

## Dynamic Approaches in Anxiety and Depressive Disorders: Defensive Styles and Parental Bonding

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### ABSTRACT

**Background:** Adopting the dynamic approach in studying psychiatric patients is considered a major psychiatric dimension. It adds much in understanding the how of illness formation.

**Objective:** We aimed at verifying and comparing the different dynamic dimensions between depressive and anxiety patient. Also we are highlighting the importance of the dynamic assessment in psychiatric practice.

**Subjects and methods:** The sample consists of three groups: a group of depressive disorder (n=60), a group of anxiety disorders (n=60) and control group (n=30). Diagnosis was established according to *ICD-10*. The anxiety and depressive disorders were subjected to: 1-Semi structural interview sheet. 2-Hamilton Depression Rating Scale (HDRS). 3-Hamilton Anxiety Rating Scale (HARS). The control group was subjected to the General Health Questionnaire. Both groups were subjected to: 1.Defense Style Questionnaire (DSQ 40). 2. Parental Bonding Instrument (PBI). **Results:** The control group tends to use more mature defense style while the groups of depressive disorder and anxiety disorder tends to use more neurotic and immature defensive styles. The group of anxiety disorders uses more mature and neurotic defense styles than the group of depressive disorders who have more tendencies towards immature defense style. On the PBI, mother care scale and father care scale were significantly lower, while father overprotection scale was significantly higher in the groups of depressive and anxiety disorders than the control group. A negative correlation was found between HDRS and mature defense style of DSQ-40 in both groups and between HARS and mature defense style of DSQ40 only in the group of anxiety disorders; while a positive correlation is found between HDRS and immature defense style in both groups of depressive disorders and anxiety disorders. There was a negative correlation between both HDRS & HARS and father care scale of PBI in the group of anxiety disorders. **Conclusion:** Differences between anxiety and depressive disorders on the dynamic level should be considered in understanding these disorders and in the implication of the therapeutic plans.

**Key words:** Anxiety, Depressive disorders, Defensive mechanisms, Parental bonding, Dynamic Approaches.

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### INTRODUCTION

Beginning with the request for a psychodynamic axis VI for DSM-III<sup>1</sup>, clinicians have argued for a diagnostic axis for defense mechanisms. Norman Sartorius criticized the current psychiatric diagnostic

nomenclature and advised to return to Freudian defense mechanisms<sup>2-3</sup>. He made a considerable effort to lay the groundwork for the 10<sup>th</sup> edition of the International Classification of Diseases (ICD-10),

Vaillant suggested that no mental status or clinical formulation should be considered complete without an effort to identify the patient's dominant defense mechanisms<sup>4</sup>.

Most attempts to create coherent links between clinical symptoms in psychiatry, specific causal factors, pathogenetic models and prognostic types have failed. Other ways of thinking about health and disease, mind and body, mental and physical, individual and social are needed if we are to formulate creative hypothesis about mental illness. Sartorius et al believe that in selected instances a return to Freudian defense mechanisms is warranted<sup>3</sup>.

Different models of dynamic approaches are not mutually exclusive but provide an integrated view of the psychic apparatus, each deal with an integrative aspect of the psychic apparatus related to major levels of human motivation (i.e. basic drives, object relations and esteem needs). They also play a crucial role in the prognosis and outcome of psychiatric disorders and consequently should be considered in the management plans<sup>5</sup>. This integrative psychic apparatus seems to have evidence of neuroscientific basis.

***This study was conducted to achieve different aims:*** *First:* to verify the hypothesis that patients with anxiety and depressive disorders have different psychodynamic profiles on more than one dimension. *Second:* to indicate that dynamic assessment of patients is of great importance in understanding the psychopathology that is reflected on diagnostic process and management plans. *Third:* to refer to that dynamic assessment in differentiate between different disorders, especially those disorders with overlapping symptomatology like anxiety and

depressive disorders, which are considered in this study.

## **SUBJECTS AND METHOD:**

### **Subjects:**

The sample consists of three groups: a group of depressive disorder (n=60), a group of anxiety disorders (n=60) and control group (n=30). The patients were recruited from psychiatric out-patient clinic and in-patient department in Kasr El Aini hospital after agreement. A written consent was obtained from each patient after giving him enough information concerning the study. Participants represent consecutive referrals of patients fulfilling the criteria for inclusion in the study. Diagnosis was established according to ICD-10<sup>6</sup>. The control group was recruited from relatives of patients attending to Kasr El Aini hospital and was screened by the General Health Questionnaire<sup>7</sup>.

The sample includes both sexes, with age range from 18 to 50 years. Patients having concurrent disorders that could complicate the assessment procedure, like those having organic mental disorders and mental retardation, were excluded.

