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Parents' Experiences of an Adolescent Child with Borderline Personality Disorder: A Narrative Analysis

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ABSTRACT

Based on in-depth interviews with 31 family members of young adults with borderline personality disorder (BPD), this study examines how parents processed and responded to worrisome acts of their adolescent daughters, i.e., running away, overdosing, suicide attempts, conflict, and violence in the time prior to and soon after the teen received a BPD diagnosis. This research contributes to qualitative research through two complementary narrative analyses. Structural analysis of narratives allows for a close understanding of how parents processed, understood, and acted in response to their adolescent in mental health distress. Following Labov (1997), the analysis tracks complicating events, resolutions, evaluations, and codas; doing so reveals that parents registered first a quantitative and then a qualitative difference in their child's acts from normalized adolescent rebellion but did not use a mental health framework prior to receiving a BPD from mental health professionals. The concept of "vital conjunctures" (Johnson-Hanks 2002, p. 865) offers a heuristic vantage point to reconsider the narratives and deepen awareness of parental perspectives when the stakes concerning the teenager are high. It is hoped that the research findings of parents' experiences, agencies, and perspectives on BPD in relation to their adolescent recognize the extraordinary mental health conditions and underscore the value of early interventions that supportively engage caregivers and effectively aid the young person's and the family's recovery.

KEYWORDS: Borderline Personality Disorder, Parents, Adolescents, Narrative Analysis

Social science research has found that many young people worldwide do not achieve culturally expected milestones of adulthood within an idealized timeframe (Arnett, 2015). Mendoza-Denton & Boum (2015) describe global macro level trends as "breached initiations," where young people's paths to adulthood entail delays, backward and forward moves, and/or opting out for some time (p. 295). This article is based on qualitative research exploring cultural, emotional, and moral experiences of families in the U.S. Midwest in which a young relative receives a borderline personality disorder (BPD) diagnosis. BPD is a mental health condition

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featuring unstable emotions and interpersonal relationships, a troubled sense of self, and potential and actual self-endangerment (American Psychiatric Association, 2016; Leichsenring et al., 2011) [2]. I learned from parents whose adolescent or young adult child received a borderline diagnosis that the hoped for launching became a prolonged crisis where milestones signaling entrance into young adulthood were often observed in the breach.

This research centers parents' experience of BPD in their adolescent child and recognizes the role of narrative in gaining understanding of challenging life events. Narrative research, in particular structural analysis of life stories, offers a means to get a sense of what, from the parents' perspectives, was going on with their distressed adolescent in the chaotic period prior to and soon after the BPD diagnosis. Tracking parents' developing understandings of and responses to their child's acts over time means attending to multiple stories contained within their accounts (Riessman, 1993). Attention to narrative drama (Mattingly & Garro, 2000) led me to identify structural elements in the telling of the story as well as content (Riessman, 1993; Labov & Waletzky, 1967; Labov, 1997). Structural analysis of the stories trained my attention to how parents processed, assessed, and acted in relation to experiences they reported about their child; how their understandings and acts shifted in the parent child relationship; how they evaluated the course of events and involved parties; and ultimately, how parents navigated this complex and difficult situation affecting their child and the family. I suggest that analysis of narrative structure contributes new understandings of parents' perspectives and agency in families with BPD and indicates the importance of early intervention that involves caregivers and enables recovery for the family as a whole.

Conducting narrative analysis of the experiences of parents whose child lives with BPD led me to invoke anthropologist/demographer Johnson-Hanks's (2002) concept of vital conjuncture, which she describes as: "a socially structured zone of possibility that emerges around specific periods of potential transformation in a life or lives […] critical durations when more than usual is at play" (p. 871); as "experiential knots during which potential futures are under debate and up for grabs (p. 872); and as "moments when seemingly established futures are called into question and when actors are called on to manage durations of radical uncertainty" (p. 878). Johnson-Hanks critiques the linear life stage model as inaccurate; she proposes replacing it with the concept of vital conjuncture, which can occur in any period of life.

In this work I adopt vital conjunctures as a conceptual aid, a heuristic vantage point to orient attention to ways we might more fully register the stakes of critical moments of "radical uncertainty" identified by parents concerning their adolescent in crisis. Bear in mind that this research does not extend to interviews with adolescents with BPD. I underscore that the concept applies to parents at the vital conjuncture affecting the child, first and foremost, but also affecting parents and the family as whole. It also considers influences of the broader context. Johnson-Hanks (2002) points to the importance of institutions and their agents at critical moments as relevant "social institutions that frame alternatives, which make certain aspirations plausible, possible, or almost unthinkable" (p. 878). Indeed, parents' stories include interactions with professionals from an array of institutions (from police to mental health providers), whose acts in relation to the child and family were significant in several direct ways: by signaling the family crisis through their

[2] Suicidality has been identified as the symptom most likely to lead to a diagnosis. Death from suicide among people with BPD is estimated to be 50 times higher than the wider society (Leichsenring et al., 2011, p. 75).

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presence, removing the child from the home, and determining a diagnosis and treatment. Finally, my analysis of context considers cultural norms and frameworks affecting parents' understanding of adolescence. Cultural ideas circulating among some sectors of American society characterize so called normal adolescent development as entailing turbulence or rebelliousness (Hoffman, 2013). Where this explanatory framework is relevant, it may influence how some parents assess and respond to their teenager, sometimes delaying early and effective intervention.

