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Original article

Clinical differences between people with borderline personality disorder with and without romantic relationships: a case-control study

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SUMMARY

Background

The aim of this study was to determine the clinical differences (e.g., psychopathology, attachment style, self-esteem) between people with BPD with and without a romantic relationship.

Methods

The sample consisted of 49 BPD outpatients. Clinical variables were measured through the Borderline Symptom List, the Aggression Questionnaire, the BDI the Experience Close in Relationship, The Childhood Trauma Questionnaire, the Conflict Tactics Scale, the Interpersonal Reactivity Index, the Communication Patterns Questionnaire, the Dyadic Adjustment Scale the Index Sexual Satisfaction and the Interpersonal Reactivity Index. Stepwise MANOVA, multiple binary logistic regression analysis and Pearson correlates were performed.

Results

BPD with RR scored significantly higher than BPD without RR in aggression, childhood trauma and Psychological Health. Physical aggression was the most significant predictor of being engaged in a romantic relationship in BPD.

Conclusions

People with BPD and RR have a higher-level symptomatology in comparison to BPD without RR sample. In addition, it was found that physical aggression was the most predictive marital variable of the presence/non-presence of a RR.

Key words: borderline personality disorder, romantic relationships, partner, aggression, intimacy, cross-sectional

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Conflict of interest
The Authors declare no conflict of interest

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Borderline personality disorder (BPD) is a severe mental disorder observed in 2 and 5.9% of community samples, 10% of psychiatric outpatients, and 15% and 20% of psychiatric inpatients [1-3]. Different factorial studies indicate that BPD is characterized by four core clusters of symptoms: identity alterations, emotional dysregulation, severe impulsivity, and interpersonal problems [4-8]. Several studies indicate that these symptoms affect the general functioning of people with BPD, in particular, their relationships [3]. This finding is relevant considering that people with BPD have more difficulty in maintaining positive and stable social relationships than people with other psychiatric disorders (*i.e.,* major depression or obsessive-compulsive disorder) [3,9,10]. Regarding this issue, different authors suggest that the duration of an RR for people with BPD is shorter compared with people with other personality disorders [11,12]. Specifically, a prospective 27-year follow-up study suggested that the prevalence of an emotional break-up in people with BPD is 40-60% higher than people without BPD [14]. Similarly, differ-

ent cross-sectional studies indicate that the presence of emotional dysregulation (*i.e.,* emotional hyperactivity) and impulsivity in people with BPD is associated with an increased risk of break-ups [14-18].

Besides the stability of these RRs, different studies have found that people with BPD, have a higher number of sexual partners throughout the course of their life, which even affects their commitment (fidelity) during the establishment of the RR in comparison to people without BPD [19-26].

Regarding the quality of RRs, different longitudinal and cross-sectional studies suggest that people with BPD have less emotional satisfaction in their RRs in comparison with their partners throughout the course of their relationships [15,16,19,20]. In addition, a cross-sectional study showed that some symptoms of BPD (*i.e.,* impulsivity, depression, interpersonal distrust) predicted a lower emotional satisfaction in RRs for people with BPD [18]. Conversely, different cross-sectional and longitudinal studies suggest that this lower emotional satisfaction at baseline predicted the presence of pathological behaviors by people with BPD at follow-up (*i.e.,* ambivalent attachment, passive-aggressive communication, continued affection demand towards the partner) [15,18,19,27]. In particular, an 18-month longitudinal study found that women with BPD showed anxious attachment in their RR at the end of the follow-up period [19]. With regard to predictors, several cross-sectional studies have reported that the presence of childhood trauma is positively associated with the development of insecure attachment in adults with BPD who are involved in RRs [28]. Moreover, some longitudinal studies over 18 months have found that a lower emotional satisfaction of the member with BPD predicted poorer clinical features of the partner without BPD (*e.g.,* presence of personality disorders [antisocial, obsessive-compulsive, and avoidant] anxious attachment, passive-aggressive communication style]) [19,20].

