

**Associations between Parent/Child Borderline Personality Disorder and Parent-  
Child Reporting of Offspring Suicidality**

by

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Suicidality reporting discrepancies between parents and children are often related to various forms of psychopathology. The prevalence of suicidality reporting discrepancy highlights the need for more research in this area. Within the suicidality reporting discrepancy context, borderline personality disorder (BPD) remains unexplored. BPD is a severe personality disorder with high suicide rates and multiple features that may impact accurate symptom disclosure. This project explored the relationship between parent/child borderline personality disorder symptom severity and reporting discrepancies. Parent-child dyads were categorized into discrepant or concordant groups based on endorsement or denial of the child's suicidality. Parents were interviewed about their children's suicidality symptoms and their own symptoms of BPD, and children were interviewed separately regarding their own suicidality and BPD symptoms. Once dyads were categorized, we ran a logistic regression using generalized linear models to see how parent and child BPD symptom severity related to discrepancy. As expected, both parent and child BPD symptom severity were positively correlated with discrepancy, and parent thoughts of dying was a covariate. Unexpectedly, the relationship between parent BPD symptoms and discrepancy did not hold when ran together with child BPD symptoms in the same model, suggesting that the children's symptoms may be more influential. Our findings support the pattern of psychopathology

related to suicidality reporting discrepancy and highlight the role of the child in symptom disclosure. Clinical and future research implications are addressed.

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## 1.0 Introduction

Acquiring accurate information about adolescents' suicidality, which includes suicidal thoughts and behaviors, is essential to their treatment. Parents and children, however, often disagree in their reporting of this information, having implications for both the parent and child. One immediate consequence of these discrepancies is the incorrect understanding of the adolescent's suicidality. If adolescents are perceived as at risk for suicide when they are not, this may lead to the adolescents receiving costly, unnecessary care. Further, this perceived risk may lead to violations of confidentiality, which may lead to more harm than good; the adolescent may lack trust in future mental health providers and show reluctance to access care (Helms & Prinstein, 2014). Conversely, the incorrect denial of suicidality may limit access to and use of potentially life-saving care. The American Academy of Child and Adolescent Psychiatry (AACAP) ranks suicide as the second leading cause of death amongst adolescents, and notes that this often occurs in conjunction with a serious mental health disorder (AACAP, 2017). Despite existing guidelines encouraging multi-informant approaches (AACAP, 2007; Lewis et al., 2014), guidelines do not discuss discrepancies, their predictors, their meaning, and how to deal with them. Erroneous interpretation of symptoms is not the only concern regarding parent-child discrepancies, however. Previous research has indicated numerous negative outcomes associated with discrepant reporting, including both parent and child psychopathology. This prior research has motivated the present study's aim to understand additional nuances of parent-child discrepancies as they relate to suicidality. The goal of the current study is to determine how these discrepancies relate to BPD symptoms in parents and children, since BPD symptoms may influence accurate symptom disclosure.



## 1.1 Parent-Child Reporting Discrepancies

Previous research has revealed the frequency of discrepant reporting of mental health symptoms between caregivers and children. For example, Yeh and Weisz (2001) showed that over 60% of their 381 parent-child dyads did not agree on any problems concerning the child. These discrepancies have been shown to occur frequently when gathering parent-child reports on the child's depression and suicidality (Jones et al., 2019; Kiss et al., 2007; Klaus, Mobilio, & King, 2009; Lauth et al., 2010; Lewis et al., 2014; Walker, Moreau, & Weissman, 1990). In most cases, researchers determine concordance between parents and children by examining correlations of dimensional measures of symptoms (Ferdinand, Van, & Verhulst, 2004; Lewis et al., 2014; Grills & Ollendick, 2003; Jones et al. 2019; Klaus, Mobilio, & King, 2009; Kiss et al., 2007; Lauth et al., 2010), with few studies determining discrepant/concordant reports through alignment of symptom disclosure or denial (Panichelli-Mindel, Flannery-Schroeder, Callahan, & Kendall, 1995; Walker, Moreau, & Weissman, 1990).

Unfortunately, the problem with these discrepancies does not lie with inaccuracy alone. Dyads in which parents disagree with their children in their reporting are much more likely to experience other forms of adversity, such as parental mental health problems. In a sample of parent-child dyads where the child reported at least one suicide attempt, maternal denial of the child's suicide attempt was associated with a personal history of suicide attempts among mothers (Walker et al., 1990). In another study, maternal affective symptoms, anxiety, and depression also positively related to discrepancies with teachers and daughters on reports of the children's symptoms (Briggs-Gowan, Carter, & Schwab-Stone, 1996). These results are not limited to maternal symptoms; in studies with mothers and fathers, the psychological symptoms of both parents have been found to positively correlate with informant-child disagreement (Jensen,

