

Maternal Borderline Personality Disorder and Negative Talk, and Young Children's Behavioral
Symptoms

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Abstract

This study examined the relationship between maternal borderline personality disorder (BPD) and maternal negative talk with offspring age 4-7 while completing a puzzle task. The study also examined the correlation between the amount of negative talk a mother uses, regardless of psychopathology, and her child's externalizing and internalizing symptoms as reported by their teacher. Measures utilized were the Manual for the Dyadic Parent-Child Interaction Coding System, DPICS, and Achenbach's Teacher Report Form, 70 children and their mothers were studied. These two measures allowed researchers to directly compare how mothers who are and are not diagnosed with BPD interact with their children and how their negative talk is related to children's behavior at school. The present study found that negative talk was not significantly different in mothers with BPD than in normative comparison mothers. However, in the sample as a whole, maternal negative talk was marginally significantly correlated with children's internalizing symptoms and significantly correlated with children's externalizing symptoms. This suggests the effects of maternal negativize may reach beyond just when the child is in an environment with their mother but to other settings as well. These findings may help inform interventions to prevent a cyclical relationship between the use of negative talk and a child's internalizing and externalizing symptoms.

Introduction

Maternal Negative Talk

Maternal negative talk has been shown to have determinantal effects on children's development. For example, negative maternal messages in childhood retrospectively reported by young women were associated with disordered eating, frequent exercise, and faulty body image (Lease, Doley, & Bond 2016). Furthermore, in 158 Norwegian children, ages two to seven, negative talk was one of three parent codes that was associated with a diagnosis of Oppositional Defiant Disorder/Conduct Disorder (Bjørseth, McNeil, & Wichstrøm, 2015). Research on maternal negative talk has largely focused on maternal hostility. However, hostility and negative talk are not entirely equivalent. Negative talk can include hostility and acts as an umbrella term that includes less severe behavior, that does not necessarily include underlying aggression hostility requires. Negative talk provides a wide range of possible comments that may be more commonly used by caregivers; it refers to any verbalized disapproval by the mother of either the child or their choices, activities, etc. and includes sarcastic and rude language and intonation. It was not limited to words but included all vocalizations that expressed disapproval, such as saying something was wrong or done incorrectly, explicitly saying "no" or a synonymous word, and telling the child not to do something.

Maternal BPD and Child Behavior Problems

BPD symptoms are characterized in the DSM-5 as including instability in interpersonal relationships, self-image, and impulsivity, while fearing abandonment, whether it be real or imagined (American Psychiatric Association, 2013). Maternal BPD is associated with problems in children's development generally (Macfie, 2009). Although negative talk has not been examined, mothers with BPD have been shown to be more hostile towards their young children

(Macfie, et. al., 2017). Moreover, maternal BPD symptoms are related to children's symptoms as reported by teachers (Campion et al., 2011, April). Specifically, children whose mothers had BPD were rated significantly higher rates on internalizing problems than normative comparisons. Furthermore, the maternal borderline feature of self-harm was associated with both externalizing and internalizing symptoms (Campion, et. al., 2001, April).

Current Study

In this study, we assessed the relationship between maternal BPD diagnoses and the use of negative talk in elementary school age children as they completed a puzzle task. The study also examined the correlation between the amount of negative talk a mother uses, regardless of psychopathology, and their child's internalizing and externalizing symptoms as reported by their teacher. We hypothesized that: (1) that mothers with BPD would use more negative talk with their four to seven year old than the normative comparison mothers with children of the same age; (2) that maternal negative talk would be positively correlated with their children's internalizing symptoms, such as anxious/depressed, withdrawn/depressed, and somatic complaints, and externalizing symptoms, including aggressive behavior and breaking rules, reported by their teachers.

Method

Participants

Participants included $N = 70$ mothers and children; $n = 34$ children whose mothers did not have any current psychological disorder diagnosis and $n = 36$ children whose mothers were diagnosed with BPD. Most dyads were from low socioeconomic backgrounds; 11% were

Hispanic and 11% were from other minority ethnic backgrounds. Of the 70 children, half were boys and half were girls with an average age of five years and four months ($SD = 11$ months) ranging from four to seven years old.

Participants were recruited from five East Tennessee counties and included participants from both rural and urban areas. Inability to give informed consent, including due to the presence of psychosis was used as exclusionary criteria. BPD mothers were recruited from mental health clinicians, including therapists, psychiatrists, and case managers. Normative participants were recruited from preschools, Boys and Girls Clubs, and Head Start by research assistants as the mothers dropped off or picked up their children. Both groups were additionally recruited by flyers placed throughout the region of interest.

