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Experiences of BPD Caregivers and Solutions for Caregiver Assistance: A Systemic Review

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Abstract

Individuals diagnosed with borderline personality disorder often battle overwhelming emotions and self-destructive tendencies such as self-harm and suicidal ideation, which may necessitate hospitalization and long-term care. These challenging aspects of borderline personality disorder put an immense strain on the mental health and familial relationships of loved ones of borderline individuals. Additionally, family attitudes towards the treatment of individuals with borderline personality disorder are currently complicated by the fact that the etiology of the disorder hypothesizes a role of adverse childhood experiences and familial aggregation in the onset of borderline personality disorder. This systematic review examines the experiences of family members of individuals with borderline personality disorder from a service user perspective as they navigate seeking out care for themselves and their loved ones, approaches that have been taken thus far to assist in the therapeutic treatment and psychoeducation of family members of BPD individuals, and areas in which warrant further consideration. Such improvements in support for family carers of those with borderline personality disorder include increasing the availability of and access to family psychoeducation and accessible mental healthcare services.

Keywords: Borderline personality disorder, BPD, family systems, family carers, psychoeducation

Jerold J. Kreisman, a leading expert on the psychiatric treatment of borderline personality disorder, offers the following poignant depiction of the relational dynamic between an individual with borderline personality disorder and their family:

> The borderline individual wanders through a vast wasteland, unsure of an identity or role in relationships. The emptiness and loneliness he or she feels trigger defense mechanisms used to soothe distorted thoughts... borderlines desperately try to maintain control of their universe by banishing ambivalence and ambiguity. Paradoxically, it only keeps them farther away from the closeness they crave (Kreisman & Kreisman, 2004).

The *Diagnostic and Statistical Manual of Mental Disorders* s (5th ed.; DSM–5; American Psychiatric Association, 2013) characterizes borderline personality disorder as an instability that pervasively wracks a person's affect, self-image, and interpersonal relationships. A typical person with borderline personality disorder may attempt to avoid abandonment by loved ones and reduce associated separation anxiety as they grapple with a history of intensity and unpredictability in their interpersonal relationships, oftentimes vacillating between extremes of idealization or devaluation. Namely, borderline individuals may face profound fears of abandonment and separation within their interpersonal relationships (Thompson, 2022, p. 119).

Among the first tasks of clinicians working with borderline clients is a thorough evaluation of current and past family environments (Shachnow et al., 1997, p. 179), and the current literature presents a strong case for systemic influences on the factors of borderline personality disorder's predispositions, precipitation, and perpetuation (Thompson, 2022, p. 119). Several

researchers identify a notable like between physical and sexual abuse from parental figures and the development of borderline personality disorder in individuals (Herman, Perry, & van der Kolk, 1989; Zanarini et al., 1989; Stone, 1990).

However, theories attempting to identify potential etiologies of BPD are complicated by the fact that not all individuals who present with the condition have a history of familial relational abuse (Paris, 2001), and even when family responsibility for borderline characteristics is scarce, the borderline-diagnosed individual does not exist in a vacuum.

The family, friends, and colleagues of a person with borderline often confront the push and pull of impulsiveness and eraticness characteristic of borderline relationships. An equivalent family or marital conflict exists in tandem with every individual complaint, often necessitating treatment for borderline family members (Kreisman & Kreisman, 2004, p. 125). Families of BPD individuals struggle greatly to cope with their own mental health challenges while bearing witness to the overwhelming emotional volatility that so often represents BPD as a disorder. This systematic review provides an in-depth exploration of the interfamilial dynamics at hand in families affected by borderline personality disorder, the attitudes family carers of BPD have towards mental health systems as they seek out care for loved ones and themselves, current perspectives within mental health services towards helping families cope with the repercussions of BPD, and areas for improvement in addressing this much-overlooked concern in the field.

Exploring Relational Dynamics and the Burden of Care in the Borderline Family

Members within the borderline family system navigate family events within a context that is specific to their individual roles, each being influenced by the conduct and actions of other family members. These roles and their interrelatedness are connected to the particular developmental history that defines that family system, evolving with the biological and emotional growth of family members (Kreisman & Kreisman, 2004, p. 121). Subideal patterns like poor communication reverberate to influence family members who develop BPD. Defectiveness in communication patterns may seem ever-present in the life of the borderline individual and may inflict itself onto future relationships even after the borderline individual has come of age and left their immediate family environment (Allen & Farmer, 1996).

