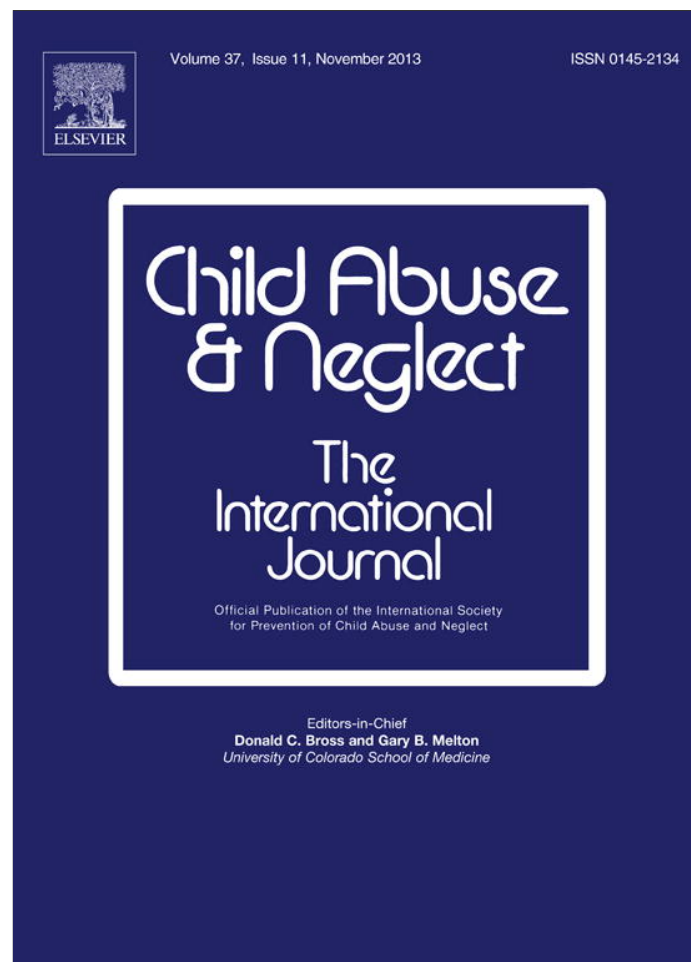


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Child Abuse & Neglect



Perceptions of childhood caretakers and borderline personality symptomatology



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ABSTRACT

Previous studies indicate that individuals with borderline personality disorder come from families marked by high levels of psychopathology as well as dysfunctional parenting styles—themes that tend to engender negative attitudes toward parents. However, we are not aware of any studies that have examined perceptions of parenting quality and borderline personality symptoms in a clinical but non-psychiatric population—the purpose of the present study. Using a cross-sectional self-report survey methodology in a sample of internal medicine outpatients, we examined participants' perceptions of the quality of parental caretaking using a one-item assessment, and examined borderline personality symptomatology using two measures. Ratings of the quality of parental care were statistically significantly inversely correlated with scores on both measures of borderline personality symptomatology. After controlling for the number of caretakers during childhood, the observed statistical relationships remained statistically significant. In this primary care sample, participants with borderline personality symptomatology perceived parents more negatively than those without such symptomatology.

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Introduction

According to a review of the extant literature, individuals with borderline personality disorder (BPD) appear to come from families with (a) relatively high levels of psychopathology, including personality disorders, and (b) dysfunctional parenting styles. With regard to high levels of psychopathology, the families of individuals with BPD appear to have higher-than-expected rates of affective and impulse disorders (Silverman et al., 1991), substance abuse and antisocial characteristics (Goldman, D'Angelo, & DeMaso, 1993), various Axis II disorders (Riso, Klein, Anderson, & Ouimette, 2000; Zanarini et al., 2004), and impulse spectrum disorders (White, Gunderson, Zanarini, & Hudson, 2003).

