpersonal dysfunction and rejection sensitivity play an important role in the experiences of those diagnosed with BPD, as the symptoms related to intrapersonal suffering are triggered and worsened in the context of interpersonal stress or experiences of rejection. This points to the value in the study of interpersonal relationships of those living with BPD.

The Impact of Borderline Personality Disorder on Interpersonal Functioning

Relationship Instability and Social Network Analyses

Individuals diagnosed with borderline personality disorder (BPD) experience significant interpersonal dysfunction compared to healthy comparison groups and other psychopathological populations, such as mood disorders and Cluster C PDs (e.g., avoidant, dependent, and

obsessive-compulsive PDs; American Psychiatric Association, 2013; Hepp et al., 2017; Labonte & Paris, 1993; Lazarus et al., 2016; Lazarus et al., 2019). BPD is associated with increased instability in relationships, as those living with BPD experience more relationship ruptures and dissolution than healthy comparison groups (Gunderson, 2007; Lazarus & Cheavens, 2017; Lazarus et al., 2019). Some studies have found that those with BPD have less people in their social networks compared to those without personality disorders (Lazarus et al., 2016; Stepp et al., 2009), however, the findings are mixed as Clifton and colleagues (2007) found no significant differences between the social network sizes of BPD and no-PD groups. Other studies have found that women diagnosed with BPD experience decreased satisfaction and social support, as well as increased conflict and criticism in their social networks (Lazarus & Cheavens, 2017; Lazarus et al., 2019). Furthermore, women with BPD experience significantly more ruptures and cut-offs in their social networks over time as compared to no-PD comparisons (Clifton et al., 2007; Lazarus et al., 2019). Severity of relationship instability and distress is often consistent for individuals with BPD, with studies documenting stability over a one-year follow-up period (Wright et al., 2013).

Affective Instability and Interpersonal Distress

Individuals diagnosed with BPD also experience affective instability and emotion dysregulation, which has negative implications for relationship functioning (Bagge et al., 2004; Russell et al., 2007). Affective instability is characterized by rapid changes in mood and affect which are sensitive to environmental and interpersonal stress for those with BPD (American Psychiatric Association, 2013; Gunderson & Phillips, 1991; Hepp et al., 2017; Russell et al., 2007). Affective instability in response to interpersonal stress is more pervasive for individuals with BPD than those with depression (Hepp et al., 2017). Individuals with BPD perceive their

social interactions more negatively compared to those with other personality disorders and those without any personality disorders (Clifton et al., 2007; Stepp et al., 2009).

The Impact of Borderline Personality Disorder on Couples and Romantic Relationships

The Bidirectional Nature of Borderline Personality Symptomology and Close Relationships

Borderline personality disorder (BPD) is characterized by interpersonal dysfunction, specifically in close relationships (Hopwood et al., 2013). Close relationships can be influential for borderline symptomology in that interpersonal stress exacerbates BPD symptoms, such as negative affect and self-destructive impulsivity (American Psychiatric Association, 2013; Bouchard & Sabourin, 2009; Brodsky et al., 2006; Lazarus et al., 2018). Close relationships also have the potential to stabilize BPD symptoms when the affected partner experiences these relationships as accepting and nurturing (American Psychiatric Association, 2013; Kuhlken et al., 2014). The relationship between BPD and close relationships, such as romantic relationships, is bidirectional; close relationships impact BPD symptomology while BPD symptomology impacts relationship quality, stability, and satisfaction for both partners (American Psychiatric Association, 2013; Bouchard & Sabourin, 2009; Brodsky et al., 2006; Kuhlken et al., 2014; Lazarus et al., 2018; Sato et al., 2020; Zeigler-Hill & Abraham, 2006).

Romantic Relationship Dysfunction: Instability, Quality, Violence, and Satisfaction

Borderline personality disorder is associated with increased relationship dysfunction (Bouchard et al., 2009; Hill et al., 2008; Javaras et al., 2017; South et al., 2008; South et al., 2020), including increased instability and decreased quality and relationship satisfaction. Individuals with BPD experience instability in their romantic relationships (Bouchard et al., 2009; Bouchard & Sabourin, 2009; Whisman & Schonbrun, 2009). For example, in a study by Bouchard and colleagues (2009), most couples with BPD experienced repetitive separation and

rejoining, with more than a quarter of couples ending their relationship within an 18-month period. However, other studies (Beeney et al., 2019b; Lavner et al., 2015) have not found the same association between BPD and relationship dissolution across time. Differences in sampling or follow-up periods may help explain these divergent findings. Bouchard and colleagues (2009) and Beeney and colleagues (2019b) both utilized a mixed sample including dating and married couples whereas Lavner and colleagues (2015) utilized a married sample. Beeney and colleagues (2019b) and Bouchard and colleagues (2009) had shorter follow up periods (12 and 18 months respectively) whereas Lavner and colleagues (2015) followed up over ten years. Beeney and colleagues (2019b) posited that their lack of findings of significant likelihood of relationship dissolution over 12 months may be explained by their shorter follow up period (Beeney et al., 2019b). Lavner and colleagues (2015) also point out that relationship distress is seemingly present at the time of marriage for couples with a partner with BPD, rather than evolving throughout the marital relationship, hence supporting the idea that some stability is reached by the time of marriage.

Multiple studies have found that those with BPD have lower quality romantic relationships compared to healthy comparisons (Bouchard et al., 2009; Bouchard & Sabourin, 2009; Lavner et al., 2015; Whisman & Schonbrun, 2009). The quality of romantic relationships for those with BPD or BPD features has been studied by assessing relationship satisfaction, communication styles and patterns, attachment styles, affect and emotional behaviors, perception, and levels of violence in these relationships amongst both partners (Beeney et al., 2019b; Bouchard et al., 2009; Lavner et al., 2015; Lazarus et al., 2018; South et al., 2008; South et al., 2020). Couples with BPD have decreased relationship satisfaction compared to no-PD comparisons and samples with other PDs (Beeney et al., 2019b; Bouchard et al., 2009; Bouchard

& Sabourin, 2009; Lavner et al., 2015; Lazarus et al., 2018; South et al., 2008; South et al., 2020; Stroud et al., 2010; Zanarini et al., 2005). Relationship satisfaction is important for individuals with BPD, as increased relationship satisfaction is a protective factor against BPD symptoms (Bouchard & Sabourin, 2009). Individuals with BPD were found to worry more often about separation in their romantic relationships, suggesting preoccupation with abandonment (Lazarus et al., 2018). Individuals in recovery from BPD were more likely to appraise their relationships as good (Bouchard & Sabourin, 2009) and to be living with a partner or spouse (Zanarini et al., 2005). Decreased relationship satisfaction in couples with BPD is the result of insecure attachment styles in both partners (Bouchard et al., 2009), increased negative interactions (Beeney et al., 2019b; Lazarus et al., 2019), maladaptive communication patterns and problem solving skills (de Montigny-Malenfant et al., 2013; Lavner et al., 2015; Miano et al., 2017b), and BPD characteristics including negative affect, emotional dysregulation, cognitive-perceptual functioning, and behavioral responses (Beeney et al., 2019b; de Montigny-Malenfant et al., 2013; Lavner et al., 2015; Miano et al., 2017a; Miano et al., 2017b; Miano et al., 2020). In couples with BPD, typically both partners are insecurely attached (Bouchard & Sabourin, 2009). Beeney and colleagues (2019a) found that increased personality disorder severity led to increased attachment anxiety in both partners and increased attachment avoidance for the PD partner. These couples' insecure attachments were associated with more withdrawal in their communication patterns which had a negative effect on their relationship satisfaction (Beeney et al., 2019a). Miano and colleagues (2020) found that insecure attachment styles partially explain the association between BPD and romantic relationship dysfunction.

Couples with a partner with BPD also display higher rates of maladaptive communication styles during conflict and stressful conversations (de Montigny-Malenfant et al., 2013; Miano et

al., 2017b). Given that couples with BPD rate their daily conflicts as more severe (South, 2014), these harmful communication styles may occur frequently in their relationships. Bouchard and colleagues (2009) found that couples with a partner with BPD exhibit increased maladaptive communication compared to control couples. Couples with a partner with BPD were more likely to avoid communication and to display demand-withdraw patterns in which the female partner with BPD withdrew and the male partner without BPD demanded (Bouchard et al., 2009). Couples with BPD also evidenced less effective problem-solving skills and increased negative communication patterns and stress during problem solving conversations (de Montigny-Malenfant et al., 2013; Lavner et al., 2015). Lavner and colleagues (2015) studied communication skills in couples with a partner with BPD and found that increased BPD symptoms were associated with increased negative communication skills and decreased positive communication skills for male partners during problem solving tasks, while increased BPD symptoms were associated only with increased negative communication skills for female partners during these tasks. Increased BPD symptoms were also associated with increased relationship distress for these couples, suggesting a relationship between BPD symptoms, negative communication skills, and relationship quality outcomes (Lavner et al., 2015).

Differences in cognitive-perceptual tendencies and decreased emotion regulation skills help to explain interpersonal dysfunction, communication deficits, and decreased relationship satisfaction in BPD (Bhatia et al., 2013; Kuhlken et al., 2014; Lazarus et al., 2018; Miano et al., 2017a; Miano et al., 2017b; Miano et al., 2020). Individuals with BPD are more likely to perceive their romantic partners as untrustworthy and to have negative attribution biases towards their partners (Bhatia et al., 2013; Miano et al., 2013; Miano et al., 2017a; Miano et al., 2020). Individuals with BPD also experience increased stress responses during relationship-threatening

situations and conversations with their partners, such as those pertaining to separation (Miano et al., 2017b). Decreased emotion regulation skills were associated with increased negative and decreased positive communication skills for individuals with BPD, as well as decreased perceptions of closeness in their relationships (Miano et al., 2017b). Individuals with BPD also experience heightened rejection sensitivity and frequently perceive their partners as rejecting while infrequently perceiving them as accepting (Lazarus et al., 2018). In response to perceptions of rejection, individuals with BPD experience increased negative affect, including fear and sadness, and respond to rejecting partners with hostility (Berenson et al., 2011; Hepp et al., 2017, 2018; Kuhlken et al., 2014; Lazarus et al., 2018). Conversely, they tend to respond to perceptions of partner acceptance with increased positive affect and decreased negative affect (Lazarus et al., 2018). Hostility towards one's partner, as displayed by individuals with BPD in their relationships, is related to and may be exhibited as one or more of Gottman and Levenson's four horsemen behaviors (defensiveness, stonewalling, criticism, and contempt; Gottman & Levenson, 1992), which have been shown to be significantly associated with marital dissolution. Beeney and colleagues (2019b) studied the presence of the four horsemen behaviors of individuals with BPD and their romantic partners. They found that increased BPD severity for one partner was associated with decreased relationship satisfaction over 12 months for both partners and that this association was partially explained by the presence of negative emotional/ four horsemen behaviors exhibited by both partners (Beeney et al., 2019b). In terms of intimate partner violence (IPV), individuals with BPD are also more likely to engage in the perpetration of minor and severe IPV, including physical, verbal, and emotional aggression and abuse (Jackson et al., 2015; South et al., 2008; Whisman & Schonbrun 2009; Zanarini et al., 1999). Research on the association between BPD and IPV has explored the constructs of attachment,

emotional dysregulation, impulsivity, cognitive-perceptual deficits, and substance abuse as possible mechanisms explaining this relationship (Jackson et al., 2015).

The Impact of Borderline Personality Disorder on Romantic Partners

Although the research on partners of individuals with BPD is scarce, the importance of studying these romantic partners has become apparent as research on the romantic relationships of those with BPD shifts towards more dynamic conceptualizations of couple functioning (Beeney et al., 2019a; Beeney et al., 2019b; Bouchard & Sabourin, 2009; Lavner et al., 2015). A couple studies have found that many romantic partners of those with BPD meet criteria for personality disorders themselves (Bouchard et al., 2009; Bouchard & Sabourin, 2009). Many of these romantic partners are also classified as insecurely attached, more so than in community couples and healthy comparisons (Bouchard et al., 2009; Bouchard & Sabourin, 2009). Partners of individuals with BPD are likely to experience relationships distress characterized by decreased relationship satisfaction, increased conflict, as well as feeling burdened by the caretaking responsibilities associated with BPD (American Psychiatric Association, 2013; Bailey & Grenyer, 2013, 2014; Beeney et al., 2019b; Lavner et al., 2015; Lazarus et al., 2018; South et al., 2008; South et al., 2020; Stroud et al., 2010). Partners of individuals with BPD report feeling like they are tiptoeing through life and enduring experiences of grief, guilt, and powerlessness (Ekdahl et al., 2011). Partners of individuals with BPD also experience difficulties with relationship instability including maladaptive communication, negative relationships with shared children, and difficulties with their partner's impulsivity, specifically social and financial impulsivity (Hoveidafar et al., 2017). As such, partners of individuals with BPD are prone to report experiencing caregiver burden and emotional difficulties, as well as feelings of powerlessness (Greer et al., 2018).

CHAPTER III: METHOD

Study Design

Interpretative Phenomenological Analysis

Data were collected using an interpretative phenomenological analysis (IPA) research design (Smith, 1996; Smith & Osborn, 2008) to explore the lived experiences of couples with a partner with BPD. IPA emphasizes the exploration of participants' experiences and the meaning they assign to their lived experiences in both their personal and social worlds (Smith & Osborn, 2008). IPA takes into account the interaction of participants' meaning-making of their own experiences with the researchers' meaning-making of the participants' experiences and assigned meanings; as such, IPA encourages researchers to attend to their own interpretative analysis of the participants' accounts of their experiences (Smith & Osborn, 2008). Consistent with IPA, in-depth semi-structured interviews were conducted, followed by analysis and engagement in interpretation-driven iterations of the interview schedule between each interview.

Dyadic Data Collection and Analysis

Given that romantic relationships consist of shared experiences that are bidirectionally influenced by both partners, dyadic data were collected to sufficiently capture the shared and differing relationship experiences and attributed meanings of both partners (Tkachuk et al., 2019). In-depth semi-structured conjoint interviews were conducted in order to obtain a holistic account of couples' shared and differing experiences in navigating their couple relationships in which one partner is an individual living with BPD. The researchers' objective was to collect rich descriptions of these couples' experiences such that participants' own perceptions and attributed meanings are brought forward in a collective space in which partners could build on each other's responses and illustrate the interaction of their experiences (Tkachuk et al., 2019).

Given IPA's attention to both personal and social world experiences (Smith & Osborn, 2008), this design fit well with the dyadic nature of the study because dyadic experiences were assumed to represent the interaction of personal and social worlds (Tkachuk et al., 2019). The researchers also assessed for couples' shared and differing experiences and attributed meanings to capture the systemic interactions of their couple and individual experiences (Tkachuk et al., 2019). To obtain a holistic and balanced understanding of the experiences of couples with a partner with BPD, the researchers conducted the interviews such that sensitive attention was given to both the strengths and struggles of the couples.

Sampling and Recruitment

A recruitment email and corresponding flyer (see Appendix A and Appendix B) were sent to a number of listservs, including a listserv associated with Virginia Tech's marriage and family therapy program, dialectical behavioral therapy (DBT) centers in the Washington metropolitan area, and online support groups including: "Quiet" (BPD) Borderline Personality Disorder Support and Resources (Facebook), Borderline Personality Relationship Support (Facebook), r/BPD (Reddit), r/BPDPartners (Reddit), and r/BorderlinePDisorder (Reddit). Interested couples were screened for eligibility via an online survey (see Appendix C). The inclusion criteria were as follows: (a) one partner reported having been diagnosed with BPD by a mental health professional; (b) the couple had been in a committed, dyadic, romantic relationship for at least one year; (c) both partners were willing to participate in the study; (d) both partners were at least 18 years old; (e) both partners were English speaking; (f) both partners consented to be interviewed and audio recorded as a couple; (g) the couple was residing in the United States.

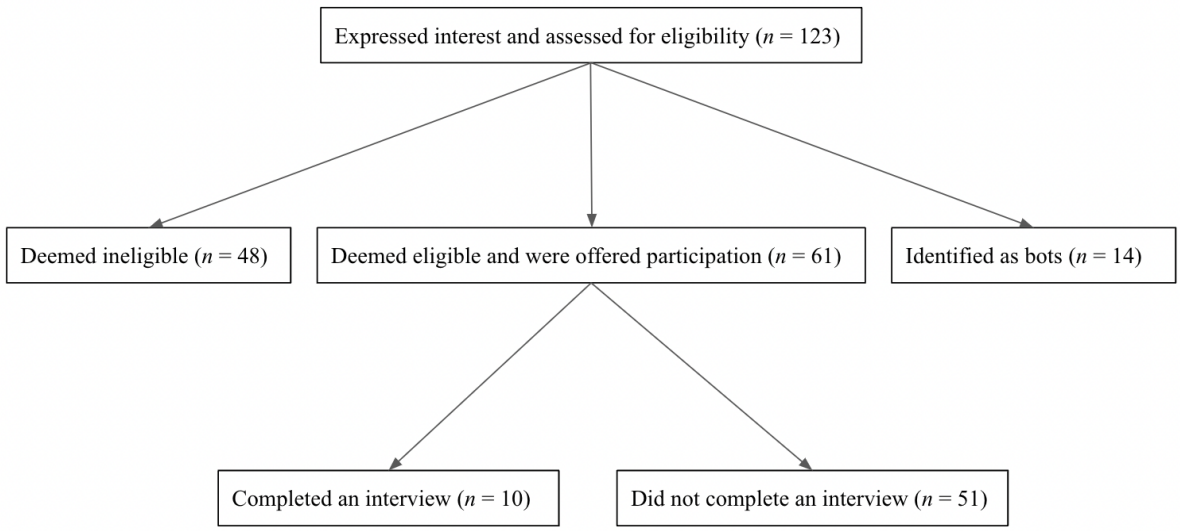
Ten couples ($N = 20$ individual partners) were recruited to participate in conjoint semi-structured interviews with the purpose of exploring their experiences of couplehood while one

partner was living with a BPD diagnosis. This sample size was sufficient for the methodological approach of IPA (Smith & Osborn, 2008). As Smith and Osborn (2008) noted, IPA studies have been conducted on samples ranging from one to greater than 15, and sample size can depend on the level of analysis and richness of data. See *Figure 1* for a consort diagram illustrating the breakdown of the recruitment process that resulted in the sample size of 10 couples. 123 screening surveys were submitted via the online screening survey (see Appendix C). Of these, 14 were identified as bot submissions using bot identification methods, including identifying responses that did not make sense, identifying repeated response entries across survey submissions, and repeated use of IP addresses. Of the remaining 109 couples, 48 were deemed ineligible; ineligibility was largely due to the following reasons: (a) couples resided outside of the United States (n = 34), (b) couples were in a relationship for less than one year (n = 10), or (c) couples submitted an incomplete survey response (n = 4). The remaining 61 couples were deemed eligible to participate and were asked to complete the consent form. Of these 61 couples, some separated shortly after submitting their screening questionnaire (n = 3), only one partner of the couple was willing to participate (n = 7), while others were unresponsive to contact attempts (n = 41). The remaining 10 couples were those that made up the final sample.

