The Interface

THE FAMILIES OF BORDERLINE PATIENTS: The Psychological Environment Revisited

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This ongoing column is dedicated to the challenging clinical interface between psychiatry and primary care—two fields that are inexorably linked.

ABSTRACT

We examine the families of patients with borderline personality disorder. According to existing data, the family members of individuals with borderline personality disorder have higher-than-expected levels of psychopathology, particularly with regard to mood, impulse, substance use, and Axis II disorders. Likewise, in the empirical literature, patients with borderline personality disorder seem to consistently portray parents in a very negative light. Collectively, this information suggests that there may be considerable levels of psychopathology in the families of patients with borderline personality disorder. In terms of family treatment, there is very little available information. Reported strategies seem to focus on psychoeducation, in addition to skills training and problem solving, and there are a number of educational resources for families on the web. Overall, this area is clearly in need of further research.

KEY WORDS

borderline personality, family members, family intervention

INTRODUCTION

The empirical literature in the area of families and borderline personality disorder (BPD) is growing. A large segment of this literature relates to studies of abuse propagated by family members during childhood (i.e., physical, sexual, emotional abuses; witnessing violence) as well as the genetic influences relating to the temperamental characteristics of affected individuals. However, in this edition of The Interface, we have elected to limit our focus to the accumulating literature on the psychopathology within the families of BPD individuals as well as the current focus of family treatment. (As a caveat, we advise the reader that not all families necessarily harbor significant psychopathology or overtly contribute to their member's Axis II disorder.)

Psychopathology in the extended families of BPD patients. A number of studies have examined various psychopathological characteristics in the extended families of BPD probands in comparison with the extended families of a control proband. For example, Silverman and colleagues compared the first-degree relatives of three proband subsamples: (1) individuals with BPD; (2) individuals with other personality disorders; and

(3) individuals with schizophrenia.[1] Compared with the other two subsamples, the relatives of BPD probands demonstrated independently greater risks for affective and impulse disorders.

In a study by Goldman, D'Angelo, and DeMaso,[2] investigators compared the family members of borderline versus non-borderline psychiatric probands. The families of individuals with BPD had significantly greater rates of depression, substance abuse, and antisocial characteristics.

Riso et al[3] compared the families of BPD probands with those probands of individuals with mood disorder or who were never-psychiatrically ill. Compared with these two control groups, investigators found increased rates of mood and Axis II disorders among the relatives of the BPD probands.

In a large study by Zanarini et al,[4] investigators compared family members of 341 BPD probands to 104 probands with another type of Axis II disorder. Over 1500 relatives of the BPD probands were interviewed. Compared with the nonBPD Axis II probands, the families of BPD probands were more likely to have BPD psychopathology, particularly subsyndromal symptoms.

Finally, in a 2003 review article, White et al[5] presented their analysis of the literature on the psychopathology among the relatives of individuals with BPD. This author group concluded that there do not appear to be familial associations with schizophrenia or major depression, but rather with impulse spectrum disorders and BPD, itself.

What can we conclude from this collection of studies on the psychopathology in the relatives of those with BPD? These data consistently suggest that there are four commonly associated areas of familial psychopathology: (1) mood disorders; (2) impulse disorders; (3) substance use disorders; and (4) Axis II disorders including BPD. It seems that the families of patients with BPD partially mirror the psychopathology encountered in the probands.

Overall...studies portray the parents of patients with BPD in a very unflattering light...one potential confound may be the patient's possible distorted perceptions of parents. If so, then there appears to be a consistent distortion in perceptions across numerous study samples and methodologies, as we were unable to find any study that portrayed parents in an equal or more positive light when compared with controls.

PSYCHOPATHOLOGY IN THE PARENTS OF BPD PATIENTS

Studies of both parents. In examining the specific literature on the psychological dysfunction in the parents of individuals with BPD, we encounter an unavoidable methodological confound. Most of these studies summarize the impressions of BPD patients, themselves, oftentimes in comparison with a control group. Because BPD patients frequently harbor histories of childhood maltreatment, have inherent difficulties with emotional regulation, and retain a propensity for splitting, the objectivity of these accounts may be suspect. However, having presented these limitations, a summary of this literature follows.

