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Parents' childhood experiences of bonding and parental psychopathology predict borderline personality disorder during adolescence in offspring

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ABSTRACT

Previous studies on borderline personality disorder (BPD) development suggest a transgenerational transmission of parent-child relationship quality, which may also be influenced by parents' mental health status. The aim of this study was twofold. First, we aimed to investigate the transgenerational effect of parental bonding experiences on the development of BPD in their offspring. Second, we examined the association between parents' mental health status and BPD in offspring. Ninety-one female adolescent psychiatric inpatients along with 87 mothers and 59 fathers were enrolled in the study. Adolescent BPD was assessed with the Structured Clinical Interview for DSM-IV-II, parental bonding with the Parental Bonding Instrument, and parents´ psychiatric symptoms with the Patient Health Questionnaire. We found that low parental care produced a transgenerational effect from mother to BPD in offspring. Further, significant associations were found between paternal psychiatric symptoms and adolescent BPD. High paternal stress levels mediated the association between maternal affect reported by fathers and BPD in daughters. There is evidence of a transgenerational effect of parental bonding specifically for female adolescents with BPD, compared with other clinical control subjects. Our findings highlight the importance of including both parents in future research and in early clinical treatment in adolescents with BPD.

1. Introduction

Borderline personality disorder (BPD) usually emerges during adolescence or early adulthood and is associated with severe impairment of psychosocial functioning and with several comorbid conditions, along with a suicide rate of about 8–10% (Chanen et al., 2008; Leichsenring et al., 2011). The core domains of BPD are marked by impulsivity and instability of relationships, affects, and self-image (American Psychiatric Association, 2013). BPD has also recently been confirmed as a valid and reliable diagnosis in patients during adolescence (Fonagy et al., 2015; Kaess et al., 2014; Miller et al., 2008).

In addition to genetic influences (Distel et al., 2008), findings from both clinical and community samples have widely highlighted the relevance of family environment as such and severe childhood maltreatment in particular for the development of BPD (Fruzzetti et al., 2005; Infurna et al., 2016; Lyons-Ruth et al., 2013; Winsper et al., 2012). According to attachment theory (Bowlby, 1983), caregivers play a key role in the development of internal models of the relational world. Therefore, parent-child bonding, representing quality of parent-child relationships and parenting, has been suggested to be an important influential factor in the pathogenesis of mental health problems (Long et al., 2015; Otowa et al., 2013; Wiggins et al., 2015). So far, several findings support the association between poor quality of parental bonding and BPD in offspring (Huang et al., 2014; Keinänen et al., 2012; Lyons-Ruth et al., 2011; Zanarini, 2000); however, in order to prevent these adverse outcomes it is important to understand the factors that may influence problematic or impaired parental bonding.

In line with the cycle of violence theory (Widom, 1989), parenting and parent-child relationships are influenced by processes of transgenerational transmission, as parents' own experiences as a child affect their nurturing practices later. The attachment theory suggests that the parents' experiences with their own parents may have led to an internal representation of their parents being responsive or, conversely, unresponsive to their needs, and this internal representation might influence the degree of responsiveness these parents are able to show toward their own children (Bowlby, 1988). Evidence from previous

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research supports the hypothesis that grandparents' harsh parenting predicts how parents function later in their own parent-child relationships (Brook et al., 2002; Conger et al., 2003; Möhler et al., 2001). Recently, this association was also confirmed for warm and supportive parenting (Belsky et al., 2005; Chen et al., 2008; Kerr et al., 2009). However, to date, research findings in this field are still controversial and incomplete; indeed, few studies have specifically examined transmission of parental bonding across generations (Miller et al., 1997; Wang et al., 2012). Additionally, to the best of our knowledge, no study has examined these associations in a sample of BPD patients or in particular in adolescent BPD patients, thus leaving the door open for further investigations.

Another important influential factor for BPD development is parents´ mental health status, an aspect also connected with the quality of parenting (Belsky and Jaffee, 2006). A large body of literature suggests that both BPD diagnoses and symptoms accumulate in families (e.g., Silverman et al., 1991; White et al., 2003; Zanarini et al., 2004). Previous studies on familial transmission of BPD have mainly focused on maternal psychopathology, suggesting an association between BPD (diagnosis or symptoms) in mothers and their offspring (Barnow et al., 2013; Reinelt et al., 2014; Schuppert et al., 2015; Whalen et al., 2014). Further studies have assessed the mental health status of both parents or close relatives of BPD patients (Belsky et al., 2012; Bradley et al., 2005; Zanarini et al., 2004), revealing a higher incidence of BPD symptoms in parents of BPD patients. To date, few studies have directly examined the mental health status of both the mother and father of BPD patients or assessed their current psychiatric symptoms (e.g., White et al., 2003).

Moreover, previous studies on BPD's antecedents were conducted mainly by comparing BPD patients with healthy controls (Lyons-Ruth et al., 2011; Paris et al., 1994; White et al., 2003); however, a negative parent-child relationship can be considered an important risk factor for the majority of adult psychiatric disorders (Stenbæk et al., 2014; Young et al., 2011). Thus, additional studies are needed to verify the specificity of perceived dysfunctional parental bonding as a risk factor for BPD.

