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PERSONALITY DISORDERS VERSUS PERCEPTION OF FAMILY OBLIGATIONS

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Summary
Contemporary family has been undergoing profound cultural changes that undermine traditional roles of its members and their mutual obligations. Psychology aims at assessing how individual traits influence their functioning as spouses, partners and parents. In view of changing cultural norms, the criteria concerning interpersonal and family obligations vary, but it is the law (legal acts) that ultimately determines the validity criteria for the obligations contracted, including marriage.
The paper concentrates on the relations between personality disorders, BPD and HPD, analyzing their structure and the partners' ability to fulfil their contracted obligations as partners and members of society.

Introduction

Focus on family. Contemporary family has been undergoing deep going cultural changes that undermine traditional roles of its members and their mutual obligations. Undertaking these problems, scientific disciplines reveal multiple aspects of the causes and mechanisms supporting or blocking adaptive patterns of mutual functioning of spouses, parents and children and vice versa. Psychology concentrates on defining how individual traits influence their functioning as spouses, partners and parents. Though, due to changing cultural norms, the appropriate criteria for interpersonal and family obligations vary; ultimately it is the law that determines, by legal acts, the validity criteria for the obligations contracted (including marriage).

Psychology and psychiatry seek to assess which psychic disorders, personality traits, cognitive, motivational and affective properties may impede the fulfilment of these obligations and acknowledging them valid legal acts. In case of marriage contracts the problem is of vital importance as every individual has a natural right to marry [6]. Various judicial systems maintain that serious psychic disorders of even one partner may question the validity of the obligations contracted. The questions posed in judicial proceedings aim at stating whether a given individual is capable or not of contracting a valid marriage and taking care of children.

Medical classification of personality disorders

Almost universally, for diagnostic, judicial and therapeutic purposes, clinicians should use ICD -10 (17) that tries to follow subsequent editions of DSM-IV-R [7] compiled by the American Psychiatric Association. Both handbooks are designed as non-theoretical, in which descriptions of types and classes of psychic disorders are based on factor analysis. Such perspective allows for singling out internally coherent and clinically significant symptoms, characteristic for a given clinical entity.

According to ICD-10 and DSM-IV-R personality disorder is a repeated and enduring pattern of inner experiences and behaviours that markedly deviate from cultural expectations accepted in the individual's culture. The pattern may show in at least two out of four areas: 1. cognitive (ways of perceiving and interpreting oneself and others); 2. affective (intensity of changeability and adequacy of emotional reactions); 3.interpersonal functioning (i.e. in the ways of establishing, keeping and terminating relationships); 4. controlling impulses (i.e. amorous, sexual, and aggressive). Such pattern causes clinically significant suffering or substantial limitation in fulfilling social roles, professional career and personal life of an individual. The symptoms cannot be caused either by psychoactive substances or CNS damage [8].

Three basic clusters of disorders have been singled out: Cluster A – paranoid personality, schizoid and schizotypal (strange, eccentric); Cluster B – narcissistic personality, borderline, histrionic and sociopathic (dramatism, instable

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emotionally and disregarding norms); Cluster C- avoidant personality, passive - dependent, obsessive- compulsive (stress, anxiety, terror).

Personality disorders, borderline including, can be characterised on three levels: 1. clinically vital behaviour patterns, also called symptoms; 2. structure or level of pathological personality organization, and underlying pathomechanisms; 3. genesis - that is the significance of conditions: biological, psychic and social that partake in their occurrence [2].

Clinical psychology regards personality disorders as more serious (deeper) than anxiety disorders (= neurosis) and less serious than psychoses (i.e. schizophrenia, affective bipolar disorders). They seem responsible for substantial adaptive difficulties, particularly in fulfilling social obligations. It refers mainly to borderline personality disorders that show already in early adulthood and differ from other personality types by a generalized pattern of instable interpersonal relationships, flexible self-image, instability of moods and considerable impulsiveness.

Nine most important symptoms (criteria) or patterns of the functioning characteristic for borderline symptoms have been singled out. Identifying at least five of them is necessary to diagnose borderline personality disorder. The said criteria are:

Criterion 1: undertaking feverish efforts to evade real or imaginary abandonment by the nearest and dearest persons.

