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Episode Title: The Impact of Growing Up With a Parent With BPD: Paths to Healing in Adulthood

Episode Number: 262

Presenter/Interviewee: Daniel S. Lobel, PhD, PSY

Beth [00:00:00] Hello to our listeners. My name is Beth Irias and I am honored to have Dr. Daniel Lobel here to talk with us about the impact of parental borderline personality disorder on children and on adult children. I'm so glad that Dr. Lobel has come to talk about this topic. He is a clinical psychologist and has been working in the area of borderline Personality Disorder for quite a while. He's written a number of books, books that I'm certainly familiar with. And is also Assistant Clinical Professor of Psychiatry at Mount Sinai School of Medicine. Thank you for coming on, Dr. Lobel. It's nice to have you.

Dr. Lobel [00:00:37] My pleasure.

Beth [00:00:38] So why don't you take a moment and tell our listeners a bit more about your work and then I'd love to know why this particular topic in your clinical specialization.

Dr. Lobel [00:00:48] So my work today has evolved into treating families that are affected by borderline personality disorder. This particular diagnosis has some very unique and particular effects, not only on the person that we would identify as the patient, but on the family as a whole. And it affects and it afflicts families as a hole. So, I very often will work with parents, sometimes siblings, children, and spouses of people who have significant symptoms of borderline personality disorder, because the disorder itself will not get better based on simple one-to-one therapy. The interventions necessary in order to bring relief to these families involves changes in the ways that the families, friends, and significant others relate to those who are affected by these symptoms. So these days I do a lot of consultation all around the world with some facilities that specialize in this because the borderline personality disorder comes up with comorbidities of lots of other disorders, not the least of which being eating disorders. And so there are a number of clinics throughout the world that I work with who admit people for eating disorders and and sometimes other kinds of behavioral disorders or self-harm disorders and many of them end up having very significant symptoms of borderline personality disorder. This particular group who suffer from these symptoms requires clinicians who have specialized skills in this area. A lot of the traditional types of therapy not only don't work. But actually make the disorder worse. And so I get contacted very, very frequently from people, most recently actually an interventionist who focuses on substance abuse intervention, but ran into BPD in the work that he was doing, and I was asked to consult on a few cases there. So it requires very specialized skills. In order to be able to work with this particular population.

Beth [00:03:16] Thank you for coming on and having this conversation. It's been my experience in clinical practice that these conversations I think are sometimes hard to have with our clients. We may be the first person in somebody's life to say, I'm sorry, what happened? What were the conversations that sometimes happened at the dinner table or what was said to you when your parents were building up or whatever it is. I know the number of times I've had the conversation of, you know, I'm not in a position to diagnose anybody else and you're just a person who's sitting in front of me. And I want to talk a little bit more about some of the things that you were just telling me and I want understand better. And then it opens up like this kind of cornucopia of information that speaks to some really difficult relational dynamics that children experience in their families and then how that's shaping. Them and their lives into adulthood. So thank you for coming on and talking about this particular topic. As we dive into a conversation about the children of borderline parents, will you please start by talking about the prevalence of border line personality disorder and where that number may be accurate or inaccurate and why that may be. Just to kind of start there of like, let's imagine starting someplace in a family tree and then how it's kind of trickling down through generations.

Dr. Lobel [00:04:48] Well, you know, the the you bring up a number of points that that are very, very significant to this this type of work. And diagnosis is a very very significant topic here and part of the reason that diagnosis is a very, very significant, topic is because the according to our what we think of in mental health is our Bible, the DSM-5, the Diagnostic and Statistical Manual. If you look at the diagnostic criterion for any kind of personality disorder. It requires sampling, extensive sampling of functioning in multiple settings. So to properly make a personality disorder diagnosis, you can't do that just sitting in a room with a patient. That's not sufficient, but that's how most of us work. Because of this issue and other issues as well, which I'm sure we'll get into during the conversation here, all of my writing refers to people with symptoms of borderline personality disorder. Also significant in this area is that this particular diagnosis is very highly stigmatized. Because of the stigmatization of the borderline personality disorder, people actually resist that diagnosis. They hide the diagnosis, they fight against the diagnosis. And a number of my colleagues have said, you know, we have to establish diagnosis, we have established diagnosis. My answer to that is no, we don't. We get into a quagmire when we try to establish this particular kind of diagnosis and even diagnosis in general in a mental health field. That's not completely true of every single area, but in the medical field, diagnosis then leads to treatment. So if a person has Staphylococcus infection in their throat, typical Staph infection or Strep infection in a particular body, that will then portend a specific antibiotic that you would use that kills staff or kills strep. In psychiatric diagnosis, we're still developing our diagnoses. That's why we're on the fifth edition of DSM-5. DSM 6 is already in progress and I've been at this for 40 years now. They keep revising the diagnoses Because the diagnoses themselves, in some cases they do. If you have a diagnosis of depression, that would indicate that antidepressants might be helpful or other kinds of specific treatments. But that point by point, here's the diagnosis, here is the treatment, does not exist in mental health. And so instead, rather than arguing over whether a person has BPD or not, we talk about the symptoms of BPD. And those would include the core symptoms of lashing out, dysregulation. Unstable sense of self, unstable relationships, unstable affect, and so on and so forth. And then we apply the interventions to the specific behaviors. And in that way, and also, as many of our colleagues know, the borderline personality disorder is part of what we call cluster B in the designation in DSM-5, which would include other personality disorders, most notably the narcissistic personality disorder. Lots of people argue, you know, is it BPD or is it NPD? It doesn't really matter. There's a tremendous amount of symptom overlap. There is not a different

treatment per se for one versus the other. We don't have medications that treat either one of those disorders. And so we're treating behavioral symptoms. And so, we focus on those behavioral symptoms as targets and then we treat them.

