Parents’ Emotional Neglect and Overprotection
According to the Recollections of Patients
With Borderline Personality Disorder

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Objective: The purpose of this study was to test clinical hypotheses about the role of emotional neglect and overprotection in the childhood of patients with borderline personality disorder. Method: The subjects were male and female borderline (N=62) and nonborderline (N=99) patients from a general hospital psychiatric clinic and a university student mental health clinic. Both groups were administered the Parental Bonding Instrument, which measures subjects’ recollections of parenting on dimensions of care and protection. Results: The findings showed that the patients with borderline personality disorder remembered both their fathers and their mothers as having been significantly less caring and more controlling than did the nonborderline patients. The results were the same for male and female subjects and for subjects from both sites. Conclusions: The recollections provide support for psychodynamic theories about the childhood of borderline patients and for a theory of biparental failure in the development of borderline pathology.

(Clinicians treating patients with borderline personality disorder have proposed that early family experience could contribute to the development of this disorder. Adler (1) suggested that the sense of loneliness felt by these patients could be accounted for by their parents’ unavailability to them when they were children. Masterson and Rinsley (2) described pathological enmeshment in childhood, with overprotective mothers interfering with autonomous development. On the basis of the developmental theory of Mahler et al. (3), Masterson and Rinsley suggested that selective maternal availability during the separation-individuation phase of development predisposes to borderline psychopathology later in life. In this view the mother accepts the child’s needs for symbiosis but rejects needs for autonomy. Consequently, one could conceptualize the ideas of Masterson and Rinsley about the childhood of patients with borderline personality disorder as combining elements of overprotection and neglect. This would explain the oscillations of attachment seen in borderline patients—oscillations between feelings of engulfment and feelings of abandonment by others (4). These ideas have been empirically investigated both by asking patients to recollect their childhoods (5–9) and by directly observing families (10). The data suggest that patients with borderline personality disorder remember their childhoods as characterized by emotional neglect. The evidence on whether neglect was remembered in relation to fathers, mothers, or both parents has been somewhat contradictory. Although most data have not suggested that borderline patients remember their parents as overprotective (5, 7, 9), one study (8) reported recollections of both overprotection and neglect.

There are methodological problems with these studies. In several cases (5–7) the instruments used to measure childhood recollections of parental behavior lacked reliability and validity. Only two previous reports (8, 9) used a well-standardized measure, Parker’s Parental Bonding Instrument. Some studies (5, 7, 9) used only female borderline patients, whereas others (6, 8) collapsed data from both male and female patients. Since the developmental path to psychopathology may be different in the two sexes, a study that allows separate analysis of reports from male and female subjects is needed. Also, some samples have been drawn from patients in hospital clinics (6, 8), whereas other studies have examined patients who are university students (5, 7, 9). A research design that allows comparison of patients drawn from different sites would be valuable, since the childhood experiences of borderline patients who reach the university level of...


TABLE 1. Scores on the Parental Bonding Instrument of Male and Female Patients With and Without Borderline Personality Disorder From Two Sites

<table>
<thead>
<tr>
<th>Item</th>
<th>Scores of Borderline Patients (N=62)</th>
<th>Scores of Nonborderline Patients (N=99)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (N=28)</td>
<td>Female (N=34)</td>
</tr>
<tr>
<td></td>
<td>University (N=10)</td>
<td>Hospital (N=18)</td>
</tr>
<tr>
<td></td>
<td>Mean SD</td>
<td>Mean SD</td>
</tr>
<tr>
<td>Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>21.7 10.3</td>
<td>22.8 6.5</td>
</tr>
<tr>
<td>Father</td>
<td>16.2 5.3</td>
<td>15.3 7.3</td>
</tr>
<tr>
<td>Protection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>17.8 10.3</td>
<td>19.6 9.5</td>
</tr>
<tr>
<td>Father</td>
<td>17.8 7.5</td>
<td>18.8 9.8</td>
</tr>
</tbody>
</table>

*Four-way ANOVA: main effect for diagnostic groups (F=15.53, df=1, 153, p=0.0001).

bFour-way ANOVA: main effect for diagnostic groups (F=8.69, df=1, 153, p=0.004).

education could be different from those of patients who do not. Finally, the sample sizes in all of the previous studies were small, limiting the generalizability of the data. The present investigation used a well-validated instrument with a larger sample of patients with borderline personality disorder and included both male and female subjects drawn from university and hospital clinic populations.

METHOD

Male and female subjects were drawn from two sites, a university student mental health service and a general hospital outpatient psychiatry clinic. Diagnoses were based on the retrospective version of the Diagnostic Interview for Borderline Patients (DIB) (11). The retrospective version has been shown to be equivalent to the interview version for purposes of establishing a diagnosis of borderline personality disorder (12). Chart review was carried out for all subjects by a senior psychiatrist (J.P.) who was blind to other measures. Patients who received scores of 7 or more out of 10 on the DIB were included in the borderline group (N=62). Those who received scores of 4 or less were assigned to the nonborderline group (N=99). To ensure that two discrete groups were obtained, patients who received a score of 5 or 6 were excluded from the study. The mean±SD ages for the total borderline and nonborderline groups were 29.6±9.6 and 29.3±8.6 years, respectively (F=0.03, df=1, 153, n.s.). Both the borderline and the nonborderline subjects were subgrouped on the basis of sex and site. The subgroup of female university students was the same as that used in a previously published preliminary report (9). The number of patients in each subgroup is reported in table 1.

