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MATERNAL EMPATHY, FAMILY CHAOS, AND THE ETIOLOGY OF BORDERLINE PERSONALITY DISORDER

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Psychoanalytic writers have traced the etiology of borderline personality disorder (BPD) to be a preoedipal disturbance in the mother-child relationship. Despite the prevalence of theories focusing on the role of mothering in the development of BPD, few empirical studies have tested the hypothesis that borderlines were the recipients of unempathic mothering. The current preliminary study compared 13 mothers of borderline adolescents with 13 mothers of normal adolescents. This study found that mothers of borderlines tended to conceive of their children egocentrically, as need-gratifying objects, rather than as individuals with distinct and evolving personalities. This study also found that the mothers of borderlines reported raising their daughters in extremely chaotic families struggling to cope with multiple hardships, including divorce and financial worries. The stressful environmental circumstances reported by the mothers likely affected the borderline daughters directly as well as the mothers’ ability to parent effectively and empathically. The results of this study suggest that, as predicted by psychoanalytic theory, a problematic mother-child relationship may play a significant role in the genesis of borderline pathology; however, the life circumstances that contextualize the mother-child relationship also need to be considered when accounting for the etiology of BPD.

Psychoanalytic writers on the etiology of borderline personality disorder (BPD) commonly emphasize that this disorder is rooted in a preoedipal disturbance of the mother-child

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relationship (Masterson, 1976; Masterson and Rinsley, 1975; Kernberg, 1975, 1976; Buie and Adler, 1982). Particularly striking to clinicians and theorists is the borderline’s powerful fear of separations, which are often experienced as complete abandonments. Accordingly, psychoanalysts have suggested that the borderline’s extreme anxiety over separations from people who are psychologically important results from an interference in the mother-child relationship during what Mahler et al. (1975) have described as the process of separation-individuation.

Separation-individuation is described as a perilous journey traveled by the mother-child pair; and the successful completion of this venture is largely dependent on the mother’s ability to respond empathically to the evolving needs of her child. According to most theorists, if the mother is psychologically unavailable, or if her own intrapsychic conflicts render her intolerant of her toddler’s increasing autonomy, then the child will have difficulty forming integrated and accurate object representations, dealing with separation and abandonment, and internalizing aspects of the mother-child relationship that normally contribute to self-soothing and a sense of security. For example, Masterson (1972, 1976; Masterson and Rinsley, 1975) claims that, as toddlers, borderlines had to deny the reality of their separateness from their mothers because the mother responded to the toddler’s age-appropriate autonomous strivings with a punishing withdrawal. Although Kernberg (1975) suggests that BPD may have a constitutional determinant, he also implicates early empathic failures on the part of the mother in the genesis of this disorder. According to Kernberg, excessive frustration due to inadequate parenting may lead the future borderline to have a vast amount of rage, which in turn interferes with the coalescence of self- and of object representations. Thus, the nascent borderline is not able to experience distinct yet integrated views of self and other that include both positive and negative attributes and affective tones. Another variant of the etiological theory of BPD from a self-psychological perspective is offered by Buie and Adler (1982, p. 59). Like the other theorists, Buie and Adler trace the etiology of BPD to “mothering that is not good enough during the phases of separation-individuation.” They propose that due to inadequate parenting, borderline patients fail “to develop adequate internal resources for holding-soothing to meet the needs of adult life.” Buie and Adler note that there are many reasons why mothers fail their would-be borderline offspring: “The inadequacy of mothering can be of many types ... ranging from traumatic unavoidable separations, to inconsistency of supportive presence, to the toddler’s being subject to the mother’s aversive anger and purposeful abandonment.”