Despite the growing literature cited above on RRs in people with BPD, the evidence is still far from clarifying relevant aspects. This is more remarkable taking into account the solid research on RRs in other types of clinical samples such as major depression obsessive-compulsive disorder [3,9,10]. For instance, research on the functioning of RRs in people with BPD is scarce. In fact, previous studies have focused on the evaluation of general clinical variables of RRs (*i.e.,* satisfaction and quality of the RR); however, the incidence of BPD people psychopathology has not been evaluated (*i.e.,* impulsivity, emotional emptiness, hostility emitted) in their RRs. On the other hand, the influence between traumatic episodes in childhood in the BPD patient and their RRs has not been evaluated.

In particular, the exposed findings have focused on the study of the variables of sentimental relationships (***i.e.,*** emotional and sexual satisfaction and the quality of the RR) of healthy people or people with other personality disorders. However, these results do not clarify that some people with BPD maintain a stable RR despite their psychopathology. Overall, the interest in addressing the RR of people with BPD with more clinical accuracy is also importantly due to healthcare parameters [3]. In fact, a large proportion of the emotional relapses treated in psychiatric emergencies and/or psychiatric hospitalization have their cause in the emotional problems that these patients present [28]. Ultimately, these emotional crises result in a direct economic cost of up to 13,000 euros per year [28].

In this context, the general objective of the current comparative study was to determine the clinical profile of a sample of people diagnosed with BPD who maintained an RR and compare it with a sample of people with the same diagnosis who did not have an RR at the time of the assessment. In addition, the specific objectives were the following: (1) to determine whether there were significant differences between the two samples of people with BPD (*i.e.,* in the general and specific psychopathology of BPD (depression, hostility, impulsivity)), type of adult attachment, self-esteem, quality of life, and type of traumatic episodes in childhood; (2) to determine whether some of the differential clinical variables between the two groups can predict romantic status (with or without a RR) in people diagnosed with BPD; and (3) to observe the correlation between the clinical variables of the person with BPD and the clinical variables of their partner (*i.e.,* personality type, communication style, attachment style, self-esteem, quality of life, emotional and sexual satisfaction, and hostility).

Method

Participants

Potentially eligible patients for the current study were initially referred to us by their clinicians as they consecutively attended the Adult Outpatient Mental Health Center of Mataró (Barcelona, Spain) from December 2016 to May 2018. Inclusion criteria for both groups were a lifetime diagnostic criteria for BPD according to the DSM-5 (APA, 2013) and being aged 18-65 years. Following other similar studies, inclusion criteria for people with BPD in an RR were twelve months in an RR or living together for four months [19,20]. Exclusion criteria for both groups were the following: (1) lifetime comorbidity with a psychotic disorder and/or pervasive developmental disorder according to DSM-5; (2) diagnostic of intellectual disability (IQ < 70) as recorded by the clinical charts; and (3) idiomatic barriers for reading/speaking Spanish or Catalan languages. Because of the great prevalence of current substance misuse among BPD patients, only

those who manifested symptoms of intoxication or substance withdrawal at the time of the assessment were excluded. Of the 55 potentially suitable outpatients, three declined to participate, mainly because they did not want to respond to sensitive issues in the questionnaires. Another three patients did not meet lifetime criteria for BPD, but had borderline traits. Hence, the final sample comprised a total of 49 BPD women: 23 patients with an RR (BPD patients and their partners) and other 26 BPD women without an RR at the time of assessment (see Figure 1). Regarding marital status of the total sample, 43.50% had married or were living with a partner at the time of the study, 18.80% with an RR not living together, and 37.70% single.

Participants attended individually, on average, one session of two hours in order to complete the administered questionnaires and the semi-structured interviews. All participants (people with BPD and partners) were interviewed directly by the authors of the manuscript, who are doctoral-level clinicians or clinical psychologists widely experienced in personality disorders and trained specifically for the assessment. The degree of agreement between interviewers for the diagnosis of BPD was high (*Cohen's Kappa* = .87). One week later, self-administered questionnaires were completed by the participants in a second session, in which any doubt regarding the items was resolved by the interviewers.

The study was approved by the hospital's Institutional Review Board, and informed consent was obtained from all patients after a full explanation of the nature of the study.

Instruments

Demographic information was collected by ad hoc questionnaires, as well as via interviews with participants when data were either no longer available or contradictorily registered in clinical records.

Personality disorder diagnosis and clinical psychopathology: SCID 5-PD, Personality Disorders [29]. For patients with BPD, diagnoses of personality disorders were determined by the Spanish version of the Structured Clinical Interview for DSM-5 (SCID 5 PD). The Spanish validation presented adequate internal consistency (*Cronbach's alpha* = .81).