This research aims to add to qualitative research in several ways: it demonstrates a novel application of structural analysis of narrative, one which leads to fuller consideration of parents' understandings and agency in relation to youth with BPD; it highlights the importance of factoring in cultural norms in relation to the mental health diagnosis; and it illustrates how a social science concept coupled with narrative analysis can deepen understandings of parents' lived experiences of BPD in their child. The research also has an applied, engaged aim: by sharing key moments in parents' experiences of their adolescent child with BPD, it is hoped that other families in similar situations might be helped, specifically, in understanding the critical importance of early intervention.

Borderline Personality Disorder

Borderline personality disorder (BPD) researchers now characterize the development of BPD according to a biopsychosocial model (Gunderson, 2009; Kernberg & Michels, 2009). While more than two-thirds of people with BPD do report childhood trauma, BPD can develop without such problems (Gunderson et al., 2011). Lingering stigmatizing of BPD has been examined by quantitative and qualitative health researchers (Aviram et al., 2006; Lester, 2009; Sisti et al., 2016), the latter reporting that many health care providers have held parents *a priori* to be solely responsible for creating pathological, traumatic environments that produce the disorder (Giffin, 2008; Dunne & Rogers, 2013). Studies also have revealed mental health professionals' reluctance to treat BPD, often because they find people with BPD difficult to work with (Kernberg, 2001; Aviram et al., 2006; Gunderson et al., 2011; Sisti et al., 2016). Indeed, problems with interpersonal relations are part of the diagnosis.

Caregiving to support treatment and recovery for persons with BPD poses many challenges. Survey research on family member experiences of BPD has found their levels of objective and subjective burden higher than the general population, and as high or even higher than what has been found among caregivers of people with serious mental illnesses (Hoffman & Fruzetti, 2007; Sheirs & Bok, 2007; Goodman et al., 2010; Bailey, 2013; Kirtley et al., 2019). Qualitative studies identify stress, worry, fatigue, confusion, isolation, and emotional pain among parents trying to care for the person with BPD (Ekdahl et al., 2011; Bauer et al., 2012; Bailey & Grenyer, 2014; Kay et al, 2018, Barr, Townsend & Grenyer, 2020a; Villet et al., 2024, Murray, Clarke & Flothmann, 2025, O'Dougherty, 2022, 2024). Parents struggle to understand whether what is going on with their family member with BPD is a behavioral or mental health problem, that is, what they describe as the "mad or bad" problem (Bauer et al., 2012, p. 956). The emotional health of family members/caregivers is adversely affected: sadness, hopelessness, shame, guilt, and, for many, a defeating sense of disempowerment are prevalent. Parental emotional distress often lasts for years prior to diagnosis (Bauer et al., 2012). Feelings of disempowerment and grief may arise for parents who hold themselves responsible for not recognizing symptoms earlier and intervening (Ekdahl et al., 2011, p. 72). The combination of caregiving burden and grief may produce "impairment in well-being" affecting the person and caregiving itself (Bailey & Grenyer, 2014, p. 807).

Qualitative research has directed attention to problems arising when family members interface with healthcare providers. Parents often received "conflicting messages" from healthcare providers on how to support their child, as well as the "paradox [that] health professionals provided little support to parent caregivers yet relied on them being responsible for caregiving when making treatment decisions" (Griffin, 2008, p. 136). Some parents were incorrectly informed by health care providers that the relative's problem was a "normal teenage issue" (Ekdahl et al., 2011, p. 72). Parents have reported that professionals provided the diagnosis in an "informal" manner with little information and conveyed a sense that parents should be providing the care without offering guidance on how to provide it effectively (Villet et al., 2024, p. 8). The vast majority reported their own perspectives were "not taken seriously" (Lawn & McMahon, 2015, p. 241). Similarly, quantitative research finds nearly two-thirds of parents received a diagnosis with no explanation and no supportive resources. A mixed methods study found lack of community or professional support; caregivers felt "excluded," and their understandings deemed "irrelevant" (Murray et al., 2025, p. 5).

From early to recent studies and in a variety of national contexts, a similar picture arises of parents and caregivers struggling over extensive periods to provide care for a person with BPD in isolation from community and professional support. Their burdens, extending to emotional distress and disempowerment, are not alleviated after family members interface with health care providers. The situation is indeed perplexing, especially as helpful solutions exist: providers can include the family in the treatment plan, and they can extend help for family members/caregivers, notably through family psychoeducation (Hoffman et al., 2005 and 2007). Villet et al. (2025) underscore that early intervention and collaboration between health care professionals and families are important for treatment and recovery. The authors state, "involving families in care may have a therapeutic effect on the patient's relatives, assisting them in navigating autonomy and individual agency" (p. 10; see also Spaniol & Nelson, 2015).

Qualitative healthcare research has usefully analyzed interview content to identify themes describing the range and depth of caregiving challenges faced by parents of a family member with BPD. This research asks: How do parents narratively construct changes in their understandings of their adolescent's behaviors before and following a BPD diagnosis? How do their narratives represent changes in parental agency, in relationships with their child, and in interactions with institutions during the period of uncertainty prior to and surrounding the BPD diagnosis? It is hoped that narrative analysis and conceptual framing shed light on how parents understand events and related dynamics related to the borderline diagnosis and reveal indicators for early intervention and services in support of recovery.