Despite the prevalence of theories focusing on the role of mothering in the development of BPD, the evidentiary basis for these theories remains scant. Generalizations about the mothers of these patients largely come either from patients’ historical accounts—for whom distortions are characteristic—or from transference patterns that can never definitively demonstrate how the other person in early interactions actually behaved. Relatively few empirical studies have tested the hypothesis that a disturbed mother-child relationship contributes to BPD. Moreover, existing studies offer conflicting findings concerning the personality profiles and parenting styles of mothers of borderlines (Gunderson and Englund, 1981). For example, Gunderson and his colleagues (1980) found mothers of borderlines to be relatively neglectful of their borderline child, whereas Soloff and Millward (1983) found mothers of borderlines to be significantly more pathologically overinvolved with their children, to the point of being extremely intrusive and controlling. Recently published research (Torgersen and Alnaes, 1992; Zweig-Frank and Paris, 1991) found that borderlines remember their mothers as less caring and more controlling than do comparison groups.
The contradictory research findings may be due, in part, to methodological flaws characterizing much of the existing research on this topic. Indeed, a review of the literature indicates that, with the exception of qualitative studies by Berkowitz and colleagues (Shapiro et al., 1975; Zinner and Shapiro, 1975), no studies actually assessed the mothers of borderlines directly. Rather, some studies focused exclusively on the borderline’s recollection of her mother, a method that is highly problematic in light of the tendency of borderlines to distort in their recollections. Other studies relied on social work summaries to evaluate the mothers’ personality and parenting styles, an approach that is also potentially biased since clinicians are likely to view their patients’ mothers through the lens of prevalent theoretical formulations.

In a preliminary effort to explore the hypothesis that a disturbed mother-child relationship contributes to the etiology of BPD, this study involved lengthy semistructured interviews with mothers of female borderline adolescents and with mothers of a comparison group of normal teenagers. We hoped, first, to explore the hypothesis that a lack of maternal empathy is associated with BPD, and second, to examine the role played by factors pertaining to the quality of family life in the etiology of BPD.

Methods

Subjects were the mothers of adolescent girls with a diagnosis of borderline personality disorder (BPD) \( N = 13 \) and mothers of adolescent girls with normal functioning \( N = 13 \). The adolescent daughters of these mothers were previously identified and involved in related research (Westen et al., 1990; Ludolph et al., 1990).

Borderline Adolescents

Borderline adolescents were identified at two inpatient psychiatric settings. The borderline adolescents ranged in age from fourteen to eighteen at the time of initial contact with a member of the research team. Excluded from this study were adolescent inpatients with chronic psychosis, clear evidence of neuropathology (such as documented epilepsy or severe head injury), I.Q. scores below 70, or medical problems that would complicate diagnosis or psychological testing.

The diagnosis of borderline personality disorder was made on the basis of the Diagnostic Interview for Borderlines (DIB) (Gunderson et al., 1981). The DIB provides a highly reliable and valid way of assessing the presence or absence of symptoms, character traits, and relationship patterns associated with BPD (Cornell et al., 1983; Gunderson and Kolb, 1978; McManus et al., 1984) and has been shown to distinguish \( DSM-III \) diagnosed borderlines with sensitivity and specificity typically above .80 (Amnellius et al., 1985). Research by McManus et al. (1984) and Ludolph et al. (1990) has documented that adolescent borderline patients can be discriminated with the DIB. As in other research using the DIB, patients were defined as meeting criteria for BPD by obtaining DIB scores greater than or equal to seven. Methods and reliability of diagnosis are described more thoroughly elsewhere (Westen et al., 1990; Ludolph et al., 1990).

Normal Adolescents

Normal adolescent girls were located through a local public high school whose students, like the hospitalized patients, tend
to be of lower-middle to middle-class socioeconomic background. Normal adolescents were selected to match the psychiatric adolescent sample in age, sex, and race. Interested students filled out a brief screening questionnaire, which asked about a history of psychotherapy, truancy, chronic depression, absence of friends, social life, and serious illness. Students who met demographic criteria for age, sex, and race, and did not report difficulties in the domains inquired about in the questionnaire, were contacted, as were their parents, to solicit participation in the project. A $10.00 gift certificate was offered as compensation if they participated in the study. All normal adolescent participants were also administered the DIB to insure the absence of borderline pathology. None received a score greater than five on the DIB (mean = 2.39). Although these girls appeared to lack serious character pathology, they were by no means "supernormal." Indeed, several manifested neurotic symptoms and/or character patterns, including phobias, eating disturbances, and obsessional or hysterical styles.

Groups of Mothers

All the mothers of the previously identified female adolescents were contacted to see if they would be interested in participating in this research. Only mothers of females were invited to participate in this study, to avoid potentially important gender confounds in the mother-child relationship. The time of data collection after the child's discharge ranged from six weeks to six years. Waiting for at least six weeks following the daughter's discharge before collecting data insured that the mother would be past the initial crisis of her daughter's hospitalization. We were able to locate 25 mothers of the 43 discharged borderlines (58%). Of these, 15 agreed to participate (60%). We were able to locate 19 mothers of the 26 normal adolescents (73%). Of these, 13 agreed to participate (68%). At the time of their participation in this study, no differences were found in the socioeconomic status of the two groups of mothers as assessed by Hollingshead and Redlich's (1958) measure. Subjects were paid $35.00 for participation in the study, and were interviewed by one of three female graduate students in clinical psychology.

