Perceived Parental Styles in Depressed and Anxious Patients

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30 Patients with DSM-IV depression, 13 with DSM-IV anxiety disorders and 20 normal controls were studied by the Parental Bonding Instrument (PBI).

On the whole, the 3 groups did not differ significantly on the parental care and over protection dimensions as assessed by the instrument. However, when the depressive group was subcategorized into a major depressive subgroup (n = 10), depression with psychotic features subgroup (n = 10) and adjustment disorder with depression subgroup (n = 10), significant differences appeared. Mean maternal care scores were significantly lower in patients with major depression when compared to controls (P < 0.05). Also, comparing the PBI mean scores between the depressive subgroups showed that the mean paternal care score in the patients with depression with psychotic features was significantly lower than that of the major depressive subgroup. Implications of these results are clarified in the discussion.

(Egypt.J.Psychiat., 2000, 23: 83- 90).

INTRODUCTION

Developmental stress is becoming increasingly appreciated as a potential psychosocial risk for vulnerability to psychiatric illness (Rutter, 1999, Parker and Asher, 1987). Rearing styles characterized by excessive control and lack of care are thought to be the main factors contributing to such psychosocial adversity (Parker and Asher, 1987). Several studies have shown that, compared to controls, adult depressed patients recall their parents as less caring and more overprotective (Blatt et al. 1979; Gotlib et al. 1988).

However, studies which assessed the image of parents as recalled by patients with different types of depression found that neurotic and reactive depressives reported the lowest scores as regards parental care (Parker, 1983). Also, Sato et al. (1997) found that depressives with melancholic features reported significantly less disturbing images of their parents when compared to non-melancholic depressives.

This study aims to compare the image of parental rearing in adults with different types of depression and anxiety compared to normal controls.

Design of the study 30 consecutive patients with DSM-IV depression, 13 with DSM-IV anxiety disorder were taken from the outpatient psychiatric clinic in Kasr El Aini hospital for the purpose of our study. 20 normal controls were collected from the workers in the psychiatric out and in-patient units and friends visiting the patients.

Exclusion Criteria

(A) For Patients

History of substance abuse.

Clinical picture suggestive of organic mental symptoms.

(B) For Controls

A positive family history of mood disorder.

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Index score of 45 or more (Zung, 1971) on the Zung Self Rating Scale for anxiety.

Index score of 50 or more (Zung, 1965) on the Zung Self Rating Scale for depression.

Procedure:

A) (For Patients and Controls)

(1) Clinical interview by application of the SCAN (WHO, 1998) was applied on patients and controls. The author of the study has received official training in application of the SCAN and in turn trained the psychiatric residents in the way to apply it. Repeated meetings and discussions took place until agreement in rating of individual symptoms was felt to be favourable.

(2) The Parental Bonding Instrument (PBI: Parker et al. 1979): This is a 25 item self-report measure of an individual's perception of his or her parents rearing practices up to the age of 16 years. It consists of two factor-analytically derived scales, namely care and over-protection, for each parent. The 12 care items reflect the dimension of affection and nurturance versus emotional rejection and neglect. The 13 over-protection items assess the dimension of exercising rigid control versus fostering autonomy. The PBI subscales have been shown to possess a high level of internal consistency and test-retest reliability. In addition, subjects responses to the PBI are significantly correlated with the reports of their parents and siblings in both clinical and non-clinical populations. The PBI has also been shown to be uninfluenced by current depressed mood.

(B) Zung Self Rating Scale for Anxiety (Zung, 1971): Only for patients with anxiety disorder and for controls.

(C) Zung Self Rating Scale for Depression (Zung, 1965): Only for patients with depressive disorder and for controls.

Statistical analysis was done by t-test and chi-square test.

RESULTS

Table (1) shows the socio-demographic data of the patient and control group. Patients in the anxiety group are significantly younger than the control group. Females are also over represented in the anxiety group in comparison with the depressed and control groups. Most of the patients and controls were married and working. Also, most of the patients and controls were educated beyond the primary level.

As regards DSM-IV diagnosis the depressed group consisted of 10 patients with major depression (3 of whom were in a recurrent episode), 10 with adjustment disorder with depressed mood, and 10 with major depression with psychotic features. As regards the anxiety group, 4 had panic disorder without agoraphobia, 4 with generalized anxiety disorder, 4 with OCD and one with social phobia. The mean score for the Zung Anxiety Scale in anxiety patients was 48.75 (±8) and for normal controls was 30.5 (±6) ($P < 0.02$). The mean score for the Zung Depression Scale in depressed patients was 57.7 (±9.8) and in controls was 25.6 (±4.6) ($P < 0.01$). The mean Zung score for depression in each of the 3 depressive subcategories i.e. major depression, adjustment disorder with depression and depression with psychotic features was 54.8 (±11), 59.7 (±7.7) and 58.5 (±12.36) respectively ($P > 0.05$).

Comparison of mean PBI values between depressed patients anxious patients and controls (tables 2,3 respectively) did not show significant differences.

