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Original article

Clinical differences and associations between women with borderline personality and their partners: an exploratory study

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SUMMARY

Introduction

One of the most interesting areas of interpersonal functioning in people with Borderline Personality Disorder (BPD) is their romantic relationships (RR). In this empirical context, our main objective was to identify the principal differences and associations between clinical and relational variables in women with BPD compared with their partners.

Methods

A cross-sectional, comparative study was carried out on women with BPD (n = 23) and their partners (n = 23). Clinical and relational variables were measured using the following: the World Health Organization Quality of Life (WHOQOL) instrument, the Rosenberg Self-Esteem scale, the Personality Inventory (NEO PI-R), the Conflict Tactics Scale (CTS), the Communication Patterns Questionnaire (CPQ), the Experiences in Close Relationships scale (ECR), the Dyadic Adjustment Scale (DAS), and the Index of Sexual Satisfaction (ISS). Stepwise MANCOVA, MANOVA and Pearson correlates were performed.

Results

Partners scored significantly higher than did women with BPD on social relationships ($F = 6.08, p = .01$), self-esteem ($F = 12.90, p < .001$), agreeableness ($F = 12.19, p < .001$), conscientiousness ($F = 14.00, p < .001$), avoidant communication style ($F= 72.78, p < .001$), cohesion ($F= 10.09, p < .001$), and affection ($F = 72.20, p < .001$). Conversely, BPD women scored significantly higher than their partners did on demanding communication ($F = 278.76, p < .001$), consensus ($F = 62.36, p < .001$) emotional satisfaction ($F = 11.08, p < .001$), and anxious attachment ($F = 38.94, p < .001$). Correlation analyses showed significant positive associations between agreeableness in partners and demanding communication style in BPD women($r = .43, p = .03$). Likewise, satisfaction in the BPD group was positively associated with conscientiousness in partners ($r = .53, p = .01$).

Conclusions

Women with BPD and their Partners shown a relational dyadic based on hiperdemanding communication of the BPD and an avoidant and contention pattern of the partner.

Key words: borderline personality disorder, romantic relationships, pathological dyadic, partner, intimacy

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The Authors declare no conflict of interest

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Introduction

Borderline Personality Disorder (BPD) is a severe, chronic mental disorder, with a prevalence of between 2 and 5.9% in community samples and between 15% and 20% in psychiatric outpatient samples [1-4]. Because of the symptomatic heterogeneity of BPD, empirical studies have tended to group BPD into four clusters of interrelated symptoms: emotional deregulation, high impulsivity, identity disturbances, and interpersonal dysfunction [3,5,6].

In relation to the last cluster mentioned above, interpersonal dysfunction, various longitudinal and cross-sectional studies have shown patients in this group to have a higher number of recurring interpersonal conflicts compared with healthy controls [5-8]. Studies to date have positively associated this interpersonal dysfunction with certain developmental factors, such as childhood traumatic episodes (CTE), insecure attachment, hypomentallizing, and early maladaptive schemas [9-12].

Such interpersonal dysfunction has its greatest expression in the context of romantic relationships (RRs). In particular, various studies have found positive associations between interpersonal dysfunction and instability in RRs in people with BPD [13]. In addition, it should be noted that a considerable number of emotional relapses treated during psychiatric emergencies and/or hospitalisation are the cause of romantic breakdowns and/or conflicts with partners [14,15].

Furthermore, longitudinal studies have found that people with BPD have shorter-lasting RRs and a higher number of romantic partners (i.e., through infidelity or promiscuity) compared with healthy controls [8,14-17]. In this same vein, cross-sectional studies have found people with BPD to manifest more maladaptive relational behaviours(i.e., passive-aggressive communication styles, insecure attachment styles, intimate aggression) compared with healthy controls. These behaviours promote a recurring pattern of ruptures-reconciliations [14,18-20]. Moreover, other cross-sectional and longitudinal studies have reported that some clinical characteristics of people with BPD (i.e., the presence of CTE, low self-esteem, low social cognition) are positively associated with marital aggression and ultimately the break-up of RRs compared with samples with no BPD [14,21-25].