The Parental Bonding Instrument (13) was administered to all subjects. This is a self-report scale measuring perceptions of two dimensions (care and protection) underlying parental behavior. The care items range from affection to neglect. The protection items range from overprotection to allowance of independence. The instrument requires subjects to score their parents on a 4-point Likert scale (0–3) on 25 items (12 concerning care and 13 concerning protection) as remembered from their first 16 years. Scores for care (range=0–36) and protection (range=0–39) were obtained for each parent. The Parental Bonding Instrument has been standardized in a series of large-scale normative studies and has reasonable test-retest and split-half reliability (14). Tests for validity of the instrument in both normative and clinical populations showed concurrence with ratings of parental behavior made by siblings, with parents' self-ratings, and with clinical ratings drawn from interviews of subjects and their parents (14).

RESULTS

The mean scores and standard deviations for care and protection for both borderline and nonborderline patients according to sex and site are presented in table 1. In order to investigate whether the Parental Bonding Instrument scores could be differentiated according to diagnostic group, sex of patient, or site, two four-way, mixed-design analyses of variance (ANOVAs) were carried out for both the care and protection scores with diagnostic group, sex of patient, and site as the three between-subject factors and sex of parent as the within-subject factor.

The ANOVA for care yielded a highly significant main effect for diagnostic group: the borderline patients remembered their parents as being less caring than did the nonborderline patients. Differences in the main effects of sex of patient and site did not reach significance. The only interaction that reached significance was Sex of Parent by Sex of Patient (F=8.36, df=1, 153, p=0.004). A post hoc Tukey test revealed that mothers were perceived as more caring than fathers by male patients only (p=0.01).

The ANOVA for protection also yielded a highly significant main effect for diagnostic group: the bor-
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derline patients remembered their parents as more protective than did the nonborderline patients. Differences in the main effects of sex of patient and site did not reach significance. A trend was obtained with respect to sex of parent: mothers were perceived as more protective than fathers (F=3.20, df=1, 153, p=0.08). None of the two-way or higher-order interactions was significant.

DISCUSSION

The care scores on the Parental Bonding Instrument support earlier studies showing that borderline patients remember their parents as emotionally neglectful (5–9) and resolve earlier contradictions about whether neglect was perceived as coming from one parent (5) or both (6–9). Borderline patients in this study reported low levels of care from both mother and father. Assuming that the perceptions of our borderline patients were accurate, this failure of both parents is in accord with Adler’s theory (1) that borderline patients experience an inadequate holding environment in childhood, which leads to affective instability and impulsivity later in life. The question of whether perceptions might be different for male and female patients was answered by our data, which showed that the male and female borderline patients had the same memories of their parents. This justifies combining data on male and female patients in future studies. The fact that the results were the same for university students and hospital clinic patients shows that the findings are not specific to any particular group of borderline patients.

The protection scores on the Parental Bonding Instrument, which show that the borderline patients remembered both parents as overprotective, contradict earlier studies (5–9) that failed to demonstrate significant differences between borderline patients and other patients on measures of overprotection. Three of these studies (5–7) did not use a well-validated measure of overprotection. In a previous study from our center that did use the Parental Bonding Instrument (9), we also did not find a difference in protection scores between borderline and nonborderline female university students. However, the means in table 1 show that by surveying patients of both sexes from two sites, we were able to detect a difference which had been obscured by studying female students only. The validity of this finding is supported by the fact that the means for our nonborderline group were very close to those reported for community samples (14), whereas our borderline patients had much higher protection scores than the community norms. In addition, our findings confirm those of another study in which the Parental Bonding Instrument was used (8). This provides empirical confirmation of the hypotheses advanced by Masterson and Rinsley (2) about the mothers of borderline patients.

When the results for both care and protection are combined, the recollections of the borderline patients conform to what Parker has termed “affectless control,” which is most strongly associated with depressive syndromes (14). This makes sense, since borderline patients have a high rate of comorbid affective disorder (15). Borderline patients are telling us that they remember their parents as both failing to provide basic emotional support and preventing them from separating. This suggests that the parents of borderline patients could have put their own emotional needs ahead of empathic responsiveness to their children.

The fact that affectless control was recollected by borderline patients in relation to both of their parents is interesting in the light of theoretical speculations which have tended to focus exclusively on the role of the mother (1, 2). It is possible that the child who will become a patient with borderline personality disorder is unable to buffer negative experiences with one parent by positive experiences with the other.

The findings of this study can explain only some of the variance in the development of borderline personality disorder. Other reports, for example, have demonstrated a higher incidence of physical and sexual abuse in the histories of borderline patients (16, 17). Moreover, there is evidence for constitutional factors in the borderline syndrome (18).

The question of falsification must be considered in interpreting any study that uses a retrospective design. This is especially true for borderline patients, who tend to distort features of their interpersonal relationships (1). However, borderline patients have not uniformly described all aspects of their childhood experiences as negative when wider surveys of their childhood memories have been done (7). Prospective studies or studies of high-risk subjects are needed (18). In spite of these limitations, the convergence of evidence from studies that have used different methods provides support for the validity of the findings. The evidence in this study supports a number of clinical impressions from psychotherapists and makes theoretical sense in accounting for some of the psychopathology seen in borderline patients.

REFERENCES


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