

**Did my parents make me miserable?**

**Examining the links between parental style, core beliefs and  
depression.**

**Research Thesis**

**Author:** Rajshree Shah

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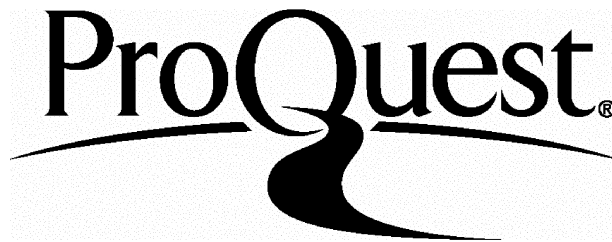
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## **ABSTRACT:**

The relationship between perceived parental style in childhood and depression in adulthood has been extensively researched over the past two decades since the development of the Parental Bonding Instrument (Parker, et al., 1979). However, less attention has been devoted to finding factors that mediate this relationship. Parker (1993) conducted a study examining for links with personality vulnerability factors, depression and parental style on depressed participants. Unfortunately, he failed to find links between PBI scores and depression levels in his sample and so could only speculate on the diathesis-stress model.

The aim of the present study was to test the proposal that the relationship between parental style and depression is mediated by core beliefs. Young's (1990) Schema Questionnaire was used to identify the most relevant core beliefs to depression. There were 70 participants in each of two groups, a clinical and non-clinical group.

For the clinical group, perceived paternal overprotection or control was associated with depression in adulthood, and this relationship was mediated by the core belief, vulnerability to harm and illness. For the non-clinical group, there was a relationship between perceived maternal overprotection and depression in adulthood. This was mediated by three core beliefs (self-sacrifice, failure to achieve, and social undesirability).

These findings are contrary to conventional wisdom, which regards the relationship with the maternal figure, and the 'care' dimension, as the primary predictors of affective disorder in adulthood. There is a scarcity of research on men and fatherhood. Therefore, there is room for speculation about these surprising results. It is suggested that the findings with the clinical group may suggest abuse, and that in the non-clinical group might reflect the gender difference between the two groups.

## **1. CHAPTER ONE : INTRODUCTION**

### **1.1. Overview of Chapter One:**

The overall aim of this study is to contribute to a better understanding of the aetiology of depression, with a particular focus on the role of perceived parental style. Numerous studies have shown a clear association between parental style and depression in adulthood (e.g., Blatt & Homman, 1992; Brewin *et al.*, 1993), but little is known of the means by which this relationship might be mediated. To redress the balance, this study pursues the possibility that a particular parenting style affects a diathesis to depression by inducing a vulnerable cognitive style (rather than by disposing directly to depression). It investigates the strength of the associations, if any, between parenting style (as perceived by the depressed person reflecting on their childhood), core beliefs (or early maladaptive schemas), and depressive symptomatology. A model is proposed in which the link between parental style and depression is mediated by core beliefs or schemas, and this model is then systematically tested.

This introduction will therefore outline the key concepts of depression, parental style and bonding, and core beliefs (or schemas). The psychological literature generally, and more specifically the cognitive framework, will be used.

### **1.2. Introduction:**

*“If this feeling of emptiness, of something ‘without form, and void’, can be deliberately accepted, not denied, then the sequel can be intense richness and fullness of*

*perception, a sense of the world reborn.*” (Milner, 1959, cited in Formaini 1991, pp 38).

It is generally appreciated that in order to accept, one must possess an understanding of that which is being accepted - making an informed choice. Psychology is about understanding and treating people, and involves communicating effectively about emotional distress and coping. Maybe the most important element in the profession is not imparting “truth” to patients, but facilitating their journey in making sense of their experiences. This concept adds a new dimension to the traditional expert-patient relationship, and renders it much more ambiguous.

The balance between holding and sharing generally available information regarding a particular psychopathology and adopting an individually tailored approach with each client is difficult to strike, but is important. The difficulty is further enhanced when the language is shared between lay and professional persons, but the meaning is not. For example, everyone probably has some idea of what *depression*, or *parental style*, or *core beliefs* mean or could mean. Also, most people, professional and lay alike, assume that there is a link between a child’s upbringing and how they are emotionally as adults. Kuyken *et al.* (1992) suggest that there are more similarities than differences in lay and professional theories of depression. Their data suggest that depressed patients and non-depressed lay persons have relatively extensive beliefs about the causes of depression. These beliefs do not only arise from personal experience (participants had knowledge about things of which they had no first-hand experience), and they are comparable to those held by clinical psychologists. These findings are important ones for clinical practice. They also

facilitate the aim of this study - to gain a better understanding of the aetiology of depression.

Prior to examining the relationship between parental style and depression in detail, it seems logical to outline the main phenomena pertinent in this study. The next section will provide an account of depression, drawn from the abundance of available literature.

### **1.3. Depression:**

This section will introduce the concept of depression, and consider ways of defining this construct. After a resumé of its demographic characteristics, three theoretical models of depression will be presented - medical, psychoanalytical and cognitive - with the greatest emphasis on cognitive theory, as this forms the basis of this study. Finally, there will be a summary of treatments for depression. This will highlight obstacles to successful intervention and the need for developing alternative forms of treatment.

#### ***1.3.1. Introduction to Depression:***

Clinical depression is so widespread that it has been called the ‘common cold of psychiatry’ (Seligman, 1975). As such, it is not surprising that there is a copious literature on the subject of depression, attempting to understand and treat this debilitating condition. It has been found to affect numerous individuals across all age, class, gender and ethnic boundaries. However, the psychiatric literature is complicated by the variety of meanings attached to the term “depression”. Angold (1988) has made a bold attempt to categorise the term into a useful analytical

framework, combining the various viewpoints and dimensions in the literature to date:

1. Depression as a description of the low end of the ordinary fluctuations of normal mood.
2. Depression as a description of the unhappiness, sadness or psychic pain felt as a response to some unpleasant situation or event.
3. Depression as a trait.
4. Depression as an individual symptom.
5. Depression as a syndrome.
6. Depression as a disorder.
7. Depression as a disease.
8. Cause of handicap.

Angold (1988) notes that this system distinguishes: normal states from abnormal ones; “elemental” phenomena (e.g., mood disturbance) from “compound” uses (e.g., biological, cognitive and behavioural concomitants); and depression as a state, trait or reaction. Obviously, these categories are not mutually exclusive, and some are more established than others. However, they do provide a useful framework to organise the information available in the psychological literature on depression. A more formal definition is found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994).

### ***1.3.2. Definition of Depression:***

According to DSM-IV (American Psychiatric Association, 1994), the common symptoms of depression include: loss of motivation, sadness, anhedonia, low self-esteem, somatic complaints, and difficulty in concentrating (Appendix 1).

The common symptoms of mania (the opposite of depression) are: greatly increased energy, racing thoughts, pressured speech, wild and extravagant behaviours, and grandiosity. The majority of people who suffer from depression never experience mania, but people who suffer from manic episodes typically also have depressive episodes. Hence, these affective disorders are categorised into bipolar affective disorder and unipolar depression. This study is mainly concerned with the more common unipolar depression, although anecdotal information about the bipolar condition was collected. The DSM-IV divides unipolar depression into *major depressive disorder* (MDD - one or more episode of severe depressive symptoms for a period of two weeks or more) and *dysthymic disorder* (DD - which is characterised by a chronic experience of moderate to severe depressive symptoms, lasting for at least a two year period). Although the usefulness of such diagnostic criteria is currently being debated, this seems to be a necessary framework for a term that has meaning both at a professional and at a lay person's level.

### ***1.3.3. Demographic Characteristics of Depression.***

Klerman (1988) has written a thought-provoking paper, speculating on the increase in depression over the last 30-40 years. He reminds readers of the dynamic and temporal nature of conditions by discussing aspects such as age, period and cohort effects. He reports that the conventional wisdom has been that depression increases with age, and explains how this has intuitive "face validity". As individuals grow older, they experience more loss: the deaths of relatives, friends and other important persons; children grow up, become independent and move away. With age, there is increased likelihood of medical illness, infirmity and disability. On retirement, there is often a decrease in income and a loss of social status. Also,

and perhaps more significantly, the elderly individuals anticipate their own death and the awareness of human mortality increases. In his meta-analysis, however, Klerman finds that the conventional wisdom is supported only by data collected in surveys. When clinical diagnoses with structured interviewing techniques are used, there is no increase in prevalence of depression with age. In fact, the highest prevalence of depressive disorder is found to occur among young adults.

Having established that there has been an overall increase in depression and that there is an earlier age of onset, Klerman (1988) suggests that some form of period or cohort effect must be operating. He concludes that coming to maturity in the period 1960 - 1975 seems to have had an impact on the likelihood of depressive illness. Brodaty *et al.* (1997) also examined depression across ages, and found apparently robust phenomenological differences in depression between older and younger participants. They suggest that their study might aid in understanding the neurobiology of depression.

Parker *et al.* (1995) suggest that low parental care should be in the established list of major risk factors (such as female sex, younger age and divorce / separation). They did however, suggest that these may be predisposing factors to a variety of psychiatric disorders, and not specifically to major depression. Richards *et al.* (1997) conclude that divorce and separation have a long-term and specific impact on mental health, particularly depression, anxiety and alcohol abuse. Rodgers (1994) reported that women who had divorced had high levels of depression, but only among those whose parents had divorced. Pathways between parental divorce and own divorce are likely to be complex, and may interact with social causation factors. Employment status and, by implication, social status have been associated with

depression in adulthood (Rutter and Madge, 1976). However, the combination of these psychological and sociological factors is no better demonstrated than when considering gender issues in adulthood depression. Therefore, the next section has been devoted to do this in some detail.

#### *1.3.3.1. Gender issues in depression:*

With respect to gender, there is substantial evidence from various sources to suggest that females show higher lifetime prevalence than males (e.g., Weissman and Klerman, 1977). However, there is some suggestion that the gender ratios may have been narrowing in recent years (Murphy and Wetzel, 1980; Rice *et al.*, 1984).

Nolen-Hoeksema (1987) offers one possible explanation for this gender difference, suggesting that men have adopted a more adaptive response (engage in distracting behaviours that dampen their mood when depressed) than women (who ruminate about their depressed states and their possible causes, hence amplifying their moods). She identifies four gender differences which have implications in clinical practice:

- sex role demands might prevent a seriously depressed man from seeking the help he needs;
- sex role expectations of women might encourage them to pay too much attention to their own hedonics;
- seriously depressed women may be more likely to be detected than seriously depressed men;
- mildly depressed women may be more likely to become moderately or severely depressed.

Conversely, Phillips (1993) voiced the concern that boys often fail to learn a language with which they could describe their feelings. Without language, it is hard



for anyone to make sense of what it is they feel. Indeed, the very words that are used to talk about feelings are dominated by female metaphors. For example, words like “thrusting” and “incisive” suggest masculinity, while “empty”, “drained” or “full” are words with gender-specific connotations suggesting feminine containment (Thomas, 1996). Brown *et al.* (1988) studied depression in women, and suggested that those most likely to benefit from cognitive therapy are in the subgroup who get into the habit of depression, and need a jolt to get a more positive perspective on life.

In her comprehensive resumé of sex differences in unipolar depression, Nolen-Hoeksema (1987) notes that the failure to find gender differences in some studies may be because goals and lifestyles of male and female college students are more likely to be similar than in non-student populations. Indeed, twelve out of a possible twenty relevant studies viewed in a literature search used college samples. For example, Hammen and Padesky (1977) failed to find significant gender differences on BDI scores when they asked over 2,000 students to complete the self-report questionnaires. However, the men in the depressed subsample were statistically distinguishable from depressed women by a combination of items that included an inability to cry, loss of interest in other people, a sense of failure, and a variety of somatic responses. Women were characterised by indecisiveness and self-dislike. A more recent study by Gjerde (1995) found that a mostly allocentric (undersocialisation and interpersonal antagonism) mode of behaviour anticipates chronic depressive symptoms in young men, whereas a mostly autocentric (oversocialisation and introspective concern with self) mode of behaviour anticipates chronic depressive symptoms in young women.

Most studies consider gender as an adjunct to their main area of interest, but Sowa and Lustman (1984) conducted a study investigating gender differences specifically. They found that men reported experiencing a significantly greater number of stressful life changes, but women perceived their stressors as more severe. They found a gender variation in the relationship between cognitive distortion and depression. Men reported significantly less depression than women, while simultaneously expressing higher levels of cognitive distortion. In contrast, levels of cognitive distortion for women were three times more powerful in predicting depressive mood. They suggest that Beck's (1974) aetiological model, in which cognitive distortions are involved in the development and maintenance of depression, is most applicable to female depression. Also, Scott *et al.* (1988) reported a significantly higher incidence of unipolar depression in families of female chronic depressives, and suggest that this finding may mean that chronic depression has differing aetiologies in males and females. It is apparent that there are various ways of conceptualising gender differences in depression. However, the evidence seems to suggest that there are qualitative differences in depression among men and women, a point worth noting in clinical practice.

#### ***1.3.4. Theoretical Models of Depression:***

The main schools of thought to date have been:

- Medical model
- Psychoanalytic model
- Cognitive model

#### *1.3.4.1. The Medical Model:*

The medical model suggests an imbalance in brain chemistry. Medication is the standard treatment for depression. The patient information leaflet with each packet of paroxetine (“Seroxat”), one of the new class of antidepressants, contains the reminder that “Depression is a common illness; It is nothing to be ashamed of. It is not a sign of weakness. It can be treated successfully.” It explains the latest understanding of the biochemical aetiology of depression very simply: “Everyone has a substance called serotonin in their body. Low levels of serotonin in the brain are thought to be a cause of depression and other related conditions. ‘Seroxat’ is one of a group of medicines called selective serotonin reuptake inhibitor (SSRI) antidepressants and works by bringing the levels of serotonin back to normal.”

However, there are compelling reasons why medication might not be the preferred form of treatment for some individuals. Firstly, antidepressants produce side-effects which reduce compliance (Hollon, 1981). Secondly, a proportion of patients do not respond, and some refuse drug treatments altogether. Finally, there is some evidence to suggest that a combination treatment of medication and psychotherapy is optimally effective (Bowers, 1990). Lam *et al.* (1997) have shown that dysfunctional attitudes impair spontaneous recovery from depression, and that the effects of antidepressant drug treatment may obscure this effect. They conclude that recovery from depression may include a complex mixture of biological and psychological pathways.

#### *1.3.4.2. The Psychoanalytic Model:*

The psychoanalytic literature is unanimous in regarding melancholic depression as a pathological form of mourning, in which the lost object is an

“internal object” and not necessarily an actual person. For example, Freud (1917) suggested that “in melancholia, the occasions which give rise to the illness extend for the most part beyond the clear case of a loss by death, and include all those situations of being slighted, neglected or disappointed, which can import opposed feelings of love and hate into the relationship or reinforce an already existing ambivalence” (pp 251). The psychoanalytic view suggests that the internal object is ambivalently invested. Therefore, the depressed person feels dependent on the same object to which he or she is none the less hostile. Pedder (1982; cited in Brown & Pedder, 1991), for example, moved Freud’s idea beyond relationships with other people, to include situations in the environment: “Depression, for example may follow failure to achieve some longed for ambition or position vital to self-esteem” (pp 23). In depression, he or she imagines having destroyed this object (hence the self-reproach), but is incapable of surviving without it (hence the depression). This view of depression assumes that, even in health, these people are subject to a state of precarious balance, since their stability is based on a complex, ambivalent relationship towards an internal object.

To review these models in depth is beyond the scope of this study, but both the medical and the psychoanalytical models suggest that the condition of depression is very much out of the control of the individual - this is the way they are, predisposed to depression. The interventions - medication or long-term therapy - based on these models reflect this concept. They suggest that a person can only move out of a depressed episode with extensive external, professional help. However, this idea could be construed as colluding with intense feelings of being out of control that often accompany an episode of depression. These models can be

contrasted with the cognitive model, with its emphasis on developing internalised skills of control.