As for aggressive behaviour in RR, a number of cross-sectional and longitudinal studies have found a positive association between aggression and various typical BPD symptoms (i.e., emotional deregulation, impulsivity, depressive mood) [14,26,27]. That is, compared with healthy controls, people with BPD have been found to exhibit more aggressive behaviours (i.e., physical, verbal, psychological aggression) towards their partners [14,28,29]. For example, one four-month longitudinal follow-up study reported that 37% of partners of people with BPD were victims of physical or psychological aggression [30]. Similarly, other studies have found between 20 and 60% of partners of people with BPD to experience physical aggression, 80% verbal aggression [14,29]. Finally, other research has shown a positive association between aggression (i.e., hostility, physical and/or verbal aggression) and emotional and sexual dissatisfaction in RRs [14,30].

Regarding the clinical profile of partners of people with BPD, an 18-month follow-up study found that these partners exhibited a greater number of maladaptive behaviours (i.e., greater physical aggression, avoidant communication style, avoidant attachment style) than did partners of people without BPD [14]. Some studies have also reported a higher incidence of personality disorders (paranoid, obsessive-compulsive and avoidant disorders) in the partners of people with BPD compared with partners of people without BPD [14,31,32].

The findings presented in this paper are based on a comparative clinical framework involving BPD patients and healthy controls. However, empirical study of the clinical profile of partners of people with BPD is in an emerging context [14,16]. Thus far, previous studies have failed to generate robust results on associations and differences in relational and clinical variables between people with BPD and their partners.

In this empirical context, the overall objective of the study was to determine the main clinical differences between people with BPD and their partners. Specifically, the objectives were: i) to identify differences in clinical variables between people with BPD and their partners, in terms of quality of life, self-esteem, and personality dimensions; ii) to elucidate differences in relational variables between people with BPD and their partners, in terms of communication style, attachment style, and emotional and sexual satisfaction; and iii) to determine the associations between the clinical and relational variables of people with BPD and their partners.

Methods

Participants

Potentially eligible participants were initially referred to us by their clinicians as they consecutively attended the Adult Outpatient Mental Health Centre in Mataró (Barcelona, Spain) from December 2016 to May 2018. The inclusion criteria for the BPD group were meeting the diagnostic criteria for BPD according to the DSM-5 [1], being aged 18-65 years, and, in accordance with similar studies, having been in an RR for twelve months or having lived with their partner for four months [14,16,33]. The exclusion criteria for the BPD group were the following: i) having lifetime comorbidity with a schizophrenia spectrum disorder and/or pervasive developmental disorder, according to DSM-5; ii) having a diagnosed intellectual disability (IQ < 70), as not edin their clinical records; and iii) having any idiomatic barriers to reading/speaking Spanish or Catalan languages. Because of the considerable prevalence of substance misuse among BPD patients, only those who showed symptoms of intoxication or substance withdrawal at the time of assessment were excluded. Of the 27 potentially suitable outpatients, two declined to participate, mainly because they did not want to

answer sensitive questions in the questionnaires. Another two patients did not meet the lifetime criterion for BPD but had borderline traits. Hence, the final sample comprised 23 participants in total: 23 BPD women and their 23 partners (see Figure 1).

Participants individually attended one session of two hours, on average, in order to complete the administered questionnaires and semi-structured interviews. All the participants (women with BPD and their partners) were interviewed directly by the authors of this paper, all of who mare doctoral-level clinicians or clinical psychologists and widely experienced in personality disorders. All three were also trained in conducting the assessment. The degree of agreement between interviewers on BPD diagnoses was high (*Cohen's Kappa* = .87). One week later, participants completed self-administered questionnaires in a second session, with the interviewers on hand to answer any questions they might have. The study was approved by the hospital's Institutional Review Board, and informed consent was obtained from all patients after being given a full explanation of the nature of the study.