### **Method:**

The two groups of anxiety and depressive disorders were subjected to the following assessment tools: 1- Semi structural interview applied in Kasr El Aini Hospital. 2- Psychometric procedures: A-Hamilton Depression Rating Scale (HDRS) B-Hamilton Anxiety Rating Scale<sup>8</sup> (HARS) (1959). C- Defense Style Questionnaire<sup>9</sup> (DSQ 40). D-Parental Bonding Instrument<sup>10</sup> (PBI). The control group was subjected to the following assessment procedures; 1- General Health Questionnaire<sup>7</sup>, 2-

Psychometric procedures: A-Defense Style Questionnaire<sup>9</sup> (DSQ 40). B- PBI<sup>10</sup>. C- Rosenberg Self-Esteem Scale<sup>11</sup>.

*1-Semi Structural Interview:* A specially designed semi structural interview was used to cover the socio-demographic data including age, sex, marital status, education and occupation and the psychiatric diagnosis, according to the ICD-10 criteria<sup>6</sup>.

#### *2-Psychometric Procedures:*

**The General Health Questionnaire (GHQ)** is an easily applicable tool with established validity and reliability. The GHQ is used in the study to screen psychiatric patients from non-patients for selection of control group. It is used in the study as an effective mean of case identification. The version used in this study was the Arabic version of the short 28-items scale<sup>12</sup>.

The original instrument contains 60 items that refers to the severity of psychological complains during the past 4 weeks relative to the person's normal situation<sup>7</sup>. Shorter versions of the GHQ have been developed. The GHQ 28 item is one of them. It includes 4 factors labeled scale "A" somatic symptoms, scale "B" anxiety and insomnia, scale "C" social dysfunction and scale "D" severe depression<sup>7</sup>. The total score of the GHQ 28 ranges from 0-28 with frequently used cut-off score 4/5 (a score within the range of 0-4 representing absence of psychopathology).

**HDRS and HARS** were used to assess the severity of depressive and anxiety disorders and the symptomatic overlap between them. These are objective tools with established validity and reliability. The Arabic version has been used in many Egyptian studies. **HDRS** is the most widely used observer-rating scale for assessment of severity of

depression<sup>13</sup>. HDRS was found to distinguish between different groups of patients drawn from general practice, day-patients care and in-patients<sup>14</sup>. It is a fairly true reflection of clinical judgments<sup>15</sup>. Also against other observer rating scales, the concurrent validity is high<sup>16</sup>. The inter-rater reliability of HDRS is also consistently high<sup>17</sup>.

**HARS** was specially developed to rate clinical anxiety in patients already diagnosed as suffering from an anxiety state (it is for use by trained rater after an ordinary clinical interview)<sup>8</sup>. Twelve groups of symptoms which were regularly observed in anxiety states were taken as the starting point. The addition of a rating of behavior at interview made 13 items. Each was rated on a five point scale from 0 to 4 in ascending order of severity<sup>17</sup>.

#### ***Defense Style Questionnaire<sup>8</sup> (DSQ 40)***

This brief questionnaire is a short easy to apply questionnaire. It was applied to obtain an assessment of ego defenses. It can yield both 20 individual defenses scores and three defense styles scores namely mature, neurotic and immature. There are two items for each of the 20 defenses. It is a self-report measure that is easily applied and has been widely used to determine the levels of maturity of defenses.

*Rating of the scale:* The ratings are made on a nine point scale for all variables. The subject responds by matching his degree of agreement or disagreement on this nine point scale. Score 1 indicates strongly disagree while score 9 indicates strongly agree. Scoring is uncomplicated, individual defense scores are simply the average of the two items for that defense. Styles scores are simply the average of the defense scores contributing to that style.

**Parental Bonding Instrument<sup>10</sup> (PBI):** was designed as a phenomenological measure to assess perceived parental characteristics, rather than actual characteristics, with the view that perception of a parent is far more likely than actual parental characteristics to influence development<sup>18</sup>.

For the purpose of this study, the instrument was translated to Arabic language by Assistant Prof. Noha Sabry and was back-translated to English by Prof. Suaad Moussa and this was supervised by Prof. Dr. Magdy Arafa. PBI includes 25 items, 12 items for care scale and 13 items for overprotection scale. Using a scaling from 0 to 3, the 12 items of the "care" scale allow a maximum score of 36, and the 13 items of the "overprotection" scale allow a maximum score of 39. These scales may be used separately or together as a bonding instrument. Used together, they allow five types of parental bonding: average (defined statistically), high care-low overprotection (which might be conceptualized as optimal bonding), low care-low overprotection (conceptualized as absent or weak bonding), high care-high overprotection (conceptualized as affectionate constraint) and low care-high overprotection (conceptualized as affectionless control). The normative Sydney data research are used to assign patients to the different quadrants, for mothers, the mean cut-off "care score" is 27 and the mean cut-off "protection score" is 13.5; for fathers, the mean cut-off "care score" is 24 and the mean cut-off "protection score" is 12.5. The subject responds by remembering his mother/father in his first 16 years. We exclude patients whose parents died as they were very young and they did not remember anything about their parents.

