Received: 24 March 2023 | Accepted: 31 January 2024

DOI: 10.1111/jmft.12693

ORIGINAL ARTICLE

JMFT Journal of Marital and Family Therapy

Assessing family relations in borderline personality disorder: A relational approach

Mariona Roca PhD[1] | **Anna Vilaregut PhD**[1] | **Teresa Pretel-Luque PhD**[1] | **Natàlia Calvo PhD**[2,3] | **Álvaro Frías PhD**[4] | **Marc Ferrer MD, PhD**[2,3]

[1]FPCEE Blanquerna, Universitat Ramon Llull, Barcelona, Spain

[2]Psychiatry Department, Vall d'Hebron University Hospital, Mental Health Network Biomedical Research Center (CIBERSAM), Barcelona, Spain

[3]Psychiatry Department, Mental Health and Addictions Group, Vall d'Hebron Research Institute (VHIR), Barcelona, Spain

[4]Adult Outpatient Mental Health Center, Consorci Sanitari del Maresme, Mataró, Spain

Correspondence
Mariona Roca, PhD, FPCEE Blanquerna, Universitat Ramon Llull, C/Císter 34, 08022 Barcelona, Spain.
Email: marionars1@blanquerna.url.edu

Funding information
State Research Agency of the Government of Spain,
Grant/Award Number: PSI 2017-83146-R

Abstract

The aims of the current study are to describe the basic family relationships, parental bonding patterns, and dyadic adjustment of families with offspring diagnosed with borderline personality disorder (BPD) and to explore the correlations between these variables related to family relations and BPD symptomatology. The sample consisted of 194 participants, including parents from the control ($N = 76$) and clinical group ($N = 76$), and patients with BPD ($N = 42$). All progenitors completed a measure of family relations, parental bonding, and dyadic adjustment. Patients completed a measure of parental bonding and borderline symptomatology. The results showed significant differences between both groups in marital and parental functioning, marital satisfaction, dyadic adjustment, and care. Correlations among family variables and BPD symptomatology were also found. In summary, findings underscore the significance of comprehending the complexity of family relationships in BPD while advocating for a relational perspective when examining the family dynamics.

KEYWORDS
borderline personality disorder, family, marital relation, parental bonding, parental relation

INTRODUCTION

Borderline personality disorder (BPD) is a complex mental disorder difficult to understand and treat, given its pervasive pattern of instability in interpersonal relationships, affectivity, and self-image. Patients with BPD tend to suffer and act with impulsivity and emotional reactivity, often leading to outbursts of anger, self-destructive behaviors, and a significant risk of suicide (American Psychiatric Association, 2013; Paris, 2019). Furthermore, BPD is quite widespread, affecting between 2% and 5.9% of the population (Tomko et al., 2014).

Like most mental disorders, it is considered that BPD has a complex and multifactorial cause, derived from the interaction of genetic vulnerability with environmental factors (Perez-Rodriguez et al., 2018) such as childhood traumatic experiences (Zanarini, 2000), disturbed attachments (Gunderson & Lyoo, 1997), and disrupted family relationships (Benjamin, 2005; Linehan, 1993). In accordance with the above, this article will focus on the study of family variables.

For instance, families of people with BPD often show neglect, poor emotional support, and invalidating family environments (Benjamin, 2005; Fruzzetti et al., 2005; Linares, 2012; Linehan, 1993). Emotional underinvolvement by parents can affect children's ability to socialize effectively, leading to interpersonal difficulties. Problems with interpersonal functioning is a core characteristic of BPD, and symptom severity is robustly associated with interpersonal dysfunction (Herr et al., 2013; McCloskey et al., 2021). In fact, behavioral deviations (such as self-harm and impulsivity) primarily manifest within interpersonal contexts (Sharp, 2016).

Hence, it is unsurprising that patients themselves often stress the importance of managing interpersonal relationships within the family, and many seek out family therapy with the aim of resolving communication issues and improving family dynamics (Vilaregut et al., 2021). Campo and D'Ascenzo (2010) observed that many families with a child diagnosed with BPD presented a relational pattern marked by swings from affective hyperinvolvement to neglect. This mixture produced difficulties in the areas of affectivity and socialization, interfering with the individuation process.

Many studies focusing on attachment theories have suggested that disrupted attachment relationships are common in individuals with BPD. Specifically, a range of literature examining parent–child bonding and the quality of parent–child relationships has shown that offspring diagnosed with BPD tend to report lower levels of parental care and higher levels of parental overprotection than their peers (Boucher et al., 2017; Huang et al., 2014; Infurna et al., 2016). Some studies have linked poor parental bonding and dysfunctional attachment patterns with BPD in offspring (Laporte & Guttman, 2007; Zanarini, 2000). Violations of parent–child boundaries may act as a relational disturbance of relevance for BPD.