As for dysfunctional parenting styles, the parents of individuals with BPD are variously reported as negative, uncaring, over-controlling, over-protective, lacking in empathy and affection, conflictual, invalidating, critical, less nurturing, under-involved, and emotionally withholding (Sansone & Sansone, 2009). For example, Nickell, Waudby, and Trull (2002) found evidence of insecure attachment to parents; Zanarini et al. (2000) found that caretakers denied the validity of their offspring's thoughts and feelings, failed to protect them, neglected their physical care, emotionally withdrew, and allotted inconsistent treatment; and Bandelow et al. (2005) summarized parenting breaches by stating that parental attitudes were significantly unfavorable in all aspects.

Although the explicit associations between psychopathology in families/parents and dysfunction in children remain indistinct, a number of theories clearly describe such influences as but one of several variables that may contribute to

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developmental outcomes in their offspring. For example, according to ecological systems theory (Bronfenbrenner, 1986), development unfolds across five environmental systems: the microsystem (i.e., institutions and groups that most immediately and directly affect the child, including family), the mesosystem (i.e., relationships between microsystems), the exosystem (i.e., the effects of a social setting that are somewhat removed from the individual but still influence him/her), the macrosystem (e.g., culture in which individuals live), and the chronosystem (i.e., transitions over the life cycle). According to this theory, relationships with parents are but one of several potentially interacting influences on developmental outcome.

Sroufe, Carlson, Levy, and Egeland (1999) describe development as a complex, systematic, and transactional process. They, like others (e.g., Bronfenbrenner, 1986; Masten & Cicchetti, 2010; Rutter, 2009), perceive prior history as related to the current context by playing a role in the selection, engagement, and interpretation of an experience.

In keeping with the theme of multiple determinants explaining the outcome of one's development, Masten and Cicchetti (2010) describe the concept of developmental cascades—i.e., various processes that influence development in potentially cumulative ways. They posit that adaptive and maladaptive functions and behaviors accumulate over time to either promote or undermine development.

Outcomes for mental health

From a different perspective, Rutter (2009) discusses the role of risk mechanisms, specifically in the context of mental disorders. In addition to environmental factors (e.g., family dynamics), Rutter discusses gene/environment interactions, developmental moderators (i.e., the idea that the impact of risk factors may vary with age), biological programming (i.e., the potential effects of life experiences on brain development), developmental perturbations (i.e., the non-genetic effects of influential environments), and the vagaries of moderating and mediating variables.

Milne et al. (2009) examined the relationship between family history and severity of mental illness. Researchers found associations between a family history of a psychiatric disorder and clinical features of that disorder in index subjects. These data support the notion that family factors (genetic and environmental) are clinically relevant as well as potentially influential in one's overall outcome in adulthood. The findings of Milne et al. (2009) are echoed in a study by Gratz, Litzman, Tull, Reynolds, and Lejuez (2011), who examined antecedents to BPD in children. These investigators found that both trait vulnerabilities and environmental stressors contributed to BPD features.

Some of the influential factors from parent to child may be reciprocal, resulting in changes in both the child and/or family processes (Shaw & Bell, 1993). In this regard, in a 9-year prospective study, Kim, Conger, Lorenz, and Elder (2001) demonstrated the reciprocal nature of negative affect in parent/adolescent interactions—a style that may have detrimental effects on adolescents' early adult social relationships.

Supported by the preceding theories and research, the majority of studies of individuals with BPD and their families indicate negative early family experiences with parents. However, it is important to note that many investigators have studied mental-health populations. These types of populations invite recall bias—i.e., in this case, the over-perception of dysfunctional childhoods due to other potential confounds such as depression, anxiety, and post-traumatic stress disorder. Indeed, the risks of these types of biases have been reported in depression (Columbel, 2007; Howe & Malone, 2011), anxiety (Mitte, 2008), and post-traumatic stress disorder (Tapia, Clarys, Bugajska, & El-Hage, 2012)—all common comorbid conditions in BPD. In an effort to investigate the parent–child relationship from a potentially less-biased perspective, we explored this relationship among patients in a primary care clinic—i.e., among individuals who were not actively seeking mental healthcare.

