Empathy in Families of Women with Borderline Personality Disorder, Anorexia Nervosa, and a Control Group*

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LISE LAPORTE, Ph.D.†

This is a study of empathy in the families of 27 women with borderline personality disorder (BPD), 28 women with restricting anorexia nervosa (AN), and 27 women without a clinical diagnosis (NC). The daughters and both parents responded to the Interpersonal Reactivity Index (IRI), an instrument for assessing four dimensions of empathy. In addition, they were personally interviewed, with the Family Interview for Protectiveness and Empathy (FIPE), about the extent of empathy expressed by the parents to their daughter during her development. On the IRI, women with BPD scored highest on the immature and lowest on the mature aspects of empathy, whereas scores of AN and NC women were all within normal limits. Parents of BPDs had the lowest IRI scores, while parents of AN and NC groups were similar to each other and to criterion.

group scores. IRI scores of AN daughters were positively correlated with their parents' scores whereas BPDs' scores were negatively correlated with those of their parents. There were no correlations between the IRI scores of NC subjects and their parents. On the FIPE, borderline daughters and parents agreed about the relative absence of empathic parenting, whereas AN and NC daughters and parents agreed as to the presence of empathic parenting. The theoretical and clinical implications of these contrasting findings are discussed.

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EMPATHY has been defined as the ability to apprehend another person's state of mind (Davis, 1983). It includes an emotional and an intellectual component (Batson, 1987; Davis, 1983; Duan & Hill, 1996; Feshbach, 1987). Whereas emotional empathy has its roots in sympathetic involvement with another person's feelings, intellectual empathy is related to the ability to recognize another's feelings without vicariously experiencing them (Batson, 1987; Mehrabian & Epstein, 1972). To develop mature empathy, it is necessary to develop the capacity to generalize from one individual or case.

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to a class of similar individuals or situations (Davis, 1983).

Empathy has been most consistently studied as an important component of the therapist-patient relationship (Rogers, 1957). There has been relatively little systematic attention given to the normal development of empathic behavior and the role played by the patient's upbringing, even though there is evidence that the empathic presence of the parents fosters empathic development in children (Chase-Lansdale, Wakschlag, & Brooks-Gunn, 1995; Eisenberg & McNally, 1993; Feshbach, 1987). Moreover, people who suffer from psychiatric disorders often report an absence of parental empathy (Brodsky & Brodsky, 1981; Ladisich & Feil, 1988).

The ability to be generally and somewhat theoretically empathic toward other people does not necessarily imply that one is empathic toward a particular person. This is especially evident in close relationships, such as in families, where there is often some degree of mutual projection and projective identification. If there is the expectation that the other person must behave in a certain way or that the other person has negative traits by his or her very nature, any behavior that corrobrates one's negative expectation or disappoints a positive expectation will lead to feelings of anger, shame, and rejection rather than empathy. This has considerable implications for the parent-child relationship.

Empathy could be a faculty that is inherent in the person or a characteristic that is shaped by the environment as mediated by the family. We will consider each of these two possibilities as they apply to families of patients with borderline personality disorder (BPD) and with anorexia nervosa (AN).

Patients with BPD have been described as being especially empathic ("borderline empathy"), easily resonating and entering into relationships with strangers (Frank & Hoffman, 1986; Gunderson, Zanarini, Kolb, & Austin, 1981; Ladisich & Feil, 1988). Yet, it seems to be difficult for them to sustain a harmonious long-term relationship. Thus, one might question whether this characteristic is identical with true empathy, as it has been defined in the literature.

Hoffman and Frank (1987) suggested that women with borderline personality disorder may have a constitutional vulnerability for heightened distress. This hypothesis has been recently supported by Gunderson and Lyoo (1997) and by preliminary studies of the serotonergic function in women with BPD (Figueroa & Silk, 1997; Martial, Paris, Leyton, et al., 1997). It implies that people with the diagnosis of BPD may be constitutionally unable to present cues that arouse empathy or, alternatively, that they exhaust the empathic capacity of those close to them by their constant expressions of distress and disarray. Thus, parents of women with BPD could have difficulty in identifying with their daughter's distress and feeling empathic concern for her. And yet, it is also possible that these parents are generally lacking in their ability to be empathic. Furthermore, given that families of borderline patients often have many socioeconomic difficulties, these parents may have been too overwhelmed to be empathic with a rather hypersensitive child.

