The Family, Family Therapy, and Borderline Personality Disorder

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The authors review recent controlled studies on the interrelationship of the family and its members with borderline disorder and propose a new model for understanding and managing this relationship. The focus of the model is on psychopathology, evaluation, and treatment of patient and family as they influence each other. In the authors' view this illness originates in cerebral dysfunction in the patient in combination with impaired relationships among family members. When the family is available, we believe that the treatment of choice is a multimodal approach involving family psychoeducation and family systems or dynamic intervention where possible, in combination with medications, individual psychotherapy, or both.


Why write about the family of the patient with borderline personality disorder (BPD)? Because the family and the patient are inseparable biologically, psychosocially, and psychodynamically. The family is affected by the patient and vice versa. We believe that a change from current working models is indicated. Our understanding of the literature suggests that family psychopathology exists that predates the birth of a vulnerable "identified patient" who has dysfunctional biological underpinnings. This combination may produce impaired relationships among family members in an already fragile family structure.

Our objective is to review findings about BPD as they relate to this model and to make treatment recommendations in keeping with our view of the patient as ill, not "bad," and of the family as suffering, and often themselves impaired, but often doing the best they can.

Definition of BPD

It is important to note that seven of the nine DSM-IV criteria for BPD have obvious and important interpersonal implications.

The first criterion deals with abandonment, in which family members are unreli-
able, threaten to (or actually do) leave, or in some way “cut off” the patient from the family. The second relates to the issue of unstable interpersonal relationships. Commonly, the patient does not have a sense of permanence or consistency in his or her relationship with others, including family members. The third criterion is identity disturbance: the patient experiences a shifting sense of who she or he is and, therefore, a lack of consistency and reliability within relationships. The fourth criterion has to do with impulsivity, which results in behaviors that can cause destabilization of the family. The fifth criterion is suicidality; our sense is that this type of behavior stems not only from the pain associated with the illness, but in part from conscious and unconscious attempts to control family behavior by use of the threat of suicide. The sixth deals with affective instability, an issue related to the first criterion, and that, too, takes its toll on family emotional consistency. Eighth, and a related problem, is anger; the patient is a potential powder keg waiting to explode, and the family may serve to ignite the patient. Later in this article we elaborate on these criteria and their interpersonal implications.

**ETIOLOGY**

We will be examining both the biological data and the psychosocial data (focused on the family model) pertaining to the causes of BPD. There is a sizable literature on patients with BPD; however, with some important recent exceptions that we discuss, until recently there has been virtually no literature on “borderline couples.” (We mean by this a relationship or a family in which one or both adults have BPD.) There are two obvious reasons for this lack of data. First, most psychotherapy of patients with BPD has been psychoanalytically oriented, with the focus on the individual. Second, family therapists usually are not primarily interested in an individual family member's diagnosis, but rather in the effects of the illness; for example, substance abuse as an effect of the BPD and what such behavior does to the family. In addition, much of what has been published is anecdotal.

**Biological Data**

For several decades, clinician-researchers, including Klein and others, have suggested that there may be a biological contribution to BPD. Research into the biological correlates of behavioral and personality traits have provided evidence that there is a heritable, biological component to some personality and behavioral traits. Specifically, there may be familial transmission of the hallmark borderline-related personality characteristics; this area recently has been exhaustively reviewed by Coccaro and Siever. Not only that, but in clinical psychopharmacologic trials, treatment has generally been associated with global improvement in patients with BPD. Parenthetically, the familial problem in combination with the cognitive impairment in BPD patients presents a situation with high potential for poor communication in both patients and their families.

**Evidence of Family Pathology**

These data are mostly correlational and relate to issues involving a complex interplay between innate vulnerability and developmental trauma. The work of Kagan and colleagues on temperament is potentially quite pertinent here; a vulnerable individual in a severely dysfunctional family may produce the symptoms we associate with BPD. Stone has proposed a psycho-biological model of the borderline conditions that explores the role of a hyperirritability that may either antedate parent-child interaction or stand apart from traditional developmental stages. It suggests that one pathway towards this hyperirritability is the trauma-
mastic effect of abuse, which may alter the neuroregulatory response system in ways that cannot be accounted for in purely developmental models.

