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Brief report

Brief report: Borderline personality symptoms and perceived caregiver criticism in adolescents

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ABSTRACT

Despite findings of an association between adolescent psychopathology and perceived parental criticism, the relation between adolescent borderline personality disorder (BPD) symptoms and perceived parental criticism has not been examined. Given the centrality of interpersonal sensitivity to BPD (relative to other forms of psychopathology), we hypothesized that adolescent BPD symptoms would be uniquely related to perceived caregiver criticism, above and beyond other forms of psychopathology and general emotion dysregulation. Adolescents (N = 109) in a residential psychiatric treatment facility completed self-report measures of BPD symptoms, perceived caregiver criticism, emotion dysregulation, and symptoms of depression, anxiety, and posttraumatic stress disorder. Results revealed a unique relation of adolescent BPD symptoms to perceived caregiver criticism, above and beyond age, gender, and other forms of psychopathology. Findings suggest that adolescent BPD symptoms may have unique relevance for adolescents' perceptions of caregivers' attitudes and behaviors, increasing the likelihood of negative perceptions.

Dysfunctional relationships are a hallmark feature of borderline personality disorder (BPD), with the caregiver–child relationship having particular significance in childhood and adolescence (Stepp et al., 2014). One aspect of the caregiver–child relationship that may be especially relevant to BPD symptoms is the parental criticism facet of familial expressed emotion (EE). Defined as family members' criticism, hostility, and/or emotional over-involvement toward an individual, the EE construct has been linked to numerous forms of psychopathology throughout development (Hooley, 2007), with the parental criticism factor in particular evidencing relations to BPD in adulthood and mood and anxiety disorders in childhood (Cheavens et al., 2005; Hooley, 2007; McCarty, Lau, Valeri, & Weisz, 2004; Silk et al., 2009). Although much of this research examines the impact of parental criticism on psychopathology, emerging research highlights a bidirectional relation between parental criticism and psychopathology (with the latter influencing both parents' actual behaviors and children's perceptions

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of parental behaviors; Hale III, Keijsers, et al., 2011; Hale III, Raaijmakers, van Hoof, & Meeus, 2011). Given evidence that perceptions of parental criticism are just as important to the caregiver–child relationship as the actual level of criticism a parent displays (Nelemans, Hale III, Branje, Hawk, & Meeus, 2013), research examining the relation of adolescent psychopathology to perceived parental criticism is needed.

BPD symptoms may be especially likely to influence perceptions of parental criticism. Specifically, given evidence of heightened interpersonal sensitivity in BPD (Stanley & Siever, 2009), adolescents with BPD symptoms (vs. other forms of psychopathology) may be particularly sensitive to criticism from their caregivers. Indeed, perceiving high levels of criticism from caregivers may be one manifestation of interpersonal sensitivity in BPD (Gunderson & Lyons-Ruth, 2008). Despite the theoretical relevance of BPD symptoms to adolescents' perceptions of parental criticism, no studies have examined this relation. This study sought to extend extant research by examining the relation of BPD symptoms to perceived caregiver criticism in a high-risk sample of adolescents in a residential psychiatric treatment facility (found to have high levels of psychopathology and relationship difficulties; Chin, Ebesutani, & Young, 2013). Given evidence of the unique role of interpersonal sensitivity in BPD (relative to other forms of psychopathology; Stanley & Siever, 2009), BPD symptoms were expected to evidence a unique relation to perceived caregiver criticism beyond other forms of psychopathology theoretically and/or empirically linked to perceived caregiver criticism or caregiver–child relationship difficulties, including depression, anxiety, posttraumatic stress disorder (PTSD), and emotion dysregulation (Han & Shaffer, 2014; Morris, Gabert-Quillen, & Delahanty, 2012; Nelemans et al., 2013).

Method

Participants

Participants were 109 adolescents in a residential psychiatric treatment facility in Mississippi. Referrals to this facility stem from unsuccessful maintenance of youth in a less restrictive level of care, often due to aggressive behaviors or chronic school failure. See Table 1 for participant demographic and diagnostic characteristics.

Procedure

All procedures were approved by the university Institutional Review Board and Facility Review Board. Parental/guardian consent and adolescent assent were obtained prior to participation (n = 5 declined participation). Participants completed questionnaires assessing baseline symptoms, family experiences, and life events. Assessments were conducted by clinical psychology interns.

Table 1
Demographic and diagnostic characteristics of adolescents.

Demographic characteristics	M (SD) or % (n)
Age	14.28 (1.38)
Gender: female	46.7% (n = 51)
Race/ethnicity	
African-American/black	56% (n = 61)
White	34.9% (n = 38)
Asian-American	0.9% (n = 1)
Other	8.3% (n = 9)
Psychiatric diagnoses[a]	
Mood disorder, NOS	34.9% (n = 38)
Oppositional defiant disorder	17.4% (n = 19)
Major depressive disorder	12.8% (n = 14)
Attention-deficit/hyperactivity disorder	9.2% (n = 10)
Bipolar disorder	7.3% (n = 8)
Depressive disorder, NOS	5.5% (n = 6)
Adjustment disorder, with mixed disturbance of mood and conduct	4.6% (n = 5)
Impulse control disorder	1.8% (n = 2)
Intermittent explosive disorder	1.8% (n = 2)
Acute stress disorder	0.9% (n = 1)
Conduct disorder	0.9% (n = 1)
Dysthymic disorder	0.9% (n = 1)
Posttraumatic stress disorder	0.9% (n = 1)
Schizophrenia	0.9% (n = 1)

Note. $N = 109$ adolescents.
[a] Primary psychiatric diagnosis assigned by the attending psychiatrist at intake.