Criterion 2: showing instable and intense interpersonal relations, especially in love relationships; easily passing from idealizing others and endowing them with extraordinary 'powers' and abilities to devaluating them that induces contempt and depreciation of previously highly regarded values. Sometimes they can turn empathetic and generous, but only when expecting unconditional satisfaction of their needs and desires. Such individuals are prone to sudden and unexpected changes in their assessment of other people.

Criterion 3: deep and chronically instable picture of oneself (real I, ideal I, obligate I), and flexible sense of self-identity. Sudden changes of the picture of oneself appear as externally unfounded, unexpected and surprising identification with different value systems, goals, preferences and sexual orientations. Such individuals can easily pass from the role of somebody needful of help to the role of a tormentor, from a sense of helplessness to strength and power, from self -admiration to utter worthlessness and nihilism.

Criterion 4: individual impulsiveness revealing in direct or indirect self-destructive behaviour. One group of destructive behaviours may include gambling, overspending, overeating, undertaking risky sexual activities with casual partners, abuse of psychoactive substances or dangerous driving.

Criterion 5: the next group of damaging behaviours concerns acts of self-aggression of varying character and intensity, besides threatening, blackmailing or suicidal attempts.

Criterion 6: individuals with borderline personality show emotional instability due to deep reactive emotional disorders, such as intense dystrophic episodes, irritation or anxiety that usually last for a few hours, but never longer than few days.

Criterion 7: such individuals suffer from permanent sense of emptiness, inability to perceive their feelings, thoughts and experiences.

Criterion 8: such individuals are easily bored that leads them to looking for new sensations and undertaking risky decisions. They demonstrate inadequately intense anger and find it most difficult to control it. Anger shows when they suspect their carers' or partners' withdrawal from the relationship or seeming neglect or possible abandonment.

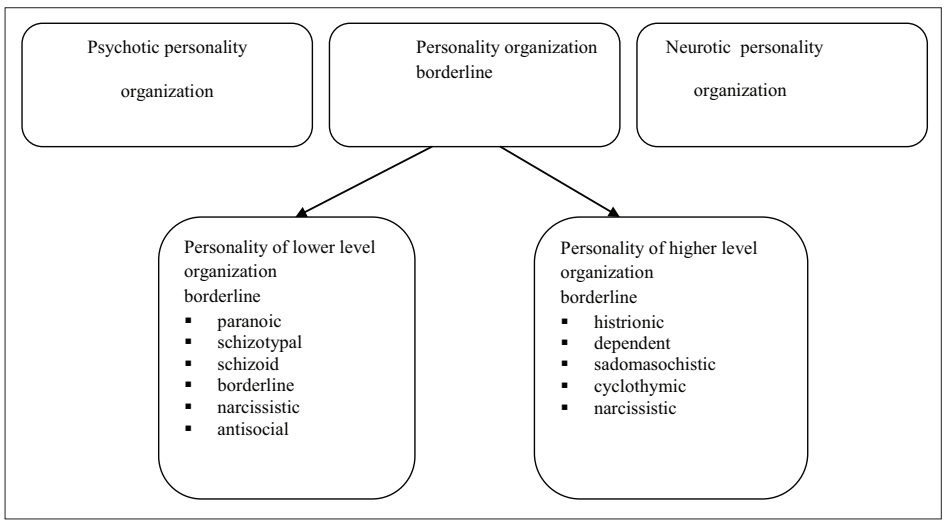
Criterion 9: in more stressful situations such individuals show passing paranoiac and dissocial symptoms (such as depersonalizing or de-realizing), which usually last for a short period of time (few minutes or hours). Such symptoms are not enough to diagnose psychic disorder on Axis I according to DSM-IV-R, such as schizophrenia or schizoaffective disorders. Sense of depersonalizing and de-realizing shows mainly in the response to the real or imaginary abandonment of the people close to them. Sense of regaining or being with someone may cause more realistic perception of the reality [7].

Ample clinical and therapeutic evidence and every day experiences prove how difficult living with a person with BPD is. Friends, spouses and partners experience considerable chaos, instability and aggression. The less formalized relation the more difficult to foresee its development; acts of intimacy or clinging or 'blending' with the partner may unexpectedly turn into setting stiff barriers, rejection and aggression. Some explanations can be found in certain concepts of human psychology, especially in contemporary object relations theory, ego psychology and cognitive behavioural psychology [14, 20, 21].