Kreisman and Kreisman (2004, p. 122) explain how family members within the borderline family echo the stressors of other family members, resulting in regression. In children of borderline families, stressors can manifest through depression and suicidal behaviors, eating disorders, substance abuse, sexual acting out behaviors, and conduct disorders. They suggest that the structure of a borderline family tends to be centralized around the behaviors of a family member with BPD, thus bypassing other family dynamics that may come into play. Meanwhile, siblings of individuals with a borderline diagnosis present their own styles of acting-out in an attempt to regulate the imbalance within their family. They may function as the 'family hero': an adviser, peacemaker, or the 'good child'. In fact, a similar trend may also emerge in the extended family associated with the borderline family system, as well as close friends and neighbors, who may attempt to act as an intermediary to the affected family.

Among serious mental disorders, borderline personality disorder is notorious for its reputation as a burdensome disorder to address and treat (Paris, 2015). In addition to an individual with borderline personality disorder themselves, diagnosis of BPD can place a high burden on their family members, taking tolls on both their mental and physical health. Says one participant on the experience of caring for a daughter with BPD, "It's worse than a new-born baby. And some nights you just think you cannot keep going and yet you know if you don't she could—you know … So I sat up with her that night. You can't believe how tired you feel …" (Giffin, 2008). Bailey and Grenyer's (2014) study of 287 carers of individuals with mental illness found that experiences of grief and burden were significantly higher in carers of individuals with BPD than individuals with other severe mental illnesses. Family members of BPD individuals report grappling with multiple comorbid psychiatric diagnoses in their loved ones with BPD. Among the stressors contended with by the borderline family, family members often must come to terms with self-harm, suicide attempts, and resulting hospitalization in their BPD family members, circumstances which provoke fear in families as they grapple with the thought of losing their family member with BPD. Parents of BPD individuals report chronic and posttraumatic stress over the frequent fear that their child will harm themselves, or from actually being a witness to their child's self-harm (Giffin, 2008). Futhermore, parents may face rejection or blame from their borderline children who believe their parents to be the cause of their condition (Lawn & McMahon, 2015), or blame from friends or others within their social circle who demonstrate a social misunderstanding towards the realities of being a carer for an individual with BPD (O'Dougherty, 2024). In Paul Mason and Randi Kreger's infamous book *Stop Walking on Eggshells: Taking Your Life Back When Someone You Care About Has Borderline Personality Disorder* (1998), the authors detail several critical responses to living with an individual with BPD. These include depression, deficits in self-esteem, feelings of trappedness or helplessness, depression, anger, denial, bewilderment, hypervigilance, and shame. Mason and Kreger associate these responses with family members being engaged in interactional patterns that are dysfunctional and part of a codependent process MacFarlane, p. 210, 2004).

Borderline Family Carers' Impressions of Mental Health Systems

In narrative interviews, family members of individuals with BPD report adverse experiences with psychiatric services tasked with treating their loved ones with BPD. They give troubling accounts of worrisome experiences such as premature releases from psychiatric facilities and a lack of concern for the safety and well-being of their relative with BPD (O'Dougherty, 2024). Government mental health services in Australia did not take into account the treatment and care of individuals with BPD until recently. Due to the perceived causal relationship between the familial relationship and the onset of BPD, clinicians constrained the engagement of family members in their loved ones' treatment. Hence, a source of chronic and traumatic stress originates not only from bearing witness to the suffering of an individual with BPD, but also from the lack of support they are given in their interactions with mental health services (Lawn & McMahon, 2015)

Evidently, a feeling of abandonment and isolation from mental health services among relatives of individuals with borderline is by no means limited to immediate family. Significant others of individuals with BPD commonly report experiencing stigmatization and abandonment within mental healthcare regarding the treatment of their partner with borderline personality disorder, which has led to a mistrust of the healthcare system (Ekdahl et al., 2024).