Beth [00:08:44] Looking at it through the lens of symptomatology and not necessarily diagnosis, approximately what percentage of people would either largely or even loosely meet the diagnostic criteria for BPD or PD.

Dr. Lobel [00:09:01] I have my DSM-5 here so I can actually look it up because they do report, I think it's actually fairly high, I'll take a quick look at that, but I know that you're also raising the issue of underdiagnosis and overdiagnoses, which is a very, very serious issue. So, officially, the The prevalence rates, officially, the median is estimated to be 1.6 percent, but maybe as high as 5.9, so we'll call that 6 percent. So, let's say five in a hundred according to the statistics. But there is the issue, there's always the issue especially in psychiatric diagnosis of over diagnosis and under diagnosis. And there's a lot of under diagnosis because people with BPD generally don't think there's anything wrong with them. They think there's something wrong with everybody else. And so they don't seek treatment unless they have a comorbid disorder. They may have a depression in which case they will seek relief from depressive symptoms or perhaps anxiety symptoms or other symptoms like that, but will not endeavor to offer the symptoms of BPD. Or any personality disorder unless they're prompted by a very skilled therapist.

Beth [00:10:27] For the purposes of our conversation today, we're talking specifically about BPD, borderline personality disorder, with the understanding that that has a whole lot of overlap with some other diagnoses and that we're also operating in the system of the DSM. I think we'd be remiss to not acknowledge, yes, there is controversy around this diagnosis, and even understanding what are the foundations and building blocks of, quote unquote, personality disorders. And so looking at it from a trauma and foreign perspective, yes, there are reasons. Why somebody would develop a way of being in the world that now the system has classified as a personality disorder. And we're also operating within a system that we have, which is using the DSM to guide treatment and using those diagnostic criteria. So I just kind of want to acknowledge that piece of it before we move forward. With that said, so let's just choose middle figure there. So between, you said, I think, one point something and 5.9. Let's just say then, we'll say three and a half, four percent of the population may meet the diagnostic criteria for borderline personality disorder. That's not a small number when you think about it. The way that I kind of play that in my mind is like, okay, you're in a classroom of college students with some probability how many of these college students may have this condition. So yeah, you are looking if you're at a class of 20, 30 people, at least one. Uh, and, and that means that we're seeing this, if you will, in the wild quite a bit, and that it's happening for families quite a little bit. It's not like this thing that's really unknown or not experienced, it's highly rare. It's really not, it rather common.

Dr. Lobel [00:12:08] That's right. And if you if you do the calculation, so if we're looking at three or four in a hundred as being the incidence rate, you have a family could be 10 people in the family. So now it's 10 times 3% with 10 people and a family. Now your possibility is 30%.

Beth [00:12:30] I remember reading some years ago that among children, adult children of people diagnosed with borderline personality disorder, the approximate heritability was roughly 50%. And I remember that and going, hold up, what? Like let me deconstruct what

I just read, which is effectively saying if you were born or adopted into a family with a caregiver who would meet the diagnostic criteria BPD. There is a very good chance that you yourself would embody similar traits in a way of being about 50%. Can you speak to that? Certainly better than I can because you're an expert on this, but can you expand on those ideas? Because I think I'd love to start by kind of, I guess, painting the picture of BPD in the family system and how this is actually kind of playing out, not being this thing that's really rare. It's like We're seeing it in our offices.

Dr. Lobel [00:13:26] Yeah, you know that honestly the 50% transmissibility sounds a little bit high to me, quite frankly. I'm not aware, because that would suggest a dominant genetic transmission with such as, you know, non-blue eyes or dark colored hair, where if you have two parents and their is dark colored, you're very, very strongly likely to have dark colored children and things like that. To the best of my knowledge, we haven't actually identified any genes that transmit borderline personality disorder. There are brain differences that you can see in terms of how people who have this disorder function. You can see it on functional MRIs and functional PET scans. But that doesn't mean that it's biologically transmitted. I think that a very strong piece of it has to do with the parenting style. I think it's a combination of a very broad genetic vulnerability to developing borderline compared with, quite frankly, a very, very permissive parenting style that then produces children. Um, who are very highly impulsive, who can't manage their own impulses, who can't take responsibility because it's too painful for them when things go wrong. And of course, I think for the, for the sufferer, the most pernicious. Symptom is the instability of sense of self i mean the people who suffer from this disorder all of the instability comes from the instability in terms of of who they are who they perceive themselves to be sometimes they see themselves in idealized forms and they can do no wrong and they're smarter than anybody else and they are prettier than anybody else and there are you know more athletic than anybody And then at other times, they're the worst. They're horrible people, they see themselves that way. And it can go very quickly from the idealized, you know, I'm entitled kind of thing, which people find most odious, to the devalued space that they can see themselves in associated with significant self-harm and self-sabotage, which we see very commonly in this group.