Few studies have directly investigated the empathic capacity of parents of borderline women. Using the Parental Awareness Measure, Golomb, Ludolph, Westen, and colleagues (1994) compared thirteen mothers of borderline adolescents with thirteen mothers of normal girls and found that mothers were less empathic with daughters who had BPD. Also, they had raised their daughters in an atmosphere of chaos, poverty, and social isolation. In several studies, women with BPD have
recalled their parents as having been neglectful and uncaring (Gunderson, Kerr, & Englund, 1980; Walsh, 1977; Zanarini, Gunderson, Marino, et al., 1989; Zweig-Frank & Paris, 1991). Moreover, the presence of verbal, physical, and sexual abuse has been repeatedly documented in these families (Laporte & Guttmann, 1996; Zanarini, Williams, Lewis, et al., 1997). These findings suggest that borderline women experience a lack of parental empathy while growing up.

Parental empathy could have an important influence on the quality of the family relationships of women who develop BPD. We have described two types of family relationships of borderline women who grew up in their family of origin (Feldman & Guttmann, 1984). In one type, one of the parents suffered from BPD and the patient had developed certain behaviors and attitudes either as a result of direct identification with and modeling by this parent, or because of some shared genetic vulnerability. In the other type of family, one of the parents seemed to be emotionally constricted and unable to empathize with the daughter. In these families, the other parent could sometimes act as a sort of “emotional prosthesis” for the unempathic parent, by reacting appropriately to the child and interpreting the world to the spouse from an emotional point of view, thereby mitigating the effect on the child of the spouse’s emotional unresponsiveness. However, the second parent is not always capable of such empathy and, in this instance, borderline behavior might represent the patient’s frantic escalation of her attempts to be understood. This would more readily occur in a child who is constitutionally predisposed to be especially sensitive to the emotional climate within the family.

To date, there has not been any systematic study of the empathy of women with BPD. Most accounts of their family relationships have described only the patients’ perceptions or recollections, and not those of any family members. No study has directly investigated the capacity for general empathy of parents of borderline patients, nor the extent of their particular empathy for their daughters. We expect parents of borderline women to be less empathic than parents of anorectic and nonclinical women. This will be reflected in the level of parental empathy reported by each family member. We also expect that women with borderline personality disorder might have certain deficiencies when objectively tested for empathy.

Women suffering from anorexia nervosa have been described as being deficient in attending to the needs and wishes of others. They have also been described as being literal-minded and concrete rather than emotionally expressive (Bourke, Taylor, & Crisp, 1985). Is this empathic blunting related to a constitutional predisposition, to parental influence, to family dynamics, or does it result from the anorectic’s state of chronic starvation, with consequent self-preoccupation and limitations in sensitivity to others? Several authors have described a certain lack of empathic capacity on the part of parents of anorectics (Geist, 1989). Much earlier, Bruch (1970) had remarked on their emotional imperviousness to the needs of the child, and this conclusion has been supported by Dare (1985). Therefore, we would expect anorectic women and at least one of their parents to exhibit difficulties with empathy, as compared with the members of families without clinical problems.

At the same time, the family relationships of anorectic women are often described as being overly close and enmeshed, with strong bonds of loyalty, overprotection of the identified patient, and conflict avoidance between family members (Dare, 1985; Kog & Vanderkuyken, 1985; Minuchin, Rosman, & Baker,
1978). How is this enmeshment related to a possible lack of true empathy among family members? Our findings might clarify the nature of this relationship.

METHOD

Participants

To be considered for possible inclusion in this study, the identified daughter\(^1\) had to be between 16 and 40 years of age, have lived with both natural parents for the first 16 years of her life, and come from a family in which French or English is understood and spoken. The two clinical groups consisted of women who met the DSM-III-R criteria (American Psychiatric Association, 1987) for borderline personality disorder (BPD) or for restricting anorexia nervosa (AN) without an organic condition or a major psychotic disorder. The comparison group (NC) consisted of women without a psychiatric history.

