Family therapy for adolescents diagnosed as having borderline personality disorder

Anthony C. James and Margaret Vereker

The family therapy of twenty-four cases of adolescents diagnosed as having borderline personality disorder is described. In comparison to matched psychiatric controls, the families of these adolescents were more angry and irritable and had higher rates of sexual abuse and sibling psychopathology. Relationship difficulties, in particular oscillating attachments, were frequently seen in therapy, which was more tumultuous with frequent impulsive acts of self-harm.

Introduction

The aim of this paper is to outline therapeutic approaches used with families of adolescents diagnosed as having borderline personality disorder and to provide a brief comparative description of these families with matched psychiatric controls.

The diagnosis of borderline personality disorder

In the field of family therapy, concern has been expressed about the use of psychiatric diagnoses such as borderline personality disorder. Such diagnostic categories can be seen to exist as concrete entities, rather than viewing a diagnosis as a classificatory act arising within an interactive and subjective process. Even within the field of psychiatry, borderline personality disorder is a controversial and ambiguous term referring, among others, to a distinct clinical syndrome (Gunderson, 1984) and a personality type (DSM III-R) (American Psychiatric Association, 1987). Common elements are seen to include major interpersonal difficulties — often intense and unstable relationships; marked lability of behaviour; frequent

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emotional crises, with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm, and a variety of psychiatric symptoms and diagnoses, particularly affective (Higgit and Fonagy, 1992). The diagnosis can be helpful in alerting the therapist to a potential 10% suicide rate in young hospitalized adults (Stone et al., 1987). The diagnosis can be made in adolescence (McManus et al., 1984; Westen et al., 1990), although some doubt exists about the validity of doing so in developmentally immature subjects. Prospective studies may be able to address this further.

In this paper diagnosis is used pragmatically as a descriptor of a group of adolescents within their families whose presentation, relationship patterns and treatment pose particular and perhaps distinctive problems and therefore deserve attention.

Family characteristics

Families with members having borderline personality disorder are described as chaotic, disorganized and abusive; consequently therapy is often problematic and exhausting (Young, 1991). This is especially true of therapy with families containing adolescents diagnosed as having borderline personality disorder, where the life-cycle stage of individuation and separation inherent to adolescence poses particular stresses for the family.

Studies have repeatedly shown the difficult nature of these family environments. The families are reported to have higher rates of: (1) separation and loss (Links et al., 1990; Zanarini et al., 1989); (2) abuse – physical and sexual in up to 71% (Ogata et al., 1990), and (3) bi-parental failure – often secondary to parental mental illness (Gunderson et al., 1980). Borderline personality disorder appears, in part, to be familial with rates of up to 18% in first degree relatives (Zanarini et al., 1990; Johnson et al., 1995).

Shapiro (1978) noted that adolescents diagnosed as borderline personality disorder were developmentally retarded in achieving separation from their parents. The family atmosphere is regarded as hostile and over-involved (Goldberg et al., 1985). When faced with adolescent development, which is perceived as a threat to the status quo, the family becomes defensive and regressive (Clarkin et al., 1991).

The central element of the interpersonal psychopathology in families with adolescents diagnosed as having borderline personality disorder is a pattern of oscillating attachments (Melges and Swartz, 1989), which resembles, in part, the disorganized or unresolved
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pattern of attachments or 'D' type described by Main and Solomon (1986). This type of attachment pattern is characteristically seen in children who have been maltreated or abused (Carlson et al., 1989) – abuse being a common feature in the lives of many of these adolescents.

Frequently seen is an oscillation in attachment from one extreme of over-closeness, with fears of incorporation or domination, to the other extreme of separation with fears of abandonment and disintegration (Melges and Swartz, 1989). The damaging oscillation or 'toing and froing' is stabilized by triangulation or the involvement of a third party. Adolescents diagnosed as having borderline personality disorder experience others as having the power to abandon or dominate them. Impulsive acts such as overdosing, cutting, drug abuse and sexual promiscuity are seen as distance regulators, pushing people away or inciting others to become involved (Lansky et al., 1988; Melges and Swartz, 1989). Withdrawal on the part of the carer is often followed by an impulsive act which 'ties' the participant into a blame sequence, thereby allowing an under-involved emotionally unavailable third party, usually the father, to withdraw (Lansky, et al., 1988). Lansky (1987) conceptualized these behaviours as part of a response to shame rather than guilt producing dynamics. Lansky views the central difficulty for these patients to be the tendency to personality disorganization when the optimum interpersonal distance is not maintained. Shame, associated with the sense of the lack of personality cohesion, is defensively screened or blotted out by feelings of guilt over aggressive acts.