**Parental Pathology**

In the parents of borderline patients, affective disorders tend to be far more prevalent than schizophrenia, especially when the patient has a history of major depression. Borderline patients' families have a higher incidence of alcoholism, antisocial personality disorder, and other cluster B personality disorders—the same behaviors found in BPD patients. Goldman et al. recently reported higher rates of psychopathology among family members of patients with BPD compared with a control group with other psychiatric disorders. Such disruptions of the patient's environment as early loss or separation, physical and sexual abuse, and separation or divorce of the parents may be related to the type and degree of parental psychopathology. In summary, it may be worthwhile to point out the obvious, that "familial transmission" of various characteristics of borderline personality disorders seems likely, and that such transmission may result from combinations of genetic, nongenetic biological, and epigenetic (learned, environmentally induced) factors.

**Physical and Sexual Abuse**

Many borderline patients have been found to have impulsive and chaotic family environments that may include physical and sexual abuse of the patient. Physical and sexual abuse may be either a single traumatic event or chronic abuse, which has more adverse consequences. In one sample of 21 borderline patients, 14 had been sexually abused. Numerous studies have found an association between sexual and physical child abuse and subsequent BPD. Bryer et al. found that subjects who had experienced both physical and sexual abuse had a higher mean borderline symptom score than those who had experienced more limited abuse or those who had not been abused. Most studies of borderline patients are based on samples that are largely female; one exception is a study of family relations in a mostly male sample. The majority of these patients experienced severe physical abuse and a moderate level of corporal punishment.

Links et al. examined childhood sexual abuse as a specific and distinct etiological agent in BPD. Sexually abused borderline patients reported more self-mutilation, substance abuse, recurrent illusions, depersonalization, derealization, and physically self-damaging acts than nonabused borderline patients. The results of this study are consistent with the clinical impression of Stone, who noted that borderline patients as well as patients with other personality disorders often have a history of abuse. He concluded that severe abuse by a caregiver, when combined with an atmosphere of dislike and rejection, may be a causative factor of personality disorders characterized by impulsivity. Knowing that a parent has a history of family abusiveness is important in treatment planning because traumatized patients need support, sanctuary, sealing over, and specialized treatment.

**Neglect and Overprotection**

Some BPD patients describe their parents as less caring than other parents. The fathers, in particular, have been reported as showing less interest and less approval. Relationships with parents were described by BPD patients in another study as conflicted and negative; patients perceived their mothers as overinvolved, but at the same time less caring or helpful than other people's parents. Borderline patients appear more likely to undergo separation from parental figures early in life. Almost half of the BPD patients studied by Zanarini et al. underwent a significant
separation before age 6, and more than half before age 18. In another study, childhood separation from caretakers was more prevalent in borderline patients than in non-borderline control subjects, and marital separation or the death of a parent were more frequent causes of childhood separation in the borderline group.  

Clinical Reports of Family Pathology

Several issues emerge from the clinical literature. First, if the identified patient is an adolescent, the dynamics of BPD seem to involve a marked impairment in individuation from parents; this impairment in individuation has been understood as being related to hostile, overinvolved, rebellious, and chaotic interactions among the family. In addition, the family has been described as not being able to provide the tools and the context to help the patient form a firm self-identity (leaving open the question of how “identity” is formed). Finally, the family overreacts to the development of the identified patient with regression because they do not understand or cannot accept (because of their own needs) that the identified patient sometimes has the capacity to individuate.

Clinical reports suggest that when the parent has a borderline personality disorder the child is often used as a target of projection and disturbed reality distortions—that is, the parent plays out his or her internal conflicts through the child. Interestingly, it is believed that most patients with borderline personality do not marry (although statistics on this are not solid), but if they do marry, such marriages are often fraught with conflict and sexual problems. Finally, most reports have demonstrated that emotional disruption of one family member reverberates through the rest of the family (even more so than in nonborderline families) because of the intensity of the interactions.