**Statistical Analysis:** As appropriate, the

following tests are used: 1-Percentage. 2-Means. 3- Standard deviation. 4-Chi square test<sup>19</sup> for comparing groups of qualitative data. 5-Student T test for differences between independent samples means<sup>19</sup>. 6-ANOVA and Post Hoc test, ANOVA was used for comparison between three groups or more and post Hoc was used to show the significant differences between each two groups. 7- Correlations.

## RESULTS

The depressive, the anxiety and the control groups were matched as regards age, sex and marital status. The mean age for group of depressive disorders is 34.67, the mean age for the group of anxiety disorders is 31.25 and the mean age for the control group is 31.1. Female subjects are more represented than male subjects in the three groups. The three groups include more married subjects than single ones. No statistically significant differences was detected between the 3 groups as regards educational and occupational levels,

Concerning the HDRS and the HARS, (Table 1) shows that the mean and standard deviation of the total scores of HDRS in the group of depressive disorders are 26.2±8.72 and in the group of anxiety disorders 21.2±8.72.

**Table 1: Comparison of HDRS and HARS between Depressive & Anxiety Groups**

|      |      | Depressive | Anxiety | T    | P    |
|------|------|------------|---------|------|------|
| HDRS | Mean | 26.2       | 21.2    | 3.14 | .002 |
|      | SD   | 8.72       | 8.72    |      |      |
| HARS | Mean | 20.78      | 24.77   | 3.19 | .002 |
|      | SD   | 6          | 7.87    |      |      |

There is statistically significant difference between the two groups ( $P<.002$ ). The mean and standard deviation of the total score of HARS in the group of depressive disorders are 20.78±6 and in the group of anxiety

disorders are  $24.77 \pm 7.87$ . There is statistically significant difference between the two groups ( $P < .002$ ).

As for **the 3 defense styles**, (Table 2) reveals that statistically significant differences were detected on the three levels of comparison: 1) between the depressive and the control groups, 2) between the anxiety and the control groups, and 3) between the depressive and anxiety groups. Comparing depressive and control groups reveal that neurotic and immature defense styles are more used in depressive disorders group while mature defense style is more used in the control group ( $P < .000$ ). Comparison between anxiety and control groups revealed that the former use more neurotic and immature defense styles and the latter score more in using the mature defense style ( $P < .000$ ). The anxiety group tend to use neurotic and mature styles of defenses more than the depressive group while the depressive group tend to use immature style of defenses more than the anxiety group ( $P < .007$ ).

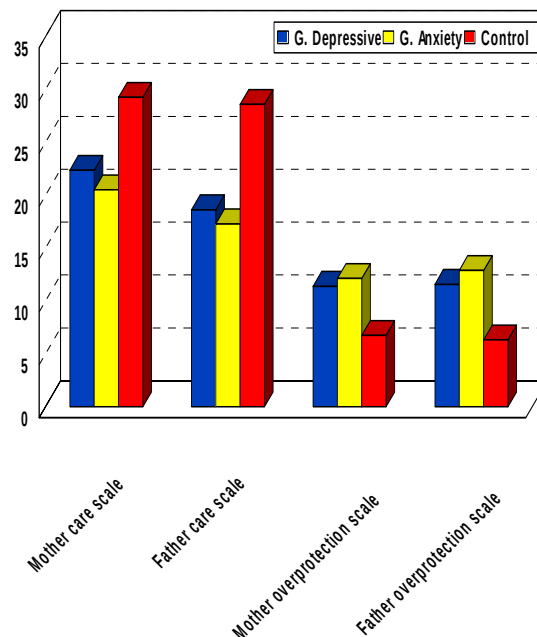
**Table 2: Comparison of Defensive Styles**

| Group |      | Mature | Neurotic | Immature |
|-------|------|--------|----------|----------|
| I     | Mean | 8.18   | 14.33    | 47.58    |
|       | SD   | 4.02   | 6.07     | 10.51    |
| III   | Mean | 31.63  | 10.47    | 21       |
|       | SD   | 2.05   | 3.93     | 4.54     |
|       | F    | 348.01 | 39.14    | 78.7     |
|       | P    | .000   | .001     | .000     |
| II    | Mean | 9.95   | 20.18    | 42.76    |
|       | SD   | 5.09   | 4.85     | 10.6     |
| III   | Mean | 31.63  | 10.47    | 21       |
|       | SD   | 2.05   | 3.93     | 4.54     |
|       | F    | 348.01 | 39.14    | 78.7     |
|       | P    | .000   | .000     | .000     |
| I     | Mean | 8.18   | 14.33    | 47.58    |
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|       | SD   | 5.09   | 4.85     | 10.6     |
|       | F    | 348.01 | 39.14    | 78.7     |
|       | P    | .022   | .000     | .007     |