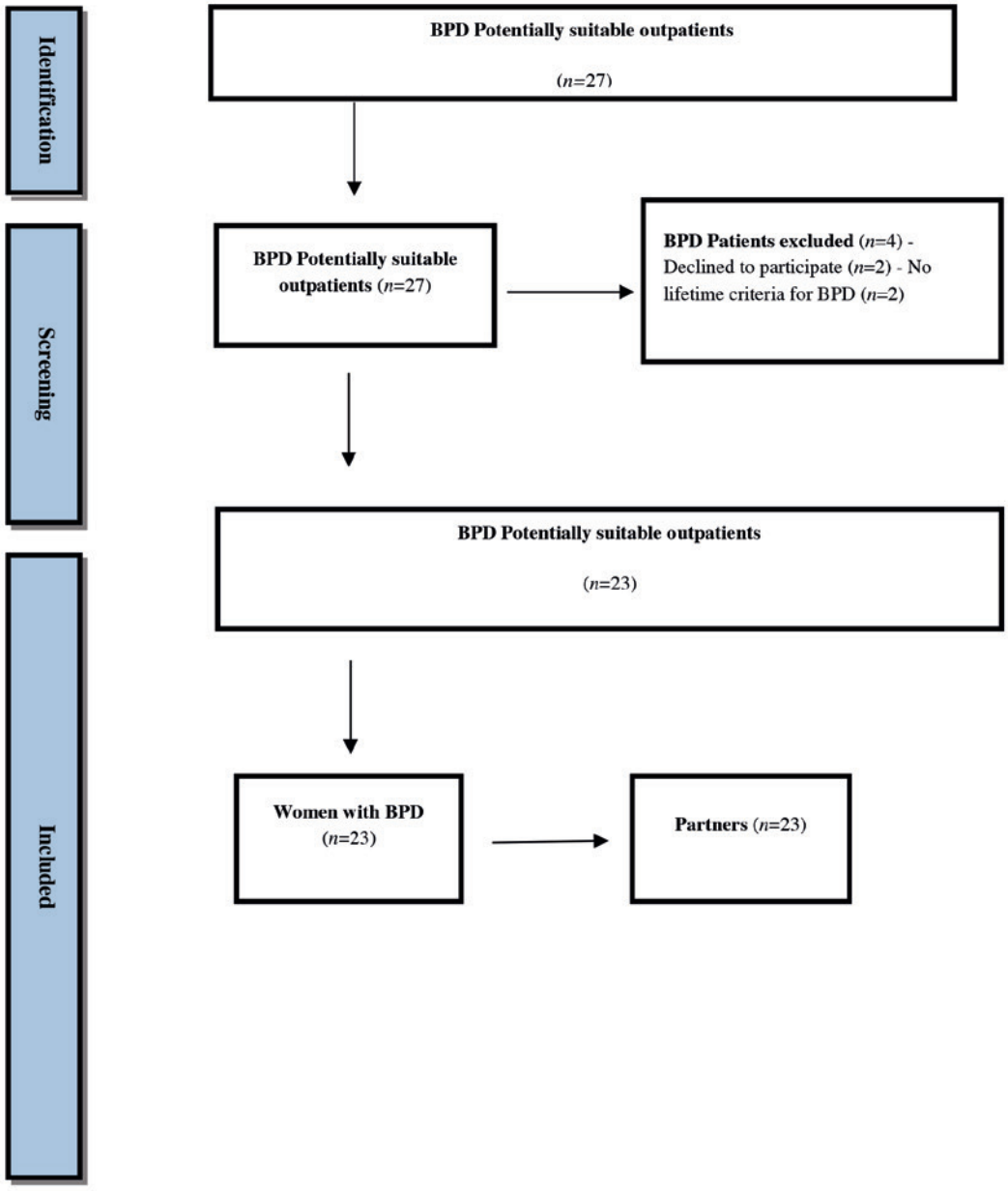

FIGURE 1. *Flow-chart of study selection.*

Instruments

Demographic information was collected using an ad hoc questionnaire, as well as via interviews with participants when such information was either no longer available in their clinical records or was contradictory.

Instruments for women with BPD and their partners

Personality Dimensions. The Personality Inventory NEO (NEO-PI-R) [34]. This self-administered questionnaire measures personality dimensions. Validation of the Spanish version showed it to have adequate internal consistency (*Cronbach´s alpha* = .60 to.90).

Depressive Mood. Beck's Depression Inventory(BDI) [35]. Validation of the Spanish version show edit to have adequate internal consistency (*Cronbach's alpha* = .90), proving it to be a reliable instrument for assessing the severity of depressed mood.

Quality of Life and Self-Esteem. The Spanish version of the World Health Organization Quality of Life, Short-Form (WHOQOL-BREF) [36] was used to measure quality of life and showed adequate internal consistency (*Cronbach's alpha* > .80); self-esteem was measured using the Spanish version of the Rosenberg Self-esteem (RSE) scale [37,38], which also showed adequate internal consistency (*Cronbach's alpha* = .87).

Attachment Style. The Experiences in Close Relationships scale (ECR-R) [39,40].The ECR-R has two dimensions: anxiety and avoidance. Validation of the Spanish version showed it to have adequate internal consistency (*Cronbach's alpha* > .65).