Meanwhile, Vanwoerden et al. (2017) examined family dynamics associated with risk for BPD in adolescents and found a relation between BPD traits in adolescents and parent–child dynamics such as guilt induction and psychological control. In addition to parent–child dynamics, the relationship between parents can also play an important role in children's mental

health. Marital conflict has been associated with internalizing and externalizing psychological outcomes (Tavassolie et al., 2016), such as eating disorders, depression, anxiety, somatization, hostility, and aggression symptoms in children and adolescents that have been exposed to disharmonious family environments (McMahon et al., 2003). Mosmann et al. (2018) maintain that positive marital functioning can act as a protective factor against psychological disorders, while poor functioning can serve to increase the risk of these disorders.

In summary, the literature clearly establishes the effects of family interactions on people's overall well-being. Family interactions have been found to have a significant impact on people's health, acting either as a protective and resilience factor or as a possible source of conflict and disorder (American Psychiatric Association, 2013, Domínguez et al., 2022). The family can be understood as an interaction circuit, meaning that the behavior of one family member will inevitably influence the behaviors of the others. Nonetheless, research tells us that family relations have an impact on each member differently and that the effects on each individual, in turn, have implications for the family's overall interactions (Roca et al., 2020; Vilaregut et al., 2021). For this reason, we are committed to approach the family as a system and take a relational approach to the assessment of family relations.

Despite the merits of an approach based on a broader view of family relations, most of the BPD literature has had a more limited focus, either on BPD patients' impact on their family members or on parent–child bonding. Few studies have considered the perspectives of both parents and children or looked at family systems as a whole. In fact, most of the studies focus only on parent–child relationships and do not attach importance to marital relationships when assessing family functioning. There is also a lack of research exploring the possible correlation between the severity of BPD symptomatology and dysfunctional family relations.

Considering this limitation, Linares' (1996, 2007, 2012) theory of basic family relationships proposes a relational approach of mental disorders; the theory assumes that the relational atmosphere in the family is defined by two dimensions, marital functioning and parental functioning. These functions are closely linked and exert bidirectional influence on one another. The above theory assumes that families with dysfunctional tendencies in one or both of the basic family relationships (marital functioning and parental functioning) will strongly influence the personality construction and mental health of the children.

Focusing on families with a member diagnosed with BPD, Linares' (1996, 2007, 2012) theory of basic family relationships identifies two different relational modalities. The first is based on the child's triangulation in the face of marital problems, a pattern that in turn affects parental functions. The second modality is one based on deprivation, where parents experience difficulties in attending to the affective and emotional needs of their children. This can lead children to feel abandoned, and they often have problems bonding with and trusting their peers. Both kinds of relational dynamics affect the child–and the future adult–in the process of individuation, bonding, and the establishment of social and affective relationships, all of which are heavily involved in BPD.

Because more research is needed in this field and because of the important role family plays in mental health, and specifically in BPD, the objective of the present study is to explore family relations in families with adolescents and young adults diagnosed with BPD from the perspective of Linares' (1996, 2007, 2012) theory of basic family relationships.

The specific objectives are twofold: (1) to describe the basic family relationships, parental bonding, and dyadic adjustment patterns of families with offspring diagnosed with BPD and to compare these families (clinical group; GCL) with families with a child without a

psychopathological diagnosis (control group; GCT) and (2) to investigate possible correlations between variables related to family relations and BPD symptomatology.

To this end, we propose the following two hypotheses: (1) The GCL (clinical group) will show lower levels of marital and parental functioning and will record higher scores for overprotection and lower scores for care and dyadic adjustment than the GCT (control group). (2) We will find a correlation between the severity of BPD symptomatology and dysfunctional family relations.

METHODS

Participants

We implemented a quasi-experimental design, using a comparison group selected through intentional nonprobabilistic sampling. The sample included 194 participants: 76 progenitors in the control group (GCT) and 76 in the clinical group (GCL), which also included 42 adolescents and young adults diagnosed with BPD. The clinical and control groups were selected by nonprobability purposive sampling. The inclusion criteria for the two groups were as follows: (a) families must have a biological or adopted offspring over 14 years old; (b) families must be living together; and (c) offspring must not have any offspring. The following additional criterion was used to select participants in the clinical group: (a) families must have offspring diagnosed with BPD. Those who presented intellectual or language difficulties affecting their ability to participate in the study were excluded.

