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BRIEF COMMUNICATION

An Exploration of Positive Parenting in Relation to Psychopathology for Youth with a Diagnosis of Bipolar Spectrum Disorder

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Abstract

Objective: Bipolar Spectrum Disorder (BSD) is a severe psychiatric disorder associated with a host of deleterious sequelae. While researchers have found a robust link between parenting variables and psychopathology for youth with BSD, few have examined positive parenting factors and associated psychopathology for these youth. Furthermore, conclusions from extant literature are hindered by a) exploring a limited range of parenting variables and b) employing retrospective reports of parenting with adult populations. This study addressed these gaps by examining how a range of contemporaneously-measured positive parenting variables were related to psychopathology among youth with a BSD diagnosis. **Methods:** One hundred fifty families with a youth aged 5-16 years participated in this study and completed screening for a mood disorder through a tertiary care facility. Participants completed measures of depression, mania, behavioural difficulties, and the parent-child relationship. **Results**: Parental characteristics (limit setting, autonomy granting, egalitarian views) were related to lower levels of psychopathology for youth screened for BSD. **Conclusions**: Taken together, the results from this study contribute to our understanding of the relation between *positive* parenting characteristics and psychopathology for youth with a diagnosis of BSD.

Key Words: *Bipolar Spectrum Disorder, child psychopathology, parenting, positive psychology*

Résumé

Objectif: Le trouble du spectre bipolaire (TSB) est un trouble psychiatrique grave associé à une panoplie de séquelles nuisibles. Même si les chercheurs ont constaté un lien robuste entre les variables de la parentalité et la psychopathologie pour les adolescents souffrant de TSB, peu ont examiné les facteurs parentaux positifs et la psychopathologie associée pour ces adolescents. En outre, les conclusions de la littérature existante sont entravées par a) l'exploration d'une gamme limitée de variables parentales et b) l'emploi d'études rétrospectives de parentalité avec des populations adultes. La présente étude a abordé ces lacunes en examinant comment une gamme de variables parentales positives mesurées simultanément était liée à la psychopathologie chez les adolescents ayant reçu un diagnostic de TSB. **Méthodes:** Cent cinquante familles ayant un enfant de 5 à 16 ans ont participé à cette étude et subi un dépistage du trouble de l'humeur dans un établissement de soins tertiaires. Les participants ont répondu à des mesures de dépression, de manie, de difficultés comportementales, et de la relation parent-enfant. **Résultats:** Les caractéristiques parentales (établissement de

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limites, octroi d'autonomie, points de vue égalitaires) étaient liées à des niveaux plus faibles de psychopathologie pour les adolescents ayant subi un dépistage du TSB. **Conclusions:** Dans leur ensemble, les résultats de cette étude contribuent à notre compréhension de la relation entre les caractéristiques parentales *positives* et la psychopathologie des adolescents ayant reçu un diagnostic de TSB.

Mots clés: *trouble du spectre bipolaire, psychopathologie de l'enfant, parentalité, psychologie positive*

Introduction

Pediatric Bipolar Disorder (PBD) is a severe psychiatric disorder characterized by distinct episodes of mania/hypomania and depression. Such episodes remit and recur, and represent a clear distinction from youths' normative functioning (American Psychiatric Association, 2013). PBD implicates a host of deleterious sequelae for youth, including impaired psychosocial functioning and interference with adaptive development (American Psychiatric Association, 2013; Geller et al., 2002). Given the substantial impact and potent mortality risk associated with PBD (Gonda et al., 2012), elucidating positive factors associated with functioning for these youth is an urgent research priority (Duffy & Carlson, 2013). This study examined the role of positive parenting in relation to psychopathology for youth with a diagnosis of PBD. Hereafter, the term Bipolar Spectrum Disorder (BSD) will be employed to encapsulate all forms of bipolar disorder.