Beth [00:15:49] Why don't you talk about the lay of the land for children growing up with one or potentially more direct caregivers who have borderline traits? What is a lived reality that is more likely for these kiddos than if they were not in the same family system?

Dr. Lobel [00:16:13] Well, that's a key question here. And the fact of the matter is, and anybody who works with this population can see it, that this population mistreats the people who are closest to them. People who suffer from BPD mistreat, and in some cases abuse the people, and in a lot of cases abuse the people that are closest them. When you look at parents who have a child with BPD, and I work with this group quite a bit. These parents are traumatized by their children. These are traumatized parents. And working with this group, when you work with the parents, if you're working with the children, you have to work with the parents. You have to recognize these parents, they've seen their child threaten suicide. In some cases, they'd been assaulted by their child and the child doing all kinds of outrageous things. When you're the child, when you grow up with someone who behaves in this fashion, the impact of that behavior on the infant child and The young child is devastating, it is devastating. The central themes, I think the ones that are most damaging, have to be understood in the context of normal developmental processes, where children, very young children are struggling to define themselves with an only partially developed brain, and they look toward their parents to define reality, to define

what is right, what is wrong, and most importantly to define themselves. In developmental psychology, we refer to a process called mirroring, which is a very, very, very important process where parents mirror to their children what they see. So if a child, for example, a two or three year old child is in daycare, let's say, and they take away a toy from another child who's playing with the toy, which is very common in day care or very, very common amongst two or 3 year olds who don't have empathy yet and don't know any better. The parent and the teacher is supposed to say, well, that's not a nice thing you did. This person is not going to like you if you take the toys away from them. Why don't you instead ask and you know and so on and so forth? In this situation with the borderline personality disorder parent due to the extensive use of lying, gaslighting, and blame shifting, they very often mirror to the child, the developing child, a distorted image, not an accurate image. One that is ridden with blame, they blame their children. They will say to their children, you ruined my life. They will stay to their Children that they are to blame for all kinds of things for anything that the parent is struggling with that the error that the parents made. They use gaslighting with their children when the children see the truth and say, Well, hey mommy or hey daddy, you forgot to bring my backpack to daycare. That's why I don't have it. They will gaslight the child and say, no, it's your fault. You didn't do what you were supposed to do this morning. You gave me a hard time brushing your teeth and therefore that's why. I forgot the backpack. This is your fault and if you and here's the real icing on the cake. If you think it's my fault, you're crazy, and they will tell the child that they are crazy or wrong or stupid for believing that which is true. In the developing sense of self and in the developing sense of agency that any child would be going through, having this kind of blame shifting, gaslighting, and flat out lying leaves them very insecure as to what's true what's not true. It leaves them insecure as they don't even know who they are. And it's quite remarkable in working with this population as adults. A lot of them can be very smart and a lot of can find ways to be very successful, at least financially or in other ways in our society. But when it comes to themselves, self-care, relationship skills, and emotional transactions, They're a mess. They have not learned how to do it because they've been misled, misguided. And confused.

Beth [00:20:58] These experiences are more common in specific family systems. Like we're talking about here today with parents who have borderline traits, we talk about similar things in addictive family systems, how does this differ from what the survivors of other types of childhood treatment might experience.

Dr. Lobel [00:21:23] It's a great question, and in answering the question, first of all, any of these clinical groups that we're talking about, whether the parent has an addictive problem, whether that parent is psychotic, whether the parents has depression, whatever it may be, and or BPD, these parents themselves are not well. And this question, which to me is, quite frankly, not even a question. If you're not well, does that affect your parenting? Of course it does. And so it depends what the symptoms are. But in situations of abuse, of alcohol abuse or substance abuse and things like that, a lot of the effect on parenting is due to impulsivity. The parent has a short fuse because they're going through a short-term withdrawal from alcohol or benzodiazepines or something else, or the parent is having cravings and they're not attentive to the child because they are looking to get their fix of whatever it is that they're addicted to, or a parent could be depressed and unable to get out of bed and unable function. But the child, children, even very young children, are able to really recognize that this is not really about them. It's not really about the child and as the child grows up they realize they had an impaired parent and largely you know there was a neglect there there could be physical abuse you know the parent could have a temper issue or could be psychotic or could use psychedelics and not know what's going

