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RELATIONSHIP QUALITY AND STABILITY IN COUPLES WHEN ONE PARTNER SUFFERS FROM BORDERLINE PERSONALITY DISORDER

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The main goal of the present study was to examine and compare the psychosocial functioning of 35 couples including a woman diagnosed with borderline personality disorder (BPD) to that of a nonclinical control sample of 35 couples. The BPD status of women from the clinical group and the prevalence of personality disorder in their partner were ascertained through the SCID-II. Participants completed self-report measures of couple functioning. A majority of couples in which the woman suffered from BPD (68.7%) evidenced frequent episodes of breakups and reconciliations and, over an 18-month period, nearly 30% of these couples dissolved their relationship. Nearly half of the men involved in a romantic relationship with a woman suffering from BPD met criteria for one personality disorder or more. As compared with nonclinical couples, clinical couples showed lower marital satisfaction, higher attachment insecurity, more demand/withdraw communication problems, and higher levels of violence.

From both conceptual and clinical viewpoints, the disruptive role of borderline personality traits and/or disorder (BPD) in relationship quality and persistence is generally thought to be extensive. Acute and chronic instability in affective, cognitive, motivational, and behavioral systems induces volatile interpersonal bonds and severe affiliative problems. Theoretically, attachment insecurity, identity diffusion, mentalization problems, and emotional reactivity should systematically disrupt couple formation processes and outcomes through nonoptimal partner choice, conflicting relationship goals, dysfunctional communication patterns, risk regulation difficulties, and diverse forms of physical and psychological violence.

However, the validity of this assumption does not rest on solid empirical grounds. A significant proportion of patients suffering from BPD (ranging from 20% to 30%) are currently involved with a romantic partner in the context of a dating, cohabiting, or married relationship (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Giesen-Bloo et al., 2007; Paris & Braveman,

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1995; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005). In addition, four methodological problems are common in the research literature. First, studies are frequently conducted with mixed groups of patients with different personality disorders (e.g., Guttman, McDermut, Miller, Chelminski, & Zimmerman, 2006). Second, borderline symptoms in couples are rarely studied and when they are, patients with the full syndrome of BPD form only a marginal part of the sample (e.g., Dailey, Burge, & Hammen, 2000). Third, when samples are specifically composed of patients with BPD and relational outcomes are examined, couple relationships are not distinguished from other types of relationships with close friends or parents (e.g., Bardenstein & McGlashan, 1989; Hoffman, Buteau, Hooley, Fruzetti, & Bruce, 2003; Widiger & Frances, 1989). Fourth, to the best of our knowledge, no studies investigating the correlates of marital satisfaction in couples including a partner suffering from BPD also scrutinized the personality and psychological characteristics of the non-BPD spouse or romantic partner.

Considering the dearth of empirical data on couples where one partner suffers from BPD, the main purpose of this study was to explore four dimensions of couple functioning (attachment status, communication style, intimate violence, and dyadic adjustment) in two groups of couples: couples where the women suffer from BPD and couples from a nonclinical control group. The prevalence of personality disorders in the partner of women diagnosed with BPD was also assessed. To the best of our knowledge, this is the first study to collect data directly from both members of couples where the women are uniformly diagnosed with BPD.

A growing body of research suggests that the attachment status of patients with BPD is closely associated with their relationship difficulties. For example, preoccupied and fearful attachment styles are generally overrepresented in BPD populations (Levy, Meehan, Weber, Reynoso, & Clarkin, 2005). Meyer and Pilkonis (2005) also observed that attachment-related anxiety, but not avoidance of proximity, is more prevalent in BPD patients. However, only one study directly evaluated the attachment style and relationship satisfaction of partners of women with the full syndrome of BPD ($n = 4$; Goldstein, 2003).

Patients diagnosed with BPD are both at risk of being abusive and victimized in close relationships. For example, Holtzworth-Munroe and Meehan (2002) showed that BPD traits are significantly associated with intimate violence and abuse. To the best of our knowledge, no study has determined whether women with BPD are prone to violence toward their romantic partner. On the other hand, when compared with patients with other personality disorders, patients with BPD report an increased hazard of experiencing adult violence and abuse (Zanarini et al., 1999). However, victimization specifically happening in the romantic relationships of patients with BPD has not been examined systematically.