The Interview

Maternal empathy was assessed through the Parental Awareness Measure (Newberger, 1980). This measure investigates how parents think about a wide range of issues deemed integral to parenting. For example, parents are asked to explain in detail how they conceptualize influences on their child's development and behavior, how they handle issues of discipline and authority, and how they learned to parent. Parental reasoning, as elicited in an hour-long semistructured interview, was rated on a four-point scale that measures the degree to which mothers are able to view their children in an empathic fashion. A level one score on the Parental Awareness Measure indicates that the mother shows little capacity for empathy, understanding the child through projection of her own experience and organizing the parental role around maternal wants and needs only. In contrast, a level four score on this measure indicates that the parent is aware of the psychological complexity of the child's personality and of the developmental changes that transform the child, the parent, and their relationship. Level four responses also indicate that the parent strives to balance her own needs with the needs of the child, so that both can be satisfactorily met. The Parental Awareness Measure has been shown to discriminate between parents with histories of child
abuse and neglect and matched comparison samples (Newberger and Cook, 1983), and to be positively associated with empathy as measured by Mehrabian and Epstein's Emotional Empathy Measure (Newberger and White, 1987).

Although the Parental Awareness Measure does not derive from an explicitly psychodynamic perspective, the concept of parental awareness encompasses many aspects of maternal empathy considered critically important by psychoanalytic theorists who write about the role of the mother in the genesis of BPD. For example, according to Masterson's model, one would expect that a borderline's mother would have difficulty describing her relationship with her daughter in a complex, integrated, and individuated fashion. Similarly, from a Kohutian perspective (see Kohut, 1971, 1977), one would predict that a borderline's mother would score very low on the Parental Awareness Measure due to her extreme egocentrism and tendency to treat her child as a need-gratifying object rather than as an individual in her own right.

Each interview was taped and then transcribed verbatim. Subsequently, the interview was independently scored by two coders, both graduate students in clinical psychology, who were blind to the diagnostic status of the daughters and did not administer any of the interviews. Interrater reliability was high, as follows: Pearson's product-moment coefficient, with Spearman-Brown's correction for double coding, was .90; the intraclass correlation coefficient with Spearman-Brown's correction for double coding was .83.

Mothers were also asked a series of questions to assess factors that are likely to have affected the way they related to their daughters and the daughters' experiences during their formative childhood years. Variables inquired about included divorces, financial resources, and perceived paternal support in child-raising tasks.

Findings

Our extensive interviews invited the mothers to give personal accounts of how they experienced the job of parenting, and how raising a child fit into their own development. We were impressed by the openness of our subjects, and by their willingness to probe into painful memories as well as to consider hypothetical scenarios. Nonetheless, in contrast to the mothers of normal adolescents, the mothers of borderline adolescents were significantly more likely to conceive of their daughters in a grossly egocentric manner, and in general portrayed family life as a series of emergencies and feats of survival.

Maternal Egocentrism

Mothers of borderline adolescents offered a significantly greater percentage of level one (egocentric) responses on the Parental Awareness Measure than did mothers of normal adolescents (t(24) = 2.40, p = .01, one-tailed test). Thus, on the average, 31% of the responses of mothers of borderlines were level one responses, whereas only 17% of the responses of mothers of normal adolescents were coded as level one. Although, on the average, mothers of borderlines offered almost twice as many level one responses as mothers of normal adolescents during the course of the administration of the Parental Awareness Measure, they also offered some higher-level, more empathic responses. Thus, if one averages all the scores offered by the mothers, the two groups of mothers cannot be differentiated statistically.

Overall, these findings support the psychodynamic hypothesis of the etiology of BPD. We found that mothers of borderlines showed a greater tendency to understand their daughters

Footnote 8: Percentage of level one scores was computed by dividing the number of level one scores of each protocol by the total number of scorable responses of that protocol.
as projections of their own experiences and to organize the parental role around the fulfillment of parental needs. Indeed, level one responses are signs of serious shortcomings in parental empathy since they are scored only when the parent demonstrates flagrant egocentrism or notably concrete understanding of children. In order to convey vividly the quality of level one reasoning, responses from interview protocols with mothers of borderlines with high percentages of level one responses will be presented.

