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Parental Characteristics in Relation to Depressive Disorders

By GORDON PARKER

SUMMARY Using a reliable and valid measure of reported parental care and overprotection (the Parental Bonding Instrument) patients with two types of depressive disorder were compared with a control group, and the relationships to depressive experience examined in a non-clinical group as well. Bipolar manic-depressive patients scored like controls whereas neurotic depressives reported less parental care and greater maternal overprotection. Depressive experience in the non-clinical group was negatively associated with low parental care and weakly associated with parental overprotection.

Introduction

The view that variables in the parent-child relationship predispose a child to later depression has been maintained for a long period by a number of theorists and this literature has been reviewed by Becker (1974). Many studies have considered the experiences of depressives with their parents but several limitations have prevented clarification. Early studies were often impressionistic and relied on small samples which were either inadequately controlled or uncontrolled. Wilson (1951) studied 12 families with a manic-depressive member and concluded that such patients were pressured to conform to parental attitudes. Cohen *et al* (1954) in a study of 12 manic-depressive patients described several parental characteristics, and especially mothers who indulged their infants' dependency needs and punished their moves to autonomy. Gibson (1958), who used a control group of schizophrenics was unable to replicate those findings in his study of 27 manic-depressive patients.

A second limitation emerges from the common practice of sampling possibly heterogeneous types of depression which may not only introduce a methodological error but also obscure important associations. While several studies of depressive patients (Munro, 1966; Abrahams and Whitlock, 1969; Raskin *et al*, 1971; Jacobson *et al*, 1975) described disturbed parent-child relationships, the samples were not homogeneous in respect to the type of depression. Abrahams and Whitlock noted that there was a steady increase of distorted family relationships as 'one progresses through the group of patients from manic-depressive psychosis to neurotic depression'. Examination of their data suggests that the manic-depressive group could not be distinguished from the controls by the quality of family relationships. In the controlled study by Munro a greater 'disturbed relationship' with a parent was found among depressives while in their controlled study Abrahams and Whitlock noted a greater likelihood of 'unsatisfactory or bad' family relationships in depressives. In all these studies there is a lack of precision in defining a poor parent-child relationship.

After considering such limitations one may agree with Becker (1974) that 'variabilities in subject sampling, the scarcity of replications, and dearth of logically interrelated studies do not yet provide a firm base for empirical generalizations or theoretical clarification'.

In the present studies attempts were made to attend to such methodological issues. The parental characteristics reported by separate groups of bipolar manic-depressive patients and neurotic depressive patients were compared with matched controls. In addition, the association between depressive experience and parental characteristics in a non-clinical group was independently assessed.

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Secondly, an attempt was made to study the influences of principal parental characteristics or dimensions. A number of factor analytic studies (Roe and Siegelman, 1963; Schaefer, 1965; Raskin *et al*, 1971) suggest that parental behaviour and attitudes may be viewed as having two principal characteristics: a care dimension and a dimension of psychological control over the child. It was felt necessary to define these dimensions and to design a brief questionnaire which would provide a reliable and valid measure of them. The Parental Bonding Instrument (PBI) was designed by Parker, Tupling and Brown (1978) to study reported care and overprotection given by parents. The view put by a number of writers (e.g. Coopersmith, 1967; Rutter, 1976) that perceived rather than actual parental characteristics are of greater relevance was accepted. The questionnaire's validity was therefore assessed against the internal consistency of the subjects' reported experiences and not against actual behaviour. Scale scores are not affected by social class of parents, or by age or sex of the respondents. The PBI and its scoring is appended (Appendix A).