#### *1.3.4.3. The Cognitive Model:*

Over two decades ago, the empirical literature on neurotic, exogenous depression was dominated by studies addressing Beck's (1967, 1974) cognitive theory, Seligman's (1974, 1975) learned helplessness model, or Lewinsohn's (1974) theory, attributing depressive states to a low rate of response-contingent positive reinforcement. The essence of Beck's theory is that the root of depression is a negative cognitive set. The depressed person is seen as having a negative view of him or herself, of the world, and of the future - the cognitive triad. The affective state of depression is said to be secondary to these negative cognitions. Although the theory recognises that an episode of depression may be externally precipitated, it is the individual's perception and appraisal of the event that render it depression inducing. This concept is in sharp contrast to those of the medical and psychoanalytic models, in apportioning much of the responsibility onto the individual themselves. Since its presentation, this theory has been the centre of much research, for example, in the field of information processing, and forms the basis of much clinical practice.

Seligman's (1974, 1975) views on depression are rooted in laboratory experiments with dogs. He showed that the prior experience with uncontrollable, noxious stimulation is said to result in *learned helplessness*. This condition is manifested in a motivational deficit, and in an interference with the learning of new response-relief contingencies. The helpless animal is said to have learned that response and outcome are independent. Seligman extrapolated these findings onto

humans suggesting that reactive depression is essentially a state of learned helplessness, characterised by the perception of lack of control. Since then, research dedicated to investigating loci of control have converged with this theory. These concepts are used extensively in management training.

Lewinsohn (1974) was a behaviourist. He proposed that a person's depression is due to their low rate of response-contingent positive reinforcement. This low rate may exist for several reasons. It may be that few events are reinforcing, or perhaps few reinforcing events are available in the person's immediate environment. The individual may lack the skills necessary to make responses that are likely to be reinforced. Lewinsohn is explicit in claiming that it is not the rate of reinforcement *per se* but the rate of response-contingent positive reinforcement that is crucial. This again incorporates the idea of the person having (or lacking) some control over their environment.

Blaney (1977) wrote a comprehensive comparison of these theories, and concluded that there was considerable overlap among the theoretical positions. Together, they suggest the importance of three variables in depression - perception, control and rate. He notes that the ideas of these three theorists have generated much research interest, and highlights two alternative theories which he suggested deserve equal attention. The first is rooted in the common observation that depressive conditions often appear to have an intropunitive quality. Forrest and Hokanson (1975) hypothesised that "one component of depression may be related to the instrumental value that depressive, self-demeaning displays have in controlling aversiveness and threat from others." In this view, depressives distort reality in a self-derogatory manner whilst non-depressives are considered to be accurate in their

perceptions and judgements. There is a conflict in the depression literature about the role of distortion, highlighting fundamental questions about who distorts, what information is distorted, and to what end. Albright and Henderson (1995) addressed this issue, and concluded that negative distortion, not realism, is characteristic of even mildly depressed subjects.

The second theory was presented by Coyne (1976). A sequence is presumed to occur when an individual undergoes a stressful experience. The experience renders the person in special need of support and validation from other people, and the depressive symptoms that emerge are designed to solicit that support. When it is forthcoming, however, the individual may doubt its sincerity and request more reassurance. Such persistent demands may be “aversive to members of their social environment,” but “accompanying indication of distress and suffering is powerful in its ability to arouse guilt in others and to inhibit any direct expression of annoyance or hostility from them”. The depressed individual may be somewhat aware of the annoyance, however, leading him to be even more needy and persistent in emitting the instrumental symptoms. Joiner *et al.* (1992) tested Coyne’s theory in college students, and found that it was the combination of depression, reassurance seeking, and low self-esteem which placed participants at greatest risk of rejection. There were significant gender differences, in that these effects were obtained for males only.

These two models conclude that certain depressive symptoms are instrumental behaviours that are maintained by their consequences. This is opposed to the suggestion that depressive symptoms are caused by the real or perceived absence of appropriate consequences for responses. Coyne (1976) suggested more

specifically that the skills whose lack leads to depression are the very skills one needs when one has experienced stress and needs support from others (e.g., ability to elicit support without also eliciting hostility). Furthermore, Birtchnell *et al.* (1991) explored the relationship between depression and dependence and concluded that, although there is a direct linear relationship between neuroticism and level of current depressive symptoms (Katz and McGuffin, 1987), neuroticism is more intrapersonal and dependence is more interpersonal.

These models paint a bleak picture for individuals suffering from depression. Perhaps one way forward would be to examine the roots of the lack of social skills that is characteristic of depressed people. Indeed, one of the recent criticisms of the cognitive approach has been of its focus on the here-and-now (with scant regard for the personal history of the client). The need for integrating Beck's cognitive model with developmental theory has recently been identified. Leahy (1995) has made a persuasive case for choosing Piaget's structural and Bowlby's object representations' developmental models with which to integrate Beck's cognitive model, to understand the primitivism and resistance of early core beliefs (schemas).

The present study also aims to redress the balance, giving an understanding of the development of a person's depression in the light of experiences with parental figures in childhood. The section on *schemas* or *core beliefs* shows how cognitive theory has responded to the need for a more integrated approach (Beck, 1991). In the next section, a broad overview of therapeutic interventions will be presented, maintaining a focus on the cognitive approach.



### **1.3.5. Treatment Considerations:**

The vast majority of depressed individuals suffer from illness episodes which either spontaneously remit or respond to one of the many forms of treatment now available (Hawton *et al.*, 1989). Drugs remain the standard treatment. However, Hollon (1981) reported drop-out rates ranging from 20% - 50%, and suggested that estimates of drug-response may be inflated by proportionately more non-responders dropping out of trials. There are compelling reasons why a psychological treatment might be preferable in some instances. Many antidepressants produce side-effects which reduce compliance. A proportion of patients do not respond, and some refuse drug treatments altogether. Indeed, drugs are a major problem in overdose and the hazards of chronic use are not well documented. There is also evidence to suggest that cognitive psychotherapy may even have a greater relapse prevention effect than short-term antidepressant medication (Blackburn *et al.*, 1986; Rush *et al.*, 1977).

However, when considering outcome of interventions, it is important to bear in mind the “quality of the clinical population”. Most of the outcome studies comparing Beck’s cognitive therapy with antidepressant medication have attempted to find markers which might predict good or poor response. These can be divided into three broad categories:

1. *Factors related to the illness:* Studies of cognitive therapy have tended to show that measures of severity and length of illness are related to poor prognosis.
2. *Premorbid characteristics of the patients:* Patients with personality disorders do not always respond well to cognitive therapy. Although it is extremely difficult to research this area (mainly because it is very difficult to diagnose a person with a personality disorder), clinically it seems that any personality traits which interfere

with the collaborative relationship can cause problems in therapy. Also, the rather vague construct of “psychological-mindedness” seems to be a relevant personality trait in predicting outcome of cognitive therapy.

3. *Cognitive factors*: Hopelessness, negative thoughts, cognitive distortions and maladaptive assumptions all proved to be closely correlated with therapy in their own right. The extent to which patients used cognitive coping strategies is also a relevant factor in predicting outcome of therapy. The patient’s familiarity with the strategies involved in the intervention would obviously facilitate the process of therapy.

Fennell and Teasdale (1987) concluded that “the important characteristic of those who improved rapidly was that they readily accepted the conceptualisation offered and that this was then ‘validated’ by evidence from their homework assignments.” In 1989, Moorey concluded that the present state of knowledge would suggest that cognitive therapists are advised to concentrate on working with patients who have a relatively acute depression, have a stable premorbid personality and, at assessment, are able to see some relevance of the cognitive model to their depression.

However, it is often chronic patients, who have failed to respond to other treatments, who are referred for cognitive therapy. Robins and Guze (1972) reviewed 20 follow-up studies of affective disorders, and reported an average incidence of 12-15% of “chronic course” cases. Chronic depression affects a large number of individuals. Unfortunately, the clinical stereotype depicting all chronic depressives as suffering from a character-based disorder still persists, and often leads to inappropriate or inadequate treatment of their illness (Weissman and Klerman, 1977). Together with the fact that only during the course of therapy is it possible to

discover the cognitive factors associated with clinical outcome, this poses a problem for treating this client group.

Much of cognitive therapy relies on modifying beliefs through the review or production of evidence that contradicts negative or maladaptive conclusions drawn by a client (Padesky 1994; Young 1990). With problems of relatively short duration, production of contradictory evidence often leads to a shift in belief. This shift in belief can occur quickly if supporting alternative beliefs (or schemas) exist. Thus, a depressed person who currently has an “I am bad” self-schema activated, may be able to shift this belief within a few weeks if this person also has an “I’m OK” schema (which is normally activated in the non-depressed state). However, people with lifelong or chronic depressive problems often do not have an alternative belief (schema) available, and therefore contradictory evidence is far less likely to shift their beliefs. For this reason, treatment of chronic problems within cognitive therapy usually involves not only testing maladaptive beliefs but also identifying and strengthening alternative, more adaptive schemas. An alternative schema must be developed before the client will be capable of accepting the evidence. Therefore, therapy for this client group has dual goals of weakening maladaptive schemas and developing more adaptive ones.

A number of authors have discussed how cognitive therapy can be modified and refined to address the cogent theoretical criticisms of Mahoney (1980), Coyne and Gotlib (1983) and others. They draw upon the evidence from clinical challenges posed by patients who do not respond adequately to standard cognitive therapy. Indeed, Young (1990) exposed the limitations of short term cognitive therapy for

depression for such patients by highlighting the necessary conditions for successful therapy:

1. Patients have access to feelings, thoughts and images with brief training.
2. The patient has identifiable problems on which to focus.
3. The patient has motivation to do homework assignments and learn self-control strategies.
4. The patient can engage in a collaborative relationship with the therapist within a few sessions.
5. Difficulties in the therapeutic relationship are not a major problem focus.
6. All cognitions and behaviour patterns can be changed through empirical analysis, logical discourse, experimentation, gradual steps, and practice.

It is not difficult to see how individuals with personality or character-based disorders violate these basic assumptions. Therefore, Robins and Hayes (1995) have identified some of the recent developments that have occurred in cognitive therapy which include:

- a distinction between “core” and more “peripheral” schemas
- an appreciation of the role of defensive processes in the avoidance of schema-related material
- a greater emphasis on exploration of the therapeutic relationship and on the patient’s interpersonal relationships in general
- a greater emphasis on the role of affective arousal for the elicitation and modification of schemas
- a greater emphasis on exploration of developmental experiences that may have been significant in the development of maladaptive schemas.

Some of these developments have borrowed theoretical concepts or techniques from other therapeutic approaches (e.g., ‘internalising a problem’, or projection, or introjection). However, since a conceptual framework that emphasises the role of dysfunctional schemas is retained, these developments can best be viewed as an evolution in the sophistication of the cognitive therapy model itself, rather than a new form of psychotherapy. Indeed, Beck described these aspects in his earlier writings, but they were not emphasised then. Researchers and scholars in other theoretical approaches have also begun to look to cognitive psychology and cognitive therapy for a language to re-describe or develop psychodynamic and other approaches (e.g., Beck, 1991; Gilbert, 1984). Bowlby (1977), with his background in the psychoanalytic school of thought suggested: “By framing the processes in terms of cognitive psychology, I believe, much greater precision becomes possible and hypotheses regarding the causative role of different sorts of childhood experiences, through the persistence of representational models of attachment figures and self at an unconscious level, can be formulated in testable form.”

Therefore, the literature suggests that it is mainly individuals suffering from chronic depression (usually women) who reach psychological services. The stereotypic belief about the personalities of these patients persists in the clinical setting (maybe becoming more generous by alluding to *features* of personality disorder). Finally, the need remains paramount to establish short term therapy that is effective for political and financial reasons. Therefore, perhaps the obvious source of information is in the developments that have been made in the cognitive treatment of people with personality disorders. The next section traces the course of Young’s

(1990) conceptualisations with regard to treating people with chronic psychological distress.

#### **1.4. Schemas or Core Beliefs:**

This section will define the key concept in cognitive therapy pertinent to this study - schemas or core beliefs - and introduce the instrument recently designed to identify sixteen of these schemas, Young's Schema Questionnaire.

##### ***1.4.1. Introduction to Schemas:***

Beck introduced the concept of the schema to cognitive theory as early as 1967, defining it as "a structure for screening, coding, and evaluating the stimuli that impinge on the organism. It is the mode by which the environment is broken down and organised into its psychologically relevant facets. On the basis of schemas, the individual is able to ... categorise and interpret his experiences in a meaningful way". This idea is based on information processing theory, which posits that schemas develop as part of normal cognitive development. Segal (1988) offers an alternative definition of schemas, based on a consensus of many researchers: "organised elements of past reactions and experience that form a relatively cohesive and persistent body of knowledge capable of guiding subsequent perception and appraisals". Segal goes on to contrast several different models of schemas which offer differing explanations regarding (a) the relationship between moods and personal construct, and (b) the interconnectedness of personal constructs within the self-system.

In 1990, Beck and his colleagues were differentiating between core beliefs (such as 'I'm no good') and conditional beliefs (such as 'If people got close to me,

they would discover the “real me” and would reject me’). The various terms used to describe critical constructs in cognitive theory and practice are:

- core beliefs, schemas or schemata (these terms are interchangeable).
- conditional beliefs or underlying dysfunctional assumptions.
- automatic thoughts or negative automatic thoughts (NATs) - cognitions that automatically and temporarily flow through one’s mind.

Core beliefs and conditional beliefs are relatively similar, in that they are both deeper cognitive structures than automatic thoughts. However, different therapeutic processes are used to evaluate and change these two types of beliefs. Padesky (1994) describes a clinical procedure designed to identify and alter the maladaptive core beliefs of clients.

Schema-focused cognitive therapy is concerned with alleviating symptoms of distress through the modification of underlying maladaptive cognitive structures or schemas (e.g., Padesky, 1994; Young, 1990). As such, it is regarded as a truly integrative approach, which includes exploration of the early childhood origins of client’s problems, the interpersonal aspects of the therapy relationship, and the utilisation of imagery and other experiential techniques in both assessment and treatment (Bricker *et al.*, 1993). The theory suggests that early maladaptive schemas (EMSs) create distress through cognitive biases, which result in the dysfunctional synthesis of environmental and intrapersonal data (Schmidt *et al.*, 1995). Once formed, EMSs are maintained in the face of contradictory evidence through the processes of distorting, not noticing, and discounting contradictory information, or by seeing this information as an exception to the schematic (and therefore, ‘normative’) rule. Therefore, the identification of relevant EMSs is a critical

component in cognitive therapy. In the next section, the reasoning behind the development of Young's Schema Questionnaire will be explored, highlighting the direction in which Beck's conceptualisations have progressed.

#### ***1.4.2. Young's Schema Questionnaire:***

Young (1990) expands the model on which short-term cognitive therapy for depression is based by incorporating four theoretical constructs - Early Maladaptive Schemas (EMS), Schema Maintenance, Schema Avoidance, and Schema Compensation. He offers a straightforward working theory which patients can understand, and which enables patients and therapists to communicate about deeper level phenomena. Although he discusses schemas as if they exist structurally, he acknowledges that they are indeed hypothetical constructs, designed to facilitate communication. Only EMSs will be discussed here, as they are most pertinent to this study. The other constructs have been described as more pertinent to the personality disorders.

Young (1990) proposed a primary emphasis on the deepest level of cognition - core beliefs or Early Maladaptive Schemas (EMSs). EMSs are the cognitive representations of stable and enduring themes that develop during childhood, and are elaborated upon throughout an individual's lifetime. These schemas serve as templates for the processing of later experience. Young identifies six defining features of EMSs:

- Most EMSs are unconditional beliefs about oneself in relation to the environment.
- EMSs are self-perpetuating, and therefore much more resistant to change than NATs or dysfunctional assumptions.
- By definition, EMSs are dysfunctional in some significant and recurring manner.



- EMSs are usually activated by events in the environment relevant to that schema.
- EMSs are closely tied to high levels of affect when activated.
- EMSs seem to be the result of dysfunctional experiences with parents, siblings, and peers during the first few years of an individual's life.