BSL 23, Borderline Symptom List (Short version) [30,31]. Psychopathology of BPD was measured by the Spanish validation that presented adequate internal consistency (*Cronbach's alpha* = .97).

NEO-PI-R, Personality Inventory NEO [32,33]. For patients with BPD and their partners the Spanish validation presented adequate internal consistency (*Cronbach´s alpha* = .60 to .90).

Depressive mood: BDI, Beck's Depression Inventory [34,35]. The Spanish validation proved to be a reliable instrument for assessing the severity of depressed mood. The Spanish validation presented adequate internal consistency (*Cronbach's alpha* = .90).

Aggression symptomatology: AQ, Buss and Perry Aggression Questionnaire [36,37]. For patients with BPD and partners, the Spanish validation of the (AQ) was used to assess aggression. The Spanish validation presented adequate internal consistency (*Cronbach's alpha* = .72-.88).

Quality of life and self-esteem: the Spanish validation of the World Health Organization Quality of Life, Short-Form (WHOQOL-BREF) was used to assess quality of life [38,39]. For patients with BPD and partners. The Spanish validation presented adequate internal consistency (*Cronbach's alpha* > .80). RSE, Rosenberg Self-esteem [40,41]. It was measured by the Spanish validation of the Rosenberg Self-esteem Scale. The Spanish validation of the RSE presented adequate internal consistency (*Cronbach's alpha* = .87).

Type of attachment: ECR-R, Experience Close in Relationship [42,43]. For patients with BPD and partners, The ECR-R has two dimensions: anxiety and avoidance. The Spanish validation presented adequate internal consistency (*Cronbach's alpha* > .65).

History of childhood trauma: CTQ, Childhood Trauma Questionnaire [44,45]. The CTQ is a standardized, retrospective 25-item self-report inventory that measures the severity of different types of childhood trauma, producing five clinical subscales, each composed of five items: emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. The Spanish validation presented adequate internal consistency (*Cronbach's alpha* = .66 to .94).

Communication patterns: CPQ, Communication Patterns Questionnaire [46,47]. It has three scales: the scale of mutual constructive communication, mutual avoidance communication, and the demand/withdraw communication scale. The English validation presented adequate internal consistency (*Cronbach's alpha* > .75).

Emotional satisfaction: DAS, Dyadic Adjustment Scale [48,49]. The DAS was used to assess level of relationship quality and satisfaction. The Spanish validation presented adequate internal consistency (*Cronbach's alpha* > .80).

Social cognition: IRI, Interpersonal Reactivity Index [50,51]. For patients with BPD and partners. The measure has four subscales: Perspective Taking, Fantasy Empathic, Concern, and Personal Distress. The Spanish validation presented adequate internal consistency (*Cronbach's alpha* > .70).

Statistical analysis

Statistical analyses were performed using the Statistical Package for the Social Sciences (SPSS for Windows, Version 23.0). The Chi-square test, Mann-Whitney U test, and t-test were first used to analyze the sociode-

mographic data, depending on the nature of the variables. Then the Shapiro-Wilk test was used to confirm the normal distribution of quantitative clinical data for both clinical groups.

A multivariate analysis of variance (MANOVA) was performed with the resolution of reducing the risk of type I error for univariate contrasts of the dependent variables that could differentiate the BPD group with RR and without RR. The partial etha square was chosen as the measure of effect size. Those variables that vary between-group significant differences ($p < .05$) are included as predictors of the sentimental status of people with BPD using a subsequent multiple binary logistic regression analysis (*Cox & Snell R-square and Negelkerke R-square)* in order to predict the presence (= 0) or (= 1) absence in people with BPD, depending on the variables used in the analyses. All ***p***-values are based on 2-tailed tests with $\alpha = .05$. Most values were presented in terms of means and standard deviation (*SDs*).

Results

Sociodemographic comparison between people with BPD with and without RR

No significant differences were obtained between the groups ($p > .05$), except in the criterion of marital status linked to the methodological condition of the study and gender (Tab. I).

Clinical comparison of people with BPD with and without RR

The psychopathological variables of people with BPD with and without RR are shown in Table II. The MANOVA did not yield significant differences in psychopathological variables ($F = .18$, $p = .18$, *Wilks* $\lambda = .81$).