Women with BPD were recruited through their therapists from eight English- and French-language hospitals of the metropolitan area. All subjects were interviewed with the Revised Retrospective Diagnostic Interview for Borderlines (DIB-R; Zanarini, Gunderson, Frankenburg, & Chauncey, 1989). Those who had a score equal to or higher than 8 on the DIB-R were included in the BPD group. Potential subjects were excluded from the study if they also met the criteria for a concurrent diagnosis of anorexia nervosa on the Eating Disorders Module of the Structured Clinical Interview for DSM-III-R (SCID; Spitzer, Williams, Gibbon, & First, 1988).

Anorectic women who were current or former outpatients were recruited through their therapists and through advertise-

\(^1\) The study included only female patients because (a) women have a greater propensity to develop eating disorders, and (b) there is a predominance of females in the borderline population.

ments. To confirm the diagnosis of restricting anorexia nervosa and exclude women with BPD, all participants were interviewed with the SCID (Spitzer et al., 1988) and the DIB-R, (Zanarini et al., 1989).

The control group was recruited through public advertisements. These women were not given a formal diagnostic evaluation but were selected if they scored within the normal range on two clinical self-report questionnaires, the Symptom Checklist-90-R (Derogatis, 1977) and the Borderline Syndrome Index (Conte, Plutchik, Karasu, & Jevrett, 1980), and on assessment with the SCID (Spitzer et al., 1988).

Procedure

The purpose of the study was explained to the women on the telephone, and sufficient information was obtained to determine whether they met all the inclusion criteria. Those who were interested were requested to invite their parents to participate in the study. If the parents agreed to participate, they were contacted by a team member and separate meetings with each family member were arranged. After giving informed consent, they completed a series of questionnaires and participated in a semi-structured interview. All participants received payment.

Each family member was individually interviewed by a clinician who had had no prior contact with the other family members. Although all procedures were kept as blind as possible, the interviewers could occasionally identify the clinical diagnosis of the daughter. However, they did not know the hypotheses regarding the associated familial patterns. Data were collected on all three members of 26 families of borderline women, 28 families of anorectic women, and 27 nonclinical families.
Instruments

The Revised Diagnostic Interview for Borderlines is a semi-structured interview that distinguishes clinically diagnosed patients with BPD from patients with other Axis II disorders (Zanarini et al., 1989). A cut-off score of 8 or more is highly indicative of Borderline Personality Disorder. The Eating Disorders Module of the Structured Clinical Interview for DSM-III-R (Spitzer et al., 1988) is a semi-structured interview that reliably demonstrates the presence of an eating disorder. The Symptom Checklist-90-R (Derogatis, 1977) is a clinical self-report scale widely used in research and evaluation studies. The Borderline Syndrome Index (Conte et al., 1980) is a self-report questionnaire that taps seven operational criteria for borderline personality organization listed in DSM-III.

We used two instruments to measure empathy because we wanted to elicit a general, somewhat theoretical empathic response as well as a response to specific family members. As a measure of general empathy, we used a self-report instrument, the Interpersonal Reactivity Index (Davis, 1983). To measure each family member’s perception of the parents’ empathy for their daughter, we developed the Family Interview for Protectiveness and Empathy.

The Interpersonal Reactivity Index (IRI) is a 28-item instrument that measures emotional and cognitive components of a person’s general capacity for empathy with four scales: (a) Perspective Taking (PT), the cognitive capacity to see things from the point of view of others without necessarily experiencing any affective involvement; (b) Empathic Concern (EC), the tendency to experience the affective reactions of sympathy, concern, and compassion for other people undergoing negative experiences; (c) Personal Distress (PD), the tendency to experience personal feelings of distress and discomfort in witnessing other people’s negative experiences; and (d) Fantasy (FS), the imaginative capacity to transpose oneself and identify strongly with fictitious characters in movies, books, and plays. Each scale reliably measures the identified variable and has adequate internal reliability, with an alpha coefficient ranging from .71 to .77 (Davis, 1983; Davis & Oathout, 1987; Litvack-Miller, McDougall, & Romney, 1997). In our study, the level of internal reliability across the four factors was adequate, ranging from .63 to .70 in the French version and from .68 to .81 in the English version. Davis (1983) reports the following normative scores for IRI factors in a nonclinical population, for women and men respectively: PT = 18 and 16.8; EC = 21.7 and 19; PD = 12.3 and 9.5; FS = 18.75 and 15.7.