on but the child is able to really see that the parent is impaired and it's about them. With the growing up with the BPD parent, the parent that has symptoms of BPD, the child is continuously told that the child is to fault, is at fault. The parent has nothing wrong with them in their own eyes, and all of the problems that occur are because the child was bad. Now two-year-old children, they're never bad. You can't be bad at two. It's not bad to not want to take a nap. It's not bad to not want to eat asparagus when you're two. Any parent knows that any child does this. And yet, systematically, because these parents are unable to take any responsibility or any ownership of anything that goes wrong, it's constantly blaming the child. And one of the manifestations of this, it is a very prominent manifestation that you don't see in other situations. These people that as adults they come into treat therapy and they come in to relationships They're guilty all the time. They don't even know what they're guilty of they feel guilty all Because they're persistently blamed they over apologize They they walk walk on eggshells literally walk on egg shells around everybody because they don't Even know they can't even understand they know that they've been told by the parent that they keep hurting the parent they keep doing things wrong and it's all their fault, it's only fault, but they don't even know what they've done wrong. So they think everything they do is wrong. And these people are very, very confused. Again, some of them, I work with some people who are CEOs of very successful businesses who grew up with this kind of parenting and they run great businesses and they have lots of money, but when it comes to their relationships, they have a lot of trouble functioning and they don't feel good. They don't feel good about themselves. They don't feel confident outside of business. They may have developed a business persona where they feel confident, but they don't feel confident in emotional transactions and intimate relationships. Some of them can't function at all. It's a huge contrast because of this constant and persistent blaming, lying, gaslighting onto the child. One person told me they didn't, they learned the word episiotomy because at four they were told by their mother that they caused the mother to have an episiotom and that the mother now has pain every time she goes to the bathroom and it's the child's fault. That's just one of a thousand examples. Four-year-old. What four- year-old even knows what an episiotomy is?

Beth [00:25:54] Thank you for that example and for describing what this impact is. It's certainly something that I've seen in my practice. Nearly the same quote, nearly the same. This is the recipe for lack of trust in relationships, for confusion about self, lack of self-worth. We could look at BPD and say... Okay, there's been research about these different methods that could help improve distress tolerance that might help the use of assertive communication for somebody who's been diagnosed with BPD. One of the things that's colloquially said in our field is it's not the person with the person IS order who's going to go to treatment. It's going be the people who have been impacted by them. So then you have these adult children. Who grew up in an environment that was unstable and unpredictable. Do we know enough about this group for any methods that are particularly effective, other than obviously, psychoeducation and just giving them a space to reflect, acknowledging, hey, that thing that sounds like it was really, quote, unquote, normal in your upbringing, that certainly feels like pretty covert abuse. Outside of that, like, are there any methods that... Have had any research for the people who have had this kind of trauma in their childhood related to borderline parents.

Dr. Lobel [00:27:31] This particular area. Like a number of areas, but especially this area of psychopathology is not amenable to research, unfortunately. You know, we like to do research and I've done lots of it in lots of places and it's really wonderful stuff. And you have your double blinds and you have one group that has a drug and the other group has a placebo and you follow them for six months. With personality disorder you would have to

follow people for their whole lives in order to do a study and When you have when you're doing a 20 or a 30 year study, and I'm not saying that we shouldn't do it I mean, we don't really live long enough to You know devote 20 or 30 or 40 or 50 years to a study that doesn't mean it's not valuable to be very valuable But the problem from a methodological point of view is that during that period there are so many confounds So, one of the people in the study also ends up developing leukemia, and another one has other trauma in their life, and so trying to study these things in a controlled setting is virtually impossible, and it's most unfortunate. So instead, we have to go with clinical experience, which was the traditional method of the psychoanalysts anyway, going all the way back to Freud and his disciples, And we have to rely on that as best as best we can while trying to study pieces of it in the laboratory, but it does not lend itself well to the study. However, what I found and what I offer is something that comes from the work that we have where there is a lot of study with post traumatic stress disorder in general. And it is, what we can offer this group is what I refer to and others refer to it too, it's not my term, emotional reprocessing. And the idea is, in my book I refer, this is my term the broken mirror. As I say, mirroring, good parents mirror their children but they do it accurately. Unhealthy parents mirror to their children things like you do everything wrong, you're wrong, and all of these other kind of things that go with the blame shifting and the gas lighting producing distorted images in the mirror that becomes the image of themselves. So they can, we can use the emotional reprocessing to go back to some very significant aspects of parenting and aspects of the self-image and repair it. And I'll give you an example. This occurred very recently, it was a true example where I was speaking to someone in their 30s and the person's mom had continuously made the case that the father lied all the time. The father was a liar, he lied all of the time, he is not to be trusted. And that the person grew up with that in their life for 30 years. And so I said to the person, can you tell me two lies that your father said to you over the last 30 years? And the young woman struggled and struggled and struggled, she tried. And I said, can you tell one lie that your father told you in 30 years, one lie. She was not able to produce a single lie. In that moment, And it's amazing, you can watch on their face. As this, it's like a rush of insight. It's like, wait a second. In my mind, he was lying to me all the time, but when I look at it now from the adult's perspective, that's the key. You're telling a child lies, children believe those lies. When they have the adult's perspectives and they can look back, that actually didn't happen at all. It was all made up. And that is a piece of healing right there. And the sum total of the healing are all of those pieces. Throughout the course of a good therapy and then beyond the actual therapy as the person learns to heal themselves

Beth [00:31:54] When I've been working in therapy with adults, and we start to untangle some of this, one of the things that I have observed is enormous distrust of self. I can't make the right decision. I need to get a lot of input from other people in order to decide which job I should accept or who I should choose as a partner or whatever, whether it's big decisions or tiny decisions of kind of decisional paralysis. And a lack of confidence. As you've said, we're talking about adults who grew up in environments where they were effectively, I think, kind of trained to disconnect from their own perception. Can you expand on that? Because it's been my experience of different realities coming into the therapy room. And you just said words like, can you think of any times that your father lied to you? That idea. Can you expand on that a little bit more? Because that's been one of the hallmarks that I've really seen in my work.