Characteristically, in these families binding and unbinding mechanisms are operative, often alternating. Binding mechanisms include demandingness, manipulative self-harm and destructive acts, while unbinding mechanisms consist of paranoid outbursts and envious attacks. These behaviours appear random if the distance regulating function is not appreciated. These families although 'unstable' are more organized than they initially appear.

Shapiro (1979) draws upon object relations theory and Bion's understanding of small group dynamics (1961) to conceptualize these families. Separation and individuation are seen as a threat to the family, which releases or stimulates the production of unconscious fantasies related to the 'basic assumptions' shared by the family of flight/fight, dependency and or pairing (see Hinshelwood, 1991). The process of projective identification (omnipotent phantasy whereby part of the split off personality is located in another and felt to be the
self; see Hinshelwood, 1991), often aggressive, is prominent particularly when the parents have had difficulties of a similar nature in their own adolescence. Schwoeri and Schwoeri's (1981) clinical findings confirm this model; these families demonstrate: (1) strongly held projections (externalization of internal conflicts; see Hinshelwood, 1991); (2) blind acceptance of violent behaviour; (3) family myths which are incongruent with reality; (4) extreme and persistent reversal of parent–child roles, and (5) tendency to use splitting (defensive psychic mechanism involving a split, for instance, into good and bad, of (a) the ego or subjective self or (b) internal representations: see Hinshelwood, 1991).

Family therapy approaches

Family therapy is regarded by many (Brown, 1987; Solomon, 1987) as the treatment of choice for adolescents diagnosed as having borderline personality disorder because of the intense relationship difficulties these youngsters experience within their families. Although the evidence for the efficacy of family therapy, as with other treatments, is scarce, Gunderson et al. (1980) found that in-patients with borderline personality disorder who do not receive family therapy undergo a massive deterioration in their clinical state.

Various models of family therapy have been proposed as part of a treatment programme. A psycho-educational component is seen by some to be beneficial (Lansky et al., 1988; Melges and Swartz, 1989), while Jones (1987) propounds a systemic approach. Dyadic work on the mother–daughter relationship is reported by Teitelman et al. (1979) as being particularly successful, although with only a small number of cases. Shapiro (1979) proposes family psychotherapy using group interpretive techniques in combination with individual psychoanalytic psychotherapy. Indeed, because many treatment programmes are multi-modal, often including residential treatment at some stage, it is difficult to evaluate the effect of family therapy in this disorder.

Therapeutic difficulties and failures are legion. Of particular note is the likelihood of the therapist being ‘pushed’ by the patient’s and family’s use of splitting and projective identification into reacting with counter-aggression or endlessly and hopeless self-sacrifice. Young (1991) highlights drop-out from family therapy when the stable but pathological triangulation of the identified patient is threatened by progress in therapy. The old patterns of relationships are re-established with reunification of the adversarial adolescent–parent.
relationship and the expulsion of the therapist — the threat of change being too great.

The study

The families were part of a retrospective study of borderline personality disorder in adolescence, described in detail elsewhere (James et al., 1996). The study involved an evaluation of the outcome of the in-patient treatment of twenty-four adolescents (twenty females, four males) diagnosed as having borderline personality disorder and matched psychiatric controls admitted to the Oxford Regional Adolescent Unit over a two-year period.