**Group I** = Depressive disorder group; **Group II** = Anxiety disorder group; **Group III** = Control group

As for the PBI, (fig. 1) shows that mother care scale and father care scales are lower in the group of depressive disorders and in the group of anxiety disorders than in the control group. This difference is of a statistical significance. Father overprotection scale is higher in the group of depressive disorders than in the control group, while mother and father overprotection scales are significantly higher in the group of anxiety disorders than control group; such differences are also of statistical significance. There is no statistically significant difference between the two groups of depressive and anxiety disorders as regards the 4 scales of Parental Bonding Instrument.

**Figure (1): Comparison of PBI between depressive disorders, anxiety disorders and control group**



As regards maternal bonding, the groups of depressive and anxiety disorders are more

presented than the control group in the affectionless (28.3% in the depressive group & 31% in the anxiety group compared to 14.3% in the control group); and in the neglectful parenting quadrants (33.3% in the depressive group & 34.5% in the anxiety group compared to 14.3% in the control group) while the control group is more presented in the optimal parenting quadrant (60.7%, compared to 35% & 25.9% in the depressive and anxiety groups respectively). On the other hand, the group of anxiety disorders is more presented in the affectionate constraint quadrant than the group of depressive disorders (fig. 2). The difference between the three groups is of a statistically significant value.

Concerning the PBI, (fig. 3) shows that the depressive and the anxiety groups are more presented in the affectionless control quadrant (38.6% and 35.8% compared to 10.3%) and neglectful parenting quadrants (24.6 and 28.3% compared to 20.7%) than the control group. The control group has more representation in the optimal parenting quadrant (62.1% compared to 33.3% in the depressive group and 26.4% in the anxiety group) who is presented more in the optimal parenting quadrant. The anxiety disorders group is more presented more in the affectionate constraint quadrant than the group of depressive disorders (9.4% compared to 3.5%). A statistically significant difference was detected between the three groups ( $p=.03$ ).

As for the correlations between HDRS and defensive styles studied in the depressive disorders group, a statistically significant negative correlation between HDRS and mature and neurotic defense styles of DSQ40 and positive correlation between HDRS and immature defense style were revealed (table 3). In the anxiety disorders

group, a statistically significant negative correlation between HDRS and mature defense style of DSQ40 and positive correlation between HDRS and immature defense style ( $p=.002$  &  $p=.026$  respectively) were detected.

The correlation between HARS and DSQ40 in the depressive group is of no statistical significance, however, a statistically significant negative correlation was found between HARS and mature defense style of DSQ40 was found in the anxiety group.

**Table 4: Correlation between HDRS, HARS and defensive styles in groups of depressive and anxiety disorders patients**

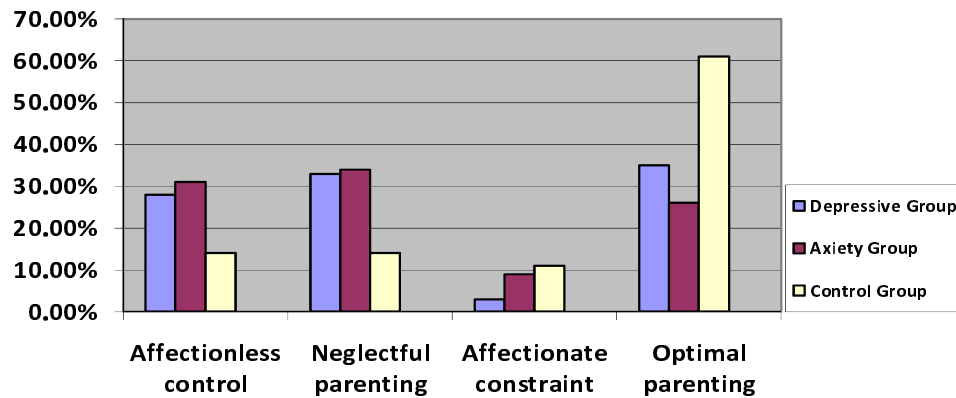
|      | Group                | Defensive styles | r     | P      |
|------|----------------------|------------------|-------|--------|
| HDRS | Depressive Disorders | Mature           | -.332 | .010** |
|      |                      | Neurotic         | -.027 | .010** |
|      |                      | Immature         | .335  | .009** |
|      | Anxiety Disorders    | Mature           | -.385 | .002** |
|      |                      | Neurotic         | .008  | .954   |
|      |                      | Immature         | .287  | .026*  |
| HARS | Depressive Disorders | Mature           | -.239 | .065   |
|      |                      | Neurotic         | .019  | .886   |
|      |                      | Immature         | .086  | .512   |
|      | Anxiety Disorders    | Mature           | -.369 | .004** |
|      |                      | Neurotic         | .065  | .624   |
|      |                      | Immature         | .139  | .291   |