In the United States, family carers of individuals with borderline personality disorder describe difficulties in locating treatment and the financial burden of affording treatment—in a narrative account, one carer described considering taking out substantial loans or selling their house to do so (Buteau et al., 2008; Lamont & Dickens, 2021). Further, families in the United States battle health insurance companies to ensure their loved ones with borderline personality disorder receive adequate care. Insurance companies may limit individuals by what type of therapy they are able to receive, often only permitting individual therapy and preventing individuals with borderline and their families from benefiting from the potential advantages of family and marital therapies (Kreisman & Kreisman, 2004, p. 123). Families also find the power inequities and animosity between borderline family systems and the clinical setting daunting, making treatment for themselves or family members unattainable and thus negatively affecting treatment outcomes (Choi, 2018). Undue stress and frustration can be caused by the very systems set in place to assist borderline individuals and their families. The medical model, which has an overwhelming influence on mental health services, allocates all decisions related to treatment management to the psychiatric community with no regard to the individual preferences of the borderline client or family (Dunne & Roger, 2011). Allen (2004, p. 138) even suggests that the clinical systems themselves might be at fault for maladaptive patterns within families affected by BPD, claiming that services may unintentionally mirror the encroachment, lack of consistency, breach of trust, and fragmentation that may be characteristic of the early experiences of borderline individuals. Interestingly, the experience of a borderline family member's hospitalization can serve as an unlikely turning point for families by catalyzing changes in familial or spousal attitudes towards family or marital therapy. Family members who may initially harbor ambivalence or reluctance to begin family therapy may find the idea of it more approachable as they band together to assist their borderline family member during hospitalization (Kreisman & Kreisman, 2004, p. 123).

Psychoeducational Approaches to Coping with BPD-Induced Challenges in the Family System

Family psychoeducation is an evidence-based solution to assisting family members of individuals with severe mental illnesses and has been shown to significantly reduce relapse rates in individuals suffering from mental illness (Dixon et al., 2001). Psychoeducational approaches have been shown highly effective in treating serious mental illnesses such as bipolar disorder and schizophrenia (Goldstein and Miklowitz, 1995), and similar approaches have been applied to BPD by researchers (Gunderson et al., 1997; Berkowitz and Gunderson, 2002) "Families [of individuals with BPD] are helped with psychoeducation to recognize triggers to BPD crises and acting-out behaviors, and are helped to interrupt these triggers by reducing family stress levels, improving crisis management skills, and reducing expressed emotion," states Malcolm MacFarlane, a psychiatrist who specializes in BPD and editor of the book, *Family Treatment of Personality Disorders*. MacFarlane proposes several effective psychoeducational approaches rooted in common psychological perspectives aimed towards the family members of borderline clients.

Systemic Approaches

Far too many mental health professionals continue to view and work with BPD clients from an individual therapeutic perspective and, in doing so, overlook the impact of the disorder on the borderline family and the opportunity for family members to assist in the therapeutic treatment process of borderline personality disorder, says MacFarlane (2004). A greater presence of family-focused models is needed in BPD treatment settings.

MacFarlane promotes a systemic approach that adopts a social constructive and narrative perspective, which sees the realities of borderline individuals and their families as being socially constructed as part of a dialoging or "languaging" process with

others. In the context of borderline personality disorder, "languaging" refers to the social relationship of the borderline individual and their family. The narrative or "life story" serves as an explanation for the borderline individual or family's life events. This process leads to the abstraction of scenarios or situations from the everyday experiences of the client and is integrated within the belief system in defense of a specific view of reality. This in turn leads to other events, possibly casting the situation in an alternate light, to be undermined or disregarded entirely. Through a series of deconstruction questions, relevant interventions in the systemic approach serve to encourage the exploration of the manner in which the BPD's self-view and worldview areconstructed through communication with the family and significant others. It is important to note that the constructivist approach does not hold a "right" or "wrong" perception of the BPD or BPD family's reality, and thus all perspectives are just as valid as one another. Numerous alternative constructions of reality may be explored. The client and family are offered support in correcting their narratives to others, which encourages greater positive interaction and personal and family growth. The systemic perspective serves borderline individuals and family systems well by acknowledging that human systems evolve rather than stay at homeostasis (MacFarlane 2004, p. 214).