Traylor, Xenakis, & Davis, 1988; Treutler & Epkins, 2003). Previous discrepancy research has shown that depressive symptoms in parents are commonly associated with various parent-child reporting discrepancies. Although some studies look at discrepancies in general, there is some specific evidence to support that over-reporting of youth symptoms is associated with maternal symptoms, relative to under-reporting of youth symptoms. Anxious mothers showed a greater tendency to overreport their child's anxiety (Frick, Silverthorn, & Evans, 1994). Overreporting from mothers of children's depressive symptoms has also been found to be predicted by maternal depression (Kiss et al., 2007). The relationship between parental symptoms and the reporting of children's symptoms supports the need for understanding the symptoms, experiences, and dynamics of other family members. This understanding is important to appropriately assess and then treat a child with mental health problems.

Despite some evidence showing that maternal anxiety and depression are commonly associated with discrepancy, there remains conflicting results in the literature. A review by Richters (1992) examined 22 studies assessing the maternal depression and discrepancy relationship. Based on the author's set of standards, none of the examined studies demonstrated this relationship (Richters, 1992). Since this review, there has been literature suggesting the existence of this relationship, highlighting the need for more work. In addition to the maternal depression discrepancy model, Kolko and Kazdin (1993) found that parent-child discrepancies were associated with three factors: family stress, parental dysfunction, and low acceptance of the child. Parental depression was one of many factors that made up the parental dysfunction rating, but it was not shown to be an individual correlate with discrepancy (Kolko & Kazdin, 1993). Although the replication of the relationship between parental depression and discrepancies is

important for validation, considering other common contributors to parent-child discrepancies may provide an increased understanding of the scope of factors that influence reporting disagreement.

Various demographic characteristics have also been associated with parent-child discrepancies. Some of the recurring variables investigated in previous research include adolescent age, gender, race, and history of adolescent psychopathology. In one study, older adolescents and those with a history of psychopathology were more likely to agree with parents on levels of suicidal thoughts, whereas racial minority parent-child dyads were more likely to disagree (Jones et al., 2019). Adolescent gender also moderated the relationship between maternal psychopathology and discrepancy in another study; mother-son discrepancies were associated with maternal psychopathology but not mother-daughter discrepancies (Jensen et al., 1988). In the same study, the impact of fathers' psychopathologies in relation to discrepancy in reporting children's symptoms, however, did not differ by child gender (Jensen et al., 1988). Knowing which groups or dyads are most at risk of discrepancy based on demographics is useful for consideration from mental health providers.

In addition to the clinical implications of conflicting information reported by parents and children, parent-child discrepancies themselves predict worse outcomes for children over time. Although the longitudinal studies on this issue are limited, the available research conveys the problematic nature of these discrepancies. One study focused on discrepancies about emotional and behavioral issues: greater discrepancies predicted more negative outcomes four years later, such as suicide attempts and self-harm (Ferdinand, Van, & Verhulst, 2004). Additionally, children in treatment who disagreed with their parents about their own anxiety symptoms had less improvement (Panichelli-Mindel et al., 1995). Negative outcomes from discrepancies may be related to the fact that discrepancy is related to family conflict (Grills & Ollendick, 2003). This

association highlights how parent and child factors impact each other, with influences on discrepancy and negative outcomes that can occur related to discrepancies. These findings highlight the need for mental health providers to consider family context when working with adolescent clients.

## **1.2 Family Environment and Borderline Personality Disorder**

Mental health problems in parents are related to discrepancies in reporting their children's symptoms. This relationship is important to understand because family factors play an important role in treatment of adolescent psychopathology and suicidality, and family functioning and behaviors can be influenced by parental psychopathology. For instance, family cohesion was found to be negatively associated with adolescent suicidality, while family conflict was positively associated (Miller, McCullough, & Johnson, 2012). In addition to direct correlates, evidence suggests parental behavior moderates the relationship between bullying and suicide. For example, parental social support has been found to protect against externalizing distress from bullying (Jantzer, Haffner, & Parzer, 2015), and parental monitoring has been shown to predict less suicidal behavior among adolescents who have been bullied (Davidson & Demaray, 2007). These relationships may be explained by the multidirectional influences within families.

