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Relationship between Childhood Trauma and Borderline Personality Features in Adolescents: The Mediating Role of Mentalizing and Emotion Regulation

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ABSTRACT

Objective: The purpose of the present study is to evaluate the structural relationships between borderline personality features and childhood trauma with the mediator role of mentalization and emotional dysregulation.

Methods: In a descriptive-correlation study, a sample of 317 adolescents 12-18 years old, from Tehran, was selected using available sampling method. A Demographic data questionnaire, the borderline personality scale, the child abuse questionnaire, Reflective function questionnaire and the difficulties in the emotion regulation scale were used. For statistical analysis, SPSS and LISREL were used to analyze the data and to investigate the hypotheses of the research.

Results: The evaluation of hypothetical model with fit indexes demonstrated that the hypothetical model fits the measurement model (CFI=0.94, NFI=0.92, and RMSEA=0.084). Structural relations analysis also showed that childhood trauma through mentalizing affects borderline personality features directly and indirectly. Also, the indirect effect of the mentalization on the borderline personality features through the emotion dysregulation was significant. Thus, based on current research findings, it can be concluded that mentalizing and emotion regulation have a mediating role in relationship between childhood trauma and borderline personality features.

Conclusions: Considering these dimensions and the effectiveness of the employed mechanisms can be helpful in developing efficacious preventive and therapeutic interventions for borderline personality disorder.

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Introduction

Borderline personality disorder (BPD) is a complex and severe mental disorder characterized by pervasive difficulties in emotion regulation, impulse control, and instability in relationships and self-image (Bateman & Fonagy, 2010). It is one of the most common personality disorders, associated with a high incidence of mental illness, low quality of life, increased suicide risk, and substantial social and economic costs (Winsper et al., 2020). BPD is not confined to clinical populations; its features exist on a continuum within the general population (Trull, 2001). Even adolescents who do not meet the full diagnostic criteria for BPD often exhibit significant BPD features that result in academic difficulties, mood disorders, interpersonal problems, and risky behaviors such as substance use (Trull, 2001). Thus, understanding the factors contributing to the development of BPD traits is essential for effective prevention and intervention (Kuo et al., 2015). Childhood trauma has been identified as a key etiological factor in the development of BPD (Ball & Links, 2009; Herman et al., 1989; Ibrahim et al., 2018). Research indicates that individuals with BPD are significantly more likely to report histories of childhood trauma compared to those with other psychiatric disorders or nonclinical populations (Cirasola et al., 2017; Hecht et al., 2014; Porter et al., 2020). Traumatic experiences before age 18 include physical, sexual, and emotional abuse, neglect, and adverse family environments such as parental substance use (Bernstein et al., 2003; Felitti et al., 1998). Among these, emotional abuse has emerged as a particularly strong predictor of BPD features (Allen, 2008; Kuo et al., 2015; Rosenstein et al., 2018), with approximately 72% of individuals with BPD reporting emotional abuse by a primary caregiver during childhood (Zanarini & Frankenburg, 1997).

While childhood trauma is a well-established risk factor for BPD, the mechanisms underlying this relationship remain incompletely understood. Emotion dysregulation is one factor that may mediate this association (Bateman & Fonagy, 2004; Koenigsberg et al., 2002). Emotion dysregulation—defined as heightened emotional sensitivity and difficulty returning to baseline after emotional arousal—has been described as a central feature of BPD (Linehan, 2018). Individuals with BPD often engage in maladaptive behaviors, such as self-harm, as attempts to manage intense emotions (Gratz & Roemer, 2004; Koenigsberg et al., 2002). Empirical evidence has linked childhood maltreatment to emotion dysregulation, which in turn predicts BPD features (Carvalho Fernando et al., 2014; Kuo et al., 2015). However, findings are mixed: while some

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studies have identified emotion dysregulation as a significant mediator (Gratz et al., 2008; Jennissen et al., 2016), others have not (van Dijke et al., 2013).