The present study aimed to overcome these limitations by examining the association between perceived parental bonding in adolescents with BPD and their parents. Furthermore, we aimed to examine the associations between parents´ mental health status and BPD in offspring. We hypothesized that poor parental bonding reported by adolescents was related to adolescent BPD and that poor parental bonding reported by parents regarding the quality of their own upbringing was associated with BPD in their offspring. Thus, we hypothesized a transgenerational effect of impaired parental bonding affecting BPD in their offspring. Furthermore, we expected the association between parental bonding as reported by parents and BPD in offspring to be mediated by the offspring's parental bonding as well as by parents´ psychiatric symptoms.

2. Methods

2.1. Procedure and participants

The ethics committee of the Medical Faculty, University of Heidelberg, approved the study protocol. Informed and written consent was obtained from both patients and their parents. Here, 138 female adolescent inpatients were approached at the Clinic of Child and Adolescent Psychiatry at the University Hospital of Heidelberg, Germany (for further information, see Infurna et al., 2016). Among them, 7 patients were excluded due to insufficient knowledge of the German language (n=2), the presence of acute psychotic symptoms (n=3), or an IQ lower than 75 (n=2). Then, patients and both their mothers and fathers were invited to participate in the study and they were included if the patient and at least one parent were willing to participate: 92.31% of mothers took part in our study, whereas 64.84% of fathers took part in the study. Estimation biases due to a potential systematic drop out for fathers were tested. No significant mean differences were found in regard to BPD symptoms between adolescents whose fathers participated in our study and those not having a father or whose fathers were not willing to participate. The final sample comprised 91 female adolescents (M_{age}=15.57 years; SD=1.36), 87 mothers (M_{age}=46.22 years; SD=5.50), and 59 fathers (M_{age}=49.15 years; SD=5.10). Overall, 83 (95.40%) biological mothers, 53 (89.83%) biological fathers, 2 (2.11%) stepfathers, 3 (3.45%) adoptive mothers, 4 (6.78%) adoptive fathers, and 1 foster mother (1.15%) participated in our study. Adolescents reported the parental bonding of the parent they conceived to be the main mother or father figure. At the time of the assessment, fifty-three adolescents (58.2%) were living with both their parents, 28 (30.8%) only with their mother, 3 (3.3%) only with their fathers, and 7 (7.7%) in the context of a residential child and youth service.

Diagnosis of BPD in inpatients was verified by experienced clinicians using structured interviews. Participants were included in the BPD group if they fulfilled at least five diagnostic criteria of BPD according to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV; APA, 1994). Forty-four patients (48.4%) met the BPD criteria (BPD group), while 47 patients (51.6%) did not meet DSM-IV criteria for BPD (clinical control group–CC group). The mean number of diagnoses in adolescent patients with BPD was significantly higher (t_{89}=−3.651, p= < 0.001) than in the CC group. The most prevalent comorbid psychiatric conditions diagnosed in the BPD group included: behavioral and emotional disorders with onset usually occurring in childhood and adolescence (F9; e.g. depressive conduct disorder); neurotic, stress-related and somatoform disorders (F4; e.g. adjustment disorders) and affective disorders (F3; e.g. moderate depressive episode). Predominant psychiatric diagnoses in the CC group were: neurotic, stress-related and somatoform disorders (F4) and affective disorders (F3). The CC group presented a significant higher number ($p < 0.05$) of neurotic, stress-related and somatoform disorders diagnoses (F4) than the BPD group. As set by the inclusion criteria, no personality disorder was found in the CC group. Additional information about the diagnostic criteria for BPD and clinical Axis-I diagnoses in both groups are given elsewhere (Infurna et al., 2016).

2.2. Assessment measure

BPD was assessed by experienced clinical psychologists and child psychiatrists in the field of adolescent BPD, using the German version (Fydrich et al., 1997) of the Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II; First et al., 1997). Assessors were rigorously trained and have previously demonstrated excellent interrater reliability of Cohen's kappa of 1.00 (Kaess et al., 2013). Other clinical diagnoses according to the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10), diagnostic criteria were ascertained by a well-established procedure of consensus between two child psychiatrists.

The German version (Richter-Appelt et al., 2004) of the Parental Bonding Instrument (PBI; Parker et al., 1979) was used to retrospectively assess two theoretically and empirically derived dimensions of parental bonding: parental affection and parental control. Each participant responded to the questionnaire twice on a 4-point Likert scale (0–3), once to describe the mother's care and protection and again to describe that of the father. The 12 items on the care subscale allow for a maximum score of 36, indicating parental affection, understanding, closeness, and emotional support, and a minimum score of 0, indicating parental coldness, indifference, and emotional rejection. On the overprotection subscale, a maximum score of 39 is indicative of parental intrusiveness, control, and prevention of independent behavior, while a minimum score of 0 suggests encouragement of autonomy and independence. In this study, the PBI was administered to both patients and their parents.

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