The intricate web of family qualities that correlate with mental health is relevant, more specifically, to personality disorders. BPD is the personality disorder of interest in the current study. Examining BPD in relation to parent-child discrepancy is justified due to the social cognitive implications. Previous work has shown that both mentalization, defined as “the ability to understand the behavior of others in terms of mental states” (Beeney et al., 2016) and self-other

boundaries mediated the correlation between attachment anxiety and BPD symptoms (Beeney et al., 2016). These deficits in social cognition are important in a discrepancy context because perpetual misunderstanding and feelings of separation within families may influence accurate symptom disclosure from parents and children. Given that BPD tends to cluster within families (Lis, Greenfield, Henry, Guilé, & Dougherty, 2007; White, Gunderson, Zanarini, & Hudson, 2003), parents and children may be more at risk of misrepresentation and/or withholding symptoms. Compared to the general population, immediate family members of individuals suffering from BPD are much more likely to develop the disorder (White et al., 2003). Also, genetic components have been shown to differ between individuals with BPD and those without (Lis et al. 2007), which further supports the clustering of BPD within families. BPD connections within families suggest that offspring of parents with BPD are at risk. This risk is important to consider due to the poorer outcomes for adolescents with BPD in all examined developmental domains (Wright, Zalewski, Hallquist, Hipwell, & Stepp, 2016).

The severity of BPD also highlights the need for exploring familial influences applying to this disorder. The suicide completion rate for people suffering from BPD is nearly 50 times higher than the general population (Holm & Severinsson, 2011). The BPD-suicide association also holds for adolescents, with BPD symptoms predicting suicidality six months later (Greenfield, et al., 2008). The suicide mortality rate for individuals suffering from BPD is also a major concern. One study indicated an 8.5% suicide mortality rate among their sample of patients diagnosed with BPD (Paris, 1990). Also, a review has shown that 10% of all BPD patients die by suicide, which is among the highest mortality rates of mental disorders (Jopling, Khalid-Khan, Chandrakumar, & Segal, 2018). Suicidal behavior can also cluster within families. Several studies have provided evidence of familial transmission of suicidality; for instance, youth suicidal behavior can be

predicted by primary caregiver suicidal behavior (Brent et al., 2015; Brodsky et al., 2008; Mann et al., 2016; Melhem et al., 2007). Moreover, this familial transmission of suicidality has been shown to persist even after controlling for other variables related to suicide, such as other mental health problems (Brent et al., 2008; Brent et al., 2015). Despite the personality disorder definition of BPD, which implies its symptoms to be stable, recent findings suggest similar instability and mutability of BPD as compared to depression over the course of seven years (Conway, Hipwell, & Stepp, 2017). The fact that persistence of BPD symptoms during adolescence is associated with severe impairment and failure to meet important developmental milestones suggests that it is an important period to intervene and address BPD symptoms, including suicidality (Winograd, Cohen, & Chen, 2008). The changing family dynamics and relationships during adolescence may also impact reporting discrepancies, making this period an ideal time to study.

An understanding of parent practices may help clarify familial transmission of suicidal behavior and BPD in addition to parent-child discrepancies. Both parenting style and adolescent BPD trajectories have reciprocal relationships over time (Stepp et al., 2014). Parenting practices that may be specific to mothers with BPD, such as exhibiting fluctuations from an aggressively controlling parent to a withdrawn state (Stepp, Whalen, Pilkonis, Hipwell, & Levine, 2012), may have profound implications on family interaction. The link between parent and child mental health must be considered generally and within the context of BPD prior to exploring discrepancies and BPD. Parent BPD may contribute to discrepancies or problems in identifying their children's suicidality due to the substantial distress and impairment that comes with BPD (Ansell, Sanislow, McGlashan, & Grilo, 2007). Communication interference may also impact the prevalence of discrepancies. Parents with BPD may have experienced emotionally dismissive households (Prairie, 2004), and are more likely to assert psychological control over their offspring (Mahan,

Kors, Simmons, & Macfie, 2018; Zalewski et al., 2014), defined as “control that constrains, invalidates, and manipulates children’s psychological and emotional experience and expression” (Barber, 1996, p. 3296). These findings are consistent with the invalidating environment associated with the development of BPD, which has been defined as the “delegitimizing of a child’s valid emotional experience or expression” (Musser, Zalewski, Stepp, & Lewis, 2018, p. 3). If a child feels invalidated by psychologically controlling parents, then there may be a high risk of inaccurate disclosure of symptoms from both parent and child. The parent may feel that the valid symptoms are not worth reporting, and the child may have learned to invalidate their own symptomology (Musser, Zalewski, Stepp, & Lewis, 2018). Misunderstandings between parents and children can contribute to multiple negative outcomes, including a lack of treatment.

### **1.3 Current Study**

Our project will examine how parent BPD symptoms and child BPD symptoms relate to parent-child reporting discrepancies regarding the child’s suicidality. This examination will involve analysis of previously collected data on 161 parent-child dyads from the Emotional and Personality Development in Youth (MoodY) study. Children were privately interviewed about their own mental health and suicidality, while parents were interviewed separately about their child’s mental health, their child’s suicidality, and their own symptoms of BPD. Dyads will be categorized into discrepant or concordant groups based on the nature of their reporting of child suicidality. Once dyads were categorized, we ran a logistic regression using a generalized linear model to see if these groups differ in parent and child BPD symptoms.