Another possible mediator between childhood trauma and BPD is mentalization—the capacity to understand one's own and others' behavior in terms of internal mental states, such as thoughts, feelings, and intentions (Bateman & Fonagy, 2016). Mentalization theory posits that adverse early environments, such as emotional abuse, disrupt the development of this cognitive-emotional capacity, thereby increasing vulnerability to BPD (Volkert et al., 2019). Prior studies have shown that impaired mentalizing mediates the relationship between childhood maltreatment and adult BPD (Chiesa & Fonagy, 2014), yet little is known about this process during adolescence. Exposure to childhood trauma may hinder the development of mentalization by disrupting secure attachment and trust, limiting opportunities for understanding one's own and others' minds (Ensink et al., 2015; Fonagy & Bateman, 2007). Consequently, difficulties in mentalization may predispose individuals to the emotional instability characteristic of BPD (Fonagy & Bateman, 2008).

Furthermore, research suggests a strong connection between mentalization and emotion regulation. Emotion regulation depends on the ability to reflect on mental states—one's own and others'—to manage emotional responses effectively (Allen et al., 2008; Jurist, 2018; Marszał & Jańczak, 2018). Mentalization enables individuals to reappraise and modulate emotions in light of social and personal contexts (Bernstein et al., 1998; Garrusi & Nakhaee, 2009). Thus, deficits in mentalization can lead to maladaptive emotional responses, exacerbating BPD symptoms (Gratz & Roemer, 2004).

Given these interrelated mechanisms, examining the mediating roles of emotion regulation and mentalization in the relationship between childhood trauma and BPD traits among adolescents is crucial. Understanding how these factors interact may inform targeted prevention and therapeutic interventions for at-risk youth. Moreover, community-based research offers valuable insights, as clinical samples may overrepresent individuals with severe pathology—a phenomenon known as Berkson's bias (Crick et al., 2005; Zargar et al., 2014).

Based on this background, the present study aims to explore whether mentalization and emotion regulation mediate the relationship between childhood trauma and borderline personality features in adolescents. Specifically, it investigates which mediator plays a stronger role and whether mentalization indirectly influences BPD traits through emotion regulation. Clarifying these

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mechanisms can deepen our understanding of BPD development and guide effective prevention and intervention strategies.

Material and Methods

The participants in this study were 317 adolescents aged 12 to 18 years from Tehran, Iran, selected through convenience sampling in 2020. Due to the COVID-19 pandemic, data collection was conducted online via Google Forms.

Inclusion criteria required participants to be between 12 and 18 years old and to have at least a sixth-grade education level. Exclusion criteria included a history of substance use disorders, current psychotropic medication use, or previous psychiatric treatment.

To encourage participation, adolescents were informed that they would receive personalized feedback on their questionnaire results via the email address they provided. Participants also received an explanation of the study's objectives at the beginning of the online form, and contact information was provided for any inquiries.

Ethical approval for the study was obtained from the University of Social Welfare and Rehabilitation Sciences (Approval Code: IR.USWR.REC.1399.188).

Measures

Childhood Trauma Questionnaire (CTQ): The *CTQ* (Bernstein et al., 2003) is a 28-item self-report inventory that assesses five domains of childhood trauma: emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. Items are rated on a 5-point Likert scale (1 = *never true* to 5 = *very often true*). Reported reliability coefficients range from .79 to .94 (Bernstein et al., 2003), and the Persian version has shown reliability coefficients between .79 and .94 (Garrusi & Nakhaee, 2009).

Reflective Functioning Questionnaire for Youths (RFQ-Y): The *RFQ-Y* (Ha, 2011) is a 46-item self-report instrument used to assess *mentalization capacity* among adolescents. Responses are given on a 6-point Likert scale ranging from *strongly disagree* to *strongly agree*. The measure includes two subscales: self-focused mentalization and other-focused mentalization, each containing 23 items. The internal consistency of the RFQ-Y has been reported as $\alpha = .78$ (Ha, 2011).

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Difficulties in Emotion Regulation Scale (DERS): The *DERS* (Gratz & Roemer, 2004) consists of 36 items that assess difficulties in various aspects of emotion regulation, such as emotional awareness, clarity, and impulse control. Items are rated on a 5-point Likert scale (1 = *almost never* to 5 = *almost always*). The total scale has demonstrated excellent reliability (α = .93; Gratz & Roemer, 2004). The Persian version has shown Cronbach's alpha coefficients ranging from .66 to .88 (Gratz & Roemer, 2004).

Borderline Personality Features Scale for Children (BPFS-C): The *BPFS-C* (Crick et al., 2005) is a 24-item self-report instrument designed to assess borderline personality features in children and adolescents. Items are rated on a 5-point Likert scale ranging from *not at all true* to *always true*. The internal consistency for the original version was α = .76 (Crick et al., 2005), and the Persian adaptation showed α = .84 (Zargar et al., 2014).

