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ARTIGO DE PERSPECTIVA/PERSPECTIVE ARTICLE

The Experience of Relatives of Patients with Borderline Personality Disorder in a Family Group Therapy

A Experiência dos Familiares de Doentes com Perturbação *Borderline* da Personalidade num Grupo de Famílias

FILIPA SANTOS MARTINS[*1,2,3], BERTA RAMOS[4], HENRIQUE GINJA[1], EVA OSÓRIO[1,3], CÁTIA GUERRA[5], INÊS MAGALHÃES, RAQUEL PEDROSA[6]

1. Department of Psychiatry, Unidade Local de Saúde S. João, Porto, Portugal
2. CINTESIS - Centre for Health Technology and Services Research, Porto, Portugal
3. Department of Neurosciences and Mental Health, Faculty of Medicine of University of Porto, Porto, Portugal
4. Hospital Magalhães Lemos, Unidade Local de Saúde Santo António, Porto, Portugal
5. Personality Disorders Community Service, Cambridgeshire and Peterborough NHS Foundation Trust, Fulbourn, United Kingdom
6. Hospital das Forças Armadas, Pólo Porto, Portugal

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Borderline personality disorder (BPD) is a severe and complex mental illness characterised by instability in interpersonal relationships, self-image, affect, and behavioural dysregulation.[1,2] Previous research has revealed the beneficial effects of family involvement in treating patients with BPD, and different family approaches have been developed.[3-7] The Psychiatry Department of Unidade Local de Saúde S. João" (ULS S. João) has a specialised program for BPD patients, which includes a monthly family group for relatives of BPD patients.[8] Family groups are composed of family members of six to eight different BPD patients who are referred to the group by the BPD patient's psychiatrist when they identify family dynamics as benefiting from an intervention, either because they need more information or because it is contributing to a worsening of the clinical situation of the person with BPD and the management of their crises. The most relevant aspect is the proximity to the person with BPD and the possible benefit of their participation in the group, and it is possible to refer more than one family member for the same individual with BPD to attend the session. Each session lasts 90 minutes and aims to provide psychoeducation, emotional communication, problem-solving skills, and reduce expressed emotion.

It is a structured intervention, composed of the following themes as shown in Table 1: diagnostic criteria and main characteristics of BPD; emotion validation and communication skills; strategies to manage crisis; how to promote autonomy and responsibility in relatives; factors that influence relationships; acceptance and change; and regulation of emotions. Family members can propose topics according to their needs. Sessions start with a warm-up section, followed by problem-solving skills, where several techniques are used (roleplay, dialectical-based therapy [DBT] skills, and a mentalization-based therapy [MBT] approach), and end with closure and a schedule for the next session.

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* Autor Correspondente/Corresponding Author: Filipa Santos Martins, MD | afilipasantosmartins@gmail.com | Psychiatry Department, Unidade Local de Saúde São João, Alameda Prof. Hernâni Monteiro, 4200-319 Porto, Portugal

Ten elements of one family group (as shown in Table 2) were invited to participate in a focus group to assess participants´ feedback about the utility, main difficulties and unmet needs. This participation was voluntary after informed consent was obtained, and anonymity was ensured.

Participants were assertive about not including patients because of the time constraints and because they believed it could create tense situations. Participants stated that their families initially were worried they would use the group to share private details about them. Still, they understood that their involvement in the family group was because they cared about them.

When asked if they considered pertinent sessions being moderated by family members, like the Family Connections protocol,[6] they stated their preference to leave this task reserved for health professionals because they believe family members cannot be impartial, and their own experience would make them more deceptive.

Participants did not present any argument against the open structure of the family group, which allows people to enter and leave anytime, but recommended an introductory session before the first session. This initial session could address some preliminary information about the disease, so they could handle hearing about other family members.

Regarding their knowledge about the disorder, participants described BPD, mentioning self-harm behaviours ("self-harm" and "suicidal ideation") but also their reaction to the disease ("impotence," "panic," "restlessness," "uncertainty," and "fear"), and one referred to "chaos". Hence, they valued the importance of quality and easily accessible information about BPD, suggested leaflets about the disease and symptoms, prognosis, and "tips" about what to (not) do. However, these pamphlets only partially replace the sessions since the participants consider that the feedback and the possibility of clarifying doubts are beneficial. Knowing what is "common" and "expected" helps deal with their families, especially in crises. Thus, psychoeducation complements psychotherapeutic strategies that must be provided in family interventions.

Strategies for dealing with crises are among the most valued learning through group attendance. Participants highlighted the importance of "keeping calm" and "being patient and present" to "be able to listen", "not judge", or "not confront". Family members describe that they try to implement the strategies they were taught, changing their attitude towards their family members.