The univariate analysis did not report significant differences in the severity of BPD symptomatology ($p > .05$). Regarding aggression (AQ scale), the BPD group with RR obtained significantly higher scores than the BPD group without RR for various types of aggression (physical aggression, verbal aggression, rage and hostility)

TABLE I. *Sociodemographic comparison between BPD women with and without RR.*

	BPD with RR (n = 23) n (%)	BPD without RR (n = 26) n (%)	Statistics χ^2/t	*p*
Gender			χ^2 = **13.93**	.00**
Male	1 *(4.50)*	1 *(3.80)*		
Female	22 *(95.50)*	25 *(96.20)*		
Age (mean/SD)	38.65 (6.46)	38.88 (9.38)	t = -.10	.92
Education level			χ^2 = 2.28	.50
No Studies	4 (18.20)	3 (11.50)	-	-
Primary	4 (18.20)	9 (34.60)	-	-
Secondary	8 (31.80)	9 (34.60)	-	-
University	7 (31.80)	5(19.20)	-	-
Marital Status			χ^2 = 49.00	.00**
Married or living with a partner	17 (72.70)	0 (.00)	-	-
RR NLT	6 (27.30)	0 (.00)	-	-
No-stable RR	0 (.00)	26 (100)	-	-
Occupation			χ^2 = 1.97	.74
Student	3 (13.60)	5 (19.20)	-	-
Employee	6 (27.30)	10 (38.50)	-	-
Unemployed	5 (22.70)	5 (19.20)	-	-
Retired due to disability	4(22.71)	3 (11.50)	-	-
Medical leave	3 (13.60)	3 (11.50)	-	-
Childs (mean/SD)	.87 (.81)	.38 (.49)	t = 2.54	.13
RR previous			χ^2 = 1.60	.20
Yes	18 (77.30)	16 (61.50)	-	-
No	5 (22.70)	10 (38.50)	-	-

BPD: Borderline Personality Disorder; NLT: Not Living Together; RR: Romantic Relationship; SD: Standard Deviation
***p < .o1 in BPD with RR vs BPD without RR*
**p < .05 in BPD with RR vs BPD without RR*

($p < .05$). The effect size was low for these variables, and the moderate-high powers.
As regards depressed mood, no significant differences were evidenced ($p > .05$).
The multivariate analysis did not report significant differences between the attachment variables ($F = 2.39$, $p = .10$, *Wilks* $\lambda = .90$). Similarly, these differences were also not observed in the univariate analysis ($p > .05$).
The MANOVA test reported significant differences in the variables of quality of life and self-esteem (F = 3.93, p = .00, Wilks $\lambda = .65$).
Regarding the quality of life, the BPD group with RR showed significantly higher scores in psychological health and lower scores in physical health compared to the BPD group without RR ($p < .05$). The effect sizes were mild and the powers moderate-high.
Regarding self-esteem, the BPD group with RR showed significantly lower scores compared to the BPD group without RR ($p < .05$). The effect size was small and the power was high.
The MANOVA analysis reported significant differences between childhood traumatic episodes variables ($F = 2.79$, $p = .02$, *Wilks* $\lambda = .74$).
The univariate analysis showed significantly higher scores in the BPD group with RR than in the BPD group without RR for various types of traumatic episodes in childhood (emotional abuse, sexual abuse and emotional abandonment) ($p < .05$). The effect sizes were slight and the potencies were moderate-high.
The multivariate analysis did not report significant differences between the variables of social cognition ($F = .17$, $p = .94$, *Wilks* $\lambda = .97$). Similarly, these differences

TABLE II. *Psychopathological comparison among clinical variables between BPD patients with and without RR.*