Method

The first study was based on a sample of 52 consecutive out-patients under treatment by the author with a primary diagnosis of neurotic depression made according to commonly accepted clinical features (Paykel, 1971; Kiloh *et al*, 1972). The following data were extracted from patients' files: age at initial consultation, sex, occupation and fathers' occupation (to determine social class), past suicide attempts and past admissions to a psychiatric hospital for depression. Scores on the Eysenck Personality Inventory (EPI) were available for some patients who had been previously tested. At the time of the study only five patients were receiving treatment and four were still depressed. The PBI was mailed and returned by post in most instances, and only two patients failed to reply. Patients were matched for age, sex and paternal social class with controls attending several general practices in Sydney. The selection of this control group has been described elsewhere (Parker *et al*, 1978).

The mean age of the patients was 31 years (range 17–55 years). There were 35 females and 15 males. Patients and their fathers revealed a higher social class distribution than the general population of Sydney as measured on the Congalton Scale (Congalton, 1969). Thirty patients (60 per cent) had completed the EPI and their neuroticism scores (mean 15.7, S.D. 5.3) suggest a higher level of neuroticism than in the general population, but consistent with that obtained in an Australian neurotic group (mean 16.4) and an Australian depressive group (mean 15.2), reported by Koller and Castanos (1969). Nine patients in the whole sample had been hospitalized for depression at some time and 15 had made previous suicide attempts. From a clinical assessment of their symptoms patients were assigned to one of three sub-groups: depression only (n = 14); depressive symptoms more marked than anxiety symptoms (n = 18); anxiety symptoms more marked than depressive symptoms (n = 18).

The second study was based on 70 consecutive manic-depressive patients, who had been treated at several hospitals. As difficulty can be experienced in distinguishing between psychotic and neurotic types of depression, only those manic-depressive patients known to have had manic episodes were selected. Attempts were made to determine the presence of manic-depressive illness in the patients' parents by interviews with the patient and/or the treating psychiatrist. Patients were matched for age, sex and paternal social class with the control group previously described. Twelve patients did not return forms sent by post and eight patients were excluded as they returned information on only one parent. Questionnaires were given to ten patients while they were in hospital, after ensuring that they were sufficiently well to understand the questionnaire.

The mean age of this sample was 44 years (range 18–73 years). There were 25 females and 25 males and again the social class distribution was somewhat higher than that of the Sydney general population. It was possible to estimate the presence or absence of manic-depressive illness in 85 per cent of the parents and of these, nine mothers and 14 fathers were considered to have had a manic-depressive illness.

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For the third study 242 students undertaking the one year post-graduate Diploma of Education course at Sydney Teachers' College were invited to complete the questionnaires anonymously. One student declined and five returned incomplete questionnaires. An analysis was therefore made of the 236 forms completed by 124 female and 112 male students, with a mean age of 24 years (range 21–45 years). These students had attended university for a minimum of three years and might have been expected to have encountered some adult stresses.

Respondents were asked to nominate their most and their next most influential parent or parent-figure in childhood and to complete a Parental Bonding Instrument for each. Their depressive experiences were measured in several ways. Firstly, respondents were asked if they had had episodes of depression, defined as a significant lowering of mood, with or without feelings of guilt, hopelessness and helplessness, or a drop in one's self-esteem or self-regard. Information on the actual number of episodes in the preceding year (recorded in subsequent tables as Depression-past year) was obtained. Information on the usual duration of these depressive episodes (Period of depression) was sought and scored on a scale from minutes to months. The Costello-Comrey scales (1967) to measure depression (Trait depression) and anxiety (Trait anxiety) were also completed. This depression scale was designed to measure 'a person's tendency to experience a depressive mood' and met the study need for a measure of trait rather than state depression. Self-esteem was measured by Rosenberg's scale (1965) on which a low score indicates a high self-esteem. Middleton's (1963) alienation scale was also included. Form A of the Eysenck Personality Inventory was used to measure neuroticism and extraversion.

For all three studies two-tailed tests of statistical significance were used.

Results

Results from the first two studies of separate groups of depressive patients will be considered first. Table I shows that the neurotic depressive patients perceived their mothers and fathers as less caring than did the controls. The neurotic depressive group also perceived a slight excess (significant only in relation to mothers) of parental overprotection. By contrast the manic-depressive patients could not be distinguished from controls on their care and overprotection scores for either parent.

