



The role of depression in perceived parenting style among patients with anxiety disorders

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ABSTRACT

Despite a long tradition of research on the relationship between parenting style and anxiety disorders, few studies have taken the effect of comorbid depression into account. This study investigated perceived parenting in 504 outpatients with panic disorder/agoraphobia, social phobia or obsessive-compulsive disorder, and in 210 psychology students. The anxiety group reported both parents as less caring and their fathers as more controlling than did the student group. However, these between-group differences disappeared when taking self-reported depressive symptoms into consideration. Also no differences in parental style were found between the three diagnostic anxiety groups, when depressive symptoms were taken into account. Self-reported depressive symptoms were more consistently associated with negatively perceived parenting style than with self-reported anxiety symptoms in both the anxiety group and the student group. Results do not support theories of parental control as a specific risk factor for anxiety disorders, but they are in accordance with prior findings showing an association between depression and perceived lack of parental care.

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1. Introduction

Early parenting has been assigned an important role in the development of depression and anxiety. The primary focus has been on two key dimensions of parenting style labeled care/acceptance (vs. rejection) and control/overprotection (vs. autonomy) (Baumrind, 1971). Regarding depression, attention has mostly been paid to parental lack of care or rejection (Beck, 1967; Bowlby, 1977), while parental control has been assumed to be associated with anxiety disorders (Chorpita & Barlow, 1998; Rapee, 1997). In his influential theory of anxiety disorders, Barlow (2002) stresses that childhood experiences of lack of control, brought on by either traumatic events or a controlling parenting style, constitute a risk factor for the development of anxiety disorders. Early experiences with diminished control are hypothesized to contribute to the development of a generalized cognitive style, characterized by distorted interpretations of events as being out of one's control. It has been suggested that a controlling parenting style is primarily associated with anxiety disorders, and studies have suggested specific links to panic disorder and agoraphobia (PDA) (Faravelli, Panichi, Pallanti, & Paterniti, 1991), social phobia (SP)

(Hudson & Rapee, 2000), and obsessive-compulsive disorder (OCD) (Rachman, 1976). The two abovementioned key dimensions in parenting style, care and control, have been researched in clinical as well as non-clinical samples, mostly by use of the Parental Bonding Instrument (PBI) (Parker, Tupling, & Brown, 1979), or the Egna Minnen Beträffande Uppfostran (EMBU; Own Memories of Parental Rearing Experiences in Childhood; Perris, 1980).

An early meta-analysis (Gerlsma, Emmelkamp, & Arrindell, 1990) indicated a rather consistent association between negatively perceived parenting and both care and control dimensions in adults with anxiety disorders compared to non-anxious controls, with the largest effect sizes on the care dimension. These results have been further supported by later studies investigating perceived parenting in individuals with anxiety disorders (Silove, Parker, Hadzi-Pavlovic, & Manicavasagar, 1991; Wilborg & Dahl, 1997). However, some of these studies only found differences between participants with anxiety disorders and healthy controls on either the care (Alonso et al., 2004; Pacchierotti et al., 2002) or the control dimension (Hafner, 1988; Turgeon, O'Connor, Marchand, & Freeston, 2002; Yoshida, Taga, Matsumoto, & Fukui, 2005). Recent large-scale epidemiological surveys, using either a full or an abbreviated version of the PBI, have further supported the assumption that adults' retrospective reports of lack of parental care are more consistently associated with both mood and anxiety disorders than parental control. However, results from these surveys are generally disorder non-specific with PBI scores explaining less than 5% of the variance in the occurrence of adult psychopathology (Enns, Cox, &

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Clara, 2002; Heider et al., 2008; Overbeek, ten Have, Vollebergh, & de Graaf, 2007).

Studies on parenting experiences in clinical samples of patients with anxiety disorders are generally characterized by small samples, and only a few studies have considered possible differences in experiences between specific anxiety disorders (Arrindell, Kwee, Methorst, & Van der Ende, 1989; Hudson & Rapee, 2000; Parker, 1979). Furthermore, there is a lack of knowledge regarding influence of depressive symptoms or comorbid disorders on reports of parenting style among individuals with anxiety disorders. Two studies found more negative reports of parenting style among participants with both an anxiety disorder and a comorbid major depressive disorder (MDD) (Alnæs & Torgersen, 1990; Torpey, Olino, & Klein, 2007), and two studies on OCD indicated that only patients with comorbid MDD reported their parents as significantly more rejecting and controlling compared to healthy controls (Lennertz et al., 2010; Vogel, Stiles, & Nordahl, 1997). These results suggest that comorbid depression may play an important role in the perception of parenting style among individuals with anxiety disorders. Correlational studies of nonclinical samples (Gerlsma et al., 1990; Parker, 1986) have also shown associations between perceived parenting style and severity of self-reported depressive and anxiety symptoms. Such studies have, however, not been conducted on patients with anxiety disorders.

1.1. Aims of the study

The primary aim of the present study is to investigate perceived parenting style in a large clinical sample of patients with various anxiety disorders (PDA, SP and OCD) by comparing (I) the anxiety group to a control group of psychology students, and (II) the three anxiety disorder groups to one another. Additionally, we sought to explore the influence of (III) comorbid depression and anxiety disorder, and (IV) the severity of self-reported anxiety and depressive symptoms on perceived parenting style.