Variables	BPD with RR (n = 23) M *(SD)*	BPD without RR (n = 26) M *(SD)*	Statistics *F*	*P*	*h2*	*P*
BSL 23	61.68 *(22.64)*	48.52 *(32.40)*	2.53	.11	.05	.34
AQ						
Physical aggression	47.14 *(12.49)*	37.08 *(12.94)*	7.29	.01*	.14	.75
Verbal aggression	49.32 *(7.64)*	41.96 *(10.76)*	7.11	.01*	.13	.74
Rage	26.50 *(4.16)*	23.68 *(5.32)*	4.01	.05*	.08	.50
Hostility	18.55 *(4.09)*	14.60 *(5.92)*	6.86	.01*	.13	.72
BDI	22.64 *(5.90)*	18.40 *(8.80)*	3.64	.06	.07	.46
ECR						
Anxious attachment	36.39 *(6.73)*	39.54 *(5.34)*	3.17	.08	.06	.41
Avoidant attachment	38.13 *(4.22)*	36.46 *(5.88)*	1.24	.27	.02	.19
WHOQOL						
Physical health	16.45 *(4.76)*	19.35 *(4.75)*	3.96	.05*	.08	.49
Psychological health	13.30 *(3.35)*	10.43 *(2.76)*	9.43	.00**	.18	.85
Social relationships	8.60 *(4.53)*	7.65 *(3.63)*	.57	.45	.01	.11
Environment	17.80 *(5.43)*	17.96 *(6.23)*	.00	.93	.00	.05
Self-esteem	16.40 *(3.99)*	20.54 *(4.87)*	8.35	.00**	.16	.80
CTQ						
Emotional abuse	13.87 *(3.79)*	10.63 *(2.63)*	11.68	.00**	.21	.91
Sexual abuse	14.04 *(5.20)*	10.25 *(3.87)*	8.06	.00**	.19	.79
Physical abuse	7.52 *(3.23)*	7.29 *(3.36)*	.05	.81	.01	.05
Emotional abandonment	11.61*(2.79)*	9.25*(2.48)*	9.36	.00**	.20	.85
Physical neglect	11.57 *(5.09)*	9.96 *(4.56)*	1.30	.26	.05	.20
IRI						
Perspective tacking	11.82*(4.65)*	*12.35 (4.97)*	.33	.56	.00	.08
Fantasy	10.76*(6.36)*	*11.04 (5.41)*	.19	.66	.00	.07
Empathic preocupation	9.80 *(4.45)*	*10.01(4.45)*	.01	.89	.00	.05
Personal distress	9.06 *(4.91)*	*10.52(5.50)*	.44	.51	.00	.09

AQ: Aggression Questionnaire; BDI: Beck Depression Inventory; BPD: Borderline Personality Disorder; BSL 23: Borderline Symptom List; CTQ: Childhood Trauma Questionnaire; IRI: Interpersonal Reactivity Index; RR: Romantic Relationship; SD: Standard Deviation; WHOQOL: World Health Organization Quality of Life.
***p < .00 in BPD people with RR vs BPD people without RR*
**p < .05 in BPD people with RR vs BPD people without RR*

were also not observed in the univariate analysis (p > .05)

Clinical predictors of romantic status in people with BPD

The clinical predictors among romantic status in people with BPD with and without RR is shown in Table III. The multiple binary logistic regression analysis was found to be statistically significant and the model explained roughly half of the variance of the marital status in BPD (χ^2 = 21.83, p = .00, *Cox and Snell* = .40, *Negelkerke* = .54). Specifically, the results showed that the most significant predictor of RR status was physical aggression and self-esteem. Specifically, greater self-esteem predicted the absence of sentimental attachment, while greater physical aggression was associated with the presence of a sentimental attachment.

Association between clinical and relational variables in BPD patients and their partner

The correlation analysis reported significant positive associations between the dimension of agreeableness of the group of couples and the demanding communication of the TLP group (r = .47, p = .03). Likewise, the satisfaction of the BPD group was positively associated with the conscience dimension of the group of couples (r = *.53*, p = .01).

Discussion

The main objective of this study was to address the clinical differences between people with BPD with an RR and those and without an RR. The main findings of this study were: (1) the BPD patient sample with an RR presented a higher level of aggression emitted, a higher incidence of childhood traumatic episodes, poorer physical health, higher levels of psychological health and lower self-esteem; (2) physical aggression was the most relevant clinical predictor to the marital status of patients with BPD; and (3) positive associations between the dimension of agreeableness of the group of couples and the demanding communication of the BPD group.