Measures

BPD

All mothers were assessed for BPD using a Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II First, Gibbon, Spitzer, Williams, & Benjamin, 1997) and a self-report form. The SCID-II interview was conducted by a licensed clinical psychologist.

Negative Talk

Children were given ten minutes to work on puzzles. The mothers were instructed before each puzzle to allow their child to do the puzzle but that they would be able to help as they felt necessary. Mothers helped to varying degrees while talking to their children. Each dyad was assured the number of puzzles completed did not matter and to just work until time ran out. Using the Manual for the Dyadic Parent-Child Interaction Coding System, DPICS, (Eyberg, McDiarmid, Duke, & Boggs, 2009), each ten-minute segment was coded by two undergraduate research assistants (reliability rating 85%) to determine the frequency of negative talk used by

each mother. Research assistants were unaware of each mother's diagnosis or lack thereof during the coding process. The coding system has 37 categories, however only negative talk was used in the current study.

Behavior problems

Behavior problems in children were measured using the Teacher Report Form (Achenbach & Rescorla, 2001). The form was filled out for each child and symptoms classified as either externalizing or internalizing behaviors. Externalizing symptoms included aggressive behavior, and rule breaking behavior. Internalizing symptoms included anxious/depressed, withdrawn/depressed, and somatic complaints.

Results

To examine how maternal negative talk differed between mothers with BPD and comparison mothers (*Hypothesis 1*), we conducted an independent samples *t*-test. Maternal group status served as the independent variable and maternal negative talk as the dependent variable. Results indicated that mothers with BPD ($M = 9.50$, $SD = 5.29$) did not significantly differ from comparison mothers ($M = 9.00$, $SD = 4.57$) in their use of negative talk with their children $t(1, 68) = 0.42$, *ns*. See Table 1.

We conducted bivariate correlation analyses to examine the relationship between maternal negative talk and internalizing and externalizing behavior symptoms in young children (*Hypothesis 2*). Results revealed maternal negative talk was marginally significantly correlated with young child internalizing symptoms. Further, maternal negative talk was significantly correlated with child externalizing symptoms. See Table 2 for correlation coefficients, means, and standard deviations.

Discussion

Mothers with and without BPD did not have significantly different frequencies of using negative talk despite previous research indicating mothers with BPD being more hostile. However, there was a marginally significant relationship between maternal negative talk and both child internalizing and a significant relationship between maternal negative talk and child externalizing symptoms. The correlation was stronger when looking at child externalizing symptoms. Children's behavior and maternal negative talk can become a perpetual cycle making it difficult to determine if negative talk causes behavior issues in young children or if behavior problems result in increased maternal negative talk, or both. This is especially of concern when considering the significant correlation between externalizing symptoms and maternal negative talk: are children acting out in response to the negative talk, or are mothers using negative talk to combat externalizing symptoms. The correlation between maternal negative talk and behavioral symptoms is also critical to understand as the children were exhibiting symptoms in environments in which their mothers are not present suggesting maternal negative has far reaching effects on a child's behavior.

This study's strengths included the use of observational coding to measure maternal negative talk as opposed to relying on mother's self-report, which have an increased potential to underestimate the frequency of negative talk. Teacher report forms regarding children's internalizing and externalizing symptoms provided an independent evaluation that mothers would be unable to provide. Weaknesses include the small sample size used in the study

It would be beneficial for future research to work on distinguishing where the cycle of negative talk and externalizing behaviors starts, with the mother or the child, and if the association strengthens or weakens as the child ages using longitudinal studies. These studies might also examine instances in which maternal negative talk is unprovoked and leads to

externalizing symptoms and instances in which the negative talk is in response to the child's actions. Pathways to the development of children's internalizing and externalizing symptoms might then be elucidated and preventive interventions designed

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Table 1

Independent Samples t-Test for Maternal Negative Talk and Maternal Group Status

Variable	<i>t</i>	<i>df</i>	BPD		Comparison	
			<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>	<i>n</i>
Maternal Negative Talk	0.42 ^{ns}	68	9.50 (5.29)	36	9.00 (4.57)	34

Note. *ns* = nonsignificant, $p < .05$; BPD = borderline personality disorder.

Table 2

Correlations between Maternal Negative Talk and Child Behavior Symptoms

Variable	Maternal	Child	<i>M (SD)</i>
	Negative Talk	Internalizing	
Maternal Negative Talk			9.26 (4.93)
Child Internalizing	.21 [†]		55.03 (11.70)
Child Externalizing	.34**	.71**	55.96 (9.59)

Note. [†] $p < .10$; ** $p < .01$.