Integrative Systemic Therapy (IST) has successfully been used in the treatment of personality disorders and utilizes a "best practices" approach to treating borderline personality disorder among others (MacFarlane, p. 211, 2004). IST makes use of several elements of evidence-based practice that have been shown to be successful in the treatment of BPD. Integrative therapies have become more common in the context of family therapy because of their enhanced receptibility among clients, greater flexibility in their treatment strategies, high level of treatment efficacy, and growing range of interventions. The approach is described as 'integrative' rather than 'integrated' because of its intention of flexibility, allowing clinicians to adapt to the specific needs and differences of borderline individuals and their families (MacFarlane, p. 211, 2004).

Culturally Safe and Trauma-Informed Systemic Approaches

Thompson suggests that special consideration must be given to individuals and families of culturally diverse backgrounds. She proposes the first "culturally safe" model of therapy for both individuals and families affected by borderline personality disorder in indigenous Australian communities. She describes how families that are victims of colonialism experience mental health concerns and mental distress at a rate higher than the general population.

To accomplish this culturally inclusive model, Thompson proposes a combination of approaches with a strong systematic foundation of Bowen family systems therapy and components of narrative therapy, supported with techniques borrowed from Dialectical Behavioral Therapy (DBT). Culturally safe IST is then influenced by the addition of an overarching framework informed by cultural safety, responsiveness, and an understanding of underlying traumas, which emphasizes the importance of autonomy and decision-making, authenticity, collaboration, and respect for diversity throughout the therapeutic experience.

The first approach that Thompson takes in the initiation of the culturally safe model is an understanding of the cultural context in which borderline clients of marginalized backgrounds exist. A specific example for Australian Aboriginal clients, which may have broader implications for other marginalized groups worldwide, is recognizing the impacts of colonization on the family and community structure. Colonization separated many Australian First Nations families and emotional and social wellbeing were disrupted in the process, which is still felt today in the form of transgenerational trauma, leading to repercussions such as domestic violence and substance abuse.

Not only does decolonizing one's practice better inform clinicians' treatment approaches to disorders so heavily informed by familial trauma such as borderline personality disorder, but it also serves to enhance the productivity of therapeutic work by embracing core concepts of the indigenous worldview. These tenets of indigenous life include the collective sense of being and belief in the connectedness of all aspects of life, which readily informs relationships with kin, family members, community, spirituality, and country, and can provide insight into attitudes towards the treatment process (Thompson, 2022, p. 124).

Psychodynamic Approach

To clinicians working with borderline, the value of the psychodynamic perspective is that it grants an improved understanding of the interpersonal and interpsychic phenomena at play in borderline behavior and how this behavior informs the borderline individual's interpersonal interactions. As the psychodynamic approach has roots in developmental theory, it can provide clinicians with insight into family intercommunication and developmental experiences, helping to construct a stronger foundation of treatment for the borderline family member and their impacted family alike. This would allow loved ones of borderline individuals to seek out the signs of maladaptive borderline dynamics within the family and thus become better informed about when they might occur and how to avoid them. By being able to mitigate a regression into maladaptive borderline tendencies, family members can reduce the burden of borderline behavior on their own sense of wellbeing. There are several critical psychodynamic concepts with which therapists and family members of individuals with borderline should be familiar.

The first (and perhaps most well-known) is *splitting*, in which the BPD individual attempts to reduce the conflict and intrapsychic anxiety they encounter when faced with the possibility of "good" and "bad" existing simultaneously within the same person. To the borderline individual, separating themselves from the perceived "bad" allows an escape from the fear of being abandoned, facing punishment, or triggering negative behaviors from a parental figure that engages in introjection. Splitting behaviors are what characterizethe fluctuations between devaluation and idealization for those with BPD. *Introjection* is the process of internalizing a significant other as well as the dominant affects associated with them. For example, a borderline individual may introject a parent and the crucial affect that the borderline person most associates them with. In an investigation into disorganized and insecure attachment styles to caregivers in borderline individuals, Mosquera et al. (2014) found that those with BPD may experience "calm introjection", which is in turn responsible for a fear of being on their own without the support of their family members (Mosquera et al., 2014; Thairovic & Bajric, 2016). Two or more family members within a borderline family system may engage in *collusion* when a shared process of projective identification takes place. In the process of collusion, individual projections within family members receive confirmation and are acted upon. This occurs most frequently in marital dyads, where both spouses consciously or unconsciously engage in collusion with one another. In *projective identification*, an attitude or sentiment is externalized and, therefore, projected onto another person. This causes one person to interact with another in a collusive manner and drives the person acted upon to display attributes projected onto them by the other. For instance, a spouse may project their own anger onto another spouse in a manner that encourages an angry response (MacFarlane 2004, pp. 217-218).