Parenting Context

While PBD is highly heritable (Craddock & Jones, 1996), extant research has only been able to identify genetic variants accounting for a small amount of variation in explaining the onset and progression of the disorder. Similar to other complex genetic illnesses, it is likely PBD is determined through a complex epigenetic mechanism characterized by interactions between genetic variants and environmental factors (Shinozaki, Hing, & Potash, 2014). The parenting context is one environmental factor shown to have substantial etiological, phenomenological, and treatment importance in the context of PBD (Belardinelli et al., 2008; Miklowitz, Biuckians, & Richards, 2006). Low levels of parental warmth (e.g., lack of positive affection), high levels of psychological control (e.g., promoting parental dependence), and parent- and child-reported family conflict have been shown to associate with BSD (Alloy, Abramson, Smith, Gibb, & Neeren, 2006; Geller et al., 2002; Timmins et al., 2016). Further, parents high in expressed emotion (i.e., highly critical, hostile, and/or overinvolved) have been shown to impact treatment outcomes for adolescents with bipolar disorder (Fredman, Baucom, Boeding, & Miklowitz, 2015; Miklowitz et al., 2013). However, research comparing parenting characteristics between youth with BSD versus youth with other complex mental health difficulties is mixed, with some studies finding group differences (e.g., Robertson, Kutcher, Bird, & Glasswick, 2001) while others do not (e.g., Neeren, Alloy, & Abramson, 2008).

This literature is limited by examining only a portion of parenting variables – predominantly negative – and thus fails to adequately capture the multifaceted nature of parenting, potentially missing essential positive parenting variables affecting youth with BSD. Further, questionable methodological practices limit the validity of the aforementioned findings by primarily employing retrospective reports of parenting with adult populations (Alloy et al., 2006). Memory biases and diagnostic labeling may confound such reports. The current study seeks to deepen and broaden extant research by examining positive parenting in relation to psychopathology for youth with BSD using contemporaneous reports of parenting at the time of diagnosis via a robust measure of parent-child relationships (Mowder, Shamah, & Zeng, 2010), the Parent and Child Relationship Inventory (PCRI; Gerard, 1994).

Incorporating Positive Variables into the Study of Psychopathology

Understanding how positive parenting relates to functioning for youth with BSD answers a recent call to integrate positive variables into the study of psychopathology (Wood & Tarrier, 2010). The current research milieu examines childhood psychopathology with a deficit-focused lens, emphasizing adverse outcomes for youth. Research endeavours seeking to understand positive factors associated with functioning for youth with severe psychiatric diagnoses fills a research gap. To date, positive psychology research has focused on non-clinical samples (Larson, 2000) with less focus on clinical samples (Adler, Horowitz, Garcia, & Moyer, 1998), especially BSD (Galvez, Thommi, & Ghhaemi, 2011). This study's focus on positive parenting characteristics and psychopathology for youth with BSD is thus quite novel.

Having a child with mental health difficulties is often challenging for parents and is associated with higher levels of parental stress (Angold et al., 1998; Maes, Broekman, Dosen, & Nauts, 2003); despite these struggles, caregivers have been shown to play a vital role in prevention and intervention efforts that promote mental health for at-risk youth (Draper, Siegel, White, Solis, & Mishna, 2009; Prevatt, 2003). It is thought that positive parenting strategies such as parental warmth, acceptance, autonomy granting

and appropriate limit setting, relate to lower levels of psychopathology due to the balanced and supportive environment afford by a healthy parent-child relationship (Geller et al., 2000; Schenkel, West, Harral, Patel, & Pavuluri, 2008; Bean, Barber, & Crane, 2006; Middleton, Scott, & Renk, 2009). This research may suggest that youth who see their caregivers as being warm and accepting, and setting appropriate limits, may experience a positive parent-child relationship, and this synergistic process may then set the stage for positive outcomes including reduced psychopathology.

The Current Study: Goals and Hypotheses

The overarching goal of this study was to understand how positive parenting relates to general psychopathology for youth screened for BSD. Increased levels of positive parenting qualities (parental support, satisfaction, involvement, communication, autonomy granting, limit setting, role orientation) were hypothesized to relate to decreased levels of psychopathology (mania, depression, total problems, internalizing difficulties, externalizing difficulties). The first aim of the study was to examine relations between parenting context and psychopathology for *all* youth screened for BSD. The secondary aim was to examine relations between parenting context and psychopathology for youth who subsequently received a BSD diagnosis. Given mixed literature, no specific hypotheses were made regarding differences in parenting context between youth with BSD versus youth with other complex mental health difficulties.

Method

Participants

Participants were recruited from a clinic specialized in screening youth for suspected mood disorders once local resources were exhausted (i.e., a tertiary care facility). One hundred and fifty families with a male (n = 99) or female (n = 51) youth aged five to 16 years (M = 9.84, SD = 2.78) participated. Most youth presented with their biological or adoptive mother (86.4%). Screening for suspected mood disorders was completed based on a clinical evaluation by a team of mental health professionals including a Psychologist, Behavioural Consultant, and a Psychiatrist. The clinical evaluation included the use of the Washington University Kiddie Schedule for Affective Disorders and Schizophrenia (WASH-U-KSADS; Geller, Williams, Zimerman, & Frazier, 1996) semi-structured interview. Based on this screening, 39% (n = 59) of youth met criteria for a BSD diagnosis (DSM-IV). All individuals serviced by the clinic were eligible to participate. See Table 1 for the overall sample demographics.

