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Editorial

The Parental Bonding Instrument

A decade of research

G. Parker

School of Psychiatry, University of New South Wales, Sydney, Australia

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The Parental Bonding Instrument (PBI) was developed (Parker et al. 1979) to allow any parental contribution to disorder to be specified and quantified. Such a need emerged from review of extant formulations of psychiatric and related disorders, with parents aetiologically implicated (e.g. the 'schizophrenogenic' or 'asthmatogenic' mother), often only by clinical assertion.

While any number of parental characteristics could be assessed, we focussed on refining and defining care and protection/control as they were consistently suggested as principal dimensions in factor analytic studies, are held to underpin interpersonal relationships (Hinde 1974), are central to theoretical expositions about child development, and as 'low care' and 'overprotection' have been consistently nominated as disposing to onset of most psychiatric conditions (Parker 1983).

While parents clearly vary in specific manifestations of care and overprotection during their child's development, the PBI assumes (in item construction and application) some constancy in levels of care and overprotection. Subjects complete the PBI as they remember each parent in the first 16 years, generating 'care' and 'protection' scores. Additionally, parents may be assigned to quadrants reflecting variations in care and overprotection (e.g. high care/low protection or 'optimal bonding'; low care/high protection or 'affectionless control').

As the rationale, development and potential uses of the PBI have been described (Parker et al. 1979), and a number of applied studies considered (Parker 1983), this overview will synthesise published reports.

First, its properties, with the specifics of a number of studies detailed elsewhere (Parker 1989). The factorial structure has been confirmed in non-clinical and clinical groups, and supported by independent demonstration of a similar two-factor ('care' and 'protection') model of parenting (the EMBU-Arrindell et al. 1986). A study of adolescents (Cubis et al. 1989) has suggested, however, that the 'protection' dimension may comprise Social Domain and Personal Domain sub-dimensions.

General population studies suggest an overall tendency for mothers to rate as more caring and as more protective than fathers; for sex of respondent to be uninfluential; for no consistent social class effects; but for the PBI to be sensitive to cultural influences.

Test-retest reliability is high over months, and moderate consistency has been shown over extended periods up to 10 years. Stability data have been less impressive for inpatients with acute schizophrenia but high consistency in community samples with schizophrenia and of depressed patients suggests the relevance of motivation rather than clinical status.

While the PBI was designed to measure perceived parental characteristics (with the belief that what is perceived is most likely to influence development), it is also necessary to examine whether PBI scores reflect 'actual' parental characteristics. Various strategies (e.g. corroborative reports by siblings and parents; contrasting scores returned by MZ and DZ twins; correlation with interview-derived parental ratings) have all supported the PBI as a measure of actual parenting, but more definitive conclusions await results from longterm child development studies.

It is often put that PBI scores should be influenced by mood state (with depressives rating negatively) and by a host of personality variables (e.g. plaintive set, 'neurotic' style, social desirability, denial). A number of studies (particularly examining mood influences) have failed to find evidence of such response biases (see Parker 1989).

In applied studies, the most distinctive and specific findings have emerged for depressive disorders. Several case-control studies (e.g. Parker 1979a) have failed to find anomalous PBI scores for those with endogen-

ous/melancholic depression (both unipolar and bipolar), in contrast to residual conditions (e.g. neurotic/reactive depression) where parents are consistently distinguished by a much greater chance of 'affectionless control', thus strongly supporting to the binary view of depression.

As parental 'affectionless control' also appears more frequent in those with anxiety neurosis (Parker 1981), social phobia (Parker 1979a) and obsessive compulsive neurosis (Hafner 1988), such a parental style might be a general risk factor for neurosis or merely for help-seeking. Partialling out 'neuroticism' scores has failed, however, to nullify links between PBI care scores and depression levels (Parker 1979b), while studies of community depressed 'cases' (Joyce, in preparation) have replicated patient studies, arguing against a mere link with help-seeking.

While the evidence favours parental 'affectionless control' as an antecedent risk factor for many neurotic conditions, parental 'affectionate constraint' (or caring overprotection) appears, by contrast, more a consequence of developmental difficulties in the child. It is over-represented in those with higher dependency or hypochondriasis levels, in asthmatics and in certain cultural groups (all Parker 1983), and, interestingly, appears over-represented in panic disorder (Silove et al., in preparation).

Although the PBI has been used in studies of delinquents, of those with drug, alcohol and eating disorders, and increasingly with certain personality disorders (e.g. borderline), too few studies have accumulated to allow any reasonable synthesis.

While schizophrenic subjects fail to return distinctly anomalous PBI scores, studies have examined whether, like the EE measure, the PBI might predict schizophrenic relapse with both positive (Parker et al. 1982; Baker et al. 1987; Warner and Atkinson 1988) and negative (Parker et al. 1988) findings.

While reductionistic and simple in design, and raising intuitive concerns about the limitations of selp-report measures, the PBI appears more robust than initially anticipated, and has refined the general proposition that psychiatric disorder is the product of anomalous parenting, with results (for instance) for depressive disorders showing impressive specificity.

Although case-control studies will still be required to examine the relevance of anomalous parenting to differing disorders and personality styles, a number of important applications of the PBI are now anticipated, including: prediction of outcome studies, pursuit of determinants of contrasting parental styles, continuity of development studies examining the extent to which earlier parenting influences selection of intimate adult partners, as well as more interactive studies examining factors in the child that may elicit parental responses – both directly and recursively.

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Prof. G. Parker
Psychiatry Unit
Prince of Wales Hospital
Randwick 2031
Australia