Results

The results of this study (James et al., 1996) confirm the notion of the family environment as being relatively difficult, even in comparison

Table 1: Psychiatric controls

<table>
<thead>
<tr>
<th></th>
<th>Cases</th>
<th>Controls</th>
<th>Odds ratio (95% confidence limits)</th>
<th>$\chi^2$</th>
<th>2-tailed $p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorce</td>
<td>11/24</td>
<td>8/22</td>
<td>1.48 (0.38–5.7)</td>
<td>0.42</td>
<td>0.51</td>
</tr>
<tr>
<td>Marital discord</td>
<td>6/24</td>
<td>6/22</td>
<td>0.89 (0.35–4.41)</td>
<td>0.03</td>
<td>0.86</td>
</tr>
<tr>
<td>Maternal psychiatric disorder</td>
<td>10/24</td>
<td>6/23</td>
<td>2.02 (0.50–8.58)</td>
<td>1.27</td>
<td>0.25</td>
</tr>
<tr>
<td>Paternal psychiatric disorder</td>
<td>6/24</td>
<td>5/22</td>
<td>1.13 (0.24–5.4)</td>
<td>0.03</td>
<td>0.85</td>
</tr>
<tr>
<td>Sibling psychiatric illness</td>
<td>9/23</td>
<td>3/22</td>
<td>4.07 (0.79–26.84)</td>
<td>3.74</td>
<td>0.05*</td>
</tr>
<tr>
<td>Maternal helplessness</td>
<td>16/24</td>
<td>7/23</td>
<td>4.57 (1.15–18.75)</td>
<td>6.17</td>
<td>0.01*</td>
</tr>
<tr>
<td>Over-involvement</td>
<td>12/24</td>
<td>7/23</td>
<td>2.29 (0.60–9.03)</td>
<td>1.87</td>
<td>0.17</td>
</tr>
<tr>
<td>Angry, irritable atmosphere</td>
<td>17/24</td>
<td>6/24</td>
<td>7.29 (1.75–13.92)</td>
<td>10.01</td>
<td>0.001**</td>
</tr>
<tr>
<td>Patient sexually abused</td>
<td>10/24</td>
<td>3/24</td>
<td>5.00 (1.01–23.06)</td>
<td>5.17</td>
<td>0.02*</td>
</tr>
<tr>
<td>Patient physically abused</td>
<td>9/24</td>
<td>5/24</td>
<td>2.28 (0.54–10.46)</td>
<td>1.61</td>
<td>0.20</td>
</tr>
<tr>
<td>Early separations</td>
<td>7/24</td>
<td>12/24</td>
<td>0.41 (0.11–1.57)</td>
<td>2.18</td>
<td>0.14</td>
</tr>
</tbody>
</table>

* probability significant
** probability highly significant

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with psychiatric controls (see Table 1), with the families which included an adolescent diagnosed with borderline personality disorder appearing particularly angry and irritable. The parents and siblings in these families demonstrated high rates of psychopathology. In this small sample there was no evidence to suggest higher rates of early separation, but the rates of sexual abuse and maternal helplessness were significantly greater. The finding of higher rates of sexual abuse is in line with many reports (Zanarini et al., 1989; Ogata et al., 1990) and confirms a relatively strong association between borderline personality disorder and early childhood sexual abuse. The higher rates of maternal helplessness and parental psychopathology lend some tentative support to the notion that in families with members having borderline disorder, both parents present as having difficulties.

Adolescents diagnosed as having borderline personality disorder were referred for a variety of reasons, notably after an attempt at deliberate self-harm, with the majority being depressed (Major Depressive Disorder (MDD) (DSM III-R) (American Psychiatric Association, 1987) (Table 2). Admission to hospital often followed a crisis, with escalating and volatile family relationships.

Patients diagnosed as having borderline personality disorder required slightly but not significantly longer treatment than controls (Table 3). What was markedly different, however, was the turmoil of the therapy as reflected in the significantly higher rates of notifiable incidents. These usually involved running away or self-harm with deep cutting and overdoses requiring transfer to a general hospital for medical treatment. Given that therapy was considerably more stormy, it was interesting to note that in both groups the adolescent

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**TABLE 2 Reasons for referral of adolescents with borderline personality disorder**

<table>
<thead>
<tr>
<th>Diagnosis (DSM III-R)</th>
<th>Cases</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depressive Disorder (MDD)</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Anorexia nervosa</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Bulimia nervosa</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Psychosis atypical</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Manic depressive – bipolar</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Hysteria</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