In summary, hard data are accumulating that there are disturbed biological substrates in the borderline patient and probably in family members as well. There is suggestive evidence that biological defects in combination with a disturbed, “bad-fit” family are etiologic in borderline disorder and that the issues of parental pathology, physical and sexual abuse, and neglect and overprotection are related in some way to the development of BPD. There is no evidence that pathologic family relationships alone can cause borderline disorder. On the other hand, researchers agree that a family can cause a vulnerable identified patient great distress, and a very ill identified patient can certainly place a heavy burden on the family.

EVALUATION AND FAMILY ASSESSMENT

Because of the explosive and crisis-like nature of borderline pathology, many therapists go quickly from the initial interview directly to treatment. We strongly urge a careful evaluation of the borderline patient and his or her family before plunging into treatment (regardless of modality) to 1) evaluate the strengths and weaknesses of the family system, 2) ask how the patient and the family may be affecting each other, especially in terms of family burden and expressed emotion, and 3) evaluate the nature and severity of family members’ psychopathology and their relationships to the patient’s. When a patient with BPD is hospitalized, we think it is mandatory to identify past and anticipate future family behavior associated with the patient’s psychopathology.

The details of how to perform a family assessment and formulation can be found in our textbook and in a recent review by Shapiro. Here we focus on issues specific to management of BPD.

TREATMENT

In our model, the focus of treatment is not either the patient or the family, but both
together. We see them as linked. No controlled trials exist of marital or family therapy intervention in BPD, so all recommendations (ours as well as those in the literature) are based on clinical experience. Further, there is no close correlation between findings in the family pathology literature and specific treatment recommendations. We will, however, try to forge that link as best we can at this point.

Our experience is based on work in both inpatient and outpatient settings. One of us (R.A.D.) has a large practice specializing in treatment of BPD, and two others (J.F.C., I.D.G.) have focused on the family model for Axis I disorders.

Goals

The goals of treatment of patient and family are as follows:

1. To educate the family on the nature of the disorder.
2. To help the family in assessing the availability of practical support (financial aid, shelter) and emotional support and making and carrying out plans to obtain them.
3. To reduce negative expressed emotion if present.
4. To improve overall family and marital function (including sexual function), rather than focusing family life on patient psychopathology.
5. To decrease enmeshment and, by extension, to decrease the patient's fantasies of rescue by a spouse or parent.
6. To support patient compliance with other modalities—for example, hospitalization (including helping to make a smooth transition from hospital to community), medication, or individual psychotherapy.
7. To help the patient (regardless of age) individuate if possible and respect the boundaries of the family.

Enabling Factors

For treatment to be accomplished, we believe that, ideally, certain enabling factors should be present. By definition, there must be a family or significant others. They must be motivated. For the treatment process to work, the family should have some ability to regulate affect, tolerate anxiety, control projection, and not totally denigrate treatment. In some situations, presence of an active psychosis in one (or more) members may make family treatment impossible.

Questions of Strategy

The incorporation of family therapy into the treatment of borderline patients raises several questions:

1. What is the place of family intervention? In our judgment it is part of a treatment package that may include medication (when indicated for certain target symptoms, such as extreme depression or psychotic symptoms) and individual therapy (when it is clinically judged that the patient has the capacity to do the cognitive work necessary to benefit from such an approach). In some cases family therapy, marital therapy, and individual therapy are needed concomitantly.
2. In which sequence? There are two possibilities. In some cases, when the family is available, we suggest that family therapy be used before individual therapy. This approach sets the stage for individualization so that the therapist and family can work together to achieve that goal rather than the family's fighting against the patient to prevent it. In other cases, it is necessary to establish a therapeudic alliance with the patient in individual therapy before starting family therapy.
3. What type of family therapy? There is no evidence to indicate that one "school"
of family therapy is more efficacious than another. We suggest a mixture of systems, dynamic, and psychoeducational family therapy as indicated (see below).