Method

Participants

Participants in this study were males and females, ages 18 years or older, being seen for non-emergent medical care at an internal medicine outpatient clinic in a mid-sized, mid-western US city. This clinic is staffed predominantly by resident physicians. We excluded individuals who upon informal observation appeared to have compromising medical (e.g., severe pain), intellectual (e.g., mental retardation), cognitive (e.g., dementia), or psychiatric symptoms (e.g., overtly psychotic) of a severity to preclude the candidate's ability to successfully complete a survey.

At the outset, 441 individuals were approached and 401 agreed to participate, for a participation rate of 90.9%. Of these, 385 completed the single-item rating of parental quality-of-care during childhood and both measures of borderline personality symptomatology. Among these 385 respondents, 64.9% were female and 35.1% male. They ranged in age from 18 to 92 years ($M = 53.60$, $SD = 16.02$). Most participants were White/Caucasian (89.6%); however, 6.5% of participants were African-American, 1.6% Asian, 1.3% Hispanic, 0.5% Native American, and 0.3% Other, with 0.3% missing data. With regard to educational attainment, all but 7.5% had at least graduated high school, and 26.5% had earned at least a bachelor's degree.

Procedure

During clinic hours, one of the authors (S.F.) solicited patients in the lobby of the outpatient clinic. After informally assessing exclusion criteria during observation of the patient at check-in (i.e., candidate appeared to have overt limitations that would preclude participation, such as psychosis, extreme pain or illness, or language difficulties), the recruiter invited

candidates to participate. This informal method of exclusion was necessary as participants needed to complete study materials before appointments with their primary care providers. Participants were informed that the study focused on examining early parenting experiences and subsequent adjustment in adulthood, and that all responses were anonymous. The study entailed the completion of a 4-page survey, which took about 10 min. Surveys were completed by participants in the lobby. Completed surveys were placed into provided envelopes, sealed, and then placed into a collection bin in the lobby.

The survey began with a demographic query that explored participants' sex, age, marital status, racial/ethnic origin, and educational level. Next, participants were asked, "How many different caretakers did you have while growing up (up to age 18)?" Respondents were then asked about their perceptions of the quality of parental caretaking: "How would you rate the overall quality of care you received as a child?" Response options were: "Terrible," "Not Very Good," "Fair," "Good," and "Excellent." For analyses, the numbers 1–5 were assigned to each of the ratings, respectively.

Last, respondents completed two measures for the assessment of BPD symptoms. The first was the BPD scale of the Personality Diagnostic Questionnaire-4 (PDQ-4; [Hyer, 1994](#)), a 9-item, true/false, self-report measure that consists of the diagnostic criteria for BPD that are listed in the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV; [American Psychiatric Association, 1994](#)). Previous versions of the PDQ have been found to be useful screening tools for BPD in both clinical settings ([Dubro, Wetzler, & Kahn, 1988](#); [Hyer et al., 1990](#)) and nonclinical settings ([Johnson & Bornstein, 1992](#)), including the use of the freestanding BPD subscale ([Patrick, Links, Van Reekum, & Mitton, 1995](#)).

The second measure for the assessment of BPD symptomatology was the Self-Harm Inventory (SHI; [Sansone, Wiederman, & Sansone, 1998](#)). The SHI is a 22-item, yes/no, self-report inventory for BPD that explores participants' histories of self-harm behavior. Each item in the inventory is preceded by the statement, "Have you ever intentionally, or on purpose, . . ." and items include, "overdosed," "cut yourself on purpose," "burned yourself on purpose," and "hit yourself." Each endorsement is in the pathological direction and the SHI total score is the summation of "yes" responses. In comparison with the Diagnostic Interview for Borderlines ([Kolb & Gunderson, 1980](#)), the benchmark for the research diagnosis of BPD, the SHI demonstrates an accuracy in diagnosis of 84%. We elected these two approaches to the determination of BPD symptoms because each assesses somewhat differing phenomenology. The PDQ-4 assesses predominantly psychological symptoms whereas the SHI assesses historical behavioral symptoms.

This project was reviewed and exempted by the Institutional Review Boards of the hospital site as well as the university. Completion of materials was assumed to be implied consent, which was explicitly clarified on the cover page of the booklet.