The Family Interview for Protectiveness and Empathy (FIPE) is a semi-structured interview that investigates family relationships during the first 16 years of the daughter’s life. It includes six questions concerning the level of maternal and paternal empathy specifically directed toward the daughter. For example: “Did you turn to your mother for intimate conversation?” or “Was your father able to understand you without your having to express what you felt in words?” Each parent was also questioned about his or her own and the spouse’s behavior. Each response is scored on a Likert scale ranging from 0 (not at all) to 3 (very much so), with a maximum total score of 18 for each parent’s level of empathy. The internal consistency of the six items for both the French and the English versions of the interview was adequate (Cronbach’s alpha = .90 for maternal empathy and .89 for paternal empathy). Construct validity was established by correlating FIPE items with the Care factor of the Parental Bonding Instrument (Parker, Tupling, & Brown, 1979),

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which measures the daughter's perception of the care and empathy of each parent during the first 16 years of her life. The correlations ranged from $r = .46$ ($p < .0001$) to $r = .76$ ($p < .0001$).

**RESULTS**

**Statistical Analysis**

Multivariate and univariate analyses of variance were conducted, using Tukey post hoc tests of pair-wise comparisons when necessary. Pearson correlation coefficients were calculated to determine relationships between family members' scores.

**Sociodemographic Data**

Women with BPD were significantly older (X = 32) than women with anorexia (X = 22) or without clinical problems (X = 21; $F = 29.25$, df = 2, $p < .001$) but did not differ in their level of schooling (X = 12.5). The parents of women with BPD had a significantly lower family income (X = $35,400; F = 5.33$, df = 2, $p < .007$), were less educated (X = 10; $F = 5.93$, df = 2, $p < .004$), and had more children (X = 2.4; $F = 3.39$, df = 2, $p < .04$) than parents of anorectic and nonclinical women who had an average income of $58,220, 13 years of schooling, and 1.6 children. French-speaking families made up 81% of the borderline group, 71% of the anorectic group and 66% of the control group. Because the proportion of French-speaking participants was not the same in each group, a series of posteriori comparisons was done in order to control for between-group differences related to differences in language. Furthermore, because of significant differences in sociodemographic data, between-group comparisons were corroborated with analyses of covariance (ANCOVAs).

**Interpersonal Reactivity Index**

A 3 (Diagnostic Group) × 3 (Family Member) multivariate analysis of variance was conducted on the four IRI factors, using family member as a repeated measure. There was a significant main effect for Member ($F = 12.74$, df = 8, $p < .0001$), but none for Group membership. A significant Group × Member interaction ($F = 2.51$, df = 16, $p < .002$) qualifies the significant member effect. Table 1 presents the mean scores and results of the following univariate analyses:

**Empathic Concern:** Women with BPD had the highest level of Empathic Concern ($p < .01$) of the whole group while mothers of BPD daughters had the lowest scores of all the mothers. The scores of the mothers of anorectic and nonclinical women were higher and not significantly different from one another. Whereas the scores of all three members of the nonclinical families were similar, fathers of BPD and AN women scored lower than their wives and daughters. **Personal Distress:** In all cases, daughters scored higher than their parents ($p < .01$). Women with BPD scored significantly higher than AN and NC women, whose scores were similar. **Fantasy:** A posteriori comparisons indicated that all the daughters scored significantly higher on Fantasy than their parents ($p < .01$).

**Intercorrelations of Family Members**

Scores on Interpersonal Reactivity Index: In the families of women with BPD, there is a preponderance of negative correlations between the scores of the daughters and their parents (see Table 2). The more empathic the daughter, the lower the parents' empathic capacities. In the families of anorectic women, there is the highest number of positive correlations between daughters' and parents' scores, with 50% of the daughters' and fathers' scores being correlated. In nonclinical families, there are almost no correlations between family members' scores.
Perceptions of Parental Empathy

Maternal and Paternal Empathy scores on the FIPE were each analyzed by a 3 × 3 ANOVA with family members constituting the repeated-measure factor and group membership the between-subjects factor (see Table 3). The ANOVA for Maternal Empathy yielded a significant Group effect (F = 8.86, df = 2, p < .0001) and a significant Member effect (F = 18.72, df = 2, p < .0001), but the interaction effect was not significant. On post hoc comparison of means, maternal empathy was scored lowest by all three members of borderlines’ families. Family members of anorectic and nonclinical women gave