4. Should the family therapist also do the individual therapy? In our experience with large numbers of inpatients and very impaired outpatients, the answer is, probably yes. We believe that there is more to be gained than lost because of the severity of the illness and because many BPD patients and families have difficulty in trusting therapists; once they find one person they can trust, it may be too hard for them to transfer to another.

5. What about medication? It is important to emphasize that the treating mental health professional should be attentive to the potential value of medications. When the treating professional is not a psychiatrist, he or she should always work closely with a psychiatric consultant so that additional opportunities to help these patients medically will not be missed.

Family Techniques

One way to conceptualize family interventions is to divide them into psychoeducational, systems, and dynamic interventions.

Psychoeducational intervention is the newest approach and is viewed by some as the "modality of the '90s." The role of the family therapist is to review with both the patient and family the symptoms, diagnosis, treatment, and prognosis of borderline personality disorder. Especially emotionally loaded issues include individuation, blame, and sexual function. The list also includes suicidality and violence on the part of the patient, as well as the fear of emotional blackmail that often stems from suicidal threats by the patient. We always recommend a frank discussion of suicide risk. We discuss this with families in front of the patient. It is important for families to know that patients may kill themselves despite good intentions and good therapy and that this possibility does not mean it is good to "overprotect" a patient to try to prevent this outcome. Often a core question is, "Who is guilty of causing the illness?" The answer, of course, is that no one is to blame and that understanding the nature of the suspected etiology (presumably) decreases the expressed emotion. In this context, Linehan's cognitive behavior program may contain relevant material to include in a psychoeducation program for families.

In systems family therapy, the first issue is to "join" with the family. This is a delicate operation that involves issues of control and power. The next step is to "reframe"—that is, to assign a positive connotation to the symptoms in the light of the family's efforts to help. There are obviously different approaches if the patient is a child, adolescent, or young adult. The therapist must walk a fine line between siding with the child and the family. The task of the therapist is to help the patient and the family achieve maximum function. In terms of boundaries, the problem often is that the marital coalition is undermined by mutual blaming centered on the pathology of the child. Also, the child (as the identified patient) is sometimes in a parental role because of a weakened marital dyad.

In dynamic family therapy, one of the central problems is transference. Transference is unusually intense and varied, ranging from highly idealizing to devaluing—with both forms often simultaneously present. Countertransference problems are especially difficult and are often reflected in family myths. For example, a common problem is that the therapist sides with one group (or spouse) versus the other. Slipp's guidelines for therapy with borderline couples are relevant here: they include covering issues of transference, countertransference, and therapeutic alliance, dealing with defenses, and, most important, exploring how a couple's individual psychopathologies have meshed in the
past. Slipp also suggests that after a working relationship with the borderline patient is established and interpersonal acting out of conflict has diminished, a changeover to individual psychoanalytic psychotherapy might be considered.

One may ask what differences in approach might be necessary between patients with borderline personality disorder as described by DSM-III-R/IV and others whose psychopathology more specifically resembles psychoanalytically derived concepts of borderline personality organization; clearly, the two do not always overlap. Because the latter group has been difficult to define and effectively treat, the answer is not obvious. As a starting point, the clinician might combine our techniques for the treatment of the family with some of the modifications of classically derived individual psychodynamic therapy described by Kernberg and others. There are obviously pros and cons to this approach and, as usual, only controlled studies can settle the issue. Gunderson’s description of two patterns of family involvement and their management also speaks to the issue of differences in approach:

One pattern is characterized by overinvolvement. Borderline offspring of such families are often actively struggling with dependency issues by denial or by anger at their parents. Whether denied or reviled, these needs for dependency are often being actively gratified by the family. . . . Such a family requires active, ongoing family participation in treatment. To exclude the family from involvement in the index borderline person’s treatment leads the parents to withhold support and, moreover, causes the patient to feel as if participation in therapy is disloyal to the parents and will lead to abandonment.