Methods

Broad Considerations

This research was undertaken mindful of the reflexive nature of qualitative narrative inquiry (see e.g., Clifford & Marcus, 1986; Denzin & Lincoln, 2000; Mauthner & Doucet, 2003). Reciprocity in the research process was from the start important to my interlocutors. Before consenting to the interview-based study, nearly every participant asked about my positionality, i.e., they asked what led me to this project. I shared that I, too, have experienced caring for a family member with mental illness. Nearly all told me (without prompting) that they volunteered to take part in the study not solely to tell their stories, but more importantly in the hopes that their stories

could help other families be spared some of the struggles they had undergone. Their consent reflected active engagement in the project.

Questions of authenticity, coherence, and representation are also significant. Bear in mind that family members are speaking for themselves; subjectivity was part and parcel of the accounts. I had no doubt that people were trying to give as factual reporting as possible. Notably, some parents qualified their remarks by saying that their memories were faulty, a problem likely due in part to the chaotic and traumatic nature of their experiences (see Frank, 1995). The expectation on my part was not for parents to be authoritative or offer some kind of definitive account, nor for them to speak for their child. No one was under an illusion that their child would offer a corroborating endorsement. I was prepared, instead, for difficult stories to tell (Lockwood, 2025; Ochs & Capp, 2001). It is worth recalling that all narratives are incomplete fragments, subjectively constructed in relation to an audience, real or imagined, and hence are in some ways co-constructed (Mattingly & Garro, 1994; Black, 2018).

It is important to be mindful of the context for what is shared in qualitative research. We know that parents are often culturally framed – and evaluate themselves – according to a good/bad binary, which includes normalized assumptions of life stages. Cultural norms also extend to assumptions that when something goes wrong with a child the parent is not just a responsible party with obligations of care, but potentially at fault. Such stigmatizing cultural framings marginalize many families, notably ones with mental health troubles, including BPD. Thus, like the rest of us, and possibly with more motivation and concern, these individuals would likely tend to convey their "thoughts, feelings and deeds in a positive light" (Ochs & Capp, 2001, p. 254; Buchbinder, 2010). While all qualitative research confronts such questions, it may be relatively more salient here given social practices of morally evaluating parents (Kremer-Sadlik, 2019).

These qualifying statements notwithstanding, I endorse the value of such work, relying on Mauthner and Doucet (1999), who state, "We suggest that subjects are reflexively constituted between the researcher and the researched, and that while they are therefore always incompletely unknown, it is possible to grasp something of their articulated experience and subjectivity through a research encounter" (p. 423). As linguistic anthropologists Ochs and Capp (2001) note, "All personal narratives are fragmented intimations of experience. Telling surely assists the construction of a tale, but the tale necessarily lies beyond the telling" (p. 283).

Ethical Considerations

The University's Human Subjects Review Board approved the study (IRB approval #46). As part of the consent process, participants were informed their participation was voluntary and they could withdraw at any time without penalty.

Research Process and Analytical Approach

I conducted interviews between 2015-2019 with people living in urban, suburban, and small-town areas of the U.S. Midwest. Recruitment was conducted as follows. The state chapter of the National Alliance on Mental Illness (NAMI) posted my research study announcement in their quarterly newsletter. The announcement asked for volunteers who had a family member with BPD to participate in a qualitative research study on their lived experiences of the disorder in a family

member. Participants affirmed that a family member had a BPD diagnosis[3]. Thirty-one family members within 24 families of young people with a BPD diagnosis participated. Interview participants included 20 mothers (four were single parents), five fathers, three siblings, a grandfather, grandmother, daughter, and partner. Participants drew from lower middle to upper middle-class families. Most participants were white. Three-quarters of the family members with BPD were young women[4]. Parents' ages ranged from 40s to 70s; their children were aged 17 to early 30s at the time of interview. In eight of the 24 families, the young person was between the ages of 17-20 at the time of parents' interviews. For this analysis, I draw from three of these eight interviews in which parents focused on their children while they were in high school and shortly after (in contrast to the other five families of this subset, where the parents described their experiences of their post-secondary school teens). I use pseudonyms for participants.

During interviews, I used two orienting questions. My opening question was: Where do you think it makes sense to begin our discussion of your experience of borderline personality disorder with a family member? The second was: How has this experience affected you? In interviews lasting an average of two and a half hours, many participants pointed out they were skipping over many events, as there were too many to recount, or they could not recall many of them. They spent almost all of their time addressing the first question, and relatively little on the second.

I completed content and then structural analyses of the narratives. Sociolinguists Labov and Waletzky's seminal work (1967) identified key structural features of oral, personal narrative: abstract (an optional, preliminary brief summary of the story), complicating events (plot development), resolution, (narrator's) evaluation, and coda. Attention to the structural properties of narratives revealed parents' perspectives on agency in these complicating events: theirs, the children, and other involved parties. The narrator's evaluations of events and agents are significant to narrative structure. A narrative without an evaluation "has no point" or can be "difficult to follow" (Labov 1997, p. 28). Narrators characterize the actors, events, or situations and thus position themselves in relation to these implicit or explicit evaluations of the acts and actors. In the interview excerpts selected for analysis here, I centered on pivotal moments in the stories (Labov, 1997). These were moments of a parent's new understanding, evaluation, or reframing of the situation, and a guide to future parental acts and approaches. Last, I considered what was said to bring the story back to the present (coda). While taking care not to overly read into their brief codas, still I viewed them as a signal of parents' sense of where their child was at during the time of interview, and how they were revising their relationship and responses to their child. After completing this structural analysis of the narratives, I turned to the concept of "vital conjunctures" to revisit the material (Johnson-Hanks, 2002).