A copy of the consent form (see Appendix D) was provided electronically via an online survey platform to each dyad that was deemed eligible based on their screening survey. Each partner of the dyad completed their own informed consent form. The consent form explained that the researchers were interested in understanding the experiences of couples in which one partner identified as having borderline personality disorder. The consent form explicitly stated that the research process was voluntary and that the couple could opt to terminate the interview at any time without penalty. To pair the couples' consent forms, they were asked to provide the name of

their partner on the form. The consent form was also reviewed verbally prior to the onset of each interview. Time was allowed for questions and couples had the opportunity to revoke consent. The online survey platform directed participants to the demographic form (see Appendix E) once consent to participate in the study was provided.

Figure 1
Consort Diagram

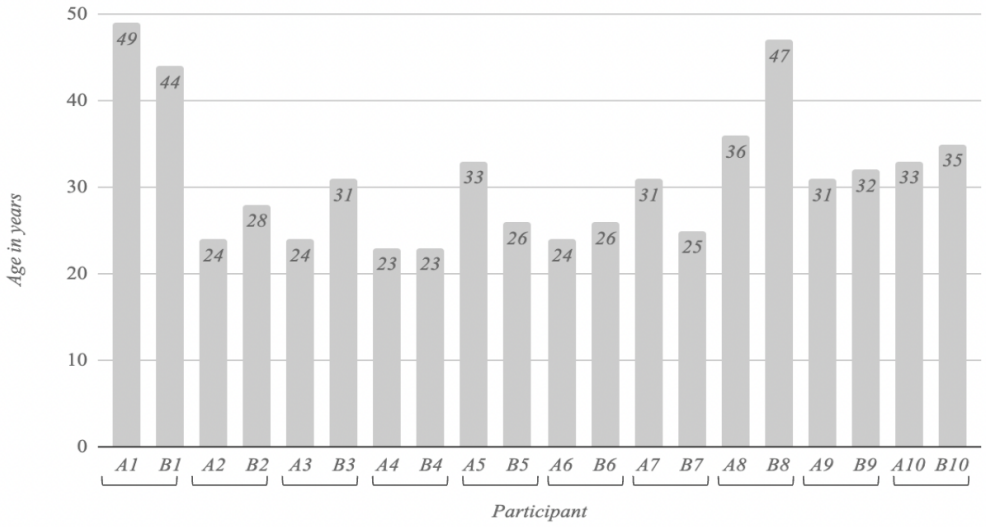


Sample Characteristics

The 10 couples were from various states in the United States, including California, Georgia, Indiana, Michigan, New York, Ohio, Oregon, Pennsylvania, and Texas. The sample was predominantly white (85%) except for three participants who identified as non-white Hispanic. The sample ranged in age from 23- to 49-years old (M = 31.25; SD = 7.84). See *Figure 2* for a breakdown of ages per partner per couple. Couples ranged in length of partnership from 1 to 14 years (M = 6.00; SD = 4.32). Couples ranged in number of children from 0 to 4 children (M = 0.95, SD = 1.43). Half the sample (n = 10) identified as heterosexual and half identified as LGBTQIA+ (n = 10; one participant identified as gay, one participant identified as lesbian, four

participants identified as bisexual, and four participants identified as pansexual). See *Figure 3* for a breakdown of sexual orientation per individual. All participants identified as cisgender except for one participant who identified as non-binary. Of the partners diagnosed with BPD, one identified as non-binary and the others identified as female. Of the partners without BPD, seven identified as male and three identified as female. Eight couples were currently in a heterosexual partnership, and two couples were in a lesbian partnership. See *Figure 4* for a breakdown of gender identities per individual. Most of the couples were unmarried and cohabitating (n = 6, 60%) and the remaining were married (n = 4, 40%). See *Figure 5* for a breakdown of marital status per couple.

Figure 2
Age per Partner

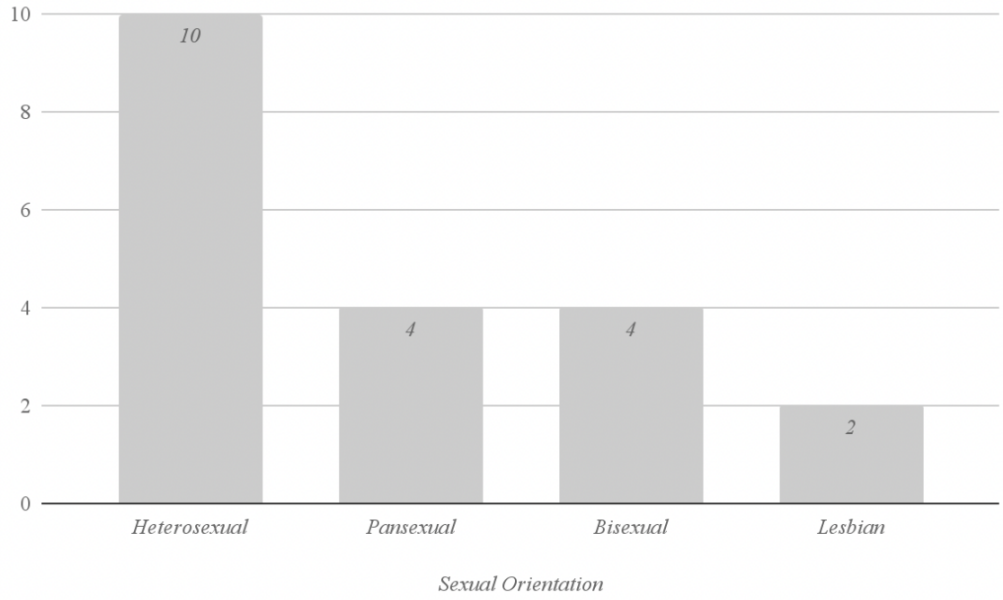


Note: Participant ages are provided per individual partner with brackets displaying the ages of each partner per couple. Couples are listed chronologically per interview. A= Partner diagnosed with BPD. B = Partner without BPD.

All participants diagnosed with BPD had been previously or were currently in treatment for BPD. Most of the participants diagnosed with BPD also reported having other mental health diagnoses, including autism spectrum disorder (n = 2), attention deficit/hyperactivity disorder (n = 4), generalized anxiety disorder (n = 1), premenstrual dysphoric disorder (n = 1), and post-

traumatic stress disorder (*n* = 2). Some partners without BPD reported mental health conditions as well, including depression (*n* = 2) and anxiety (*n* = 2), and avoidant personality disorder (*n* = 1).

Figure 3
Seuxal Orientation



In terms of religious affiliation, participants identified as Agnostic (35%), Atheist (25%), Christian (15%), Muslim (5%), Pagan (5%), and other (15%). Regarding education, 75% of participants had acquired some higher education (i.e., trade or vocational school, some college, bachelor's degree, or master's degree), while 20% had only a high school diploma, and 5% had not completed high school. Regarding occupation status and income level, 50% of participants were working full time, 20% worked part time, 25% were unemployed and looking for work, and 5% were unemployed and not looking for work. Most participants (85%) had an annual household income of less than $50,000, and the remainder (15%) had an annual household income ranging between $70,000-$100,000.

Figure 4
Gender Identity

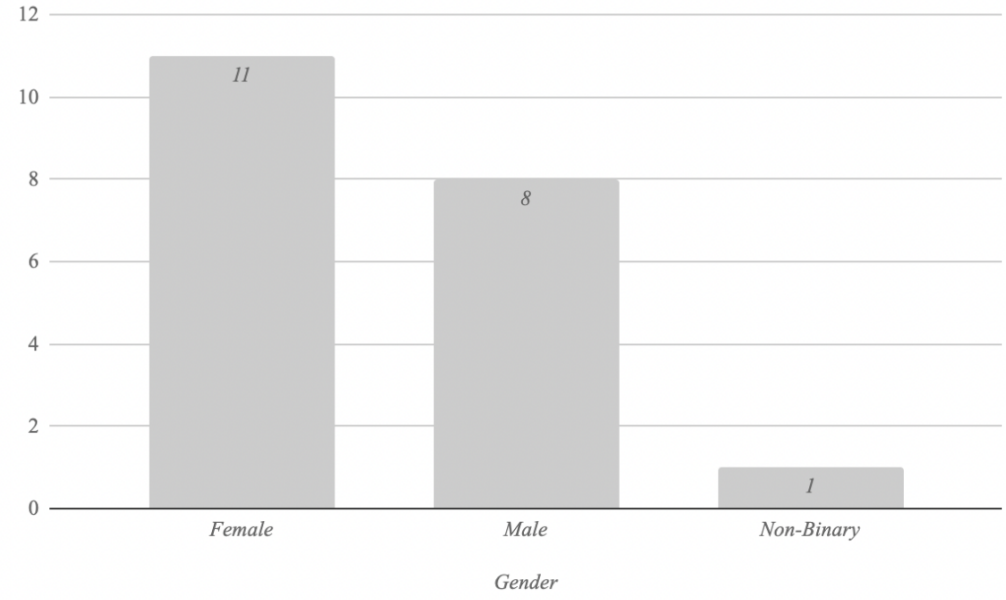
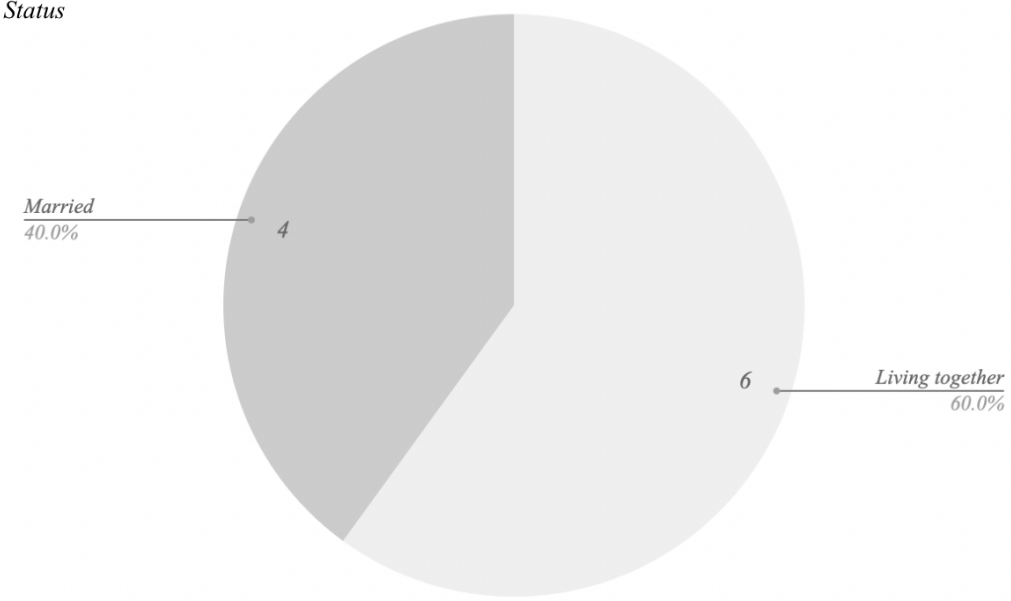


Figure 5
Marital Status



Procedures

After receiving approval from the Virginia Tech Institutional Review Board (IRB #20-1054), couples that were determined to be eligible for participation were emailed instructions to

complete the consent and demographic forms by the co-investigator (Abigail O'Leary; see Appendix H). Ineligible couples received a follow-up email informing them that they were found ineligible and provided them with a list of mental health resources (see Appendix H). The first 10 eligible couples who agreed to participate comprised the sample for this study. The co-investigator contacted these couples via email. Couples were offered to schedule a 90- to 120-minute video interview if they remained interested in participating. Interviews were scheduled at a date and time that was convenient to the couple. All interviews were conducted between August 2020 and December 2021 using an encrypted online video-chat recording platform rather than in-person because all participants lived in states outside of that in which the study took place.

Audio/Video Interview Data Storage and Transcription

All interviews were conducted by the same researcher (co-investigator: Abigail O'Leary) to ensure consistency. Please see Appendix G for the preliminary interview schedule. Interview recordings were stored in a password protected shared drive. Office 365 transcription software was utilized to transcribe the audio files from the interviews. The co-investigator (Abigail O'Leary) verified the transcripts while listening to audio files of the interviews to ensure the interviews were accurately transcribed verbatim. Once transcribed, the interview transcripts were de-identified prior to coding.

Analysis

Data analysis followed IPA guidelines (Smith & Osborn, 2008), with additional dyadic coding considerations (Tkachuk et al., 2019). Transcripts were read several times prior to coding to gain a thorough understanding of each partner's perceptions and each couple's collective experience of navigating a relationship in which one partner is an individual diagnosed with

BPD. After the preliminary review of the transcripts, notes were taken on interesting and significant comments made by each partner. Notes on these comments included paraphrasing, summarizing, initial interpretations, and connections, as well as emerging similarities and differences within and between each partner's dialogue. Then, as the transcripts were further reviewed, these notes were applied to the construction of a list of emerging *theme titles*. These theme titles include both the themes for each partner, as well as the collective themes of the dyad, in order to emphasize the shared and differing experiences and meanings portrayed by the couple.

The theme titles were initially listed chronologically, reflecting the flow of the transcripts. Then, similar theme titles were *clustered* together to form themes which reflected connections between the initial theme titles. The list of themes was altered from being listed chronologically to being categorized and combined; this clustering of themes was completed both for the themes of each individual partner, as well as for the themes describing the intersection of each partners' experience with attention paid to shared and differing meaning and experience. After the themes were clustered, they were reapplied to the transcript to ensure an accurate representation of the participants' accounts. During this process of ensuring accurate representation, participant quotes which illustrate the themes were pulled from the transcripts and paired with the theme titles. Finally, interpretations about the participants' internal worlds and psychological experiences were made and integrated into the themes.

To uphold the iterative process of IPA, previously reviewed transcripts were re-evaluated with new themes that emerged in subsequent transcripts. Then, all the themes between transcripts were further categorized in order to account for the shared themes both within and between the couples. Once all identified themes were applied to every transcript, a final list of *superordinate*

themes was constructed; these superordinate themes were categorized based on the shared and differing experiences amongst individuals with BPD, individuals without BPD, and experiences of all interviewed couples to account for both the individual and dyadic experiences throughout the data. Finally, these superordinate themes were used to compose an analytical description of the essence of the participants' reported experiences with special consideration given to distinguishing between the participants' account of their experiences and the researchers' interpretations of these accounts of navigating a relationship in which one or both partners have BPD.

Trustworthiness

A series of steps were taken to establish *trustworthiness* and *validity* (Creswell & Poth, 2016; Elliot et al., 1999). First, findings were *triangulated* with existing research (Creswell & Poth, 2016). Second, the Principal Investigator (Ashley Landers) audited themes identified by the Co-Investigator (Abigail O'Leary). Third, researchers engaged in *member checking*, a process in which results were sent to participants to elicit their feedback, to ensure that participants' stories were conveyed accurately and to increase validity and credibility (Creswell & Poth, 2016). Fourth, the researchers provided original quotes in the results section from the interviews to *ground* the results and assist the readers in evaluating whether the findings were congruent with their interpretations of participants' experiences (Elliot et al., 1999).

CHAPTER IV: RESULTS

Three superordinate themes were identified in the data that illustrate the essence of the experiences of couples navigating the impact of BPD on their romantic relationships including (a) the individual lived experience of BPD, (b) the shared experience of BPD as a relational stressor, and (c) adaptive dyadic coping in the context of BPD. In the first superordinate theme, individual partners living with BPD discussed their experiences of BPD symptoms, as well as barriers and facilitative supports to managing their BPD symptoms. Individual partners without BPD discussed witnessing and experiencing effects of their partner's BPD experience, longing for freedom from the stress of BPD, and navigating the construction of their individual role in adapting to BPD stressors. In the second superordinate theme, couples described the shared experience of BPD as a relational stressor. Couples described various obstacles to effective interpersonal functioning including internalization of reactivity, defensiveness, negative perceptions of BPD, and interpersonal skills deficits that detracted from the ability to navigate the relational stress of BPD. In the third superordinate theme, couples identified internal (e.g., attunement, intentionality, growth mindset, mutual externalization) and external (e.g., therapy, accessing information about BPD) resources that facilitated the effective management of BPD as a relational stressor through adaptive dyadic coping.

Couples experienced BPD as a relational stressor and remarked on both personal and interpersonal challenges that impacted their ability to cope with this stress. Partners with BPD had challenges in managing BPD symptomology, particularly emotion dysregulation and negative perceptions of their partner. Partners without BPD experienced negative beliefs about BPD, caregiver burden, and their own mental health issues that increased the complexity of couple interactions. Couples experienced increased conflict severity in the presence of BPD,

which was a catalyst to the activation of adaptive dyadic coping so as to protect their relationships from distress and dissolution. Couples who were struggling with BPD were unclear about how to be supportive and lacked effective communication and conflict resolution skills. In these couples, the partner with BPD described having a fixed mindset, particularly marked by shame and the inability to recover from the diagnosis and associated symptoms. Partners without BPD described obstacles to supporting their partner, including their negative appraisals of BPD and the caregiver burden they experienced. In contrast, couples who felt they were managing the relational stressor of BPD well described their process of engaging in adaptive dyadic coping through collaborative navigation and externalization of BPD. Externalization was a key resource for adaptive dyadic coping that bolstered couples' efforts to unite against BPD.