2. Material and methods

2.1. Sample

The sample consisted of 504 outpatients recruited from the Clinic for Anxiety Disorders, Aarhus University Hospital in Risskov, Denmark, between January 2008 and August 2010. Patients were assessed with the Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV) (Brown, DiNardo, & Barlow, 1994) and thus diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders – 4th Edition (DSM-IV). Other diagnoses were based on the International Classification of Diseases, Tenth Revision (ICD-10) (World Health Organization, 1992) as this is the main diagnostic system used at the clinic. Diagnostic assessments were conducted by experienced clinicians from the Clinic (mainly clinical psychologists) all of whom had prior experience with using the ADIS-IV. Throughout the study period uniformity in the diagnostic procedures was secured through weekly clinical conferences. Inclusion criteria were: a primary diagnosis according to the DSM-IV criteria of panic disorder with or without agoraphobia (PDA), social phobia (SP), and obsessive-compulsive disorder (OCD), minimum 18 years of age, and sufficient Danish language proficiency to fill out questionnaires. Exclusion criteria were: organic mental disorder, a current psychotic episode, schizophrenia, bipolar affective disorder, current alcohol or drug abuse or dependency, and severe personality disorders (schizoid, paranoid, and emotionally unstable). The number of participants recruited was: 123 (24.4%) with a principal diagnosis of PDA; 149 (29.6%) with SP; and 232 (46%) with OCD.

All participants included in the study completed the PBI and the Beck Depression Inventory at the time of the initial diagnostic assessment, whereas a smaller number of participants completed the Beck Anxiety Inventory immediately prior to treatment start. The comparison group consisted of 210 volunteer students from an introductory psychology class at Aarhus University, who filled out the questionnaires in September 2010. All participants gave written informed consent prior to inclusion in the study. The study was approved by the local Danish Ethical Committee, and by the Danish Data Protection Agency.

2.2. Measures

Perceived parenting style was measured by the PBI (Parker et al., 1979), a self-report questionnaire concerning retrospective experiences of parenting style during the first 16 years of childhood. The scale was back-translated from English to Danish. The PBI measures two dimensions, parental care and parental control, on 25 items; scored from 0 = “very unlike (him or her)” to 3 = “very like (him or her)”. The scale is filled out separately for mother and father. The questionnaire has shown good internal consistency (e.g., $\alpha = 0.88$ for care, and 0.74 for control; Parker et al., 1979), and good short- and long-term test-retest reliability (Parker, 1983a; Plantes, Prusoff, Brennan, & Parker, 1988); e.g., retest coefficients in the range of 0.64–0.83 for care, and 0.59–0.78 for control over a period of 20 years (Wilhelm, Niven, Parker, & Hadzi-Pavlovic, 2005). Additionally, self-reported parental style has been found to correlate with reports from siblings and parents (Parker, 1981). It has shown not to be influenced by fluctuations in present state depression (Parker, 1981; Wilhelm et al., 2005). In general, studies that have examined the factor structure of the PBI have supported the two parenting dimensions of care and control (Mackinnon, Henderson, & Duncan-Jones, 1989; Parker et al., 1979), although a three-factor structure has also been suggested (Murphy, Brewin, & Silka, 1997). In the present study, Cronbach's α for the PBI was high, in both the anxiety sample and the student sample: mother care 0.95 and 0.91, respectively; mother control 0.89 and 0.85; father care 0.93 and 0.95; and father control 0.90 and 0.85.

The Beck Anxiety Inventory (BAI) is a 21-item self-report instrument. Each item is scored on a 4-point scale ranging from 0 = not at all, to 3 = severely (Beck, Epstein, Brown, & Steer, 1988a). The BAI primarily measures anxiety symptoms related to autonomic activation, but cognitive symptoms of anxiety are also measured. The BAI is a commonly used questionnaire and has demonstrated good psychometric qualities (Beck & Steer, 1984; Steer, Ranieri, Beck, & Clark, 1993). In this study, Cronbach's α for BAI was 0.93 in the anxiety sample, and 0.83 in the student sample.

The Beck Depression Inventory-2nd version (BDI-II) is a 21-item self-report inventory. Each item is scored from 0 to 3 representing the severity of depressive symptoms. The BDI-II is the latest version of the BDI with the revision aimed at making the scale more consistent with DSM-IV criteria for major depressive disorders (Beck, Steer, Ball, & Ranieri, 1996). The BDI is the most widely used self-report scale in both clinical and nonclinical populations, and it has demonstrated good psychometric qualities (Beck & Steer, 1984; Beck, Steer, & Garbin, 1988b). In this study, Cronbach's α for the BDI-II was 0.92 in the anxiety sample, and 0.90 in the student sample.

3. Statistical analyses

The participants' demographic and clinical characteristics were compared using Chi-square tests, independent-sample *t*-tests, and one-way between-groups analyses of variance (ANOVA) with Tukey post hoc analyses, as appropriate. Group differences in per-

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