*“Significant experiences of early life may never recur, but their effects remain and leave their mark ... they are registered as memories, a permanent trace and an embedded internal stimulus ... Once registered, the effects of the past are indelible, incessant and inescapable. ...The residuals of the past do more than passively contribute their share to the present ... they guide, shape or distort the character of current events. Not only are they ever present, then, but they operate insidiously to transform new stimulus experiences in line with past.” (Millon 1981, pp 101).*

Although schemas play a central role in cognitive conceptualisations of personality disorder and increasingly in other disorders, research devoted to the assessment of schemas has been scarce. The development of the Schema Questionnaire (Young, 1990) has enabled the identification of sixteen EMSs, which are relevant to many longer term patients in clinical practice. Each schema can have many variations on the same theme, and most chronic patients with functional disorders have more than one of these core schemas. They are grouped into five broad categories, which correspond to general areas of functioning:

- **Impaired Autonomy** - Functional Dependence/Incompetence;  
Subjugation; Vulnerability to Harm and Illness; Enmeshment.
- **Disconnection** - Emotional Deprivation; Abandonment; Mistrust/Abuse;  
Social Isolation.

- **Undesirability** - Defectiveness/Shame; Social Undesirability; Failure to Achieve.
- **Restricted Self-Expression** - Emotional Inhibition; Self-Sacrifice; Unrelenting Standards.
- **Insufficient Limits** - Entitlement; Insufficient Self-Control/Self-Discipline.

Appendix 1 has a list of full definitions of all the sixteen core schemas listed above. Young's Schema Questionnaire (YSQ) has been shown to possess convergent and discriminant validity with respect to measures of psychological distress, self-esteem, cognitive vulnerability for depression and personality disorder symptoms (Schmidt *et al.*, 1995). It is a relatively new clinical instrument, long and therefore difficult to administer for research purposes, but it was used in the present study because the information it yields regarding individuals in psychological distress is potentially valuable. There are no other instruments designed to identify the core beliefs of people, and therefore the YSQ deserves consideration.

The case has been made that one should consider the role of core beliefs in the psychopathology of depression. However, it is also important to consider the origins of those core beliefs. According to Young's (1990) model, a strong contender for this role must be parental style, since so many of his descriptions of EMSs involve a causal role for caretaking style in childhood. In the next section, the concept of parental style will be discussed, together with reasons for using the Parental Bonding Instrument (PBI) to measure that construct.

## **1.5. Parental Style and Bonding:**

This section will introduce the concepts of parental style and "anomalous parenting". It will also present a comparison of 'bonding' and 'attachment' to clarify understanding of these terms in the light of the literature available. Finally, it will consider the evidence for the links between parental style and depression in previous research.

### ***1.5.1. Introduction to Parental Style:***

Over the past few decades, research has generally shown that parenting style seems to have a strong impact upon children's and adolescents' development (Collins and Kuczaj, 1991). Numerous researchers have proposed models of how parents interact with their offspring. As Adams (1980) has noted, all of the models represent variations in how parents prompt, or fail to prompt, their children to communicate effectively, take control of their lives, and (in so doing) enhance their self-concepts. As Beck has clearly pointed out the significant importance of a negative view of oneself in depression, it seems logical to assume that parenting style contributes to negative affect in adulthood. Parish and McCluskey (1992) found the self-concepts of college students to vary directly with the perceived level of warmth displayed by both their mothers and fathers, but not as a function of their parents' level of restrictiveness.

Prior to expounding the relationship between parental style and depression in the light of relevant literature, it is necessary to clarify the terms used within the context of this study. It has already been pointed out that these terms are differently meaningful to professional and lay persons, and this could lead to some confusion.

Indeed, within the professional body alone, there is much confusion with regard to bonding and attachment. Therefore, the next section will address this issue.

### **1.5.2. Bonding versus Attachment:**

The concept of a 'bond' between a parent and a child is generally accepted despite, as Bowlby (1969) and Rutter (1972) have indicated, the lack of a satisfactory definition. Theoretically, Parker *et al.* (1979) propose that the parent-child bonds would be broadly influenced by characteristics of the child (e.g., individual differences in attachment behaviour), characteristics of the parents or care-taking system (e.g., psychological and cultural influences), and by characteristics of the reciprocal, dynamic and evolving relationship between the child and the parents. They propose that (because it is difficult to define these reciprocal interrelationships) most research has examined the influence of single variables, instead of attempting to identify the principle dimensions of bonding. The need to examine the parental contribution to the parent-child bond resulted in the development of the Parental Bonding Instrument (PBI). This questionnaire identifies and measures the two relevant constructs pertinent to the parent-child bond. Parker *et al.* (1979), in reviewing the literature on parental qualities associated with normal behaviour (Rutter, 1972; Bowlby, 1969; Ainsworth, 1978), noted that paternal characteristics have been neglected or only briefly considered by these authors.

Attachment theory, on the other hand, holds that humans are essentially social animals who need relationships for survival, and whose first relationships with parental figures have unique characteristics (Bowlby, 1988). Attachment behaviour is any form of behaviour that results in a person attaining or maintaining proximity to an 'attachment figure', usually a care-giver. Such behaviour is most obvious in

adults, who are frightened, fatigued or sick, and is assuaged by comforting and caregiving (Bowlby, 1979). It can be seen throughout the life cycle, especially in emergencies, and its biological function appears to be the protection of the developing and vulnerable organism.

Although it may be argued that the terms “bonding” and “attachment” are similar, there are some important differences. Bowlby’s (1979) argument suggests that the infant is born with a biological propensity to seek attachment to a mother figure, and that attachment is an “instinctive” process. This is comparable to Lorenz’s (1937) experiments explaining imprinting in geese. Bonding, by contrast, is perhaps best viewed as less clearly biologically determined. The regulation of interpersonal distance is subject to more voluntary and cognitive influences. Rutter (1980) suggested that there is a difference between the general tendency to seek attachments and the formation of selective bonds that are personal, social, and reciprocal. Implicit in this distinction is the understanding that processes underlying attachment and selective bonding may be different (Parker *et al.*, 1992). Although the literature has become somewhat complicated by using the terms ‘bonding’ and ‘attachment’ interchangeably, the distinction is a valuable and necessary one.

This distinction is particularly important now, as the two theoretical concepts are forming the basis of gaining an understanding of the aetiologies of affective and interpersonal disorders in adulthood. For example, attributes of the adult intimate partner are likely to be essential to the bonding process, so that the final relationship reflects not only the past developmental experiences of the subject but also relevant characteristics of the partner. An overly deterministic view of development fails to concede such current partner effects. As illustrated by the risk factor studies with the

Intimate Bond Measure (Hickie *et al.*, 1990), a subject with no developmental vulnerabilities who cohabits with a dysfunctional partner may develop the same psychiatric disorder as a subject who reports both past and current relationships as deficient, so that continuity of negative interpersonal relationships is clearly unnecessary (at least to the onset of depressive disorders). Levels of early parental care influence wider diffuse social networks in adulthood, but do not necessarily dictate levels of affection and control in the adult intimate relationship (unless there has been gross early deprivation of parental care).

One way of defining the parental contribution to the process of bonding is to measure parental behaviours and attitudes. The Parental Bonding Instrument (PBI) has been developed to do this in a short self-report questionnaire, which delineates two factors that have been shown (by factor analysis techniques) to be central to the role of parenting - care and overprotection / control. A major benefit of this instrument is that it can be administered for both parents, so fathers are not neglected when measurement of parental style is performed. Parker (1981) uses the terms 'overprotection' and 'control' interchangeably for the second factor in numerous studies assessing the psychometric properties of the instrument. There is some evidence to suggest that this is indeed a secondary factor to care, but important nevertheless. It may be that its effect is diluted by the fact that its meaning is more ambiguous than that of 'care' (i.e., it can hold both positive and negative connotations for people, depending on their past experience). The PBI is the tool used in this study to measure perceived parental style for both parental figures, mothers and fathers.

### ***1.5.3. Parental Style and “Anomalous Parenting”:***

There is a strong theoretical argument for studying fundamental parental characteristics (and their anomalous expression). Hinde (1974) has argued for two dimensions (‘care’ and ‘protection’) as underlying all significant interpersonal relationships. Again, theoreticians such as Bowlby (1977) have defined anomalous parenting in corresponding terms - failure to provide care (i.e., by being unresponsive, disparaging, rejecting) or excessive over-protection and control.

Typical patterns of pathogenic parenting have been identified in the lives of individuals referred for mental health problems (Bowlby, 1977). These people are described as anxious, insecure individuals, often considered to be over-dependent and immature, who are apt to develop neurotic symptoms, depression or phobia. The patterns of parenting include:

- one or both parents being persistently unresponsive to the child’s care-eliciting behaviour and/or actively disparaging and rejecting;
- discontinuities of parenting, occurring more or less frequently, including periods in hospital or institution;
- persistent threats by parents not to love a child, used as means of controlling him or her;
- threats by parents to abandon the family, used either as a method of disciplining the child or as a way of coercing a spouse;
- threats by one parent either to desert or even to kill the other or else commit suicide (each of them commoner than might be supposed);
- inducing a child to feel guilty by claiming that his or her behaviour is or will be responsible for the parent’s illness or death.

It is apparent that the overriding theme is that of loss and abandonment. This concept is consistent with the psychoanalytic framework described earlier. However, manipulative means of controlling the children's behaviour also seem to play a significant role. To measure these styles of parenting, the Parental Bonding Instrument (PBI) is a useful tool.

Four styles of parenting can be derived from the combination of scores on the PBI on the dimensions of care and overprotection (Parker, 1979; Parker and Hadzi-Pavlovic, 1992):

- Optimal Parenting - low control / overprotection, high care
- Affectionate Constraint - high control / overprotection, high care
- Affectionless Control - high control / overprotection, low care
- Neglectful Parenting - low control / overprotection, low care.

This is known as the quadrant assignment method of classifying parental styles. While optimal parenting is regarded as the ideal, the other three are termed as being "anomalous parenting" styles which are more or less detrimental to their offspring. Adam *et al.* (1994) found the pattern of "affectionless control" differentiated between suicidal and non-suicidal participants, but with important gender-specific and parent-specific differences. Indeed, the use of this method of categorisation has been brought into question, due to the primary and secondary nature of the dimensions of care and control / overprotection respectively. However, it provides a simple and straightforward way of categorising (and hence comparing) the combined effect of two parents' styles.



#### ***1.5.4. Parental Style and Depression***

Previous research has attempted to delineate parenting factors which may predispose to depression in adulthood, by focusing on the loss of a parent through death or divorce (Gotlib *et al.*, 1988). This research has yielded inconsistent results. A different approach to examining the importance of the quality of early parenting involves assessing depressed individuals' perceptions of their childhood experiences. Findings in this area appear to be more consistent. For example, Perris (1966) found that both unipolar and bipolar depressed patients reported unfavourable home conditions during their childhoods.

A variety of authors have emphasised the importance of the quality of early experiences with parents in the development of adult depression. Beck's (1967) cognitive model of depression, for example, explicitly attributes the development of negative schemata and cognitions to a critical, disapproving parent. Similarly, Blatt *et al.*'s (1979) psychoanalytic formulation suggests a vulnerability to depression, stemming from impaired relations with parents. To test these claims, researchers examined the incidence of parental loss among depressed people. Brown *et al.* (1986) have argued that the loss of (or separation from) a mother before the age of 11 represents a vulnerability factor for depression. Other investigators (e.g., Perris *et al.*, 1986) disagree however, and the aetiological significance for depression of early loss of a parent is still very much an unresolved issue.

Developmental precursors of depression are particularly difficult to recognise since depression-prone individuals often appear relatively well adjusted as children - competent, sensitive and eager to please others (Zahn-Waxler *et al.*, 1991). Depressive symptoms may also emerge mostly in response to age-specific and

situation-specific stresses, and have relatively weak characterological antecedents. As Angold (1988) noted, reactive depression presumes a particular aetiology for the phenomena being described; 'It is a problem that one particular aetiological mechanism should have a special place in the definition of depressions, but that may be unavoidable given that the normal moods are clearly environmentally reactive'. However, in the absence of carefully conducted long-term prospective studies, the possibility of early vulnerability to depressive symptoms should not be prematurely excluded. Indeed, Parker (1981) examined three non-causal explanations for the association between parental style and depression and concluded that the level of depression does not influence judgement of parental characteristics. He also found that the PBI is a good measure of "actual" parenting and there was not evidence to suggest that a depressive's potentially dependent temperament elicits different parental responses.

Blatt and Homann (1992) observed that both psychoanalytic and cognitive behavioural theories are consistent in assuming that negative child rearing practices may be a precursor of later depression - "in that these experiences can be internalised by the child and become elements of representations of self and of others, leading individuals to have negative cognitive schemas about themselves, their environment, and the future". In essence, this is an aetiologically focused extension of both Beck's (1976) cognitive and Abramson *et al.*'s (1989) hopelessness theories. Beck's concepts of negative schemas and dysfunctional attitudes and Abramson's concept of hopelessness and depressotypic attributional style emerge from internal working models, which are derived from early relationships with parents (Whisman & McGarvey, 1995).

In the process of integrating these theories toward a valuable approach in clinical practice, it now seems necessary to examine the link between parental style and depression in some detail, with specific emphasis on how those relationships might be mediated. The next section will demonstrate how this aim of the present study will be achieved.

### **1.6. Parental Style, Core Beliefs, and Depression.**

Traditionally (and somewhat simplistically), cognitive theory has been renowned for concentrating on the here-and-now, whilst psychoanalytic theory dwells on early childhood experience. However, as the trend towards more individually tailored therapy continues, together with increasing respect for clients' choice and wishes, it is becoming necessary to address both aspects in an integrated approach. It follows, then, that examining the longer-standing deep-rooted issues within a cognitive framework would be the next step to advancing knowledge about psychological disorders. The present study, therefore, aims to understand whether the problem of depression in adulthood has any roots in the parental styles individuals received (perceived now, as adults). It assumes that this relationship might be mediated by specific core beliefs (or schemas).

Of course, retrospective studies such as this always encounter the problem of subjective information differentially processed by subsequent experiences, with little access, if any, to objective evidence to verify reports. However, since psychological therapy is based on alleviating emotional distress for individuals (which itself is subjective), it remains important to conduct such research to inform clinical practice (even with its scientific limitations).

Intuitively, one assumes that a child's upbringing will impact upon its adult life and recent research on interpersonal studies highlight the importance of significant relationships. Although many children seem to show a resilience in the face of adversity, evidence indicates that abnormal or disrupted relationships with significant parenting figures in childhood may play a role in the later development of dysfunctional parenting, personality, and other severe adult psychopathology. For example, accounts by psychiatric patients reveal high rates of losses and separations (as well as abuse and neglect) in childhood. Although prospective studies are now beginning to trace the effects of these types of experience in greater detail, very little is still known of the means by which developmental continuities from infancy through adulthood may be mediated Patrick *et al.* (1994).

The association between the quality of parent-child relationships and depression has been empirically established (Parker and Gladstone, 1996; Plantes, *et al.*, 1988), with the aid of instruments such as the Parental Bonding Instrument (PBI) to measure the perceived quality of parenting styles. Prior to these measures, researchers examined the incidence of parental loss among depressed people in order to assess the importance of the quality of early experiences with parents in the development of adult depression. However, links between relationships with significant caregivers and depressotypic cognitions have yet to be examined. For example, even though Beck's cognitive model of depression, as early as 1967, explicitly attributed the development of negative schemas and cognitions to a critical, disapproving parent, it is only in recent years that the tools have been developed to enable the investigation of these links with more objective, scientific procedures. Whether this is a reflection of societal resistance to admitting the existence of

abusive and neglectful parenting styles remains a matter for debate. However, the aim of this study is to fill this niche by directly addressing the nature of the relationships between negative schemas, parental style and depression, with the aid of the standard model building procedure that Whisman and Kwon (1992; cited in Parker, 1993) used in their study. They argued that five conditions are required to demonstrate that cognitive vulnerability factors mediate any relationship between “parental representations” and depression:

1. parental representations must correlate with depressive symptoms - but
2. be eliminated or substantially reduced when cognitive vulnerabilities are controlled;
3. cognitive vulnerabilities must correlate with depressive symptoms - and
4. remain significant when parental representations are controlled; and
5. parental representations must correlate with cognitive vulnerabilities.