Table (4) demonstrates the correlations between HDRS and HARS results and the different scales of PBI. In the depressive group, no statistically significant correlation was detected between HDRS and PBI scales. A statistically significant negative correlation was found between the HDRS and the father-care scale in the group of anxiety disorders patients ( $p=.002$ ). No statistically significant correlation was

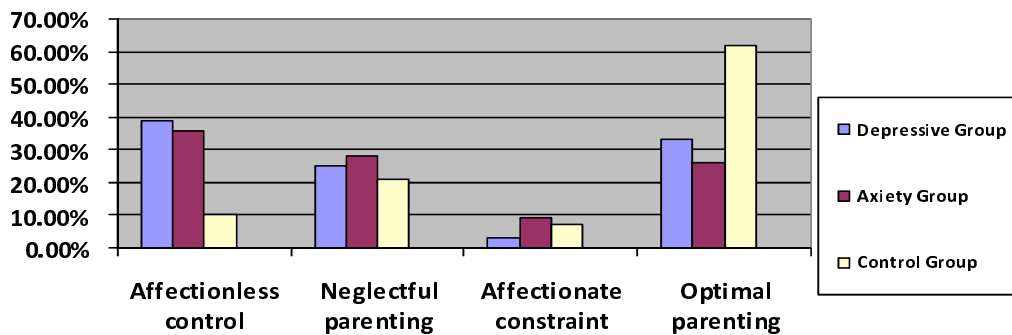
found between the HARS and PBI scales in the depressive group, while the only significant correlation was found between

HARS and the father care scale of PBI in the anxiety group.

**Figure (2):** Maternal Bonding Instrument in depressive disorders, anxiety disorders and control groups



**Figure (3):** Paternal Bonding Instrument in groups of depressive disorders, anxiety disorders and control group



**Table 4: Correlation between HDRS, HARS and Parental bonding in groups of depressive and anxiety disorders patients**

|             | Group                       | Parental Bonding      | r     | P    |
|-------------|-----------------------------|-----------------------|-------|------|
| <b>HDRS</b> | <b>Depressive Disorders</b> | Mother-care           | -.146 | .266 |
|             |                             | Mother-overprotection | .010  | .941 |
|             |                             | Father-care           | -.249 | .062 |
|             |                             | Father-overprotection | -.028 | .837 |
|             | <b>Anxiety Disorders</b>    | Mother-care           | -.047 | .726 |
|             |                             | Mother-overprotection | .033  | .807 |
|             |                             | Father-care scale     | -.421 | .002 |
|             |                             | Father-overprotection | .197  | .157 |
| <b>HARS</b> | <b>Depressive disorders</b> | Mother-care           | -.103 | .434 |
|             |                             | Mother-overprotection | -.141 | .284 |
|             |                             | Father-care           | -.128 | .341 |
|             |                             | Father-overprotection | -.142 | .293 |
|             | <b>Anxiety Disorders</b>    | Mother-care scale     | .009  | .946 |
|             |                             | Mother-overprotection | -.161 | .226 |
|             |                             | Father-care scale     | -.413 | .002 |
|             |                             | Father-overprotection | .061  | .663 |

## DISCUSSION

The mean age for the group of anxiety disorders (31.1) tends to be younger than the group of depressive disorders (34.67). This is consistent with the literature indicating that patients with anxiety disorders tend to be younger than patients with depressive disorders<sup>20</sup>. On the other hand, females were presented more common in the sample than males. This is consistent with the documented epidemiological findings indicating that depressive and anxiety disorders are more common in females<sup>21</sup>.

The mean and standard deviation of the total scores of HDRS and HARS of the groups of depressive and anxiety disorders are above the cut off score<sup>16</sup>, which indicate clinically significant degrees of anxiety and depressive psychopathology in both groups. These findings agreed with the review of ten studies about anxiety disordered patients (panic disorders, GAD & agoraphobia) performed between 1972.

and 1985 and revealed coexistent depression in an average of 49.7% of anxiety disordered patients<sup>22</sup>. On the other

hand, when reviewing seven studies of depressed patients, the same authors found coexisting anxiety disorder in 46% of depressive disordered patients.