Psychiatrists and psychologists from three public hospitals in Barcelona (Spain) were responsible for selecting and contacting patients who met the inclusion criteria. All patients were all already undergoing psychiatric and psychological treatment and had been diagnosed as meeting the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association, 2013) criteria for BPD using the Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II; First et al., 1997).

The control group was made up of 76 progenitors, chosen from a total sample of 340 participants from a previous study. As can be seen in Table 1, the sociodemographic variables of the control group matched those of the clinical group. The two groups were comparable ($p > 0.05$) in terms of the age, gender composition, length of conjugal relationship, and number of children, but they were not comparable in their education level. Children from both groups were also comparable ($p > 0.05$) in terms of age, gender, and education level.

The mean age of the parents in the GCL was 52.68 years (SD = 4.68), while in the GCT it was 53.93 years (SD = 7.22). Patients' mean age was 22.40 years (SD = 6.72), the majority were women (78.6%), and they had been diagnosed at a mean age of 18.65 years (SD = 3.5). Tables 1 and 2 show the participants' sociodemographic and clinical characteristics.

Instruments

Borderline Symptom List-23 (BSL-23): The BSL-23 is a self-administrated questionnaire created by Bohus et al. (2009) with a Spanish adaptation and validation by Soler et al. (2013). It assesses BPD symptomatology using a basic scale of 23 items, and it features an 11-item complementary scale for behavioral assessment collecting data on the frequency of behaviors characteristic of

TABLE 1 Sociodemographic characteristics of the parents in the GCL and GCT.

Variables	GCL ($N = 76$) *M* (SD)/%	GCT ($N = 76$) *M* (SD)/%
Mean age (years)	52.68 (4.68)	53.93 (7.22)
Gender		
Male	50	44.74
Female	50	55.26
Years of living as a couple	30.01 (9.75)	22.17 (6.7)
Education level		
Elementary education	44.3	6.9
Secondary education	27.8	39.1
Higher education	27.8	54
Number of children		
1	11.6	8
2	54.7	62.1
3	29.1	20.7
+4	4.6	9.2

BPD in the past week, including nonsuicidal self-injuries, suicidal behaviors, drug use, and high-risk behaviors.

Cuestionario de Evaluación de las Relaciones Familiares Básicas (Basic Family Relations Evaluation Questionnaire): The CERFB is a 25-item instrument created by Ibáñez et al. (2012). The instrument assesses marital functioning ($\alpha = 0.91$) and parental functioning ($\alpha = 0.92$).

Parental Bonding Instrument (PBI): The PBI is a 25-item instrument created by Parker et al. (1979); we used the Spanish population version adapted by Ballús-Creus (1991). The instrument evaluates two dimensions of parenting: care ($\alpha = 0.88$) and overprotection ($\alpha = 0.74$).

Dyadic Adjustment Scale (DAS): The DAS is a 32-item instrument created by Spanier (1976); we used the Spanish population version adapted by Cano-Prous et al. (2014). The instrument measures the perceptions of dyadic adjustment ($\alpha = 0.96$) of a couple by four subscales: consensus ($\alpha = 0.90$), satisfaction ($\alpha = 0.94$), affective expression ($\alpha = 0.96$), and cohesion ($\alpha = 0.86$).

Sociodemographic and Clinical Data Questionnaires: We designed two ad-hoc questionnaires to collect sociodemographic and clinical data on the families. Parents' questionnaire included information related to the gender, age, level of education, married years or living as a couple, and number of children. Patient's questionnaire included gender, age, level of education, employment status, age at diagnosis, time in treatment, psychopathological comorbidity, and visits to psychiatric emergency services.

Procedure

The study received ethical approval by the Clinical Research Ethics Committee of a university in Barcelona (PR(AG)372/2017) and those of three public hospitals in Barcelona involved in the

TABLE 2 Sociodemographic and clinical characteristics of patients.

Variables	(*N* = 42) *M* (SD)/%
Age	22.40 (6.72)
Gender	
Male	21.4
Female	78.6
Education level	
Elementary education	40.55
Secondary education	51.35
Higher education	8.1
Actual occupation	
Full-time job	14.29
Studying	40.48
Studying and part-time job	9.53
Unemployed	23.8
Not specified	11.9
Age at diagnosis	18.65 (3.5)
Time in treatment	
<12 months	45.5
1−3 years	36.4
>3 years	18.1
Comorbidity	
Attention deficit and hyperactivity disorder	6.5
Substance-related and addictive disorder	17.4
Depressive disorders	6.5
Feeding and eating disorders	6.5
None	63
Current symptomatologic status (BSL-23)	
BPD symptomatology	43.52 (17.66)
Dysfunctional behavior	6.35 (4.4)
Visits to psychiatric emergency	
0	27.3
1–5	59.1
6–10	9.1
+10	4.5

Abbreviations: BPD, borderline personality disorder; BSL-23, Borderline Symptom List-23.

study (E04PRNG7B200-1023-001, PR(AG)372/2017, PRCSA0078). The research objectives were explained to the participants, and they gave their written informed consent. Participants' voluntariness and anonymity has been preserved throughout the process.