Whisman and Kwon (1992) tested a model proposing that the relationship between parental style and depression is mediated by dysfunctional attitudes using the above procedure. Their findings supported the hypothesis that depressotypic attitudes and attributional style components mediate the relationship between parental *care* and symptoms of depression, but this was not the case for parental overprotection (or control). However, they highlighted important caveats about their study. Using a student sample may have caused the BDI scores to represent “diffuse maladaptive functioning” rather than depression. Both recall and response biases may inflate relationships between constructs. Finally, similarities in item content between the BDI and the cognitive vulnerability measures may again be responsible for inflated links.

Parker himself (1993) conducted a similar study using participants with clinically significant depression. He added the broad dimension of “negative cognitive schemas” by including measures of neuroticism, self-esteem, locus of control and dysfunctional attitudes. Unfortunately, he failed to find significant links between PBI scores and depression levels for his sample, so was only able to speculate on his results.

### **1.7. The Present Study:**

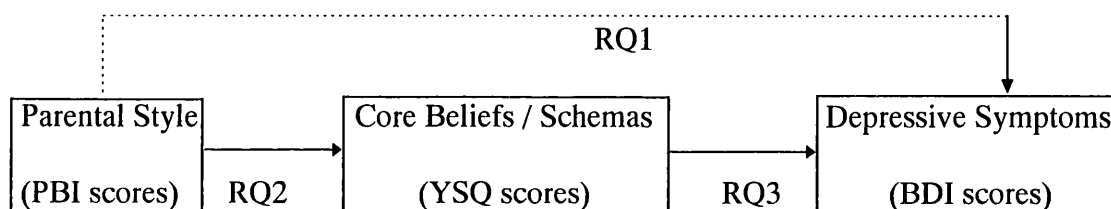
In a recent meta-analysis of cognitive theories of depression, Haaga *et al.* (1991) concluded that there is little convincing support for causal hypotheses of cognitive theory, but at the same time it would be premature to abandon them. They suggest that, for example, the idea of dysfunctional beliefs being stable is not supported by the evidence from longitudinal research on remitted depressives. However, they counter this assertion by pointing out that most of these studies did not use procedures suitable for priming latent beliefs, and therefore the hypotheses remain viable. Beck (1987) has defined *causal* or aetiological models as delineating the distal (or predisposing) factors and the proximal (or precipitating) factors in the genesis of depression. He suggests that these factors combine in varying proportions in a given case, to form the final common pathway that leads to the activation of depression. This study is concerned with the contribution made by the distal factor, parental style, to this pathway to depression.

This present study builds on the idea that the relationship between parental style and depression is mediated by negative cognitive schemas. It differs from Parker’s (1993) study in two ways. Firstly, it uses two groups, a clinical, depressed

group and a non-clinical, comparison group. Secondly, a much more refined and extensive measure of core beliefs is used - Young's Schema Questionnaire (YSQ), recently developed as a standardised tool for clinical practice.

### **1.7.1. Proposed Model:**

This study proposes a linear relationship between parental style (as measured by the PBI) and depression (as measured by the BDI). It proposes that this link would be mediated by core beliefs or schemas (as measured by YSQ). Therefore, the proposed model can be represented diagrammatically:



In order to test this model, it is necessary first to establish whether there is a link between PBI scores and BDI scores. Only then would it be possible, logically, to investigate whether or not this link is mediated by core beliefs. The four research questions below outline the process whereby, at the conclusion of this study, it will be possible to either confirm, refute or modify the proposed model.

### **1.7.2. Research Questions:**

This study addresses four primary research questions with a view to systematically testing the proposed model:

RQ 1. Is there a link between parental style and depression?

RQ 2. Is there a link between core beliefs and parental style?

RQ 3. Are core beliefs related to depression?

RQ 4. Is the link between parental style and depressive symptoms mediated by core beliefs?

By testing the associations between parental style, core beliefs and depression in pairwise correlations, it is possible to build a model of causal relationships using the statistical technique, multiple regression analysis. This method can test for mediating effects (e.g., Baron & Kenny, 1986).

In this chapter, the case has been made for conducting the present study. Depression continues to be a widespread problem. Current interventions are proving to be unsatisfactory to clients. The need to develop an understanding of the aetiology of depression seems to be the way forward. This is encouraging different schools of psychological thought to combine their knowledge into a more integrated approach. This approach is characterised by the fact that it aims to understand presenting emotional distress in the light of both early childhood experiences and current environmental factors. The present study investigates the relationship between one source of the early childhood experience - parental style - and depression in adulthood. This is done within the cognitive framework, using recent developments in cognitive theory, as this approach lends itself to empirical analysis and is becoming the central focus in the integration process.



## **2. CHAPTER TWO: METHOD**

### **2.1. Overview of Chapter Two:**

This study examined the link between parental style and depression, and investigated whether this link is mediated by core beliefs. It utilised tools commonly available in clinical practice to measure the various constructs. The Beck Depression Inventory (BDI) was used to assess the level of depression; the Parental Bonding Instrument (PBI) was used to measure parental style; and Young's Schema Questionnaire (YSQ) was used to identify the core beliefs. The data collected were quantitative in the main, but participants were encouraged to offer comments where appropriate, both verbally and in writing. Also, there was a section requesting them to describe their relationships with their parents in their own words. This qualitative information adds substance to what could otherwise be quite a "dry" study.

### **2.2. Design:**

This study was a quasi-experimental design, comparing groups on several measures and identifying patterns of association. It was an exploratory study, investigating correlational links in an attempt to develop a better understanding of the aetiology of depression. The between-subjects variable was the grouping factor (individuals with a history of depression and a comparison group without a history of depression). The participants in the comparison group were not screened to exclude depressed individuals or those with a history of depression. Given the incidence and prevalence of depression, it would not be surprising to find a proportion of the individuals in the comparison group taken from a community sample to be depressed or have a history of depression. Therefore, the groups will be referred to as 'clinical'

(those linked into services for depression) and ‘non-clinical’ (those not receiving any help for depression) rather than ‘depressed’ and ‘comparison’ or ‘control’ groups.

An important strength of this study was that it used a more varied, and hence, representative sample than many other studies investigating depression (which often use student populations). Nolen-Hoeksema (1987) concluded that gender differences in unipolar depression are not so significant in undergraduate populations.

Therefore, with this sample it was possible to consider and investigate gender differences in some aspects of the study.

#### *2.2.1. Statistical Power:*

Using Cohen’s criteria for statistical power (Cohen, 1992) for this postal questionnaire study, it was deemed necessary to obtain at least fifty participants in each group in order to carry out the stringent statistics on the data required to test the proposed model. He estimated that in order to obtain a medium effect size at  $p < .05$  significance for statistical techniques such as multiple regression, it would be necessary to recruit at least 67 participants. Therefore, since there were 70 members in each group, it was possible to use the large volume of data collected to explore patterns of association (between core beliefs, parental style and depression) with confidence.

### **2.3. Selection and Recruitment of Participants:**

#### *2.3.1. Sample Size and Response Rates:*

Altogether, 140 people took part in this study by completing and returning their questionnaires. There were even numbers (70) in each of the two groups -

clinical and non-clinical. For a comprehensive description of the characteristics of the sample, see sections 3.2. and 3.3.

It is difficult to calculate the response rate accurately, as a proportion of the questionnaires were administered by other professional colleagues. However, 57% of the questionnaires administered to the non-clinical group were returned; 42% of those to members of Depression Alliance were posted back; but only about 20% of the questionnaires intended to reach depressed outpatients were returned. The overall response rate was about 42% for this study.

### *2.3.2. General Inclusion and Exclusion Criteria for all Participants:*

All participants were adults, literate and with a good command of the English language. They were all volunteers, who were informed of the study and invited to participate.

### *2.3.3. Selection of Participants for the Clinical Group:*

Participants with a history of depression were recruited from several sources; mainly from members of Depression Alliance, a national self-help organisation, but also from various outpatient departments in the region.

Depression Alliance: In liaison with the Co-ordinator of the Depression Alliance London meetings, I attended regular group meetings held across London and the surrounding areas. I was usually asked to use the whole session to inform members of Depression Alliance about my study and to invite them to participate. Those that were willing to do so took the relevant information sheet, consent form (Appendices 4 and 5) and questionnaires away with them, together with a stamped addressed envelope (SAE), so that they could complete and return the measures in their own time. It was necessary to stress the negative as well as the positive aspects of

participating in this study, and the fact that they were under no obligation to take part. All individuals who were willing met the inclusion criteria (see 2.3.2.). The history and current state of depression was determined by their responses on the questionnaire.

Outpatient Departments: After obtaining ethical permission, I approached several Departments in order to inform clinicians - Psychologists, Counsellors, Psychotherapists - about this research study. I asked them to administer the questionnaire to clients who were suffering from a depressive episode. The clinicians were also requested to complete a short form (Appendix 6), mainly with regard to co-morbidity. Clinicians were encouraged to use the administration of the questionnaires as a means of therapeutic intervention if they felt it was appropriate to move on “stuck” clients.

#### *2.3.4. Selection of Participants for the Non-Clinical Group:*

Participants for the control group were also recruited from several different sources. Most came from a central London Friday night dance class venue attended by a wide cross-section of people. Others were members of a church or personal contacts.

Dance Class: After obtaining permission from the organiser, I made a short announcement from the platform inviting people to participate in this research study. Those who were interested approached me during the course of the evening to obtain more information. Those that were willing to participate took away the relevant information sheet, consent form (Appendices 4 and 5) and a copy of the questionnaires, together with a SAE so that they could complete the form in their own time and return it directly to me. Again, it was necessary to highlight the

negative aspects of doing the study, in order to maximise the response rate and minimise cost. After a few weeks had lapsed, there had been a poor response rate. A further announcement was made to remind those that had taken questionnaires to complete and return them.

Church meeting: Similarly, I made an announcement at a morning service. Willing participants took away the questionnaire package, together with a SAE.

Personal Contacts: A wide variety of personal contacts showed an interest in participating in this study, and their help was gratefully received. In particular, colleagues and friends of my older siblings made a substantial contribution, which added to the strength of this study in being conducted on a more representative community sample.

## **2.4. Procedures:**

### *2.4.1. Ethical Procedures:*

Ethical approval was requested and granted (see Appendix 3) from four separate committees:

- The Joint UCL/UCLH Committees on the Ethics of Human Research (The University College London Hospitals), to cover the healthy volunteers and those members of Depression Alliance who participated in the study.
- Harrow Research Ethics Committee for the outpatients recruited from Northwick Park Hospital.
- Hounslow District Research Ethics Committee for the outpatient recruited from West Middlesex University Hospital NHS Trust.

- Essex Rivers Healthcare Research Ethics Committee for the outpatients recruited in Colchester and Clacton.

#### *2.4.2. Administration Procedures:*

A variety of procedures were employed to administer the questionnaires to willing volunteers (see sections 2.3.3. and 2.3.4.). The majority of the participants were recruited by myself. I told them who I was, why I was doing this research, and what the research was about, as per the information sheet (see Appendix 4). Additionally, all these participants were informed about: the length of time it would take them to complete the pack of questionnaires; that doing this may leave them feeling somewhat more miserable because of the personal and negative nature of the questions; that they were under no obligation to take part; and to only take one if they were still willing and able to complete it (due to the cost of producing the packs). They were encouraged to complete *all* the questions and were invited to add comments if they wished to do so.

In the Depression Alliance group meetings, there was ample opportunity to discuss and clarify these instructions. This opportunity was more restricted in the recruitment of the non-clinical group, although I was still accessible to most of the individuals who took part.

When the completed questionnaires were returned, I removed the consent forms (which contained identifying information) to safeguard confidentiality. I then entered the raw data into SPSS (Statistical Package for Social Scientists), using the unique number on each questionnaire pack to identify the individuals. Once the dataset was complete, the total scores on the three standardised questionnaires (BDI,

PBI, and YSQ) were computed according to the appropriate scoring procedures for each. The data were then analysed to test the proposed model (see section 2.6.2).

#### *2.4.3. Qualitative and Demographic Information:*

The first part of the questionnaire pack requested non-identifying personal details from the participants, and was designed specifically for this study (see Appendix 7). It was important to strike a balance between multiple choice questions and the opportunity for the participants to use their personal descriptions. This information was categorised into *demographic characteristics of the sample* and *psychological characteristics of the sample* (see sections 3.2. and 3.3.). The data obtained from the three “open-ended” questions were subsequently categorised at the discretion of the author.

There was also an opportunity for the participant to provide some qualitative information, describing their relationships with parental figures in their own words. Although these data were only used for anecdotal purposes in this study (see Discussion), they lend themselves to a more formal content analysis.

## **2.5. Measures:**

In order to test the proposed model, it was necessary to obtain as valid and reliable a measure of depression, parental style and core beliefs as possible. Therefore, three standardised self-report questionnaires used in clinical practice were chosen for this study.

#### *2.5.1. Beck Depression Inventory:*

The Beck Depression Inventory (BDI) is a widely used 21-item multiple choice self-report questionnaire (see Appendix 8), yielding a numerical score

reflecting the presence and severity of depressed mood. Each item is rated on a 0 to 3 scale, and inventory scores can range from 0 to 63. The total BDI score represents the severity of the particular symptoms experienced. Although the BDI is not indicative of the full clinical syndrome of depression, it is a reliable and well-validated measure of depressive symptomatology (see Beck, Steer and Garbin, 1988, for a review). It also has subscales reflecting cognitive-affective and somatic aspects of depression.

The BDI possesses high internal consistency and discriminant validity and has been shown in both psychiatric and student samples to possess high convergent validity with psychiatric ratings of depression severity (Bumberry *et al.*, 1978). Finally, the BDI is a sensitive screening device for current symptomatology, producing few or no false negatives when compared with DSM-III affective disorder diagnoses (Oliver and Simmons, 1984). Beck *et al.* (1988) reported a mean alpha coefficient of .81 for use with non-psychiatric populations.

#### 2.5.2. *Parental Bonding Instrument:*

The Parental Bonding Instrument (PBI) (Parker *et al.*, 1979) is a 25-item self-report measure, which focuses on an individual's judgements concerning the parental contribution to the parent-child relationship (see Appendix 9). It assesses participants' perceptions of their parents during their childhoods, asking adult respondents to rate each parent or parental figure as they remembered them during their first sixteen years of life. Ratings of maternal and paternal "care" and "overprotection" are generated from the scores. Care involves, at one extreme, parental affection, warmth, and empathy. At the other extreme, it involves coldness, indifference, and rejection. The dimension of overprotection or control ranges from



intrusiveness and infantilisation through to the detached promotion of independence. The degree of agreement with the statements is indicated using a 4-point Likert scale (scored 0-3). The group of statements connected with *care* include “Spoke to me with a warm and friendly voice” and “Did not seem to understand what I needed or wanted”, and those with *control* or *overprotection* include “Let me decide things for myself” and “Invaded my privacy”.

The PBI is highly reliable and is insensitive to the effects of the respondent’s mood. There is considerable support for its validity as a measure of both actual and perceived parenting, based on studies using family corroborative witnesses, twin studies (Neale *et al.*, 1994; MacKinnon *et al.*, 1993), and studies using independent raters. It is a psychometrically stable instrument, has high test-retest reliability and internal consistency, and is not much affected by personality characteristics (Parker, 1989). Perhaps most importantly, research suggests that the PBI is a valid measure of actual (not merely perceived) parental characteristics (Parker, 1989; Parker & Lipscombe, 1981).

