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Parental Bonding Instrument

Exploring for links between scores and obsessionality

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Abstract The view that those with obsessive compulsive disorder or obsessional personality have been exposed to overcontrolling and overcritical parenting is examined. Two measures of obsessionality (the Maudsley Obsessional-Compulsive Inventory and the Leyton Obsessional-Compulsivity Inventory) were completed by 344 nonclinical subjects. They also scored their parents on the Parental Bonding Instrument (PBI), a measure assessing perceived levels of parental care and overprotection, before and after controlling for levels of state depression, trait anxiety and neuroticism in the analyses. Those scoring as more obsessional returned higher PBI protection scale scores. Links with PBI care scale scores were less clear, essentially restricted to the Maudsley Inventory, and variably influenced by controlling other variables.

Introduction

Exposure to parental characteristics of low care and overprotection has been thought to determine later psychopathology in the children, a general proposition that has been reviewed in some detail (Parker 1983). The relevance and quantification of the proposed parental style risk factor has been pursued using a self-report measure of earlier parenting experiences, the Parental Bonding Instrument or PBI (Parker et al. 1979). The PBI allows ‘care’ and ‘overprotection’ scores to be derived for each parent, and in effect assigns parents to one of four contrasting quadrants, with ‘high care low overprotection’ labelled ‘optimal bonding’ and the contrasting quadrant labelled ‘affectionless control’.

Studies have allowed the relevance of ‘anomalous parenting’ to be considered for a range of adult psychiatric disorders and personality dimensions. An important step in pursuing aetiological hypotheses has been the clarification of whether such parental experiences are a non-specific risk factor to all manner of psychopathology in adult life or rather have some specificity to certain disorders. A large number of case-control studies have assisted resolution of the latter point. For example, several studies (see Parker and Hadzi-Pavlovic 1992) have established that melancholics (both those with unipolar and bipolar courses) return similar PBI scores to age- and sex-matched controls, while non-melancholic depressives are much more likely to rate their parents as uncaring and are somewhat more likely to report parental overprotection. Also, several case-control studies of schizophrenics (e.g. Parker et al. 1982, 1988) have either failed to find differences in PBI scores or, at best, have suggested anomalous scores for fathers only, and any such atypical paternal characteristics seem to be more a consequence of schizophrenia in the child rather than an antecedent risk factor. Therefore, the greater likelihood that subjects with ‘neurotic’ disorders will return anomalous PBI scores challenges, to some degree, the suggestion that anomalous parenting is a non-specific risk factor for all adult psychiatric conditions.

The possibility that PBI-defined anomalous parenting may represent a non-specific risk factor for or be otherwise associated with, all ‘neurotic’ conditions or dimensions is another aspect of the non-specificity hypothesis that is worth looking into. Certainly, parental affectionless control has been reported as being overrepresented in subjects with higher levels of anxiety, depression and neuroticism, as well as in those with neurotic depression and generalised anxiety disorder (see Parker 1983) and in those diagnosed as having an avoidant personality disorder (Stravynski et al. 1989). Other conditions are not characterized by any such pattern, i.e. there is no clear overrepresentation of parents in that quadrant or in any other PBI quadrant. To illustrate the latter, subjects with panic disorder (Silove et al. 1991), hypochondriasis and dependency (Parker 1989) have been reported as more likely to...
assign their parents to the ‘high care-high overprotection’ (‘affectionate constraint’) quadrant, a pattern that is interpreted (Parker 1983) as more likely to reflect a parental response to some early manifestations of anxiety or dependency in a child rather than being an antecedent causal determinant of the condition.

In the present study, we examined for any link between PBI scores and obsessionality, being aware of only two previous studies in this area. Hafner (1988) undertook a postal survey of an obsessive-compulsive neurosis support group, with 93 members (47% response rate) responding and with 81 meeting DSM-III-R criteria for obsessive-compulsive disorder. Those subjects reported strikingly low maternal and paternal care scores, and significantly raised maternal protection scores. Kimeidis et al. (1992) administered a ‘current’ and ‘brief’ (i.e. eight-item) PBI form, together with a measure for psychopathology that included dimensions assessing obsessions, compulsions and ruminations, to 631 Australian adolescents. Both higher obsession and rumination scores were significantly linked with low parental (i.e. maternal and paternal) care and with paternal overprotection. By contrast, higher compulsion scores were linked with both higher maternal and paternal protection scores, but not with parental care scores.