Results

Participants' ratings of the quality of care received from parents/caretakers during childhood ranged from 1 to 5 ($M = 4.06$, $SD = 1.03$). Specifically, 8 (2.1%) indicated "Terrible," 30 (7.8%) indicated "Not Very Good," 55 (14.3%) indicated "Fair," 128 (33.2%) indicated "Good," and 164 (42.6%) indicated "Excellent." Although 12 respondents did not indicate how many different caretakers they had while growing up, 200 (53.6%) respondents indicated two caretakers during childhood, 98 (26.3%) indicated one caretaker, 39 (10.5%) indicated three caretakers, and 36 (9.7%) indicated four or more caretakers. Scores on the PDQ-4 ranged from 0 to 9 ($M = 1.58$, $SD = 1.96$) whereas scores on the SHI ranged from 0 to 15 ($M = 1.69$, $SD = 2.72$).

Ratings of quality of parental care during childhood were not statistically significantly correlated with respondent age ($r = .10$, $p < .07$), sex ($r = -.07$, $p < .18$), or education ($r = .06$, $p < .29$). However, ratings of quality of parental care were statistically significantly correlated with scores on both the PDQ-4 ($r = -.27$, $p < .001$) and the SHI ($r = -.25$, $p < .001$).

Because the number of different caretakers during childhood was statistically significantly correlated with ratings of the quality of parental care ($r = -.36$, $p < .001$) as well as scores on the PDQ-4 ($r = .23$, $p < .001$) and the SHI ($r = .17$, $p < .01$), we investigated whether the number of caretakers mediated the relationships between rated quality of parental care and scores on the measures of BPD symptomatology. Partial correlation coefficients continued to display a statistically significant relationship between the rated quality of parental care and scores on the PDQ-4 (partial $r = -.21$, $p < .001$) and the SHI (partial $r = -.20$, $p < .001$), even after controlling for number of different caretakers.

Discussion

Findings in this study indicate that individuals in an internal medicine setting with BPD symptomatology rated the quality of their parental caretaking lower than participants without these symptoms. Because the sample was not seeking treatment for mental health issues, this study is less prone to the potential biases of recall due to active major psychiatric illnesses. In addition, this observed relationship was noted with two distinct measures for BPD and results were found to be independent of the number of different caretakers experienced during childhood. Overall, findings contribute to and support the general empirical impression that individuals with BPD or BPD symptomatology perceive themselves as having had difficult childhoods, characterized by problematic caretaking by parents and/or others.

Findings in this study provide additional support for the role of parents as a potential developmental factor in the lives of patients with BPD. In keeping with various developmental theories, it is important to emphasize that the role of parents is but one of many possible contributory factors to the developmental incursions that these individuals experience. Clearly, development is the complex interaction of a number of variables, with parents being just one variable.

This study has a number of potential limitations. First and foremost, all data were self-report in nature. Therefore, the elicited information is still potentially subject to various forms of response bias. Second, both measures for the assessment

of BPD are self-report in nature and are known to be somewhat over-inclusive (i.e., they tend to generate false positives). Third, we did not control for active major psychiatric illnesses in the study population; some participants may have been experiencing acute mental illness, which may have biased their recall. Fourth, some excluded participants may have altered findings. Fifth, our assessment of participants' perceptions of parental caretaking was fairly simplistic, which was adapted because of the busy nature of the clinic in which the study took place (i.e., participants needed to complete study materials before appointments with their physicians). Although the item assessing parental quality appears to have face validity and appears to provide a reasonable global assessment of participants' perceptions, we do not have any evidence that this single item is reliable and valid. Finally, because the global nature of our query about parental caretaking does not provide clarity as to why respondents endorsed this item in a particular manner, a future study might include additional items to tease out the nature of these perceptions.

Despite the preceding potential limitations, this is one of the few studies to examine in a non-treatment-seeking population (for mental health issues) attitudes toward parents/caretakers by individuals with borderline personality symptomatology. The sample size was reasonably large, the sample was consecutive, and the measures are generally unique to this literature. As in previous studies, findings support the empirical conclusion that individuals with BPD report poor parental experiences, which appear to be independent of the number of caretakers one has experienced.

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