Communication and couple satisfaction are closely linked (Christensen & Shenk, 1991). In general, distressed couples evidence less mutual constructive communication, more avoidance of communication, more demand/withdraw communication, and more conflicts over psychological distance in their relationships. Past investigations have also shown that wife demand/husband withdraw communication is more likely across groups of distressed or nondistressed couples than husband demand/wife withdraw communication.

HYPOTHESES

Four main hypotheses were tested. Compared with partners of couples from the control group, both partners of couples in which women were diagnosed with BPD will evidence (a) more insecure attachment styles, (b) higher rates of physical and psychological violence, (c) less mutual communication and more demand-withdraw patterns, and (d) lower levels of dyadic adjustment. The prevalence of personality disorders in men romantically involved with women suffering from BPD was examined on an exploratory basis and no hypotheses were formulated.

METHOD

Participants

Clinical couples. This sample of clinical couples was composed of 35 heterosexual dating ($n = 6$), cohabiting ($n = 21$), and married ($n = 8$) couples. Women from the clinical group were on average 33.83 years old ($SD = 10.46$) and their partners were 38 years old ($SD = 11.89$). The women met the *DSM-IV* (American Psychiatric Association, 1994) diagnostic threshold for BPD according both to their psychiatrist and to the SCID-II-borderline section. Women with BPD had a mean Global Assessment of Functioning score (GAF; American Psychiatric Association, 1994) of 49.91 ($SD = 5.72$) and the mean GAF score of their partner was 67.24 ($SD = 8.50$). Women met a mean of 7.2 BPD criteria ($SD = 1.51$) out of nine (48.6% of sample met eight criteria or more). Mean duration of relationship was 5 years and 11 months ($SD = 8.8$ years, ranging from 2 months to 38 years). Most couples had been living together for a mean duration of 4 years and 11 months ($SD = 7.87$) and they had a mean number of 1.28 children ($SD = 1.33$; range = 0–5). Most of the women diagnosed with BPD (70.6%) had an annual income of < $15,000 CND whereas their partner rarely had (14.3%) an annual income over $45,000 CND. In addition, 32.9% of women with BPD and 22.9% of their partners completed a college education or more. Women with BPD had a mean of 4.43 lifetime suicide attempts ($SD = 5.86$; range = 0–25) and 3.93 parasuicide behaviors in the last 12 months ($SD = 5.04$; range = 0–20). Mean number of days spent in hospitalization in the last year was 9.21 ($SD = 19.42$; min = 0, max = 80). Almost all women (34 out of 35) were undergoing treatment at the time of the study. A large proportion of women reported childhood physical (50%) and sexual abuse (77.1%). Comparable figures for men were 22.9% and 18.2%. Over the last year, these men spent a mean of 2.63 days hospitalized for psychiatric reasons ($SD = 15.21$; min = 0, max = 90). In addition, they had a mean lifetime of .26 suicide attempts ($SD = .66$; range = 0–3) and they reported .20 parasuicide behaviors in the last 12 months ($SD = .66$; range = 0–3).

Control couples. The control group was formed of 35 cohabiting or married couples selected from a larger representative sample of 316 couples (Godbout, Lussier, & Sabourin, 2006). Six variables were used to minimize the presence of borderline personality traits and general psychopathology in the control group. Couples in which the woman met the following characteristics were excluded: antecedent of childhood or adolescent sexual abuse ($n = 43$) or physical abuse ($n = 5$), extreme trait anger (Spielberger, 1988; 2 *SD* above the mean; $n = 11$), extreme psychological symptoms (2 *SD* above the mean; $n = 11$), problematic alcohol use ($n = 7$), and consultations with a mental health professional in the last year ($n = 15$). Afterwards, in order to form the final control group, 35 couples were matched in a stepwise fashion with couples from the clinical group on age, education, and annual income.

Control women were on average 35.64 years old ($SD = 11.21$) and their partners were 37.36 years old ($SD = 11.05$). Couples had been involved for a mean duration of 16.5 years ($SD = 12.53$), were either married or cohabiting ($M = 13.23$ years, $SD = 10.08$), and had a mean number of 1.71 children ($SD = 1.27$).