Using various methodologies and types of BPD patient samples, investigators have assembled a number of patient-derived perceptions about parents. The parents of individuals with BPD have been described by offspring as negative;[6] uncaring and over-controlling;[7,8,9] unempathetic;[10] conflictual;[11] invalidating and critical;[12] aversive, less nurturing, and less affectionate;[13] emotionally withholding;[14] over-protective;[15,16] over-involved as well as under-involved;[17] and hostile.[18]

As for examples of individual studies, in a sample of 393 participants, Nickell et al[19] found that insecure attachment (i.e., anxious or ambivalent attachment) and the perception of a lack of caring from mother were uniquely associated with borderline personality features. In a sample of 358 patients with BPD and 109 Axis II controls, Zanarini et al[20] found that the BPD subsample was significantly more likely to report that caretakers denied the validity of their thoughts and feelings, failed to protect them, neglected their physical care, withdrew emotionally, and treated them inconsistently.

Finally, in a study comparing 66 BPD patients with 109 controls, Bandelow et al[21] found that the BPD subsample described the attitude of their parents toward them as significantly more unfavorable in all aspects.

Overall, these studies portray the parents of patients with BPD in a very unflattering light. Again, one potential confound may be the patient's possible distorted perceptions of parents. If so, then there appears to be a consistent distortion in perceptions across numerous study samples and

methodologies, as we were unable to find any study that portrayed parents in an equal or more positive light when compared with controls.

Studies of mothers. In addition to studies examining the general impressions of both parents, several empirical studies provide insight into the BPD individual's specific relationship with mother. In these studies, the mothers of those with BPD have been portrayed as ego-centric and using the child for their own ego-gratifying needs,[22] less caring,[23] inconsistent and over-involved,[24] and in mourning (i.e., having suffered a loss within two years of the patient's birth).[25]

Studies of fathers. Few studies directly address the specific relationship of the borderline individual with father. In a study by Baker et al, fathers were rated particularly unfavorable by BPD patients.[26] The investigators found that this negative response was related to the age of the respondent as well as a history of paternal sexual abuse.

TENTATIVE CONCLUSIONS

Recall that in the studies of relatives of BPD patients, there were high levels of Axis II psychopathology, including BPD. Parents also appear to be displaying dysfunctional interpersonal patterns. Is it possible that we are observing a "borderline style" of interaction in the rearing of offspring? Specifically, if we examine the key themes in the literature on parenting styles, one gets the overall sense of behavioral over-involvement (e.g., over-controlling, over-protective) coupled with emotional under-involvement (e.g., a lack of empathy/affection, emotional withholding). This paradoxical style of interaction might be well explained by the presence of a parent with BPD. This interactional pattern might be experienced as, "Let me control you, while you emotionally take care of me," which in empirical studies translates as emotional under-involvement. Given the nature of this hypothesized parental experience, this may explain the clinical and empirical observation of these patients' tendencies to form anxious or ambivalent attachments in adulthood.

THE CHILDREN OF MOTHERS WITH BPD

Several studies have examined the effects of BPD mothers on their young charges, typically in conjunction with a control group. For example, Hobson and colleagues explored the mother/infant dyad of BPD versus community mothers.[27] Mothers with BPD were found to be less available for positive engagement, intrusively insensitive, and disorganized. Barnow and colleagues compared the children of BPD mothers with those of depressed mothers, mothers with Cluster C personality disorders, and mothers without psychopathology.[28] In this study, the children of BPD mothers were more harm avoidant, had lower self esteem, and exhibited more emotional and behavioral problems. Weiss et al[29] compared the children of mothers with BPD with mothers with a nonBPD personality disorder. The children of BPD mothers were more impulsive and had more psychiatric diagnoses, including a higher prevalence of BPD. In a study by Newman et al,[30] BPD mothers were compared with community mothers. In this study, BPD mothers were less sensitive and structured in their interactions with offspring, and likewise, the infants were less eager to interact, less satisfied, less competent, and more distressed. Finally, in a related study, Marantz and Coates examined boys with and without gender identity disorder; 53 percent of boys with versus six percent of boys without the disorder had mothers with diagnoses of BPD.[31] These data suggest that, compared with various other of types mothers, mothers with BPD, themselves, appear to exert a negative influence on their young charges.