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TABLE 3  Treatment of patients with borderline personality disorder

<table>
<thead>
<tr>
<th>Hospital course</th>
<th>Cases</th>
<th>Controls</th>
<th>t</th>
<th>df</th>
<th>2-tailed p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of stay: mean (sd) in weeks</td>
<td>13.5 (8.2)</td>
<td>11.4 (8.1)</td>
<td>0.90</td>
<td>46</td>
<td>0.37</td>
</tr>
<tr>
<td>Notifiable incidents: mean (sd)</td>
<td>6.3 (5.0)</td>
<td>1.6 (3.4)</td>
<td>3.70</td>
<td>46</td>
<td>0.000*</td>
</tr>
<tr>
<td>Transfers to general hospital: mean (sd)</td>
<td>1.6 (1.4)</td>
<td>0.3 (0.62)</td>
<td>4.02</td>
<td>46</td>
<td>0.000*</td>
</tr>
<tr>
<td>GAS score on admission: mean (sd)</td>
<td>36.2 (2.0)</td>
<td>35.6 (3.9)</td>
<td>0.67</td>
<td>46</td>
<td>0.5</td>
</tr>
<tr>
<td>GAS score at discharge: mean (sd)</td>
<td>60.8 (9.2)</td>
<td>64.1 (7.0)</td>
<td>-1.40</td>
<td>46</td>
<td>0.16</td>
</tr>
<tr>
<td>Change in GAS score: mean (sd)</td>
<td>24.5 (8.3)</td>
<td>28.5 (7.4)</td>
<td>-1.70</td>
<td>46</td>
<td>0.08</td>
</tr>
</tbody>
</table>

sd = standard deviation
*: p < 0.0001 highly significant

appeared to improve to a similar degree, as reflected by the Global Assessment of Functioning (GAS) (Endicott et al., 1976) (Table 3).

Treatment

The treatment offered to the patients with borderline personality disorder and psychiatric controls were similar; in all cases family therapy was a principal component.

The unit did not undertake a formal psycho-educational approach, although psychiatric support and advice was available to the families. The diagnosis of borderline personality disorder was not given, as experience had shown that labelling the identified patient runs counter to attempts at systemic thinking. The family model used was influenced by structural family therapy (Minuchin and Fishman, 1981; Fishman, 1988) and ‘Milan’ systemic therapy (Campbell et al., 1989).

Structural family therapy was used particularly in cases where there were confused or disorganized hierarchies, boundary confusion and reversal of parental–child roles. Dyadic work with the parents alone was often indicated and allowed clearer definition of a parent and sibling subsystem. Structural techniques of enactment, at least early on in therapy, were extremely hazardous and often resulted in therapeutic failure. This was particularly true where there were high
levels of ‘expressed emotion’ of a highly involved but none the less critical and hostile nature.

Case example

E, a fifteen-year-old adolescent, had been seen as an outpatient at a child guidance clinic following angry outbursts at home, school non-attendance and a threatened overdose. The family was highly religious and seemingly democratic in its organization and setting of rules, with a strong prohibition against aggression. Both parents had come from abusive families and had been subject to physical abuse in their childhood. For the mother, the abuse had extended up to the time of her marriage. E’s behaviour was seen to be very much against the family’s culture and as a consequence he was being ostracized. The family atmosphere was highly involved but critical. Initial family therapy sessions, using a structural model, attempted to restore the family hierarchy which had effectively been inverted, with E in a dominant position.

Following a session in which there was enactment of the difficulties around appropriate rule-setting, and with only gentle intensification, a serious altercation resulted between father and son. The father asked E to turn the television down; E refused. They argued and fought, ending up with the father physically restraining E. E ran up to his bedroom and threatened to kill himself by jumping out of the window with a rope around his neck.

The characteristic pattern of oscillating attachment (Melges and Swartz, 1989), in response to difficulties in regulating interpersonal distance, was repeated in the family therapy sessions and in relation to the unit as a whole.