In previous studies, both borderline personality disorder and chronic depression have been linked with reports of low care and high overprotection (Patrick *et al.*, 1994). While the combination of low care and high overprotection may at first seem contradictory, it is perhaps helpful to think of parents who are emotionally inaccessible and unwilling to offer any comfort to a distressed child, yet who are also demanding and intrusive.

### 2.5.3. *The Schema Questionnaire:*

The Schema Questionnaire (Young, 1990; revised 1991) is a 205-item self-report inventory designed to measure 16 early maladaptive schemas (EMSs) (see

Appendices 2 and 10) or core beliefs. It was developed using five independent samples with over 1,500 participants. It is a relatively new instrument and, as such, its psychometric properties have not been rigorously developed and assessed with a variety of populations. However, Schmidt *et al.* (1995) have shown that its primary subscales possess adequate test-retest reliability and internal consistency. The YSQ has also been found to possess convergent and discriminant validity with respect to measures of psychological distress, self-esteem, cognitive vulnerability for depression, and personality disorder symptoms (Schmidt *et al.*, 1995).

Schmidt *et al.* (1995) have acknowledged that their use of a non-clinical student sample was a limitation, and have expressed reservations about using only self-report for the assessment of core beliefs. However, they conclude that the YSQ is a promising tool for clinical and research use, with the proviso that some YSQ items may overlap with current symptomatology and life events stress.

The decision to use the YSQ in this study (even though it is lengthy and therefore difficult to administer as part of a research project) was based on the fact that it yields information about crucial beliefs by asking very direct questions. It is becoming increasingly necessary to search for the roots of emotional distress, and this instrument makes a bold attempt to do this by asking participants to rate statements such as “I often get angry and irritable if I don’t get what I want” and “I’m not confident in my ability to solve everyday problems as they come up”. These items are rated on a six-point scale, ranging from 1 = “completely untrue of me” to 6 = “describes me perfectly”. It is hoped that this study will validate the use of this instrument with data from a community and depressed samples.

## **2.6. Data Analysis:**

### *2.6.1. Demographic and Psychological Factors:*

In the main, frequencies and percentages were used to present the categorical demographic and psychological data collected. The Chi-square test was used to measure differences between the two groups (clinical and non-clinical) on categorical data where appropriate (i.e., where the observed and expected frequencies in the cells were large enough to warrant a test for difference).

To measure the differences between the two groups in the scores on the three standardised questionnaires (BDI, PBI and YSQ), independent t-tests were used. Levene's Test for Equality of Variance was used to test the homogeneity of the data, and unequal variance t-tests were used where appropriate. Samples of this size (70 in each group) are likely to be relatively normally distributed, although there may be some variation in the "shape" of the normal distribution between the two groups.

The scores on all three questionnaires were also analysed with respect to gender, both in the two groups separately and combined as a total sample population, using independent samples t-tests. The findings are reported in section 3.2.2.7.

### *2.6.2. Testing the Proposed Model:*

Firstly, Pearson correlations, for parametric data, were computed to test all the pairwise links in the proposed model (PBI - BDI scores; PBI - YSQ scores; and YSQ - BDI scores). Then, multiple regression analysis was used with the variables that involved the significant correlations, to build and test the proposed model for the clinical and non-clinical groups separately (Baron & Kenny, 1986). The research questions systematically guide this line of inquiry.

#### 2.6.2.1. Is there a link between parental style and depressive symptoms?

Linear regression enter method was used on SPSS (ver. 7.5) to calculate the size of the contribution made by parental style (independent variable) in accounting for the variance in the dependent variable (depression). The calculations were carried out separately for the two groups (clinical and non-clinical). Each measure of depression (cognitive-affective, somatic, and total BDI score) was the dependent variable in separate calculations. Only those parental styles found to be significantly correlated to the BDI score in question were used in the list of independent variables. The results were presented as percentage values (Adjusted  $R^2 \times 100$ ).

#### 2.6.2.2. Is there a link between core beliefs and parental style?

This technique was repeated to calculate the size of the contribution made by core beliefs (those that were found to correlate with the parental style) to parental style(s) (dependent variable(s)). Again, the results were presented as percentage values (Adjusted  $R^2 \times 100$ ).

#### 2.6.2.3. Are core beliefs related to depression?

Finally, the size of the contribution made by the core beliefs (which were found to be significantly associated with the appropriate parental style) in accounting for the variance in depression scores were calculated, using the appropriate BDI scores as dependent variables. Adding this percentage (Adjusted  $R^2 \times 100$ ) to the diagram of the proposed model completed it. All the pairwise links were established.

#### 2.6.2.4. Is the link between parental style and depressive symptoms mediated by core beliefs?

Having established which core belief(s) and parental style(s) make significant contributions to the predictability of depressive symptoms in adulthood, it was then

possible to test whether the relationship between parental style and depression was independent of, or mediated by core beliefs. Using the linear multiple regression block enter method, with the BDI score entered as the dependent variable, the core beliefs (associated with the parental style in question, and shown to make significant contribution to that BDI score) were entered in the first block, and the parental style (which made a significant contribution to account for the variance in that BDI score) was entered in the second block.

If the results of this computation show that the parental style (in the second block) no longer make a significant contribution to account for the variance in the BDI scores, then the core belief(s) are said to be *perfect* mediator(s). This would support the proposed model, which suggests that certain parenting styles (experienced in childhood) cause people to have dysfunctional beliefs about themselves, which then causes depression in adulthood.

If the result of the same computation indicate that the contribution made by the parental style (in accounting for the variance in the BDI score) is considerably weakened ( but continues to be significant) compared to the result from research question one, then the core belief(s) are said to be *imperfect* mediator(s).

If the parental style in question continues to make the same contribution to the predictability of depression, even after the effects of the core beliefs have been partialled out, then the mediation model is not supported and the relationship between parental style and depression is found to be independent of core beliefs. In this way, it is possible to build and test the proposed model.

### *2.6.3. Which core beliefs are the best predictors of depression?*

Finally, the data from this study lend themselves to answer this clinically relevant question (as a subsidiary to research question three), aside from the main aim of testing the proposed model. I thought this was important enough to warrant a section devoted to it. Statistically, one must acknowledge the likelihood of Type I errors when conducting numerous correlations (2.4 of the 48 correlations (3 x 16) are likely to be significant by chance). However, using the data from this study to rank order the core beliefs that most frequently feature in depression could provide some valuable information for clinicians.

The linear multiple regression enter method was used to identify the core belief(s) (independent variables) (out of all sixteen) which made a significant contribution in accounting for the variance in BDI scores (dependent variable - separate computations for cognitive-affective, somatic, and total scores). These calculations were carried out separately on the two groups (clinical and non-clinical).

Those core beliefs found to make a significant contribution (those that were almost significant (i.e.,  $p < .10$ ) were also included in this calculation to ensure that the most influential core beliefs were retained in the analysis) were then used in linear multiple regression stepwise method. Again, the BDI score in question was entered as the dependent variable, and the identified core beliefs were the independent variables. This method was used to rank the core beliefs in order of size of contribution each one made in accounting for the variance in the BDI scores. The results were presented in tabular format (see section 3.5.1.).

### **3. CHAPTER THREE: RESULTS**

#### **3.1. Overview of Chapter Three:**

The overall aim of this chapter is to test the model proposed in the Introduction, using Baron & Kenny's (1986) the mediator framework. It will aim to answer these research questions as clearly and concisely as the data will allow. However, it is important to remember that this is an exploratory study, and as such is investigating correlational links and attempting to identify factors significant in gaining a better understanding of depression. Therefore, the research questions are deliberately broad, to engender a curious spirit, but are contained by the proposed model.

This chapter will be divided into four parts. Part one will present the demographic and psychological characteristics of the sample. Part two will systematically test the proposed model, in relation to the data collected from the clinical group. Part three will do the same for the data from the non-clinical group. The final part will use the data to highlight some clinically relevant information and conclude the chapter with a summary of the main findings.

#### **3.2. PART ONE: Demographic and Psychological Characteristics of the Sample:**

##### **3.2.1. Demographic Characteristics of the Sample:**

In this section, I will describe the demographic characteristics of the sample who participated in this study. Altogether 140 people took part, with equal numbers (70) in each of the two groups (clinical and non-clinical group). The participants in the clinical group were 22 (31%) outpatients and 48 (69%) members of Depression Alliance.

### 3.2.1.1. Gender and Age:

Table 1 shows the distribution of the sample with respect to gender.

*Table 1: Number of male and female participants in the two groups:*

<b>Gender</b>	<b>Non-clinical group (% of group)</b>	<b>Clinical group (% of group)</b>	<b>Total (% of whole sample)</b>
<b>Male</b>	34 (49%)	23 (33%)	57 (41%)
<b>Female</b>	35 (50%)	47 (67%)	82 (59%)

One person in the non-clinical group failed to complete any personal demographic information. The male to female ratio for this sample was 1:1.4 respectively. There were twice as many females in the clinical group as males, whereas the gender ratio within the non-clinical group was more balanced. A Chi-square test showed a significant difference between the depressed and non-clinical group ( $\chi^2_{[2]} = 3.87$ ,  $p < .05$ ) in terms of gender.

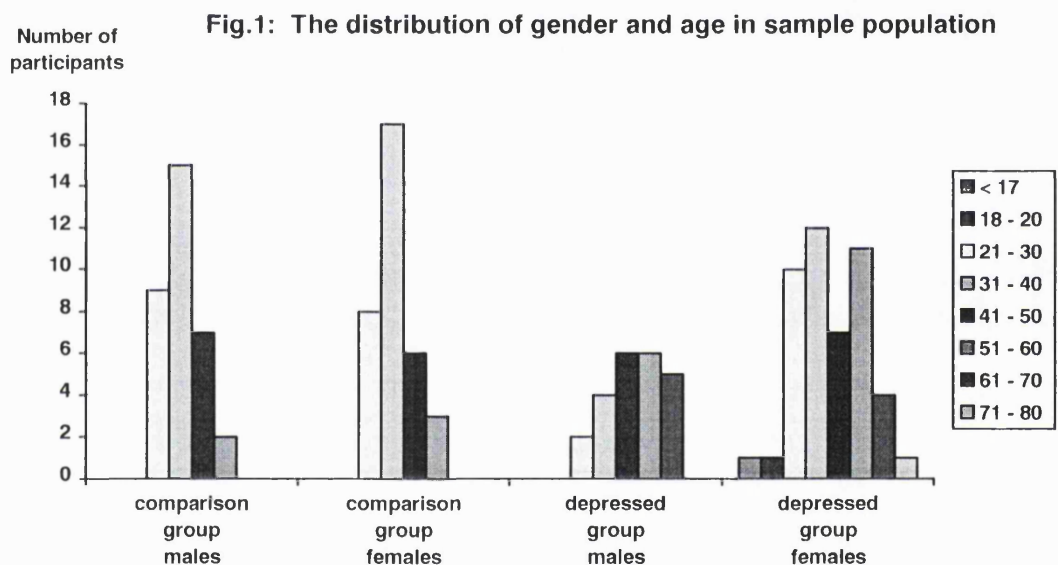
Table 2 describes the sample in terms of age.

*Table 2: The distribution of age in the two groups:*

<b>Age Range</b>	<b>Non-clinical group (% of group)</b>	<b>Clinical group (% of group)</b>	<b>Total (% of whole sample)</b>
<b>&lt; 17</b>	0 (0%)	1 (1%)	1 (1%)
<b>18 - 20</b>	0 (0%)	1 (1%)	1 (1%)
<b>21 - 30</b>	17 (25%)	12 (17%)	29 (21%)
<b>31 - 40</b>	32 (47%)	16 (23%)	48 (35%)
<b>41 - 50</b>	14 (21%)	13 (19%)	27 (20%)
<b>51 - 60</b>	5 (7%)	17 (24%)	22 (16%)
<b>61 - 70</b>	0 (0%)	9 (13%)	9 (7%)
<b>71 - 80</b>	0 (0%)	1 (1%)	1 (1%)



Almost all the participants were adults, apart from one who was a 15 year old who attended Depression Alliance meetings. Seventy-six percent of the participants in this study were between the ages of 21 - 50 years. There was a significant difference between the two groups in terms of age ( $\chi^2_{171} = 24.75, p < .001$ ). There was a wider age range among the clinical group, with more older adults, but both groups' ages were reasonably normally distributed. Figure 1 shows this wider age range graphically, as well as the variation in distribution of gender in the two groups.



### 3.2.1.2. Marital and Family Status:

Table 3 shows the sample in terms of marital status. In this sample, 39% had never been married, 44% were married, cohabiting or in a stable relationship, and 17% were either divorced, separated or widowed. There were more participants in the clinical group who were divorced or widowed, but this effect might be explained by the difference in ages between the two groups. There was no significant

difference in marital status between the clinical and non-clinical groups ( $\chi^2_{[6]} = 8.58$ , NS).

*Table 3: Marital status in the two groups:*

<b>Marital Status</b>	<b>Non-clinical group (% of group)</b>	<b>Clinical group (% of group)</b>	<b>Total (% of whole sample)</b>
<b>Single (never married)</b>	31 (45%)	23 (33%)	54 (39%)
<b>Divorced</b>	4 (6%)	10 (14%)	14 (10%)
<b>Separated</b>	4 (6%)	2 (3%)	6 (4%)
<b>Widowed</b>	1 (1%)	3 (4%)	4 (3%)
<b>Married</b>	26 (38%)	29 (41%)	55 (40%)
<b>Cohabiting</b>	0 (0%)	2 (3%)	2 (1%)
<b>In stable relationship</b>	3 (4%)	1 (1%)	4 (3%)
<b>Total</b>	69 (99%)	70 (100%)	139 (99%)

Table 4 shows how many of the participants in the two groups were parents and also contains some information about their dependants.

*Table 4: Family status in the two groups:*

<b>Family Status</b>	<b>Non-clinical group (% of group)</b>	<b>Clinical group (% of group)</b>	<b>Total (% of whole sample)</b>
<b>How many are parents?</b>	24 (35%)	38 (54%)	62 (45%)
<b>How many living with dependent children?</b>	20 (29%)	18 (26%)	38 (28%)
<b>How many not living with dependent children?</b>	1 (2%)	6 (9%)	7 (5%)
<b>How many with grown-up children?</b>	3 (4%)	14 (20%)	17 (12%)

The higher number of parents in the clinical group could again be a function of the age differences between the two groups. In total, 45% of the sample were parents. Similar numbers of participants in the two groups had children living with them, but as would be expected with the aforementioned age and divorce rate differences between the two groups, more depressed people had children who had grown up and left home or were not living with them.

Finally, and not surprisingly, 94% of the sample population were heterosexual. Four were unwilling to answer that question (all from the clinical group). Two individuals from the clinical group reported being homosexual, and one in each of the groups was bisexual.

### 3.2.1.3. *Employment Status:*

Table 5 shows the sample in terms of employment status.

*Table 5: Employment status in the two groups:*

<b>Employment Status</b>	<b>Non-clinical group (% of group)</b>	<b>Clinical group (% of group)</b>	<b>Total (% of whole sample)</b>
<b>Self-employed</b>	5 (7%)	4 (6%)	9 (7%)
<b>Employed (full-time)</b>	49 (71%)	17 (24%)	66 (48%)
<b>Employed (part-time)</b>	8 (12%)	8 (11%)	16 (12%)
<b>Unemployed</b>	1 (1%)	22 (31%)	23 (17%)
<b>Made redundant</b>	1 (1%)	1 (1%)	2 (1%)
<b>Retired</b>	2 (3%)	13 (19%)	15 (11%)
<b>Student</b>	3 (4%)	5 (7%)	8 (6%)
<b>Total</b>	69 (99%)	70 (100%)	139 (99%)

Almost 50% of the sample were in full-time employment, but this was largely due to a high employment rate among the non-clinical group. 96% of the unemployment in this study was contained within the clinical group. Also, there were six times as many retired people in the clinical group, but again this may be a reflection of the age differences between the two groups. Although there were comparable numbers in each of the two groups of those who were self-employed, employed on a part-time basis, made redundant, and students, there was a significant difference between the clinical and non-clinical groups ( $\chi^2_{[6]} = 43.36, p < .001$ ) probably due to this difference in level of full-time employment and unemployment.