Measures

The *Parent Child Relationship Inventory* (PCRI; Gerard, 1994) is 78-item measure comprised of seven subscales: Parental Support (i.e., degree of perceived support in raising child; "When it comes to raising my child, I feel alone most of the time."), Satisfaction with Parenting (i.e., degree of fulfillment from parenthood; "I generally feel good about myself as a parent."), Parental Involvement (i.e., engagement/familiarity with child; "I love my child just the way he or she is."), Communication (i.e., parent's perception of ability to communicate with child; "My child tells me all about his or her friends."), Limit Setting (i.e., parent's perception of effectiveness of disciplinary practices; "I wish I could set firmer limits with my child."), Autonomy Granting (i.e., parent's ability to facilitate child's independence; "I have a hard time letting go of my child."), and Role Orientation (i.e., parent's endorsement of egalitarian views; "A woman can have a satisfying career and be a good mother too."). Parents rated items on a 4-point Likert scale (1 = *Strongly Agree* to 4 = *Strongly Disagree*). The PCRI subscales exhibited acceptable reliability in the current study (α = .67 to .84) with the exception of the Communication scale (α = .48), which was excluded from analyses.

The 20-item *Beck Depression Inventory for Youth* (BDI-Y; Beck, Beck, & Jolly, 2001) was used to measure depression symptoms. Youth indicated the extent to which each statement described them on a 4-point Likert scale. The BDI-Y showed excellent reliability in the current study (α = .92).

The *Child Mania Rating Scale* (CMRS; Pavuluri, Henry, Devineni, Carbray, & Birmaher, 2006) was used to measure youth mania symptoms. Parents rated 21 items based on their child's behaviour and emotions in the past month using a 4-point Likert scale. The CMRS had good reliability in this study (α = .83).

The 113-item *Child Behaviour Checklist* (CBCL6-18; Achenbach & Rescorla, 2001) is a screener for emotional and behavioural problems in youth ages six to 18. Parents indicated how often each behaviour occurred in the past six months on a 3-point Likert scale. The scale measures Internalizing Difficulties (i.e., anxious/depressed, withdrawn/depressed, somatic complaints), Externalizing Difficulties (i.e., rule-breaking behaviour, aggressive behaviour), and Total Problems (i.e., internalizing difficulties, externalizing difficulties, social problems, thought problems, attention problems). In this study, reliability ranged from .87 to .93 for these domains.

Procedure

This study was approved by the University Research Ethics Board (REB) as well as the internal REB for the tertiary care facility. Upon ethical clearance, parents of youth assessed for a mood disorder (N = 194) were contacted by telephone and asked to consent to the use of information

Table 1. Demographic variables for the full sample

	% of sample	
Assessment results		
Bipolar spectrum diagnosis	39%	
Lifetime diagnoses		
Mood disorders	79%	
Anxiety disorders	79%	
Adhd	66%	
Learning disability	56%	
Externalizing disorders	36%	
Medical condition	30%	
Ocd/tourette's	20%	
Pdd	5%	
Parent marital status		
Single parent	38%	
Partner or spouse	62%	
Family income		
Less than $20,000	21%	
$20,000 - $39,999	24%	
$40,000 - $59,999	30%	
Greater than $60,000	25%	
Parent psychopathology	Mother	Father
Psychiatric hospitalization	18%	12%
Bsd diagnosis	18%	21%
Any mental health diagnosis	44%	43%

ADHD = Attention Deficit-Hyperactivity Disorder; OCD = Obsessive Compulsive Disorder; PDD = Pervasive Developmental Disorder

gathered during the mood screening process, for the purpose of the current study. Youth over the age of 16 were asked to provide verbal consent. Of those contacted, 178 (91.8%) agreed to participate. Upon consent, a chart review was performed and information pertaining to the study measures was extracted. Of the 178 consented participants, 150 (84.3%) participants had at least one of the questionnaire measures of interest completed, and were included for data analysis.

Data Analysis

In the first step of data analysis, bivariate correlations were examined to determine which parenting strategies significantly related to child psychopathology.