Personality organization disorders

A. Borderline personality. Since mid-fifties of the 20th century, hospital clinicians and outpatient psychotherapists described their professional experiences mainly as case studies. They covered the patients diagnosed as schizophrenics and neurotics. Both groups showed fragility of structure and immaturity of ego functions. The pro-

Fig 1. Personality organization: psychotic, borderline and neurotic versus types of personality disorders according to Kernberg designed by Cierpiałkowska [3]



gress made in therapeutic processes differed considerably from the observations made when treating psychotics and neurotics. That was to become an important issue to recognise that psychosis and neurosis do not cover the whole spectrum of psychic disorders. Yet, it used to be difficult to explain their essence and etiology on the basis of the existing knowledge.

Soon scientific studies began to deal with the specificity of clinical descriptions and symptoms. New terms came into being, such as borderline schizophrenia, thymo-schizophrenia, a-typical affective disorders or pseudo-neurotic schizophrenia [9, 19]. The term 'borderline' came into use to help systematize some problems, and to refer to a vast area between neurosis and psychosis, in which various psychic disorders are situated. The term 'borderline character' pointed to a particular type of personality disorders with the symptoms on the borderline of neurosis and psychosis.

Psychoanalysis and psychopathology took up the premises and developments of object relations theory conducted by Kernberg [14] Masterson [24] and Stone [30]. Psychotic personality organization, borderline or neurotic, indicates the attained level of development of psychic structure (pathology level) conditioned by early childhood experiences with significant persons (mother or the person in this role). The experiences acquired on the basis of real mother – child relations occur due to such mechanisms as, introjection, identification and internalization, and are internalized as positive and negative representations of the self-object [13] that undergo appropriate developmental stages.

Each personality organization, borderline including, stands for 'a specific stable form of pathological ego structure' [12] characterized with: 1. some kind of defence mechanisms used; 2. identity integration level; 3. potential or ability to test reality.

Kernberg maintained [13, 24] that all types of personality disorders singled out in DSM-IV and ICD 10 are characterised by fixation at the beginning or end of the second phase of development (that is diversification of the positive and negative self – object dyad), thus they belong to borderline personality organization (Fig. 1)

Primary defence mechanisms are accompanied with various perception distortions that differ from the principles of reality, being non-specific symptoms of weak ego (mind) [12]. Cognitive structures that activate in the person of neurotic personality organization in difficult situations, in borderline organization are so weakened that they are unable to control impulses, such as aggressive or sexual. Their high reactivity, biologically conditioned, causes considerable tension accompanied with low tolerance of anxiety, and absence of such mature ways of handling problems, as rationalization or sublimation. To get rid of unmanageable emotional tension, they use most primitive destructive or self-destructive behaviours. It may be banging on the wall, inflicting cigarette burns, drinking or taking drugs, causing road accidents, as bumping into another car, in result damaging one's own new car, throwing things at family members only to alleviate their tormenting pain and suffering [3].

The 'I' and identity cohesion disorders characteristic of borderline personality organization result from impaired development of the structure of the self. The 'I' and identity cohesion disorders cause repeated oscillating from a positive to negative picture of oneself, which never integrate. They consider people as totally good or totally bad, and perceive themselves in black/white colours. Their sense of value is liable to constant fluctuations, presenting either vastly overstated or understated self- assessments. Due to the difficulty in accepting thoughts, emotions or behaviours incompatible with the actual picture of themselves, they often employ such defence mechanisms as negations that reinforce such split [9,29].

Relations with persons with borderline disorders are incoherent. They change topics, paying no heed to the sense of their message, and how they talk about themselves and others. They show themselves in diverse and often contradictory states. Within days or weeks they can fully identify with different, often extreme political ideologies, world views and religious opinions. They can also impersonate the persons they consider important, adopting their life style, facial expression, gesticulation and movements. During such identification period they can fully share their interests, values and life style; simultaneously, in similar social or family circumstances, making no reference to the changing outer conditions, thus behaving unpredictably [9].

Identity dispersion often reveals itself in sex life, not only in recognised and revealed preferences but also sexual orientation. Sometimes persons with borderline personality organization perceive themselves as homo or bi-sexual. Such behaviours lead to several tensions and conflicts in marriage, becoming a source of suffering and humiliation for their partners [3].