Case example

A fifteen-year-old girl with severe conduct problems and depression, had throughout her admission denigrated everything in the unit, including all relationships with staff. This mirrored her stance within her family, where she had experienced physical abuse. During her admission she took one overdose and ran off when she feared she was becoming too close to her key nurse. After seeming improvement, she caused a serious fire in the unit on the day of her discharge case conference.
Case example

Z, a fifteen-year-old depressed girl with anorexic symptoms, who had taken several overdoses, complained that her parents were awful and she wanted nothing further to do with them. The parents, for their part, appeared keen for help as a family. The father, in particular, was desperately trying to seek to reassure his daughter of his love for her. The more he tried to get close to her, the more she rejected him — the power balance obviously being in favour of the daughter. He seemed to be weak and ineffectual, often pleading, to her disdain and later apparent indifference. The mother, meanwhile, looked on — although outwardly cool, underneath she was angry, if not furious with this 'affair' being conducted in front of her.

This triangular relationship was mirrored within the unit, with the nursing staff playing the part of the silent, angry mother, while the therapist unwittingly re-enacted the father's one-down, ineffectual stance. This became clear, not only in the family therapy supervision, but also in the larger staff support group, where considerable tensions were being played out between the therapist and nursing team. This dynamic, which was powerfully enacted, but with few words, gave some insight into the couple's relationship. In family sessions exploration of problems between the couple was met with denial and an assertion of unity. In contrast, the parents and daughter could see straight through the unit's stance to the underlying confusion and differences, which they eagerly pointed out. The therapeutic focus shifted from the family to the unit–family therapy subsystem. Exploration of the troubled relationship between the family therapist and nursing staff showed how Z and the family had been triangulated, detouring from a conflictual relationship. Once this had been acknowledged and differences explored, progress was possible in the family sessions.

The Milan systemic approach (Campbell et al., 1989) has certain distinctive advantages when working with these families. The stance of neutrality, in combination with positive connotation, often allowed a therapeutic window to develop in the face of angry, irritable relationships, where splitting and projections predominated. Circular questioning made it possible to track the behavioural relationship system, built up prior to and after an impulsive act, and to address the underlying beliefs. (It was these beliefs, rather than the actions themselves, which would be positively connoted, which often intro-
duced a pronounced difference into a family system, heavily built upon hostile, negative connotations.)

Case example

MOTHER: I believe she did it (taking an overdose) because she is so selfish. She never thinks of anyone.

MICHAEL (brother): That's not true. She's always on your side mum; whenever there is an argument she agrees with you.

THERAPIST: Who agrees with Michael?

FATHER: I would. She always takes my wife's side.

THERAPIST: Always?

FATHER: Yes. [Fed up]

THERAPIST: Michael, What happens to your father when Alex [Alexandra] takes your mother's side?

MICHAEL: I don't know - he goes off - fed up like now.

THERAPIST: How does it affect your mother, when your father goes off?

MOTHER: It doesn't.

MICHAEL: I don't know.

ALEXANDRA: She used to get angry, now she just gets miserable.

THERAPIST: Who notices this the most?

MICHAEL: Alex.

Hypotheses centring on the dynamic of oscillating attachment were often powerful. The oscillating attachment patterns were exaggerated by the inherent drive of adolescence towards separation and individuation from parents who had difficulties separating themselves (Shapiro, 1978). Alongside this understanding, it was felt important to convey to the families the appreciation that too rapid changes might be life-threatening, and the status quo, damaging and costly though it was, was a solution of sorts.

Case example

A fourteen-year-old girl with a history of anorexia nervosa and previous overdoses threatened another overdose in response to a perceived rebuff from her mother. Her mother responded by drawing closer to her daughter, rather than expressing the anger she felt towards her. Circular questioning, informed by a hypothesis centring upon the mother's fear of abandonment, revealed a similarity between mother's and daughter's adolescence, but with mother revealing a history of abuse. Positive connotation of the daughter's actions as
being connected to her mother's previously denied distress allowed a
different, less critical and blaming stance to be adopted. A shift
forward was achieved, with a change in the mother–daughter
relationship and later, involvement of a previously distant father.