Instruments

Personality disorder diagnoses. A French version of the Structured Clinical Interview for *DSM-IV*, Axis II was used (SCID-II; First, Spitzer, Gibbon, Williams, & Benjamin, 1997). In the present study, a third ($n = 12$) of all SCID-II interviews were randomly selected and recoded by a second independent rater. The two judges were advanced graduate students in clinical psychology. For women, raters agreed on the BPD diagnosis in 11 out of the 12 cases. The case for which judge diagnoses differed was excluded from the study. For men involved with a woman diagnosed with BPD, intraclass correlation coefficients (Shrout & Fleiss, 1979) reached .90 ($n = 13$).

Attachment. Attachment representations were measured using the Experiences in Close Relationships Questionnaire (ECR; Brennan, Clark, & Shaver, 1998). Factor analysis indicated the presence of two interrelated dimensions of attachment: anxiety about rejection (18 items) and avoidance of intimacy (18 items; Lafontaine & Lussier, 2003). Individuals can also be classified according to four attachment styles: secure, fearful, avoidant, and preoccupied. In the present study, alpha coefficients were high (.90 for anxiety and .87 for avoidance).

Intimate violence. Intimate violence was measured using a French short form of the Conflict Tactics Scale (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). Only the physical and psychological violence sections were used. Straus et al. (1996) reported alpha cœfficients varying between .79 and .95. Alphas varied between .75 and .85 in our sample.

Communication patterns. Communication patterns in couples were assessed using the 11-item short form of the Communication Pattern Questionnaire (CPQ; Christensen, 1987). The scale consists of three subscales: Mutual Constructive Communication, Demand Withdraw Communication, and Demand Withdraw Roles. Stability and validity coefficients of the CPQ are satisfactory (Christensen & Heavey, 1990). In our sample, alphas ranged between .55 and .75.

Psychological distress. Psychological distress was assessed with the shortened version of the Psychiatric Symptom Inventory (PSI-14; Ilfeld, 1978). Items on the PSI-14 assess four domains: depression (five items; $\alpha = .89$), anxiety (three items; $\alpha = .79$), aggression (four items; $\alpha = .91$), and cognitive problems (two items; $\alpha = .90$). The PSI-14 shows good internal consistency (.92), construct validity, and criteria validity (Préville, Potvin, & Boyer, 1995).

Dyadic adjustment. An 8-item version of the Dyadic Adjustment Scale (DAS-8; Spanier, 1976) was used to assess level of relationship quality and satisfaction. The predictive validity of this short version of the DAS is supported in a 3-year longitudinal study of couple dissolution (Sabourin, Valois, & Lussier, 2005). In the present sample, alpha was .85.

RESULTS

Union Status Instability and Union Dissolution

Most of the clinical couples (68.7%, $n = 22/32$) reported a pattern of episodic relationship instability, i.e., breaking up and coming back together (mean = 2.58 times, min = 0, max = 14) approximately once every 6 1/2 months. In addition, during the course of the present study, which was conducted over an 18-month period, 28.6% (10 out of 35) of clinical couples reported having broken up "definitively."

Prevalence of Personality Disorder in the Non-BPD Partner

Nearly half of our sample of men (44.1%) met criteria for at least one personality disorder. More specifically, ten men (29.4%) met criteria for one Axis II diagnosis, two men (5.9%) for two Axis II diagnoses, two (5.9%) for three diagnoses, and one (2.9%) for six diagnoses. The four most prevalent personality disorders observed in these men were paranoid (14.7%), antisocial (14.7%), obsessive–compulsive (14.7%), and avoidant (11.8%). In addition, 52.9% of the sample met criteria A of antisocial personality disorder (antisocial behaviors before age 15).