Despite the challenges that BPD posed within the relationship, couples activated adaptive dyadic coping to reduce the detrimental impact of BPD. Many couples noted that BPD brought them together and required them to activate healthy relationship maintenance behaviors that they might have overlooked if BPD had not placed extraneous stress on the relationship. All couples identified resources that assisted in coping with BPD. Couples that took a collaborative stance against BPD were attuned to their partners' emotional needs, had compassion for one another, and displayed a willingness to be vulnerable in sharing their experiences. Open and clear communication and boundary setting supported effective conflict resolution and facilitated accountability and trust between partners. Other resources included acceptance of the presence of BPD, dedication to relationship longevity, commitment to navigating relational stress, hope, and patience. Couples illustrated how these resources served to promote relational health. Couples described the transition to shared triumph, suggesting that these resources serve to propel adaptive dyadic coping with BPD over time.

The superordinate themes and associated theme clusters are illustrated below in descriptive couple quotes. Areas of convergence and divergence are discussed. Partners diagnosed with BPD are depicted as *Partner A* and partners without a BPD diagnosis are depicted as *Partner B.* Couples are labeled numerically reflecting the order of interviews. As such, a quote labeled *3B* would symbolize a quote from the partner without BPD of the third couple interviewed. A quote labeled *9A* would symbolize a quote from the partner with BPD of the ninth couple interviewed. For a summary of the results and associated superordinate themes, theme clusters, theme sub-clusters, and theme titles, see Appendix I.

Superordinate Theme One: Individual Lived Experiences of BPD

Couples described their individual experiences of BPD; individuals with BPD described the internal experience of having BPD, and their partners described bearing witness to and experiencing BPD symptoms, as well as their experience of being partnered with someone with BPD. Individuals with BPD described how they managed symptoms toward recovery, whereas individuals without BPD described witnessing and experiencing BPD, longing for their partner's recovery, and how they responded to BPD.

The Experience of BPD Symptoms

Individuals with BPD: Experiences of Internal Instability. All individuals with BPD noted symptoms of instability in emotion, mood, identity, worth, and perception. They described the experience of BPD as episodic and heightened during interpersonal conflict with their romantic partners. These individuals also described experiencing intense and extreme emotions. For example, one participant stated: "It's like feeling every emotion, but the intensity of it is turned to the max volume, like every emotion that you feel is just extreme. If you're happy it's to the extreme… Sad, it's to the extreme… Excited, it's to the extreme" (7A). Participants also

described experiencing emotion dysregulation and the impact it had on their perceptions: "Rage comes over me and transports me to a world where I almost don't recognize myself or other people" (1A). Some participants with BPD made sense of their struggles with emotion dysregulation and unstable perceptions in the context of trauma responses: "Everything is so raw all the time, so it's like really easy to enter that fight, flight, or freeze response. Everything becomes a trauma response" (3A); "For a long time I didn't believe Partner B loved me, I thought he was lying to me… I didn't believe him. But it wasn't his fault… It was my own experience and trauma and childhood that made me feel that way" (2A); "It's a reaction to trauma for one, and it's a defense mechanism, even though it's not a good one. It's also kind of like having two faces…You go from nice to bad… It's like a rollercoaster" (10A). Individuals with BPD also described the impact that emotion dysregulation has in relational contexts:

> "Every little emotion just feels like it's ridiculously amplified and you make up these scenarios in your head that you know are ridiculous, but they feel real to you. So, you feel like you're being abandoned by someone even if they're just hanging out with someone else… But you're like, 'That's ridiculous because they're allowed to have other friends. You're being stupid, so stop that.' And you just have to tell yourself that… It's just, your brain is being ridiculous." (7A)

Participants with BPD also reported an unstable sense of self: "I've always had a lot of emptiness… There wasn't really a stable version of myself" (5A). They identified how this unstable sense of self impacted their perceptions and interactions in their romantic relationships, resulting in fear of rejection or abandonment:

> "The biggest thing is my feeling unvalued and feeling worthless myself and I get these thoughts in my head that he doesn't trust me or he's cheating. That is, he's never been

> unfaithful to me. But I tend to spin a lot…because of the attachment that borderlines have and being afraid of rejection or being afraid that somebody's gonna leave you." (8A)

These unstable perceptions also resulted in splitting or idealization/devaluation. One participant described how impulsivity acted as a barrier to the self-regulation required to avoid devaluing their partners during conflict or BPD episodes:

> "In our fights I just hear myself saying things and they'll be coming out of my mouth, and I'm like, 'Why am I saying this mean shit to him?' Like he does not deserve that… I need to respect him. He is my partner, I love him. But when I'm splitting on him, when I'm not pedestaling him, when I'm hating him or really just being rude to him, I'll catch myself and be like, 'Wow, I'm just really saying this out loud.'" (2A)

Individuals without BPD: Experiencing their Partner's Internal Instability. All of the individuals without BPD described witnessing and experiencing the effects of BPD symptoms, including unstable emotions, perceptions, and reactivity. Most of the descriptions of the experience of BPD of partners without BPD converged with those descriptions of partners with BPD; the BPD experiences that partners without BPD witnessed were congruent with the experiences of BPD reported by partners with BPD. One participant stated: "Partner A vacillates between one of the most confident and self-assured people that I know to one of the least confident, most self-conscious people I know, and I mean it can literally happen like that on a dime" (2B). Many partners without BPD described experiencing uncertainty when they encountered their partner's affective instability: "You just don't know what to do, how to keep that really healthy-feeling person there" (1A); "It's just like whoa, where did that come from? Moods come out of nowhere and you don't know why" (3B). Individuals with BPD agreed that their partners were unsure of how to respond to their affective instability, suggesting

convergence: “Something that’s incredibly impacted our relationship is my fear of abandonment… It causes conflict and he’s over here like, he doesn’t know what to do” (8A). Another individual without BPD stated:

> “Being with the same person but seeing a lot of different sides... and not even sides but more like reactions. And seeing different reactions to what you would assume is the same thing, just there was already something going on and you weren’t aware of that. You know, like, some mental, cognitive distortion or memory or something that’s going on that you’re just not aware of, and then you see a seemingly different person.” (3B)

And another participant without BPD described experiencing their partner’s splitting:

> “It’s [splitting is] offering a judgment and typically not merely of my actions. One could say, you know, ‘That was a bad thing to say, bad thing to do.’ But the message is more like, ‘You are a bad person and a bad boyfriend and a bad debate partner and a bad conversationalist.’ And I’ve been ‘Bad, bad at everything that matters right now. You fail at all of it.’” (1B)

The Recovery Process

All of the individuals with BPD described efforts towards managing their symptomology and factors that promoted their recovery. Participants without BPD acknowledged longing for their partner’s recovery and described offering support toward recovery.

Individuals with BPD: Factors Promoting their Recovery. Participants with BPD noted various factors that promoted recovery, including reparative experiences; accessing social support, therapy, medication, self-help books, and DBT self-help groups; the construction of boundaries that reflect new beliefs to promote recovery; and developing skills that promote recovery such as insight, distress tolerance, and wise mind.

Reparative Experiences. Individuals with BPD described their partnerships as playing an integral role in recovery. They noted that their partners provided support and made active efforts toward relational repair, which in turn decreased the symptoms of BPD. To illustrate: "I don't know how I would have handled it by myself without having a supportive husband to go through it [diagnosis] with me. I don't think that I would have handled it very well" (8A). Others shared how their partners supported their coping: "He was really the first person to offer actual, tangible help in real time and consistently as well. I could let my guard down and I could de-escalate with him" (3A).

Participants also discussed how negative experiences in past romantic relationships aggravated BPD, and for many their current relationships were healing and buffered against the detrimental impact of BPD. To illustrate this contrast, one participant stated:

> "I was in a really abusive relationship, and I was just depressed and alone and it made everything worse. And then when I got into my healthy relationship, it really helped my mental health and I was like, 'Oh hey, I'm not being treated this horrible way anymore, so maybe I'm not...' like it helped my self-esteem which helped my BPD because I felt like I deserved to be loved." (7A)

This same individual described the differences between past romantic partners' responses to BPD in comparison to the supportive stance of her current partner:

> "I was already on my way to being more healthy at the time that we got together and then she helped, she was very comforting, like, 'Hey, I know you're maybe gonna have a symptom or like an episode or something, but I'm still gonna be here. I'm not gonna abandon you. Everything is gonna be OK.' So, it was easier than any other relationship

that I'd had. Other people would be like, 'You can't act like this. I'm not gonna indulge in this kind of behavior.'" (7A)

Another participant echoed a similar experience:

"This is the first long term relationship I've had. My other longest relationship was just under a year, and it wasn't a very honest relationship. I wasn't honest with myself or my other partner. We've been able to build a home and something that I never thought that I'd be able to have for a long time, and I think this is something that's common with a lot of people that have BPD…Now I'm almost 25 and in a long term committed relationship. And we have cats and a really beautiful home. Every day is kind of magical." (3A)

Others described an increased sense of hope for recovery that resulted from having a healthy romantic relationship: "I did not know that I could ever possibly have a relationship this close and this healthy. And that's been amazing. And it reminds me that like, man. People with borderline personality disorder, they could do anything" (5A). Another stated,

"There was this epiphany that I had really early on in our relationship… In every other relationship I've ever wanted to be in, I wanted to convince the person that I was the best person around and like they definitely want to be with me, but for him I was like, 'Hey, I actually need to be the best person and for that I got to go to therapy.'" (4A)

Others noted how their romantic relationship motivated their recovery:

"I've had relationships before this one and my BPD affected those more-so because I wasn't as into getting better… But since we've been together, I've been trying to… Focus more on healing and just like acknowledging, OK, I have borderline personality disorder. I don't have to fit that stereotype, or like tick all of those boxes for the rest of

my life. So, kind of learning how to grow with my BPD and even growing in our relationship with it." (3A)

Individuals with BPD accessed mental health resources to better understand themselves and to adaptively manage BPD including social support, therapy, medication, self-help books, peer support groups, and dialectical behavioral therapy (DBT) self-help groups. Utilizing DBT improved their BPD symptoms, especially interpersonal skills:

"I think this is the first relationship where I've actually had such good communication because at this point, I've been through DBT, which helped me quite a bit in being able to understand my own emotions and just being mindful of situations and not making assumptions about my partner. Those have all been pretty serious problems in the past, but that's just so much easier now that I actually have strategies to do that. And I'm still in therapy so that helps too with communication. When I'm struggling, I can talk to my therapist and that's really helpful." (5A)

Therapy was also helpful to manage symptoms and to learn how to seek support from their romantic partners. For instance, one participant stated:

"I think a lot of it was me going to therapy and being able to articulate it better. Especially at the beginning it was just, you know, me crying and him holding me but… As time went on, I was able to describe it a little bit better and he knew, I guess he kind of figured out specific ways to make me feel better." (4A)

Individuals with BPD constructed boundaries based on new beliefs that supported their recovery and engaged in both accountability and conflict resolution. One participant described this accountability: "The few people I've met who have it, we've all agreed, 'Yes, you have it.

Yes, that's an issue, but it doesn't make it OK for your actions, that you need to be accountable for that'" (10A). Others also described this accountability:

> "You have to take responsibility for the things that you're doing and realize that you also have toxic behaviors because of your borderline personality disorder. It might not be your fault entirely, but you still have to take responsibility for your actions. You can't just be like, 'I have a mental illness, so I don't have to take responsibility for my actions 'cause it's not my fault…' That's not how it is. You have to recognize your toxic behaviors and work on them. If you want your relationship to work anyway." (7A)

Individuals with BPD: Challenges to their Recovery. Recovery had a different meaning among the participants. Some individuals believed in the idea of recovery, whereas others felt the struggle to manage BPD would be lifelong. Regardless, all of the individuals with BPD noted challenges to recovery including multiple diagnoses, difficulty accessing support, and non-linear growth.

Individuals with multiple mental health diagnoses disclosed how the intersection of these conditions made it difficult to tease apart their symptoms: "I have so many other problems and disorders…It's hard for me to really parse out what aspect of my experience is what disorder" (1A). Some felt that a lack of support in their romantic relationships was a challenge in recovery. Although they longed for more support, they felt undeserving of it. Some felt misunderstood: "He'll never fully be able to understand my thought process or feelings… When I express it, he doesn't understand it. Or I can't put it into words that he can understand" (9A). Others felt patronized: "I get very, very defensive when he brings up borderline… It makes me feel like it's all my fault because I'm the one with an illness" (8A). Individuals with BPD sometimes felt that their partners focus on BPD was frustrating:

> "Partner B has gotten really into talking about borderline personality disorder a lot and he reads these forums a lot and he wants to quote this stuff to me and have me see that I should develop insight as a result and I'm thinking, 'Boy, I'm in therapy already three times a week,' you know? …Almost like the very word *borderline personality* is now becoming this sort of trigger for me… It's making me angry just to hear all about borderline personality disorder all the time." (1A)

The symptoms of BPD appeared to fluctuate over time alongside stressful life events or other mental health disorders, such as premenstrual dysphoric disorder or depression. Recovery was described as non-linear:

> "Sometimes I meet all the diagnostic criteria at different times in my life and then sometimes I'm doing good, and I don't meet enough to even be diagnosed anymore at some points in my life. Then I'll get super depressed and be not doing well again. And I'll meet another five and I'm on it again." (7A)

Individuals without BPD: Longing for Partner's Recovery. Individual partners without BPD experienced caregiver burden characterized by a preoccupation with BPD's presence in the relationship and a desire to be unburdened. They experienced resentment and longed for freedom from the burden of BPD: "It's difficult to do anything else without having a little thing in the back of your mind. You don't forget, you have to continue to be worried about this thing [BPD]. It would just be nice to not have to" (1B). Serving in a supportive role was challenging at times: "Sometimes it's been really hard to support it" (3B), "I was very much leaning on him for being my therapist and being my, like, 'Keep Partner A sane, make me feel better, make me feel better'" (2A).

On the other hand, individual partners without BPD felt pride and investment in their partner's recovery. For example: "She's worked really hard, and I recognize that and I tell her that all the time. And that I'm proud of her for putting in the work that she's done, making the changes that she's done… I'm happy" (5B); "She's totally different than she was a year ago. And that's honestly super impressive from what I've read. Some people struggle with this stuff for 20-30 years before they even start to get better, and she's been doing really well" (7B).

Individual Responses to the Experience of Partnership with Someone with BPD

Partners without BPD described distinct ways of responding to the stressor of BPD: (a) changing their own behavior to avoid negative interactions with the partner with BPD (i.e., walking on eggshells), (b) accepting responsibility for their role in the relational dynamic, and (c) striving to recognize their impact on BPD symptoms and relational dynamics.

Avoiding Negative Interactions. Individuals without BPD tried to avoid negative interactions with their partners. When their partner was unpredictable and conflict was on the rise, they tended to withdraw and avoid their partner: "I'm very careful in how I approach tougher issues… I've referred to it as a minefield before. Sometimes it's like navigating a minefield and you just gotta be careful so that it doesn't end up in a giant fight" (8B). Such avoidance was intended to prevent escalation of BPD symptoms: "If we're trying to solve a problem, I try not to say anything that doesn't need to be said in that situation just to avoid a problem while we're trying to complete the task" (9B). Although partners without BPD acknowledge avoiding negative interactions with their partners, they also recognized this may be maladaptive. For instance, one partner said: "It doesn't work. I don't think it's healthy at all" (9B). Avoidance was sometimes motivated by the fear of negative interactions. For example:

> "Feeling like I was trapped by her BPD and in the relationship as in, 'Well, if I leave bad things are going to happen. If I don't act a certain way, bad things are going to happen. If I don't agree all the time… bad things will happen.'…And when I realized that that was what I was afraid of, trying to avoid that and trying to be proactive, but proactive in the sense of trying to avoid these bad things that happen, not trying necessarily to help or to get anywhere or move forward, but to just stay in this place where everything is kind of OK. And to not go backward." (3B)

Partners with BPD concurred that their partners without BPD avoided negative interactions, as reflected by couple 7:

> A: "I think that sometimes she does feel like there are things that she's afraid to talk to me about because she's afraid that I'm going to get upset from my BPD."
>
> B: "Yeah, that's true, that's true."
>
> A: "And then she'll wait a couple days and she'll think on it, and then she'll be like, 'Alright. There's something that I want to talk to you about, but you can't get upset because of your BPD. I'm afraid you're gonna get upset because of your BPD.' And then I have to mentally prepare myself. Like, alright, push that BPD down just a little bit and be objective about this."

Navigating One's Individual Impact on BPD Symptoms. In contrast to avoiding, many partners without BPD increased understanding of their role in relational stressors associated with BPD. The understanding of BPD and their individual influence on BPD described by these partners was largely congruent with the descriptions of the BPD experience provided by partners with BPD, suggesting convergence amongst partners in the dyads in their understanding of BPD. Partners without BPD recognized their own influence on their partner's BPD symptoms. For

instance: “I don’t feel like it’s just you coming in and having this challenge [BPD] and making things harder for us and being mean to me. I bring my own shit to the table too and our challenges really engage together” (10B). Another stated:

> “Working with my own therapist on certain things in our relationship has shed a lot of light on my own trauma and certain things that happened with me, so it’s been painful at times, but it’s been good overall, I think, because when I think back to before you and I got together and even like shortly after that, things were very different and I was a very different person and I had a lot of reasons not to like myself and I had to get over those in order to maintain this, and I’m still doing it. I’m still doing it.” (3B)

Partners without BPD not only recognized their own influence but took responsibility for how their actions could potentially be triggering. One couple (7) shared:

> A: “I would also say it’s important to watch what kind of language and word choice that you use.”
>
> B: “Yeah, you have to watch your tone, which is something I’ve had to work on myself.
>
> A: Because even the slightest change of tone and word usage can just trigger something and you’re like, ‘Oh well, that’s it. I’m dysregulated.’”
>
> B: “[It] Can set off that BPD. So, you have to be kind.”

Understanding BPD changed the way partners without BPD responded to their partner’s symptoms:

> “One of the hallmarks [of BPD] is binary thinking, which becomes really difficult to move past this, all or nothing, like if I do something to make Partner A angry, that anger kind of supersedes any good part of our relationship that is otherwise present, it just kind of blacks it out and it can be difficult to come back to like, ‘Hey, we are OK and I love

you and we're angry with one another right now. But we're not always angry with one another.' And I think in day to day life remembering that we experience vastly different things emotionally and I can't fully understand what Partner A is experiencing emotionally, and having to remember that that takes a physical toll in a way that I don't experience… like how tired she might be from what she's been going through in her head all day." (2B)

Partners without BPD played a supportive role, which aided in the regulation of BPD symptoms:

"I know I've had a lot of resistance at certain points where I'm just like, 'This is bullshit... What the fuck, why are you acting like this?' But that goes back to the point of, well, you can't take it personally against you, you can't see it as them personally attacking you, even though they kind of are… I've found that there needs to be a general baseline support, like, 'OK, well, alright, there's a reason why you had that reaction, there's a reason why that is your response to this or whatever, or this is why you're acting this way, or saying these things.' I guess I've had to learn how to support it and how to support you without triggering you." (3B)

Superordinate Theme Two: The Shared Experience of BPD as a Relational Stressor

BPD is a relational stressor for couples. BPD posed challenges in the relationship including internalization, disconnection, negative appraisals, and skills deficits in knowledge and communication. BPD both drained and enriched their relationships because although it served as a relational stressor, it also served as a catalyst for developing adaptive dyadic coping.