First, as in other similar studies, the present investigation showed that people with BPD and an RR exhibited high scores in aggression and presence of childhood traumatic episodes [6,19,20,52]. These results support theoretical lines of other correlative studies regarding the severity of the psychopathology of BPD (*i.e.,* impulsivity, hostility emitted, avoidant attachment style) and the presence of childhood traumatic episodes [53-56]. As in other longitudinal and cross-sectional studies, the present investigation found that people with BPD who maintain an RR have greater avoidant attachment and childhood trauma than those without an RR [19,46,57]. In addition, following the line of these authors, it is possible that people with BPD with presence of trauma in childhood have a greater search for stable RR due to patterns of emotional dependence generated by the "false stability" in their RR 46,57. However, unlike these studies, this research establishes a more specific clinical and methodological framework by delimiting the differences between groups of patients with the same diagnosis (inter-BPD), which makes it possible to clarify that aggression is not merely a psychopathology. primarily more observable in people with BPD, but RRs are erected in a psychosocial context of high risk for the risk, either as an eliciting, triggering and/ or exacerbating external variable of its manifestation.

Another finding of this study was that people with BPD with a RR had a significantly higher self-esteem deficit than people with BPD without a RR. In turn, they presented significantly greater psychological well-being (WHOQOL scale). This apparent contradiction suggests that patients with RS could "use" the sentimental attachment as a compensatory mechanism for a minor "self-love", so that relationship would acquire a very relevant meaning for their identity or self-concept.

Second, the most predictive marital status variable was "physical aggression". This result supports a prospec-

TABLE III. *Clinical predictors of romantic status in people with BPD.*

Predictive variables	*B*	*Standar error*	*Wald*	*p*	Odds ratio Exp[β]
CTQ					
Emotional abuse	- .25	.24	1.02	.31	.77
Sexual abuse	- .02	.13	.03	.84	.97
Emotional abandonment	- .13	.27	.22	.63	.97
Self-esteem	.20	.10	3.5	.05*	1.22
AQ					
Physical aggression	- .07	.03	4.90	.02*	.92

AQ: Aggression Questionnaire; BPD: Borderline Personality Disorder; CTQ: Childhood Trauma Questionnaire; SD: Standard Deviation
***p < .01*
**p < .05*

tive four-month follow-up study about BPD and RR, which suggests that 37% of couples of people with BPD were victims of physical and psychological violence [26]. In the same line, other correlative studies on aggression in people with BPD and RRs indicate that approximately 20 to 60% of couples presented physical aggression and 80% verbal aggression in their RR [19,27]. In addition, different studies indicate that the determining variable of the cyclic pattern of ruptures-reconciliations in the RRs of people with BPD was domestic violence [19,20,57,58]. On the other hand, the results of the present study follow the line of various correlative studies on emotional hyperactivity and aggression in the BPD, which suggest that people with BPD have more reactive response to their partners due to marital conflicts [19,59-61].

Another relevant result for this research was that positive correlations were found between the pleasantness of couples and the demanding communication of people with BPD. This result makes us tentatively hypothesize that RR is consolidated in a pathogenic and insanely persistent relational dynamic. These findings are consistent with a longitudinal study on a BPD sample [19]. Along the same lines, significant positive correlations were also found between conscience of the partner and emotional satisfaction of people with BPD. Taken together, this suggests that relational dynamics are exercised on the basis of clearly established roles within an interdependence, with a more emotionally demanding tendency (hyper-demand) on the part of the patient with BPD and a more restraining predisposition at the level emotional on the other side of the relationship.

In summary, the findings of the present research tentatively support the approach of systemic partner interventions in patients with BPD (e.g., TICP) [62,63]. Likewise, the implementation of cognitive-behavioral techniques to work codependency in the partner of the patient with BPD would be justified [63].

This study has several limitations that must be considered. First, it is a cross-sectional study in which casual relationships cannot be established between the variables of the RR and the psychopathology of the people with BPD. Second, because this study is cross-sectional, we do not know the evolution of the RRs of the participants and their current marital status. Similarly, some data were collected retrospectively (*i.e.,* childhood traumatic episodes), which increases the risk of bias. Third, the sample size makes it difficult to generalize the results. Also, research has been limited to heterosexual associations and the participants with BPD were generally female. This limitation reduces the generality of the conclusions shown above.

Finally, different longitudinal and cross-sectional studies are needed on RR in people with BPD. Specifically, it would be decisive to know the incidence of Axis I and Axis II psychiatric disorders, childhood trauma and early maladaptive schemes in BPD samples and their couples. These results could provide relevant clinical information to elucidate more clearly a relational pattern between people with BPD and their partners.

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