Due to the weakness of ego, poor cognitive abilities, primitive defence mechanisms and identity disorders, persons with borderline personality organization find it difficult to distinguish themselves from others and to differentiate between the inner and outer realities. Difficulties in distinguishing the latter makes them experience emotions and motivations such as, fury, hate or jealousy or envy, which they attribute to others. They fiercely fight those they take for enemies, revenge themselves on wrongdoers; envy those perceived as possessing extraordinary abilities and talents; they fear those they take for tormentors. If, projecting their inner negative states on the spouse, they perceive him/her as a torturer and oppressor and not as someone close and devoted [3].

Individuals with borderline personality disorders find it difficult to control impulses and desires due to the weakness of the ego structure and function [9]. They often break relationships, abandoning former ones for those seemingly better. For instance, a woman enraged with her husband may leave or even file for divorce; a man enraged with his boss who expects more commitment from him, may hand in his resignation regardless of economic consequences. Difficulties in controlling impulses may also bring about aggressive and violent behaviour towards family and friends [11].

Typical behaviours in family and partnership relations. In marriage and partnership the following repeated behavioural cycles can be observed: a) if a person with BPD stops idealizing his/her partner, (s)he more and more frequently experiences frustration of various needs and desires, which lead to the sense of growing emotional tension easily slipping into anger; b) anger, motivated by personality traits, especially difficulties in modulating emotions, escalates and turns into fury, accompanied by aggression verbal or physical; c) after angry explosions there come intense fear of abandonment, often specific sense of guilt originating from the fear of 'damaging' or 'devastating' a good and caring carer or partner; d) fear turns into terror accompanied with a sense of helplessness and powerlessness, the aggressor and tormentor becomes a helpless child in need of support and care. Seemingly unmotivated emotional instability of BPD persons brings tremendous chaos into partnership and family relations with destructive and oppressive results [9].

B. Histrionic personality. The concept of hysteria belongs to the oldest ones in medicine and covers a group of personality disorders and symptoms of hysterical reaction – hysterical neurosis and conversion hysteria. As a psychopathological unit, hysteria was first described by Jean M. Charcot, who thought it showed in shallow and abnormally modulated affect, concentration on oneself and preoccupation with sex [27]. He influenced Freud and Breuer, who began to study psychological mechanisms of hysteria, isolating, among others, hysterical neurosis. Subsequently, conversion and anxiety hysteria were distinguished. In conversion hysteria conflicts are managed by turning into somatic symptoms or through dissociations. In anxiety hysteria, the ego cannot overcome anxiety in spite of obsessive or phobic mechanisms. In conversion hysteria states of seeming emotional indifference are typical in spite of apparently serious character of the trait (*la belle indifference*). According to Freud, hysterical persons are liable either to exhibitionism and seductiveness or frigidity and immaturity [25].

The term psychopathic hysteria was later introduced to denote a tendency to escape into illness, theatrical behaviour, strong emotional expression, egocentrism, un-

controlled fantasizing and lying, sometimes pseudology [10]. Jakubik [10] further characterises histrionic personality as shallow, unstable, inauthentic in demonstrating feelings, egocentric, self-indulgent, emotionally changeable and exaggerated, tending do dramatize, dependant on others, self-centred, intolerant of frustration and criticism, and showing manipulative tendencies. In sexual matters they can be seductive and hyperactive or frigid and sexually immature.

According to ICD-10 this type of personality is regarded in a very similar manner, though this diagnostic category also includes psycho-infantile personality [17].

Psychological mechanisms of histrionic disorders. As the majority of hysteria symptoms and hysterical personality traits escape control and causation mechanisms, they are considered unexpected, surprising and unpredictable, irritating because inauthentic and false [16]. Sometimes a histrionic person demonstrates his/her feelings as if confirm oneself, for (s)he does not believe, does not know whether these feelings are his/her own or imposed on him/her. Such 'inner uncertainty' originates from the inability to reconcile two contradictory value systems [4].

Systematic concept of hysteria assumed that personality disorders are characterised with two basic traits: excessive demand for confirming information (upholding the state of cognitive structures) and low tolerance of incoming diverse information. The situations of information deficit or abundant information diversity trigger off individual adaptive mechanisms, operating according to the principle of evasion [15].