Dr. Lobel [00:32:56] Yeah, well the clarification of the perception, because these things were perceived from a perspective, sometimes from two or three or five years of age. But those memories, granted as they were recorded by a five-year-old, still exist in the brain

and they can now be examined by someone who's now an adult and have a much better view, an objective view. But with regard to the lack of self-confidence and the lack of self trust, which are central symptoms, they're profound in many adults who grew up with one or more borderline parent, there's another factor here that's quite strong. And in fact, it's one of the tougher but also one of them more damaging factors, which is that the borderline themselves, people have borderline. One of the distinguishing factors of the borderlines, it's so interesting, is that healthy people have a drive toward autonomy and independence. So, if you're raising a child and your child's one or two or three and you're feeding the child, at some point the healthy child is going to grab the spoon out of your hand. No, I want to do it. Or you're tying the child's shoelace. No, let me do it, let do it! Healthiest thing you could imagine. It is the natural drive toward autonomy and independence. Individuals who suffer from borderline personality amongst any other group that I've seen, They don't have that. They look at autonomy and independence as being a bad thing, and they resist the development of autonomy and dependence. Therefore, they end up seeking out relationships that are codependent. They have other people do for them what they're able to do for themselves, because in having other people to do them, it reassures them that they're lovable. So, there was one person who, as an adult, had the father. Call every morning at 6 a.m. It was not convenient for the father to call him and that was the person's alarm clock and I said well why don't why don t you just set an alarm clock well my father calls me every morning and I know he loves me if he didn't do that I would feel like he didn t love me and therefore I would be unlovable. As this translates to parenting the sufferers of significant symptoms of BPD discourage autonomy and independence and even growth in their own children in order to keep them close to them and dependent on them so that they can feel secure and not deal with the fear of being alone that is very prevalent in most people who suffer from this disorder. And so the parent is actually inhibiting growth in general and most specifically growth in autonomy and independence. And they do this by constantly questioning the child. Are you sure you know what you're doing? You might be making a big mistake when the child decides to join a hockey club after school or picking friends. Oh, gee, you know, the people you're the friends you're choosing, I don't know. You know, they come from bad families and they might not be good and you might want to think about choosing others. And then on top of that, so there's this inculcation of doubt in everything the child does, combined with blame for anything and everything that goes wrong. And the child feels like. Ultimately comes to feel like I'm defective. How can I, I can't make any decisions. Everyone I make is wrong. That's part of what comes through in the broken mirror.

Beth [00:36:51] My next question was going to be, how do you, granted folks who might come to see you in therapy know that this is your specialization, so there's that, but blank slate, you're working with a client for the first time, they don't know anything about you. Many of us put on our assessment hats and we're keeping these pages of the DSM floating around in our minds and how am I going to categorize what this person is going through? How do you separate out what you just said from. Anxiety from low self-esteem. What are some of the major indicators to you though this is something different and it's more than that? It's more social anxiety. This is coming from a deeper place.

Dr. Lobel [00:37:37] That's a great question and it's really interesting and it actually is such a powerful start to the therapy because what happens is these people will come in, these adult children will come and they'll tell you that they're not secure about their decision making or they'll ask you to help them make decisions. I'm trying to make this big decision, oh really what is that, whether we should for Chinese food or Italian food for dinner. You're like, really? And so what I'll ask the person is I'll say, well, what is your

history of decision-making? Tell me about times in your life when you've made decisions, how you've make those decisions, and how they come out. And it's really, it's so striking as a therapist, they'll tell you about a whole list of good Decisions that they made but they don't they discount it they discount. They don't own it and and Actually, they the in order to survive growing up with a parent or both parents who have a Severe personality disorder. They have to make good decisions because they're taking care of themselves. They're raising themselves So they actually learn how to make decisions, but they believe that they do and so in the questioning you ask them what is your history? What kind of decisions have you made? What kind of job do you have? How did you make that decision? How that work out for you? And you walk through that. Later on, you will take that and they'll tell you, I don't know, I don't have any confidence in my decision and say, well, what's your record? What's your record? The best we know from from long studies in behavior that the best predictor of future behavior is past behavior. So if you're someone who's made very good decisions in the past, who can make a better decision than you. And that is very healing for the people because, and forgive me for being verbose, but the people with BPD, this gets into another issue, are transactional. They're very transactional in their functioning. Meaning, the past doesn't matter. Only the present matters. So if you have a relationship with someone who has borderline personality disorder and you treat them beautifully every day for 10 years, and then you do one thing wrong, you're a horrible partner. But I did everything right for 10 years. No, that doesn't matter. The only thing that matters right now is you're not giving me what I want right now. So the parent treats the child and teaches the child to operate on a transactional basis looking only at the present, not drawing from past, which in many cases are past successes. And so you're helping this adult child start to use contextual thinking, which is a much healthier, more mature thinking, and move away from this transactionality which is childlike and distorted.