Shared Obstacles to Interpersonal Effectiveness in the Context of BPD

Couples experienced obstacles to interpersonal effectiveness that they attributed to BPD, which included internalization of BPD, disconnection, negative appraisals, and skill deficits (e.g., in knowledge of BPD, communication, conflict resolution). Each of these obstacles increased the difficulty of managing the relational stress of BPD.

Internalization. Internalization constrained couples' efforts to minimize the impact of BPD. Internalization contributed to the personalization of BPD symptoms (i.e., partners without BPD personalizing BPD symptoms) and projection of internalized shame of having BPD (i.e., partners with BPD projected their own negative beliefs about their BPD onto their partners, assuming that their partners must feel negatively towards them for having BPD because they felt negatively about having BPD themselves). These processes of internalization disrupted efforts toward conflict resolution and problem-solving. The personalization of BPD prevented the resolution of conflict. For example, one partner said: "So that is one thing, taking things personal, is something that really affects our conflict. I think a lot of that has to do with my borderline" (8A). Partners without BPD struggled with personalization of BPD symptoms. To illustrate: "When she's in those moments, I get more of a 'I feel this way because of you,' vibe from her" (9B). When BPD was internalized by the partner without BPD, they were unable to provide emotional support. For instance, one couple (1) said:

> A: "If I'm angry, that's so personally threatening to him so it's hard for him to really support me, and I don't really feel supported that well."
>
> B: "Yeah, I want to be [supportive]. And I realize that I'm not… Sometimes I wish I could. Other times I'm like, 'How could you even possibly ask that of me, given the way

that you're treating me right now? I mean, good luck finding somebody who's going to put up with that.' But that's the nature of the beast [BPD]."

Partners with BPD internalized shame of being diagnosed with BPD; they held negative beliefs about their BPD diagnosis. This led to partners with BPD engaging in projection during interpersonal conflict, wherein they assumed that their partners without BPD held the same negative beliefs about BPD that they held themselves. This projection led to increased conflict, as partners without BPD experienced their partners' projections as accusations or criticisms. One member of a couple described how the partner with BPD's internalized shame filters into their conflict:

"I'm angry that this happened to me, that I have this [BPD]. Sometimes that anger and that shame filters into our relationship, makes me feel like maybe he thinks of me negatively... I'm like, 'He didn't choose this, he didn't ask for this,'… That makes me really hard on myself. I'm harder on myself than anyone else, I think, and that filters into our relationship." (8A)

Her partner reflected back her process of projection: "Maybe not feeling equal or thinking that you're not equal even though nobody else sees it that way," (8B).

This internalized shame acted as a barrier to receiving support. Even well intended support was perceived as pity when shame was present: "That would be a struggle to kind of get over, someone's kindness, taking it as pity or something… That's one struggle I might have with receiving support" (1A).

Projection of internalized shame caused partners with BPD to falsely perceive their partner during conflict, assuming their partners without BPD held the same shameful beliefs about them that they held about themselves. This process was illustrated by one couple:

"I remember in the beginning of our relationship, whenever we would get in a fight, I felt very dumb. I remember how I used to say all the time, 'I'm not stupid, I'm not stupid, I'm not stupid.' And he'd always be like, 'I've never said you were stupid. Why do you keep saying that? I never said you were stupid.' I'd say, 'Don't treat me like a child,' and he'd say, 'I never treated you like a child, I never said you were a child.'" (8A)

Partners converged in their identification of this shame, however, many partners diverged in their view of whether this shame was warranted: Partners without BPD tended to think that their partners with BPD ought not to be ashamed of their diagnosis.

Disconnection. Disconnection was an obstacle to effectively navigating BPD as a relational stressor. Distrust, being closed off, and conflict avoidance fueled disconnection in couples' relationships. To illustrate, one partner without BPD stated: "Trust. We have trust issues. We have communication issues. We both can be very dependent but want to be independent at the same time. I think that causes issues… Those are our main issues that cause everything else" (6B). Another couple (9) described how BPD symptoms can trigger disconnection:

B: "I'd say one that's a big trigger for me is if she's really emotional and starts disassociating and stonewalling. Then it's a really big trigger for me."

A: "I do, I do tend to do that a lot and then I see that he gets triggered, which triggers me even more and it's a vicious cycle."

Other couples described conflict avoidance: "We just go our own way. Deal with it by ourselves and then come back. We don't really regroup all the time" (6A).

Avoidance perpetuated avoidance. To illustrate:

> "It's hard. It doesn't really feel like we can come to a resolution, even after a big argument... We kind of both just walk away because everything gets so emotionally charged that there isn't really a resolution. And then you don't really want to come back and revisit it because of what happened the first time, so it's kind of like, 'Well, let's just avoid that.'" (8B)

The provision of support does not always land well. For example, one partner with BPD stated: "He copes with it and supports the best way he can. I see that, I do, but sometimes I wish he would understand so he could help support me in the way I feel like I need at the time" (9A). Transparency facilitates more open communication. For instance, one partner stated: "I needed to be honest about my emotions so he could be supportive" (3A). Others noted they were unable to articulate emotions. For instance: "I'll get upset or mad and I won't be able to articulate why I'm upset or mad, so I just have to like go sit off for a while think, 'OK, what is actually upsetting me right now?'" (4A). In the height of BPD symptoms, some partners with BPD are unable to be vulnerable. For example:

> "Usually, I'll wind up getting hurt and breaking something, which just blows up the situation more, and then he'll say, 'Hey, let's take a breath…' and it's, 'Well, what the hell, take a breath? Like fuck you, what do you think this is?' Or if I'm really anxious, I know that he'll come from a really deep place of caring, and… My body and everything feels so foreign and gross… I don't want him to see me so vulnerable even though he's really the only person who I would want to see me like that." (3A)

Negative Appraisals of BPD. Negative appraisals of BPD interfered with adaptive dyadic coping. When BPD was perceived as a problem, couples blamed their relationship issues on BPD and experienced shame, hopelessness, or helplessness. To illustrate, one couple agreed:

"B: If it weren't for borderline personality disorder, I really think that we would be one of the best adjusted, least prone to fighting couples that there is. A: It's true" (1). BPD can contribute to relational resentment. For example:

> "When things were bad in the relationship and since I saw these symptoms in her, I would put more of it on her, like, 'This is all your fault,' or, 'Things are bad right now because of you,' or, 'Our intimacy problems are because of you, because you have this (BPD).'" (9B)

Shame appeared to contribute to relational conflict as one couple (9) noted:

A: "I just felt like I was going to be labeled like a crazy person… I felt crazy."

B: "If I brought up BPD, it was just triggering. Like just saying 'BPD' instantly triggered her."

Shame invited partners with BPD to behave defensively. Partner 8A stated, "But I think the way that borderline affects our conflict is me feeling attacked, me feeling like I have to constantly defend myself. And then when borderline gets brought up in an argument that can explode everything." While her partner described how feeling attacked is an obstacle to conflict resolution:

> "As soon as she feels like she's being attacked or maybe you're disagreeing because you don't think her idea is good or her stance is good, then the emotions come in and then once the emotions come in, then all rational stuff goes out the window and then it's a completely different topic altogether." (8B)

Couples that were struggling to manage BPD felt hopeless and helpless, which fueled disconnection. BPD recovery is often non-linear, and hopelessness sabotages the relationship:

> "I thought we were good, I thought we knew how to manage this, and I thought you would become this stronger person than you had been before. So, it hits hard. It's hard not to feel like, 'God. This is going to be the way it is 'till we die.' Because how do you fix this? We want to fix it and we felt like we fixed it and then it's not fixed. You don't even know where you went wrong." (1B)
>
> "There's been times where she's tried to verbalize it to me and there's just no way I'll understand. I put a lot of what she tells me together with a lot of the stuff I read and it's just impossible to understand unless you have this disorder, like, I've come to that realization." (9B)
>
> Another couple (2) felt helplessness when working together to regulate a BPD episode:
>
> A: "I'll walk into the room, and I'll just start crying and saying I'm worthless and a piece of shit and just like, 'Nothing's happening, nothing's going for me, I'm a failure.'"
>
> B: "And then in those moments it's really hard to remind her of truths... It's hard to make her believe those things. I can sit there and affirm how I feel and the positive aspects that I see in her. But depending on the severity of the mood, sometimes I can help, and sometimes I can't. Sometimes time is the only thing that allows that to really pass."

Skills Deficits. Deficits also prevented effective coping with BPD including not knowing how to support the partner with BPD and a lack of conflict resolution and external supports.

Many partners without BPD initially had an insufficient understanding of BPD. One noted: "In the beginning, I handled it wrong. So, when her symptoms would show up, I would not know what I was dealing with at the time. So, I would handle it the wrong way in the early years," (9B). Similarly, another said:

> "I could see ways where I help, but I do know ways where I don't help and where I make the situation worse or make what she goes through worse. But I think it's just 'cause I don't understand what she's going through, and I don't understand the disease (BPD) myself." (6B)

Not only did these couples not understand BPD, but they also were unclear about how to be supportive. For instance, couple 7 shared:

> A: "That was a really bad adjustment period 'cause Partner B's mental health really went downhill too because she didn't know what to do to help me because usually it was like she could do something about it. But this time it was like nothing was working. She was tired. So tired from just trying to stay positive for me all the time."
>
> B: "There was nothing I could do, I got super depressed too for a few days, if not a week. That was a pretty rough time for both of us."

These couples lacked conflict resolution skills which stunted their ability to cope with BPD. To illustrate, one partner stated:

> "I would say that I communicate, but not in the best ways. She doesn't say nothing at all… I don't really know how she feels most of the time. And her body language might tell me something else than what she may be actually feeling so I just kind of distance myself and then that pisses her off, 'cause I don't know how she really feels, she might actually be wanting me right here by her side talking to work or comforting or some type of way. But I don't know that… I don't wanna argue. I just want it to be good, so I just stay away, but it's her thinking I wanna go do something else or have other things that's more important but I just don't want to piss her off." (6B)

Similarly, couple 8 described their converged understanding of their conflict:

A: “Our conflict has been really bad, to the point where you know we’ve been on the verge of divorce multiple times. It’s gotten to the point where it’s difficult for us to resolve.”

B: “It seems like what happens is she takes it personal, then it gets emotional. Then she raises her voice and starts yelling and then I get upset. Now I’m angry and then the thing that we were actually discussing is gone and now the whole fight is something completely different and we’re talking about something I did, or she did six years ago.”

A: “Yeah, 20 different subjects.”

B: “Yeah yeah. And then you know, nothing ever gets resolved in that.”

The lack of external supports, such as therapy, also constrained couples’ efforts to cope with BPD. Although some couples reported the need for the support of therapy, some were simply unable to afford it. For example, one participant stated: “We’re trying to find a way to go to therapy and do it where it’s cheap and find something that works for us... With just the two of us and nobody to go… It’s hard” (6B).

What BPD Demands and Provides: The Double-Edged Sword of BPD

Couples described BPD as a double-edged sword that demanded relational energy and skills, but also required them to activate adaptive dyadic coping. In essence, BPD as a relational stressor served as a catalyst for the development of adaptive relationship skills. Partners with and without BPD converged in agreement that BPD served as a catalyst in this way.

Navigating BPD as a Couple. Couples described the demands of BPD as straining:

“It strains it, it makes it to where we’re good for like a week and then I’m off and I say hurtful things. And then for a couple of days or a week, we’re not good. So, it’s almost like a teeter totter where we go back and forth.” (10A)

Another participant shared a similar sentiment:

"The whole nature of the disorder is to make things out of hand, to blow things out of proportion, to go from, 'I don't like what you did,' to, 'I don't like you,' to, 'Go away forever.' And it doesn't take much to get from one to the next or the next, so to actually put into practice the sort of like, 'OK, let's pump the brakes and let's not get carried away,' I can't tell you how many times I've said, 'Hey, don't get carried away,'…There's a single mindedness that takes over as soon as a certain threshold of overwhelm is reached, and once that's reached, there is no getting out of however horrible it's going to end up." (1B)

Couples had to work together to decrease the impact of splitting, which was a common symptom of BPD. Couple 7 shared:

B: "You can tell me when you suspect that you're gonna be splitting soon, you're like, 'Hey, I think I'm gonna be splitting pretty soon.' You're able to recognize that you're starting to go down that path. A: Yeah, so we worked out a system 'cause nobody can predict the future. That's ridiculous. You don't even know if you're gonna be alive tomorrow. And so, we worked out a system where, if I feel like I'm starting to have those kinds of feelings, I'll sit on them for 24 hours."

B: "Yes."

A: "And if I'm still feeling the same way tomorrow, then maybe I'll say something about it, but until then, I don't even say anything because usually when I was having those feelings."

B: "They go away."

A: "The next day I would go to sleep and I would feel fine the next day."

B: “Mmhmm.”

A: “Because my emotions just change so quickly from like one day to the next. I’ll be like, ‘Oh, I don’t even know who that was yesterday.’”

Others described how ongoing symptom management of BPD requires continuous commitment to adaptive dyadic coping:

> “I think in a relationship that didn’t involve BPD or any personality disorder… those things (skills) could kind of just be seen as, ‘Yeah well, so we don’t communicate sometimes. Oh well, whatever we’ll get over it...’ It’s like, ‘No, this has to be like a daily process,’ and it’s not just, the doctor says we should communicate more, or my therapist says we need to talk. It’s like, no, we need to or else… It’s not just going to be detrimental to our relationship, but it could be detrimental to the person going through recovery too.” (3B)

BPD as a Catalyst for Building Adaptive Relationship Skills. The development of effective relational skills was required to engage in adaptive dyadic coping in managing BPD. Relational skills played an integral role in promoting the health of their romantic relationship. The couples that lacked adaptive relationship skills converged in agreement that they would have been beneficial in reducing the relational stress of BPD. For instance, participant 3B stated: “I think it makes it so that because of BPD, I understand that these things have to exist in our relationship, the strengths and how we communicate… The BPD diagnosis makes it so that these are necessities, not options.” Couples illuminated the complex relationship between BPD, the necessity of therapy, and the development of relational skills. For example, one participant stated: “I mean, I’d say the BPD triggering going to therapy, triggering the better communication skills that probably helped” (4B). Couple 5 shared similar converging sentiments:

A: “I think it’s helped our relationship a lot, that’s my perspective on it, because I have such good strategies now for what I want in a relationship, for getting what I want in a relationship, for communication, like... I mean. It’s definitely the best thing that could have happened for any future relationships for me. Because I was, I had so much trouble building and keeping relationships up to this point…Yeah, it’s a positive growth. We have positive experiences to share with other people.”

B: “We do. We do.”

Superordinate Theme Three: Adaptive Dyadic Coping with BPD

Although some couples were still working towards interpersonal effectiveness, most couples were successfully coping with the relational stressor of BPD. Interpersonal resources developed over time and assisted couples with adaptive coping. Couples that accessed adaptive dyadic coping no longer described BPD as a barrier to relationship satisfaction. Both internal and external resources assisted in the development and maintenance of adaptive dyadic coping. Internal resources included attunement, intentionality, maintaining a growth mindset, and the mutual externalization of BPD. External resources included accessing individual and couple therapy and increasing knowledge of BPD. Most couples described a timeline of seeking therapy and more information about BPD, which helped them identify and build the relational resources necessary to promote adaptive dyadic coping over time.

External Resources

Couples identified external resources such as therapy and accessing information about BPD as promoting adaptive dyadic coping. Couples explained how these external resources were integral in their journey towards successfully coping with BPD. Partners with and without converged in agreement regarding the external resources that supported their relationships.

Therapy. Couples described how attending therapy improved their relationship in the context of managing BPD. Therapy provided couples with interpersonal skills, as well as skills for managing BPD symptoms; these resources promoted increased dyadic coping. One couple attributed their increased communication skills to each partner's therapy experiences:

> "I think this is the first relationship where I've actually had such good communication because at this point, I've been through DBT therapy, which helped me quite a bit, understanding, being able to understand my own emotions and just being mindful of situations and not making assumptions about my partner. Those have all been pretty serious problems in the past, but now that's just so much easier now that I actually have strategies to do that. And I'm still in therapy so that helps too with communication." (5A)

This couple (5) went on to discuss how therapy for the partner without BPD helped the couple to change their negative interaction patterns that had previously been not only an obstacle to managing BPD, but a trigger to BPD symptoms:

> A: "So it's like as Partner B is working through some of her things in therapy there have been some things that will be triggering for Partner B… It's been a conversation that's kept getting pushed aside because I think neither one of us wants to experience those heavy emotions that Partner B is having."
>
> B: "Yeah, I don't like my feelings either. I don't want to talk about my feelings. But that's part of what I'm working on [in therapy], is being able to acknowledge them and being able to talk about them, and not put them on Partner A and communicate them when they come up. Just be aware of them."
>
> A: "Yup, and then I've learned to try and prompt the discussion more."

One couple (4) described how therapy provided them with skills that protected their relationship from the potential negative impacts of BPD:

> A: "I don't think it's impacted us super negatively because I've learned a lot of coping mechanisms. I have been going to therapy for a while now…"
>
> B: "Yeah. I mean, we definitely had conversations outside of the individual incidents, especially as she started going to therapy and got better at articulating, 'This is what I'm feeling. This is how I need you to act during those times.'"

Another couple described attending therapy as an essential component of managing BPD:

> "Does your partner who has BPD have a therapist? Are they actively seeking therapy right now? Are you actively seeking therapy right now? If you aren't, then you need to and if you don't think that that's necessary, then you are probably not going to have a very good time, unless you have a really, really, really good support network.'" (3B)

This same partner without BPD described how therapy has been resourceful to him:

> "Having someone to constantly be telling me, 'Well, OK, that's a cognitive distortion, what do we do? OK, we label it and then find a rational response to it that's more in line with reality, et cetera, et cetera.' And you know, just challenging those core beliefs that were fueling my interrogations and inquisitions sometimes when she would have an episode." (3B)

Therapy provided couples with resources to increase their relational skills and better equipped them to effectively respond to and cope with the presence of BPD in their relationship.