It is useful to bear in mind that parents' stories do not (and likely cannot) reveal what parents were actually thinking at the time of the events. Their stories are retrospective, subjective, partial accounts from their perspectives only, and not their child's. The purpose of this narrative analysis

[3] The full project entailed interviews with local mental health BPD specialists, my completion of a 12 session Family Connections© parent education class for families with BPD, and participation for five years in a peer support group, both offered by the state NAMI chapter, where I met another 30 or more family members. Participation in these forums offered me significant educational background; I learned a good deal from what people shared confidentially. These additional fieldwork activities did not include any recruitment for the interviews; what is reported here derives solely from the separately conducted interviews.

[4] Quantitative health research finds the prevalence is roughly equal by gender, yet women are up to three times as likely to receive a BPD diagnosis as men (Leichsenring et al., 2011; Sansone & Sansone, 2011; Skodol & Bender, 2003).

is to center parents' attempts to reconstruct their experiences and understandings of their child's issues at the time prior to and surrounding the diagnosis.

Findings and Discussion

From Fabrications to Running Away to a Plethora of Diagnoses (Vignette 1)

Betina's interview was punctuated with brief expressive evaluations ("super crazy," "really weird") concerning the especially alarming and protracted period of two months during which her daughter was on the run. Her story culminates in a pivotal ("surreal") moment when the parents finally found their daughter in a hospital. The plot resolution, Silvia's homecoming from the behavioral health unit, offers a sharp contrast between the crisis period and the potential return of stability.

While Betina marked her story of BPD as starting at their daughter Silvia's birth (where she and her husband reportedly felt this child differed from her other children), she very quickly turned in the interview to middle school when Silvia became "belligerent…oppositional defiant -- we just assumed that's what it was. It just kept getting worse, police got involved. It got super crazy to the point that she ran away one time and didn't come back." In Silvia's senior year of high school, Betina and her husband worked hard to find out where their 18-year-old was.

> We call police who can't do anything because of her age; they could only ask if she wants a ride home. … We're talking to attorneys, and we're talking to mental health. Not a day went by that we weren't trying to figure this whole piece of the puzzle out. I couldn't sleep at night. It was just terrible. … We were at dinner one night, and everyone was sitting here, and they [Silvia's three sisters] were like 'mom, do realize that we aren't up in the middle of the night? The police haven't been here.' It was just, I think you live with this for so long that it was just a part of your lives and didn't realize, until she was gone, just how much craziness.

What did the craziness entail before Silvia ran away? Why, in particular, did the police show up? Betina guessed Silvia called the police because she was angry about the consequences her parents administered, such as taking her cell phone away. Indeed, the cell phone was an important element in Betina's story. Silvia, she noted, shared photos of herself on social media with fake blood saying her mother had beaten her. Silvia texted herself from her mother's cell phone saying "'I hate you. You're an awful child.' It would look like I was texting her these horrendous things. I'm like 'why, why would you do that?' Silvia showed people the texts and got sympathy."

Returning to the runaway period in Betina's account: after two months away, Silvia called her mother from a hospital telling her to come get her. Betina raced over, but staff wouldn't let her see her daughter. As it turned out, Silvia had told hospital staff that an older adult male (with whom she had been staying and who had brought her to the hospital following an overdose) was her custodian or step-father. Silvia hadn't (yet) given her mother permission to see her. Betina recalled:

> It was really weird. He [the adult male] was able to go in and talk to her. It was all getting super crazy. We've got all these people involved that we don't know. All of a sudden, we're not her family, but we're supposed to pay for her. She's telling all these stories that are so bizarre that we can't even grasp. It was just so crazy. And she's not even our daughter. We see her, it has been a couple of months. She had lost weight, acted really

> whiney…usually she's very confident, very athletic, she knows what she wants. She's a go-getter. And it was kind of the complete opposite. I think they were probably testing out different medications. She was maybe on something to keep her calm… she'd lay on my lap. It was really hard to see.

Silvia was in the hospital for about a month, during which time the parents couldn't obtain a diagnosis from the hospital because of HIPAA protections given Silvia's age. At the hospital, the parents learned of bewildering fabrications Silvia had reported: that her parents had locked the refrigerator ("Who would do that?" Betina wondered); that they had kept her in the basement. When the parents asked Silvia to explain why she had made these things up, she purportedly said, "'oh I was just having a bad day. I was just joking.'" Yet, she had called social services multiple times saying her parents were abusive and had repeated the stories in the hospital. After describing the first meeting(s) at the behavioral health unit where Betina was confronted with her physically and behaviorally altered child, and where unsympathetic mental health providers appeared to endorse Silvia's allegations of abuse, Betina announced: "I just felt like the whole world was against us… such a surreal thing."

Structurally in Betina's narrative, the condensed statements referencing oppositional defiance and Silvia's running away serve as the story's abstract. The "craziness" that heightened when Silvia ran away from home was the complicating event (after many preceding challenges). The pivotal ("surreal") events occurred at the hospital when Betina recounted painful moments in which she and Silvia's father were no longer [recognized as] her parents, but rather first a male adult whom the parents didn't know, and then mental health professionals stepped into that role. Their daughter was no longer herself after losing weight during two months on the run and receiving medication at the behavioral health unit. The mother's reconstruction of the circumstances of her daughter's hospitalization and of the hospital staff's framing of her and her husband's parenting underscores how deeply disturbing the situation felt to her.