Table 1
Socio-Demographic Variables in Depressed, Anxious and Control Groups

(1) Age	Mean	±SD
Depressed group (n = 30)	35	13.3
Anxiety group (n = 13)	27.25*	8.2
Control group (n = 2)	37.85	11.6
(2) Sex	**Male (%)**	**Female (%)**
Depressed group (n = 30)	60	40
Anxiety group (n = 13)	38	62
Control group (n = 20) 60	60	40
(3) Marital Status	**Married (%)**	**Unmarried (%)**
Depressed group (n = 30)	60	40
Anxiety group (n = 13)	54	46
Control group (n = 20) 60	70	30
(4) Educational Level	**Illiterate & Primary School (%)**	**Higher Education (%)**
Depressed group (n = 30)	47	53
Anxiety group (n = 13)	31	69
Control group (n = 20) 60	50	50
(5) Occupation	**Student (%)**	**Working (%)** / **unemployed (%)**
Depressed group (n = 30)	20	77 / 3
Anxiety group (n = 13)	23	77 / 0
Control group (n = 20) 60	5	80 / 15

* Statistically Significant (P< 0.05).

Table 2
Comparison of Mean PBI Values in Depressed Patients and Control Group

PBI Dimension	Depressed group (n = 30)		Control group (n = 20)		T-value	P. value
	Mean	±S.D.	Mean	±S.D.		
(1) Maternal care	21	8.75	25.5	7.14	1.91	P> 0.05
(2) Paternal care	19	9.5	20	8.5	0.38	P> 0.05
(3) Maternal Overprotection	15	8.8	14.4	7.3	0.26	P> 0.05
(4) Paternal Overprotection	14	8.2	17.8	10.9	1.3	P> 0.05

Table 3
Comparison of Mean PBI Values in Patients with Anxiety Disorder and Control Group

PBI Dimension	Anxiety group (n = 13)		Control group (n = 20)		T-value	P. value
	Mean	±S.D.	Mean	±S.D.		
(1) Maternal care	21	9.3	25.5	7.14	1.6	P> 0.05
(2) Paternal care	22	8.8	20	8.5	0.6	P> 0.05
(3) Maternal Overprotection	15	8.4	14.4	7.3	0.2	P> 0.05
(4) Paternal Overprotection	14.5	8.2	17.8	10.9	0.89	P> 0.05

Also, comparison of PBI values between depressed and anxious patients did not reveal significant differences (table 4).

Table 4
Comparison of Mean PBI Values in Depressed and Anxious Group

PBI Dimension	Depressed group (n = 30)		Anxiety group (n = 13)		T-value	P. value
	Mean	±S.D.	Mean	±S.D.		
(1) Maternal care	21.1	8.75	21	9.3	0.03	P> 0.05
(2) Paternal care	19	9.5	22	8.8	0.9	P> 0.05
(3) Maternal Overprotection	14.4	8.8	15	8.4	0.2	P> 0.05
(4) Paternal Overprotection	14	8.2	14.5	8.2	0.18	P> 0.05

Table 5
Comparison of Mean PBI Values in Patients with Major Depression and Control Group

PBI Dimension	Major Depressed group (n = 10)		Control group (n = 20)		T-value	P. value
	Mean	±S.D.	Mean	±S.D.		
(1) Maternal care	17.6	9.8	25.5	7.14	2.52	P> 0.02
(2) Paternal care	24.3	5.7	20	8.5	1.38	P> 0.05
(3) Maternal Overprotection	13.6	9.3	14.4	7.3	0.26	P> 0.05
(4) Paternal Overprotection	11.4	6.7	17.8	10.9	1.65	P> 0.05

As regards comparison of PBI values in depressive subcategories and control group, patients with major depression scored significantly less than controls in the maternal care dimension (mean = 17.6±9.8) versus 25.5 (±7.14) respectively ($P < 0.02$, table 5). Comparison of mean PBI values between the other depressive subcategories i.e., adjustment disorder with depressed mood and psychotic depressives on the one hand with the control group on the other hand did not reveal significant differences (tables 6, 7 respectively).

Table 6
Comparison of Mean PBI Values in Patient with Adjustment Disorder with Depressed Mood and Control Group

PBI Dimension	Adjustment disorder group (n = 30)		Control group (n = 20)		T-value	P. value
	Mean	±S.D.	Mean	±S.D.		
(1) Maternal care	23.6	7.3	25.5	7.14	0.67	P> 0.05
(2) Paternal care	19.6	7.2	20	8.5	0.13	P> 0.05
(3) Maternal Overprotection	15.4	6.9	14.4	7.3	0.46	P> 0.05
(4) Paternal Overprotection	15	7.2	17.8	10.9	0.45	P> 0.05

Table 7
Comparison of Mean PBI Values in Patient with Psychotic Depression and Control Group

PBI Dimension	Psychotic Depressive group (n = 30)		Control group (n = 20)		T-value	P. value
	Mean	±S.D.	Mean	±S.D.		
(1) Maternal care	22.4	8.5	25.57	7.14	1.03	P> 0.05
(2) Paternal care	14.4	12.3	20	8.5	1.51	P> 0.05
(3) Maternal Overprotection	14.4	9	13.7	7.3	0.23	P> 0.05
(4) Paternal Overprotection	16	10.3	17.8	10.9	0.25	P> 0.05

Comparison of mean PBI scores across the different depressive subcategorie revealed only a significant difference in the paternal care dimension between th patient with major depression and those with psychotic depression (mean 24.3±5.7 and 14.4±12.3 respectively ($t = 2.2, P < 0.05$).