It must be noted that psychodynamic literature which offers specic strategies geared to assist family members of borderline clients is sparse. After thorough review of literature on psychodynamic approaches to borderline family assistance, it is shown that a psychodynamic perspective favors family psychoeducation and awareness rather than clinical aid aimed towards borderline families in the public or private sector.

Psychobiological Approach

Substantial evidence exists indicating that commonly occuring personality traits of borderline individuals can be transitioned through families, and BPD appears in parents and other close family members of BPD-diagnosed individuals, indicating a genetic predisposition.

The research-bound biological aspect of BPD does well to be shared with borderline individuals and families as a beneficial element of the psychoeducational process. A biologically based understanding of the disorder brings a sense of assurance to families to know that BPD symptoms can be partially attributed to a biological or biochemical ingredient instead of being chalked up solely to faulty parenting or family dynamics. As a result, guilt and blame within the borderline family system are often alleviated. Families gain hope for improvement of their or their loved one's symptoms or experiences when they are informed of the ways in which medication can be used for borderline symptom management (MacFarlane, 2004 p. 221).

Nonetheless, borderline individuals and their families should be cautioned not to use this understanding of biological factors to minimize their own responsibility towards managing BPD and resolving familial and relational conflicts, as biological factors are only one component of a much more complex scenario. BPD exists as a multidetermined and multifaceted disorder with many components that are equally non-biological. Thus, the borderline individual and their family must take responsibility for much-needed interpersonal and behavioral interventions to improve the state of their lives and relationships (MacFarlane, 2004 p. 221).

Cognitive-Behavioral Approach

Some psychotherapeutic interventions have fortunately begun offering therapeutic support for significant others of BPD individuals in the form of mentalization-based therapy (MBT) and dialectical behavioral therapy (DBT) (Ekdahl et al., 2024).

Dialectical behavioral therapy (DBT) was initially introduced by Linehan (1987) to assist in the treatment of suicidal ideation and self-harming behaviors in women with BPD. The aim of DBT is to teach a range of approaches and skills, such as enhanced communication, problem-solving, relationship approaches, improvement of capabilities and regulation of emotions, and interpersonal skills. DBT now stands as the most frequently studied and used psychosocial approach to treat borderline personality disorder (Rands et al., 2024).

According to a comprehensive review of treatment approaches for adolesecent individuals with BPD, a combination of both DBT therapy for BPD-diagnosed individuals and family intervention has been shown to be far more effective in reducing BPD behavioral tendencies such as self-harm, depressive symptoms, and suicidal ideation, as well as improving interpersonal skills and emotional regulation in those struggling with such tendencies. Regulating the associated behavioral tendencies of borderline individuals in this way yields clear benefits to families of borderline individuals, such as improved clarity in parent-child communication, a reduction in reported caregiver burden, parental stress, and concerns over child

behavior. Additional benefits of combined DBT and family intervention include improvements in parental mastery, coping, and affect (Pu et al., 2023).

Successful Communication with the Borderline Family Member

For parents of children with borderline personality disorder, establishing appropriate boundaries is necessary to foster healthy relationships. In order for a healthy process of separation between parents and their borderline adolescent, parents must not harbor ambivalence about their own identities and provide their offspring with coherent expectations (von Broembsen, 1986). Several self-help books with the loved ones of borderline individuals as a target audience are now well-known in the borderline and carer communities, one of whose primary goals is to assist families in learning to engage in healthy communication and boundary-setting with their loved ones. Kreisman and Straus' (1991) *I Hate You—Don't Leave Me: Understanding the Borderline Personality*, identifies several key areas where problems arise for family members of BPD individuals, which include enduring the rage issues, mood swings, and impulsivity characteristic of BPD. An array of challenging negative feelings is commonly experienced by families, Kreisman and Straus (1991) claim, which can involve fear, guilt, and anger. However, the authors offer a number of proactive solutions to managing these challenging emotions in borderline carer families, including the support, empathy, and truth (SET) model to engage in effective communication with borderline family members (Kreisman and Straus, 1991).