Communication Patterns. The Communication Patterns Questionnaire (CPQ) [41,42]. This has three scales: the mutual constructive communication scale; the mutual avoidance communication scale; and the demand/withdraw communication scale. Validation of the Spanish version showed it to have adequate internal consistency (*Cronbach's alpha* > .75).

Intimate Aggression. TheConflict Tactics Scale(CTS-2) [43]. This 39-item self-report instrument measures levels of intimate violence in an RR. It has four scales: negotiation; physical aggression; sexual cohesion; and injuries. Validation of the Spanish version showed it to have adequate internal consistency (*Cronbach's alpha* = .88).

Emotional and Sexual Satisfaction. TheDyadic Adjustment Scale (DAS) [45,46]. The DAS was used to assess satisfaction with relationships. Validation of the Spanish version showed it to have adequate internal consistency (*Cronbach's alpha* > .80). The Sexual Satisfaction Index (SSI) [47,48] provided an overall score of sexual dysfunction. Validation of the Spanish version showed it to have adequate internal consistency (*Cronbach's alpha* = .76 to .86).

Social Cognition. The Interpersonal Reactivity Index (IRI) [49]. This measure has four subscales: Perspective-Taking, Fantasy, Empathic Concern, and Personal Distress. Validation of the Spanish version showed it to have adequate internal consistency (*Cronbach's alpha* > .70).

Instruments for women with BPD only

Personality Disorder Diagnosis. Personality Disorders (SCID 5 – PD) [49]. The original version in English was translated into Spanish and later revised by a native Spanish speaker (bilingual) with knowledge of psychology. Here, a semi-structured interview is used to diagnose BPD. The Spanish version showed adequate internal consistency (*Cronbach's alpha* = .81).

Statistical analysis

Depending on the nature of the variables, the chi-square test, Mann-Whitney U test, ort-test was used to analyse the sociodemographic data. The Shapiro-Wilk test was then used to confirm the normal distribution of the quantitative clinical data for both clinical groups.

An initial analysis of covariance (MANCOVA) was performed using depressive mood and social cognition as covariates to observe their effect on variance in the BPD patients group and that of their partners.

A MANOVA was then performed, this time to compare the psychopathological and relational variables of the patients and their partners. As a measure of effect size, the partial eta square (small > .02, medium > .05, large > .08) was calculated ($p < .05$ being used to denote a significant univariate contrast). Pearson correlations were performed to identify possible associations between the most relevant variables for the patients and their partners. Statistical analyses were performed using the Statistical Package for the Social Sciences (SPSS for Windows, Version 23.0).

Results

Sociodemographic differences between women with BPD and their partners

The groups differed statistically only on occupation, where a higher level of active employment was apparent in the partners group ($p < .05$). A MANCOVA revealed no statistically significant differences for the variables depressive mood or social cognition ($p < .05$) (see Table I).

Clinical differences between women with BPD and their partners

Clinical differences between women with BPD and their partners are shown in Table II.

One MANOVA revealed statistically significant differences between the two groups for quality of life and self-esteem ($F = 33.22$, $p = .00$, *Wilks* $\lambda = .22$). The univariate analysis showed that the partners group scored significantly higher on social relationships and self-esteem ($p < .05$). Effect sizes were small, the power moderate to high.

TABLE I. *Sociodemographic comparison between BPD women and their partners.*

	Women with BPD (n = 23) n (%)	Partner (n = 23) n (%)	Statistics χ^2 / t / *F*	*P*
Age (mean/SD)	38.65 (6.46)	40.42 (9.23)	t = -.86	.23
Education level	4 (18.20)	1(3.30)	χ^2 = 6.58	.08
– No studies	4 (18.20)	6 (27.30)	-	-
– Primary	8 (31.80)	10(53.60)	-	-
– Secondary	7 (31.80)	5 (15.80)	-	-
University			-	-
Occupation	3 (13.60)	2 (8.70)	χ^2 = 3.83	.03*
– Student	6 (27.30)	18 (78.30)	-	-
– Employee	5 (22.70)	2 (8.70)	-	-
– Unemployed	4(22.71)	1 (4.30)	-	-
– Retired due to disability	3 (13.60)	0 (.00)	-	-
Medical leave			-	-
Children (mean/SD)	.87 (.81)	.80 (.76)	t = -.07	.94
BDI (mean/SD)	22.64 (5.90)	19.06 (4.28)	*F* = 1.24	.23
IRI (mean/SD)				
– Fantasy	11.82 (4.65)	10.00 (4.46)	*F* = 1.24	.22
– Perspective Tacking	10.76 (6.36)	13.77 (6.59)	*F* = .94	.35
– Empathic Preoccupation	9.80 (4.45)	9.62 (6.39)	*F* = .08	.93
– Personal Distress	9.06 (4.91)	6.46 (40.25)	*F* = 1.79	.08