Data were collected anonymously, and participants completed the questionnaires online at their convenience. To evaluate the proposed structural relationships, Structural Equation Modeling (SEM) was performed using LISREL, Mplus, and SPSS software. Descriptive statistics, including means, standard deviations, and score ranges, were computed to summarize the study variables. SEM was used to test the hypothesized mediation model, examining both direct and indirect relationships among childhood trauma, mentalization, emotion regulation, and borderline personality features.

Results

The participants' ages ranged from 12 to 18 years (M = 16.05, SD = 1.54). Of the total sample, 262 participants (82.4%) were female and 55 (17.6%) were male. Almost all participants were single (n = 313, 98.9%). Descriptive statistics, including means, standard deviations, and ranges for the study variables, are presented in Table 1, and the correlation matrix for these variables is provided in Table 2.

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Table 1. Means, Standard Deviations, and Ranges for variables

Variables	Means	Standard Deviation	Range
Childhood trauma (total)	43.03	16.70	89
Emotional Abuse	9.62	4.97	20
Physical Abuse	6.69	3.05	20
Sexual Abuse	7.30	4.33	20
Emotional Neglect	11.67	5.25	20
Physical Neglect	7.75	3.36	17
Mentalization (Self-focused)	4.27	0.96	3
Mentalization (Other-focused)	4.02	0.82	3
Emotion Dysregulation (total)	97.18	23.54	109
Non-Acceptance	15.22	5.38	24
Goal-Directed	15.60	5.25	20
Impulsivity	14.62	5.39	24
Strategies	20.29	7.89	31
Awareness	17.62	3.63	18
Clarity	13.82	3.96	20
Borderline Personality Features (total)	61.51	13.65	72
Affective Instability	16.15	3.60	18
Identity Problems	15.36	4.04	19
Interpersonal Problems	14.95	4.09	21
Self-Harm	15.05	4.47	22

Table 2. Correlation matrix of research variables

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1	Emotional abuse	1																				
2	Physical abuse	0.61**	1																			
3	Sexual abuse	0.44**	0.54**	1																		
4	Emotional neglect	0.69**	0.44**	0.31**	1																	
5	Physical neglect	0.7**	0.51**	0.35**	0.72**	1																
6	Clarity	0.42**	0.18**	0.2**	0.38**	0.37**	1															
7	Awareness	0.44**	0.19**	0.25**	0.4**	0.35**	0.58**	1														
8	Strategies	0.15	0.06	0.11*	0.28**	0.24**	0.27**	0.12*	1													
9	Impulsivity	0.45**	0.28**	0.25**	0.34**	0.34**	0.54**	0.64**	0.03	1												
10	Goal-directed	0.24**	0.07	0.11*	0.21**	0.18**	0.39**	0.56**	0.02	0.64**	1											
11	Non-acceptance	0.44**	0.3**	.21**	0.4**	0.37**	0.49**	0.55**	-0.01	0.62**	0.45**	1										
12	Factor 1	-0.16**	-0.02	-0.05	-0.16**	-0.12*	-0.36**	-0.28**	0.00	-0.43**	-0.21**	-0.32**	1									
13	Factor 2	-0.10	0.04	0.04	-0.07	-0.06	-0.24	-0.19**	-0.03	-0.26**	-0.2**	-0.25**	0.62**	1								
14	Factor 3	-0.2**	-0.04	-0.02	-0.18**	-0.2**	-0.39**	-0.39**	-0.01	-0.43**	-0.29**	-0.32**	0.37**	0.19**	1							
15	Factor 4	0.42**	0.29**	0.26**	0.45**	0.43**	0.51**	0.44**	0.27**	0.4**	0.31**	0.42**	-0.21**	-0.11*	-0.25**	1						
16	Factor 5	0.39**	0.24**	0.15**	0.35**	0.4**	0.36**	0.38**	0.25**	0.37**	0.27**	0.41**	-0.18**	-0.1	-0.24**	0.43**	1					
17	Factor 6	0.38**	0.25**	0.16**	0.28**	0.29**	0.33**	0.34**	0.13*	0.33**	0.24**	0.35**	-0.19*	-0.13*	-0.21**	0.41**	0.38**	1				
18	Instability	0.41**	0.23**	0.19**	0.35**	0.31**	0.49**	0.59**	-0.00	0.69**	0.46**	-0.54**	-0.51**	-0.41**	-0.33**	0.38**	0.32**	0.37**	1			
19	Identity	0.35**	0.13**	0.14**	0.35**	0.29**	0.58**	0.63**	0.07	0.56**	0.50**	0.52**	-0.41**	-0.34**	-0.32**	0.38**	0.34**	0.31**	0.64**	1		
20	Interpersonal	0.54**	0.37**	0.3**	0.44**	0.45**	0.48**	0.58**	0.2**	0.55**	0.41**	0.49**	-0.2**	-0.16**	-0.33**	0.44**	0.39**	0.41**	0.59**	0.53**	1	
21	Self-harm	0.46**	0.27**	0.27**	0.4**	0.38**	0.57**	0.59**	0.21**	0.63**	0.4**	0.53**	-0.44**	-0.35**	-0.43**	0.49**	0.36**	0.4**	0.62**	0.63**	0.63**	1