Accessing Information about BPD. Increased knowledge of BPD was an integral resource for couples. This increased knowledge allowed couples to contextualize the episodes and symptoms of BPD, which in turn enabled them to respond to BPD rather than react to it. One couple described how awareness of BPD has been helpful:

> "It's helped me to have kind of a toolkit to reach into or just a knowledge base of like, 'OK, I can interpret these things through this lens now and understand them a little more clearly.' Like big fights or just big emotional moments, I have a better perception of those, then I think I would otherwise knowing that Partner A has BPD and having talked so extensively about it, and I think that that really helps just like to navigate our relationship." (2B).

Another couple described how contextualizing relational stress in the framework of BPD promotes understanding and togetherness:

> "I think the thing that has kept us together, ironically enough, was getting my diagnosis and understanding a lot of the conflict. Even though the conflict has been still been very, very difficult and hard to get through… We understand a lot of it now, so in some ways it has helped. I think that's one of the reasons we're able to stay together." (8A)

A contextualized understanding of BPD appeared to decrease a number of the obstacles identified in the previous section (e.g., disconnection, negative appraisals of BPD and blaming BPD, personalization, lack of conflict management skills). For example, one couple described how an increased understanding of BPD promoted empathy, and said empathy served as an antidote to disconnection: "I've done my fair share of research on what it's like to have it, and I can only imagine the pain she goes through sometimes. So, I try to be sympathetic of that. Put myself in her shoes" (7B). Another couple described how knowledge of BPD helped to decrease negative appraisals of BPD and increase adaptive coping:

> "I would definitely reiterate: Read, teach yourself. As a partner of someone with BPD, the more you can learn about BPD, how it presents itself, what your partner may be experiencing, the more perspective you can gain on that, the easier it becomes to extend

> that grace that I was talking about. Because if you don't understand it, you get into it, like when we first started dating, we'd get into a fight and sometimes Partner A would be like off the handle angry and I'm just like, 'What? Where is this anger coming from?' And the more I learned about BPD, the more I realized, 'Oh, OK, that is a symptom of BPD.' Like anger as though I'd just murdered a puppy in front of her face. It's like the highest level of intensity that you can possibly experience, and I don't know what that's like. There are very few times in my life that I've been that angry… It definitely helped me to gain a lot of perspective and as I kind of immerse myself more in a world where I encounter more information about BPD and more people's experiences with BPD, it's opened my perspective up a lot to be able to understand better what Partner A is going through in these times." (2B)

Internal Resources

All couples identified internal resources that promoted adaptive dyadic coping in the context of BPD. Internal resources were necessary to overcome the obstacles of BPD described in superordinate theme two. The activation of these resources strengthened couples' abilities to cope with the stress of BPD. These internal resources included emotional attunement, intentionality, having a growth mindset, and the mutual externalization of BPD and presented cognitively (e.g., perspective-taking, dedication, self-awareness, depersonalization, externalization), emotionally (e.g., compassion, hope, patience), and relationally (e.g., empathic responding, boundaries, vulnerability, communication).

Attunement. Emotional attunement strengthened couples' abilities to cope with BPD. Attunement was comprised of perspective-taking, compassion, validation, empathic responding, vulnerability, and support. Couples that were attuned were able to adopt one another's

perspectives, which increased compassion between partners. One couple described how perspective-taking increased compassion:

> "I think on a day to day it can be difficult to navigate the shifts in mood. We will be driving somewhere or going to visit friends or even just coming back to the house and then all of a sudden, Partner A is like, deeply sad. Or really irritated. And I can tell. Her body language shifts and the way she talks and communicates shifts and I'm like, 'Hey what's going on?' And sometimes there's a wall there of, 'I can't even communicate this. I'm just in it right now.' And then, other times, it's like, 'I'm just really sad and I can't tell you why, I'm just devastatingly sad right now, or I'm super irritated and I'm not irritated at you, but I am mega irritated.' To compare it to myself, I think that when I have those really strong feelings, I'm able to take a little bit of time to myself and breathe it out and kind of come back to a normalcy. I know that with BPD it's a lot more difficult for Partner A to get out of those extreme emotions. Coming back to normalcy is a much more arduous and labor-intensive process." (2B)

Another couple illustrated how perspective-taking increased compassion:

> "Just the fact that you know you had that horrible experience from the moment you were born, the people who were supposed to be your protectors and caregivers didn't meet your most basic needs, and so that really messes with things, especially so young and how all your neurons are getting mapped out and built in that time. That was at that essential time. What you learned was that people who were supposed to love and help you were going to hurt you. And so, it makes so much sense to me, like the brain is so really brilliant that it has these defenses that it then builds in and so knowing that is very different for me than just having a partner who says shitty things sometimes when they're

upset. If it was that, I probably would eventually have to work around to 'Why am I doing this?' Not that it gives you an excuse but understanding why you're wired that way gives me empathy and understanding." (10B)

This increased compassion led to increased communicated validation and empathy between partners; partners communicated their compassion for one another in the form of validation and empathic responding. Communicated validation and empathic responding were imperative in navigating the impact of BPD on the relationship, as illustrated: "He will be like, 'I can see why you think that way… Let me at least say that I understand your perspective. Let me validate you.' That's important, validating me is so incredibly important and he's very good at that" (2A). The communication of compassion was strengthened by genuine empathic responding: "It [compassion] can't just be like IT support. 'Did you turn it off and back on again? Did you try thinking about it this way? Did you try?' You know... it has to actually be genuine" (3B).

Partners that offered one another compassion in the communicated forms of validation and empathic responding created more emotional safety; partners that experienced their partner as validating and empathetic felt more comfortable sharing their emotional experiences because they knew those experiences would be received with compassion. This emotional safety promoted increased vulnerability wherein partners were better able to access and share their emotional internal worlds. Vulnerability also promoted discussion of each partner's emotional experience, described by participants as "openness" (5B). Openness increased the capacity for more in-depth understanding of one another's experiences, which allowed for increased attunement between partners, as increased understanding of one another's experiences bolstered partners' abilities to adopt one another's perspectives. One couple stated: "I definitely try to be

really open about everything that's happening. Especially if something that we're experiencing has triggered me. Just really open and honest about what's going on" (5A). Openness also strengthened partners' abilities to support one another, as openness promoted dialogue surrounding each partner's needs regarding relational support. One couple explained how openness promotes support:

> "Now it's easier and I think we have a much more supportive relationship and I think I can directly ask for support more now because I've learned how to, and I've learned how to actually accept help and love to a certain extent, because I know before, I would be kind of combative and I know I still can be sometimes, either unwilling to ask for help or unwilling to explain a situation and just acting crazy, but not explaining, you know, 'I'm under a lot of distress right now.'" (3A)

Couples' supportiveness assisted in managing the stressors of BPD. To illustrate:

> "Yeah, I do, I try to be as supportive as I can… I wanna support her and hopefully, I know there's no magic here, and it's (BPD's) not just going to go away... This is what it's going to be forever, there's just you know, better ways of dealing with it and acknowledging it to make it easier to navigate." (8B)

Another couple explains the imperativeness of support in managing BPD relationally:

> "Just being supportive, incredibly supportive, whatever your partner needs to do. Whether it's finding a new therapist or leaving a therapist, or whether it's a step forward, a step back, or you're just hanging out in space for a certain amount of time. So don't worry about it, just keep supporting each other and I think that's the main takeaway." (5B)

Intentionality. Intentionality was another integral resource in adaptive dyadic coping with BPD. Intentionality related to self-care, self-awareness, open communication, and establishing clear boundaries, all of which strengthened couples' abilities to cope with BPD. Intentionality in the use of these resources reduced BPD symptoms, interpersonal conflict, and caregiver burnout over time, and also promoted adaptive dyadic coping.

Intentionality in self-care was important for coping and reduced caregiver burden for partners without BPD. For example, one partner without BPD stated, "I need me time to recharge so that I can then be what Partner A needs me to be" (2B). The importance of intentionality in self-care was mutually agreed upon as beneficial. Couple 7 illustrated:

> B: "I'm just really easily able to not have to sacrifice my own health at this point for someone else. And it's not really a boundary I had to establish; she's always understood that. Matter of fact, she's had to push me to do that 'cause it's not something I always did at the beginning of the relationship, it was more… I would do whatever I could to ease her splitting, help her calm down and stuff… I don't think I've ever not taken care of myself, do you? I've always been pretty good about doing that 'cause I mean, I can't take care of her if I can't take care of myself."
>
> A: "And I take care of you a lot too… It doesn't just go one way or another."
>
> B: "Yeah, and helping her get through those episodes helps me out in a way too 'cause I feel better knowing that we can get through it together."

When partners without BPD engaged in intentional self-care, it reduced shame for the partners with BPD who often perceived themselves as a burden. For instance: "It's nice when I see you actually take the space for yourself 'cause then I don't feel like a burden or like I'm a trigger in your life, or like you have to deal with me" (3A).

Effective communication was another essential component in navigating the relational stress of BPD. Effective communication promoted understanding and facilitated the opportunity for couples to create shared meaning around their experiences of BPD. For illustration, one partner said: "You need to have communication skills, or it needs to be brought to attention. Shouldn't be something that should wait. I think the boundaries and the communication things need to be worked out in the beginning" (6B). Other partners without BPD remarked:

> "Communication skills. There was a point this last year where we weren't really talking a lot, like we were spending time together, but we weren't communicating quite a bit and I noticed it, and I was kind of bothered by it and I was like, 'Can we eat in the kitchen and not just go straight to watching TV?' Because we need to have time to talk about things. I need this time and a space to be able to feel like I can communicate these things." (5B)

Couples distinguished effective communication from non-effective. To illustrate: "Communication is a big thing, 'cause sometimes there is communication but it's not effective communication and it's not what actually needs to be communicated" (3B).

Couples described communication as an asset. For instance, couple 7 stated:

> A: "I think communication is one of our really big strengths. Any time we have any kind of, anything that we're not feeling OK about, we always go to the other person and say, 'Hey, we need to talk about this.'"
>
> B: "We're always talking about our feelings, even if it's like a neutral or good thing, we're always expressing ourselves. Helping each other understand where we're coming from. Discussing how we feel about the other person doing something."
>
> A: "Yeah, we always always communicate with each other about everything, yeah."

B: “Communication, trust, and respect. Those are some most important aspects of the relationship. We have a lot of strengths.”

Being intentional in setting clear boundaries also assisted couples in coping with the stressors of BPD. Couples who felt they were successfully managing BPD set boundaries that protected against resentment and caregiver burden. One partner with BPD described how her partner “has been honest about… when it’s too much” (2A). Other couples echoed the importance of boundaries. As illustrated by couple 7:

B: “I’d also advise people who are with someone who has BPD and they don’t have it or they don’t have it as bad, they also need to take care of themselves. You can’t let your partner do exactly that and take everything out of you.”

A: “Yeah.”

B: “Drain everything out of you. You have to set boundaries and they have to be understanding of that.”

A: “It’s true.”

Couples described holding themselves responsible for their own reactions and behaviors. Couple 10 stated:

B: “I always feel like I should be able to pull back and not engage and be better at identifying when you’ve kind of flipped into that and I’m not perfect at all. Probably I don’t even think I’m good at that. Maybe a little better these days. And then I kind of get to that piece for like, OK, but when we get into it then I can say hurtful things too and I don’t feel like… Like not excuse, but I understand why you do it. I feel like I should be more able to not do that in return, so uhm, I definitely have some guilt around that.”

A: “It’s not your responsibility to have to pull back or to do these things. I’m responsible for my emotions and feelings and actions, and that doesn’t mean you are.”

This was echoed by another couple (2) who described similar boundaries:

A: “It’s also not a partner’s job of the person without BPD to fix any problems the person with BPD has. I mean, it’s nice to be a support system for them… The partner needs to self-preserve if they feel like it’s gone too far and recognize that they can only do so much before they have to leave that partner with BPD. It would be horrible if Partner B felt trapped with me in a relationship, I would feel incredibly guilty and I’d rather him not stay with me if that was the case.”

B: “Healthy and openly communicated boundaries are super important.”

Boundaries also protected these couples from allowing BPD to serve as an excuse for harmful behavior. For instance, 7B said: “Her BPD is a reason for her actions, but it’s not an excuse so we got it. We talk about it. And I’m very understanding, and I know that it isn’t easy.” Similarly, 2A stated:

“In a fight with Partner B, I would never say, ‘Well, I said that to you because I have BPD.’ Sometimes I say that stuff and I’ll be like, ‘Oh shit,’ like, I can’t think that. A big, big slogan is that like, BPD doesn’t excuse the behavior, but I can have empathy for myself for having it and not being more lenient on myself like, ‘OK, you might be experiencing this stuff because of BPD, but you need to work through this stuff now that you recognize it, you recognized it now, but you need to work through it. It’s not an excuse anymore.’”

Couples' intentional use of self-awareness increased their insight and understanding of their individual roles and their shared relational process. Awareness of past trauma was mutually acknowledged by couples:

> A: "I typically bring a lot of past trauma into my fights with Partner B. Not like, 'Well, this happened to me,' but like you know, this fear of like, 'This could happen to me again because it's happened to me, and Partner B might do this to me.'"
>
> B: "Our fights can be really brutal. I certainly wouldn't say that it's entirely BPD, we both have a lot of past trauma that we carry into fights, and I think that splitting and binary thinking can lead to more intense fights." (2)

Another couple (5) explained how they utilized self-awareness in order to increase understanding and shift their interaction patterns. They mention how they accessed supportive external resources such as therapy which bolstered this process:

> B: "I did have a hard time communicating. I'm better now… I'm very good at making things seem like they're fine."
>
> A: "When they're not fine."
>
> B: "When they're not fine, yeah. I have a hard time being confrontational."
>
> A: "If I didn't know that something was wrong and I've just been doing it over and over again for the past, however long, that's just like, 'Oh no! Oh!' It makes me feel terrible.
>
> B: Yeah. But I don't know how to say anything when it's small... For me, it's like, 'OK. It's like one thing and one thing…' But then it grows to be a big issue for me. And then when it all comes out, I have an emotional dump on Partner A. And Partner A is like, 'You haven't shared this! How long has this been going on?' And then that can send Partner A off on a spiral."

A: “Yeah.”

B: “She's like, ‘I didn't know there was anything wrong this whole time, I didn't see this.’ Because I didn't tell you… That's why I go to therapy. To talk about how to talk about my feelings.”

Other couples discussed the importance of self-awareness in facilitating understanding of their relational dynamics, as well as in facilitating accountability for partners with BPD:

“There’s definitely been times where I can see him tense up or anticipate me to react a certain way. Which is totally understandable and even in the moment, a lot of the time for me, I’m like, I understand why the anticipation for me to have a negative reaction is there.” (3A)

One couple (7) described a similar process marked by self-awareness and accountability:

A: “And also. It takes two people to make a relationship work, so it’s not just about the other partner that doesn’t have BPD. The partner with BPD has to put in the work too.”

B: “Yes.”

A: “Because you're doing things that are trying to make your emotions feel better and like frantically trying to avoid abandonment, whether it’s real or not, but you’re also hurting other people because you’re trying to protect yourself. So, you have to recognize those kinds of behavior and do something about them. Like, ‘Yeah, you’re doing that, but what can you do for the other person?’ Because if you love that other person and you don’t want them to leave you, you have to take responsibility.”

Commitment to Growth. A mutual dedication to reducing the impact of BPD was part of a growth mindset (i.e., viewing the self and one’s partner as capable of growth and change over time) that in turn fostered relational longevity. Relationship longevity was maintained by

couples' commitment to growth; they used their growth mindsets as motivators to foster longevity of their relationships. This commitment to growth fostered a mutual dedication to reducing the detrimental impact of BPD and to fostering relational longevity. For instance:

> "I'm always going to do my best to be supportive of whatever struggles we go through together because every struggle she goes through is a struggle that I go through 'cause it's a team effort at this point, like, we're married, so every issue that we have any problem we face, it's going to be faced together. It's not a solo effort anymore. We're not facing this on our own." (7B)

Other couples echoed similar sentiments:

"We want to be together, and we want to have a future together. Having that singular established goal as like the driver behind all of the effort in our relationship really helps. We have a point; we have a purpose. So even in the midst of really angry fights, it's like, 'No, we still want this. We still want to come out the other side of this together.' So, like whatever work that takes, whatever communication we have to do to figure out, we're gonna do it… I've consistently affirmed to her, like, 'Hey, I'm not going anywhere.' I'm in this." (2B)

Maintaining a growth mindset increased couples' capacity for coping with relational stressors of BPD; they saw their relationships as works in progress which protected against the impacts of relational stress introduced by BPD, as they did not view BPD as the pitfall of their relationship but rather as something to be worked through. This commitment to growth comprised of hopefulness, dedication, willingness to change, and patience. Couples discussed how the growth they have experienced throughout their relationship promoted increased hope for future progress, which contributed to their growth mindsets. One partner described how the experience of progress in the context of his relationship increased his hope for one day attaining

a functional relationship: “I used to think that most if not all relationships were dysfunctional and, I don’t believe that anymore.” (3B). Couple 7 echoed sentiments of hopefulness:

A: “Yeah, I mean in the beginning it was much more of an issue.”

B: “Yeah.”

A: “But we got through the hard parts and it’s much easier now.”

B: “At this point I can only see it either getting better or staying how it is.”

A: “Yeah.”

B: “Which right now it’s doing very well.”

Another couple further described sentiments of hope:

> “There was definitely a time when I believed that I didn't have anything to bring to the table... I thought it would be impossible for anyone to be able to handle what I had going on. I was concerned about telling people about it because, even my own thoughts about borderline personality disorder, because it has so many different presentations, I didn’t think that I could possibly have it. I had this very negative idea of what it was, so I was worried about that, and I did not know that I could ever possibly have a relationship this close and this healthy… I’m so grateful for what I have now. It makes me look at myself with a little more compassion in that way. It’s like, ‘You’re great, you’re fine, it’s OK.’ It’s really cool. It’s possible to have a healthy relationship and have BPD.” (5A)

Dedication also served to strengthen commitment to growth, which in turn fostered relationship longevity. One couple described their dedication:

> “We’ve had challenges, but when we face them, we face them together and there’s a lot of communication about it. We just try to keep as open communication as possible… We

have challenges. But we get through it. I think we get through it together really, really well." (5B)

Mutual dedication to the relationship promoted relational longevity. For example, one couple stated:

1A: "I guess, in part, his devotion to the relationship. No one has ever been devoted like that."