Case 1. Mrs. Brown and Mary. Mrs. Brown was enraged with her borderline daughter, Mary, about whom she flatly stated: "I never want to see her as long as I live." Throughout the interview, she showed little empathy for Mary, whom she portrayed as malicious, lazy, and fat. In contrast to her depiction of Mary, Mrs. Brown actively favored her younger, more gratifying daughter, Caroline.

The interviewer asked Mrs. Brown how she handled issues of discipline and authority. Because Mrs. Brown did not have a unified conception of what motivates child behavior, when spanking and grounding failed to change Mary's behavior, she was at a loss about what else to do. Mrs. Brown showed little appreciation for her daughter's experience of events, but rather, harshly blamed her child for being unresponsive to the mother's own wishes.

She never minded spankings, didn't faze her. She didn't mind staying in her room for three months—you know, I mean, not that she stayed in her room for three months. But it wouldn't have fazed her! Being grounded—nothing. Having things taken away—nothing ever bothered her. . . . And I thought maybe she is just conning me, maybe it does bother her. But in the years to come I found out it really didn't. Nothing fazed her. So, she was different. My youngest daughter, all I have to say is "Caroline, I am disappointed" and she is just in tears and she never does it again. I mean, she is—she says "I love you, I am sorry" and then I reassure—"I do love you, I was just angry with you." But that works with her. Mary, you could have dropped the Eiffel Tower on her. It didn't bother her. . . .

Further responses offered by Mrs. Brown indicate that she views her daughters through an egocentric lens, and that her description of Mary is not simply a veridical perception of an indifferent or unresponsive child. For example, when asked to tell the interviewer more about the methods she employed to encourage her children to obey, Mrs. Brown focused on whether her children responded to her authority in a gratifying fashion, and ignored the interviewer's prompting to consider why she chose a particular disciplinary approach. Thus, at a point in the interview when more empathic and informed mothers reflected on how one might best promote socialization of the child or attempt to address the causes underlying undesirable behaviors, and more typical mothers stressed the importance of values and reviewed the merits of various punishment and reward systems, Mrs. Brown concentrated on her experience of Caroline as a warm-hearted daughter and Mary as a devalued, less than human creature, a "robot":

. . . Caroline gave of like I care, and I am listening. Mary was like—whoever talked to her . . . it was like there was a robot there, there was nothing. I can't explain that—I don't know. But—they are just feelings. What it all comes down to, I really think, I—t love Caroline a lot. She gives it back to me. Uh, from the time Mary was three years old, I don't think I've ever loved her again.

It is striking that this mother, who offered more than 50% level one responses on the Parental Awareness Measure, reported relating to her child in ways that corroborate many of the psychoanalytic descriptions of dynamics that give rise to borderline pathology. If Mrs. Brown's recollection is accurate, it is clear that even as a toddler and preschooler, Mary was the recipient of considerable maternal projection, which likely
affected her evolving sense of self. As Mrs. Brown herself observed:

...I felt Mary was an extension of myself... and I was hard on her, I really was. I screamed and yelled. I was nervous. I was—like, "no!", you know, "Don't get your clothes dirty!" You know, because my parents would think I was a terrible person if they saw you dirty! I was, you know, uh, a lowlife....

Apparently, Mrs. Brown’s experience of Mary as a negative reflection of herself grew so powerful that she ultimately found it difficult to admit that Mary was in fact her child: “I always felt that I wasn’t really her mother because I couldn’t feel her. My youngest one I can.” Mrs. Brown’s early overidentification with Mary on the one hand, and subsequent wholesale repudiation of her on the other, resonate with theoretical descriptions of the difficulties experienced by mother-toddler pairs during separation-individuation. Certainly, Mrs. Brown’s need to vilify Mary and extol Caroline vividly demonstrates the strength of parental projections and a defensive reliance on splitting (Kernberg, 1976).

Case 2. Mrs. Mead and Linda. Like Mrs. Brown, Mrs. Mead showed little empathy or insight regarding the personality of her borderline daughter, Linda. Rather, with marked egocentrism, when asked to describe her daughter, she focused on Linda’s failure to affirm Mrs. Mead’s own emotional needs and sense of reality.