Data analysis

Statistical analyses were carried out using the Statistical Package for Social Sciences (SPSS; v.26). Because the variables met the assumptions of normality, we used parametric tests. Between-group differences in demographic variables were assessed using Student's *t*-test for continuous variables, while categorical variables were analyzed using χ^2 tests. We conducted a descriptive analysis for the CERFB, PBI, and DAS variables, and the Student's *t*-test was used for intergroup analysis to compare the means of the independent samples. When the *t*-test indicated a significant difference, effect size was calculated and classified according to Cohen's *d* criteria (Cohen's *d*: 0.2, 0.5, 0.8 for small, medium, and large effect sizes, respectively, corresponding to the quartiles for effect sizes). For the purpose of intragroup analysis of the GCL, we carried out a correlation study using Pearson's correlation coefficient. To examine the differences in the perception of parental bonding between fathers, mothers, and their offspring, we used a correlation analysis. Finally, bivariate correlations were carried out to determine relations between family relations and BPD symptomatology.

RESULTS

Regarding the first objective, Table 3 shows significant differences between the GCL and GCT in the CERFB, DAS, and PBI scales. Results showed that, compared to GCT parents, GCL parents reported lower marital and parental functioning, lower levels of care for their offspring, and lower degrees of satisfaction and dyadic adjustment with their partners.

Within the clinical group, Table 4 shows similarities and discrepancies between parents' perceptions of care and overprotection of their children and also children's perceptions of their parents. As can be seen, significant differences were found between the scores for the care variable registered by fathers and children and also between the scores for care and overprotectiveness recorded by mothers and children. In other words, there is evidence of disparities in the perceptions of these family members.

Regarding the second objective, Table 5 shows the correlations between the severity of BPD symptomatology, the number of psychiatric emergency visits, and time in treatment compared to basic family relations, dyadic adjustment, and parental bonding as perceived by parents and offspring in the GCL. Results showed that scores for marital functioning, satisfaction, cohesion, and total dyadic adjustment correlated with the current severity of BPD symptomatology.

In terms of views of parental bonding, findings revealed that parents' perceptions of care correlated negatively with their offspring's time in treatment, while parents' scores for overprotection correlated positively with the number of psychiatric emergency visits. Meanwhile, the results showed a negative correlation between BPD patients' view of the degree of overprotectiveness of their parents and the current severity of their BPD symptomatology. In contrast, the BPD patients' perceptions of overprotection correlated positively with the number of psychiatric emergency visits they had made and their time in treatment.

TABLE 3 Descriptive analyses for CERFB, PBI, and DAS and comparison between the GCL and the GCT.

Measure	Variable	GCL ($N = 76$) M (SD)	GCT ($N = 76$) M (SD)	t (p)	d	95% CI
CERFB	Parental functioning	38.28 (6.11)	44.88 (5.84)	6.8 (0.000)***	1.10**	0.76–1.44
	Marital functioning	50.92 (10.9)	56.25 (9.68)	3.18 (0.002)**	0.51**	0.19–0.84
PBI	Care	25.49 (5.09)	29.25 (4.87)	4.62 (0.000)***	0.75**	0.42–1.08
	Overprotection	9.32 (5.37)	8.74 (4.92)	0.70 (0.48)	–	–
DAS	Consensus	52.37 (8.02)	53.28 (9.95)	0.62 (0.53)	–	–
	Satisfaction	36.01 (7.26)	41.29 (5.96)	4.89 (0.000)***	0.79**	0.46–1.12
	Cohesion	15.37 (5.14)	16.08 (4.75)	0.88 (0.37)	–	–
	Affectional expression	8.53 (2.96)	8.99 (2.4)	1.05 (0.29)	–	–
	Total	112.28 (19.17)	119.63 (20.08)	2.3 (0.02)*	0.37*	0.05–0.69

Abbreviations: CERFB, Basic Family Relations Evaluation Questionnaire; CI, confidence interval; DAS, Dyadic Adjustment Scale; PBI, Parental Bonding Instrument.