In order to compare broad types of parental bonding, scores of neurotic depressives and controls were plotted separately for mothers and fathers on axes measuring care and overprotection so that they intersected at the means determined from four large, normal groups (Parker, 1977). For mothers the mean care score is 27.0 and the mean overprotection score is 13.5; for fathers the mean care score is 24.0 and the mean overprotection score is 12.5. It can be seen in Table II that neurotic depressives and controls differed significantly in their distributions of maternal scores, depressives' mothers most commonly occupying the quadrant reflecting low care with high overprotection. Scores from neurotic depressives and their controls were similarly plotted for fathers and found to differ significantly, depressives' fathers being more likely to occupy two quadrants reflecting low care with high overprotection and low care with low overprotection.

Similar comparisons were made between the 50 manic-depressive patients and their matched controls. In this group there was no significant difference between the patients and controls with regard to parental bonding.

TABLE I

Mean PBI scores for depressive patients and matched controls

	Study I Neurotic depressives (n = 50)		Study II Manic depressives (n = 50)	
	Patients	Controls	Patients	Controls
Maternal care	19.9	28.3**	25.9	25.6
Paternal care	14.7	25.2**	21.8	23.5
Maternal overprotection	19.1	14.3*	14.0	13.2
Paternal overprotection	16.4	13.9	12.7	11.5

** P < .001 * P < .01

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TABLE II

Distribution of assessments of parents by depressive patients and controls in quadrants representing four broad bonding types (see Fig. 1)

Study and group	Parent	Low care, High over-protection	High care, High over-protection	High care, Low over-protection	Low care, Low over-protection	χ^2	Significance
Study I—neurotic depressive patients							
Control	Mother	12	18	16	4	16.78	< .001
Patient	Mother	30	6	8	6		
Control	Father	14	8	22	6	20.61	< .001
Patient	Father	26	5	4	15		
Study II—manic-depressive patients							
Control	Mother	16	8	16	10	1.78	NS
Patient	Mother	20	5	18	7		
Control	Father	15	8	15	12	1.39	NS
Patient	Father	10	10	17	13		

In the second study a comparison was also made of PBI scale scores for those parents likely to be manic-depressive and those parents where a manic-depressive diagnosis was unlikely. Table III shows that the scores of the nine mothers and the 14 fathers presumed to have manic-depressive illness were not distinguished from the same-sexed parents presumed to be without that illness.

In the third study, the non-clinical group, mean neuroticism (10.9), extraversion (12.0) and lie (2.9) scores were similar to Australian general population norms for the Eysenck Personality Inventory (Koller and Castanos, 1969). The mean scores on the self-esteem scale was 1.5, on the alienation scale 2.2 and on the anxiety scale 27.5. The mean score on the trait depression scale was −27.1. After adding 60 to each score for ease of data handling (and subsequent references will be to those derived scores) that mean was 32.9.

TABLE III

Comparison of mean scale scores for parents with and without manic-depressive illness in the second study

Parent and scale	Manic-depressive illness: Likely	Manic-depressive illness: Not likely	t	Significance
Mother				
Care	26.3	26.2	0.05	NS
Overprotection	13.3 (n=9)	14.5 (n=32)	0.32	NS
Father				
Care	20.8	21.4	0.19	NS
Overprotection	14.1 (n=14)	12.3 (n=30)	0.55	NS

Episodes of depression, as defined, were experienced by 223 (95 per cent) respondents. The number of episodes in the preceding year ranged from 0–80 with a mean of 6.3. Only 9 per cent had not been depressed. Of those who had experienced depression, 8 per cent considered that the average attack lasted for minutes, 39 per cent said for hours, 39 per cent for days, 6 per cent for weeks and 8 per cent for months.