Though their agency was blocked, the parents fought back–defending themselves as competent parents. The abuse allegations were reviewed and dismissed, and staff released Silvia into the parents' care. The parents (with an attorney's advice) then made a deal with Silvia: she could come home provided she signed authorizations for them to see her hospital records. Betina recalled finally seeing the diagnoses of "BPD, eating disorder, anxiety, depression. It just kept going and going and going…this whole plethora of things." This brief depiction of diagnostic labels added another weighty element of disturbing news.

Betina's narrative included critical evaluations of other authorities involved with Silvia. Her greatest frustration was with the school for never letting the parents know their daughter was saying she was being abused by them, and for not calling social services or the police. Betina said:

> That was the worst of it. Why did they all hide it? […] The hardest thing…we could have gotten her help, we could have gotten help for ourselves, but we just didn't know what we were dealing with. We just thought she was being defiant…hanging out with bad kids […] That's why we ended up getting an attorney, because it just all didn't make sense.

Although the school was "totally in the wrong," Betina eventually halted the legal process, reasoning, "I didn't want to go through any more stuff, and I didn't want my kid to go through any more stuff. I just wanted it to be over."

This story reached narrative resolution and had an explicit coda. Betina reported that Silvia had found the college she was attending through a sports scholarship. Our first meeting took place

over the summer, which Silvia was spending out of state with a fellow student and family and teaching exercise classes. Betina noted that Silvia was a fine physical activity teacher and overall great with kids: "When Silvia babysits, there's no TV. She keeps the kids super active, super fun, with super exciting, creative ideas. Whatever she does she is very passionate about." This story closed with a return to normality, where Betina reported on her daughter's positive qualities and acts leading her into adulthood.

Like many participants, Betina pointed out she was skipping over many events. As noted previously, she used wording expressive of her own feelings and reactions to the alarming events. By contrast, most participants' accounts offered little or no mention of how they felt about what was happening. Parental focus on the child makes sense. Yet, as Betina's account indicates, what they described at length as having happened to their daughter, son, sibling, grandchild, partner, during this vital conjuncture, *also happened to them*. They, too, were actors in the family dramas they recounted, both witnesses and actors with critical roles; they were people acting and being acted upon.

The narrative arc of Silvia's account contrasts with the other two vignettes, where parents eventually reduced, rather than, as in Betina's case, resumed caregiving roles (for a time).

False Accusations, Threats and Leaving Home, Involuntarily and Voluntarily (Vignette 2)

Narrative analysis in this vignette points to the moment the parent reached a new understanding of their child's needs and agency, which resulted in a shift in parental role and interactions. Sally, who lived in a small town, reported that her daughter Jackie was a victim of mental, verbal, and emotional abuse from her stepmother during five years of shared custody.

> At five years old Jackie would call me, crying so hard. They grounded her to her room for an entire week because she said she wanted to come home. She was not allowed to talk about home. She was not allowed to talk about [Sally's second husband]. She wasn't allowed to talk about her animals. When she started school, she wasn't allowed to talk about school.

Sally believed that her ex-husband was a good father, and it was important for him to be in their daughter's life. Eventually, the state intervened to end joint custody. Sally recalled, "the deputy escorted me over to remove her from their home. … her dad is hollering at me from the yard, and his lady friend is in the house by the window screaming profanities. We got her in the car and away we went." The court ordered counseling for Jackie and the family.

The mother recalled fondly how she and Jackie used to do everything together, but when her daughter turned 16, "all hell broke loose with her. It was not following the rules. It was calling the cops on me, telling the cops that I was abusing her because she had come out finally as gay." (Sally affirmed her full support of her daughter's lesbian identity.) Professional investigation deemed the accusation of abuse was not credible. Jackie was removed from her mother's home, evaluated, and placed into residential treatment after telling school counselors that she "didn't want to come home because she was scared of what she would do to us [her mother and stepfather]." With this news, Sally reported having locked up the guns she and her husband owned in a new location and having locked their bedroom door. Then she and the stepfather picked Jackie up from school and "away we went" to the residential treatment facility.

Sally believed her daughter's accusation of abuse was in response to her having taken away her car for four months after Jackie violated state law prohibiting new drivers under the age of 18 from driving with passengers. Sally said it was this act, the false accusation of abuse, that prompted

her to come to the realization that "holy shit, we have a problem. There is way more going on here than I ever realized. … It was that night I realized she was capable of more than anything I had ever given her credit for." After Jackie returned home from residential treatment, the same conflicts repeated over driving, according to Sally. This time the mother again took the car away. This punishment angered Jackie, who said, "how could [Sally] do that to her; [she] didn't love her." Jackie once again called the police to say her mother was abusing her, but the same police officer responded to her call and lectured her on the harms of false accusations.

Notably, the mother then turned to updates marking the story's resolution. At the time of the interview Jackie was 17 years old, had left her mother's home, and was living with friends. The mother-daughter relationship, Sally noted, was now "more stable." Sally explained that her own mother was having major health issues, and that she herself had developed "a whole litany of [health] issues." She said she realized:

> Something's got to give. I have to start paying attention. I cannot live everybody else's lives for them. That's what I felt like I was doing … "If I was just there enough, if I was just next to them, if I just supported them, if I just gave them enough money, if I just gave them enough time, they would do this, they could do that" – and none of it was working. It took my health taking a toll that I had to step back and see what I could do differently.