*$p \leq 0.05$; **$p \leq 0.005$; ***$p \leq 0.001$.

TABLE 4 Parental bonding differences between father/patient and mother/patient for the clinical group (GCL).

	Fathers ($N = 38$)		Mothers ($N = 38$)	
Child ($N = 33$)[a]	Care, r (p)	Overprotection, r (p)	Care, r (p)	Overprotection, r (p)
Care	0.42 (0.014)*	−0.2 (0.25)	0.72 (0.000)***	−0.12 (0.51)
Overprotection	−0.23 (0.19)	0.27 (0.13)	−0.22 (0.21)	.73 (0.000)***

[a]Of the 42 patients, nine responses were missing.

*$p \leq 0.05$; **$p \leq 0.005$; ***$p \leq 0.001$.

DISCUSSION

With the present study, we aimed to explore family relations following Linares' (1996, 2007, 2012) theory of basic family relationships in families with offspring with BPD. This was accomplished first by assessing the basic family relationships, parental bonding, and dyadic adjustment of families with offspring diagnosed with BPD and second, by examining the correlations between these family characteristics and the severity of BPD symptomatology.

As a first important result, our study showed that parents of patients with BPD recorded much lower scores for the parental functioning component of the CERFB and for the care factor of the PBI than parents of offspring without psychiatric diagnoses. This finding is congruent with other studies (Laporte & Guttman, 2007). Our findings were also consistent with the literature when it comes to patients' perceptions, as they echo other studies that have found that people with BPD experience their parents as lacking in affection and overcontrolling (Boucher et al., 2017; Huang et al., 2014; Infurna et al., 2016). This suggests the possibility of emotional neglect, poor emotional support, and invalidation from both parents; concepts have

TABLE 5 Correlations between clinical variables and family relations, parental bonding, and dyadic adjustment.

		BSL-23		Psychiatric emergency visits	Time in treatment
		BPD symptomatology	Dysfunctional behavior		
Instrument	**Variable**	***r* (*p*)**	***r* (*p*)**	***r* (*p*)**	***r* (*p*)**
CERFB	Parental	−0.17 (0.2)	−0.2 (0.13)	−1.41 (0.37)	−0.18 (0.24)
	Marital	0.34 (0.01)**	0.45 (0.000)***	0.18 (0.24)	0.05 (0.75)
PBI parent–child	Care	0.07 (0.56)	0.14 (0.3)	−0.067 (0.67)	−0.4 (0.01)*
	Overprotection	−0.25 (0.06)	−0.7 (0.6)	0.33 (0.03)*	0.29 (0.07)
PBI child–parent	Care	−0.06 (0.6)	0.02 (0.87)	−0.18 (0.25)	−0.06 (0.69)
	Overprotection	−0.29 (0.02)*	−0.001 (0.99)	0.36 (0.02)*	0.37 (0.019)*
DAS	Consensus	0.02 (0.86)	0.13 (0.33)	0.19 (0.2)	−0.04 (0.8)
	Satisfaction	0.30 (0.02)*	0.23 (0.08)	0.22 (0.15)	0.11 (0.48)
	Cohesion	0.29 (0.03)*	0.39 (0.003)**	0.28 (0.06)	0.04 (0.8)
	Affectional expression	0.10 (0.43)	0.24 (0.07)	0.08 (0.6)	−0.17 (0.29)
	Total	0.22 (0.09)	0.29 (0.03)*	0.27 (0.08)	0.01 (0.94)

Abbreviations: BPD, borderline personality disorder; BSL-23, Borderline Symptom List; CERFB, Basic Family Relations Evaluation Questionnaire; DAS, Dyadic Adjustment Scale; PBI, Parental Bonding Instrument.

*$p \leq 0.05$; **$p \leq 0.005$; ***$p \leq 0.001$.

been tied to BPD in studies by several authors (Benjamin, 2005; Campo & D'Ascenzo, 2010; Fruzzetti et al., 2005; Gunderson & Lyoo, 1997; Linares, 1996, 2007, 2012; Linehan, 1993; Zanarini, 2000). Indeed, our findings revealed discrepancies between parent's and children's perceptions of parental bonding, most prominently in mothers' and children's views of care and overprotection. This result suggests that patients with BPD tend to experience their family environments and relationships more negatively than their parents (Fruzzetti et al., 2005; Gunderson & Lyoo, 1997; Infurna et al., 2016), and it underlines the difficulties in family communication (Vilaregut et al., 2021).