Next, the three subscales from the parenting measure (PCRI) most highly correlated with child psychopathology were used to predict the Internalizing, Externalizing, and Total scales from the CBCL. Only the three most correlated subscales were used in the follow-up regression models, as opposed to all subscales on the PCRI, in an attempt to reduce the number of analyses conducted and avoid increasing Type I error (false positives).

Next, *t*-tests were used to compare youth who received a diagnosis of BSD with youth who did not receive a diagnosis of BSD on all key study variables: PCRI, CBCL, BDI, CMRS.

Lastly, the regression models tested in step two of the data analysis plan were tested again while examining BSD (coded as a dichotomous variable) as a moderator.

Treatment of Data

Several data-checking procedures were applied before analyses were conducted. Specifically, variables were examined for violations in normality, though none of the variables required transformation. Similarly, data were assessed for outliers (i.e., two standard deviations above/below the mean) and no cases were removed. Due to missing data, some analyses include a reduced number of participants. When available, all participants with complete data were included in analyses.

Results

Descriptive Statistics

Table 2 shows means, standard deviations, and zero-order correlations for all variables.

Parenting Context and Complex Mental Health

Three parenting characteristics – Limit Setting, Autonomy Granting, and Role Orientation – were most consistently related to Total Problems, Internalizing Difficulties, and Externalizing Difficulties (see Table 2). These characteristics were entered into separate simultaneous regressions with age and gender as covariates. Table 3 displays the regression coefficients. The first regression was significant [$F(5, 92) = 4.66$, $p = .001$]. Predictor variables accounted for 20% of the variance in Total Problems. Higher levels of Limit Setting related to lower levels of Total Problems [$t(92) = -2.10$, $p = .039$]. The second regression was significant [$F(5, 92) = 3.65$, $p = .005$]. Predictor variables accounted for 17% of the variance in Internalizing Difficulties. No significant unique predictors emerged. Finally, the third regression was significant [$F(5, 92) = 3.88$, $p = .003$]. Predictor variables accounted for 17% of the variance in Externalizing Difficulties. Higher levels of Limit Setting predicted lower levels of Externalizing Difficulties [$t(92) = -.67$, $p = .004$].

Parenting Context and BSD

Descriptive statistics. Of the 150 youth screened, 59 (39%) were diagnosed with BSD; 66% ($n = 39$) were male and 33% ($n = 20$) were female. Independent samples *t*-tests (Table 4) revealed no significant differences between youth

Table 2. Descriptive statistics

Measure	M(SD)	1	2	3	4	5	6	7	8	9	10	11
PCRI												
1. Parental Support	20.08 (4.20)	___	.27**	0.06	.42**	.34**	0.08	-0.12	-0.09	-0.18	-.25*	-0.22
2. Satisfaction	31.75 (5.60)		___	.46**	0.18	0.07	0.08	-0.14	-0.08	-0.18	-0.05	-0.09
3. Involvement	44.18 (5.13)			___	.23*	0.16	0.19	-0.14	-0.06	-0.18	-0.02	0.01
4. Limit Setting	25.56 (4.71)				___	.53**	. 13	-.26*	-.33**	-.37**	-0.19	-0.06
5. Autonomy Granting	25.98 (3.64)					___	.35**	-.33**	-0.16	-.37**	-.31**	-0.14
6. Role Orientation	27.07 (4.01)						___	-.21**	-0.13	-.21*	-0.05	-0.07
CBCL												.
7. Internalizing	23.50 (10.56)							___	.27**	.77**	.26*	38**
8. Externalizing	34.37 (9.55)								___	.70**	.37**	-0.08
9. Total Problems	101.08 (27.29)									___	.48**	.26*
CMRS											___	
10. Mania	28.01 (10.77)											0.01
BDI												___
11. Depression	16.92 (10.84)											

** p<.001, two-tailed

Table 3. Summary of Regression Models for Limit Setting, Autonomy Granting and Role Orientation predicting Total Problems, Internalizing Difficulties, and Externalizing Difficulties