Well, Linda is an extremely spoiled child.... Oh God that girl was such a liar and I was so gullible. If she told me the sky was green I would believe it; that’s how sincere she would come across. And did all them dumb things, nothing but one big lie.... She can be really sweet, but then she can be nasty too. Not so much since she came out of the hospital. But before, I mean it was fight after fight, it was, we were physically at each other. I mean it didn’t bother her at all to take and shove me or you know, whatever. The physical contact was there and ah, it’s just as though, ‘so what you’re in my way, get out!’

Like Mrs. Brown, Mrs. Mead also had difficulty disciplining her daughter, whom she described as incorrigible. Mrs. Mead had no underlying conception of what motivated her daughter’s behavior and therefore could not respond effectively or empathically to her daughter’s difficulties, including her possible abuse of alcohol.

Interviewer: What did you rely on to make Linda mind you?
Mrs. Mead: It was bribery. If she would do what I wanted her to do, I’d buy her an outfit. I’d give her some money.
Interviewer: And what were your reasons for that approach?
Mrs. Mead: Well, I felt that I had to buy her love. By pacifying her I was keeping her in a real good mood. She wasn’t nasty... she wasn’t doing things that she normally did because she had what she wanted.
Interviewer: How did that work out for her?
Mrs. Mead: Beautifully for her, she was reaping all the, ah, all the riches here.
Interviewer: And how did it work out for you?
Mrs. Mead: I was torn apart. I was, ahh, my self-esteem was so low I spent most of my hours crying and ahh wondering where is this going to end.
Interviewer: And how come it was like that?
Mrs. Mead: Well, I guess it was like that because of what she was doing. She never came right out and said, but I assumed she was doing some type of drugs. I know she was drinking alcohol quite a bit.
Interviewer: Could there have been another way then to get her to mind you?
Mrs. Mead: No. Her mind was just strictly focused on whatever she was doing at the time. I tried locking the
doors. I tried locking her in her room. Ahh, and that just brought it to physical abuse.

As indicated by her responses, Mrs. Mead has little ability to evaluate and then respond to her daughter’s needs. Indeed, Mrs. Mead’s understanding of her relationship with her daughter is extremely egocentric: because she feels exploited, she assumes her daughter is “reaping . . . all the riches” and ignores the evidence of her daughter’s serious personality difficulties. Mrs. Mead is unhappy with her relationship with her daughter, but rather than assume some share of responsibility for her difficulty parenting this child, she places all the blame on her daughter’s shoulders. Indeed, she describes herself as the innocent victim of her powerful daughter who maliciously misbehaves and causes Mrs. Mead to suffer from low self-esteem. When asked why her own self-esteem is so low, she focuses on her daughter’s transgressions and does not consider other factors—including personal vulnerabilities and life experiences unrelated to her daughter—that contributed to her distress.

Context of the Mother-Daughter Relationship

We thus found that mothers of borderines in comparison to mothers of normal teenagers tended to conceive of their daughters in an egocentric fashion. It is important to consider, however, the life circumstances that contextualize the mother-child relationship.

Distinguishing relevant variables that contribute to the etiology of BPD is extremely difficult because many potentially pathogenic variables are interdependent. Parents who are suffering extreme life stresses such as separations, losses, and financial difficulties are likely to have their attention diverted from their children’s needs and experiences and hence to respond less empathically. Yet, variables such as multiple divorces and disruptions in family composition may themselves reflect in part parental object-relational disturbances. Although it may not be possible to quantify the extent to which different risk factors independently contribute to borderline pathology, it is nonetheless important to consider broader family variables that certainly influence the mother-child relationship. Indeed, many mothers of borderines described the toll on their parenting of life stresses, including highly conflicted marriages and financial worries. As Mrs. Rollins observed, when reflecting upon her inability to attend to the needs of her borderline daughter, Laura:

... I have been in survival mode you know, a lot of times. When you are in a bad marriage you are kind of in survival mode, because what are you going to do? And when you are in a survival mode, constantly thinking about how you are going to survive, I think sometimes you overlook what those needs are. You don’t think about those needs. And you may know what they are, but just knowing what the need is doesn’t mean you take action to do anything about it, right? When do you actually take the action, and, you know, when are you going to follow through on knowing about what the need is? Somebody had told me what Laura really needed at that time, would I have followed through on knowing about what this need is? ... I don’t know because I was working, I was going to school at night, those were important to me at that time. I could see myself getting a job and getting out of this. I was on ADC prior to that, you know, getting out of that, that no dead-end street. I could see hope for that and that was my need at that time, and can a person look at somebody else’s needs and do something about it when they are so caught up in getting their own just to survive?