A review of the narrative structure of Sally's interview reveals some Janus-like moments of evaluation. She looked backward to reassess where her daughter was at and then forward to register how she should not ignore, but rather give due respect for, a newly arrived at understanding of her daughter's agency. Sally explicitly identified two pivotal moments that led her to shift her understanding and eventual relations with her daughter. First, her daughter's lie about abuse prompted Sally to re-evaluate Jackie's situation as involving something more problematic than and different from her prior sense of a difficult teenager phase. Sally herself offered an evaluative context for her daughter's acts. She tied the fabrications to the stepmother's punitive behavior. Sally believed that from a young age Jackie had to "figure out what dad and [stepmother] wanted and make her truth about that. Sometimes she would tell lies that were so big (e.g., that their house burnt down) that she would back herself into a corner, and she couldn't get herself out of it." Sally registered a second moment of new understanding when her mother's and her own deteriorating health made her re-evaluate her approach. She also critically assessed her own parental efforts, finding that doing too much wasn't the right strategy, and that, overall, nothing she did was working. Her revised strategy was to reduce parental involvement. In a closing coda, Sally noted that she co-signed on an apartment for her daughter and friend and continued to pay for a lot of things (from food to rent), but things were different: Sally said she now tells Jackie when she is not feeling well and unable to act on a request.

From Verbal to Physical Conflict and onto Self-Harm (Vignette 3)

In this vignette, a dramatic event is pivotal in the parents' understandings but does not lead them to take extraordinary measures. Instead, from their account, the child's worrisome acts and worsening state, a deteriorating family environment, and increasing involvement of health professionals and institutions lead to a significant shift in the parents' relationship with their daughter.

Rita and Samuel described their daughter Miranda as a captivating, high spirited, affectionate child, who came to the family through adoption beginning in elementary school. In middle school things changed. According to the mother, Miranda became disrespectful of and antagonistic toward both parents. Rita acknowledged that in such instances she would respond in anger. At a social event during this time, a psychologist the parents met assured them Miranda's misbehavior was "just a phase" and that all would work out. But he was wrong.

Things turned violent during dinner a few weeks before the school year began. According to Rita, Miranda (age 14) told her mother she had to fill out a sports team form. Rita asked her to bring her the form. Miranda said she responded curtly, "get it yourself," to which the mother retorted, "well, if you don't want the uniform…." Rita said that Miranda threw a glass of water in her face, then seemed to be trying to turn the food-laden dining room table over. Samuel restrained Miranda and then released her. The child was unharmed, but she caused physical injury to the father leading to hospitalization. The parents reported that a month later, a repeat event occurred. This time the parents called the police, who took Miranda to a youth shelter. In the aftermath, a child mental health crisis team assigned brief therapy. Samuel recalled this intervention as uniquely helpful as it included weekly check-ins with the parents.

Few parents in the study reported physical aggression; the threat or danger of suicide, however, was a concern for virtually all families I met. The parents reported this was Miranda's next phase. Three times suicide ideation and overdosing led to hospitalization. Miranda's second stay (age 15) at a behavioral health unit was under a week. At discharge, the parents said staff told them she had refused group therapy (Dialectical Behavioral Therapy, an evidence-based therapy used for BPD treatment), and that they "can't do anything with her." The parents recalled wondering why the mental health specialists had given up so quickly and what the discharge note "BPD deferred" meant, but said they did not ask any questions. In the parents' story, a year later, Miranda secretly stopped attending high school. Nevertheless, Samuel noted with annoyance, the school did not follow up with them over truancy. That winter, Miranda ran away for 48 hours. Not long after, parents said she spoke of suicide and was hospitalized. By then, Rita and Samuel said they came to believe they couldn't provide her the help she needed at home and that the negativity in the parent-child relationship was detrimental to her and the family.

After a good deal of trouble getting beyond health insurance blockages, Miranda was placed in two residential treatment facilities. The parents recalled that staff at the first facility frequently called them on cold winter nights to inform them their daughter had escaped (and was away for several hours). Some months later after again leaving the facility, Miranda called her parents to pick her up. When they did, she reported having met two men who offered to help her leave the state. Miranda agreed to go to the hospital for health exams where, according to Rita, the emergency room adult psychiatrist shrugged off their concern of possible sexual victimization as a "lifestyle choice" and discharged Miranda to the same (insecure) residential treatment center. The following day the residential staff brought her to the hospital's adolescent behavioral health unit, where the child psychiatrist responded with serious attention to her being at risk. Weeks later, Miranda was placed in a secure treatment center "in the middle of nowhere," as Rita noted, adding this move reduced their stress. Rita and Samuel reported that Miranda "did beautifully" at this location. Unfortunately, the effects "wore off," as Samuel put it. The parents recalled Miranda (age 18) declined therapy, quit her medications and high school and became decreasingly active and increasingly hostile to parental rules. She left home, reconnecting after a year of estrangement.

Attention to narrative structure indicates how the parents experienced the events relating to their daughter. According to the narrative structure, style of telling, and intensity of detail (redacted

here), the dining room table incident was the pivotal moment. After this point, the parents sought professional help. One therapist suggested seeing Miranda as a "trauma kid," whose acts stemmed from anxiety leading her to feel the need to be in control. This formulation helped the parents gain some perspective on psychological bases of Miranda's disturbing words and acts.