Table 6 shows the kinds of occupations this sample were employed in.

*Table 6: Types of employment in the two groups:*

<b>Type of Employment</b>	<b>Non-clinical group (% of group)</b>	<b>Clinical group (% of group)</b>	<b>Total (% of whole sample)</b>
<b>Student</b>	5 (8%)	3 (4%)	8 (6%)
<b>Engineer / IT</b>	14 (21%)	6 (9%)	20 (15%)
<b>Manager / Sales</b>	10 (15%)	9 (13%)	19 (14%)
<b>Consultant / Director</b>			
<b>Administration / Secretarial / Accounts</b>	11 (17%)	11 (16%)	22 (16%)
<b>Housewife</b>	0 (0%)	4 (6%)	4 (3%)
<b>Caring Profession - doctor; nurse; police</b>	21 (32%)	9 (13%)	30 (22%)
<b>Teacher / Lecturer</b>	3 (5%)	3 (4%)	6 (4%)
<b>Other</b>	2 (3%)	25 (36%)	27 (20%)
<b>Total</b>	<b>66 (94%)</b>	<b>70 (100%)</b>	<b>136 (97%)</b>

There was a strongly significant difference between the clinical and non-clinical groups with regard to the types of occupation. The ‘Other’ category incorporated situations such as retirement and long-term sick leave, and therefore it is not surprising that the majority in this category were within the clinical group. It is worth noting that there were no housewives and twice as many engineers/IT and caring profession individuals in the non-clinical group as in the clinical group. Also, three people in the non-clinical group (in addition to the one who completed no personal demographic details) failed to provide this information.

#### **3.2.1.4. Ethnicity:**

How people described their ethnicity was difficult to categorise simply, but the method employed was to take the first “label” they applied as their description. On this basis, Table 7 shows the ethnicity of the sample for this study. It is worth noting that 9% of the sample did not complete this open-ended question.

*Table 7: Table showing how people describe their own ethnicity.*

<b>Ethnicity of the Sample: How people described their own ethnicity.</b>	<b>Non-clinical group (% of group)</b>	<b>Clinical group (% of group)</b>	<b>Total (% of whole sample)</b>
<b>British</b>	8 (13%)	13 (20%)	21 (17%)
<b>English</b>	7 (11%)	15 (23%)	22 (17%)
<b>White</b>	14 (22%)	26 (41%)	40 (32%)
<b>European</b>	2 (3%)	1 (2%)	3 (2%)
<b>Asian / Indian</b>	11 (18%)	3 (5%)	14 (11%)
<b>Black</b>	2 (3%)	1 (2%)	3 (2%)
<b>White/European</b>	7 (11%)	2 (3%)	9 (7%)
<b>Other</b>	12 (19%)	3 (5%)	15 (12%)
<b>Total</b>	<b>63 (90%)</b>	<b>64 (91%)</b>	<b>127 ( 91%)</b>

The 'Other' category included people from Latin America and Australia. Seventeen percent of the sample population described themselves as "British" and another 17% used the label "English" to describe their own ethnicity. However, twice as many depressed people as individuals in the non-clinical group preferred to use "White" as a label, and this category made up a third of the total sample population. Similarly, of those who considered themselves "European" (9%), mainly in the non-clinical group, 7% qualified their label as "White European". There were 11% of "Asian/Indian" origin and three and a half times as many of these were in the non-clinical group as in the clinical group. Only 2% used the label "Black", again with the majority being in the non-clinical group rather than in the clinical group.

#### **3.2.1.5. Religion:**

The rules used to categorise how participants described their religion were similarly arbitrary, but where individuals named a type of religion and specified that they were non-practising, they were categorised as "Agnostic". On this basis, Table 8 shows the religious orientations of this sample.

There was a significant difference between the clinical and non-clinical groups ( $\chi^2_{[7]} = 23.46, p < .001$ ). Interestingly, the same number of individuals labeled themselves as either "Christian" or "Church of England", but the proportions between the two groups were almost exactly reversed. This may be a reflection of one of the sources of participants for the non-clinical group being from a church, but there was not a very big response rate from there. There were six times as many Hindus in the non-clinical group as the clinical group, but they only accounted for 5% of the total sample population. However, 10% of the total population was in the

“Other” category, and there were 12 times as many of these in the clinical group as in the non-clinical group. This included “Buddhism”, “Pagan”, “Islam”, “Christian Spiritualist” and “Sikh”.

*Table 8: Table showing how people describe their religious beliefs.*

<b>Religious Beliefs of the Sample:</b>	<b>Non-clinical group (% of group)</b>	<b>Clinical group (% of group)</b>	<b>Total (% of whole sample)</b>
<b>Christian</b>	22 (34%)	9 (13%)	31 (23%)
<b>Catholic</b>	9 (14%)	5 (7%)	14 (10%)
<b>Atheist</b>	8 (12%)	10 (15%)	18 (13%)
<b>Agnostic</b>	7 (11%)	9 (13%)	16 (12%)
<b>Church of England</b>	11 (17%)	20 (29%)	31 (23%)
<b>Protestant</b>	1 (2%)	3 (4%)	4 (3%)
<b>Hindu</b>	6 (9%)	1 (1%)	7 (5%)
<b>Other</b>	1 (2%)	12 (17%)	13 (10%)
<b>Total</b>	65 (93%)	69 (99%)	134 (96%)

### **3.2.1.6. Summary of demographic characteristics:**

Significant differences were found between the clinical and non-clinical groups on almost all of the dimensions measured (age, gender, co-habiting with children, employment status, type of occupation, ethnicity, religion). Only marital status and whether or not participants were parents were not significantly different between the two groups. While it is not possible to correct for all these variables in subsequent analyses, they should be noted as potential factors in influencing the outcome of those analyses.

### 3.2.2. Psychological Characteristics of the Sample:

In this section, I will describe the psychological characteristics of the sample who participated in this study, with particular emphasis on clinical depression.

#### 3.2.2.1. Subjective Reports of “Clinical Depression”.

The participants were asked whether they had ever been clinically depressed in the past, and whether they were so now. In asking this question, I was particularly interested in their subjective understanding of “clinical depression”. They were given three options: “Yes”, “No”, and “Don’t Know”. Some also chose to add a fourth category to this selection: “Sometimes”. Table 9 shows the distribution of responses to these two questions for this sample.

*Table 9: People’s subjective labelling of themselves as “clinically depressed”.*

<b>Clinical Depression within the Sample:</b>	<b>Non-clinical group (% of group)</b>	<b>Clinical group (% of group)</b>	<b>Total (% of whole sample)</b>
<b>History of Clinical Depression?</b>	Chi-square $\chi^2_{[2]} = 83.89^{***}$		
Yes	4 (6%)	56 (80%)	60 (43%)
No	59 (86%)	8 (11%)	67 (48%)
Don’t Know	6 (9%)	6 (9%)	12 (9%)
<b>Currently Clinically Depressed?</b>	Chi-square $\chi^2_{[2]} = 44.85^{***}$		
Yes	1 (2%)	31 (44%)	32 (23%)
No	60 (88%)	25 (36%)	85 (62%)
Don’t Know	6 (9%)	12 (17%)	18 (13%)
Sometimes	1 (2%)	2 (3%)	3 (2%)

\*\*\* p<.001



As would be expected, there was a significant difference between the clinical and non-clinical groups on both aspects of self-reported “clinical depression” (current and historical). However, it is worth noting at this point that 6% of the non-clinical group did report to having been clinically depressed in the past, and 9% were not sure. This highlights the fact that the non-clinical group was obtained from a representative community sample, and not screened to exclude depressed individuals. Given the incidence and prevalence of depression, it is not surprising that some individuals in the non-clinical group were currently depressed. Nine percent did not know whether they had ever been clinically depressed, suggesting perhaps that they did not have a clear understanding of the term “clinical depression”. Eleven percent of the clinical group reported no such history, suggesting that (for some at least) this may be their first episode of “clinical depression”.

Only 23% of the total sample population reported to being “clinically depressed” currently, as opposed to the expected 50%. As this is less than half the expected value for ideal experimental conditions, this may have some bearing when testing out the proposed model. The categorical BDI scores below (see Table 10) underscore this finding further, highlighting the difficulty of obtaining homogenous groups in a clinical population for experimental research.

*Table 10: Categorical analysis of BDI scores.*

<b>Level of Mood (BDI score)</b>	<b>Non-clinical group (% of group)</b>	<b>Clinical group (% of group)</b>	<b>Total (% of whole sample)</b>
<b>Normal / Asymptomatic (BDI score &lt; 9)</b>	50 (76%)	11 (18%)	61 (47%)
<b>Mild (BDI score 10 - 15)</b>	13 (20%)	14 (22%)	27 (21%)
<b>Mild - Moderate (BDI score 16 - 19)</b>	1 (2%)	9 (14%)	10 (8%)
<b>Moderate to Severe (BDI score 20 - 29)</b>	2 (3%)	13 (21%)	15 (12%)
<b>Severe (BDI score &gt; 29)</b>	0 (0%)	16 (25%)	16 (12%)
<b>Total</b>	<b>66 (94%)</b>	<b>63 (90%)</b>	<b>129 (92%)</b>

Note.<sup>1</sup>

Eight percent of all the BDI questionnaires (6% of the non-clinical group and 10% in the clinical group) were not completed correctly, and therefore those data could not form a part of the above analysis. However, there was a significant difference between the two groups' severity of depressed mood, as measured by the BDI ( $\chi^2_{[4]} = 55.40, p < .001$ ).

### **3.2.2.2. Types of Treatment for Depression Experienced by the Sample**

#### **Population.**

The other important information collected from the participants with regard to their depression (if any) was the open-ended question about the types of treatment they received, both in the past and currently. These data were categorised after collection, and Table 11 shows the frequencies of each of the treatment methods used in the past and currently.

<sup>1</sup>The BDI is rated on a 4-point ascending multiple choice scale ranging from 0 - 3, in which 0 is asymptomatic and 3 is symptomatic of depression.

*Table 11: Types of treatment for depression experienced by this sample.*

<b>Types of Treatment for Depression within the Sample:</b>	<b>Non-clinical group (% of group)</b>	<b>Clinical group (% of group)</b>	<b>Total (% of whole sample)</b>
<b>Treatment in the past:</b>			
Medication / ECT	1 (2%)	23 (33%)	24 (17%)
Psychotherapy / Counselling	0 (0%)	6 (9%)	6 (4%)
Psychotherapy + Medication	0 (0%)	17 (24%)	17 (12%)
Other Therapy e.g. Art, Group	2 (3%)	0 (0%)	2 (1%)
Other Therapy e.g. Art, Group + Medication	0 (0%)	1 (1%)	1 (1%)
Hospitalisation	0 (0%)	6 (9%)	6 (4%)
Other	1 (2%)	1 (1%)	2 (1%)
Everything	0 (0%)	5 (7%)	5 (4%)
Nothing	64 (94%)	11 (16%)	75 (54%)
<b>Total</b>	<b>68 (97%)</b>	<b>70 (100%)</b>	<b>138 (99%)</b>
<b>Current treatment:</b>			
Medication / ECT	0 (0%)	23 (33%)	23 (17%)
Psychotherapy / Counselling	1 (2%)	7 (10%)	8 (6%)
Psychotherapy + Medication	0 (0%)	11 (16%)	11 (8%)
Other Therapy e.g. Art, Group	0 (0%)	2 (3%)	2 (1%)
Other Therapy e.g. Art, Group + Medication	0 (0%)	4 (6%)	4 (3%)
Everything	0 (0%)	1 (1%)	1 (1%)
Nothing	67 (99%)	21 (30%)	88 (64%)
<b>Total</b>	<b>68 (97%)</b>	<b>70 (100%)</b>	<b>138 (99%)</b>

\*\*\*p<.001

As would be expected 54% of the total population (94% of the non-clinical and 16% of the clinical group) had never received any treatment for depression and 64% (98% and 30% respectively) were not receiving anything at the time of this study. Medication formed 39% of the treatment regime in the past for this sample, but only 29% were currently receiving medication as part of their treatment. However, 23% received other types of therapy (including psychotherapy) in the past, but only 19% of the total population were currently receiving these as part of their treatment regime. One person in the non-clinical group was currently receiving counselling, and four individuals from this group had received help in the past (one with medication, and three with other therapies).

### 3.2.2.3. Beck Depression Inventory (BDI) Scores.

This section examines the scores on the BDI for the clinical and non-clinical groups (see Table 12). The three BDI scores - cognitive-affective, somatic and total - were used in the analyses.

*Table 12: Description of the BDI scores for this sample.*

Factor measured	Non-clinical group		Clinical group		Independent t-test
	Mean (S.D.)	Minimum Maximum	Mean (S.D.)	Minimum Maximum	
<b>BDI cognitive/affective</b>	3.75 (3.51)	0 12	14.26 (8.51)	0 33	9.41 <sup>***</sup>
<b>BDI somatic score</b>	2.25 (2.21)	0 9	6.92 (4.12)	0 16	7.98 <sup>***</sup>
<b>BDI total score</b>	6.03 (5.07)	0 20	20.62 (11.91)	0 49	8.98 <sup>***</sup>

<sup>\*\*\*</sup>p<.001 Note:<sup>2</sup>

The mean total BDI score for the non-clinical group is in the “Normal / Asymptomatic” category, and the scores for the clinical group were in the “Moderate-Severe” category. Also, it is worth noting that the range of scores for the two groups differs tremendously (20 points for the non-clinical group; 49 points for the clinical group). The skewed nature of the data meant that equal variances could not be assumed when testing the two groups for differences in BDI scores, and t-tests were adjusted for unequal variances where appropriate.

<sup>2</sup> The BDI is rated on a 4-point ascending multiple choice scale ranging from 0 - 3, in which 0 is asymptomatic and 3 is symptomatic of depression. Total possible ranges are: cognitive-affective = 0 - 39; somatic = 0 - 24; total = 0 - 63.

### 3.2.2.4. Parental Bonding Instrument (PBI) Scores.

This section examines the scores on the PBI for the clinical and non-clinical groups (see Table 13).

*Table 13: Description of the PBI scores for this sample.*

Factor measured	Non-clinical group		Clinical group		Independent t-test
	Mean (S.D.)	Minimum Maximum	Mean (S.D.)	Minimum Maximum	
<b>PBI paternal care score</b>	24.69 (8.20)	0 36	16.84 (9.65)	2 36	4.86 <sup>***</sup>
<b>PBI paternal overprotection</b>	10.48 (7.01)	0 36	15.64 (7.62)	0 32	3.86 <sup>***</sup>
<b>PBI maternal care score</b>	26.74 (7.61)	5 36	19.66 (10.75)	0 46	4.23 <sup>***</sup>
<b>PBI maternal overprotection</b>	13.00 (8.65)	0 41	17.17 (7.34)	2 34	2.86 <sup>***</sup>

<sup>\*\*\*</sup> p<.001; Note:<sup>3</sup>

The PBI scores obtained for paternal care and overprotection and maternal overprotection were normally distributed, and those for maternal care were slightly skewed. However, with the appropriate adjustments for unequal variance in the t-tests, it is clear that the two groups (clinical and non-clinical) were significantly different from each other. These results indicate that depressed adults' perceptions of the parenting they received in the first sixteen years of their lives is substantially different (more overprotective, less caring) to those of individuals who do not have a history of depression.

<sup>3</sup> All variables were rated on a four-point anchored bipolar scale in which 1 = "very like"; 2 = "moderately like"; 3 = "moderately unlike"; 4 = "very unlike".