1B: "I know we both really want it to work. A: We both really want it to work."

A willingness to change was another integral part of fostering the growth mindset that helped to promote relationship longevity. To illustrate: "We're very willing to grow and find other ways to make our relationship more stable and more accessible for both of us" (3A). Couple (5) similarly stated:

B: "Come to be open to listening to new ideas, to be open to each other and to be open to change. You meet some people and they're like, 'No, this is what I do. This is all I am and I'm not doing anything for you.' Take it or leave it kind of a situation."

A: "Yeah, it's like rigidity."

B: "Yeah."

A: "I really value that you can go with the flow."

B: "And I want to do better. You know, I'm always trying to do better for myself or my partner, for the people around me."

A: "Such a kind, caring human being, and yeah. Trying to do better."

Patience was another resource that bolstered the commitment to growth that fostered relationship longevity. For instance, couple 7 shared:

B: "Patience. That's what comes to mind first."

A: “Yeah, definitely.”

B: “You definitely can’t expect it to get better overnight. Or even like after a few months. This is something that takes years of work.”

Another couple (3) described a similar sentiment:

B: “What borderline personality disorder does to our relationship or what it means to our relationship, is that it takes a lot of patience on both parts.”

A: “Probably more so on yours, though.”

B: “Yeah, exactly, that’s what I was gonna say.”

A: “Yeah, yeah.”

B: “But yeah, it does take a lot of patience and sometimes it’s hard to find that, but… I think that’s a key thing, is having patience.”

Another couple illustrated the value of patience, given the non-linear trajectory of BPD recovery:

“She kept apologizing, I’m like, ‘Dude it’s OK, I understand, you're in a really, really bad place,’ like, ‘You’re in between counselors, and you had this really triggering event happen and it’s just completely thrown you for a loop and it’s fine.’ I know she is struggling but I knew she was going to try to seek out help again… So, like when she is off, I know she’s going to come back, I know she’s going to work hard to try to fix things.” (5B)

Externalization. When BPD was externalized from the diagnosed partner and from the relationship, internal resources (e.g., attunement, intentionality, commitment to growth) were more accessible, which promoted adaptive dyadic coping with BPD. Externalization also reduced obstacles (e.g., personalization, blaming BPD, shame of BPD), which also promoted

adaptive dyadic coping with BPD. When BPD was mutually externalized, BPD was seen as separate from the partner that was diagnosed with BPD. To illustrate: “It feels like I’m fighting with BPD sometimes instead of Partner A” (2B), “I know it’s not Partner A, it’s the BPD” (5B), and “I was thinking that you understood it was your BPD, it was not you” (7B).

Viewing BPD in the context of trauma promoted mutual externalization. To illustrate:

> 10B: “I think the most important thing to me in defining it is remembering that it’s a reaction to your childhood trauma, and that is really important to me. I almost wanna say it’s similar to the fight, flee, fawn thing.”
>
> 10A: “It’s a reaction to trauma for one, and it’s a defense mechanism, even though it’s not a good one.”

Some partners with BPD experienced less shame when couples mutually externalized BPD, as they felt their partners without BPD understood their experience of suffering at the hands of BPD rather than judging or blaming them for their BPD symptoms. One partner with BPD explained: “It’s validating to know that he knows the symptoms that I have aren’t my fault” (4A).

Externalization of BPD also facilitated depersonalization of the behaviors of partners with BPD during episodes of increased symptomology. One partner without BPD stated: “Now when we have these big fights, I know it’s not that you just hate me, there’s other things at play” (9B). Other couples described how externalization of BPD promoted depersonalization. To illustrate:

> “There can be unexpected outbursts and what seems like ridiculous or outrageous reactions to something. But knowing that BPD’s there, you realize that you can’t

personally get involved with it or take it personally, you have to just see it as that's just what's happening and go with the flow, but don't get swept up by it." (3B)

Couple 4 echoed converging sentiments regarding how depersonalization is made possible by externalization of BPD:

B: "Sometimes when something goes wrong and you just break down, it's her but it's not her reaction to me specifically, so it's not on me from her. It's just, that's what her brain does when in these sorts of circumstances, and knowing that doesn't make me feel bad about myself for that…"

A: "It's refreshing. Especially since I've been in relationships where there was not that sort of like understanding and support, it was just, you know, 'You're upset, you need to get over it, you're an adult. Why are you this upset over such a small thing?' It's refreshing… I know that that's not something that people typically have to do in relationships, so I appreciate it."

When couples externalized BPD, partners without BPD were better able to engage in their role as a support to their partner with BPD. For example:

"Once you kind of realize that the emotion itself isn't like a thing that can be logic-ed away, it's not that you're upset because XYZ, you're upset because your brain is just kind of being an ass right now. You kind of learn to take a different approach where, I could argue this away if I was feeling this way, but this person is not me. They're not feeling it for the same reason. I have to take this other approach, which is often just… hugs, tea, watching something stupid." (4B)

"Knowing that she's struggling with that [BPD] makes it easier to accept or deal with some of the stuff that maybe I wouldn't deal with in other personal relationships. You

know the arguing and stuff like that. Knowing that there's a reason why she gets so angry... It makes it a little bit easier to be OK with it, I guess, it's like, well, we're working on this." (9B)

"I guess if I was in a relationship with somebody that wasn't diagnosed with borderline or whatever and our interactions were that way, it probably wouldn't be a relationship that I would stay in, but because I understand that she's struggling with that, it makes me wanna help her work through it." (8B)

Couples that mutually externalized BPD also collaborated as a united front against the influence of BPD as a relational stressor. To illustrate: "You definitely can't let them do it [cope with BPD] alone. You have to do it with them" (7B), "I didn't have to do this on my own" (8A), "We've had challenges, but we face them together" (5B), "I think we're a really good team" (3A), "Having a goal post to work towards together, knowing that we want to get to that goal post together definitely helps" (2B).

As illustrated above, couples that externalized BPD were better able to tap into resources to buffer against the impact of BPD; they were better able to access adaptive dyadic coping in the context of BPD. Increased adaptive dyadic coping also helped to quiet the symptoms of BPD, which in turn contributed to increased relational satisfaction for both partners. Couple 7 described convergence in how having externalized BPD allowed not only for couple collaboration as a united front against BPD, but also helped to quiet BPD symptomology:

A: "I've never really had a successful relationship with BPD before. Until now, all it's always been like, 'I can't do this anymore.' I'm gone.' And everyone leaves."

B: "Or you get taken advantage of or abused or…"

A: “Or I get taken advantage of or abused or something like that. So, this is new for me, but it’s nice because it’s like… I have had to do a lot of work on myself to make it work too and it’s like, it’s only working because I found someone who is actually willing to do the work with me.”

B: “We’re learning it together.”

Overall Findings

Overall, increased individual (i.e., partners with BPD and partners without BPD) adaptive coping with BPD served to lessen the severity of BPD symptoms, which decreased relational stress imposed on couples by BPD. Decreased BPD symptoms and consequent decreased relational stress promoted couple access to adaptive dyadic coping with BPD. Engaging in adaptive dyadic coping also had a positive effect on BPD symptomology; when increased adaptive dyadic coping was present, BPD symptoms quieted. Couples that engaged in adaptive dyadic coping utilizing external (e.g., therapy, accessing information about BPD) and internal (e.g., attunement, intentionality, commitment to growth, externalization) resources fared better in overcoming obstacles (e.g., internalization, disconnectedness, negative appraisals of BPD, skills deficits) associated with BPD. Adaptive dyadic coping served to reduce the negative impact of BPD on relationship satisfaction and longevity.

CHAPTER V: DISCUSSION

This study was one of the first qualitative studies that used dyadic data to examine the experience and impact of BPD on couples' relationships. Such research is needed to explore the systemic dynamics of couples with a partner diagnosed with BPD (Beeney et al., 2019b; Bouchard & Sabourin, 2009). Three superordinate themes were derived pertaining to (1) the lived experience of BPD among individual partners (i.e., both partners with and without BPD), (2) the shared experience of BPD as a relational stressor, and (3) the ways that couples manifested dyadic coping in response to BPD. Few in-depth qualitative studies have been conducted with persons with BPD, which have primarily focused on the individual and lived experiences of the disorder and its associated stigma (e.g., Black et al., 2014; Myburgh et al., 2016; Nehls, 1999; Rivera-Segarra et al., 2014). No previous studies, to our knowledge, have focused on couples with a partner with BPD or particularly on how BPD impacts couples' romantic relationship experiences. Such research is desperately needed to give voice to what could be regarded as a marginalized community, considering the tremendous stigma associated with BPD even in clinical settings (Black et al., 2011; Markham, 2003; Markham & Trower, 2003; Nehls, 1998, 1999; Sansone & Sansone, 2013; Veysey, 2014).

Much of the previous literature has focused primarily on the experiences of BPD at the individual level. For example, studies tend to explore either the experiences of individuals diagnosed with BPD (e.g., Black et al., 2014; Myburgh et al., 2016; Nehls, 1999) or partners of individuals diagnosed with BPD (e.g., Bailey & Grenyer, 2013, 2014). Studies focused on the romantic partnerships of persons diagnosed with BPD have tended to explore relational functioning, quality, and stability and the social or relational challenges associated with BPD (e.g., Bouchard & Sabourin, 2009; Bouchard et al., 2009; South et al., 2008; South et al., 2020;

Whisman & Schonbrun, 2009). Increased BPD symptoms have been associated with relational difficulties (Lavner et al., 2015), while recovery from BPD has been associated with greater relational satisfaction, relational longevity, and adaptive relational behaviors (Bouchard & Sabourin, 2009; Lazarus et al., 2018). More recent research has examined the complex interaction of BPD and romantic relationships (Beeney et al., 2019b; Kuhlken et al., 2014; Lazarus et al., 2018). This complex interaction between BPD and romantic relationships continues to warrant further exploration. Is it that reductions in BPD symptoms or recovery leads to greater relational effectiveness or relational effectiveness leads to reduced BPD symptoms?

This study revealed a number of important findings. The first major finding was that although BPD is a relational stressor, couples with an individual diagnosed with BPD can report having a satisfactory and adaptive romantic relationship. BPD is often regarded for its association with relational distress and dissolution (Bouchard et al., 2009; Hill et al., 2008; Javaras et al., 2017; South et al., 2008; South et al., 2020), but it does not always pose a threat to relationship satisfaction and longevity (Beeney et al., 2019b; Bouchard & Sabourin, 2009; Lavner et al., 2015; Zanarini et al., 2005). Although the associated symptoms of BPD can prevent individuals with BPD from developing healthy adaptive romantic relationships (Bagge et al., 2004; Hepp et al., 2017; Russell et al., 2007), this study serves as additional evidence that couples with an individual with BPD can and do successfully adapt to BPD and find ways to buffer against its detrimental impact on their romantic relationships. Although we would not necessarily suggest that BPD serves to strengthen couples' relationships, it appears that the adaptive dyadic coping required indeed benefits these romantic relationships. BPD, like other stressors, has the potential to harm romantic relationships. However, when managed well (i.e., like other stressors), BPD can invite couples to unite against a common cause and activate a

multitude of adaptive dyadic coping skills, which in turn benefits their romantic relationships. Although partners of individuals with BPD can feel like they are walking on eggshells at times and are vulnerable to caregiver burden (Bailey & Grenyer, 2013, 2014; Ekdahl et al., 2011; Greer et al., 2018; Hoveidafar et al., 2017), couples appear to move beyond this to activate adaptive dyadic coping. Partners are not powerless to BPD, rather they play a critical role in responding to it, which in turn has the capacity to quiet the symptomology of BPD (Lazarus et al., 2018). In essence, the activation of adaptive dyadic coping mutually quiets BPD symptomology and enhances relational outcomes (e.g., couples report feeling united against BPD, feeling more satisfied and committed to their relationships).

The second major finding of this study was that couples can access resources that promote adaptive dyadic coping in the context of BPD. Dyadic coping comprises both adaptive and maladaptive methods towards relational stress management (e.g., stress communication and empathic responding function as adaptive dyadic coping, whereas avoidance of stress functions as maladaptive dyadic coping; Falconier et al., 2015). The current study offers new insight by illuminating how couples successfully cope with BPD using adaptive dyadic coping skills. Couples that can work together to combat the obstacles introduced by BPD are able to tap into resources that promote adaptive dyadic coping rather than maladaptive dyadic coping. The resources that couples in the current study accessed were both external and internal in nature and included attending therapy, increasing knowledge of BPD, and accessing attunement, intentionality, commitment to growth, and mutual externalization of BPD.

Existing research on dyadic coping suggests that when couples work together to increase their effective coping with stressors, they report greater relational satisfaction (Bodenmann, 1997; Falconier et al., 2015). Dyadic coping is defined as relational efforts to manage stressors

impacting couple relationships (Bodenmann, 1997). Dyadic coping ranges from maladaptive to adaptive coping efforts. In the current study, we refer to adaptive dyadic coping to describe adaptive efforts at managing the relational stress of BPD. Adaptive efforts include those that enrich couple relationships rather than deteriorate them. For example, avoidance is considered a maladaptive dyadic coping effort because although avoidance is a relational coping strategy, it can exacerbate relational distress (Falconier et al., 2015). On the other hand, empathic responding is considered an adaptive dyadic coping effort because it serves as a coping strategy that also enriches the couple relationship (Falconier et al., 2015).

In this study, couples described engaging in adaptive dyadic coping, wherein they experienced trust and pride in their relationship, resulting in greater satisfaction, and ultimately decreased the symptomology of BPD and the reported negative impact of BPD on their relationships. Although partners without BPD played a critical role in buffering against the deleterious impact of BPD, it was the activation of adaptive dyadic coping (e.g., shared and mutual efforts to collaborate against BPD using effective coping skills) that benefitted these relationships. This is important to note, as it may not be enough to enhance partner support in the context of BPD; it may also be necessary to promote and enhance adaptive dyadic coping among these couples. In other words, enhancing adaptive dyadic coping serves to mitigate the detrimental impact of BPD on relational satisfaction (Bouchard et al., 2009; South et al., 2008; South et al., 2020).

Couples in the current study were also able to access dyadic coping strategies that enhance most romantic relationships, such as stress communication, supportive engagement, empathic responding, and collaboration (Falconier et al., 2015). Attending to the successful management of BPD among couples is as important as examining the risks for relational distress

and dissolution. Most couples in this study described high levels of relational satisfaction that they attributed to their activation of adaptive dyadic coping. BPD was not necessarily the "relationship killer" it is sometimes assumed to be, rather, adaptive dyadic coping promotes relational satisfaction in couples with an individual diagnosed with BPD.

The third major finding of this study relates to externalization, which was a prominent component of adaptive dyadic coping. The mutual externalization of BPD promoted adaptive dyadic coping in the context of BPD. Not all couples reported mutual externalization of BPD. If either partner had not yet externalized BPD, couples faced more challenges in overcoming obstacles introduced by BPD (e.g., internalization, disconnectedness, negative appraisals of BPD). Partners with BPD who had not yet externalized BPD experienced shame associated with their diagnosis, which prevented them from accepting support from their romantic partner. They felt undeserving and even patronized by their partner's attempts to offer support. Similarly, partners without BPD who had not yet externalized BPD tended to personalize their partner's BPD symptoms. They attributed their partner's shifts in mood to their own actions, felt it was their own fault, and felt responsible for any splitting or devaluation. These couples experienced more obstacles with BPD. The mindset was fixed, and they felt hopeless and stuck.

In contrast, when the partner with BPD had externalized the disorder, they were able to move toward recovery and were more accepting of their partner's support. Partners without BPD were also better equipped to position themselves in support of their partner when they viewed BPD as separate from their partner. They did not see themselves as victims or passive recipients of BPD, but rather recognized their role and actively engaged in a supportive stance to combat the deleterious impact of BPD. They depersonalized the symptoms of BPD and recognized BPD as a reflection of underlying pain within their partner, rather than as directed toward them. This

supportive stance facilitated a reparative experience for the partner with BPD that enhanced their recovery. The mutual externalization of BPD is best understood as the cumulative effect that results from both partner's inputs.

When mutual externalization occurs, partners with BPD can see themselves as separate from their diagnosis, which allows them to accept their partner's support; partners without BPD are able to refrain from personalization, which allows them to provide support to their partner. The combination of both partner's inputs results in a mutual externalization of BPD, which promotes adaptive dyadic coping. In narrative therapy, this is referred to as the *united front* (White & Epson, 1990). Couples that achieved this mutual externalization of BPD were better able to engage in adaptive dyadic coping in response to BPD, which was manifested in attunement, intentionality, and commitment to growth. This mutual externalization also appeared to reduce shared obstacles to interpersonal effectiveness associated with BPD such as internalization, disconnection, and negative appraisals of BPD. Mutual externalization of BPD assisted couples in separating the self from symptomology and the person/partner from pathology. Couples that viewed BPD and its symptoms as separate from the diagnosed partner and from the relationship experienced greater hope and reported a willingness to change; BPD was viewed as a stressor that could be overcome by the couple. This belief increased couples' motivation to learn about BPD, tap into relational resources, and ultimately strengthened dyadic coping. Couples that successfully externalized BPD were better positioned to access other relational resources that promote adaptive dyadic coping, ultimately equipping them to overcome the aforementioned obstacles and experience relational satisfaction.

Mutual externalization promoted the formation of a supportive and compassionate united front against BPD. Previous research has suggested that BPD symptoms worsen in the context of

rejection from romantic partners and improve in the context of partner support (Bouchard & Sabourin, 2009; Brodsky et al., 2006; Kuhlken et al., 2014; Lazarus et al., 2018; Sato et al., 2020). As such, the current findings are congruent with previous research and build on extant research by suggesting that externalization of BPD may serve as a mechanism through which couples can increase the supportiveness that aids in BPD recovery. Previous research has also suggested that BPD does not always pose a threat to relationship longevity and satisfaction (Beeney et al., 2019b; Bouchard & Sabourin, 2009; Lavner et al., 2015), and that some couples, particularly those with a BPD partner in recovery, report high relationship satisfaction (Bouchard & Sabourin, 2009; Zanarini et al., 2005). Externalization of BPD from the self was associated with self-compassion and recovery efforts, which increased the capacity of individuals with BPD to engage in adaptive dyadic coping. The current study adds to our understanding of how couples navigating BPD experience their relationships, as well as the mechanisms through which they navigate relational obstacles and challenges together using adaptive dyadic coping, in order to achieve and maintain relationship satisfaction and longevity.