Second Generation Family Therapies

Among others, Bernardon and Pernice-Duca (2012) propose that integration of second-generation family therapy with other therapies may be effective in the treatment of borderline personality disorder. Namely, they have found that narrative-attachment style therapy is ideal when combined with components of mentalization-based therapy when working collectively with borderline individuals and their families, as it is focused on increasing reflective functioning in the therapeutic setting. To complement psychiatric interventions, medication is useful in treating individuals with BPD when integrated with narrative therapy (Tadros, Cappetto, and Kaur, 2019). Tadros, Cappetto, and Kaur (2019) discuss implementing talk therapy in combination with Naltrexone (commonly used for alcohol and opioid dependence) in settings of high client support, in which clients are asked to retell their stories and re-author narratives in a positive light (Tadros, Cappetto, & Kaur, 2019).

Current Recommendations for Best Practice in Assisting Family Carers

The American Psychiatric Association's practice guidelines were updated in 2023 to include greater emphasis on the psychotherapeutic approaches of borderline personality disorder treatment. MBT, DBT, and schema-focused therapy (DFT) are among its most effective treatments recommendations. When taking into consideration the familial and genetic aspects of borderline personality disorder, it can be argued that the borderline family could also benefit from MBT and DBT treatment due to the well-established connection between familial and relational dysfunction and borderline symptom onset (Thompson, 2022).

Findings: Effective Solutions and Deficits in Resources for Borderline Family Carers

A myriad of evidence-based theoretical knowledge informs the current attitudes and goals towards the nature of support, treatment, and psychoeducation available to BPD-diagnosed individuals. Some perspectives oriented towards familial support for immediate family members, extended family, and partners of those with BPD have gained more acclaim and are thus implemented more readily into practice than others. Regardless, save for a small handful of well-developed sources, there is little solid consensus on how family caregivers of an individual with BPD navigate the mental health resources (or a lack thereof) at their disposal, nor public policy implications for individuals responsible for the care of a disorder that is at best distressing and at worst debilitating. This review serves as a call to action in addressing the psychosocial, psychoeducational, and psychotherapeutic needs of the family borderline care community.

References

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). APA.

Bailey R. C. & Grenyer B.F.S. (2014) Supporting a Person with Personality Disorder: a Study of Carer Burden and Well-Being. *Journal of Personality Disorders*. http://doi.org/10.1521/pedi_2014_28_136

Berkowitz, C. B. and Gunderson, J. G. (2002). Multifamily Psychoeducational Treatment of Borderline Personality Disorder. In W. R. McFarlane (Ed.), *Multifamily Groups in the Treatment of Severe Psychiatric Disorders* (pp. 268-290). New York: Guilford Press.

Bernardon, S., & Pernice-Duca, F. (2010). A Family Systems Perspective to Recovery from Posttraumatic Stress in Children. *The Family Journal, 18*(4), 349–357. https://doi.org/10.1177/1066480710376618

Buteau, E., Dawkins, K., and Hoffman, P. (2008). In Their Own Words: Improving Services and Hopefulness for Families Dealing with BPD. Social Work in Mental Health, 6(1–2), 203–214. http://doi.org/10.1300/J200v06n01_16

Choi, H. (2018). Family Systemic Approaches for Borderline Personality Disorder in Acute Adult Mental Health Care Settings. *Australian and New Zealand Journal of Family Therapy, 39*(2), 155–173.

Dixon, L., McFarlane, W. R., Lefley, H., Lucksted, A., Cohen, M., Falloon, I., Mueser, K., Miklowitz, D., Solomon, P., and Sondheimer, D. (2001). Evidence-Based Practices for Services to Families of People with Psychiatric Disabilities. Psychiatric Services, 52(7), 903–910. https://doi.org/10.1176/appi.ps.52.7.903

Dunne, E., & Roger, B. (2011). 'They Told Me I Had This Personality disorder ... All of a Sudden I Was Wasting Their Time' Personality Disorder and the Inpatient Experience. Journal of Mental Health, 20(3), 226–233.