### ***3.2.2.5. Young's Schema Questionnaire (YSQ) Scores.***

This section examines scores on the Young's Schema Questionnaire (YSQ) for the clinical and non-clinical groups (see Table 14). The YSQ is scored in such a way as to enable the direct comparison of the 16 core beliefs (or schemas) it elicits. Different numbers of questions relate to each core belief, but by calculating the average scores of all the questions for each it is possible to obtain the item mean scores (see Table 14). Self-Sacrifice and Unrelenting Standards were the highest scores for the non-clinical group, whilst Self-Sacrifice and Emotional Deprivation were the highest scores in the clinical group. Ten out of the possible sixteen scales have a mean score below 2.00 in the non-clinical group, whereas all those in the clinical group are above that figure. The two groups differed significantly on all sixteen core beliefs (or schemas) measured by the YSQ.

### ***3.2.2.6. Summary of Psychological Characteristics.***

To summarise this section on the psychological characteristics of the sample, there were significant differences between the clinical and non-clinical groups on all of the factors measured by the three standardised questionnaires - the BDI, the PBI and YSQ. For the 23 factors measured, 22 were significant at the  $p < .001$  level and only one (Entitlement on the YSQ) was significant at the  $p < .05$  level.

*Table 14: Description of the YSQ scores for this sample.*

Factor measured	Non-clinical group		Clinical group		Independent T-test <sup>4</sup>
	Mean (S.D.)	Minimum Maximum	Mean (S.D.)	Minimum Maximum	
<b>YSQ Abandonment</b>	1.74 (0.75)	1.00 3.78	3.08 (1.26)	1.00 5.72	7.05 <sup>***</sup>
<b>YSQ Functional Dependence / Incompetence</b>	1.58 (0.71)	1.00 4.13	2.80 (1.16)	1.00 5.60	7.17 <sup>***</sup>
<b>YSQ Defectiveness / Shame</b>	1.52 (0.59)	1.00 3.33	2.97 (1.44)	1.00 5.87	7.43 <sup>***</sup>
<b>YSQ Emotional Deprivation</b>	2.20 (1.25)	1.00 5.22	3.77 (1.60)	1.00 6.00	6.39 <sup>***</sup>
<b>YSQ Emotional Inhibition</b>	2.02 (0.97)	1.00 5.00	3.49 (1.27)	1.22 6.00	7.42 <sup>***</sup>
<b>YSQ Enmeshment</b>	1.52 (0.66)	1.00 4.09	2.11 (1.00)	1.00 5.82	3.91 <sup>***</sup>
<b>YSQ Entitlement</b>	2.35 (0.73)	1.00 3.91	2.68 (0.91)	1.09 5.45	2.32 <sup>*</sup>
<b>YSQ Failure to Achieve</b>	1.72 (0.85)	1.00 5.67	3.06 (1.31)	1.00 6.00	6.90 <sup>***</sup>
<b>YSQ Insufficient Self-Control / Self-Discipline</b>	2.17 (0.61)	1.13 3.73	3.18 (1.04)	1.07 5.60	6.76 <sup>***</sup>
<b>YSQ Mistrust / Abuse</b>	1.98 (0.87)	1.00 4.18	3.16 (1.15)	1.29 5.53	6.68 <sup>***</sup>
<b>YSQ Subjugation</b>	1.92 (0.77)	1.00 4.00	3.14 (1.20)	1.00 5.80	6.92 <sup>***</sup>
<b>YSQ Social Isolation</b>	1.89 (0.89)	1.00 4.50	3.49 (1.60)	1.00 8.60	7.16 <sup>***</sup>
<b>YSQ Self-Sacrifice</b>	2.95 (0.74)	1.47 4.71	3.68 (0.86)	1.88 5.88	5.12 <sup>***</sup>
<b>YSQ Social Undesirability</b>	1.82 (0.73)	1.00 3.67	3.15 (1.17)	1.00 5.22	7.90 <sup>***</sup>
<b>YSQ Unrelenting Standard</b>	2.76 (0.73)	1.31 4.19	3.43 (0.97)	1.13 5.63	4.26 <sup>***</sup>
<b>YSQ Vulnerability to Harm and Illness</b>	1.96 (0.86)	1.00 4.50	3.04 (1.03)	1.07 5.21	6.63 <sup>***</sup>

<sup>\*</sup>p<.05 <sup>\*\*\*</sup>p<.001 Note:<sup>5</sup>

<sup>4</sup> Levene's Test for Equality of Variance was used to test the homogeneity of the data, and unequal variance t-tests were used where appropriate.

<sup>5</sup> All variable were rated on a six-point anchored unipolar scale ranging from 1 = "completely untrue" to 6 = "describe perfectly".



### 3.2.2.7. *Gender differences:*

Before concluding this section on the psychological characteristics of the sample, a short examination of gender differences within the sample seems appropriate. Independent-samples t-tests were computed on the scores from all three standardised questionnaires (BDI, PBI and YSQ) with respect to gender (both for the two groups separately, and for the whole sample).

In the non-clinical group, there were significant differences between the genders for three of the scales (BDI somatic scores:  $t = 3.28$ ,  $p < .01$ ; BDI total scores:  $t = 2.42$ ,  $p < .05$ ; and YSQ Emotional Inhibition scores:  $t = 2.07$ ,  $p < .05$ ). Equal variances could not be assumed for the somatic or emotional inhibition scores, but the BDI total scores were normally distributed between the genders in the non-clinical group.

For the clinical group, there were significant differences between male and female participants on BDI cognitive-affective scores ( $t = 2.61$ ,  $p < .05$ ), BDI total scores ( $t = 2.27$ ,  $p < .05$ ), and YSQ Entitlement scores ( $t = 2.36$ ,  $p < .05$ ). This time, the YSQ Entitlement scores were normally distributed, but equal variances could not be assumed for the two BDI scores.

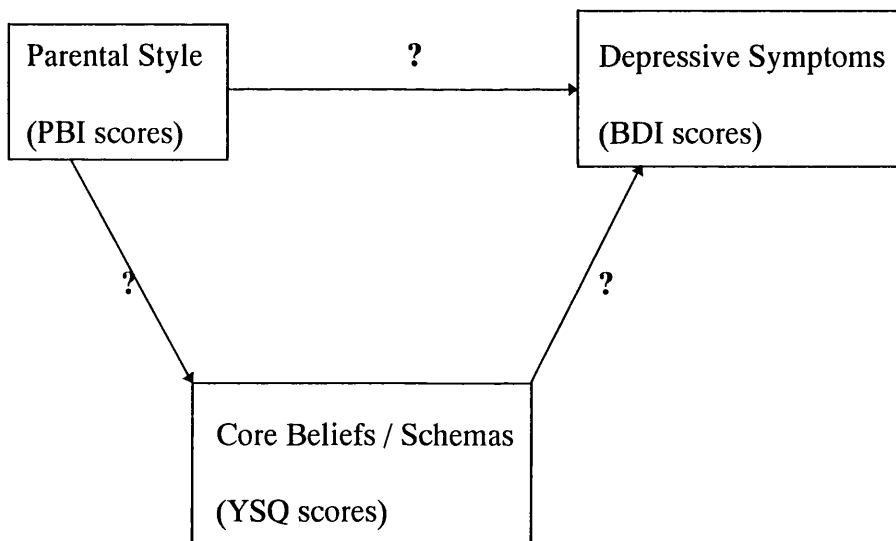
When the two groups were combined and gender differences examined for the total sample population (140 participants), significant differences between men and women were observed in five of the possible twenty-three scales: PBI maternal care scores ( $t = 2.32$ ,  $p < .05$ ); YSQ Self-Sacrifice scores ( $t = 2.46$ ,  $p < .05$ ); and all three BDI scores [somatic: ( $t = 3.13$ ,  $p < .01$ ); cognitive-affective: ( $t = 3.51$ ,  $p < .001$ ); and total ( $t = 3.48$ ,  $p < .001$ )]. However, only BDI somatic scores were normally distributed across the genders. These results will be discussed in the next chapter.

### **3.3. PART TWO: Application of the Proposed Model to the Clinical Group.**

In this part, the proposed model will be systematically tested (the four research questions will guide this inquiry), using the data collected from the clinical group.

#### **3.3.1. Proposed Model:**

This study proposed a linear relationship between parental style (as measured by the PBI) and depression (as measured by the BDI). It was proposed that this link would be mediated by core beliefs or schemas (as measured by YSQ). Therefore, diagrammatically, the model can be represented as:



*Figure 2: Proposed model.*

In order to test this model within a mediator framework (Baron & Kenny, 1986), it is necessary first to establish whether there is a link between PBI scores and BDI scores. Only then would it be possible, logically, to investigate whether or not this link is mediated by core beliefs. The four research questions below test this

model systematically, in order to either confirm, refute or modify the hypothesised model, as it applies to the clinical group in this sample.

### 3.3.2. Research Question 1: Is there a link between parental style and depressive symptoms?

In order to investigate whether there is relationship between adults' perceptions of the parental style they experienced in childhood and their clinical depression in adulthood, it is necessary to correlate the scores on the standardised questionnaires that measure these factors. Table 15 shows how parental care and overprotection were correlated with cognitive-affective and somatic symptoms of depression, as well as the overall score for depression.

*Table 15: Correlations between parental style and depression in the clinical group.*

	<b>BDI cognitive / affective score</b>	<b>BDI somatic score</b>	<b>Total BDI score</b>
<b>PBI paternal care score</b>	-.24 (N = 57)	-.11 (N = 53)	-.23 (N = 53)
<b>PBI paternal overprotection score</b>	.30* (N = 55)	.22 (N = 51)	.29* (N = 51)
<b>PBI maternal care score</b>	-.13 (N = 62)	.01 (N = 58)	-.10 (N = 58)
<b>PBI maternal overprotection score</b>	.04 (N = 60)	-.09 (N = 56)	-.01 (N = 56)

\*p<0.05

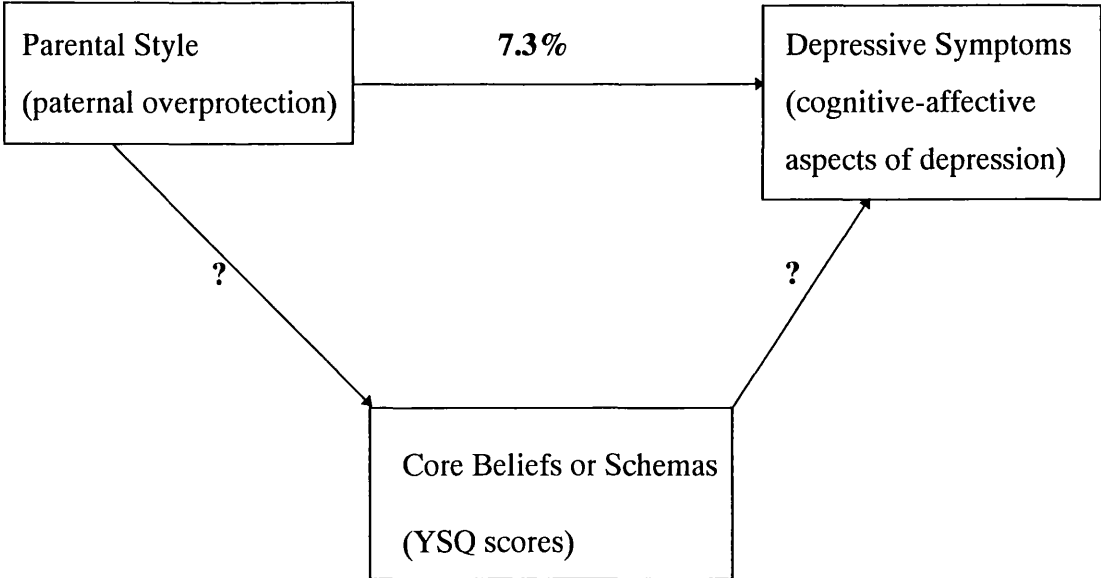
In the clinical group, paternal overprotection was significantly positively correlated with the cognitive-affective aspects of depression, and hence with the overall BDI score. The other PBI scales were unrelated to BDI scores. Therefore, only paternal overprotection was used in further analysis. The size of the

contribution made by paternal overprotection to the predictability of cognitive-affective and total BDI scores can be measured using linear regression analysis (see Table 16). The results indicate that 7.3% ( $F = 5.27, p < .05$ ) of the variance in cognitive-affective BDI scores and 6.6% ( $F = 4.55, p < .05$ ) of the total BDI scores is accounted for by paternal overprotection.

*Table 16: Regression summary: parental style and depression.*

Dependent variable	F	p	% Var	Independent variable	B	t	p
BDI cognitive affective scale	5.265	.026	7.3	PBI paternal overprotection	.346	2.29	.026

To summarise, paternal overprotection is related to the cognitive-affective aspects of depression among a clinical sample. By incorporating this information, the proposed model can be modified:



*Figure 3: Proposed model incorporating parental style and depression link in the clinical group.*

### **3.3.3. Research Question 2: Is there a link between core beliefs and parental style?**

Having established that there is a link between paternal overprotection and cognitive-affective symptoms of depression in the clinical group, the subsequent step in testing the proposed model systematically (Baron & Kenny, 1986) is to test the relationship between this parental style and core beliefs. Table 17 shows Pearson's correlations between parental style and core beliefs, for the clinical group. When conducting numerous correlations such as this ( $4 \times 16 = 64$ ) one must be aware of the possibility of Type I errors (that is, the likelihood of a number of findings being significant by chance). However, for the sixteen correlations related to paternal overprotection (which is the only parental style found to be relevant in testing this proposed model for the clinical group) these errors are negligible.

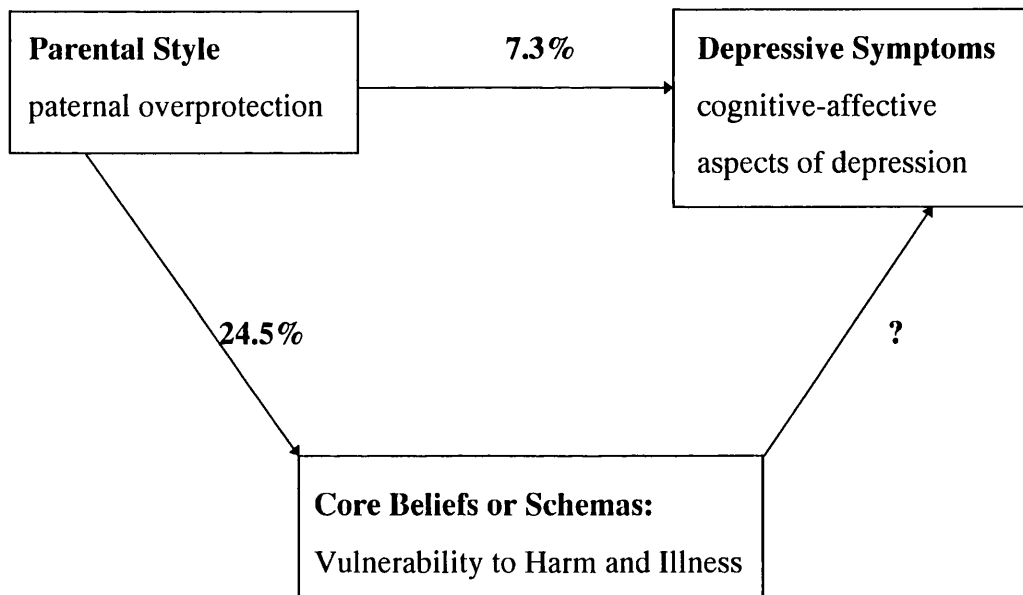
To summarise (see Table 17), less parental care is associated with more dysfunctional core beliefs. The majority of the significant relationships in the care scores for the clinical group were negatively associated with paternal care only. However, to develop the model further (see Figure 4), attention to the role of the father figure's overprotection is necessary. The clinical group showed significant relationships between *paternal* overprotection scores and only four of the core beliefs. Abandonment was negatively correlated, whilst the other three (Mistrust/Abuse, Social Isolation, and Vulnerability to Harm and Illness) were positively correlated with paternal overprotection.