To address missing data, the mean substitution method was applied. Examination of the correlation matrix revealed no issues of multicollinearity among the observed variables, as the correlation coefficients ranged from –.51 to .72, remaining well below the threshold of .85, which indicates potential multicollinearity problems (Kline, 2015).

The structural equation modeling (SEM) results demonstrated an adequate fit between the hypothetical model and the data. The fit indices are summarized in Table 3 and indicate an acceptable model fit.

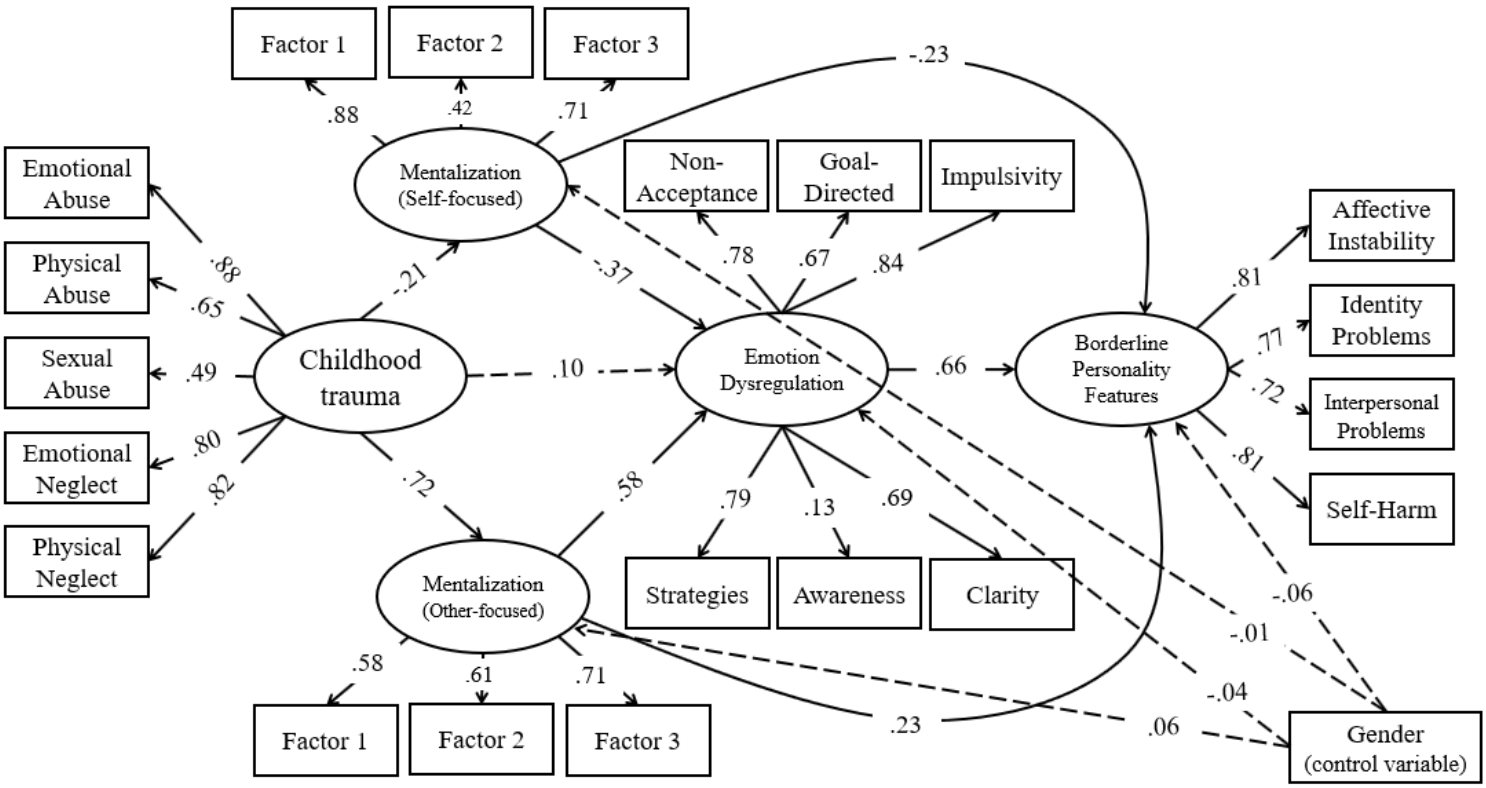
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Table 3. Structural model fit indices