BPD: Borderline Personality Disorder; SD: Standard Deviation
***p < .00 in women with BPD vs partner*
**p < .05 in women with BPD vs partner*

TABLE II. *Psychopathological comparison among clinical variables between BPD women and their partners.*

	Women with BPD (n = 23) M *(SD)*	Partner (n = 23) M *(SD)*	Statistics *F*	*P*	η2	*P*
WHOQOL						
– Physical health	16.45 *(4.76)*	11.53 *(6.10)*	.75	.39	.15	.56
– Psychological health	13.30 *(3.35)*	7.76 *(5.33)*	1.71	.19	.17	.65
Social relationships	8.60 *(4.53)*	28.65 *(9.99)*	6.08	.01*	.21	.87
Envorinment	17.80 *(5.43)*	16.28 *(4.89)*	.14	.70	.10	.32
Self-esteem	16.40 *(3.99)*	27.10 *(10.90)*	12.90	.00**	.75	.93
NEO PIR						
– Neuroticism	109.10 *(28.07)*	138.53 *(25.12)*	12.10	.00**	.24	.92
– Extraversion	102.71 *(35.04)*	138.68 *(22.59)*	14.52	.00**	.28	.96
– Openness	104.95 *(33.84)*	126.42 *(33.39)*	4.06	.07	.20	.50
– Agreeableness	93.76 *(37.74)*	133.68 *(34.19)*	12.19	.00**	.39	.92
– Conscientiousness	104.00 *(35.33)*	145.47 *(34.62)*	14.00	.00**	.43	.95

BPD: Borderline Personality Disorder; NEO PIR: Neuroticism Extraversion Openness Personality Inventory Revised; SD: Standard Deviation; WHOQOL: World Health Organization Quality of Life
***p < .00 in women with BPD vs partner*
**p < .05 in women with BPD vs partner*

Another MANOVA also revealed statistically significant differences between the personality dimensions ($F = 7.23$, $p = .00$, *Wilks* $\lambda = .48$). The univariate analysis showed that the partners group scored significantly higher on neuroticism, extraversion, agreeableness, and conscientiousness compared with the BPD group ($p < .05$). Effect sizes were medium to large, the power high.

Relational differences between women with BPD and their partners

The relational differences between women with BPD and their partners are shown in Table III.

One MANOVA showed statistically significant differences between the communication style variables ($F = 129.02$, $p = .00$, *Wilks* $\lambda = .08$). The univariate analysis revealed that the partners group scored significantly higher on avoidant communication compared with the BPD group ($p < .05$). Conversely, the BPD group scored significantly higher on demanding communication style ($p < .05$). Effect sizes were small, the power high.

Another MANOVA revealed no statistically significant differences between the variables of intimate aggression ($F = 2.92$, $p = .08$, *Wilks* $\lambda = .56$). Similarly, the univariate analysis showed no significant differences between the two groups.

A further MANOVA did reveal statistically significant differences between the attachment style variables ($F = 2.38$, $p = .00$, *Wilks* $\lambda = .35$). The univariate analysis showed that the BPD group scored significantly higher on anxious attachment compared with the partner group ($p < .05$). Effect sizes were small, the power moderate to high.

The final MANOVA revealed statistically significant differences between the variables for emotional satisfaction and sexual satisfaction ($F = 281.71$, $p = .00$, *Wilks* $\lambda = .03$). Regarding emotional satisfaction, the BPD group presented significantly higher scores on consensus and satisfaction ($p < .05$). In contrast, the partners group showed significantly higher scores on cohesion and affection ($p < .05$). The effect sizes were small, the power moderate to high. For sexual satisfaction, the univariate analysis showed no statistically significant differences ($p > .05$).