Ekdahl, S., Carlson, E., Idvall, E., and Perseius, K. (2024). Need of Support for Significant Others to Persons with Borderline Personality Disorder–A Swedish Focus Group Study. *Scandinavian Journal of Caring Sciences*, *38*(1), 240–248. https://doi.org/10.1111/scs.13221

Giffin, J. (2008). Family Experience of Borderline Personality Disorder. *Australian & New Zealand Journal of Family Therapy*, *29*(3), 133–138. https://doi.org/10.1375/anft.29.3.133

Goldstein, M. J. and Miklowitz, D. J. (1995). The Effectiveness of Psychoeducational Family Therapy in the Treatment of Schizophrenic Disorders. *Journal of Marital and Family Therapy, 21,* 361-376.

Gunderson, J. G., Berkowitz, C., and Ruiz-Sancho, A. (1997). Families of Borderline Patients: A Psychoeducational Approach. *Bulletin of the Menninger Clinic, 61*(4), 446-457.

Herman, J. L., Perry, C., and van der Kolk, B. A. (1989). Childhood Trauma in Borderline Personality Disorder. *American Journal of Psychiatry, 146*(4), 490-495. doi: 10.1176/ajp.146.4.490

Joyce P.R., McKenzie J.M., Luty S.E., Mulder R.T., Carter J.D., Sullivan P.F., & Cloninger C.R. (2003). Temperament, Childhood Environment and Psychopathology as Risk Factors for Avoidant and Borderline Personality Disorders. *Australian & New Zealand Journal of Psychiatry*, *37*(6), 756–764. https://doi.org/10.1080/j.1440-1614.2003.01263.

Juul, S., Jakobsen, J. C., Hestbaek, E., Jørgensen, C. K., Olsen, M. H., Rishede, M., & Frandsen, F. W. (2023). Short-Term versus Long-Term Mentalization-Based Therapy for Borderline Personality Disorder: A Randomized Clinical Trial (MBT-RCT). *Psychotherapy and Psychosomatics*, *92*(5), 329+. https://dx-doi-org.libdatabase.newpaltz.edu/10.1159/000534289

Kreisman, J. K. & Kreisman, J. J. (2004). Marital and Family Treatment of Borderline Personality Disorder. In M. M. MacFarlane (Ed.), *Family Treatment of Personality Disorders* (pp. 117-148). The Haworth Press. Print.

Kreisman, J. J., & Straus, H. (1991). *I Hate You--Don't Leave Me: Understanding The Borderline Personality*. Avon.

Lamont, E., & Dickens, G. L. (2021). Mental Health Services, Care Provision, and Professional Support for People Diagnosed with Borderline Personality Disorder: Systematic Review of Service-User, Family, and carer perspectives. *Journal of Mental Health*, *30*(5), 619–633. https://doi.org/10.1080/09638237.2019.1608923

Lawn, S., & McMahon, J. (2015). Experiences of Family Carers of People Diagnosed with Borderline Personality Disorder. Journal of Psychiatric and Mental Health Nursing, 22(4), 234–243. doi:10.1111/ jpm.12193

Lawson, C. A. (2004). Treating the Borderline Mother: Integrating EMDR with a Family Systems Perspective. In M. M. MacFarlane (Ed.), *Family Treatment of Personality Disorders* (pp. 305-334). The Haworth Press. Print.

Leichsenring, F., Fonagy, P., Heim, N., Kernberg, O. F., Leweke, F., Luyten, P., Salzer, S., Spitzer, C., & Steinert, C. (2024). Borderline Personality Disorder: A Comprehensive Review of Diagnosis and Clinical Presentation, Etiology, Treatment, and Current Controversies. *World Psychiatry : Official Journal of the World Psychiatric Association (WPA)*, *23*(1), 4–25. https://doi.org/10.1002/wps.21156

Linehan, M. M. (1987). Dialectical Behavior Therapy in Groups: Treating Borderline Personality Disorders and Suicidal Behavior. In C. M. Brody (Ed.), *Women's Therapy Groups: Paradigms of Feminist Treatment* (pp. 145–162). Springer.

MacFarlane, M. M. (2004). Systematic Treatment of Borderline Personality Disorder: An Integrative Approach. In M. M. MacFarlane (Ed.), *Family Treatment of Personality Disorders* (pp. 205-240). The Haworth Press.