Clinical Implications

BPD is inherently a relational disorder. However, research has only scratched the surface in its understanding of the complex interaction between BPD and romantic relationships (Beeney et al., 2019b; Bouchard & Sabourin, 2009). Given the relational nature of BPD, couples with a partner with BPD may benefit from various interventions, particularly couple therapy. However, in order for the field of couple and family therapy to best serve couples impacted by the relational stressor of BPD, couple therapists need increased knowledge and understanding of these couples and their successful dyadic coping with BPD. Understanding of the unique challenges associated with BPD in romantic relationships, as well as with the resources that may

promote adaptive dyadic coping is essential. Couple therapists are uniquely positioned to assist couples coping with BPD by promoting adaptive dyadic coping and strengthening the relational repository of skills that buffer against the detrimental impact of BPD (e.g., attunement, intentionality, communication, mutual externalization).

Superordinate Theme One: Individual Lived Experiences of BPD

The findings of the first theme offer in-depth descriptions of individual partner experiences of BPD symptoms, the recovery efforts of partners with BPD, and the experiences of partners without BPD in their partnerships with individuals with BPD. Individual partner experiences of BPD symptoms include both the symptoms experienced internally by the partner with BPD as well as the collateral experiences of BPD symptoms by partners without BPD. Partners with BPD offered rich descriptions of their experiences of internal instability, offering first-hand descriptions of their experiences of emotion dysregulation, instability of mood, instability of perceptions, and instability of sense of self, as well as how these symptoms arise in relational contexts. Couple therapists may use these findings in order to increase their knowledge of how partners with BPD experience the disorder in the context of their romantic relationships, which may help them to increase their understanding of and compassion for these experiences. These findings also provide therapists with an understanding of the ways in which BPD symptoms are experienced by partners of individuals with BPD. Partners without BPD offered rich descriptions of their experience of witnessing and collaterally experiencing BPD symptoms in the presence of their partners with BPD, including experiencing their partner's instability, feeling uncertain as to how to effectively offer support, and the ways in which these individuals respond to the experience of partnership with someone with BPD (e.g., avoiding negative interactions and navigating one's individual impact on BPD symptoms). These findings offer

insights to couple therapists in need of understanding the experience of partnership with someone with BPD, including the various ways in which partners without BPD may attempt to alter or lessen the symptoms of their partners with BPD.

Superordinate Theme Two: The Shared Experience of BPD as a Relational Stressor

Therapists working with individuals with BPD, partners of individuals with BPD, or couples with a partner with BPD can use the findings of the second theme in order to increase their understanding of the relational stress of BPD. Rather than viewing BPD as a detrimental force acting upon the relationship and the partner of the individual with BPD, therapists will come to understand how each partner influences the dynamic relational interactions as well as the presentation of BPD. This theme offers therapists the opportunity to increase their knowledge regarding expected relational challenges and obstacles in the context of a romantic relationship in which one partner is diagnosed with BPD. Increased awareness of these challenges and obstacles (e.g., internalization, disconnection, negative appraisals of BPD, and skills deficits) equips therapists to identify these challenges and obstacles in their clients' relationships. Along with an increased awareness of these obstacles, therapists may also increase their understanding of these obstacles from a relational perspective such that they begin to view, and as such help their clients view, these obstacles as normative outcomes of maladaptive coping strategies in the face of BPD. With an understanding of these challenges, therapists may be better equipped to identify treatment goals and areas of focus for treatment, such as increasing relational skills, altering negative appraisals of BPD, and increasing connection and attunement. This offers therapists the opportunity to adopt a perspective of these challenges that allows them and their clients to view them as obstacles to be overcome through therapeutic change. Similarly to any

negative interaction cycle present between the clients of a couple therapist, the challenges and obstacles associated with BPD can be managed, decreased, or overcome.

Within the second theme, couples also discussed the positives of the influence of BPD on their relationships; most couples identified BPD as a catalyst for positive change in their relational processes. Some couples felt as though the need for coping with BPD served as a gateway to effective interpersonal functioning. As such, therapists may benefit from adopting this strengths-based approach in viewing BPD as an opportunity for positive change. Many therapists refrain from working with individuals with BPD due to the biased belief that BPD cannot be treated. However, the current findings offer evidence that with the adoption of a growth mindset, BPD can be a catalyst for positive change. Rather than viewing BPD as a hopeless relationship killer, therapists can begin to understand the challenges associated with BPD as dynamic, bidirectional, systemic outcomes of couple processes.

Superordinate Theme Three: Adaptive Dyadic Coping with BPD

The findings of the third theme offers couple therapists an in-depth understanding of the kinds of resources that promote adaptive dyadic coping in the context of BPD. These findings identify the resources couples can access to bolster against the impact of BPD on their relationships, including external resources (e.g., therapy, accessing information about BPD) and internal resources (e.g., attunement, intentionality, commitment to growth, and externalization of BPD). Awareness of these resources may equip couple therapists and other clinicians working with individuals with BPD, partners of individuals with BPD, or couples with a partner with BPD to understand what kinds of work can be done in therapy to improve clients' coping with BPD's impact on their well-being and relationship functioning. Couples therapists may use these findings in order to enrich case conceptualization (i.e., Which resources are the therapist's clients

missing? What impact does that have on couple functioning?), identify treatment goals (i.e., Which resources need to be built in the context of therapy? Which resources are already present as strengths that can be reinforced?), as well as select interventions and therapeutic approaches that support these treatment goals (i.e., Which resources are the therapist's clients missing? Which therapeutic approaches target the change that reflects these missing resources? What therapeutic interventions will aid in clients' building these resources and moving towards adaptive dyadic coping?). Overall, therapists may benefit from increasing their understanding of these experiences and relational processes as this increased understanding may support case conceptualization and the selection of therapeutic approaches and interventions.

Finally, given that externalization was a key factor in couples' management of BPD, narrative couple therapy may offer unique advantages to consider as an approach to treatment. Couples that achieved mutual externalization accessed all other resources for dyadic coping (e.g., attunement, intentionality, and commitment to growth)and therefore more easily navigated and overcame relational obstacles introduced by BPD. Therapists must not only harbor an awareness of the obstacles associated with BPD, but also understand the need to foster in the context of therapy the development or enhancement of adaptive dyadic coping, which can be utilized to buffer against the deleterious effects of BPD. This may include efforts to deconstruct the problem-saturated narratives of BPD. Many couples also described their dyadic coping in a cyclical manner in which their triggers, emotions, perceptual responses, and behavioral responses were outlined, while repaired positive-interaction cycles were described in order to explain how they adapted over time. These descriptions of cyclical interactions mapped onto the negative and positive interaction cycles used in emotion-focused couple therapy (EFT; Greenberg & Johnson, 1988). Couple therapists may consider utilizing EFT with narrative interventions in order to treat

this population (see Angus & Greenberg, 2011 for further direction on the integration of emotion-focused and narrative couple therapies).

Limitations

While this study expands upon previous research on the impact of BPD on romantic relationships, it is not without limitations. Such limitations are in regard to the sample composition. One sampling limitation is that there could be a lack of generalizability due to the limited sample size. Another sampling limitation concerns the homogeneity of the sample, as the current sample consisted of mostly white couples (all except one couple), and most of the partners with BPD identified as female (all except one couple); as such, the results of the current study may not represent the diverse population of couples navigating BPD. Future qualitative data collection should aim to gather a more diverse sample and intentionally include more racially diverse couples as well as couples in which male-identifying partners are diagnosed with BPD. Male-identifying individuals with BPD are underrepresented in research on BPD. This may be in part due to the decreased likelihood of men being diagnosed with BPD compared to women (American Psychiatric Association, 2013). There are questions as to whether this decreased rate of diagnosis in men is due to clinician bias in overdiagnosing women and underdiagnosing men with BPD. Regardless, intentional sampling of male-identifying individuals diagnosed with BPD is important as this population is underrepresented in extant research on BPD.

A third sampling limitation concerns the recruitment of couples with a partner with self-reported diagnosed BPD. While self-report measurement has weaknesses, given the shame and stigma associated with BPD, we assume that individuals without BPD would be unlikely to self-report the diagnosis. Prior research suggests that self-reports of diagnosed disorders tend to

provide underestimates of disorder prevalence (Beals et al., 2005; Kessler, 2000), suggesting that it is unlikely that participants that self-reported a BPD diagnosis were overreporting. Of course, we recognize that by virtue of utilizing a sample that self-reported a BPD diagnosis, we may have tended to capture individuals with greater acceptance for their diagnosis (which may also be reflective of greater participation in treatment). The current sample also comprised of individuals diagnosed with BPD who have been or are currently receiving mental health treatment, which likely influenced the findings of the current study as many participants discussed how therapy served as an integral resource in recovery and adaptive dyadic coping. The current method also conducted conjoint interviews to gather dyadic data; this may have limited the experiences that partners chose to share in the presence of their romantic partner. And finally, the current sample also had multiple mental health diagnoses across both partners in most couples; these co-occurring mental health disorders could have influenced the data as confounding variables that were not able to be accounted for due to the qualitative study design. Future research on BPD couples should aim to account for co-occurring mental health disorders and explore how these disorders impact couple experiences of dyadic coping.

Future Research Directions

In terms of populations, future research should aim to explore the experiences of couples with a male-identifying partner with BPD. The current sample consisted of only one couple in which the partner diagnosed with BPD identified as male. There is limited research on BPD's presentation in men, and no research exploring the couple experiences of couples with a male-identifying partner with BPD. A few couples mentioned the impact that their struggles with BPD have on their children; as such, future research should aim to explore the systemic nature of BPD and the impact that couples' experiences of managing BPD has on parenting, co-parenting, and

family relational outcomes. And finally, half of the current sample comprised of couples identifying in the LGBTQ+ community, and yet the majority (except two lesbian couples) were in heterosexual relationships. Future research should aim to explore the specific experiences of the intersection of the LGBTQ+ identity and the experience of having BPD, as well as the experiences of LGBTQ+ individuals diagnosed with BPD in the context of same-sex relationships.

Future research should also aim to explore how the experiences of couples navigating BPD maps onto the double-ABCX model of family stress theory (McCubbin & Patterson, 1983). The double-ABCX model of family stress theory discusses the perceptual influences and impact of resources on family stress and crisis management outcomes, and how these influences determine the adaptive outcomes of families experiencing stress and crises (McCubbin & Patterson, 1983). Many couples in the current study discussed how their perceptions of BPD influenced the level of stress associated with BPD's presence, as well as the resources they accessed to better navigate stressors imposed by BPD. These perceptions and access to resources seemed to determine whether or not the couples could adapt to the stress of BPD on their relationships. Researching the experience of navigating BPD in the couple context through the lens of family stress theory may help us increase our understanding of how couples navigate and adapt to the demands of BPD. Finally, further research should also aim to further explore how dyadic coping (Bodenmann, 1997) promotes relationship satisfaction in couple relationships in which one partner has BPD. Quantitative and mixed methods approaches to studying BPD in the framework of dyadic coping may likely strengthen the findings of the current study and shed light on new ways in which dyadic coping can improve relationships of those couples with a partner with BPD.

Conclusion

The sample of the current study comprises a group of individuals living with BPD while also successfully engaging in long-term relationships, and their stories can help us understand how to help other couples to better navigate BPD. The current study increases our understanding of the impact of BPD on romantic relationships by illustrating how couples can access resources to activate adaptive dyadic coping in order to better manage the stressors imposed on their relationships by BPD. The current study offers guidance on adaptive dyadic coping to other couples navigating BPD as well as therapists treating this population. This study also contributes to the destigmatization of BPD as it shows that couples navigating BPD can successfully access and benefit from the same adaptive dyadic coping strategies that other couples utilize to manage normative life stressors.

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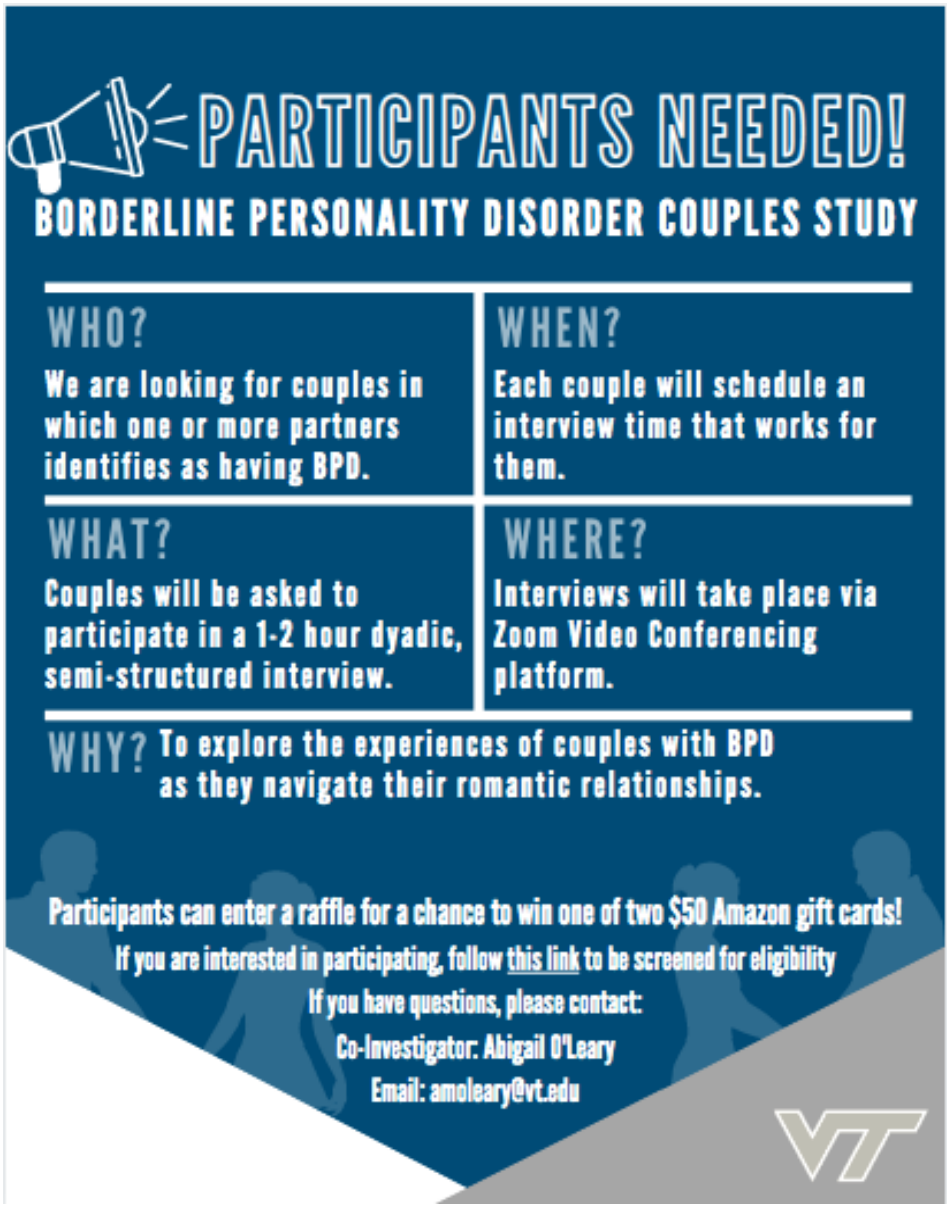
Appendix A: Recruitment Flyer



Appendix B: Recruitment Email Template

Subject Line: In Search of Participants for Borderline Personality Disorder Couple Study

Hello,

The purpose of this email is to invite you to participate in a research study on couples in which one or both partners identify as having borderline personality disorder. This research has been reviewed by the Virginia Tech Institutional Review Board (IRB# ##-###).

The aim of this study is to learn about the experiences of couples with BPD as they navigate their romantic relationships. We are interested in learning about your story.
We are seeking couples in which one or both partners identify as having borderline personality disorder to complete a semi-structured, dyadic interview. You may be eligible to participate if: (1) you identify as having borderline personality disorder; (2) you are in a romantic relationship of at least one year; (3) you are at least 18 years old; (4) you are English speaking; and (5) you consent to complete a semi-structured, dyadic interview OR if (1) you are partnered with or married to someone that identifies as having borderline personality disorder; (2) you are in a romantic relationship of at least one year; (3) you are at least 18 years old; (4) you are English speaking; and (5) you consent to complete a semi-structured, dyadic interview.

Eligible participants will be contacted to set up a time for an interview that will last approximately 1-2 hours.

If you are interested in participating, please complete our initial screening survey via this link. If you have questions or would like to receive additional information, please email Abigail O'Leary (amoleary@vt.edu).

Sincerely,

Ashley Landers (Principal Investigator)
Assistant Professor, Virginia Tech

Abigail O'Leary (Co-Investigator)
Graduate Student, Virginia Tech

Appendix C: Screening Tool

Start of Block: Default Question Block

Are you 18 or older?

- o Yes
- o No

Are you fluent in English reading, writing, and speaking?

- o Yes
- o No

Do you self-identify as having borderline personality disorder OR are you in a romantic relationship with someone with borderline personality disorder (BPD)? Check all that apply.

- ☐ I identify as having BPD
- ☐ I do not identify as having BPD
- ☐ I am in a relationship with someone with BPD
- ☐ I am not in a relationship with someone with BPD

Are you in a committed, dyadic, romantic relationship of at least one year in length?

- o Yes
- o No

Please provide your name (Last, First)

_____

Please provide your email address:

- o Email: _____
- o I do not have an email address

Please provide your phone number:

_____

Please provide your partner's name (Last, First)

_____

Please provide your partner's email address:

- o Email: _____
- o My partner does not have an email address

Please provide your partner's phone number:

_____

Do we have your permission to contact you via email or phone?

- o Yes
- o No
- o Email only
- o Phone only

Do we have your permission to contact your partner via email or phone?

- o Yes
- o No
- o Email only
- o Phone only

If you are eligible to be a part of this study based on your responses, you will be contacted by the co-investigator (Abigail O'Leary).