Theoretical and clinical observations suggest that anomalous PBI scores (and particularly high protection scores) should be anticipated in those with obsessive-compulsive disorder (OCD). Psychodynamic theories of both OCD and obsessional personality emphasise the relevance of unresolved separation-individuation of the child from the mother (Salzman and Thaler 1981). Those authors have noted that many neo-Freudian theorists have also postulated rigidity in parental child rearing, with parents being described as overcontrolling or overinvolved. Clinical reports offer some substantiation, with Adams (1973) noting a parental style of having difficulty in letting the child be his/her own person, as well as categorising all rebellion as ‘bad’ and all conformity to parental wishes as ‘good’. In a Taiwanese study, Tseng (1973) described very close relationships between ten obsessive children and their mothers, and he rated five mothers as being overcritical and six as being overprotective.

A number of related but more refined hypotheses have been proposed. Rachman (1976), for instance, has proposed an ‘overcontrol’ model, whereby a constitutionally predisposed ‘hypersensitivity’ in the child is overlaid by parental overconcern and overcontrol, with variable expressions of the latter leading to varying types of OCD. Specifically, he predicted that ‘cleaners’ and ‘checkers’ would both report their parents as overcontrolling, but that the cleaners would also report overprotection and the checkers, overcriticism. This hypothesis was examined empirically by Stetkeet al. (1985), who found no differences for fathers, but noted that checkers did report their mothers as more meticulous and demanding.

Family models have also been proposed in attempts to explain the origins of any overprotection or control. A number of reports (e.g. Clark and Bolton 1985; Hoover and Insel 1984; Tseng 1973) have described unsatisfactory marital relationships and socialisation patterns for the parents of children with obsessional symptoms. Most commentators have interpreted such features as encouraging the parent to seek solace in relating to their child, leading to a pattern of parental control and over-involvement.

We undertook, and now report, an exploratory study with the PBI measure, hypothesising in particular that higher PBI protection scores would be linked with higher obsessionality scores. Conceding Rachman’s general point of a predisposing ‘hypersensitivity’, which we interpreted as expressed or mediated by anxiety or neuroticism, we sought to assess whether any links between the PBI scale and obsessionality were direct links or whether they reflected secondary processes emerging from such characteristics. Again, as mood state is a recognised influence on some self-report measures, we examined for any effect emerging from a depressed mood. Thus, we report a study examining for primary links between PBI scores and obsessionality, and, if demonstrated, whether such links were more a consequence of any associated anxiety, depression or general neuroticism, rather than obsessionality per se.

Materials and method

Subjects were volunteers recruited from the introductory psychology classes at the Pennsylvania State University. They received partial course credit for participation. As noted earlier, the PBI was our predictor measure, and is now briefly described. It has 12 ‘care’ and 13 ‘protection’ items, with each parent being scored on a 4-point Likert scale as remembered in the child’s first 16 years. The PBI has been shown to have satisfactory short-term and long-term (i.e. 10-year interval) test-retest reliability, to be insensitive to mood state effects and to have satisfactory validity as a measure of both actual and perceived parenting (Parker 1989). In developmental studies, raw scale scores have been shown to be negatively correlated, so that an overprotective parent is rated, in effect, as less caring and, conversely, a caring parent is effectively not rated as overprotective. The intermediate scores on the two scales suggest that applied research may benefit by examining the independent contribution of each construct, a theoretical concern supported by a recent study. In a volunteer community sample, Mackinnon et al. (1993) have demonstrated that lack of care (as against overprotection) is the primary risk factor for depression, with a logistic regression analysis failing to find evidence of an interaction effect between low care and high protection.

Two outcome measures of obsessionality were completed by our sample members: the Maudsley Obsessional-Compulsive Inventory (MOI) and a version of the Leyton Obsessionality Inventory (LOI). The MOI is a 50-item measure with a ‘true-false’ response format, designed more to measure obsessive compulsive complaints or symptoms rather than personality traits, and with its validity supported by checks against therapist ratings and moderate agreement (0.6) with LOI scores (Rachman and Hodgson 1980). The LOI is a 69-item ‘yes-no’ questionnaire (with 46-item symptom and 23-item trait personality scales), validated initially and subsequently (Murphy et al. 1979) by its capacity to differentiate obsessive patients from normal subjects, but recognised as being sensitive to response sets (Cooper 1970). Snowden (1980) subsequently developed a paper-and-pencil version producing equivalent scores, and recommended modification to a number of items unsuitable for single people and males. After making some minor changes to improve its suitability for American subjects, we used this 46-item symptom scale. Three measures were included to control for effects of anxiety,