Fitness index	Acceptable domain	value
χ^2		640.37
χ^2/df	Less than 5	3.23
CFI	More than 0.90	0.94
IFI	More than 0.90	0.94
RFI	More than 0.90	0.91
NFI	More than 0.90	0.92
SRMR	Less than 0.1	0.091
RMSEA	Less than 0.08	0.084

χ^2 = 640.37, χ^2/df = 3.23, CFI = 0.94, IFI = 0.94, RFI = 0.91, NFI = 0.92, SRMR = 0.091, and RMSEA = 0.084.

These indices collectively confirm that the proposed structural model provides a good representation of the observed data.



Note: A solid line indicates a significant path, and a dashed line indicates a nonsignificant path

Figure 1. Hypothetical structural model with standard coefficients

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As shown in Figure 1, childhood trauma significantly predicted self-focused mentalization (β = –.21, p < .01), other-focused mentalization (β = .72, p < .01), and emotion dysregulation (β = .10, *ns*). In turn, self-focused mentalization (β = –.23, p < .01), other-focused mentalization (β = .23, p < .01), and emotion dysregulation (β = .66, p < .01) significantly predicted borderline personality features.

Additionally, both types of mentalization directly influenced emotion dysregulation: Self-focused mentalization (β = –.37, p < .01) and other-focused mentalization (β = .58, p < .01). The effect of gender, included as a control variable, was nonsignificant for all endogenous variables. Figure 1 illustrates the standardized path coefficients, where solid lines represent significant paths and dashed lines denote nonsignificant ones.

To test the mediating effects of mentalization and emotion dysregulation, the bootstrap method (with a 95% confidence interval) was employed. A mediation effect was considered significant when zero was not included in the confidence interval (table 4).

Table 4. Bootstrap test results for mediating effects (hypothetical model)

Independent variable	Mediator variable	Dependent variable	indirect standardized coefficient	Bootstrap confidence interval 95%		Estimation Error	p value
				Low bound	High bound		
Childhood trauma	Mentalization (Self-focused)	Borderline Personality Features	0.048	0.004	0.091	0.022	0.032
Childhood trauma	Mentalization (Other-focused)	Borderline Personality Features	0.166	0.011	0.317	0.078	0.035
Childhood trauma	Emotion Dysregulation	Borderline Personality Features	0.066	- 0.105	0.230	0.085	0.462
Mentalization (Self-focused)	Emotion Dysregulation	Borderline Personality Features	- 0.244	- 0.334	-0.135	0.055	0.001
Mentalization (Other-focused)	Emotion Dysregulation	Borderline Personality Features	0.382	0.200	0.568	0.094	0.001

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Results indicated a significant indirect effect of childhood trauma on borderline personality features through: Self-focused mentalization**:** β = .048, 95% CI [0.004, 0.091] and Other-focused mentalization**:** β = .166, 95% CI [0.011, 0.317]. However, the indirect pathway through emotion dysregulation alone was not significant (β = .066, 95% CI [–0.105, 0.230]).