Attachment Categories and Attachment Dimensions

Differences between women with BPD and their romantic partner. The frequency of the four attachment categories in women and men of the clinical group was as follows: secure, 0% versus 31.4% [$\chi^2(1, N = 70) = 13.05$, $p < .001$]; fearful, 37.1% versus 22.9% [$\chi^2(1, N = 70) = 1.70$, ns]; preoccupied, 60% versus 31.4% [$\chi^2(1, N = 70) = 5.76$, $p < .05$]; dismissive, 2.9% versus 4.3% [$\chi^2(1, N = 70) = 2.91$, ns]. Avoidance of intimacy in women with BPD ($M = 3.09$, $SD = 1.15$) was not statistically stronger than that observed in their romantic partner, $M = 2.79$, $SD = 1.10$, t (34) = .99, ns. However, rejection anxiety was higher in women with BPD ($M = 4.95$, $SD = 1.20$) than in their romantic partner,

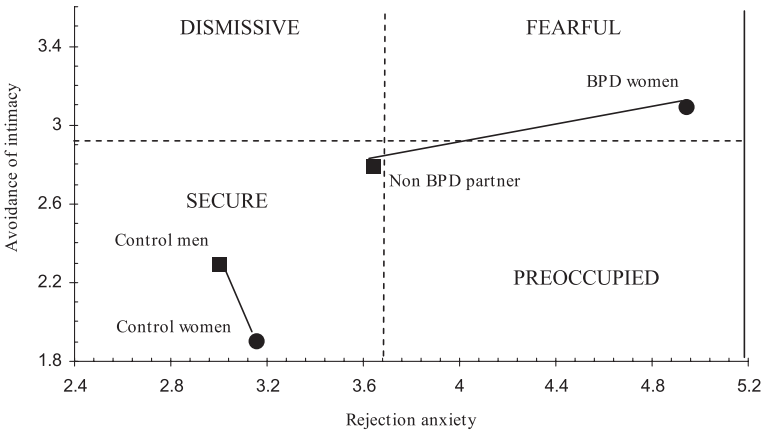

Figure 1. Mean scores for the two dimensions of attachment in clinical and nonclinical couples. *All differences are significant at $p < .05$ except for the difference in rejection anxiety between men and women from the control group, $t = 0.88$, dl = 34, ns.

$M = 3.64$, $SD = 0.88$, $t(34) = 5.51$, $p < .001$. Mean anxiety and avoidance scores for each of the four attachment categories are plotted for both clinical and control couples in Figure 1. As expected, control participants were generally securely attached. Women diagnosed with BPD were located in the fearful quadrant but not very far from the border between fearful and preoccupied attachment. However, their partners were mostly located at the border of the secure and preoccupied quadrants but not very far from the fearful and dismissive attachment categories.

Differences between women from both samples. The four attachment categories were not randomly distributed in women of the clinical and nonclinical groups: secure, 0% versus 68.6% [$\chi^2(1, N = 70) = 36.52$, $p < .001$]; fearful, 37.1% versus 2.9% [$\chi^2(1, N = 70) = 12.86$, $p < .001$]; preoccupied, 60.5% versus 22.9% [$\chi^2(1, N = 70) = 9.95$, $p < .01$]; dismissive, 2.9% versus 5.7% [$\chi^2(1, N = 70) = 0.35$, ns]. Avoidance of intimacy in women with BPD ($M = 3.09$, $SD = 1.15$) was statistically higher than that observed in women from the nonclinical group, $M = 1.9$, $SD = .77$, $t(59.31) = 5.03$, $p < .001$. Rejection anxiety was also significantly higher in women with BPD ($M = 4.95$, $SD = 1.20$) than in women from the nonclinical group, $M = 3.16$, $SD = 1.12$, $t(68) = 6.45$, $p < .001$.

Differences between men from both samples. The distribution of the four attachment categories in men of the clinical and nonclinical group was as follows: secure, 31.4% versus 65.7% [$\chi^2(1, N = 70) = 8.24$, $p < .01$]; fearful, 22.9% versus 8.6% [$\chi^2(1, N = 70) = 2.70$, ns]; preoccupied, 31.4% versus 17.1% [$\chi^2(1, N = 70) = 1.95$, ns]; dismissive, 14.3% versus 8.6% [$\chi^2(1, N = 70) = .56$, ns]. Avoidance of intimacy in men of the clinical group ($M = 2.79$, $SD = 1.10$) was statistically stronger than what was observed in men from the nonclinical group, $M = 2.30$, $SD = 0.77$, $t(70) = 2.15$, $p < .05$. Rejection anxiety was also higher in men from the clinical group ($M = 3.64$, $SD = 0.88$) than in men from the nonclinical group, $M = 3.00$, $SD = .78$, $t(70) = 3.23$, $p < .01$).