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IMPLICATIONS FOR FAMILY INTERVENTION

The preceding findings suggest the following: (1) the families of individuals with BPD are likely to be peppered with members who suffer from mood, impulse, substance use, and Axis II disorders including BPD; (2) parents may exhibit parenting styles that are characterized by behavioral over-involvement (e.g., over-controlling, over-protective) and emotional under-involvement (e.g., lack of empathy/affection, emotionally withholding); (3) mothers may be ego-centric (e.g., use the child for their own ego-gratifying needs), less caring, inconsistent, and over-involved; (4)

fathers may be perceived negatively, particularly when they are the perpetrators of sexual abuse; and (5) the children of BPD mothers may be more emotionally and behaviorally disturbed, as evidenced by their greater number of psychiatric diagnoses including BPD. This summary indicates that there may be psychological insolvency throughout the family stream, from older relatives to parents to children. This insolvency appears to be characterized by impulsivity and various psychiatric disturbances, including mood disorders and BPD. Therefore, family intervention must be undertaken with care because of the overall levels of possible psychopathology in multiple members.

The preceding observation of a greater likelihood of psychopathology in the families of patients with BPD may account for the tone of contemporary treatment recommendations. Succinctly, programs for family members are few in number[32] and most authors in the area appear to be advocating a psychoeducational approach. For example, Gunderson, Berkowitz, and Ruiz-Sancho[33] underscore the relevance of psychoeducation as well as Murray-Swank and Dixon.[34]

Hoffman et al[35] have developed a family-based treatment program called Family Connections. This program provides participants with psychoeducation on BPD, coping skills, family skills, and opportunities for family members to build support networks. In their preliminary assessments of the program, family members reported a significant reduction in grief and burden.

Apfelbaum and Gagliesi describe a multicomponent, family-based treatment for BPD. The treatment components include the identification of the fundamental problem, psychoeducation, containment of expressed emotions, and skills training.[36]

Blum and colleagues have developed a 20-week, manual-based, group treatment program for outpatients with borderline personality disorder called Systems Training for Emotional Predictability and Problem Solving (STEPPS).[37] This program combines cognitive-behavioral elements with skills training and encourages the participation of family members and significant others.

To further the mission of psychoeducation, a number of resources for families are available. For example, the journal *Psychiatric Services* published in 2001 a summary on BPD for consumers and families.[38] This two-page article describes the disorder, its treatment, and course/outcome, and can be easily downloaded as a pdf file. Information for families is also available through the Borderline Personality Disorder Resource Center, which can be downloaded at http://bpdresourcecenter.org/. The National Institutes of Mental Health has an educational summary of BPD (http://www.nimh.nih.gov/health/publications/borderline-personality-disorder.shtml) as well as the Mayo Clinic (http://www.mayoclinic.com/health/borderline-personality-disorder/DS00442).

While psychoeducation is a predominant theme in the contemporary treatment approach to families with a BPD member, there may be some unforeseen risks. Specifically, Hoffman et al[39] explored family members' knowledge about BPD. In this study, greater knowledge about BPD was associated with greater family member distress, burden, depression, and hostility toward the patient.

CONCLUSIONS

Individuals with BPD seem likely to come from families that harbor a higher-than-expected rate of psychopathology, particularly in the areas of impulse, mood, substance use, and Axis II disorders. In turn, many of these family patterns appear to be mirrored in the psychopathology of the patients. The contemporary tone of family treatment appears to place an emphasis on psychoeducation with the family. This is not necessarily to the exclusion of other interventions, such as skills training and problem-solving. While there are few data confirming the efficacy of family treatments in BPD, a number of psychoeducational resources are available for affected families. Overall, this is an area that clearly warrants additional research.

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