Beth [00:40:31] I love that you just brought up context and that's something that I've spent a lot of time thinking of in the therapy room. Human beings love to sort information, people, concepts, and we sometimes glaze over really important details. It sounds like for you, when you're trying to tease out diagnostically what's going on potentially for this person sitting right in front of me, you're try to draw information about. More context so that you understand what this person's world looked like and then how that's potentially impacting them now. When you're talking about the average, again, sorting, you're taking about the AVERAGE adult child of a borderline parent, can you rattle off some of those most common traits? Are born from this context of instability and lying or misrepresentation, etc.

Dr. Lobel [00:41:28] Yeah, well one thing, and these are not necessarily symptoms that are unique to this group, but they take a very specific form in this group and they're very prominent in this group. And one of the most prominent is anxiety, but it's a specific kind of anxiety, it could be very severe anxiety, because they're used to dealing with a parent, which has then been expanded into their entire world of social relationships that are in fact transactional. What that means is all of the stuff you did in the past, all the great nice things that you did and supportive things and healthy things, that doesn't count. And so because of the instability of the parent's character, you never know who's going to show up. It could be the nice parent that shows up, who's had a good day, who where everything has went his or her way and the child everything's okay or the parent could have had a terrible day shows up as the mean parent the child has no idea where that comes from because the child doesn't even know what the parent was doing during the day and so these children become very anxious about rapprochement about reuniting with other people they never feel like they're there's no continuity so they could have had wonderful

time with a partner or someone they're dating or a friend or an authority figure and then the next time they're in near panic state because they don't know how the person's going to show up. Even though they left them in a good situation, they still have no idea how they're going to show out. And these adult children become very good at reading. They'll talk to you about how with their parents they could read the steps, the they would step on the floor and know is it the good one or the bad one depending on how they step or how they close the door or how do they breathe. So one symptom would be this very high level of anxiety that you see in almost all situations. Another one is the guilt, and I don't see this kind of guilt in almost any other diagnostic group. It is a pervasive guilt with very frequent apologizing, a sense that basically they think that they're toxic. They've been raised to believe that they are toxic because the parent has told them that everything is their fault, and anytime they don't agree with the parent, they're wrong, period, end of story. There also is the lack, as you brought up quite correctly, the lack of self-confidence. They also feel guilty about doing anything beneficial for themselves. The term selfish becomes super toxic. So if you think about it, and I talk with this group a lot, what's the opposite of selfish? It's selfless. Being selfless, meaning having no sense of self, that's not a healthy situation. You may choose certain circumstances to protect a child where you'll put the child's welfare above your own, and you may even risk your life to do it. But to incorporate in the character a person who's selfless. A person who does not champion for themselves, who does assert their needs, who does not protect themselves, is not a healthy condition and it's very common. The next one is boundaries. The person now healthy people they like boundaries if you have friends coming into your home who have never been in your home before and they're healthy people you would say possibly hypothetically you would you know we have a no smoking house we don't smoke in the house so if you're going to have a cigarette or a cigar or whatever If you don't mind, we would appreciate very much if you would smoke outside, there's a deck outside with a seat and an ashtray, but please don't smoke in the house because we don't do that. A healthy person would say, oh, Beth, thank you so much for telling me that. I would feel horrible if I came into your house and lit up a cigar in your living room and then found out after the fact that it's a non-smoking house. I would be horrible about that. Individuals with BPD are offended by boundaries. So someone who has symptoms of BPD, you say, well, you know, we don't have, we don't smoke in the house. Well, how about in the garage? No, we, don't, we didn't have smoking in the house. Well, how about vape? How about if I vape, no, no we don, we don't have vaping in the house. Well, how about if I go in the bathroom, it's cold out. How about if I go into the bathroom and open the window and they fight against the boundaries because they feel that boundaries are an indication that you don't love them or you don't care about them. And they make that claim. So the children of these people, although they may have boundaries, they still see boundaries as offensive. They're reluctant to set boundaries And in many cases, they don't know how to do it because their efforts which may have been healthy They never work because like I say healthy people accept boundaries and are happy about them because boundaries make them feel safe And they give them a guide to a healthy relationship people with borderline personality symptoms test boundaries because they see them as an affront. They see them as a lack of love and they constantly test the boundaries. Well, what about this? Well, what about that? What about they catch them? Well only happen once. What only happens what so you can see in these people their relationship to boundaries is weak. Another very important factor or or symptom is that they're very afraid of people adults children have a very hard time being intimate. They don't trust people, uh, especially in intimate relationships and especially authority figures because it was the parent, you know, in many cases they've, they've seen other authority figures, teachers at school, parents of other children that are kind to them, but not, not their own. And they become terrified. They project the, uh the unhealthy

experiences that they've had with their own parents onto other people's parents or authority figures in general. And they become, they're terrified, they live, people who are very articulate can't even speak sometimes.