The data from the MoodY study will fill in some gaps within discrepancy research. To our knowledge, the current project will be the first to look at parent BPD symptoms in relation to parent-child discrepancies related to any mental health outcome. Given the high suicide risk associated with BPD, the impacts parental BPD symptoms have on family functioning, and the fact that BPD and suicidality cluster within families, understanding how parent BPD influences discrepancies in parent-child reporting of child suicidality is important.

Previous research has informed the following hypotheses:

- 1) Disagreement between parents and children about the children's suicidality will be related to higher BPD symptom severity in both the parents and the children. This hypothesis stems from the bodies of research showing parent and child psychopathology associated with discrepancies about the child's symptoms. Although BPD symptoms have not been looked at within the discrepancy context, these trends will likely generalize since suicidality disagreement is common.
- 2) Parent BPD symptom severity will show a stronger relationship with discrepancy than child BPD symptom severity. BPD is associated with parenting practices that could increase discrepancy rates, such as psychological control. Although controlling parents may seem as if they would have a better understanding of their children's symptoms, Mahan et al. (2018) note that parental intrusion is most often manipulative and conducive to invalidation. Invalidation of the child's experiences may increase the likelihood of discrepancy and may suggest enhanced parent BPD symptoms.



## **2.0 Method**

### **2.1 Participants**

For the current project, a subset of data from the MoodY study will be used for our analysis ( $N = 165$ ). The MoodY study is a longitudinal investigation of affective instability, a core feature of BPD, among youth. To participate, youth and their primary caregiver were first screened for eligibility. Adolescents were required to be aged 11-13 and receiving either mental health treatment, behavioral health treatment, or medication for mental health at the time of screening. Also, adolescents were required to show evidence of elevated affective instability and BPD symptoms. The measures for these constructs were the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD; Zanarini et al., 2003) and the Personality Assessment Inventory Affective Instability Subscale (PAI; Morey, 2014). Based on responses from the child's caregiver, a score of 5-10 for the MSI-BPD and 12-18 for the PAI Affective Instability Subscale were required for eligibility. Eligible child-caregiver dyads were invited to participate in three waves of data collection at baseline, 9-month, and 18-month follow-up assessments. Dyads were assessed via diagnostic interviews, behavioral interaction tasks with electrodes measuring psychophysiological data, and self-report questionnaires. All caregivers gave informed consent, and adolescents gave informed assent. Dyads were compensated for their participation at each wave. This project was conducted following IRB protocol (IRB PRO#: 14030244).

The data that will be analyzed for the current project were collected at baseline sessions of the MoodY study. Caregivers were not specifically recruited because of a BPD diagnosis. Considering that adolescents were recruited based on BPD symptoms, especially affective

instability, and that BPD can run in families, we can expect that caregivers will likely exhibit a range of BPD symptoms. Thus, all caregivers will be included, and BPD will be measured dimensionally. Parent and child BPD symptom severity scores included all BPD items except for the suicidality and self-harm items. Our dimensional approach is justified because multiple criteria for BPD acted as individual predictors of suicidal behavior, including affective instability, identity disturbance, and impulsivity (Yen et al., 2004).

38% of adolescents were 13 years old ( $M = 12.03$ ,  $SD = 0.92$ ), and the caregivers' ages were more variable ( $M = 39.84$ ,  $SD = 7.25$ ). Among adolescents, male representation (53%) was slightly higher than female representation (47%). Caregivers were almost entirely female (93%). Nearly all caregivers (98%) and adolescents (96%) identified as non-Hispanic or Latino. Racial representation amongst youth included mostly white (42%) and black/African American (41%) participants, and about 17% of adolescents were biracial. Over half of the caregivers identified as white (53%) with about 40% identifying as black/African American. Almost all caregivers were biological parents (94%).

## 2.2 Measures

Separate interviews were conducted for each parent and child. Although each interview contained multiple items, the current project will only focus on the following measures: adolescents' reports on their own suicidality, parents' reports on their child's suicidality, parents' reports of their own BPD symptoms, and children's reports of their own BPD symptoms. Each interview asked informants about symptoms within the past few years, and the self-report

questionnaire focused on symptoms within the past few weeks. Dyads were ensured confidentiality barring any immediate risk to either participant's well-being.

### **2.2.1 Childhood Interview for DSM-IV Borderline Personality Disorder (CI-BPD)**

Previous research has validated the use of the CI-BPD for adolescent samples (Sharp, Ha, Michonski, Venta, & Carbone, 2012). This interview is used to assess BPD symptoms in adolescents (Zanarini, 2003). The severity score of child BPD symptoms in this interview will be used as the measure for child BPD symptoms. Data gathered from item seven in this interview will also be used for analysis in the current project. This item focuses on adolescent nonsuicidal self-injury (NSSI) and suicidality. A score of 0 for this item indicates that the symptom is not present, a 1 indicates the presence of suicidality (including NSSI) that is subthreshold as a symptom of BPD, and 2 indicates that the threshold has been met for a symptom of BPD.