As a rule individual sense of value is incorrect, exaggerated (feeling of superiority) or understated (inferiority complex). Both disorders increase the need for the information confirming one's worth. Individual sense of value increases through satisfying social approval or lowering someone else's worth. In result, histrionic persons are most concerned with 'how others see me' [16]. They usually are worried to reveal their real selves. Social approval does not diminish their feeling of being threatened. As a rule, social anxiety is stronger than biological and obstructs the subject's ability to work for the couple's 'common good' [15].

Man of highly tuned awareness is able to incorporate two contradictory structures (knowing he is good and bad, wise and stupid, loving and hating, etc.). On the contrary, hysteric's awareness is unable to incorporate two value systems simultaneously, and must interchangeably realize one or another functional structure depending on the actual hierarchy of values [16]. This brings about a sense of being misunderstood by others and a strong wish to seek their approval. Sometimes to get acclaim, a hysterical person is ready to demolish his/her life so far and 'to begin anew'. As a rule, such person does not get adequately strong support from others, which evokes a sense of anxiety that reinforces his/her looking for self support from them (= a vicious circle mechanism). Kępiński maintained that the problem of hysteria is that of inhibited development, of immature personality /.../ [the person] affected with HPD wants to have preferential treatment of a child" [16].

Hysterics can recognise neither the truth about themselves nor about the world around them. The case in point is 'fantastic pseudology' as an instance of subconscious distortion of the reality. Hysterics are unbeatable in manipulating persons, moods or attitudes, and enjoy managing others, which means manoeuvring them into the situations of their making while taking no personal responsibility [16].

Due to emotional immaturity, histrionical persons are incapable of developing emotional needs and attitudes with others, which often make them sexually frigid, suffering from anorgasmia, demonstrating shallow maternal feelings and treating children as 'toys'. In sexual relations they enjoy flirting and gaining their partners' admiration. Love often becomes domination [16].

The above list of the traits characteristic for histrionic persons comes from the observations by clinical psychiatrists and practicing psychologists, and concentrates on the manifestations and symptoms of the disorder, attaching less significance to their etiology. However they are of utmost importance in clinical practice.

Some psychological conceptions explain hysterical behaviour concentrating on the sexual. Psychoanalysis maintains that hysterical symptoms appear when conflicts between the oral and the oedipal phases take place. Then defence mechanisms such as regression, denial and identification are activated. The choice of symptom (with the choice of the organ affected) depends above all on the content of subconscious fantasy, on the erogenous potential of the given zone, on early identification, and on the symbolic representation in power conflict, the given organ can symbolize.

It must also be noted that when Freud was working on his theories, people were concerned with other anxieties. Sex life used to be severely restricted, unlike the situation today [26].

According to Cierpiałkowska [1], Kernberg's model (within object relations theory) is one of the fastest developing concepts of personality disorders. Kernberg singled out three structural levels of personality organization including neurotic organization, characterised with denial, as being its most consolidated form. Consolidation and integration of the ego is the result of the final phase of develo-

pment of psychophysical structure. Every disturbed personality organization (histrionic including) means 'specific, stable form of the pathological ego structure' characterized with: 1) kind of defence mechanisms used; 2) integration and identity level; 3) potential or ability to test reality. Kernberg maintained that all types of disturbed personality are characterized with fixations at the beginning or the end of the second phase of development that is differentiating of the positive – negative dyad *self – object,* thus they belong to borderline personality organization [12].

The most characteristic trait of borderline personality organization is employing primitive defence mechanisms, such as splitting idealization and devaluation, projection, projective identification or denial. When activated such defence mechanisms are important to understand the patterns according to which individuals function in marriage, partnership and family relations; as some of them are significantly dysfunctional.

Conclusion

The above discussion on the persons with borderline personality organization signalizes only the most prominent behavioural patterns that unquestionably influence the ways they function in relations with others, in particular in marriage, partnership and family. It is becoming a common practice that in divorce and child care suits, the parties involved undergo psychiatric and psychological examination, which should assess their ability to contract a valid marriage, consequently their ability to take up significant marital obligations [23,5].