Comparison of mean PBI scores between the different depressive subcategories an the anxiety group did not reveal any significant differences.

DISCUSSION

This study does not confirm Parker's (1979b) finding that patients with reactive and neurotic depression report higher levels of negatively perceived parental memories when compared to controls. However, since selection of patients in Parker's (1979b) study was not based on DSM-IV criteria it is possible that his neurotic depressions would qualify better today for DSM-IV major depression rather than for adjustment disorder. Also, the finding that patients with major depression reported lower levels of maternal care than controls is confirmed by other studies e.g. (Mackinnon et al. 1993; Plantes et al. 1988). However, the fact that maternal and not paternal care was the mean differentiating factor between major depression and controls in the present study confirms the general idea that it is the mother who forms the

main attachment figure for the child in his early development (Bowlby, 1979). However, it should be remembered that attachment theory which combines psychoanalysis, object relations and ethology regards biology as an interaction between genetic predispositions and early experiential factors (Parkes, 1991). As such it offers an integrative reasoning in the understanding of behaviour and emphasizes the important effect early attachments have in forming healthy internal working models (Main et al. 1985).

These models which are formed early in life determine the way people will organize their experiences and relationships later on. These models are presently assessed with a reasonable degree of reliability (van Ijzendoorn, 1995) by the adult attachment interview (Main, 1991).

As regards the finding of a lack of difference in the PBI ratings between anxiety patients and controls, it should be emphasized that not all forms of anxiety are associated with poor parenting. For example, PBI ratings in OCD patients did not show differences between patients and controls in Vogel et al's (1997) study. However, Arafa et al. (1992) showed that the fathers of social phobics in the gulf area showed higher overprotection scores than controls, and a culture specific explanation was suggested accordingly.

However, the lack of significant differences in levels of overprotection between patients and controls in the present study is explained by the fact that parental control in the Egyptian culture is considered generally high and well tolerated (Khattab et al. 1994).

Lastly, the finding of a significant difference in perceived paternal care between patients with psychotic depression and patients with major depression point to the resemblance of the former group to schizophrenia where the role of the father is more acknowledged as a potential risk factor for future psychiatric morbidity (Parker, 1983).

Conclusions and Recommendations

Perceived parental styles and even perceived emotions in general (Hooley and Teasdale, 1989) are becoming legitimate areas for scientific inquiry rather than the old view that regarded the subjective experiences of patients as a narrative that cannot withstand scientific assessment (Holmes, 1998).

Patients with DSM-IV major depression do have a history of poor maternal attachments, a finding which points to the importance of investigating these patients' early attachments in a routine way by direct questionning which generally does not consume much time and yields important experiential material.

Patients with anxiety disorders are not only heterogenous as regards modern classifications (e.g. DSM-IV) but also as regards early parenting. Future studies in the field of early attachments in anxiety disorders should aim to compare homogenous samples with controls and to use appropriate questions as regards the group under investigation. For example, Vogel et al. (1997) recommend in OCD patients to ask questions related to parental obsessionalism and perfectionism which are areas not covered by the present PBI rating instrument.

Encouraging research in the psychological-biological interaction as conceptualized by attachment theory might yield new models which help in understanding human behaviour both psychologically and biologically. For example, Kraemer, (1992) has recently offered a neurophysiological explanation for the psychological working models suggested by Main et al. (1985).

Finally, it is hoped that this study would be a step in understanding our patients more and in giving them time to listen to their early experiences even in busy clinic hours.

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الخصائص الوالدية كما يدركها مرضى الاكتئاب والقلق

أجريت هذه الدراسة على ٣٠ مريضاً بالاكتئاب و١٣ مريضاً بالقلق و٢٠ من الأسوياء كعينة ضابطة بهدف مقارنة الخصائص الوالدية، كما يدركها مرضى الإكتئاب والقلق بالمقارنة بالأسوياء، وقد طبقت فيها اختبارالرابطة الوالدية لباركر ١٩٧٩، حيث تبين أن مرضى نوبات الإكتئاب العظمى يدركون اهتمام الأم بأنه أقل بدرجة ذات دلالة إحصائية عن الأسوياء، كما أن مرضى الإكتئاب المصحوب بأعراض ذهانية يدركون اهتمام الأب بأنه أقل بدرجة ذات دلالة إحصائية عن مرضى نوبات الإكتئاب العظمى.

أما مرضى القلق فلم يختلفوا عن مرضى الإكتئاب أو الأسوياء فيما يختص بإدراكهم للخصائص الوالدية.

وقد تناولت الدراسة تحليل هذه النتائج ومناقشتها وتقديم الرأى والتوصيات المناسبة.