Mothers were nominated by 75 per cent as the more, and by 24 per cent as the less important parent. Fathers were nominated by 23 per cent as the more, and by 67 per cent as the less important parent. Grandmothers were the next most frequent relative to be nominated as one of the influential parents to respondents. The biological mother was not nominated by four of the respondents, one mother being regarded as ineffectual while three had deserted. The biological father was not nominated by 23 of the respondents, one being regarded as ineffectual,

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while 11 had deserted and 11 had died when the respondent was young.

On the Parental Bonding Instrument, mean scores of 27.5 for care and 13.3 for overprotection were obtained for those nominated the more important parent, and 23.1 for care and 12.8 for overprotection for those nominated the less important parent. On the care scale female parents (mean 27.4) scored higher ($t = 5.31$, $P < .001$) than did the male parents (mean 24.4). On the overprotection scale, female parent scores (mean 13.8) could not be distinguished ($t = 1.03$, NS) from male parent scores (mean 12.3).

Raw care and raw overprotection scores for the two nominated parents were separately intercorrelated with other variables. Significant negative correlations between parental care (from either parent) and the trait depression measure were found. Significant positive correlations were found between parental overprotection from either parent and the trait depression measure. When raw care and raw overprotection scores were intercorrelated, coefficients of $-.47$ ($P < .001$) for the more important and -0.37 ($P < .001$) for the less important parent were found. As overprotection was associated with lack of care, it appeared important to partial out the care component from the raw overprotection score, and the overprotection component from the raw care score, and to re-examine the association between these independent parental scores and the other variables. Table IV shows that significant associations between parental care (from either parent) and lower trait depression, higher self-esteem and lower alienation were found. Several other significant correlations were demonstrated for one parent but not found for the other. Correlations were generally stronger for the less important than for the more important parent. Table IV shows that overprotection from the more important parent was significantly associated with neuroticism, trait anxiety, longer duration of depressive episodes and lower self-esteem. Correlations were generally stronger for the more important than for the less important parent and no association between overprotection from the less important parent and other variables was obtained. Although the relationship between parental overprotection for either parent and depression is in the predicted direction, both failed to reach significance at the 1 per cent level.

Mean scores of the variables under examination were compared against the quadrants formed by the intersection of the two scales and against a middle or average position, the latter being added as a non-clinical group was under study. Fig 1 shows the average position and the four conceptualized parental bonding positions (Parker *et al*, 1978). An appropriate radius was determined so that the average group contained approximately one fifth of the total sample. On the basis of independent care and overprotection scores for each parent, respondents were assigned to one of the five regions established. Mean scores of the variables in each region were

TABLE IV

Product moment correlation coefficients of the independent care and overprotection scores for each parent against main variables

Variable	More important parent		Less important parent	
	Care	Overprotection	Care	Overprotection
Trait depression	−.24***	+.17*	−.31***	+.15*
Depression--past year	−.12	+.16*	−.11	+.11
Period of depression	+.01	+.21**	−.12	+.11
Self-esteem	+.19**	−.18**	+.23***	−.09
Alienation	−.17**	+.12	−.27***	+.09
Trait anxiety	−.04	+.25***	−.22***	.00
Neuroticism	−.03	+.25***	−.23***	+.07
Extraversion	+.12	−.13	+.08	−.03

*** $P < .001$ ** $P < .01$ * $P < .05$

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then subjected to an analysis of variance. For the more important parent the distribution of mean scores for trait depression and self-esteem differed significantly (Table V). Two positions occupied by that parent were associated clearly with extremes in the mean scores of several of the variables. Those respondents exposed to high care with low overprotection had scores suggesting the lowest trait depression, the highest self-esteem, lowest trait anxiety and lowest alienation. They had the fewest episodes of depression in the preceding year. By comparison, those respondents exposed to low care with high overprotection had scores suggesting the highest trait depression, lowest self-esteem, highest neuroticism, highest trait anxiety and greatest alienation. They had the greatest number of depressive episodes in the preceding year and their episodes lasted longest. For the less important parent these two bonding positions were again clearly associated with extremes in the mean scores of several variables (Table VI). Those exposed to high care with low overprotection had scores suggesting the lowest trait depression, highest self-esteem, lowest neuroticism, lowest trait anxiety and lowest alienation. Those exposed to low care with high overprotection had scores suggesting the highest trait depression, highest neuroticism, highest alienation and lowest self-esteem. They also had the greatest number of depressive episodes in the preceding year and their episodes lasted longest.