In general, the mothers of borderines ranked themselves as experiencing much higher rates of stress during their daughters’ childhoods than mothers of normal teenagers (t(23) = 2.98, p = .003, one-tailed). This overall stress rating reflected a range of hardships and life circumstances and not just the
inherent difficulties of parenting a disturbed child. For example, although at the time of their participation in this study no difference was found in the socioeconomic status of the mothers of borderline and normal adolescents as rated by Hollingshead and Redlich's widely used scale, the mothers of borderline did report experiencing significantly greater financial difficulty when their daughter was born ($t_{[23]} = 2.19, p = .02$, one-tailed), when she was five ($t_{[23]} = 2.30, p = .01$, one-tailed), and even currently ($t_{[23]} = 2.72, p = .005$, one-tailed test) than did mothers of normal teenagers.

Family composition also significantly differentiated the two groups, with mothers of borderlines reporting greater family dissolution than mothers of normal teenagers. Only 4 of the 13 mothers of borderline adolescents (30.8%) were still married to their daughter's father, whereas 10 of the 12 mothers of normal teenagers (83.3%) remained married to the father of the teenager at the time this study was conducted ($\chi^2 = 5.03, df = 1, p = .025$; Fisher's Exact, $p = .01$). Given the high rates of divorce among mothers of borderlines, it is not surprising that these subjects reported significantly lower parental involvement of the teenager's biological father in comparison to mothers of normal adolescents ($t_{[23]} = 2.30, p = .01$, one-tailed). The high divorce rate among mothers of borderlines may also contribute to the increased financial difficulty reported by this group. The higher "stress" reported by the mothers of borderlines may also reflect the fact that they had significantly more biological children to care for than did mothers of normal teenagers ($t_{[23]} = 2.16, p = .04$, two-tailed), and that raising these children was complicated by the fact that they were likely to have different biological fathers. Thus, 8 out of 13 (61.5%) mothers of borderlines reported that their biological children had different fathers, in contrast to 2 out of 12 (16.7%) for the mothers of normal teenagers ($\chi^2 = 3.53, df = 1, p = .06$; Fisher's Exact, $p = .03$).

Our findings on the relatively more stressful and less stable family circumstance of borderlines suggest that the psychoanalytic emphasis on the critical role of the quality of mothering in the genesis of BPD may need to be broadened to consider the interaction of maternal personality dynamics with environmental and systemic variables. Even relatively healthy caretakers might respond with less than optimal empathy to their children under the conditions experienced by these mothers, many of whom, in addition, were characterologically poorly equipped for the task of mothering. The importance of considering factors other than the role of empathic failure on the part of the mother of a prepubescent child in the genesis of BPD is underscored by recent documentation of the high rate of sexual abuse characterizing borderline samples (Herman et al., 1989; Ogata et al., 1990; Westen et al., 1990; Zanarini et al., 1989). Indeed, research conducted on a sample that included many of the borderline daughters referred to in this study also documented that these disturbed adolescents had a history of childhood trauma, including abuse, neglect, and disrupted attachments throughout childhood (Ludolph et al., 1990). In that study, which relied on a chart review method, sources other than the borderline patient often confirmed that these patients were subjected to early-childhood trauma, including sexual abuse.

Consideration of two families of borderline youngsters illustrates the interaction between dysfunctional parental character styles and the extremely difficult circumstances and highly dysfunctional family dynamics that spawn borderline adolescents.

**Case 3. Mrs. Kane and Diane.** Diane is the third of five closely spaced children. Diane's father left his wife and three children when Diane was six weeks old. Mrs. Kane married her second husband a year later. Although this marriage lasted ten years, Mrs. Kane concluded that "Diane never had a father . . . her stepfather was not involved with her personally, gave her no personal attention other than mistreating her." Indeed, Diane's stepfather began sexually abusing her when she turned eight. Upon learning that Diane and her older brother were sexually abused by their stepfather, Mrs. Kane filed for divorce. She also became seriously depressed and for six months did not
leave the house or let her children leave the house. This mother struggled as the primary financial provider and single parent of five children for five years. During this time, her oldest son's drug addiction became a source of great family conflict. Mrs. Kane is currently married to her third husband.