In this study, a statistically significant difference was detected between the anxiety and depressive groups on HDRS and HARS. This is consistent with results of Clark et al. who found that patients with major depression scored significantly higher than patients with panic disorder on HDRS, Beck Depression Inventory and the depression scale of the Cognitions Checklist, while patients with panic disorder scored significantly higher than patients with major depression on HARS, Beck Anxiety Inventory and the anxiety scale of the Cognitions Checklist. It can then be concluded that in spite of the overlap between symptoms of anxiety and depressive disorders, they should be viewed as two separate disorders<sup>23</sup>.

The global assessment of defense style shows that the anxiety and depressive groups tend to use neurotic and immature defense styles more than the control group, while the control group tends to use more mature defense style. Yet, comparison of



the 3 defense styles in depressive and anxiety groups revealed significant differences between the two groups; mature defense style and neurotic defense style were more presented in the group of anxiety disorders, while immature defense style more presented in the group of depressive disorders.

These results go along with the investigation of whether anxiety or depressive disorders are related to the use of specific defenses using DSQ. Compared to controls, anxiety and depressive disorder patients scored higher for the immature defense style (24). Moreover, anxiety disorder patients obtained significantly higher scores for the neurotic defense style than both depressive disorder patients and controls. This is also consistent with Andrews et al. who found that the depressed patients when recovered used fewer immature defenses than the anxiety disorder patients<sup>25</sup>. These findings reflect relatively more severe pathology in depressive disorders with more pronounced regression of the psyche to immature phases, with gradual reconstitution of more adaptive ego defenses as recovery occurs. The PBI as an instrument for parental bonding is a widely used questionnaire, the PBI, when compared with a detailed standardized interview, the Childhood Experiences of Care and Abuse (CECA). The maternal care scale of the PBI compares reasonably well as an index of overall neglect in childhood to that provided by the CECA<sup>26</sup>.

The results of the study show that depressive patients group is characterized by higher degree of paternal overprotection, but lesser degree of paternal and maternal care. This agrees with the study done to assess parental rearing styles in four groups

of depressed patients, 47 unipolar, 21 bipolar, 34 with neurotic-reactive depression and 39 with unspecified depressive disorder. The 4 groups completed after recovery the Egna Minnen av Barndoms Uppfostran (EMBU). The results compared with those obtained from 205 healthy individual. Patients in all diagnostic groups scored lower than controls on "emotional warmth", and this applies to both parents. However, the difference is statistically significant only for the unipolar group which confirmed the assumption that, rearing practices which deprived the child of love might be an important risk factor predisposing to depression<sup>27</sup>.

Many studies have suggested that dysfunctional parental styles characterized by low levels of care and high levels of protection "affectionless control" are in particular related to depressive disorder, although some studies have failed to establish the significance of high levels of protection<sup>28-30</sup>.

Comparison between the control and the anxiety disorders groups as regard the 4 scales of PBI revealed significant differences between the two groups for all the 4 scales. Mother care scale and father care scale were significantly lower in the group of anxiety disorders than control group, while mother overprotection scale and father overprotection scale were significantly higher in the anxiety group than control group.

Parental characteristics of agoraphobia and social phobic patients were assessed using the PBI for each parent, and found that the phobic group viewed their mothers and fathers as less caring and more overprotective more than the control group<sup>31</sup>.

On the other hand, comparison between the group of depressive disorders and group of anxiety disorders as regard the 4 scales of PBI shows no statistically significant differences between the two groups for all 4 scales. From the present study and other studies we can conclude that parental rearing style of less caring is confined to both depressive disorders and anxiety disorders and the parental rearing style of overprotection is confined more to anxiety disorders; this finding reflects the impact of overprotection on restricting the usual developmental process of independence, autonomy and social competence.

Comparison between the 3 groups as regard maternal bonding instrument and paternal bonding instrument reveals that depressive and anxiety groups were more presented in the affectionless control quadrant (low care-high overprotection) and neglectful parenting quadrant (low care-low overprotection), while the control group was more classified in the optimal parenting quadrant (high care-low overprotection). The group of anxiety disorder was more presented than the group of depressive disorder in the affectionate constraint quadrant (high care-high overprotection). This elaborates more the view that rearing style of less caring is confined to both depressive and anxiety disorders while parental rearing style of overprotection is confined more to anxiety disorders where the person experience the world as insecure and inhospitable. The vulnerability of human existence manifests itself in more specific feeling of disruption that results from lack of protection<sup>32</sup>.

In both groups of depressive and anxiety disorders, a significant negative correlation was detected between HDRS and mature defense style of DSQ40, a significant

positive correlation was found between HDRS and immature defense style but no correlation between HDRS and neurotic defense style was revealed<sup>33</sup>.