The consideration of NSSI as an indicator of adolescent suicidality in the current project is justified by previous research. A review of findings suggests a strong relationship between NSSI and suicide risk in adolescents (Lofthouse & Yager-Schweller, 2009). Since NSSI is a risk factor for adolescent suicidality, our project will consider reports of NSSI when determining whether participants report or deny the adolescents' suicidality.

### **2.2.2 Structured Interview for DSM-IV Personality (SIDP)**

This measurement assesses parent BPD symptoms (Pfohl, Blum, & Zimmerman, 1997). Although this semistructured interview assesses multiple personality disorders, the MoodY study

only collected data from the BPD items. Scoring for this interview is based on a 4-point scale: 0 indicates that symptoms are not present, 1 indicates subthreshold symptoms, 2 indicates threshold symptoms, and 3 indicates a strong presence of threshold symptoms. The SIDP has been shown to be valid and reliable in psychiatric patient and non-clinical samples (Jane, Pagan, Turkheimer, Fiedler, & Oltmanns, 2006; Pilkonis, Heape, Proietti, Clark, & McDavid, 1995). The parent BPD symptom severity scores collected from this interview will show relationships between these symptoms and parent-child reporting discrepancies.

### **2.2.3 Symptom Checklist 90 Revised (SCL-90-R)**

Validated by Sereda & Dembitskyi (2016), the SCL-90-R assessed parent psychological symptoms via self-report in the MoodY Study (Derogatis & Savitz, 1999). The parent suicidality items were used for the current project, including parent thoughts of death and thoughts of ending own life. These items were analyzed as covariates in relation to parent-child discrepancy since maternal suicidality has been shown to be associated with parent-child discrepancy about the child's suicidality (Walker et al., 1990).

### 3.0 Results

Categorization of the data produced 127 concordant and 34 discrepant dyads. Initially, dyads were categorized into one of four groups based on the direction of their discrepancy or concordance (i.e. parent overreport, parent underreport, concordant yes, or concordant no). These groups did not have a large enough sample in some of the groups to be representative ( $n < 15$ ). Instead of the four groups, dyads were collapsed into their respective discrepant or concordant group. With improved representation of discrepant dyads, a logistic regression using generalized linear models revealed the relationship between discrepancy and parent/child BPD symptom severity. We ran four models, each controlling for the child's age and household income: child BPD symptom severity and discrepancy, parent BPD symptom severity and discrepancy, parent thoughts of dying and discrepancy, and a combination model of parent and child BPD symptom severity as they relate to discrepancy. Annual household income was a categorical variable measured on a scale from 1-7 (1 = less than \$20,000; 2 = \$20,000-\$39,000; 3 = \$40,000-\$59,000; 4 = \$60,000-\$79,000; 5 = \$80,000-\$99,000; 6 = \$100,000-\$119,000; 7 = above \$120,000). Other demographic covariates were dropped from the models because they did not show initial correlations with discrepancy. A chi square analysis revealed that child gender and child race were independent of discrepancy ( $p > .05$ ) and were also dropped from the models.

Out of the 127 concordant dyads, 31 consisted of families in which both the parent and child endorsed the child's suicidality, and 91 dyads agreed on their denial of the suicidality symptoms. The concordant dyads included 61 female adolescents and 66 male adolescents. 79 of the adolescents in concordant dyads identified as a racial minority. The age distribution for concordant dyads consisted of 35 11-year-olds, 41 12-year-olds, and 51 13-year-olds. Within the 34 discrepant

dyads, 13 were comprised of an adolescent endorsement and parent denial of the adolescents' suicidality symptoms, whereas 21 dyads involved a parent endorsement and an adolescent denial. There were 15 female and 19 male adolescents in the discrepant sample, and 18 adolescents within this sample identified as a racial minority. The age distribution for discrepant dyads included 16 11-year-olds, eight 12-year-olds, and 10 13-year-olds.

### 3.1 Model 1

This model aimed to address our hypothesis stating that children with higher symptom severity scores are more likely to disagree with their parents about the children's suicidality symptoms. Consistent with our hypothesis, parent-child discrepancy about the child's suicidality symptoms was significantly related to child BPD symptom severity,  $est. = .20, s.e. = .05, df = 150, p < .001$ . Child BPD symptom severity was positively associated with parent-child discrepancy; for every unit increase in child BPD symptom severity, there was a .20 log odds increase in chances of being discrepant. The child's age was negatively associated with discrepancy in this model,  $est. = -.59, s.e. = .23, df = 150, p < .05$ , but income was not significantly related to discrepancy.