**Case 4. Mrs. Pringle and Katie.** Like Diane, Katie was raised in a chaotic and abusive environment. Her biological father divorced her mother when the child was three. The following year, Mrs. Pringle remarried a man who adopted Katie. Following her adoption, Katie lost all contact with her biological father. Mrs. Pringle met her second husband at church. Katie’s adoptive father was apparently addicted to alcohol, marijuana, and cocaine. He frequently physically abused her mother, and sexually abused Katie. After twelve conflict-ridden years, the marriage dissolved, apparently after Katie’s adoptive father began an adulterous relationship. Mrs. Pringle reported that the second divorce traumatized the entire family and may have contributed to Katie’s acute suicidality and hospitalization. Following the divorce, Katie resumed contact with her biological father. Katie no longer visits with her adoptive father.

**Discussion**

Given the limitations of the data, as detailed below, this study can only be seen as a pilot project that is exploratory in intent. Thus the results of the comparisons between the two groups will have to be interpreted with caution. Nonetheless, we consider this preliminary study to be of interest since it represents one of the only research efforts to directly examine the widely held psychoanalytic hypothesis that borderline pathology reflects disturbances in the mother-child relationship. The results of this study suggest that psychoanalytic theories of the etiology of BPD are correct insofar as the mothers of borderlines in our sample tended to conceive of their children in an egocentric and unempathic fashion.

Perhaps equally informatively, this study also revealed that many of the borderline daughters were raised in extremely chaotic families struggling to cope with multiple hardships. The stressful environmental circumstances reported by the mothers undoubtedly affected the borderline daughter directly, and the mother’s ability to parent effectively and empathically.

Based on the reports of mothers of borderlines in our sample, it is likely that many of the borderline daughters took their first autonomous steps in households characterized by tumult, rather than in the relatively safe confines of the experimental nursery that housed Mahler’s classic study of separation-individuation. How might a toddler feel when trying to assert her independence in a chaotic environment? Can the mother, or any one else for that matter, even notice her exploratory steps? If the mother should notice, her response to her toddler is likely to be affected by family living conditions as well as by her own conflicts around dependency and abandonment. The relative neglect of the impact of life stress on the parenting of borderlines by psychoanalytic theorists of borderline etiology seems to stem from the problematic assumption of an average expectable environment. Our findings suggest that accounts of the etiology of BPD need to be embedded in an understanding of the larger context of the borderline’s family life and living conditions.

There is still much to be learned about the etiology of BPD. Although this pilot study found evidence confirming the psychoanalytically derived prediction that mothers of borderlines would have difficulty responding empathically to their daughters, we were not able to test the hypothesis that BPD dates from the preoedipal years of childhood. Until longitudinal studies document the quality of the borderline’s preoedipal relationship with her mother, this central hypothesis will remain empirically untested. Thus, we cannot tell from this or other available studies whether the only period in which BPD is generated is the preoedipal, or whether later experiences cause, exacerbate, or modulate borderline pathology.
An even more serious repercussion of the retrospective nature of this study is that we were not able to discern whether the daughters themselves, by virtue of their innate temperaments, contributed to a dysfunctional parent-child relationship. Clearly, mothers respond differently to different children, and children contribute significantly to the relationships they develop with their parents. One should note, however, that the interview administered to assess maternal empathy included questions that refer to child-rearing in general (e.g., “How would you describe a good child?” “How do children learn to be good?” “How would you describe a good relationship between a parent and a child?”) and even included a long series of questions related to the parental choices faced by a hypothetical mother of a hypothetical adolescent caught shoplifting. Although the philosophy of child rearing articulated by the mothers of borderline was probably shaped by their experience of raising a particularly difficult daughter, our interviews focused on ways of thinking about parenting in general, as well as on the particular experience of raising the adolescent involved in this research. The responses of our subjects, therefore, reflected their experiences of parenting all of their children, as well as their intellectual convictions and emotional resources. Nonetheless, this study does not rule out the possibility that BPD may in part or in some cases reflect constitutional vulnerabilities that in turn contribute to difficult mother-child relations; indeed, we tend to believe this to be so.