Discussion

This paper describes a small-scale study of the families and treatment
of in-patient adolescents diagnosed as having borderline personality
disorder, compared to matched psychiatric controls. It has several
limitations, including small numbers and the retrospective nature of
the data, with all the methodological problems that implies.

Whatever one's views about the appropriateness of diagnostic
categories such as borderline personality disorder, this paper high-
lights a particularly difficult group of adolescents to treat. The pattern
of relationship difficulties, for example, extreme oscillating attach-
ments, formed the kernel of problems posed for the therapy team, and
marked the difference between these adolescents and the controls,
who themselves were a particularly disturbed group.

The centrality of oscillating attachments as the dynamic problem in
these families suggests a natural link between family therapy practice
and attachment theory. Applying attachment theory concepts to
family therapy, Byng-Hall (1995) sets out the need for creating a
secure base for therapy, with elements of positive connotation, using
the therapist's knowledge of insecure attachments, and exploration of
past losses, as a means of creating a coherent story which is acceptable
to the family. There are many similarities to the approaches described
here, but with one crucial difference – the family therapists dealing
with families with adolescents diagnosed as having borderline
personality disorder were not encouraged to form attachments, but
rather to use the systemic stance of neutrality (Campbell et al., 1989),
thus avoiding potentially overwhelmingly powerful entanglements
which often end in therapeutic failure.

Comment needs to be made on the sex ratio of adolescents
diagnosed as having borderline personality disorder. In line with
most studies (Ludolph et al., 1990; Westen et al., 1990), this study
confirmed an excess of females, which raises the question whether this
is a real or artefactual finding. The association of borderline
personality disorder and sexual abuse suggests a possible pejorative
sex bias – a way of categorizing victims of sexual abuse, the large
majority of whom are female. Against such an argument are the

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findings that only a small proportion of victims of sexual abuse have personality difficulties, and while the association of borderline personality disorder with sexual abuse is strong, it is not an exclusive one; studies reveal that between 30% and 60% of those with borderline personality disorder have no history of sexual abuse. Nevertheless, this does remain a possible explanation.

Alternatively, is the diagnostic process biased? The diagnostic criteria for borderline personality disorder are not sex-specific. However, while there are some 'hard' criteria to base the diagnosis upon, including the number of attempts at self-harm, the term 'manipulative' attempts at self-harm (included in the Diagnostic Interview for Borderlines (DIB)) could very well introduce a sex bias into the mind of the therapist. Research findings are equivocal on this point. Using standardized diagnostic procedures, McManus et al. (1984) found, in one US correctional facility for delinquents, an equal proportion of males and females having borderline personality disorder (37% vs. 35%). As noted above, studies in psychiatric settings consistently reveal (Ludolph et al., 1990; Westen et al., 1990) a greater rate among females. Is this, then, to do with the setting or context? In other words, is the sex bias to do with the process of psychiatric labelling which, if true, is not specific to this diagnostic category, but may apply to others such as depression? In order to overcome potential ascertainment and referral biases, which may account for a significant proportion of the alleged female excess, it would be necessary to carry out a whole population survey using standardized criteria.

The retrospective collection of data, without an initial hypothesis in mind, did not allow the use of appropriate measures of family functioning. All the measures used refer to the 'index' patient, and only overall clinical impressions of the family's functioning could be inferred. The findings of higher rates of anger and irritability, sexual abuse, sibling and parental psychopathology can thus only be regarded as tentative. However, these findings are in line with other studies and do suggest the difficult nature of these family environments. Family therapy is consequently problematic with such families and systemic family therapy, with its emphasis upon neutrality and positive connotation, appears to be particularly useful. The specific effects of family therapy, however, could not be disentangled from the rest of the treatment programme, which involved a number of therapeutic approaches including hospital admission, individual counselling and, often, pharmacotherapy.
This study can only be regarded as preliminary. It is proposed to carry out a prospective study using measures of family interaction and the Adult Attachment Interview (George et al., 1985) to assess the quality of relationships, which seem to be at the core of this disorder, controlling for other therapies as far as possible.

Acknowledgements

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References


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Borderline personality disorder