Associations between clinical variables and relational variables

Associations between clinical variables and relational variables in women with BPD and their partners

Associations between clinical variables and relational variables in women with BPD and their partners are shown in Table IV. The correlation analysis revealed sig-

TABLE III. *Clinical differences in relational variables between BPD women and their partners.*

	Women with BPD (*n = 23*) M (*SD*)	Partner (n = 23) M (*SD*)	Statistics *F*	*P*	η2	*P*
CPQ						
– Constructive com.	23.96 *(9.65)*	25.61 *(18.44)*	.13	.71	.00	.06
– Avoidant com.	24.17 *(6.61)*	72.78 *(29.24)*	59.90	.00**	.25	1.00
Demanding com.	85.30 *(18.31)*	10.56 *(5.48)*	278.76	.00**	.26	1.00
CTS						
– Med. physical aggression	24.40 *(41.40)*	32.78 *(10.64)*	.69	.40	.05	.12
– Psychological aggression	15.28 *(43.23)*	32.56 *(12.83)*	2.68	.10	.11	.36
– Physical grave aggression	12.20 *(42.96)*	23.56 *(5.22)*	1.19	.28	.06	.18
Argumentation	13.48 *(43.48)*	14.00 *(6.60)*	.00	.96	.02	.05
ECR						
– Anxious attachment	36.39 *(6.73)*	7.84 *(5.29)*	38.94	.00**	.31	1.00
– Avoidant attachment	38.13 *(4.22)*	39.17 *(12.22)*	.16	.69	.01	.06
DAS						
Consens	41.09 *(11.44)*	21.11 *(14.10)*	62.36	.00**	.26	1.00
– Satisfaction	26.96 *(7.23)*	*20.41* (4.19)	11.08	.00**	.02	.090
– Cohesion	13.74 *(5.26)*	*18.71* (4.31)	10.09	.00**	.19	.87
– Affection	8.57 *(3.48)*	75.53 *(11.75)*	72.20	.00**	.19	1.00
– DAS Total	85.87 *(17.13)*	*84.57* (19.06)	.20	.88	.00	.05
ISS Total	63.99 *(11.02)*	49.20 *(11.09)*	2.84	.10	.11	.45

BPD: Borderline Personality Disorder; CPQ: Communication Patterns Questionnaire; CTS: Conflict Tactics Scale; ECR: Experience Close Relationship; DAS: Dyadic Adjustment Scale; ISS: Index Sexual Satisfaction; SD: Standard Deviation

***p < .00 in women with BPD vs partner*

**p < .05 in women with BPD vs partner*

TABLE IV. *Associations between clinical variables and relational variables of Women with BPD and their partners.*

Partner variables (n = 23) r/(p)	Womenwith BPD (n = 23) Demanding com.	Anxious attachment	Consens	Satisfaction
Neuroticism	.70 (.77)	.37 (.20)	-.13 (.58)	-.32 (.16)
Extraversion	.37 (.11)	.07 (.74)	.04 (.95)	.13 (.57)
Aggreableness	**.47 (.03)***	.26 (.26)	.15 (.52)	-.06 (.79)
Conscientciouness	-.01 (.96)	.28 (.22)	.09 (.70)	**.53 (.01)***
Social relationships	-.19 (.58)	-.24 (.49)	.12 (.72)	-.46 (.17)
Self-esteem	-.11 (.65)	-.09 (.70)	-.02 (.93)	.35 (.15)
Afection	.31 (.20)	-.41 (.07)	.34 (.15)	-.35 (.15)

BPD: Borderline Personality Disorder
***p < .00.*
**p < .05.*

nificant positive associations between the dimensions of agreeableness in the partners group and demanding communication style in the BPD group (r = .43, p = .03). Likewise, satisfaction in the BPD group was positively associated with conscientiousness in the partners group (r = .53, p = .01).

Associations between clinical variables and relational variables in partners

Correlation analysis showed significant positive associations between psychological health and satisfaction in partners (r = .72, p = .02).In addition, a higher score on social relations was positively associated with affect (r = .70, p = .03).

Discussion

The primary objective of this research was to determine the main clinical differences and associations in clinical and relational variables between people with BPD and their partners (see Figure 2). Overall, one of our most significant results was that their RRs were more satisfying for the women with BPD than for their partners. The lower satisfaction of partners is particularly important, given that their psychological health showed a significant positive correlation with emotional satisfaction. These findings are in contrast with the results of other studies that have reported higher emotional satisfaction in non-BPD partners compared with BPD partners in an RR [14,16]. However, it is important to stress that our study measured differences and associations between RR members in comparison with other comparative studies [14,16].