Limitations of this study also include a relatively small sample size and the absence of an appropriate psychiatric comparison group. As noted, these limitations require us to interpret the data with caution. Unfortunately, it was difficult to determine what would constitute an appropriate psychiatric comparison group for our mothers of borderlines. In order to control for the effects of having a disturbed and hospitalized adolescent, our design originally included a comparison group of mothers of nonborderline psychiatrically hospitalized adolescents. Our experience indicated, however, that this comparison group was not adequate for the purposes of a study aimed at assessing the mothers of patients since it emerged that several of the subjects in this comparison group had borderline siblings, some of whom had even been hospitalized at the same facility, but were not assessed for inclusion in this study. Additionally, many of the girls in our original psychiatric comparison group were themselves diagnosed as manifesting personality disorders with disturbed object relations and serious ego deficits, and therefore psychoanalytic theory would predict that their mothers would also demonstrate a lack of maternal empathy, although the specific dynamics of the parent-child relationship might be somewhat different. Indeed, as reported elsewhere (Golomb, 1990), although we were able to distinguish between the parenting styles and family circumstances experienced by mothers of borderline adolescents and mothers of normal adolescents, assessments of maternal empathy and life stress did not differentiate mothers of borderlines from mothers of psychiatrically hospitalized adolescent females who did not manifest symptoms of borderline personality disorder as defined by the Diagnostic Interview for Borderlines (Gunderson et al., 1981). This research, then, does not enable us to predict whether a child exposed to gross failures in parental empathy and adverse family circumstances will develop a Borderline Personality Disorder or will follow a different, though perhaps equally problematic developmental course. Although failures in maternal empathy as well as family chaos seem to play a significant role in the etiology of BPD, it does not follow that a lack of maternal empathy or the experience of life stress will always result in the creation of a borderline offspring. Indeed, as Paris and Zweig-Frank (1992) persuasively argue, some of the etiological risk factors for BPD are also risk factors for the development of other emotional disorders, and the etiology of BPD itself needs to be understood within a multifactorial context.

Given the findings of this study that families of borderlines are characterized by a high degree of disorganization, it would
be useful for future research to compare mothers of border-
lines with a group of mothers who report similar adverse family
circumstances on measures of maternal empathy. Such a study
might enable us to specify the extent to which maternal empa-
thy per se critically determines borderline outcome.

Important directions for future research also include an
examination of the role of the father in the etiology of BPD.
Our decision to focus on the mothers of borderlines reflected in
part the difficulty of identifying and locating the psychological
fathers of borderline adolescents. For example, how does one
determine who is the “father” of a youngster who had irregular
contact with her biological father and lived for several years
with a stepfather who the mother has since divorced? Nonethe-
less, fathers, even by virtue of their absence, play an important
role in child development (see Lamb, 1976). At the very least,
it is possible that the absence of a father increases the daughter’s
vulnerability to the vicissitudes of her relationship with her
mother. Alternatively, a reasonably caring father may com-
penstate for a mother who has difficulty relating to her daughter
in an empathic fashion.

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IN THE EYE OF THE BEHOLDER: HELMHOLTZIAN PERCEPTION AND THE ORIGINS OF FREUD’S 1900 THEORY OF TRANSFERENCE

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Freud's 1900 theory of transference was indebted to the convergence of philosophy and physiology found in nineteenth-century theories of visual perception. The author maps out the post-Kantian philosophical and German physiological currents that gave rise to Hermann von Helmholtz's influential work on perception, and proposes that Freud's 1900 theory of transference was a creative synthesis of novel notions like unconscious wishing and psychic defense with a Helmholtzian model of visual illusion.

If dreams are the royal road to the unconscious, then transference is the path most taken, the beaten trail clinicians follow everyday. How did transference come to assume such a central position within psychoanalysis? How did the marginally significant concept Freud presented in Studies in Hysteria develop into one of the critical issues of psychoanalytic technique?

In approaching these questions one enters difficult terrain, for the years that followed Studies in Hysteria were cataclysmic ones in which Freud built his topographic model of mind. In this paper, I shall focus on an aspect of this larger transformation that pertains to the development of transference theory. How, if at all, did Freud's intellectual life between 1895 and 1900—his desire to build a model of mind which culminated in Chapter 7 of the Interpretation of Dreams—contribute to a reworking of his 1895 model of transference?

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