Predicting Total Problems[1] (n = 97)				
Variables	B	SE B	β	p
Gender	-2.65	5.29	-.05	.617
Age Group	4.62	5.19	.09	.376
Limit Setting	-1.34	.64	-.24	.039
Autonomy Granting	-1.47	.86	-.20	.089
Role Orientation	-.617	.67	-.09	.359
Predicting Internalizing Difficulties[2] (n = 97)				
Variables	B	SE B	β	p
Gender	3.03	2.15	.14	.161
Age Group	2.53	2.11	.12	.231
Limit Setting	-.25	.26	-.11	.340
Autonomy Granting	-.56	.35	-.20	.108
Role Orientation	-.34	.27	-.13	.210
Predicting Externalizing Difficulties[3] (n = 97)				
Variables	B	SE B	β	p
Gender	-5.01	1.87	-.26	.009
Age Group	-.42	1.84	-.02	.819
Limit Setting	-.67	.23	-.34	.004
Autonomy Granting	.06	.30	.02	.845
Role Orientation	-.16	.24	-.07	.501

[1]R^2= .20, F(5, 92) = 4.66, p =.001; [2]R^2= .17, F(5, 92) = 3.88, p =.003; [3]R^2= .17, F(5, 92) = 3.66, p =.005; Gender (0 = M, 1 = F), Age Group (1 = 5-9 years, 2 = 10-16 years).

with BSD and youth with other complex mental health difficulties on all variables except mania symptoms, with parents reporting higher levels of mania for youth with BSD [$t(79) = 2.42$, $p = .018$].

Regression analyses. To examine relations between parenting characteristics and psychopathology, separate hierarchical regressions (following guidelines by Aiken & West, 1991) were conducted with Total Problems, Internalizing Difficulties, and Externalizing Difficulties as outcome variables. The interactive effect of BSD diagnosis was also examined by considering Diagnostic Group as a moderator of the relation between parenting characteristics and symptoms. Diagnostic Group was coded dichotomously (i.e., presence/absence of BSD diagnosis). Covariates (Gender, Age) were entered in Step 1, parenting characteristics (Limit Setting, Autonomy Granting, Role Orientation) and BSD were entered in Step 2, and the interaction between parenting characteristics and BSD (Limit Setting X BSD, Autonomy Granting X BSD, or Role Orientation X BSD) were entered in Step 3.

Step 3 of the first regression was significant [$F(9, 77) = 2.81$, $p = .007$] and predictor variables accounted for 25% of the variance in predicting Total Problems. However, there were no significant interaction effects. Step 3 of the second regression model was significant [$F(9, 77) = 2.25$, $p = .027$] and predictor variables accounted for 21% of the variance in predicting Internalizing Difficulties. There were no significant interaction effects. Step 3 of the third regression model was not significant in predicting Externalizing Difficulties [$F(9, 77) = 1.89$, $p = .067$], with no significant interaction effects.

Discussion

While researchers have found a robust link between parenting variables and psychopathology for youth with BSD, few have examined positive parenting factors and associated functioning for these youth. Taking a positive clinical psychology approach (Wood & Tarrier, 2010), this study aimed to extend and deepen knowledge about positive parenting in relation to psychopathology for youth with a diagnosis of BSD. This study supports that positive parenting

characteristics relate to lower levels of psychopathology. Specifically, higher levels of limit setting, autonomy granting, and egalitarian views associated with lower levels of internalizing, externalizing, and total problems for the overall sample. As well, our results suggest few differences exist between positive parenting characteristics for youth with a diagnosis of BSD and youth with other complex mental health difficulties also referred to a tertiary care facility.

Table 4. Summary of t-tests Comparing Youth Diagnosed with BSD to Youth with Complex Mental Health Difficulties

Variables	t	df	p
PCRI			
Parental Support	-0.94	86	0.341
Satisfaction	1.75	87	0.084
Involvement	0.31	86	0.76
Limit Setting	-1.31	86	0.192
Autonomy Granting	-0.36	86	0.719
Role Orientation	-0.84	86	0.402
CBCL			
Internalizing	1.01	92	0.317
Externalizing	0.35	92	0.73
Total Problems	1.2	92	0.234
CMRS			
Mania	2.42	79	.018*
BDI- Y			
Depression	-0.67	67	0.503

* p <.05; PCRI = Parent and Child Relationship Inventory; CBCL = Child Behaviour Checklist; CMRS = Child Mania Rating Scale; BDI-Y = Beck Depression Inventory- Youth Version.