### 3.2 Model 2

We also expected that parents with higher BPD symptom severity scores would be more likely to disagree with their children. Our hypothesis was confirmed in analysis; parent-child discrepancy was significantly related to parent BPD symptom severity,  $est. = .23, s.e. = .10, df = 150, p < .05$ . This positive association showed that for every unit increase in parent BPD symptom severity, there was a .23 log odds increase in chances of a discrepant dyad. Like the previous model, the child's age was negatively associated with discrepancy,  $est. = -.49, s.e. = .22, df = 150, p < .05$ . The relationship between income and discrepancy was non-significant.

### 3.3 Model 3

Our third model assessed the covariate of parent suicidality as it relates to discrepancy. We expected that both parent thoughts of dying and parent thoughts of ending own life would be related to discrepancy. Parent thoughts of ending life did not show an initial correlation with discrepancy, so we did not include it in the model. Parent thoughts of dying, however, was significantly correlated with discrepancy,  $est. = .56, s.e. = .25, df = 137, p < .05$ . Every unit increase in parent thoughts of dying occurred alongside a .56 log odds increase in chances of being discrepant. The child's age and income were not significantly related to discrepancy in this model.

### 3.4 Model 4

The final model referred to our hypotheses inferring that parent BPD symptoms will be more strongly related to discrepancy than child BPD symptoms. In this model, both parent and child BPD symptoms are independent variables with discrepancy as the dependent variable. Unexpectedly, the child's BPD symptoms were highly correlated with discrepancy,  $est. = .19$ ,  $s.e. = .06$ ,  $df = 149$ ,  $p < .001$ . For every unit increase in child BPD symptom severity, there was a .19 log odds increase in chances of a discrepant dyad. Conversely, parent BPD symptom severity showed a non-significant relationship with discrepancy in this model. Also, the child's age was negatively correlated with discrepancy,  $est. = -.58$ ,  $s.e. = .23$ ,  $df = 149$ ,  $p < .05$ , but income was not significantly related to discrepancy.



## 4.0 Discussion

This study aimed to increase our understanding of when families are more likely to disagree about an adolescent's suicidality symptoms. Using data collected from parent-child dyads interviewed separately, we categorized dyads into concordant or discrepant groups. This categorization was followed by statistical analysis showing that both parents and children with higher BPD symptom severity were more likely to disagree, and children's BPD symptoms showed a stronger relationship with discrepancy than the parents' symptoms.

We were interested in whether BPD symptoms would be associated with greater discrepancy between parents and children in terms of the children's suicidal thoughts and behaviors. Our first of three main findings coincide with our expectations: parents with higher BPD symptom severity are more likely to disagree with their children regarding their children's suicidal thoughts and behaviors. This finding aligns with the notion of previous research: various parent symptoms are related to discrepancy, especially regarding the child's suicidality (Jones et al., 2019; Kiss et al., 2007; Klaus et al., 2009; Lauth et al., 2010; Lewis et al., 2014; Walker et al., 1990). While aligning with the patterns of previous literature, this finding also fills the gap highlighting how BPD fits within the discrepancy context. Our study diverges in methodology from most the previous research indicating parents' symptoms related to discrepancy. Instead of observed reporting differences utilized by Walker et al. (1990) and the current study, most literature incorporated dimensional measures of agreement (Jones et al., 2019; Kiss et al., 2007; Klaus et al., 2009; Lauth et al., 2010; Lewis et al., 2014). One explanation for the parent's BPD symptoms as they relate to discrepancy is that parents with more severe BPD may be more likely to invalidate their children's experiences (Mahan, Kors, Simmons, & Macfie, 2018; Zalewski et

al., 2014). In the context of our study, parents may disregard their children's disclosure of suicidality as if their symptoms were not real or meaningful. Invalidation in households may make children less likely to disclose their symptoms to parents. Consequently, children may report their symptoms in benign clinical settings, and parents may not know the full extent of their children's symptoms. Moreover, parents would likely underreport their children's symptoms if they tend to invalidate their children's experiences.

Our interest in BPD symptoms as they relate to discrepancy also led us to investigate the relationship between the child's BPD symptoms and disagreement. We found that children with higher BPD symptom severity are more likely to disagree with their parents, which also supports our hypothesis. In addition to parent symptoms, prior work has shown that children's symptoms commonly relate to discrepancies (Ferdinand et al., 2004; Panichelli-Mindel et al., 1995). The critical difference between our findings and the results of previous research is the type of relationship: Ferdinand et al. (2004) and Panichelli-Mindel et. al (1995) have shown discrepancy as a predictor of negative outcomes, whereas our project shows a correlation between the adolescents' BPD symptoms and discrepancy. Experiencing or witnessing past invalidation by parents may teach children to invalidate their own experiences or be fearful to disclose symptoms even in clinical settings. Either scenario may increase discrepancy rates. Conversely, a history of invalidated experiences may lead to overcompensation from children through attention seeking behaviors to satisfy a potential craving for feedback. This overcompensation may manifest as an overreport of the child's own symptoms during an interview. Attachment styles of children may also influence symptom disclosure. Adults suffering from BPD show more fearful and preoccupied attachment (Choi-Kain et al., 2009). Although this study used an adult sample, children's disclosure tendencies may be influenced based on their attachment style. Also, a meta-analysis