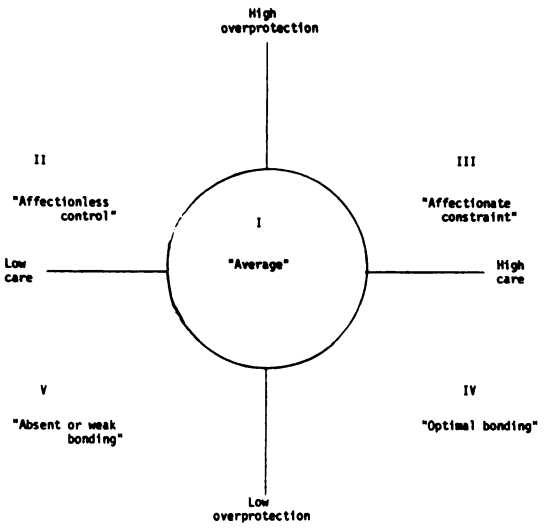


FIG 1.—Conceptualized parental bonding positions allowed by the two scales of the PBI.

Discussion

Before considering the results of these studies, several methodological issues should be noted. In the first study it is conceivable that the author might have influenced subjects' scoring of their parents through the therapeutic situation, so that some neurotic depressives

TABLE V

Mean scores on main variables for respondents occupying five bonding positions to the more important parent

	Parental bonding position						
Variable	I Average	I Low care, High over-protection	III High care, High over-protection	IV High care, Low over-protection	V Low care, Low over-protection	F ratio	Significance
Trait depression	30.7	37.9	32.9	28.8	36.5	4.00	< .01
Trait anxiety	26.5	30.6	29.5	25.3	26.4	2.28	NS
Depression—past year	6.0	10.2	6.0	4.5	5.8	1.96	NS
Period of depression	2.7	2.8	2.8	2.5	2.3	1.92	NS
Self-esteem	1.2	2.1	1.6	1.2	1.5	3.47	< .01
Alienation	2.1	2.7	2.1	1.9	2.3	2.16	NS
Neuroticism	10.9	12.3	11.8	10.0	9.7	2.57	< .05
Extraversion	11.3	11.7	12.7	12.4	11.8	0.86	NS
N	40	40	47	66	43		

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TABLE VI

Mean scores on main variables for respondents occupying five bonding positions to the less important parent

Variable	Parental bonding position					F ratio	Significance
	I Average	II Low care, High over-protection	III High care, High over-protection	IV High care, Low over-protection	V Low care, Low over-protection		
Trait depression	30.4	39.2	32.6	28.0	37.4	5.93	< .001
Trait anxiety	27.8	30.0	26.0	24.9	31.3	3.13	< .02
Depression—past year	4.4	11.8	3.8	6.7	5.1	4.07	< .01
Period of depression	2.4	2.8	2.7	2.5	2.7	1.19	NS
Self-esteem	1.4	1.9	1.3	1.2	1.9	2.57	< .05
Alienation	1.9	3.0	1.9	1.9	2.5	6.13	< .001
Neuroticism	10.7	12.8	10.4	9.7	11.9	3.04	< .02
Extraversion	12.4	11.8	11.7	12.8	10.7	1.67	NS
N	42	39	52	62	41		

gave back the writer's interpretation rather than their own account of their parents. Again, depression in any of the patients may have distorted their judgement of a parent. As only five of the patients were receiving treatment for depression at the time of completing the questionnaire, that possibility seems unlikely. Replication of the first two studies is indicated with sampling biases removed by selecting patients randomly from several available sources, and establishing that they are not depressed at time of study.