Mosquera, D., Gonzalez, A., & Leeds, A. M. (2014). Early Experience, Structural Dissociation, and Emotional Dysregulation in Borderline Personality Disorder: The Role of Insecure and Disorganized Attachment. *Borderline personality disorder and emotion dysregulation*, *1*, 15. https://doi.org/10.1186/2051-6673-1-15

O'Dougherty, M. (2024). Stubborn Families: Logics of Care of a family member with borderline personality disorder. *Culture, Medicine, and Psychiatry*, *48*(4), 768–791. https://doi.org/10.1007/s11013-024-09853-9

Paris, J. (2001). Psychosocial Adversity. In W. J. Livesley (Ed.,) *Handbook of Personality Disorders: Theory, Research, and Treatment* (pp. 231-241). New York: Guilford Press.

Paris J. (2015). Why Patients with Severe Personality Disorders are Overmedicated. *The Journal of Clinical Psychiatry*, *76*(4), e521. https://doi.org/10.4088/JCP.14com09441

Pu, J., Zaidi, M. F., Patel, M., Atluri, L. M., Gonzalez, N. A., Sakhamuri, N., Athiyaman, S., Randhi, B., Gutlapalli, S. D., & Mohammed, L. (2023). The Influence of Family Intervention on the Treatment of Adolescent Patients with Borderline Personality Disorder: A Literature Review. *Cureus*, *15*(6), e40758. https://doi.org/10.7759/cureus.40758

Rands, A. M., Benson, D., Rapacz, A. L., & Lloyd, T. (2024). Evidence-Based Group Therapy for Severe Mental Illness (SMI): Treatment for Schizophrenia and Borderline Personality Disorder. *Group Dynamics: Theory, Research, and Practice*, *28*(3), 178–198. https://s443-doi-org.libdatabase.newpaltz.edu/10.1037/gdn0000220

Raskin, J. D., Maynard, D., & Gayle, M. C. (2022). Psychologist attitudes toward DSM-5 and its alternatives. *Professional Psychology: Research and Practice,53*(6)*,* 553–563. https://doi.org/10.1037/pro0000480

Shachnow, J., Clarkin, J., DiPalma, C. S., Thurston, F., Hull, J., and Shearin, E. (1997). Biparental Psychopathology and Borderline Personality Disorder. *Psychiatry, 60*(2), 171-81. 10.1080/00332747.1997.11024796.

Silverman, J. M., Pinkham, L., Horvath, T. B., Coccaro, E. E., Klar, H., Schear, S., Apter, S., Davidson, M., Mohs, R. C., and Siever, L. J. (1991). Affective and Impulsive Personality Disorder Traits in the Relatives of Patients with Borderline Personality Disorder. *American Journal of Psychiatry, 148*, 1378-1385. https://doi.org/10.1176/ajp.148.10.1378

Stone, M. H. (1990). Abuse and Abusiveness in Borderline Personality. In P. S. Links (Ed.), *Family Environment and Borderline Personality Disorder* (pp. 133-148). Washington, DC: American Psychiatric Press.

Tadros, E., Cappetto, M., & Kaur, L. (2019). Treating Symptoms of Borderline Personality Disorder Through Narrative Therapy and Naltrexone. The American Journal of Family Therapy, 47(2), 87–101.

Thairovic, S., & Bajric, A. (2016). Child-Parent Attachment Styles and Borderline Personality Disorder Relationship. *Mediterranean Journal of Clinical Psychology*, *4*(2), 1–27.

Thompson, J. (2022). Culturally Safe Integrative Systemic Therapy for First Nations families living with borderline personality disorder. *Australian and New Zealand Journal of Family Therapy*, *43*(1), 118–139. https://doi.org/10.1002/anzf.1479

van Reekum, R., Links, P. S., and Boiago, I. (1993). Constitutional Factors in Borderline Personality Disorder: Genetics, Brain Dysfunction, and Biological Markers. In J. Paris (Ed.), *Borderline Personality Disorder: Etiology and Treatment* (pp. 13-38). Washington, DC: American Psychiatric Press.

von Broembsen, F. Separation Crisis in a Family with a Borderline Adolescent. *Am J Psychoanal* **46**, 62–75 (1986). https://doi.org/10.1007/BF01254625

Zanarini, M. C., Frankenburg, F. R., Dubo, E. D., Sickel, A. E., Trikha, A., Levin, A., and Reynolds, V. (1998). Axis I Comorbidity of Borderline Personality Disorder. *American Journal of Psychiatry, 155*(12), 1733-1739. 10.1176/ajp.155.12.1733