indicates that anxious-ambivalent attachment styles change more over time than secure and disorganized attachment styles (Vice, 2004). Children with higher BPD symptom severity and fearful attachment may underreport their symptoms if their attachment style leads them to believe that they are unworthy of support. Conversely, children who show preoccupied attachment may overreport their symptoms to maintain the inconsistent attention shown by their caregivers.

Because parent suicidality has been shown to correlate with discrepancy (Walker et al., 1990), we tested parent thoughts of dying as a covariate with discrepancy. The third major finding indicates that parents who think about death are more likely to disagree with their children. This result supports our hypothesis since parents with higher BPD symptom severity show higher risk of reporting discrepancies, and suicidal thoughts and behaviors are symptoms of BPD. Extending the findings of Walker et al. (1990), illustrating that mothers showed elevated suicide attempts when they disagreed with their children, our result also shows parental suicidality associated with discrepancy in a BPD context. A characteristic of BPD that may explain this finding is the projection of victims' internal states, such as motives and affective states, onto others (Weston, 1991). Perhaps parents with more thoughts of dying and high BPD symptom severity are more likely to project their own suicidality to their children. This projection may lead to a discrepant parent overreport.

Believing that parents' BPD symptoms would relate more strongly to discrepancy than the children's BPD symptoms, we compared the two relationships. The final finding diverges from our hypothesis. When entering both parent and adolescent BPD symptoms into the same model, only adolescent BPD symptom severity explained unique variance in discrepancy. The literature has shown that children are at a higher risk of psychopathology when their parents suffer from BPD, including BPD itself and impulse control disorders (Weiss et al., 1996). Parenting practices

among mothers with BPD often include psychologically controlling and manipulative behavior as well as inconsistent involvement (Bezirgianian, Cohen, & Brook, 1993; Mahan et al., 2018; Stepp et al., 2012; Zalewski et al., 2014). These parenting practices may impede various developmental milestones in offspring (Macfie, 2009). Parental control and manipulation may increase the likelihood of discrepancy, since this behavior may prevent parents from realizing their children's symptoms. Because of the large body of literature discussing the implications of BPD on parenting, which include practices that may elicit discrepancies, we assumed that parents' BPD symptom severity would show a stronger correlation with discrepancy. This finding may be explained by the fact that children, not parents, were recruited based on symptoms of BPD. Although parents did show meaningful BPD symptoms, this sample of children may have symptoms that influence family functioning more than their parents. Also, previous research has shown the reciprocity between adolescent BPD trajectories and parenting styles, highlighting the bidirectional relationship between adolescent BPD symptoms and harsh punishment and low warmth from parents (Stepp et al., 2014). Additionally, child temperament can exacerbate parenting practices associated with BPD (Zalewski et al., 2014). This research supports that adolescents with BPD play an active role within families, which may broaden to symptom reporting contexts.

Related projects should address our limitations. Initial screenings regarding the child's suicidality may increase the sample of discrepant dyads, which may also increase representation of the different types of discrepancy. Previous research has been somewhat unclear about common discrepancy patterns. For example, some studies have shown the trend of parents underreporting their children's suicidality (Klaus et al., 2009; Lewis et al., 2014; Walker et al., 1990). For depression reporting, mothers have been shown to overreport their children's symptoms (Kiss et al., 2007). On the contrary, one study found no trend indicating which direction the parent or child

tend to report despite finding that child suicidality discrepancies were among the most common (Lauth et al., 2010). Separate agreement measures for suicidal thoughts and behaviors should also be incorporated into future projects. Meaningful differences between suicidal thought discrepancies and behavior discrepancies would show which groups are more at risk and guide intervention. In addition, agreement scores would more accurately operationalize discrepant dyads, strengthening the validity of the correlation between those scores and BPD symptoms. Although there is not a standardized method for measuring discrepancies, many projects have used dimensional measures with kappa statistics (Grills & Ollendick, 2003; Jones et al., 2019; Klaus et al., 2009; Lewis et al., 2014). Also, recent work suggests the use of latent difference score modeling, arguing that it provides more flexible measures of discrepancy (de Haan, Prinzie, Sentse, & Jongerling, 2018). Addressing the correlational weaknesses of our study, future projects should consider longitudinal methods to potentially establish BPD as a predictor of discrepancy over time.