Depression, as defined in the questionnaire, was almost a universal experience in the third study group, with more than six episodes experienced on average in the preceding year. A number of the depressive episodes may have involved a neurotic depressive syndrome, as 14 per cent of the respondents considered their average depressive episodes to last weeks or months, when persistence of symptoms has been considered to suggest a depressive syndrome (Craig and Van Natta, 1976). An attempt was made to identify respondents' two most influential parent-figures, rather than restrict consideration to biological parents. It is of interest that someone other than a biological parent was nominated by 11 per cent, mainly because a biological parent was absent in the early years, and that 25 per cent considered someone other than their mother to be their most important parent. While this technique appears a realistic one in assessing the influence of relevant parents on depression it would appear worthwhile to obtain more information on factors affecting the nomination of parent-figures than was sought in the present study. Selection of a group whose members were of a similar educational background and age, and engaged in a common training program allowed several social variables to be controlled. Nevertheless, in considering the ubiquity of depressive experiences, chosen parent-figures and the associations between depression and reported parental characteristics, it must be acknowledged that the group was unrepresentative of the general population.

In the second study of bipolar manic-depressive patients the negative findings appear worthy of emphasis. Deficiencies in reported parental attitudes and behaviours were not found in this group, and there was no suggestion that the manic-depressive illness of a parent influenced parental attitudes and behaviours.

Results from the neurotic depressive patients and the students can be considered together. Associations between perceived characteristics of low care and/or high overprotection in parents and certain later depressive experiences were demonstrated in both groups. In considering these associations three broad explanations might be offered.

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Firstly, those with a depressive or neurotic temperament might tend to judge parental and subsequent relationships negatively. There has been a number of studies suggesting that neurotics and depressives tend to selectively monitor negative events, inaccurately attribute responsibility, and are sensitive to negative interpersonal interaction with others (see Beck, 1976). Examination of the tone of the items in the questionnaire suggests that negative judgements of a parent might be expressed in scoring that parent as low on care and high on overprotection. As stated earlier the Parental Bonding Instrument has as yet only been tested as a valid measure of the perceived characteristics, and not of actual behaviours of parents. While there was little evidence of depression in the neurotic depressive patients at the time of the study that possibility cannot be refuted until the influence of a depressed mood on PBI scores has been formally assessed. Further analysis of findings in the third study was made to examine the influence of neuroticism. Trait depression scores correlated -0.28 ($P < .001$) with raw care scores and $+.22$ ($P < .001$) with raw overprotection scores for the more important parent. After partialling out the effect of EPI neuroticism scores, trait depression scores correlated -0.27 ($P < .001$) with raw care scores and $+.14$ ($P < .02$) with raw overprotection scores. For the less important parent controlling for neuroticism reduced the correlation between trait depression scores and raw care scores from $-.33$ to $-.27$ ($P < .001$) and reduced the correlation between trait depression scores and raw overprotection scores from $+.21$ to $.11$ ($P = .05$). Thus neuroticism would not appear to influence the way in which respondents score their parents on the care scale of the PBI, but it may exert some influence on scoring of parents on the overprotection scale of the PBI.

Secondly, it might be that those with a depressive temperament elicit less parental care and/or greater parental overprotection. Lewis and Rosenblum (1974) have collected considerable evidence that infants and children influence the behaviour of the care-giver. As the present studies were not designed to test such a mechanism that explanation cannot be refuted.

Thirdly, low parental care and/or parental overprotection may be antecedent causes of several grades of depressive experience. Wylie (1961) concluded, after an extensive review, that there is 'some limited evidence that a child's level of self-regard is associated with the parents' reported level of regard for him', and a subsequent study by Coopersmith (1967) suggested a causal association between maternal affection and a child's self-esteem. Is it that those who are exposed to deficient parental care tend to place a lower estimate on their worth and are then more likely to experience further devaluation or depression?