Physical and Psychological Violence

Differences between women with BPD and their romantic partner. Women with BPD exhibited more physical violence ($M = 7.20$, $SD = 19.05$) than their partner, $M = 1.34$, $SD = 3.02$, Wilcoxon signed ranks tests, $z(35) = 3.05$, $p < .01$. Moreover, women with BPD also showed more psychological violence ($M = 29.29$, $SD = 32.22$) than their partner, $M = 11.91$, $SD = 14.91$, Wilcoxon signed ranks tests, $z(35) = 3.51$, $p < .001$. Women with BPD

experienced less physical violence ($M = 1.51$, $SD = 2.72$) than their partner, $M = 6.34$, $SD = 14.17$, Wilcoxon signed ranks tests, z (35) $= 2.25$, $p < .05$. Finally, women with BPD did not experience a different rate of psychological violence ($M = 13.37$, $SD = 18.33$) than their partner, $M = 23.54$, $SD = 29.07$, Wilcoxon signed ranks tests, $z(35) = 1.77$, ns.

For women with BPD, rates of experienced physical violence were strongly associated with physical violence reportedly committed by their partner, $r = .75$, $p < .001$. Likewise, for women with BPD, rates of psychological violence were moderately associated with that reported by their partner, $r = .40$, $p < .05$. Men involved with a women suffering from BPD reported rates of physical violence moderately associated with that of their partner, $r = .34$, $p < .05$. Finally, men involved with a woman suffering from BPD reported rates of psychological violence moderately associated with that of their partner, $r = .49$, $p < .01$.

Differences between women from both samples. As compared with women from the control group ($M = .79$, $SD = 2.32$), women with BPD exhibited more physical violence, $M = 7.20$, $SD = 19.04$, Mann–Whitney U-test, $z(35) = 3.06$, $p < .01$. Women with BPD also evidenced more psychological violence ($M = 29.29$, $SD = 32.21$) than women from the control group, $M = 4.62$, $SD = 5.70$, Mann–Whitney U-test, $z(35) = 4.40$, $p < .001$. Women with BPD also experienced more physical violence ($M = 1.51$, $SD = 2.72$) than women from the control group, $M = 0.31$, $SD = .89$, Mann–Whitney U-test, $z(35) = 2.30$, $p < .05$. Finally, women with BPD reported being subjected to more psychological violence ($M = 13.37$, $SD = 18.34$) than women from the control group, $M = 3.88$, $SD = 5.00$, Mann–Whitney U-test, $z(35) = 2.82$, $p < .01$.

Differences between men from both samples. Men from the clinical group did not exhibit more physical violence ($M = 1.34$, $SD = 3.02$) than men from the nonclinical group, $M = .66$, $SD = 1.75$), Mann–Whitney U-test, $z = 1.33$, ns. In addition, rates of psychological violence did not distinguish men from the clinical group ($M = 11.91$, $SD = 14.91$) from those of the control group, $M = 4.74$, $SD = 5.59$, Mann–Whitney U-test, $z = 1.76$, ns. However, men of the clinical group experienced more physical violence ($M = 6.34$, $SD = 14.17$) than men from the nonclinical group, $M = .66$, $SD = 1.75$, Mann–Whitney U-test, $z = 3.25$, $p < .001$. They also experienced more psychological violence ($M = 23.54$, $SD = 29.07$) than men from the control group, $M = 4.29$, $SD = 5.28$, Mann–Whitney U-test, $z = 3.22$, $p < .001$.

Communication Patterns

Differences between women with BPD and their romantic partner. No significant sex differences were observed between women diagnosed with BPD and their love partner on all four scales of the Communication Pattern Questionnaire.