Borderline patients also come from families characterized by abuse (violent or incestuous) or neglect. In this pattern, the parents are likely to be angry at their offspring for having either solicited or been sent for treatment. These parents will be overtly resentful of treatment efforts that require their involvement in an examination of the family interactions. Meetings with the parents alone may be required in order to solicit their support for the borderline person’s treatment. In such meetings, it is useful to be formally educative about the nature of the offspring’s illness and to attempt to reassure the parents that the treatment is directed toward helping the patient develop more independence and, specifically, that it is not directed at blaming them. (p. 2753)

It is important to emphasize that the techniques we are recommending are not unique to BPD. They can be found in contemporary family approaches to schizophrenia and major affective disorder, including bipolar illness. These techniques are also commonly and centrally utilized in group therapy. Powerful reality testing is provided by the group (family) members, so that regression and intense transference distortions are minimized. Group (family) members assume responsibility for their actions and for changing behaviors and come to expect the same of the identified patient, and the sessions can serve as a positive “holding environment.”

Phases of Therapy

Early in therapy the main issue is to deal with the anxiety and helplessness the family feels with regard to the patient. Anger is strong on both sides, and that issue has to be dealt with early on to lay the foundation for work on the more difficult issues of changing family structure and function. In the middle phases, issues of enmeshment and lack of conflict resolution come to the fore. In the late stages, the main issue is to try to reach the best possible functional compromise among all members and “close the wounds.” Should the therapy be continuous or intermittent? We recommend the former, but
in practice the latter is common because patient and family needs and stressful events interact with treatment interventions.

Treatment of Choice

In our judgment, when the family is available and motivated, the treatment of choice is family psychoeducation, with family (systems or dynamic) intervention where possible, in combination with pharmacotherapy and/or individual psychotherapy as needed. This prescription may put us at variance with many psychopharmacologists as well as therapists of different persuasions; in our experience, however, this form of treatment may lead to the best long-range function, not only for the family, but also for the patient.

Prognosis for Families

Prognosis is unknown; presumably the families, like their patient-members, also get better (that is, "level out") after two decades of decreased function and great difficulty, but information on this is lacking. In this context, the issue of survival for the family of the patient with BPD must be addressed. Families need to be educated about the illness of the patient and told that although the illness may have genetic roots, the family is not to blame. Furthermore, like mania, the symptoms of BPD have the potential to cause great family distress and to create a heavy burden on family members. Therefore, the family has to be careful not to exacerbate a difficult situation by blaming the patient for symptoms of functional difficulties the patient is unable to control. (A similar dilemma exists for families when a member has bipolar disorder or schizophrenia.) Consumer support groups like the National Alliance for the Mentally Ill are invaluable for all concerned. Finally, the family must be prepared for the fact that these conditions are often lifelong, entailing long-term costs for therapy and the need for estate planning.

Conclusion

In summary, we are faced with the question, What is this disorder and how do we treat it? The data suggest that the etiology of this illness may be in part genetic, with possible familial transmission of the hallmark borderline-related personality characteristics. As we begin to know more about the life course of BPD patients, we see that biologic dysfunction and symptoms typically begin early, perhaps in preadolescence, but reach their full expression during the individual's 20s and 30s, resulting in at least two decades of symptoms and problems for patients and their families. The most fascinating aspect of the life course in BPD is that the degree of symptomatology seems to level off in the patient's 40s and 50s, but there is evidence that the functional level at which this occurs is lower than before the illness. Very few medical illnesses fit this model (in psychiatry one subset of patients with schizophrenia have this life course, and in medicine there are some similarities to regional enteritis), again raising the perplexing question of etiology.

This review of etiology, evaluation, and treatment has led us to several conclusions. We believe that BPD may be a treatable (that is, manageable) illness. Increasing evidence supports the notion of crucial genetic-biological underpinnings. In addition, there are suggestions of family psychopathology that may be related to etiology. The patient affects the family and vice versa, and in some cases treatment should involve a family component.

Further research is needed on these and other issues concerned with this challenging disorder, which has such high morbidity and mortality and which involves both patients and their families over many generations.

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REFERENCES