Gender differences should also continue to be explored in future discrepancy work. Our results finding no differences in disclosure tendencies between adolescent males and females appear to align with previous studies. De and Kazdin (2005) indicate no developing trends of reporting differences, but school and community samples have had mixed results with adolescent gender as it relates to discrepancy. Despite the lack of trends, there is little research on BPD and discrepancy in suicidality, so gender differences are worth continued investigation. One study theorized that gendered expectation may make boys less likely to disclose symptoms and found that both boys and girls felt they should react stoically and independently to their experiences of symptoms (MacLean, Sweeting, & Hunt, 2010). These reactions may make adolescents less inclined to disclose symptoms if they feel pressured to take matters in their own hands. Gendered

stereotypes, especially traditional masculinity emphasizing stoicism, may exacerbate pressures to conceal symptoms. Identification of the potential pressures will help clinicians better understand which adolescents may be more at risk and fight stigma surrounding help seeking through symptom disclosure.

Since the children's BPD symptom severity was more strongly correlated with discrepancy than the parents' symptoms, other factors associated with the children's BPD symptoms should be considered in future research. Namely, adolescents' attachment styles as they relate to BPD may also influence disclosure patterns. Focusing on attachment style may help explain why the children's symptoms seem to matter more. Even if other projects replicate the greater significance of the children's BPD symptoms, parenting factors should not be ignored. Parents and children should be asked whether any type of invalidation of the child's symptoms has occurred. Showing whether invalidation is predictive of discrepancy is critical for clinical intervention and preventative efforts.

#### **4.1 Clinical Implications**

Our findings illustrate that dyads in which at least one member demonstrates meaningful BPD symptoms may require more proactive intervention and education. Clinicians should also learn more about the specific risks of discrepancy, helping them understand when to take preventative measures. Additionally, guidelines may need to specifically address optimal approaches for dealing with discrepant dyads. The commonality of suicidality discrepancies makes these guidelines warranted, and they should include supplemental information regarding the

related symptoms. For instance, there may be key distinctions between treatment of depression related to discrepancy and BPD related to discrepancy. Overall, more work is needed before incorporating specific practices.

## **4.2 Strengths and Limitations**

With a relatively large number of dyads ( $N = 161$ ), our sample is representative of both male and female adolescents, allowing investigation into gender differences. Also, age and race were diverse amongst youth and parents. Within the range of eligible ages for youth, each age was decently represented, and white and African American representation were nearly equal in youth. Although caregivers were mostly biological mothers, lacking representation of fathers and stepfamily, this sample strengthens the discrepancy patterns seen amongst mothers. One limitation of this project was the low number of discrepant dyads ( $n = 34$ ) compared to concordant dyads ( $n = 127$ ). The number of discrepant dyads prevented us from dividing this group into subgroups: one in which the parents overreport or the children underreport symptoms, and the other for parents that underreport or children overreport symptoms. Because we could not utilize these subgroups, we also could not indicate which discrepancy type is more common.

Another limitation is that the interview items used to determine endorsement or denial of suicidality symptoms combined both suicidal thoughts and behaviors. A combined suicidality variable may be problematic since suicidal behaviors may be more detectable than suicidal thoughts. Parents and children may be more likely to agree about the child's suicidality if the child engages in behaviors. In contrast, suicidal thoughts may easily go unnoticed. If a child suffering

from suicidal thoughts does not disclose their symptoms, their parents may have no other way of understanding their children's symptoms. This misunderstanding may make discrepancy more likely. Separation of thoughts and behaviors may more accurately indicate which type of suicidality symptoms are more at risk for discrepancy.

Strict categorization based on symptom endorsement versus denial was also a weakness of our project. Instead, dimensional agreement scores between parents and adolescents may more accurately indicate discrepant dyads. For example, consider a dyad in which the parent endorses one instance of suicidality in the child that has since been treated, but the child endorses persistent suicidality. Categorization would identify this dyad as concordant, whereas dimensional measures would likely show a low agreement score that is more accurate. Also, our project could not determine which informant is more accurate when describing the adolescents' suicidality symptoms. Although adolescent BPD symptoms were more strongly correlated with reporting discrepancies than parent BPD symptoms, we could not compare the accuracy between parent and child reports.

### **4.3 Conclusion**

When considered separately, our project shows that parent and child BPD symptom severity are related to discrepancy about the child's symptoms of suicidality. Together, however, the child's BPD symptoms are more strongly related to discrepancy. The main aim of this study was to identify conditions under which there is a risk of inaccurate information regarding adolescents' symptoms of suicidality. Suicidality discrepancies exacerbated by BPD portray this



risk, which, in turn, can affect adolescent treatment. To help ensure that clinicians acquire accurate symptom information, more research and consideration of discrepancy risks is necessary.

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