<table>
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<tr>
<th>Table 1</th>
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<tr>
<td>Mean Scores and Standard Deviations of IRI Subscales for Mothers, Fathers, and Daughters of Borderline, Anorectic, and Nonclinical Families</td>
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</table>

<table>
<thead>
<tr>
<th>Perspective Taking</th>
<th>Borderline</th>
<th>M</th>
<th>F</th>
<th>D</th>
<th>Anorectic</th>
<th>M</th>
<th>F</th>
<th>D</th>
<th>Nonclinical</th>
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<th>F</th>
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<tr>
<td>X</td>
<td>17.3</td>
<td>16.9</td>
<td>14.9</td>
<td>18.3</td>
<td>18.0</td>
<td>17.9</td>
<td>18.5</td>
<td>18.1</td>
<td>16.7</td>
<td>1.71</td>
<td>2.06</td>
<td>.34</td>
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<tr>
<td>SD</td>
<td>5.3</td>
<td>3.9</td>
<td>4.7</td>
<td>4.9</td>
<td>5.5</td>
<td>6.5</td>
<td>6.1</td>
<td>4.9</td>
<td>4.3</td>
<td>.15</td>
<td>2.50*</td>
<td>3.30**</td>
</tr>
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</table>

| Empathic Concern | X | 20.1 | 21.8 | 24.0 | 23.6 | 20.2 | 22.0 | 22.2 | 21.0 | 21.8 | 1.93 | 17.96*** | 4.14** |
| SD | 4.9 | 4.0 | 3.1 | 4.4 | 5.6 | 5.0 | 4.6 | 4.4 | 4.4 | .15 | 2.50* | 3.30** |

| Personal Distress | X | 12.3 | 12.9 | 20.2 | 11.6 | 10.5 | 15.6 | 14.8 | 11.0 | 14.2 | 1.93 | 17.96*** | 4.14** |
| SD | 5.5 | 4.8 | 6.9 | 5.8 | 5.3 | 6.3 | 5.3 | 5.8 | 5.6 | .15 | 2.50* | 3.30** |

| Fantasy | X | 10.7 | 8.4 | 19.8 | 13.2 | 12.1 | 17.2 | 13.8 | 11.5 | 19.2 | 1.56 | 38.59*** | 2.11 |
| SD | 5.3 | 5.5 | 6.3 | 5.4 | 6.4 | 4.3 | 5.3 | 5.8 | 4.9 |

Note: M = Mother, F = Father, D = Daughter.
* p < .05; ** p < .01; *** p < .001

<table>
<thead>
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<th>Table 2</th>
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<tr>
<td>Correlations Between Daughters—Mothers and Daughters—Fathers IRI Scores</td>
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<tr>
<th>IRI</th>
<th>PTa</th>
<th>FSa</th>
<th>Eca</th>
<th>PDa</th>
<th>PTb</th>
<th>FSb</th>
<th>Ec</th>
<th>PDb</th>
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<tr>
<td>Borderline Families</td>
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<td></td>
</tr>
<tr>
<td>Perspective Taking (PT)</td>
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<td>.04</td>
<td>-.12</td>
<td>.04</td>
<td>.21</td>
<td>-.26</td>
<td>-.14</td>
<td>.08</td>
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<td>-.25</td>
<td>.21</td>
<td>-.36*</td>
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<td>.07</td>
<td>-.01</td>
<td>-.10</td>
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<tr>
<td>Empathic Concern (EC)</td>
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<td>-.39*</td>
<td>.09</td>
<td>-.48*</td>
<td>-.41*</td>
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<td>.06</td>
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<td>Personal Distress (PD)</td>
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<td>-.04</td>
<td>-.05</td>
<td>.10</td>
<td>-.31</td>
<td>-.31</td>
<td>-.31</td>
<td>-.39*</td>
</tr>
</tbody>
</table>

| Anorectic Families |
| Perspective Taking | -.18 | .28 | .03 | -.13 | .57** | .30 | .55** | -.27 |
| Fantasy Scale | -.14 | .01 | -.21 | -.23 | .38* | .18 | .25 | .13 |
| Empathic Concern | -.08 | .47** | .12 | -.07 | .64** | .49** | .73** | .06 |
| Personal Distress | -.05 | .00 | -.09 | .17 | -.05 | -.15 | -.01 | .47** |