What also registered for them, however and here evaluation emerged in the narrative was that at a certain point when the parents found themselves living in a space of constant tension in which, in their minds, "everything" could erupt into parent-child conflict, they determined their home was not a safe or good environment for their daughter or the family. The parents came to believe that Miranda had figured out she could ignore parental authority, and they had very little means of managing their daughter when out of control. In other words, the parents registered the effectiveness of their daughter's agency and the limits of their own.

At critical moments, they sought institutions and agents to intervene, including to provide a safe place where their daughter could get help and where the family could learn more effective ways of interacting with their daughter. In doing so, it appears they acted upon a sense that the differences in Miranda's acts, especially suicide ideation and self-abandonment, should be seen as markedly different, i.e., outside their frame of everyday adolescence. The parents reported at the close of the interview that Miranda was living in housing for young adults with mental health diagnoses, had graduated from high school and was on reasonably good terms with them.

What Is at Stake: Narratives through the Lens of Vital Conjuncture

The concept of vital conjuncture (Johnson-Hanks, 2002) aptly characterizes parents' narratives concerning the time period of their adolescent moving toward adulthood through a diagnosis of borderline personality disorder (BPD). During these difficult times, parents in the full study were confounded by their child's negative emotions and acts and struggled to comprehend and take care of their child, who was going through harrowing experiences: for most, suicide attempts, self-injury, or other self-endangerment leading to in-patient behavioral health and residential treatment; for some, the criminal justice system or homelessness; for all, family life engulfed in stress and conflict. At some point in the process, the young person was assigned the mental health diagnosis of BPD.

The concept of vital conjunctures helps us register that the time period was one of "critical duration" and "radical uncertainty" in which stakes were high (Johnson-Hanks, 2002, p. 871; 878). Specifically, questions and ambiguities arose over what was going on with the adolescent. Anthropologist Jenkins (2015) argues that the "very categories of adolescence and adolescent psychopathology are cultural-historical products" and there is a "continuum between normal and abnormal" (p. 259). Interviews suggest parents pondered whether what was going on with their adolescents constituted a difference in magnitude (a quantitative difference) or in kind (qualitative difference) from real or imagined other teens.

Only a couple of parents I met considered a borderline diagnosis in relation to their child on their own. Very few had specific knowledge of BPD prior to diagnosis; the parents who knew of it heard it was hard to treat. Rather than a mental health diagnosis, parents believed their child was exhibiting some sort of extreme adolescence, or rather, they wrestled with uncertainty over how to understand their child and how to handle a terribly conflicted parent-child relationship. Korbin and Anderson-Fye (2011) cite Margaret Mead asserting that "'storm and stress' is not a universal condition across societies" (p. 418), but rather that intergenerational conflict and adolescent rebellion are variously constructed in specific sociocultural contexts (see also Korbin,

2013; LeVine, 2011; Jenkins & Csordas, 2020). By the same token, such acts and interactions may have become naturalized cultural understandings among some sociocultural sectors of the contemporary U.S. (Hoffman, 2013).

I suggest that a sense that adolescence is a turbulent period of rebellion provides a ready-made explanatory framework that some Americans may accept and may contribute to delayed recognition and intervention for the young people with BPD. This framework regarding teen rebellion may well have led parents, if not to normalize the behavior, then to not characterize it medically as a mental health condition. Betina initially characterized her daughter's behaviors within a culturally inflected perspective of adolescence as entailing extremes of high emotions and intergenerational conflict. Sally, like many parents, didn't discuss the diagnosis. Rita and Samuel had vague recollections of parent education sessions offered through residential facilities; these sessions did not cover BPD in their recollection. Only sometime after Miranda was once again in residential treatment did her parents look into what the cryptic phrase "BPD deferred" on the discharge papers meant. They reviewed the criteria in the DSM and found most of the nine criteria were met. Some parents in this study, including Rita and Samuel, believed a professional "deferred" the diagnosis because the young person was an adolescent, thus in a developmental phase of life (see also Jenkins & Csordas, 2020, p. 115). Others reported professionals used the potentially more accessible language of "emotion dysregulation." Such adjustments may be helpful; however, the unfamiliar diagnosis and treatment for BPD and lack of psychoeducation on BPD may have contributed to parents' confusion and stress.

The BPD diagnosis made sense to parents in the sample as a whole; they found some or many of the descriptive diagnostic criteria corresponded to things they had experienced with their child. The diagnosis led them to eventually sort out the confusion over what was going on and at some point, move toward a new understanding, including ways to alter their parenting. Some eventually found family psychoeducation courses on mental illness or specifically on BPD.

In her work, Johnson-Hanks (2002) points to the importance of "social institutions that frame alternatives, which make certain aspirations plausible, possible, or almost unthinkable" (2002, p. 878). At some point of crisis, the youth and parents came into contact (voluntarily or not) with a variety of forceful institutions and agents. In these stressful conjunctures, parents found themselves engaged with mental health professionals and institutions who forcefully asserted agency in response to the child and over the family, and in so doing offered object confirmation of familial crisis. Parents in this study evaluated these agents variously. While parents recognized many beneficial interventions of people in systems of authority, they also identified some questionable and unethical acts. Such professional interventions, even where potentially helpful, simultaneously signaled parents' reduced agency.