Differences between women from both samples. Constructive mutual communication scores were lower in women with BPD ($M = 5.81$, $SD = 1.89$) than in women from the control group, $M = 6.99$, $SD = 1.82$, $t(68) = 2.68$, $p < .01$. Likewise, total demand/withdraw scores were higher for women with BPD ($M = 4.51$, $SD = 1.89$) than for control women, $M = 3.55$, $SD = 1.87$), $t(68) = 2.14$, $p < .05$. The men-demand/women-withdraw communication pattern was also less frequently reported by women with BPD ($M = 4.13$, $SD = 1.90$) than by women from the control group, $M = 3.24$, $SD = 1.90$, $t(68) = 2.14$, $p = .055$. The total probability of demand/withdraw communication scores in couples where women were diagnosed with BPD ($M = 4.51$, $SD = 1.89$) was higher than that observed in control couples, $M = 3.55$, $SD = 1.87$, $t(68) = 2.14$, $p < .05$. Finally, women-demand/men-withdraw communication scores in couples where the woman has BPD ($M = 4.90$, $SD = 2.64$) did not differ from those of women from the control group, $M = 3.87$, $SD = 2.18$, $t(68) = 1.79$, ns.

Differences between men from both samples. In couples with a BPD partner, men's constructive mutual communication scores ($M = 6.36$, $SD = 1.59$) were not different from those of men from the control group, $M = 7.02$, $SD = 1.84$, $t(68) = 1.60$, ns. However, men living with a partner diagnosed with BPD reported higher total demand/withdraw scores ($M = 4.78$, $SD = 1.42$) than men from the control group, $M = 3.55$, $SD = 1.54$), $t(68) = p < .001$. They

also reported higher women-demand/men-withdraw communication scores (men with BPD partner, $M = 4.64$, $SD = 2.04$; men from the control group, $M = 3.59$, $SD = 1.70$, $t(68) = 2.35$, $p < .05$), higher men-demand/women-withdraw communication scores (men with BPD partner, $M = 4.94$, $SD = 1.69$; men from the control group, $M = 3.51$, $SD = 1.88$, $t(68) = 3.30$, $p < .01$), and higher total demand/withdraw communication scores (men with BPD partner, $M = 4.78$, $SD = 1.42$; men from the control group, $M = 3.55$, $SD = 1.54$ $t(68) = 3.48$, $p < .001$).

Couple Satisfaction

Couple satisfaction scores for women with BPD ($M = 26.23$, $SD = 7.30$) were not different from those of their partner, $M = 27.97$, $SD = 6.33$, $t(34) = 1.41$, ns. However, women with BPD were more dissatisfied with their relationship ($M = 26.23$, $SD = 7.30$) than women from the control group, $M = 32.74$, $SD = .71$, $t(68) = 4.58$, $p < .001$. In men with a BPD partner, couple satisfaction scores ($M = 27.97$, $SD = 6.33$) were lower than those reported by men from the control group, $M = 32.37$, $SD = 4.87$, $t(68) = 3.26$, $p < .05$. These sex differences between the clinical and the nonclinical groups were statistically strong ($d = .80$ for the difference between men and $d = 1.26$ for women) and, using a cutoff of 27 (see Sabourin et al., 2005), 49% of women with BPD and 40% of men who are romantically involved with them were clinically distressed.

DISCUSSION

This preliminary exploration provides one of the first empirically based glimpses on relationship processes and outcomes in couples with a BPD partner. Up to now, research efforts have lagged behind the rich clinical descriptions of the marital context of BPD. Three key findings emerge from this study.

First, our results showed that BPD was associated with a pattern of episodic relationship instability. Almost 70% of the couples with a BPD partner reported, once every 6-month period, incidents of union termination followed by reunion. These severe commitment problems are consistent with clinical hypotheses of disruptive couple formation processes in BPD (Fruzetti & Fruzetti, 2003; Kernberg, 1995).

The second major finding of the present study was that nearly half of the men romantically involved with a woman suffering from BPD were diagnosed with a personality disorder. The expected prevalence of personality disorders in the general population goes from 9% to 14% (Charitat & Schmitt, 2002). Thus, in most likelihood, the partner-choice process in BPD is not random. Whether assortative mating in women with BPD is guided by genetic factors, social homogamy, or psychodynamic processes, or by a combination of these causes, remains to be determined. Another important finding was that half of the men met criteria A for antisocial personality disorder (conduct disorder before age 15). This finding could, if replicated, help explain high levels of revictimization and intimate violence in couples where the woman suffers from BPD.