| Nonclinical Families |
| Perspective Taking | -.23 | .01 | -.20 | -.28 | .12 | .19 | .04 | -.02 |
| Fantasy Scale | -.12 | -.16 | -.01 | .20 | -.28 | -.25 | -.16 | .22 |
| Empathic Concern | -.16 | -.16 | -.21 | -.06 | .12 | -.10 | .23 | .29 |
| Personal Distress | .07 | .04 | .37* | .40* | -.21 | -.08 | -.16 | .16 |

a daughter—mother and b daughter—father correlations; * p < .05; ** p < .01; *** p < .001.
higher, similar scores to their mothers ($p < .05$). All the daughters scored the empathy of their mothers lower than did their parents ($p < .05$).

The ANOVA for Paternal Empathy produced a significant Group effect ($F = 19.43$, df = 2, $p < .0001$), and a significant Group $\times$ Member interaction effect ($F = 2.44$, df = 4, $p < .05$). All three family members of the BPD group gave paternal empathy the lowest score and mothers of borderlines scored paternal empathy lower than the fathers scored themselves ($p < .01$). In families of anorectic and nonclinical women, fathers’ empathy was scored lower by daughters than by either parent ($p < .05$).

In scoring their parents’ empathy (see Figure), there was a stepwise progression in the daughter’s scores, such that the borderline daughters scored their parents lowest, the anorectic daughters somewhat higher, and daughters in the control group gave the highest empathy scores to their parents. However, in all cases, daughters scored their mothers’ empathy higher than their fathers’ ($F = 12.76$, df = 1, $p < .001$).

**Intercorrelations of Family Members’ Scores on the FIPE:** Whereas the women with BPD agreed strongly with both their parents as to the lack of empathy demonstrated by their mothers, the perceptions of anorectic and control subjects of their mothers’ empathy were correlated only with their fathers’ perceptions. In contrast, in families of borderline and anorectic women, the daughters’ perceptions of their fathers’ empathy were correlated with their mothers’ perceptions. Nonclinical daughters’ perceptions were correlated with the perceptions of both their parents. In all three types of family, there was no correlation between the parents’ scores (see Table 4).

**DISCUSSION**

Parents of women with BPD are less empathic than parents of women with anorexia nervosa and parents of women in the control group. On the IRI, mothers of women with BPD scored lowest of all parents on Empathic Concern. In the interview, all family members agreed that both parents were unempathic toward their daughter. The lack of empathy shown by both parents is congruent with the postulate of “biparental failure” as a risk factor for the development of BPD (Links, 1990; Paris & Frank, 1989), with the findings of Gunderson et al. (1980) and with the observations of Feldman and Guttman (1984). The father’s lack of empathy for the daughter has never before been described. Although mothers’ lack of empathy toward their borderline daughters is described in the literature,

### Table 3

<table>
<thead>
<tr>
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<th>Borderline Families</th>
<th>Anorectic Families</th>
<th>Nonclinical Families</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>SD</td>
<td>X</td>
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<tr>
<td><strong>Mother’s Empathy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother’s Perception</td>
<td>8.52</td>
<td>(5.5)</td>
<td>12.37</td>
</tr>
<tr>
<td>Father’s Perception</td>
<td>8.36</td>
<td>(4.6)</td>
<td>11.83</td>
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<tr>
<td>Daughter’s Perception</td>
<td>6.80</td>
<td>(6.1)</td>
<td>8.17</td>
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<tr>
<td><strong>Father’s Empathy</strong></td>
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<td></td>
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<tr>
<td>Mother’s Perception</td>
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<td>(2.2)</td>
<td>8.45</td>
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<td>Father’s Perception</td>
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<td>(4.1)</td>
<td>8.79</td>
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<tr>
<td>Daughter’s Perception</td>
<td>3.48</td>
<td>(4.5)</td>
<td>6.37</td>
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their inability to show general empathic concern has never before been objectively demonstrated.