Appendix D: Consent Form

Virginia Polytechnic Institute and State University Consent to Take Part in a Research Study

Principal Investigator: Ashley Landers, PhD, Assistant Professor, Virginia Tech
Other study contact(s): Abigail O'Leary (Co-Investigator, graduate student, Virginia Tech)

Key Information: The following is a short summary of this study to help you decide whether or not to be a part of this study. More detailed information is listed later on in this form.

The purpose of this voluntary interview is to explore the impact that borderline personality disorder has on couples' relationships. This study seeks to gain in-depth knowledge about couples' experiences of navigating borderline personality disorder's impact on romantic relationships. Interview questions will focus on various aspects of relationship functioning such as communication and problem solving. You will also be asked if you are willing to be contacted by the researchers with follow-up questions after completing the survey. The interviews will be administered online via Zoom and can be completed by the participants in the space of their

choosing. The interview is expected to take approximately 1-2 hours depending on the degree of feedback provided by the participant.

Detailed Information: The following is more detailed information about this study in addition to the information listed above.

Who can I talk to?
Should you have any questions about this study, you may contact one of the research investigators at:
Abigail O'Leary, graduate student, Co-Investigator at amoleary@vt.edu

This research has been reviewed by the Virginia Tech Institutional Review Board (IRB). You may communicate with them at 540-231-3732 or irb@vt.edu if:
- You have questions about your rights as a research subject
- Your questions, concerns, or complaints are not being answered by the research team
- You cannot reach the research team
- You want to talk to someone besides the research team to provide feedback about this research

How many people will be studied?
We plan to include about 14 people in this research study.

What happens if I say yes, I want to be in this research?
It is important for you to know that participation is voluntary and you are free to withdraw from this study at any time without penalty. You are free to not answer any questions that you choose. Should you become distressed at any time, please feel free to take a break from the interview and return at your convenience or discontinue entirely.

What happens if I say yes, but I change my mind later?
Participation is completely voluntary and you can leave the research at any time, for any reason, and it will not be held against you. You do not have to inform anyone if you decide to discontinue.

Is there any way being in this study could be bad for me? (Detailed Risks)
The researchers anticipate minimal risks for participating in this research study. Some interview questions may cause emotional discomfort, depending on personal experiences with the topic of the study. Survey answers are not being evaluated by the research team on an individual basis, so if you are concerned about your well-being please consult a physician or mental health professional. When you finish the survey, whether you complete it or choose to discontinue, you

will be provided a list of resources (also listed below) that may help address any adverse reactions you have while taking the survey.

You may choose not to answer any question at any time. You may choose to stop the interview at any time. The researcher will provide mental health referrals if you would like to further process the thoughts and emotions that arise from the interview. Payment for service from any

mental health providers to which you are referred shall be your responsibility, and shall not be covered by the researchers, nor Virginia Tech.

Resources available to you include:
1. National Sexual Assault Hotline | 1.800.656.HOPE | Free. Confidential. 24/7.
2. Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), a free, 24-hour hotline available to anyone in suicidal crisis or emotional distress. Your call will be routed to the nearest crisis center to you.
3. Veterans Suicide Prevention Hotline 1-800-273-TALK, Veterans Press 1
4. Domestic Violence Hotline: 1.800.799.SAFE (7233) 1.800.787.3224 (TTY) Anonymous & Confidential Help 24/7
5. Crisis Text Line: Text Hello to 741741. Entirely text-based for anyone who doesn't feel comfortable or safe talking on the phone.

Find more resources available to you here:
United States National Suicide and Crisis Hotlines
1. National Hope Line Network - 1- 800- Suicide
2. National Suicide Prevention Lifeline - 1-800-273-Talk

DC/MD/NOVA Suicide and Crisis Hotlines
1. Crisis Link - (703) 527-4077
2. National Alliance on Mental Illness (NAMI) Crisis Text Line - Text 741741
3. Fairfax County Emergency Services - (703) 573-5679
4. DC ACCESS Helpline- 1-888-7WE-HELP
5. Maryland Crisis Hotline - dial 2-1-1 and choose option 1; Text 898-211
6. Crisis Link Text Line - Text "CONNECT" to 855-11 and a PRS Crisis Link volunteer will respond within minutes

Find a Therapist
1. Psychology Today Therapist Directory: https://www.psychologytoday.com/us?tr=Hdr_Brand
2. Dialectical Behavioral Therapist Directory: https://dbtproviders.com/

Will being in this study help me in any way?
You may or may not directly benefit from the research. However, taking the survey might allow you to feel psychological relief after sharing your story. There is no guarantee that taking this survey will provide these benefits.

Findings from this study may be used for publications, conference presentations, community presentations, and research brief reports.

What happens to the information collected for the research?
Every effort will be made to keep the information you provide strictly confidential. Individuals with access to participant data include the Principal Investigator and the Co-Investigators.

All interview data will be securely stored in order to protect your confidentiality. Portions of your interview answers may be quoted in study reports and/or in other publications, however, identifying information will not be disclosed on any reports or publications.

If identifiers are removed from your private information or samples that are collected during this research, that information or those samples could be used for future research studies or

distributed to another investigator for future research studies without your additional informed consent.

Please note the Virginia Tech Institutional Review Board (IRB) may view the study's data for auditing purposes. The IRB is responsible for the oversight of the protection of human participants involved in research.

Will I receive compensation for participating in this interview?
You will have the opportunity to enter a raffle for a chance to win a $50 Amazon gift card.

Can I be removed from the research without my OK?
No participant will be removed from the study under any circumstances.

Please indicate your name (Last, First)

_____

Please indicate your partner's name (Last, First)

_____

Do you self-identify as having borderline personality disorder (BPD)?

- o Yes
- o No

Have you been diagnosed with borderline personality disorder (BPD)?

- o Yes
- o No

Would you like to be entered into a raffle for a chance to receive a $50 Amazon gift card?

- o Yes (If yes, provide email address below)

  _____

- o No

Do we have your permission to follow up with you after the interview in order to ask for your feedback on our results? This process ensures that your voice and story is reflected accurately in our results.

- o Yes
- o No

Once you have read this document please choose a response option below:

Do you consent to video and audio recording of the interview?

- o I consent to video recording
- o I consent to audio recording
- o I consent to video and audio recording
- o I do not consent to video or audio recording (Selecting this response indicates a decline to participate in this study)

Once you have read this document please choose a response option below:

Declining to participate in this survey will bring you to a list of mental health resources.
Agreeing to participate will bring you to a demographics survey.
Do you consent to participating in this study?

- o No, I decline to participate
- o Yes, I consent and agree to participate

Please sign below to confirm your consent.

Appendix E: Demographic Questionnaire

Thank you for taking the time to participate in this study exploring the impact of borderline personality disorder on couples' relationships. Before we can schedule an interview, we ask you to complete a brief demographic questionnaire. If you are uncomfortable answering any of the following questions, you may choose to not answer those questions.

Q1 How old are you in years?

_____

Q2 What is your gender?

- ○ Male
- ○ Female
- ○ Trans-identified
- ○ Other _____

Q3 What is your race?

- ○ White
- ○ Black or African American
- ○ Hispanic, Latino, Spanish
- ○ American Indian or Alaska Native
- ○ Asian
- ○ Native Hawaiian or Pacific Islander
- ○ Other _____

Q4 Are you of Hispanic, Latino, or Spanish origin?

- ○ No, not of Hispanic, Latino, or Spanish origin
- ○ Yes, Mexican, Mexican Am., Chicano
- ○ Yes, Puerto Rican
- ○ Yes, Cuban
- ○ Yes, another Hispanic, Latino, or Spanish origin: (fill in the blank)

_____

Q5 What is the highest degree or level of education you've completed?

- ○ Less than high school diploma
- ○ Completed high school diploma or the equivalent (e.g., GED)
- ○ Completed trade, technical or vocational school
- ○ Completed some college
- ○ Bachelor's degree
- ○ Master's degree
- ○ Doctorate degree

Q6 What are your religious or spiritual beliefs or affiliations?

- ○ Christian (Catholic, Protestant, other)
- ○ Jewish
- ○ Muslim
- ○ Buddhist
- ○ Hindi
- ○ Tao
- ○ Atheist
- ○ Pagan
- ○ Other: _____

Q7 What is your employment status?

- ○ Employed, working 40 or more hours per week
- ○ Employed, working 1-39 hours per week
- ○ Not employed, looking for work
- ○ Not employed, not looking for work
- ○ Retired
- ○ Disabled, not able to work

Q8 Do you self-identify as having borderline personality disorder (BPD)?

- ○ Yes
- ○ No

Q9 Have you been diagnosed with borderline personality disorder (BPD)?

- ○ Yes
- ○ No

Q10 Are you in treatment for borderline personality disorder (BPD)?

- ○ Yes - Individual Therapy
- ○ Yes - Couples Therapy
- ○ Yes - Family Therapy
- ○ Yes - Group Therapy
- ○ Yes - Psychopharmacology
- ○ Yes - Other
- ○ No
- ○ I do not identify as having BPD

Appendix F: Mental Health Resources and Referrals

Resources for Participants

United States National Suicide and Crisis Hotlines

1. **National Hope Line Network -** 1- 800- Suicide
2. **National Suicide Prevention Lifeline -** 1-800-273-Talk

DC/MD/NOVA Suicide and Crisis Hotlines

1. **Crisis Link -** (703) 527-4077
2. **National Alliance on Mental Illness (NAMI) Crisis Text Line -** Text 741741
3. **Fairfax County Emergency Services -** (703) 573-5679
4. **DC ACCESS Helpline-** 1-888-7WE-HELP
5. **Maryland Crisis Hotline -** dial 2-1-1 and choose option 1; Text 898-211
6. **Crisis Link Text Line -** Text "CONNECT" to 855-11 and a PRS Crisis Link volunteer will respond within minutes

Find a Therapist

1. **Psychology Today Therapist Directory:** https://www.psychologytoday.com/us?tr=Hdr_Brand
2. **Dialectical Behavioral Therapist Directory:** https://dbtproviders.com/

Appendix G: Interview Schedule

- Grand tour question 1: What has been each of your experiences so far in your romantic relationship relating to the presence of borderline personality disorder (BPD) in the relationship?
    - How would you describe borderline personality disorder?
        - How would you explain BPD to someone who doesn't know about it?
    - How would you both describe the impact that BPD has had on your relationship?
        - Follow up about relationship satisfaction specifically if not mentioned.
    - How has your relationship been influenced by BPD, if at all?
    - *For BPD partners:* How has your BPD experience been influenced by your relationship, if at all?
        - *For non-BPD partners:* How would you describe the ways in which your partner's BPD has been influenced by your relationship, if at all?
    - How would you describe your relationship strengths and struggles?
        - How would you describe BPD's role in these relationship strengths, if any?
        - How would you describe BPD's role in these relationship struggles, if any?
    - How would you describe your experiences of support, coping, and/or adjustment in your relationship related to BPD?
    - How would you describe your communication style and problem-solving skills in your relationship?
        - What role would you say BPD plays in your communication style and problem-solving skills, if any?

- Grand tour question 2: How would you describe your experiences of stigma surrounding BPD, if at all?
    - *For BPD partners:* What was your experience of disclosing your BPD to your partner?
    - *For non-BPD partners:* What was your experience of learning about your partner's BPD?
    - How would you describe your experiences in your social and personal lives related to BPD stigma and/or acceptance?
        - How would you describe your experiences in mental health and medical care related to BPD stigma and/or acceptance?
    - *For BPD partners:* Do you share your BPD-identity with close others?
        - If so, how has that experience been?
        - If not, why not?
    - *For non-BPD partners:* Do you share your partner's BPD-identity with close others?
        - If so, how has that experience been?
        - If not, why not?

Appendix H: Screening Follow-Up Email Templates

Eligible Participants

Subject Line: Invitation to Participate in Borderline Personality Disorder Couple Study

Hello,

Thank you for completing the screening survey for our study on couples with borderline personality disorder! Based on your survey responses, you and your partner are eligible to participate in our study. This research has been reviewed by the Virginia Tech Institutional Review Board (IRB# ##-###). The aim of this study is to learn about the experiences of couples with BPD as they navigate their romantic relationships. We are interested in learning about your story.

If you and your partner are still interested in participating, each of you will need to complete our consent form and demographic questionnaire. Each of you can complete your own individual consent form and demographics questionnaire using this link. After the forms have been completed, I will reach out to you both to schedule a time for our interview. The interview will last approximately 1-2 hours.

If you have questions or would like to receive additional information, please email Abigail O'Leary (amoleary@vt.edu).

Thank you again! Your interest in our study is greatly appreciated.

Sincerely,

Ashley Landers (Principal Investigator)
Assistant Professor, Virginia Tech

Abigail O'Leary (Co-Investigator)
Graduate Student, Virginia Tech

Ineligible Participants

Subject Line: Follow-Up on Interest in Borderline Personality Disorder Couple Study

Hello,

Thank you for completing the screening survey for our study on couples with borderline personality disorder! Based on your survey responses, you and your partner are ineligible to participate in our study. We apologize for any inconvenience. We have included a list of resources below might you find them helpful.

> Resources:
> *United States National Suicide and Crisis Hotlines*
> *1. National Hope Line Network - 1- 800- Suicide*
> *2. National Suicide Prevention Lifeline - 1-800-273-Talk*
>
> *DC/MD/NOVA Suicide and Crisis Hotlines*
> *1. Crisis Link - (703) 527-4077*
> *2. National Alliance on Mental Illness (NAMI) Crisis Text Line - Text 741741*
> *3. Fairfax County Emergency Services - (703) 573-5679*
> *4. DC ACCESS Helpline- 1-888-7WE-HELP*
> *5. Maryland Crisis Hotline - dial 2-1-1 and choose option 1; Text 898-211*
> *6. Crisis Link Text Line - Text "CONNECT" to 855-11 and a PRS Crisis Link volunteer will respond within minutes*
>
> *Find a Therapist*
> *1. Psychology Today Therapist Directory: https://www.psychologytoday.com/us?tr=Hdr_Brand*
> *2. Dialectical Behavioral Therapist Directory: https://dbtproviders.com/*

If you have questions or would like to receive additional information, please email Abigail O'Leary (amoleary@vt.edu).

Thank you again! Your interest in our study is greatly appreciated.

Sincerely,

Ashley Landers (Principal Investigator)
Assistant Professor, Virginia Tech

Abigail O'Leary (Co-Investigator)
Graduate Student, Virginia Tech

Appendix I: Theme Tree

Superordinate Themes →	Theme Clusters →	Theme Sub-Clusters →	Theme Titles
Individual Lived Experiences of BPD$_{ab}$	The Experience of BPD Symptoms$_{ab}$	Individuals with BPD: Experiences of Internal Instability$_{a}$	● Emotion dysregulation/Reactivity$_{a}$ ● Instability of mood$_{a}$ ● Instability of perceptions$_{a}$ ● Unstable sense of self$_{a}$
		Individuals without BPD: Experiencing their Partner's Internal Instability$_{b}$	● Experiencing partner's unstable sense of self$_{b}$ ● Experiencing partner's emotional instability$_{b}$ ● Uncertainty of how to help their partner$_{b}$
	The Recovery Process$_{ab}$	Individuals with BPD: Factors Promoting their Recovery$_{a}$	● Reparative experiences: Fostering a conducive environment for healing (e.g. moving out of FOO home, choosing supportive relationships)$_{a}$ ● Accessing resources (e.g. social support, DBT/therapy, medication, self-help books, DBT self-help groups)$_{a}$ ● Construction of growth guidelines (e.g. new beliefs, boundaries, rules)$_{a}$ ● Developing adaptive skills$_{a}$
		Individuals with BPD: Challenges to their Recovery$_{a}$	● Multiple diagnoses$_{a}$ ● Challenges accessing support$_{a}$ ● Non-linear growth$_{a}$
		Individuals without BPD: Longing and Hoping for their Partner's Recovery$_{b}$	● Caregiver burden$_{b}$ ● Investment in partner's recovery$_{b}$ ● Longing for partner's recovery$_{b}$
	Individual Responses to the Experience of Partnership with Someone with BPD$_{b}$		● Avoiding negative interactions$_{b}$ ● Navigating one's individual impact on BPD symptoms$_{b}$
The Shared Experience of BPD as a Relational Stressor$_{ab}$	Shared Obstacles to Interpersonal Effectiveness$_{ab}$	Internalization$_{ab}$	● Projection$_{a}$ ● Personalization$_{b}$
		Disconnection$_{ab}$	● Conflict avoidance$_{ab}$ ● Lack of collaboration$_{ab}$ ● Mistrust$_{ab}$
		Negative Appraisals of BPD$_{ab}$	● Blaming BPD$_{ab}$ ● Shame of BPD$_{a}$ ● Hopelessness$_{ab}$ ● Helplessness$_{ab}$

		Skills Deficits$_{ab}$	• Lack of knowledge on supporting someone with BPD$_{b}$ • Lack of conflict management skills$_{ab}$ • Lack of external supports$_{ab}$
	What BPD Demands and Provides$_{ab}$	The Double-Edged Sword of BPD$_{ab}$	• Navigating BPD as a couple$_{ab}$ • BPD as a catalyst for building adaptive relationship skills$_{ab}$
Adaptive Dyadic Coping in the Context of BPD$_{ab}$	External Resources$_{ab}$		• Therapy$_{ab}$ • Accessing information about BPD$_{ab}$
	Internal Resources$_{ab}$	Attunement$_{ab}$	• Perspective Taking$_{ab}$ • Compassion/Validation$_{ab}$ • Empathic responding$_{ab}$ • Openness/Vulnerability$_{ab}$
		Intentionality$_{ab}$	• Self-care$_{b}$ • Open and effective communication$_{ab}$ • Boundaries$_{b}$ • Self-awareness$_{a}$
		Commitment to Growth$_{ab}$	• Hope for partner's recovery from BPD$_{b}$ • Dedication to relationship longevity$_{ab}$ • Willingness to change$_{ab}$ • Having patience$_{b}$
		Externalization$_{ab}$	• Experiencing partner as separate from BPD$_{b}$ • Experiencing self as separate from BPD$_{ab}$ • Depersonalization$_{b}$ • Collaboration/ united front against BPD$_{ab}$

Experienced or reported by Partner A (person diagnosed with BPD)$_{a}$
Experienced or reported by Partner B (person without BPD diagnosis)$_{b}$
Experienced or reported by both Partner A and Partner B$_{ab}$