Third, couples in which the woman suffers from BPD differed from control couples on a diversity of psychosocial variables: attachment representations, intimate violence, self-reported communication patterns, psychological distress, and relationship satisfaction. More specifically, our first hypothesis concerning attachment insecurity was mostly confirmed. As compared with control couples, both members of couples where the woman has BPD evidenced higher rates of insecure attachment. These results replicated those of Meyer and Pilkonis (2005), who found that BPD is more strongly associated with rejection anxiety than with avoidance of intimacy.

In the present sample, women suffering from BPD were also generally paired with men reporting both high levels of rejection anxiety and intimacy avoidance, as compared with control couples. Nearly 70% of these men adopted insecure attachment representations. The

nonrandom pairing of individuals with insecure attachments suggests the presence of massive affect regulation difficulties characterized by a chaotic mixture of rapidly evolving hyperactivation and deactivation strategies. Pervasive preoccupation with perceived abandonment, fears of dependency, bursts of rage, devaluation, and behavioral avoidance probably alternate so that these couples get locked into vicious interpersonal cycles leading to low relationship quality and persistance. These hypotheses will need to be tested in future studies.

The hypothesis concerning the high prevalence of intimate violence in couples with a BPD partner was partly confirmed. There is a high rate of psychological violence but a consistent rate of physical violence (minor assaults) in couples where the woman has been diagnosed with BPD. These results replicate and extend those of other studies showing an association between intimate violence and borderline personality traits in men (Dutton & Starzomski, 1993; Holtzworth-Munroe & Meehan, 2002). Few studies have addressed the problem of intimate violence in women with personality disorders. The distribution of violence was highly heterogeneous in our sample. Seventy-three percent of our sample of women with BPD reported not being submitted to physical violence in the last year, but still a minority of couples exhibited high levels of mutual violence. Future studies will be needed to explain this heterogeneity.

The hypothesis that relationship satisfaction would be lower in couples with a BPD partner was confirmed. We also observed that these couples evidenced less mutual communication and more general avoidance of communication than control couples. Couples where the woman suffers from BPD also had a tendency to report more frequently a pattern of communication characterized by woman withdraw/man demand. This result is opposite to what is generally observed in distressed couples (Christensen & Shenk, 1991). However, even if couple dissatisfaction and communication problems were significantly higher in couples with a partner suffering from BPD, a large proportion of these couples, 51% for women and 60% for men, could be classified as satisfied with their union. This finding is somewhat surprising in light of some highly dysfunctional clinical descriptions of borderline couples (Lachkar, 1992) and considering that in the present sample, many other psychosocial factors traditionally associated with poor relationship functioning were observed: high rates of attachment problems, intimate violence, and psychological distress.

These findings of a higher than expected rate of relationship satisfaction and, for some couples, of long relationship duration, regardless of their highly unstable and conflictual functioning, raise questions. Past studies have revealed that, as compared with securely attached couples, couples where both partners are insecurely attached (which is the case for 68.6% of our BPD sample) can generally stay longer in an unsatisfying relationship (see Davila & Bradbury, 2001). It could well be that personality disorders and attachment insecurity in both partners have a more complex relation with union duration and satisfaction than what clinicians normally expect. An autonomous, sensitive partner expecting emotional support when needed, feeling strong enough to separate if too uncomfortable in a relationship, and not sharing the fundamental mistrust of others is not necessarily the ideal ''understanding'' partner in the mind of a patient with BPD.

Replication studies in other treatment settings with a larger sample of couples are necessary. Nevertheless, the direct assessment of personality disorders in both partners, using a well-studied standardized diagnostic interview, represents a strength of our study. Many studies focused on self-reported borderline personality traits. To the best of our knowledge, this is the first study based on a sample of couples where the women have the full syndrome of BPD, reliably diagnosed by two independent raters. The present findings underline the importance of integrating personality disorder research with couple studies. Finally, the complex relation between men's personality characteristics and the clinical symptomatology observed in women diagnosed with BPD should be scrutinized in longitudinal studies to test multiple models of influence. Whereas these preliminary findings are important, the small size of this sample composed of women with BPD recruited in a treatment setting limits their generalizability.

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