It may be that these parents were unempathic specifically toward this particular daughter because of her constitutional vulnerability for heightened distress and her inability to present cues that clearly arouse empathy. However, this explanation must be weighed against the fact that the parents’ low empathy scores represent their own evaluation of their empathic capacity. Thus, they might not have the general ability to apprehend another person’s state of mind. With Gunderson and Lyoo (1997), we suggest that one way of finding further evidence for either of these two explanations would be to study the parents’ relationships with their other children and to obtain the siblings’ opinions of their parents’ empathic capacities.

Women with BPD score highest of all daughters and parents on Empathic Concern and Personal Distress and lowest on

![Figure. Daughters' perceptions of their mothers' and fathers' empathy.](image)

### Table 4

<table>
<thead>
<tr>
<th>Empathy</th>
<th>Borderline Families</th>
<th>Anorectic Families</th>
<th>Nonclinical Families</th>
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<tr>
<td></td>
<td>Mother</td>
<td>Father</td>
<td>Mother</td>
</tr>
<tr>
<td>Maternal</td>
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<tr>
<td>Paternal</td>
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<td>.32</td>
<td>.52**</td>
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† *p < .05; *p < .05; **p < .01

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Perspective Taking. Their scores are also higher than the mean scores of a normal population (Davis, 1983). Because these scores reflect a disproportion between the affective and cognitive components of empathy, it is probably more accurate to use the term "borderline sensitivity" rather than "borderline empathy" (Frank & Hoffman, 1986) to describe their way of relating, so as not to confuse it with a multidimensional capacity that includes both the cognitive and emotional components of empathy (Davis, 1983).

In most instances, the IRI scores of the borderline women and their parents go in opposite directions, so that the daughter's scores cannot be explained by a process of direct identification with a parent. However, their heightened sensitivity may be partly attributable to the abusive family environment in which they were brought up. Seventy-nine percent of these women suffered verbal abuse and 57% suffered physical abuse from other family members, as compared with 46% and 18% for anorectic women, and 52% and none for nonclinical women (Laporte & Guttman, 1999). Whereas some women from each group experienced some form of sexual abuse, this occurred within the nuclear family only in the case of borderline women, who were also unique in having been sexually abused by more than one person. The parents' empathic deficiency—combined with their often unpredictable abuse—may make it necessary for the child to be able to read quickly and accurately other people's moods, in the interest of self-preservation. This sensitivity may be reflected in the high levels of Empathic Concern and Personal Distress found among the borderline women and may be the same faculty that is measured by the PONS test used by Frank and Hoffman (1986) in their study of borderline empathy. However, Perspective Taking—the cognitive capacity to see things from another person's point of view—may be required for the more sustained empathy and relational competence that is required for long-term relationships (Davis & Oathout, 1987; Long & Andrews, 1990) and is lacking in borderline patients.

On the IRI, the women with anorexia nervosa are more similar to the nonclinical than to the borderline women. These findings differ from those reported by Gillberg and her colleagues (Gillberg, Rastam, & Gillberg, 1995) in the only other study of empathy in anorectic patients. However, their sample is not comparable to ours, given that they reported anorexia associated with extreme disorders of empathy such as autism, Asperger's Syndrome, elective mutism, and Tourette Syndrome (Gillberg, 1996).

In the families of anorectic and nonclinical women, all the parents had similar levels of empathy on the IRI and there was little difference between mothers' and fathers' scores. Although anorectics' fathers scored significantly lower than their wives and daughters on Empathic Concern (EC), their average score was not significantly different from that of the fathers of nonclinical women. In spite of the lower level of EC reported by the fathers, the greatest number of positive correlations on the IRI was between the scores of anorectic daughters and their fathers. These findings corroborate our expectation that the anorectic woman's empathy would go in the same direction as the empathy of one of her parents, but they do not support our prediction that parents of anorectic women would be less empathic than parents in the control group.

In the families of anorectic women, the positive intercorrelations between family members' FIPE scores reflect agreement between the daughter and each of her parents about the relatively high degree of empathy expressed by each parent to-
ward the daughter during her development. In contrast with the women with BPD, and in consonance with the literature on the early life of women who develop anorexia nervosa (Bruch, 1970), these daughters were probably quite easy to raise and the family functioned in a more cohesive and harmonious manner. The only area of disagreement in these families was between husband and wife on the FIPE scores. This may reflect their way of dealing with the pain of having an anorectic daughter by attributing her problem to the other parent’s faulty behavior.