How might parental overprotection dispose to depression? As there is some evidence (Coopersmith, 1967; Becker, 1974) that social contexts and prestige hierarchies influence self-esteem and depressive experiences, it would appear plausible to suggest that parental overprotection might restrict the development of self-esteem by constraining the process of social competence. The 'learned helplessness' model of depression proposed by Seligman (1975) might also be of relevance, since he suggests that when an organism can make no effective response three disruptions result: motivation to respond is decreased, ability to perceive success is undermined and emotionality is heightened. It could be that an overprotective parent, who controls, infantilizes and discourages independence, is the one who assists a child's expectation that outcome is independent of its responses, thus promoting any tendency to depression. The present studies were not designed, however, to examine possible mechanisms underlying the demonstrated associations. More work is required to determine if parental characteristics of low care and overprotection are antecedent causes of depressive experience, anxiety, neuroticism and social incompetence.

It has often been said that classification should precede identification of causes. Adherence to that principle, when an attempt was made to preserve the boundaries between several expressions of depression, would appear to have been of assistance in the present studies. Neurotic depressive disorders and non-clinical depression in a normal group are associated with reported low levels of parental care and

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high levels of parental overprotection. By contrast, no association between bipolar manic-depressive disorder and those parental dimensions was found. These findings would appear to clarify the relevance of parental characteristics as antecedents to several depressive disorders.

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Appendix A

The Parental Bonding Instrument and its scoring. Scores for the care scale are shown in Arabic numerals. Scores for the overprotection scale are shown in Roman numerals.

Female/Male Parent Form:

This questionnaire lists various attitudes and behaviours of parents. As you remember your MOTHER/FATHER in your first 16 years would you place a tick in the most appropriate brackets next to each question.

		Very like	Moderately like	Moderately unlike	Very unlike
1.	Spoke to me with a warm and friendly voice	(3)	(2)	(1)	( )
2.	Did not help me as much as I needed	( )	(1)	(2)	(3)
3.	Let me do those things I liked doing	( )	(I)	(II)	(III)
4.	Seemed emotionally cold to me	( )	(1)	(2)	(3)
5.	Appeared to understand my problems and worries	(3)	(2)	(1)	( )
6.	Was affectionate to me	(3)	(2)	(1)	( )
7.	Liked me to make my own decisions	( )	(I)	(II)	(III)
8.	Did not want me to grow up	(III)	(II)	(I)	( )
9.	Tried to control everything I did	(III)	(II)	(I)	( )
10.	Invaded my privacy	(III)	(II)	(I)	( )
11.	Enjoyed talking things over with me	(3)	(2)	(1)	( )
12.	Frequently smiled at me	(3)	(2)	(1)	( )
13.	Tended to baby me	(III)	(II)	(I)	( )
14.	Did not seem to understand what I needed or wanted	( )	(1)	(2)	(3)
15.	Let me decide things for myself	( )	(I)	(II)	(III)
16.	Made me feel I wasn't wanted	( )	(1)	(2)	(3)
17.	Could make me feel better when I was upset	(3)	(2)	(1)	( )
18.	Did not talk with me very much	( )	(1)	(2)	(3)
19.	Tried to make me dependent on her/him	(III)	(II)	(I)	( )
20.	Felt I could not look after myself unless she/he was around	(III)	(II)	(I)	( )
21.	Gave me as much freedom as I wanted	( )	(I)	(II)	(III)
22.	Let me go out as often as I wanted	( )	(I)	(II)	(III)
23.	Was overprotective of me	(III)	(II)	(I)	( )
24.	Did not praise me	( )	(1)	(2)	(3)
25.	Let me dress in any way I pleased	( )	(I)	(II)	(III)

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