Parenting Context and General Psychopathology

Limit setting, autonomy granting, and egalitarian views emerged as consistently related to psychopathology (internalizing difficulties, externalizing difficulties, total problems). Of these, limit setting emerged as a significant unique predictor. This finding is consistent with a robust literature supporting the relation between limit setting and lower levels of problematic youth behaviour (e.g., externalizing behaviours, delinquency, depression, risk taking; Roche & Leventhal, 2009), suggesting youth with complex mental health difficulties benefit from increased structure and guidance afforded by their parents. Parents may find themselves balancing the importance of allowing their children enough autonomy to develop, while also providing limits to guide them through development. For this sample, parenting that provides a sense of routine and organization for youth seems to be particularly important. Although preliminary, this finding may suggest that youth who struggle with complex mental health difficulties, and thus are burdened with managing ones' mental health while navigating normative youth experiences, benefit from having a parent who consistently provides routine and organization allowing for better youth adjustment and lower psychopathology.

However, given the cross-sectional design of the study, it is important to consider that, in contrast, it may also be that children exhibiting less externalizing behavior are less likely to precipitate the need for limit setting. Youth who display lower levels of externalizing behavior may have parents who report successfully implementing appropriate limit setting due to the high level of concordance with rules and guidelines set out for these children. Such distinctions should be explored in future longitudinal research.

Parenting Context and BSD

Overall, there were no significant differences in reported positive parenting, or links between positive parenting and psychopathology, when comparing youth who did or did not receive a diagnosis of BSD. These findings are consistent with retrospective studies suggesting parenting context for families with a youth diagnosed with BSD is similar to other youth (e.g., healthy controls, youth with unipolar depression; Neeren et al., 2008). The majority of research in this domain has focused on comparing youth with BSD to normal controls and focusing on negative parenting strategies; by examining youth with a BSD diagnosis compared to youth with a range of complex mental health diagnoses, and including measures of positive parenting, the current study adds to the extant knowledge. This study also addresses an important methodological issue hindering past research by utilizing contemporaneous reports of parenting for youth in the initial or early stages of a BSD diagnosis, and thus results were not confounded by diagnosis or retrospective reporting.

Limitations and Future Directions

The study results should be interpreted in light of the following limitations. First, the heterogeneous sample makes concrete conclusions regarding youth with BSD difficult as it involved youth with overlapping disorders. Although this reflects common clinical practice, this heterogeneity may have minimized differences in relations between parenting characteristics and psychopathology for youth with and without a BSD diagnosis. Future research should aim to screen participants for comorbidity, control for this in analyses, and include a non-clinical comparison group. Additionally, the participants included in this study were recruited from a specialized tertiary care facility designed to diagnose mood related disorders, and represent a unique subset of youth with psychopathology. This limits generalizability to broader populations. Despite these limitations, the present study provided important information about

youth who received a diagnosis of BSD, a largely understudied population.

Second, this study predominantly involved mothers, therefore it will be important for future research to determine the influence of other caregivers in relation to functioning for youth with BSD. This limitation notwithstanding, our methodology provides ecological validity by having the parent who may typically participate in the youths' clinical care also reporting on youths' functioning.

Third, the use of self- and parent-report measures is subject to bias, and future research should include multiple modalities of measuring these constructs (e.g., observations, interviews). Additionally, there was a high degree of maternal psychopathology reported (44% of mothers reported having a mental health diagnosis) for this sample, which could have biased parental report of child psychopathology as well as self-reported parenting strategies. Research has established that parental psychopathology can significantly influence parent report of child functioning (Kroes, Veerman, & De-Bruyn, 2003; De Los Reyes & Kazdin, 2005) and this may have affected the current results. Future research should aim to control for specific types of parent psychopathology when using parent report measures of child psychopathology and family functioning.

Lastly, the cross-sectional retrospective design precludes inferences regarding causality, and thus future studies should attempt longitudinal investigations of these relations. These findings are preliminary and should be interpreted with caution, conditional upon replication.

Conclusions

Overall, this study suggests similar links between parenting context and psychopathology for youth with a diagnosis of BSD and youth with other complex mental health difficulties. This study adds to current literature due to limited information about the relation between positive parenting characteristics and psychopathology for youth with BSD. By eliminating the biases inherent in retrospective reporting, particularly after a child has received a BSD diagnosis, this study uses contemporaneous reports of parenting for youth in the initial or early stages of a BSD diagnosis to further the mixed research regarding whether parenting context differs between youth with and without a diagnosis of BSD. The conclusions from this study confirm that positive parenting relates to lower psychopathology for youth with BSD, when examined concurrently. The results of this study further support and encourage the need to focus on positive parenting characteristics when understanding psychopathology for youth with BSD.

Acknowledgments / Conflicts of Interest

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