Besides their concern with some essential criteria future spouses should fulfil, law courts concentrate on the most essential problem, which is the person's ability to recognize the essence of the obligations contracted in taking vows and an accurate assessment of one's ability to fulfil them. In case of borderline personality such abilities seem relatively restricted, due to instability, emotional cognitive and interpersonal ambivalence, also concerning self-identity (sexual identity including) [2].

Expert psychiatrists and psychologists are aware that such instability and ambivalence are impossible to reflect and monitor, and these persons remain deeply convinced that it is their environment that changes their attitudes and conduct toward them. In consequence, their functioning remains changeable and hesitant. Disturbed persons, whether borderline or hysterical, find it extremely difficult to tell the inner from the outer, and establish what originates from his/her behaviour and from the partner's. In the person's subjective belief, the decision to leave comes from the partner. Likewise his/her personality traits, such as impulsiveness and aggression are projected on the partner, ascribing instability and aggression to him. In spite of manipulative and coercive behaviours disturbed persons feel trapped. Thus, the obligations contracted in marriage and partnerships are often impossible to fulfil.

Court appointed expert psychologists find it difficult to assess the individual ability of the persons with histrionic personality to fulfil individual and family obligations due to the complex conditions that cause family disadaptation. Personality disorders show in disharmonic attitudes and behaviours in several spheres of life. In the situations they find difficult they react with defence mechanisms with increased anxiety, fear, and emotional tension. They overconcentrate on providing a sense of security for themselves and on evading rational solutions. If a dialogue is attempted, their attitude is egocentric and claimative, simultaneously manipulative and submissive [4].

In perceiving reality and personal problems it is not only individual traits that are significant but also sexual problems originating from the kind of emotional bonds and sexual temperament. Besides personality traits, inhibitions and sense of inferiority in male roles, shyness, fears linked with sexual and temperamental spheres are often cause misunderstandings and misreading of mutual intentions. It should be remembered that perception of the other person and budding emotional and sexual bonds occur against a strictly determined personal background of both partners. These traits are chiefly responsible for immature relationships, such as inability to strike a partnership, craving for parental attitudes, excess of taking over giving, imposing one's sexuality on the partner [28].

Both civil and canon courts enumerate several common obligations, such as common living, cherishing interpersonal relations and heterosexual union. Obligations may come under various names and descriptions considered essential or inalienable [22].

Most frequently, in judicial proceedings, expert psychologists explain that the person who entered into partnership reveals disturbed personality and psychic immaturity. Such partners are unable to fully participate in the relationship, thus unable to accept marital attributes unconditionally. Excessively individualised expectations toward the union make it difficult to function within it. Immaturity and excessive subjectivism makes it difficult to comprehend one's own mistakes, which change the character of marital relations [4].

Therapy of such persons is difficult. It must be founded on the traits representing the person's strong points and needs. A person with HPD needs affirmation from others on his/her own conditions, still such approval should be gran-

ted. A sense of security, approval and sympathy diminish anxiety and fear, as the person does not have to fight to be liked. (S)he becomes stronger and finds it easier to stabilize his/her value system, gain self- confidence, and make more independent decisions. One can hope that long therapy may bring changes in perceiving oneself and others, and thus become more responsible. However, it should be remembered that therapeutic effects tend to be only partly successful in case of disturbed persons.

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ASMENYBĖS SUTRIKIMAI IR ĮSIPAREIGOJIMAI ŠEIMOJE

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Raktažodžiai: šeiminiai įsipareigojimai, krizė, ribinis asmenybės sutrikimas, histrioninis asmenybės sutrikimas

Santrauka

Šiandienos šeimą ištikę gilūs kultūriniai pokyčiai pakirto tradicinės šeimos narių vaidmenis ir jų tarpusavio įsipareigojimus. Psichologija siekia išmatuoti, kaip individualūs bruožai paveikia sutuoktinių, partnerių ir tėvų vaidmenų funkcionavimą. Tarpasmeninių ir šeimos įsipareigojimų kriterijai įvairuoja keičiantis kultūrinėms normoms, bet galiausiai būtent įstatymas (teisiniai aktai) lemia sudarytų įsipareigojimų galiojimo kriterijus, įskaitant ir santuoką. Straipsnis nagrinėja ryšį tarp ribinio ir histrioninio asmenybės sutrikimų bei sugebėjimų vykdyti sudarytus partnerio ir visuomenės nario įsipareigojimus.

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