These findings are consistent with the commonly held clinical view that episodes of psychiatric illness entail a potent psychologically reversible regression with gradual reconstitution of more adaptive ego defenses as recovery occurs. However it does not appear to be consistent with the alternative view that defense style is a trait dependent variable.

Akkerman et al. put the possibility that some ego defenses may exist as a relatively stable characteristics, whereas others are subjects to variation with changes in state<sup>34</sup>. The authors suggest that mature and neurotic defenses are relatively stable and resistant to short-term change in relation to episodes of illness such as depression. On the other hand, immature defenses may be more sensitive to state changes and show a temporary increase in relation to episodes of illness

In the present study, there is a significant negative correlation between HDRS and mature defense style of DSQ40, and a significant positive correlation between HDRS and immature defense style, but no correlation was detected between HDRS and neurotic defense style. This can usher to the view that that mature and immature defense styles change with the disease state and severity of the illness, but neurotic defenses are relatively stable. Revival the importance of evaluating defensive styles as clinical predictors in comprehensive assessment of patients may overcome the limitation of standardized assessments and detecting the factors that plausibly contribute to marked differences in depressive disorders outcome<sup>35</sup>.

In the group of depressive disorders there is no significant correlation between HARS and DSQ40 while in the group of anxiety disorders there is significant negative correlation between HARS and mature style of DSQ40. Such results indicate that the mature defense style reduces with the disease state and the severity of the illness.

There is no significant correlation between HDRS/HARS and PBI. This may indicate that parenting dysfunction does not change with the severity of the illness. The relationship between parental style and depression might be explained by other factors like unhealthier core beliefs. This was examined by Shah and Waller using Young's Schema Questionnaire as the measure of these beliefs and PBI as measure for parental style. On YSQ, the comparisons show that the depressed group had significantly unhealthier core beliefs on all 16 core beliefs of the individual YSQ scales<sup>36</sup>. Williams and Riskind, view that attachment has considerable utility in potentially extending and refining current vulnerability models through a consideration of interpersonal context and the cognitive mechanisms by which negative interpersonal experiences may confer increased risk to later anxious and depressive symptoms<sup>37</sup>. The relative small number and the heterogeneity of the different sub-diagnoses included in the study can be considered as one of the limitations of the study. The consideration of the biological perspective and its correlation with the dynamic one can be recommended in future study.

## CONCLUSIONS

1. In spite of the overlap between anxiety and depressive disorders at a descriptive level, there are evident differences between them at a dynamic level. 2- The dynamic

dimension in anxiety and depressive disorders should be considered in their understanding and in the implication on the therapeutic plans. Such consideration should not be restricted to the classical psychoanalytic models, but it can be broadened to include the different modern or short term psychotherapeutic approaches.

## REFERENCES

1. American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 3<sup>rd</sup> Edition. Washington, DC, American Psychiatric Association 1980.
2. Karasu T.B., Skodol A.E. Sixth axis for DSM-III: Psychodynamic evaluation. *Am J Psychiatry* 1980.
3. Sartorius N, Jablensky A, Regier DA. Sources and Traditions of Classifications in Psychiatry. Toronto, Hogrefe and Huber 1990.
4. Vaillant GE. The place of defense mechanisms in diagnostic formulation and in modern clinical practice, in *Ego Mechanisms of Defense: A Guide for Clinicians and Researchers*. Washington, DC, American Psychiatric Press 1992.
5. Ma K. Attachment theory in adult psychiatry. Part 1: Conceptualizations, measurement and clinical research findings. *Adv Psychiatric Treat* 2006;12:440-49.
6. World Health Organization (WHO) ICD-10 Classification of Mental and Behavioral Disorders, Clinical Descriptions and Diagnostic Guidelines for the ICD-10: Geneva. WHO 1993.
7. Goldberg D, and Williams P. A user's guide to the General Health Questionnaire. Windsor, Berkshire: NFER-Nelson 1983.
8. Hamilton M. The assessment of anxiety states by rating. *Br. J. Med. Psychol* 1959;32:50-55.
9. Andrews G, Singh M, Bond M. The Defense Style Questionnaire. *J. Nerv. Ment. Dis* 1993;181:246-56.
10. Parker G, Tupling H, Brown LB. A Parental Bonding Instrument. *Br. J. Med. Psychology* 1979a;52:1-10.
11. Rosenberg M. Society and the Adolescent Self-Image. Princeton N-J: Princeton University Press 1965.