Although there is plentiful scientific evidence suggesting that the parent–child relationship is a relevant factor in the course and prognosis of BPD (Boucher et al., 2017; Infurna et al., 2016), this study has sought to go beyond parent–child dynamics to explore relationships between parents following Linares' (1996, 2007, 2012) theory of basic family relationships.

The results here confirm that the presence of a child with BPD has implications for these systemic family relations. In terms of marital functioning, for example, parents of offspring with BPD displayed lower levels of marital satisfaction and scored lower for their perceptions of their marital relationships, a finding which is consistent with Linares' (1996, 2007, 2012) theory of basic family relationships. Poor relationships between parents can cause them difficulties in coping effectively with the emotional needs of their children and act as a risk factor for psychological disorders (McMahon et al., 2003; Mosmann et al., 2018). This marital conflict can also lead to practices of triangulation by the child and to the inclusion of the child in the dispute, with offspring sometimes forced to mediate or take sides in conjugal problems between

their parents (Linares, 1996, 2007, 2012; Vanwoerden et al. 2017). In other words, parents may fail to maintain a responsible and protective parental role and experience difficulties in attending to the affective and emotional needs of their children (Campo & D'Ascenzo, 2010; Linares, 1996, 2007, 2012).

Nevertheless, our study showed that better marital relations were associated with the severity of current symptomatology. These results are consistent with Linares' (1996, 2007, 2012) theory of basic family relationships, which tells us that marital and parental relations are closely linked and exert bidirectional influence on one another, meaning that both are relevant here. Following Linares' (1996, 2007, 2012) theory of basic family relationships, some families can be positioned in the framework of deprivation, characterized by a lack of care and neglect. In such a context, faced with this experience of relational abandonment and biparental neglect, patients show greater symptomatic destabilization (Benjamin, 2005; Fruzzetti et al., 2005; Linares, 1996, 2007, 2012; Linehan, 1993; Zanarini, 2000). Additionally, parental overprotection is also related with current symptomatology and, consequently, correlates with psychiatric emergency department visits. This finding suggests that parental hyperinvolvement affects patients' autonomy and the individuation process (Campo & D'Ascenzo, 2010; Linares, 1996, 2007, 2012). In contrast, there were some encouraging findings, specifically, the strong link between parental caregiving and time in the treatment of offspring with BPD. This finding suggests that the family can serve as a protective factor and promote resilience, not only act as a possible source of conflict and disorder (American Psychiatric Association, 2013, Domínguez et al., 2022).

Although the present study has shed light on the role of family relations in BPD taking a relational approach, it also has some limitations. The first was not evaluating families with separated or divorced parents, as these family structures are becoming increasingly common, and their particularities must be considered both in clinical practice and in research. Therefore, future research should replicate this study involving families with separated or divorced parents. Second, all recruited families were aware of their offspring's diagnosis and treatment, as they all had shown an interest in participating in the study. Thus, we were unable to explore the perception of family relationships in parents not involved in their offspring's mental health condition. This lack of family implication might be common given the widely studied hypothesis of biparental neglect in these families.

This study has several clinical implications for individuals with BPD and their families, as considering the family from a relational approach can improve the assessment and treatment of BPD. Such a perspective might help determine the best treatment approach or establish a therapeutic plan for both the patient and the family.

CONCLUSIONS

In conclusion, findings reinforce the important role of family interactions in the individual's overall well-being. To understand and comprehend the complexity of family relationships in BPD, it is essential to consider the family from a relational approach, rather than from an individual perspective, as family relations influence each member differently and have an impact on interactions and family dynamics.

ACKNOWLEDGMENTS

The authors would like to thank the State Research Agency of the Government of Spain for the aid to R + D + i projects with reference number PSI 2017-83146-R. The study is being carried

out as part of a project financed by the State Research Agency of the Government of Spain for the aid to R + D + i projects with reference number PSI 2017-83146-R. With the submission of this abstract, the author would like to undertake that: My University representative is fully aware of this submission. All authors of this research article have directly participated in the planning, execution, and analysis of this study. All authors of this article have read and approved the final version submitted. The content of this manuscript has not been copyrighted or published previously. The content of this manuscript is not now under consideration for publication elsewhere. The content of this manuscript will not be copyrighted, submitted, or published elsewhere, while acceptance by the journal is under consideration. There are no directly related manuscripts published or unpublished by any authors of this article.

ORCID

Mariona Roca https://orcid.org/0000-0003-4208-2262

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

Ballús-Creus, C. (1991). *Adaptación del parental bonding instrument*. Escuela Profesional de Psicología Clínica.