Significant serial mediation effects were also found: Self-focused mentalization → emotion dysregulation → BPD features**:** β = –.244, 95% CI [–0.334, –0.135] and Other-focused mentalization → emotion dysregulation → BPD features**:** β = .382, 95% CI [0.200, 0.568].

These findings suggest that childhood trauma primarily impacts mentalization capacity, which subsequently influences borderline personality features both directly and indirectly through emotion dysregulation. The model supports a sequential pathway, where early traumatic experiences disrupt mentalization, leading to impaired emotion regulation and, ultimately, increased BPD traits.

Discussion

The findings of this study confirmed the research hypothesis that mentalization mediates the relationship between childhood trauma and borderline personality features in adolescents. This result aligns with previous studies highlighting the crucial role of mentalization in understanding how early adverse experiences contribute to personality pathology (Ensink et al., 2014; Hill et al., 2011; Kay, 2018; Chiesa & Fonagy, 2014). The relationship between childhood trauma and deficits in mentalization may be explained by the disruption of children's motivation and ability to construct coherent representations of relationships, which are often distorted as a result of abusive or neglectful experiences (Fonagy & Luyten, 2009). Such traumatic experiences can undermine the developmental emergence of mentalization, increasing vulnerability to interpersonal and emotional difficulties later in life (Chiesa & Fonagy, 2014).

An important contribution of this study lies in demonstrating that self-focused and other-focused mentalization differentially predict emotion regulation and borderline personality features. Specifically, self-focused mentalization negatively predicted BPD features, while other-focused mentalization positively predicted them. This suggests that the ability to accurately perceive and interpret one's own mental states—such as emotions and intentions—may be more protective and

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adaptive than focusing excessively on others' internal experiences. Conversely, heightened sensitivity to others' emotions, when not integrated with accurate self-understanding, may lead to hypermentalization, a maladaptive pattern characterized by over-attribution of meaning to others' behaviors (Fonagy & Bateman, 2008). This pattern has been frequently observed among individuals with borderline personality symptoms, who tend to exhibit elevated interpersonal sensitivity and preoccupation with others' emotional states (Barnow et al., 2009; Lazarus et al., 2014; Rezaei et al., 2018).

Moreover, this study confirmed the indirect role of mentalization in predicting emotion regulation difficulties, consistent with previous research (Innamorati et al., 2017; Sharp et al., 2011). The findings indicate that childhood trauma does not directly cause emotion dysregulation, but rather contributes to it indirectly through deficits in mentalization. In other words, impairments in mentalization mediate the pathway from early trauma to later emotional instability and maladaptive behavioral responses. This interpretation supports the developmental perspective that mentalization facilitates emotional understanding and regulation by allowing individuals to represent and process their internal states independently from external influences (Fonagy & Allison, 2014; Fonagy & Target, 2006).

In developmental terms, mentalization enables children to comprehend and organize emotional experiences, thereby laying the foundation for self-regulation (Fonagy & Target, 2006). When trauma impairs this ability, emotional regulation becomes less effective, increasing susceptibility to emotional instability and borderline personality features. Thus, the results suggest a sequential pathway: childhood trauma disrupts mentalization, which leads to emotion dysregulation and, subsequently, the emergence of borderline personality traits.

Overall, the present study contributes to a growing body of literature suggesting that mentalization and emotion regulation act as key mediators in the development of borderline personality disorder. It extends prior findings by evaluating this mechanism within an integrated model and among adolescents, a group for whom early intervention may be particularly beneficial. Emotional trauma in childhood appears to establish a vulnerability that, when coupled with impaired mentalization and emotional control, fosters maladaptive personality patterns consistent with BPD.

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Limitations and Recommendations

Several limitations should be acknowledged. First, the study employed a convenience sampling method, which may limit the generalizability of findings. Second, data collection occurred online due to the COVID-19 pandemic, potentially excluding adolescents without internet access or familiarity with digital platforms. Third, the cross-sectional design restricts causal inferences; future research should employ longitudinal designs to clarify temporal relationships among the variables. Finally, reliance solely on self-report instruments may introduce response bias; future studies could incorporate clinical interviews, observational data, or multi-informant reports to enhance the validity of findings.

Data availability statement

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

Ethics statement

The studies involving human participants were reviewed and approved by ethics committee of Social Welfare and Rehabilitation Sciences University.

Author contributions

All authors contributed to the study conception and design, material preparation, data collection and analysis. All authors contributed to the article and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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