One aspect discussed by the family members was their difficulty in understanding their relative's reactions, which affects their relationship with their relatives with BPD. They also recognise that besides their effort, if their response is unpredictable, it will affect family members' feelings. Based on the therapists ' feedback, roleplay was identified as helpful in reflecting on their behaviour and alternatives for action. They saw the group as a safe environment to put into practice some of the knowledge learned. In addition, the existence of feedback from health professionals on their services is highly valued.

However, they stated several difficulties they felt during the experience. First, they pointed out the difficulty of participating in roleplay or creating symbolic images because of the difficulty in understanding the purpose of these activities. They believed these activities were childish and did not understand the need for symbolic use or other representations since verbal communication could be enough. Besides, they mentioned needing help understanding the conclusions the technicians obtain from the symbolic representations. Second, they mentioned their difficulty in putting themselves in the role of the patient diagnosed with BPD due to problems understanding how they feel. One possible explanation for these difficulties is that these family members share the mentalisation difficulties described in BPD.[9] These difficulties are significant as they can lead to dropouts. One participant mentioned that his husband stopped attending the family group because of the role-play exercises. On the one hand, these difficulties highlight the need to intervene and address problems before participants give up. On the other hand, it leads us to believe that this group model is not ideal for everyone, who may benefit from more psychoeducational than psychotherapeutic strategies.

Participants were also asked which techniques they would like to see used in future editions of the family group. Participants highlighted an expectation to provide more assertive and directive instructions about behaving or reacting to their relatives. This expectation could also explain why family members are so eager for guidance on how to (re) act with their family members, especially in crises.

Participants also recognised that the family group provides the opportunity to promote emotional support, even though it simultaneously carries a high emotional burden. If, on the one hand, there is emotional tension when experiencing difficulties between them, on the other hand, there is a feeling of relief from those who share their thoughts. Also, sharing everyday experiences causes anticipatory anxiety by expecting their family members to go through that situation. Still, on the other hand, these situations motivate reflection and anticipation of how they should react.

Even though this focus group included a small number of participants, some of whom were relatives of the same patient, and was conducted by the therapists who moderated the sessions, which may have caused response bias towards pleasing the therapist, it allowed exploring different perspectives on the problem and the group.

This assessment allowed the therapists to modify the organisation and structure of the family groups. The main changes included more psycho-educational tools, namely information leaflets, to structure the session. In addition, the role-play exercises now included a therapist and not just the family members of individuals with BPD, which made it easier to carry out the exercise.

Our study is in line with what is found in the existing literature. Most of the existing literature suggests that multi-family groups are effective, improving the outcomes of psychological well-being, quality of life and empowerment, thus contributing to improvements in patients and family members.[5,10] In addition, Sheikhan *et al*[11] qualitatively assessed the effectiveness of the Family Connections programme for family members of individuals with BPD, recognising its potential to increase their understanding of the disease and the strategies to implement in crises. In addition, the participants also commented on the relevance of psychoeducational material, as was the case in this study.

In future research, it will be essential to compare the strategies used in family groups for relatives of BPD patients. It would also be necessary to understand the patient's statement about the impact of their family members' participation in these groups and assess the clinical implications, namely, whether the clinical improvements resulted from the change in the system (patient-family member).

Table 1. List of multifamily group sessions and summary description of each session.

Session 1: ***Borderline Personality Disorder***	DSM-5 diagnosis and characteristics such as impulsivity, emptiness and emotional instability.
Session 2: ***Validation***	Difference between validating and agreeing; validation techniques and their importance.
Session 3: ***Communication***	Effective and empathetic communication strategies, avoiding judgement and criticism.
Session 4: ***Crisis*** **(part 1)**	How to react to emotional crises in a calm and validating way, without overprotection.
Session 5: ***Crisis*** **(part 2)**	Differentiating between mild and severe crises and specific strategies for each type.
Session 6: ***After a crisis situation***	Reflection on the crisis, objectives and prevention of future occurrences.
Session 7: ***Prioritising***	Prioritisation, realistic expectations and crisis prevention.
Session 8: ***Autonomy***	Promoting autonomy, healthy limits and recognising achievements.
Session 9: ***Autonomy and Responsibility***	Assertive communication with the DEAR CCC technique and developing responsibility.
Session 10: ***Emotion regulation***	Strategies for dealing with difficult emotions and avoiding conflicts.
Session 11: ***Factors that prevent a good relationship***	Behaviours and attitudes that hinder healthy relationships with the patient.
Session 12: ***Tolerance for suffering***	Distraction, relaxation and acceptance techniques for dealing with suffering.
Session 13: ***Acceptance and change***	Balance between accepting the situation and promoting change with compassion and persistence.
Session 14: ***Family kit***	A set of practical strategies to support the patient and promote autonomy.

AWARDS AND PREVIOUS PRESENTATIONS:
The results of this research were presented at the XVI Congresso Nacional de Psiquiatria and the XI Congresso da Associação Psiquiátrica Alentejana.

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