Benjamin, L. S. (2005). Interpersonal theory of personality disorders: The structural analysis of social behavior and interpersonal reconstructive therapy. In M. F. Lenzenweger & J. F. Clarkin (Eds.), *Major theories of personality disorder* (pp. 157–230). Guilford Press.

Bohus, M., Kleindienst, N., Limberger, M. F., Stieglitz, R.-D., Domsalla, M., Chapman, A. L., Steil, R., Philipsen, A., & Wolf, M. (2009). The short version of the Borderline Symptom List (BSL-23): development and initial data on psychometric properties. *Psychopathology*, *42*(1), 32–39. https://doi.org/10.1159/000173701

Boucher, M. È., Pugliese, J., Allard-Chapais, C., Lecours, S., Ahoundova, L., Chouinard, R., & Gaham, S. (2017). Parent–child relationship associated with the development of borderline personality disorder: A systematic review. *Personality and Mental Health*, *11*(4), 229–255. https://doi.org/10.1002/pmh.1385

Campo, C., & D'Ascenzo, I. (2010). El Trastorno Límite de la Personalidad: Diagnóstico e Intervención desde la perspectiva sistémica. *Redes: Revista de Psicoterapia Relacional e Intervenciones Sociales*, *24*, 23–51.

Cano-Prous, A., Martín-Lanas, R., Moyá-Querejeta, J., Beunza-Nuin, M. I., Lahortiga-Ramos, F., & García-Granero, M. (2014). Psychometric properties of a Spanish version of the Dyadic Adjustment Scale. *International Journal of Clinical and Health Psychology*, *14*(2), 137–144. https://doi.org/10.1016/S1697-2600(14)70047-X

Domínguez, I., Nuño, L., Freixa, N., Hidalgo, C., Cervera, G., Corominas, A., & Balcells-Oliveró, M. (2022). Multifamily therapy in the community mental health network: A pragmatic randomized and controlled study. *Journal of Marital and Family Therapy*, *49*(1), 205–221. https://doi.org/10.1111/jmft.12617

First, M., Gibbon, M., Spitzer, R., Williams, J., & Benjamin, L. (1997). *The structured clinical interview for DSM-IV Axis II Personality Disorders (SCID-II)*. American Psychiatric Press.

Fruzzetti, A. E., Shenk, C., & Hoffman, P. D. (2005). Family interaction and the development of borderline personality disorder: A transactional model. *Development and Psychopathology*, *17*(4), 1007–1030. https://doi.org/10.1017/S0954579405050479

Gunderson, J. G., & Lyoo, I. K. (1997). Family problems and relationships for adults with borderline personality disorder. *Harvard Review of Psychiatry*, *4*(5), 272–278. https://doi.org/10.3109/10673229709030553

Herr, N. R., Rosenthal, M. Z., Geiger, P. J., & Erikson, K. (2013). Difficulties with emotion regulation mediate the relationship between borderline personality disorder symptom severity and interpersonal problems. *Personality and Mental Health*, *7*(3), 191–202. https://doi.org/10.1002/pmh.1204

Huang, J., Napolitano, L. A., Wu, J., Yang, Y., Xi, Y., Li, Y., & Li, K. (2014). Childhood experiences of parental rearing patterns reported by Chinese patients with borderline personality disorder. *International Journal of Psychology*, *49*(1), 38–45. https://doi.org/10.1002/ijop.12007

Ibáñez, N., Linares, J. L., Vilaregut, A., Virgili, C., & Campreciós, M. (2012). Propiedades psicométricas del Cuestionario de Evaluación de las Relaciones Familiares Básicas (CERFB). *Psicothema*, *24*(3), 489–494.

Infurna, M. R., Brunner, R., Holz, B., Parzer, P., Giannone, F., Reichl, C., Fischer, G., Resch, F., & Kaess, M. (2016). The specific role of childhood abuse, parental bonding, and family functioning in female adolescents with borderline personality disorder. *Journal of Personality Disorders*, *30*(2), 177–192. https://doi.org/10.1521/pedi_2015_29_186

Laporte, L., & Guttman, H. (2007). Recollections of parental bonding among women with borderline personality disorder as compared with women with anorexia nervosa and a control group. *Australian Journal of Psychology*, *59*(3), 132–139. https://doi.org/10.1080/00049530701449463

Linares, J. L. (1996). *Identidad y narrativa: La terapia familiar en la práctica clínica*. Paidós.

Linares, J. L. (2007). La personalidad y sus trastornos desde una perspectiva sistémica. *Clínica y Salud*, *18*(3), 381–399. http://www.redalyc.org/pdf/1806/180613877008.pdf

Linares, J. L. (2012). *Terapia familiar ultramoderna*. Herder.