Beth [00:47:49] Thank you for that. I mean, there is so much more here that we can say in an hour. But thank you for entertaining that question of kind of the quick and dirty. These are the things that you might see in therapy. There's more. Yeah, there's certainly more. When you were talking about this and some of these trickle-down effects of growing up with a parent with borderline traits, one of the things that I was thinking like moving into adulthood. A lot of folks now are talking about estrangement, no-contact relationship with parent. This is controversial. Many of us, we all have our different sociocultural lens that's affecting how we interact with our elders, and that is part of the conversation. Can adults who have a parent with BPD, can they have healthy relationships? Or I guess safe relationships with that parent and how do we support them in doing that? Because also the flip side of this, and you've already mentioned it, but often the tendency toward enmeshment, like my job is to meet your need parent. And if I'm not doing that, then I'm being good. And so we stay kind of looped into this. And so sometimes what I've seen is the only way to try to break that cycle is to not have any contact with that person because it's so easy to slip back in. In your work. How do we help clients work toward a safer, healthier relationship with that parent, acknowledging that that may involve no contact.

Dr. Lobel [00:49:25] So this is a wonderful question, and it, as I'm sure you realize, is a tremendous clagmire. Because we have cultural expectations, we have religious expectations that the parent-child relationship is sacred. The parent with these symptoms capitalizes on that and believes that no matter what they do, that the child should be of service and loyal and have a warm place in the heart. So there are a lot of factors that have to be worked through in this situation. In my book about adult children, the first part of it speaks about myths that people come to believe when they grow up with a parent with BPD. And one of the myths is that it's okay to hurt someone that you love, that that's okay. So the first thing is to understand, no, that's not okay. That a person who says they're your mother or your father and they love you, but they hurt you all the time, that is not a consistent icon or concept. So the, so the first is to recognize that that is a lie. It is not okay to hurt people. You may do it by accident, but it's not okay do it on purpose. And you should minimize doing it by accidentally. The second thing is the work on boundaries. That not only should your parent not hurt you, nobody should hurt you. And you are entitled by every legal system, by every moral system, by every religious system, you're entitled to stop people from hurting you. And you shouldn't do that. It is healthy and adaptive to do that, and you teach the person how to do that. Then, when you're dealing with the parent who's still alive in this situation, you apply the boundaries selectively. So one of the things we haven't talked about yet, it's very prominent though, we should definitely address it in this podcast, is this issue of triangulation. Parents with The symptoms of BPD very, very often triangulate the children. This is when you try to polarize. It happens a lot if the marriage is intact, or even if the marriage is not intact, this parental alienation occurs. Parents with BPD will triangulate their children's spouse, take a position against the spouse or, you know, oh, you know, that no good husband of yours, blah, blah blah, and all this other kind of thing. So, the selective application of boundaries starts with any one of those things. So if you try to triangulate me with my spouse or with my friends, then I no longer discuss my relationships with them with you. Topic is off limits. We can talk about anything else, but we're not talking about my relationship with my spouse. I wouldn't have them say this to the parent, but in their own mind, they should realize you're trying to hurt my relationship. With my spouse, I don't discuss that with you anymore. And in the same

fashion if the A parent, if talking about work, sometimes the child will talk to the parent about work. Oh, you shouldn't work there. That's not a good place to work. Or, you know, that's only for low lives or losers. You collect these boundaries. Wherever the interaction is toxic, you put up a boundary and then you work with everything else. Unfortunately, if the parent is incredibly toxic in every situation, there are very areas that may still be on limits to actually talk about, but you craft the relationship around the toxicity, parceling out the toxic areas by the use of enduring a boundary in that area. It's hard to do.

Beth [00:53:33] That's actually what I was just going to say. That is very difficult to do. In my work with these individuals, this is potentially years, years of practicing. One of the things that I've said is you've had years of a different way of being and learning a new way of being to not talk about your intimate relationship with your parent might feel really uncomfortable and your parent might be upset because it's a change in. How you've been operating. I've noticed for me, it's been a lot of pacing and also normalization. I'm like, of course, this is gonna feel weird. And also, you know, like I was thinking about the lying that you'd been talking about. One things that I've seen a lot is a lot of secret keeping. They're like, if I don't know everything about you, then you have broken my trust. Then you have done something that's actively damaging to me or to the family when you don't tell me about. Whatever, you know, the job change or whatever it is. And how much in therapy, I think at least, at least in my work, it's a lot of kind of going slow of like unpacking these norms that are just accepted and then deconstructing, like what would it be like to not talk to your parent so much about your intimate relationship? And to be like, yeah, we're good. We went to this great Brazilian place the other night, and then to just move along or whatever it is, or just be like yeah, it's fine. Thanks for asking. Have you seen that new movie yet? I've talked a lot with my clients about the concepts I'm pulling from NPD work, but gray rocking this concept of how do I not give a ton of information still satisfy the need, but otherwise be kind of boring in that area. So that I can try to direct the conversation or interaction someplace a little bit safer for me.