The character of the father-daughter correlations on the IRI (negative for women with BPD, positive for women with anorexia) suggests that fathers play an important role in the development of their daughters. The positive correlations between the IRI scores of the anorectic women and their fathers were particularly strong and numerous. The nature and meaning of this relationship is not clear and should be investigated more thoroughly. It may reflect the cohesiveness or enmeshment that has been described in the families of anorectic patients (Kog & Vandereycken, 1985; Minuchin et al., 1978) and may signify the existence of a relationship that could ultimately constrict the daughter’s autonomy.

With respect to the women in the control group, their empathy scores were generally the closest to the IRI scores for normal populations (Davis, 1983). Family members’ scores on the FIPE resembled those in the families of anorectic women. Whereas there were few significant correlations between the IRI scores of mothers, fathers or daughters in the control group, family members all agreed with one another on the FIPE, as to the empathy demonstrated by each parent for the daughter. In nonclinical populations there may therefore be a more autonomous development of the capacity for empathy and less conflict between family members’ feelings of personal autonomy and their ability to agree about certain objective situations.

It is interesting to note that all the daughters perceived their mothers as being more empathic than their fathers, even in the case of the women with BPD, who perceived both parents as being quite deficient. This perception is certainly concordant with the fact that Davis’ norms for the IRI are somewhat higher for women than for men for each of the four categories of the IRI (Davis, 1983). Therefore, there is some indication that they reflect a gender reality rather than a gender bias.

**Limitations**

There are some limitations to this study. Whereas there is usually a high rate of separation, desertion, and divorce in the families of women with BPD (Laporte & Guttman, 1996), the parents in this study had remained together throughout the daughter’s most formative years and had remained sufficiently connected with their daughter to agree to an interview. Even so, a number of parents refused to participate because they dreaded talking “again” about a very difficult period of their lives. Some borderline daughters who were contacted were completely cut off from their parents and could not even ask them to participate. Such a nonrandom sample may limit the generalizability of our findings, although it is noteworthy that, even with these comparatively involved parents, our hypotheses have been supported.

There is another potential limitation in that the average age of women with BPD is 10 years more than that of the anorectic and nonclinical women. However, this age difference does reflect a clinical reality. The diagnosis of BPD is usually given to older women, who have repeatedly sought mental health services—clinicians being reluctant to give younger women such an
extreme diagnosis. Anorexia nervosa, however, usually develops in a younger age group and is diagnosed fairly early in its course.

It has been reported that empathic capacities change with age: Perspective Taking and Empathic Concern increase with maturity (Davis & Franzoi, 1991) while Personal Distress—the more “self-oriented” form of empathy—declines with age (Davis, 1983). Nevertheless, the borderline women in this study scored significantly lower on Perspective Taking and higher on Personal Distress than the others. Only their scores for Empathic Concern are congruent with the difference in age. Therefore, this factor is a relative, not an absolute, limitation of the study.

Clinical Implications

This study has some clinical implications. Women with BPD score highest on the more “immature” aspects of empathy, and their parents score lowest of all the parents on empathy. If parental empathy is an important factor in facilitating normal development, it may be desirable to pay closer attention to such deficits and to develop methods of fostering empathic responsiveness in the parents and empathic maturation in the daughter. Family therapists—especially those whose practice includes families of young children—are in a particularly good position to act as empathic models and as interpreters and advocates of the child’s need for understanding. It may be helpful to use techniques of role reversal to foster parental empathy specifically for the identified daughter.

In the case of women with anorexia nervosa, our results support the repeatedly described observation of overcohesiveness and lack of conflict resolution in these families that impede the patient’s maturation. Here, it is clinically indicated to select interventions that increase the patient’s autonomy. Family intervention is more suitable with anorectic teenagers, whereas individual therapy is more effective in increasing the autonomy of anorectic women over the age of 19 (Russell, Szmukler, Dare, & Eisler, 1987).

For the nonclinical families, we have confirmed that the members’ empathy scores most resemble those of normative groups. Nonclinical families leave us with the interesting reflection that it seems to be possible for each family member to be quite individualistic in his or her general empathic responses and yet to provide a cohesive family response toward a specific family member.

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