Additionally, the fact that the partners of women with BPD scored significantly higher on the social relationships variable suggests that they may form other types of interpersonal attachments. These other social relationships may give them personal satisfaction, given their reported dissatisfaction in their RR [14,33]. If so, in psychotherapeutic work with partners of patients with BPD, consolidating other social attachments may be a protective factor against potential burn-out caused by living with a person with BPD. These findings are consistent with those of a cross-sectional study that found partners in RRs to report a higher number of social relationships, compared with their BPD partner [33].

Another interesting finding of this study was that women with BPD had a significantly more demanding communication style, while their partners displayed amore avoidant communication style. Furthermore, there was a significant positive correlation between the two variables. These findings are consistent with those of a longitudinal study examining BPD samples [14] and provide tentative evidence of a transactional (not merely "intrapsychic") origin of the relational psychopathology of a person with BPD in an RR. Thus, a solid and dysfunctional attachment seems to develop, whose equilibrium is based on the principle of a pathological dyadic comprising both members. In relation to the potential clinical characteristics that could be modulating this dysfunctional dyadic, the partners in the present study scored significantly higher than their BPD partners did on the personality dimensions of agreeableness and conscientiousness, as well as on the variable affection.

Patients with BPD scored significantly higher than their partners did on anxious attachment. Taken together, these results suggest that the relational dyadic operates on the basis of clearly fixed roles within an interdependency: a more emotionally demanding tendency (hyperdemanding) on the part of the BPD patient; and a ten-

dency to be more emotionally contained, on the part of their partners. However, we cannot state conclusively whether these roles actually represent the "states" or "traits" of those involved in the RR, since the data were self-reported and cross-cutting in nature. Longitudinal studies are therefore necessary, preferably with a more ecological evaluation methodology based primarily on observational records [14,17,33].

A number of clinical implications for psychotherapeutic treatment arise from the findings of this research. First, our results support approaches such as systemic partner interventions or behaviouralfamily therapy for patients with BPD [41]. Likewise, the use of cognitive-behavioural techniques to work on co-dependence and assertiveness in the partners of patients with BPD would be justified [41]. However, it is important to stress that not all patients with BPD will be susceptible to these types of therapeutic interventions. Rather, this intervention framework should be limited to BPD patients in RRs that have been stable for a period of time (for at least 12 months) and who are motivated to change, and where both members of the RR comprise a pathological dyadic [41].

This study has various limitations that should be considered. First, since it is a cross-cutting study, causal relationships between the psychopathology of women with BPD and relational variables of their RRs cannot be established. In this sense, it is not possible to know the current romantic status of the participants. Second, the sample size was small and thus the generalisation and reliability of our results are limited. Third, the partners of the participants with BPD were not assessed at the categorical level (psychiatric disorders of Axis I and Axis II). And finally, only self-administered instruments of a dimensional nature were used.

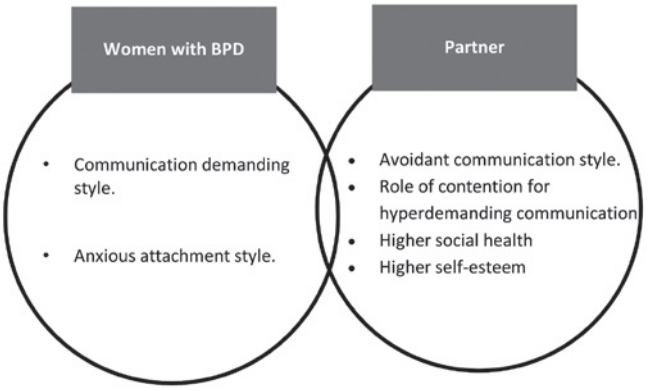

FIGURE 2. *Relational dyadic between women with BPD and their partners.*

In conclusion, further longitudinal and cross-sectional studies of the RRs of people with BPD are needed. Specifically, it would be useful to know the incidence of Axis I and Axis II psychiatric disorders, childhood trauma, and early maladaptive schemas in samples of people with BPD and their partners. Such clinical data could prove useful in elucidating a relational pattern between people with BPD and their partners (Fig. 2).

Ethical statements

Authors declare that all subjects have given their informed consent and the study protocol has been approved by the investigation ethical committee of Hospital of Mataro, Barcelona.

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