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Press.

McCloskey, K. D., Cox, D. W., Ogrodniczuk, J. S., Laverdière, O., Joyce, A. S., & Kealy, D. (2021). Interpersonal problems and social dysfunction: Examining patients with avoidant and borderline personality disorder symptoms. *Journal of Clinical Psychology*, *77*(1), 329–339. https://doi.org/10.1002/jclp.23033

McMahon, S. D., Grant, K. E., Compas, B. E., Thurm, A. E., & Ey, S. (2003). Stress and psychopathology in children and adolescents: Is there evidence of specificity? *Journal of Child Psychology and Psychiatry*, *44*(1), 107–133. https://doi.org/10.1111/1469-7610.00105

Mosmann, C., da Costa, C. B., da Silva, A. G. M., & Luz, S. K. (2018). Children with clinical psychological symptoms: The discriminant role of conjugality, coparenting and parenting. *Trends in Psychology*, *26*(1), 429–456. https://doi.org/10.9788/TP2018.1-17En

Paris, J. (2019). Suicidality in borderline personality disorder. *Medicina*, *55*(6), 223. https://doi.org/10.3390/medicina55060223

Parker, G., Tupling, H., & Brown, L. B. (1979). A parental bonding instrument. *British Journal of Medical Psychology*, *52*(1), 1–10. https://doi.org/10.1111/j.2044-8341.1979.tb02487.x

Perez-Rodriguez, M. M., Bulbena-Cabré, A., Bassir Nia, A., Zipursky, G., Goodman, M., & New, A. S. (2018). The neurobiology of borderline personality disorder. *Psychiatric Clinics of North America*, *41*(4), 633–650. https://doi.org/10.1016/j.psc.2018.07.012

Roca, M., Vilaregut, A., Palma, C., Barón, F. J., Campreciós, M., & Mercadal, L. (2020). Basic family relations, parental bonding, and dyadic adjustment in families with a member with psychosis. *Community Mental Health Journal*, *56*(7), 1262–1268. https://doi.org/10.1007/s10597-020-00581-z

Sharp, C. (2016). Current trends in BPD research as indicative of a broader sea-change in psychiatric nosology. *Personality Disorders: Theory, Research, and Treatment*, *7*(4), 334–343. https://doi.org/10.1037/per0000199

Soler, J., Vega, D., Feliu-Soler, A., Trujols, J., Soto, Á., Elices, M., Ortiz, C., Pérez, V., Bohus, M., & Pascual, J. C. (2013). Validation of the Spanish version of the borderline symptom list, short form (BSL-23). *BMC Psychiatry*, *13*(1), 1317. https://doi.org/10.1186/1471-244X-13-139

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family*, *38*(1), 15–28. https://doi.org/10.2307/350547

Tavassolie, T., Dudding, S., Madigan, A. L., Thorvardarson, E., & Winsler, A. (2016). Differences in perceived parenting style between mothers and fathers: Implications for child outcomes and marital conflict. *Journal of Child and Family Studies*, *25*(6), 2055–2068. https://doi.org/10.1007/S10826-016-0376-Y

Tomko, R. L., Trull, T. J., Wood, P. K., & Sher, K. J. (2014). Characteristics of borderline personality disorder in a community sample: Comorbidity, treatment utilization, and general functioning. *Journal of Personality Disorders*, *28*(5), 734–750. https://doi.org/10.1521/pedi_2012_26_093

Vanwoerden, S., Kalpakci, A., & Sharp, C. (2017). The relations between inadequate parent–child boundaries and borderline personality disorder in adolescence. *Psychiatry Research*, *257*, 462–471. https://doi.org/10.1016/J.PSYCHRES.2017.08.015

Vilaregut, A., Roca, M., Ferrer, M., Pretel-Luque, T., & Calvo, N. (2022). Exploring the psychological impact of COVID-19 on adolescents with borderline personality disorder and their mothers: A focus group study. *Clinical Child Psychology and Psychiatry*, *27*, 157–176. https://doi.org/10.1177/13591045211058318

Zanarini, M. C. (2000). Childhood experiences associated with the development of borderline personality disorder. *Psychiatric Clinics of North America*, *23*(1), 89–101. https://doi.org/10.1016/S0193-953X(05)70145-3

How to cite this article: Roca, M., Vilaregut, A., Pretel-Luque, T., Calvo, N., Frías, Á., & Ferrer, M. (2024). Assessing family relations in borderline personality disorder: A relational approach. *Journal of Marital and Family Therapy*, 1–13. https://doi.org/10.1111/jmft.12693