Conclusion

The stories presented here and the qualitative literature on family member experiences of mental illness overall offer possible recommendations for professionals and community members. First, we need to listen to parents of young people experiencing distress, we need to ask them how they are doing and what they need. Professionals can assist by offering support and helping them discern warning signs and consider treatment options (Friesen et al., 2022; Lamont & Dickens, 2021; Myers, 2024). Family members and caregivers offer insights useful for healthcare professionals and community members aiming to assist family recovery. Caregivers call for empathic partnering with providers (Barr et al., 2020; Foye et al., 2022); long term, reliable

partnering with clinicians (Friesen et al., 2022), including checking in with family members on their own mental health and offering an array of effective support services (Dunne & Rogers, 2013). By eliciting and listening to parents' stories, professionals and community members could better help families obtain support earlier on and potentially decrease and avoid acute and chronic crises and related damage. The stakes and effects of such efforts at understanding experiences with children diagnosed with BPD affect how parents respond to their child, including whether and when to seek professional help. These matters extend to questions of identity and agency. Johnson-Hanks (2002) underscores in her work that vital conjunctures entail high stakes that affect "not only the stream of future events but also the future person, the range of identities that could potentially be framed" (p. 872).

Specialists in medical and psychological anthropology have probed what it means to parent a young person coming of age with a psychiatric diagnosis. Jenkins and Csordas (2020), in their discussion of the impact of the "discourse of diagnosis" (p. 113) on parents of adolescents in residential behavioral health treatment, conclude that what matters most is not so much the specific diagnosis nor whether the parents understand the diagnosis as professionals do, but rather that the understandings "are experientially and pragmatically consequential" for those affected by the diagnosis, that is, the person and family (p. 116). Myers' (2024) research on youth mental health crises entailing a psychotic break emphasizes that some parents on their own interpreted the worrisome signs outside of a diagnostic frame. They acted in ways they believed were protective of their children, yet doing so led to delays in seeking treatment. Myers underscores parents need support in understanding their child's mental health experiences and how to support recovery.

Parents in this study were confronted with imperatives to alter their relationships with their teens. In two vignettes, parents came to a place where they registered that the mental health/emotional/developmental needs of their adolescent were at times beyond their capacities and possibly beyond the viability of the home as an environment conducive to treatment and recovery. In the third, another adult brought the person to a mental health treatment center. Each vignette ends with a coda reflecting the close of the stories, offering a sense of the future. In two families, the daughters found independent housing more definitively and furthered their education on their own initiatives. In one, the high school senior returned home and then found a college out of state to attend the following year. In the first vignette, the parent reasserted their role with some agency and control; in the other two narratives, parents reduced or relinquished their roles. All codas reflect parents' sense of their child's agency as an emerging adult.

It may be important for mental health practitioners, parents, and the broader community not only to recognize a qualitative change in the adolescent, indexed by the diagnosis and indicative of a need for another level and kind of support, but also to not lose sight of these young people as emerging adults doing what they can to carve out a future and evolving sense of self. Psychiatric anthropologist Hopper (2007) made this statement regarding recovery from schizophrenia: "recovery… will require not only that we re-evaluate damaged selves but re-examine what it means to hold onto provisionally undamaged ones as well" (p. 878). The analysis here leads me to underscore a bit paradoxically the importance of maintaining, as do the parents featured here, a kind of dual vision, that is, seeing both the extraordinary and the non-pathological circumstances of a young person seeking adulthood and interacting with the young person in accordance with that dual vision.

Finally, Johnson-Hanks underscores in her critique of linear life stage models that vital conjunctures can occur in any period of life. Narrative analysis and conceptual framing of vital conjunctures made it clear that the events describing a young person's emerging adulthood through

a borderline diagnosis simultaneously led to the parents' own vital conjunctures with direct effects on their sense of self, agency, well-being, and future. Seeing emerging adulthood with BPD as a vital conjuncture for parents as well as the family member with the disorder offers not only a more compassionate perspective, but also a stronger analytical and engaged approach. Doing so reminds us parents also need to be seen by others and by themselves as provisionally undamaged, and in need of support, so that all family members recover.

Limitations of this study include recruitment through an organization dedicated to supporting people impacted by mental illness, hence a pool of participants potentially concerned and educated about mental illness. The study employed a relatively unstructured format, which meant that participants could choose what to discuss of their experiences of BPD in an adolescent family member. While the open interview format corresponded to the aims of the study, namely what and how family members volunteered to report of their experiences of BPD in a close relative, such variation limits comparability. A sense that parents may be deemed responsible for their children's outcomes could have led some participants to in some ways emphasize positive aspects of their parenting. The findings of this small scale, qualitative study also reflect the lived experiences of family members of a specific demographic (mostly white middle class) and region (U.S. Midwest). Despite these limitations, this study offers a novel contribution to the field of BPD research and to qualitative research through its structural and content analysis of parents' narratives of their experiences of BPD in their adolescent child.

Declarations

Author Contributions

MO'D developed the study design and methods, conducted all interviews with study participants, completed the data analysis, interpretation, and drafted the manuscript. The interviews were professionally transcribed.

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Institutional Review Board Statement

The research was approved by the University's institutional review board.

Informed Consent Form

Potential participants received a document describing the study objectives and contact information of the principal investigator (PI). Before any research activities began, the PI discussed the research purpose and consent process verbally with participants. The consent form expressly states participant rights to: not answer any questions; end the interview at any time; and withdraw from the study without in any instance having to provide a justification. Prior to beginning the interview, local participants signed hard copy consent forms; non-local participants signed an electronic copy of the form beforehand.

Data availability statement

Readers wishing further details about the study may contact the corresponding author. In keeping with the consent agreement, data, including de-identified data, are not available.

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Conflict of Interest

The author declares there are no conflicts of interest concerning the publication of this work.

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