12. Okasha A, Kamel M, Fares R. et al. An epidemiological study of depressive symptoms in rural, urban population in Egypt. *Egypt J Psychiatry* 1988.
13. Ashcroft GW, Blackburn IM, Cundall RI. Affective Disorders. In Forrest A; Affleck J. & Zeall, A. (eds). *Companion to Psychiatric Studies*. 2<sup>nd</sup> ed. Edinburgh: Churchill Livingstone 1978.
14. Carrol BJ, Fielding JM, Blashki E. Depression Rating Scale: A critical review. *Arch. Gen. Psychiatry* 1973;28:361-66.
15. Zeally AK, and Aitken RCB. Measurement of mood. *Proc. R. Soc. Med.* Quoted from: Chris Thompson. *The Instrument of Psychiatric Research*. Chicheser: John Willey and Sons 1969.
16. Kearns NP, Cruchshank CA, Mc Guigan KJ, et al. A comparison of Depression Rating Scales. *Br. J. Psychiatry* 1982;141:45-49.
17. Hamilton M. A rating Scale for Depression. *J Neuro Neurosurg Psychiat* 1960;23:56-62.
18. Parker G. The measurement of pathogenic parental style and its relevance to psychiatric disorder. *Soc Psychiatry* 1984;19:75-81.
19. Surwillo WW. *Experimental Design in Psychiatry*. New York. Grune & Stratton 1980.
20. Roth M, Gurney, C. Carside, R. et al. Studies in the classification of affective disorders: the relationship between anxiety and depressive illness *B J Psychiatry* 1972;121:147-61.
21. Kaplan HI, and Sadock BJ. Mood disorders. In Kaplan & Sadock's *Synopsis of Psychiatry*. 8<sup>th</sup> eds. Williams & Wilkins Publisher 1998;524-73.
22. Wetzel S & Katz MM. Problems with the differentiation of anxiety & depression. *J. Psychiat. Res* 1989;23:1-12.
23. Clark DA, Beck AT, Beck JS. Symptom differences in major depression, dysthymia, panic disorder and generalized anxiety disorder. *Am. J. Psychiatry* 1994;151:205-09.
24. Spinhoven P, and Kooiman CG. Defense style in depressed and anxious psychiatric outpatients: An explorative study. *J. Nerv. Ment. Dis* 1997;185:87-94.
25. Andrews G, Pollock C, Stewart G. The determination of defense style by questionnaire. *Arch. Gen. Psychiatry* 1989;46:455-60.
26. Lancaster G, Rollinson L, Hill J. The measurement of a major childhood risk for depression: comparison of the Parental Bonding Instrument (PBI) 'Parental Care' and the Childhood Experience of Care and Abuse (CECA) 'Parental Neglect'. *J Affect Disord* 2007;101(1):263-67.
27. Perris C, Arrindell WA, Perris H et al. Perceived depriving parental rearing and depression. *Br. J. Psychiatry* 1986;148:170-75.
28. Burbach DJ, Kashani JH, Rosenberg TK. Parental bonding and depressive disorders in adolescents. *J. Child Psychol. Psychiatry* 1989;30:417-29.
29. Plantes MM, Prusoff BA, Brennan J et al. Parental representations of depressed outpatients from a USA sample. *J. Affect Disord* 1988;15:149-55.
30. Parker G & Hadzi-Pavlovic D. Parental representations of melancholic and non-melancholic depressives: examining for specificity to depressive type & for evidence of additive effects. *Psychol Med* 1992;22:657-65.
31. Parker G. Parental characteristics in relation to depressive disorders. *B J Psychiatry* 1979b;134:138-47.
32. Glas G. Anxiety-animal reactions and the embodiment of meaning. B. Fulford, K. Morris, J Zsadler & G Stanghellini (Eds). *Nature and Narrative: an introduction to the new philosophy of psychiatry*. Oxford: New York 2003.
33. Antony MM & McCabe RE. Anxiety Disorders: Social & Specific Phobia. In A Tasman, J Kay, J A Liberman (eds). *Psychiatry* 2<sup>nd</sup> ed. John Wiley & Sons, Ltd England 2004.
34. Akkerman K, Carr V, Lewin T. Changes in ego defenses with recovery from depression. *J. Nerv. Ment. Dis* 1992;180:634-38.
35. Serretti A, Calati R, Osmano O et al. Dissecting the determinants of depressive disorders outcome : An in depth analysis of two clinical cases. *Ann Gen Psychiatry* 2007;6:5doi:10-1186/1744-859.
36. Shah R, and Waller G. Parental style and vulnerability to depression, the role of core beliefs. *J. Nerv. Ment. Dis* 2000;188:19-25.
37. Williams NL, and Riskind JH. Special issue on cognitive vulnerability and attachment. *Journal of cognitive psychotherapy: an International Quarterly* 2000;18:134-40.

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