Dr. Lobel [00:55:28] That's exactly right. We're not looking for additional conflict, there's already plenty of that. We're looking for confrontation, there are already plenty for that, I mean there's a role for that. But you're exactly right, and so if they hit an area like your relationship with your spouse or work, fine, everything's fine. Well what's new? Nothing really, everything is fine. And so it's just, it's not really officially a non-response, but it is pragmatically a non response. It doesn't allow for any vulnerability, there's nothing to attack there, everything's fine. How could everything just be fine? I don't know, mom, it's fine, what can I tell you, move on. That also is, just to get back for a second, what you were speaking about, is what a boundary violation? We talk about boundary disorder, we haven't used that term yet, but the boundary disorder that these people with borderline have is incredible, and the idea that you're allowed to have private thoughts, that somehow you're betraying the family, if you have private thoughts? I mean, that is... So outrageously unhealthy that it's almost the epitome of a boundary disorder. And you know, these kids who are brought up that way, they think they have to tell their parents everything. It's true. And they do that in relationships too. Very common when I work with younger people, even if they've resolved the relationship with the parent or the parent is deceased in many cases, they go into new relationships. They go into these dating situations, for example, oversharing. That's another symptom. They overshare. And it's like, why are you telling these, you don't even know these people. Why are you just getting to meet someone over a cup of coffee? Why are telling them all that stuff? I don't know. Isn't that what you do? No, that's not what you. People have to earn your trust. They don't just... Get it?

Beth [00:57:21] There's so much more that I wanted to ask and can be said about this topic, and I'm also grateful for what we've been able to cover in this hour. Yes, we're talking about recognizing it, and we're taking about some themes, but I also realize what we're really talking about is a lot of grief work for the way that our culture immortalizes a parent and the way it just evolutionarily, we do. We rely on our caregivers. Everything in our lives at some point in time and to not have had what we were hoping we would have had, I think, is an enormous loss. For our listeners, Dr. Lobel, who want to learn more about supporting adult children of parents with borderline traits, what are some of the best ways to do that? Like what resources do you prefer?

Dr. Lobel [00:58:15] Well, there's the book which I just wrote, it was published April of this year on adult children of borderline, you've probably seen it, the adult children of Borderline parents. There is some that you can get, I've collaborated with Randi Kreger, who is known for the Stop Walking on Eggshells work, she's done many, and we're actually collaborating on something right now, but we've collaborated on that. There is always NAMI, that it can be very, very helpful. There's also an organization in Atlanta, the Personality Disorder Awareness Network, PDAN, P-D-A-N, they can be found online. And, you know, if you can find, and I'm not saying it's easy to find, unfortunately I don't have any specific references, but working with other people who have been through what you've been through, like in a group setting, would be ideal. Because these people feel like what they're experiencing, nobody, because most people don't even believe them. If they actually tell these stories, people don't believe them, they can't believe that a parent would behave that way. They don't understand the impact of all this stuff. Even therapists, sadly, who are not specifically trained, they'll say, oh, you know, he's an old man, give him another chance, talking about the father who's devastating the adult child. And that's not the right answer. You can't just give everybody an unlimited amount of chance. You got to draw some boundaries. So if you can find a group therapy. Experience this tremendous value to working with others who have been through what you are been through and are helping each other to recover much like other disorders homogeneous groups that can be very helpful.

Beth [01:00:10] Thank you, I appreciate all of those resources and I think you bring up a great point there about trying to find a group particularly geared for other people who have been through this. And for our listeners, Dr. Lobel, specifically who want to learn more about you and about your work, what's the best way to do that?

Dr. Lobel [01:00:27] I have a website. It's called My Side of the Couch. It goes good with your website, I think. I also write a column for Psychology Today, which is also called My Side of The Couch, or you could just put my name in. I almost have 100 blogs. By a couple of weeks, I'll hit the 100 mark. The books that I've written, there are a number of that I've done this is not not my first one so really if you google me or my side of the couch you you will find me

Beth [01:01:02] I really appreciate your work and you spending the time to talk about this. I think you and I would both agree that this is kind of an under-discussed topic, and it's not uncommon for it to be affecting the lives of our clients. So thank you for your specialization and for coming on. I know you've given me a lot to think about, as well as some resources in what I might reach for when working with clients who have been through this. Thank you again for coming, Dr. Lobel, I appreciate it.

Dr. Lobel [01:01:27] Well, thank you for having me. And I will also add that it's really just starting now, but there are some centers that specialize in BPD that are coming up now. There are a couple of them in New York City, actually Mount Sinai has a program in New york city. I heard from some parents earlier that Elmhurst has a nice program there for that. And of course there's McLean Hospital, which is part of the Boston complex. So there are some people that are organizations that are ahead of the curve on this one.

Beth [01:02:02] Absolutely. Thank you. I appreciate you bringing that up. Like I said, I think there's a lot more to be said, but I think you gave us a great overview and also some resources where we can learn more. Again, for our listeners, we've had Dr. Daniel Lobel here to talk with us. Thank you so much for joining us, Dr. Lobel.

Dr. Lobel [01:02:18] It's my pleasure.