*Table 17: Correlations between parental style and core beliefs in the clinical group.*

Core Belief / Schema	Clinical Group			
	PBI paternal care score	PBI maternal care score	PBI paternal overprotection score	PBI maternal overprotection score
<b>Abandonment</b>	-.40** (N = 49)	-.19 (N = 55)	-.46** (N = 47)	.26 (N = 54)
<b>Functional Dependence/ Incompetence</b>	-.21 (N = 54)	.09 (N = 59)	.22 (N = 53)	.21 (N = 57)
<b>Defectiveness/ Shame</b>	-.34* (N = 53)	-.08 (N = 58)	.20 (N = 51)	.20 (N = 56)
<b>Emotional Deprivation</b>	-.33* (N = 56)	-.40** (N = 61)	.25 (N = 54)	.22 (N = 60)
<b>Emotional Inhibition</b>	-.20 (N = 53)	-.11 (N = 58)	.08 (N = 52)	.16 (N = 56)
<b>Enmeshment</b>	-.02 (N = 51)	-.13 (N = 55)	-.15 (N = 50)	.26 (N = 53)
<b>Entitlement</b>	-.02 (N = 55)	-.11 (N = 60)	-.06 (N = 54)	.21 (N = 58)
<b>Failure to Achieve</b>	-.21 (N = 53)	-.03 (N = 57)	.10 (N = 51)	-.01 (N = 55)
<b>Insufficient Self-Control/Self-Discipline</b>	-.10 (N = 53)	.03 (N = 52)	-.10 (N = 52)	.01 (N = 56)
<b>Mistrust/Abuse</b>	-.37** (N = 55)	-.24 (N = 61)	.28* (N = 53)	.20 (N = 59)
<b>Subjugation</b>	-.40** (N = 54)	-.03 (N = 59)	.22 (N = 53)	.14 (N = 57)
<b>Social Isolation</b>	-.31* (N = 56)	-.19 (N = 61)	.32* (N = 54)	.26 (N = 59)
<b>Self-Sacrifice</b>	-.01 (N = 51)	-.15 (N = 55)	.08 (N = 50)	.12 (N = 53)
<b>Social Undesirability</b>	-.33* (N = 56)	.03 (N = 62)	.23 (N = 54)	.02 (N = 60)
<b>Unrelenting Standards</b>	-.27* (N = 52)	-.07 (N = 57)	.16 (N = 50)	.03 (N = 55)
<b>Vulnerability to Harm and Illness</b>	-.33* (N = 56)	.03 (N = 61)	.44** (N = 54)	.05 (N = 59)

\*p<0.05, \*\*p<0.01

The size of the contribution made by each of these four core beliefs to the predictability of PBI paternal overprotection scores can be measured using linear regression analysis. The results indicate that only Vulnerability to Harm and Illness makes a significant independent contribution ( $t = 2.03, p < .05$ ) to the overall variance in PBI paternal overprotection scores (24.5%;  $F = 4.57, p < .01$ ) (see Table 18). By incorporating this additional information, the proposed model can be further elaborated:



*Figure 4: Proposed model incorporating parental style and core beliefs link in the clinical group.*

*Table 18: Regression summary: parental style and core beliefs.*

<b>Dependent variable</b>	<b>F</b>	<b>p</b>	<b>% Var</b>	<b>Independent variable</b>	<b>B</b>	<b>t</b>	<b>p</b>
PBI paternal overprotection	4.570	.004	24.5	YSQ Mistrust and Abuse	-3.25	-1.85	.072
				YSQ Vulnerability to Harm and Illness	2.94	2.03	.049
				YSQ Social Isolation	1.05	.90	.371
				YSQ Abandonment	2.71	1.64	.109

### **3.3.4. Research Question 3: Are core beliefs related to depression?**

So far, section 3.3.2. has shown a link between parental style and depression, and section 3.3.3. identified a relationship between parental style and core beliefs in the clinical group. The aim of this section is to find the link, if any exists, between core beliefs and depression (in order to saturate the proposed model and complete the preparation for testing it within a mediator framework). Table 19 shows the size and direction of these correlations (together with the levels of significance) for the clinical group. It is apparent that almost all of the sixteen core beliefs are significantly positively related to depression as measured by the BDI.



*Table 19: Correlations between core beliefs and depression in the clinical group.*

<b>Core Belief / Schema</b>	<b>BDI cognitive /affective score</b>	<b>BDI somatic score</b>	<b>Total BDI score</b>
<b>Abandonment</b>	.71 <sup>***</sup> (N = 59)	.50 <sup>***</sup> (N = 56)	.69 <sup>***</sup> (N = 56)
<b>Functional Dependence/ Incompetence</b>	.64 <sup>***</sup> (N = 63)	.48 <sup>***</sup> (N = 58)	.62 <sup>***</sup> (N = 58)
<b>Defectiveness/ Shame</b>	.65 <sup>***</sup> (N = 63)	.59 <sup>***</sup> (N = 59)	.68 <sup>***</sup> (N = 59)
<b>Emotional Deprivation</b>	.47 <sup>***</sup> (N = 67)	.44 <sup>***</sup> (N = 62)	.49 <sup>***</sup> (N = 62)
<b>Emotional Inhibition</b>	.71 <sup>***</sup> (N = 64)	.56 <sup>***</sup> (N = 59)	.71 <sup>***</sup> (N = 59)
<b>Enmeshment</b>	.34 <sup>**</sup> (N = 60)	.14 (N = 56)	.28 <sup>*</sup> (N = 56)
<b>Entitlement</b>	.04 (N = 66)	-.08 (N = 61)	.00 (N = 61)
<b>Failure to Achieve</b>	.51 <sup>***</sup> (N = 62)	.29 <sup>*</sup> (N = 58)	.46 <sup>***</sup> (N = 58)
<b>Insufficient Self-Control/Self-Discipline</b>	.66 <sup>***</sup> (N = 64)	.56 <sup>***</sup> (N = 60)	.65 <sup>***</sup> (N = 60)
<b>Mistrust/Abuse</b>	.69 <sup>***</sup> (N = 66)	.59 <sup>***</sup> (N = 62)	.72 <sup>***</sup> (N = 62)
<b>Subjugation</b>	.55 <sup>***</sup> (N = 64)	.45 <sup>***</sup> (N = 61)	.56 <sup>***</sup> (N = 61)
<b>Social Isolation</b>	.60 <sup>***</sup> (N = 66)	.54 <sup>***</sup> (N = 62)	.63 <sup>***</sup> (N = 62)
<b>Self-Sacrifice</b>	.45 <sup>***</sup> (N = 61)	.28 <sup>*</sup> (N = 57)	.41 <sup>***</sup> (N = 57)
<b>Social Undesirability</b>	.55 <sup>***</sup> (N = 67)	.44 <sup>***</sup> (N = 63)	.53 <sup>***</sup> (N = 63)
<b>Unrelenting Standards</b>	.37 <sup>**</sup> (N = 61)	.25 (N = 58)	.36 <sup>**</sup> (N = 58)
<b>Vulnerability to Harm and Illness</b>	.74 <sup>***</sup> (N = 67)	.61 <sup>***</sup> (N = 62)	.74 <sup>***</sup> (N = 62)

\*p<0.05, \*\*p<0.01, \*\*\*p<0.001

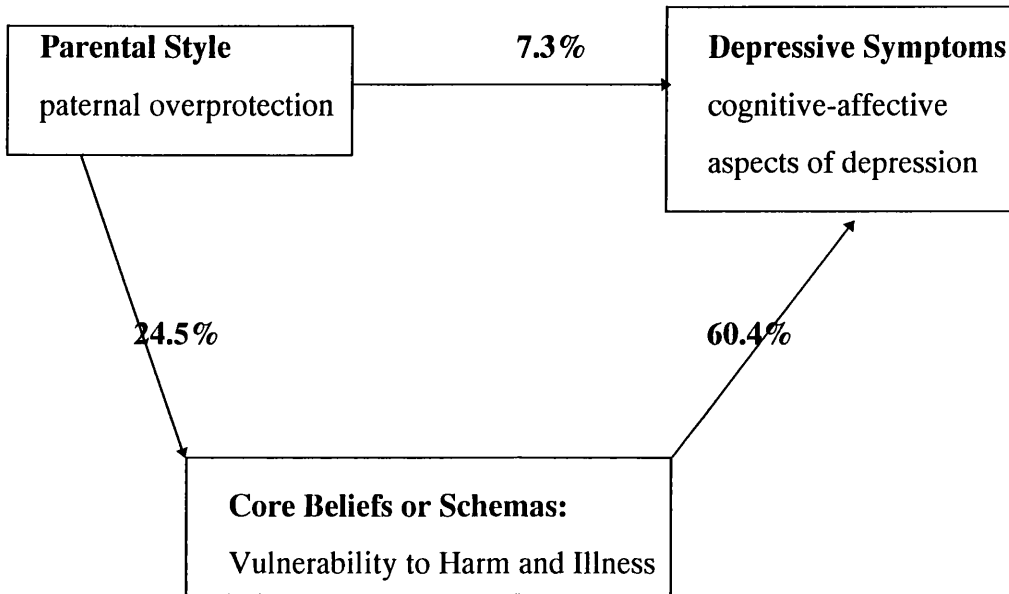
However, the focus for this study is testing the proposed model. The size of the contribution made by the four core beliefs pertinent to paternal overprotection (Abandonment, Mistrust/Abuse, Social Isolation and Vulnerability to Harm and Illness) to the predictability of the cognitive-affective BDI scores can be measured using linear regression analysis. The results indicate that 60.4% ( $F = 21.93, p < .001$ ) of the variance in cognitive-affective BDI scores is accounted for by the four core beliefs, but only Vulnerability to Harm and Illness makes a solely significant contribution (see Table 20).

*Table 20: Regression summary: core beliefs and depression.*

<b>Dependent variable</b>	<b>F</b>	<b>p</b>	<b>% Var</b>	<b>Independent variable</b>	<b>B</b>	<b>t</b>	<b>p</b>
BDI cognitive affective scores	21.93	.0001	60.4	YSQ Mistrust and Abuse	1.00	.81	.422
				YSQ Vulnerability to Harm and Illness	3.78	3.66	.001
				YSQ Social Isolation	1.12	1.56	.126
				YSQ Abandonment	1.12	.56	.579

The addition of this pairwise information to the proposed model completes it

(see Figure 5):



*Figure 5: Proposed model incorporating core beliefs and depression link in the clinical group.*

In the next section, it will be possible to ascertain whether the link between this particular parental style (paternal overprotection) and depressive symptoms (particularly cognitive-affective symptoms) is mediated by the core belief of Vulnerability to Harm and Illness, or whether these relationships are independent of each other.

### **3.3.5. Research Question 4: Is the link between parental style and depressive symptoms mediated by core beliefs?**

All the necessary pairwise relationships between the components of the proposed model have been tested. Within the mediator model, the next step is to ascertain whether the relationship between parental style and depression is independent of their associations with core beliefs, or whether core beliefs mediate this link. This is done (Baron & Kenny, 1986) by employing regression analysis (block enter technique) to test the mediation model (see Fig. 5).

The results indicate that paternal overprotection does not add anything to the degree of variance in BDI cognitive-affective scores accounted for, once the effect of the core belief (Vulnerability to Harm and Illness) has been removed.

Furthermore, the findings were similar when this technique was used for the overall BDI scores, which were also found to be significantly related to paternal overprotection. The difference was that two core beliefs (Vulnerability to Harm and Illness and Social Isolation) made significant contributions in accounting for the degree of variance in total BDI scores.

To conclude, the data from this study support the proposed model in that they are consistent with the view that, for the clinical group, depression (more specifically, the cognitive-affective component of depression) is caused by perceived paternal overprotection in childhood. Moreover, this relationship is mediated by the core belief of Vulnerability to Harm and Illness. Therefore, it appears that retrospectively perceived paternal overprotection in childhood is linked to depression in adulthood by causing the person to feel vulnerable to harm and illness (and socially isolated, to some extent). However, that is not to say that this is the only

model describing depression in adulthood. There are numerous others and, as this is not a review of depression in adulthood, it would not be appropriate to select any others for discussion here. This exploratory study specifically aimed to systematically test a mediation model proposing that the relationship between parental style and depression in adulthood (which has been shown by numerous studies) is mediated by core beliefs. To this end, the main finding from this study indicates that the link found between paternal overprotection and depression is mediated by the core belief of Vulnerability to Harm and Illness.

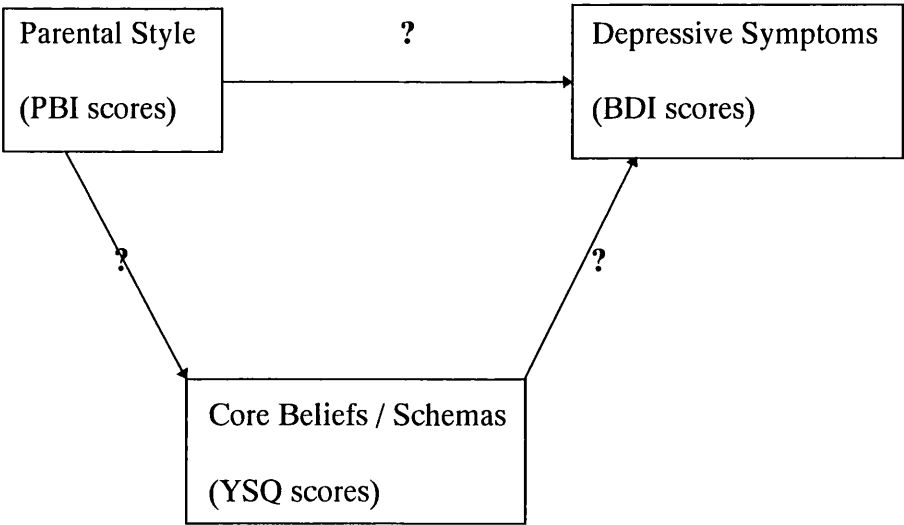
***3.4. PART THREE: Application of the Proposed Model to the Non-Clinical***

***Group.***

In this final part, the proposed model will be systematically tested (the four research questions will also guide this inquiry) using the data collected from the non-clinical group.

**3.4.1. A Reminder of the Proposed Model:**

This study proposed a linear relationship between parental style (as measured by the PBI) and depression (as measured by the BDI). It was proposed that this link would be mediated by core beliefs or schemas (as measured by YSQ). Therefore, diagrammatically, the model can be represented as:



*Figure 6: Reminder of the proposed model.*

In order to test this model within a mediator framework (Baron & Kenny, 1986), it is necessary first to establish whether there is a link between PBI scores and

BDI scores. Then it is possible to investigate whether or not this link is mediated by core beliefs. The four research questions will test this model systematically, in order to either confirm, refute or modify the hypothesised model, as it applies to the non-clinical sample in this study.

### 3.4.2. Research Question 1: Is there a link between parental style and depressive symptoms?

In order to investigate whether there is relationship between adults' perceptions of the parental style they received in childhood and their depression in adulthood, it is necessary to correlate the scores on the standardised questionnaires that measure these factors. Table 21 shows how parental care and overprotection are correlated with cognitive-affective and somatic symptoms of depression, as well as the overall score for depression in the non-clinical group.

*Table 21: Correlations between parental style and depression in the non-clinical group.*

	<b>BDI cognitive / affective score</b>	<b>BDI somatic score</b>	<b>Total BDI score</b>
<b>PBI paternal care score</b>	-.43 <sup>***</sup> (N = 63)	-.36 <sup>**</sup> (N = 64)	-.46 <sup>***</sup> (N = 63)
<b>PBI paternal overprotection score</b>	.12 (N = 63)	.21 (N = 64)	.18 (N = 63)
<b>PBI maternal care score</b>	-.38 <sup>**</sup> (N = 61)	-.29 <sup>*</sup> (N = 61)	-.39 <sup>**</sup> (N = 61)
<b>PBI maternal overprotection score</b>	.20 (N = 61)	.28 <sup>*</sup> (N = 61)	.26 <sup>*</sup> (N = 61)

\*p<0.05, \*\*p<0.01, \*\*\*p<0.001

In the non-clinical group, care from both parents was negatively correlated with all the different aspects of depression (BDI cognitive-affective, somatic and total scores). Therefore, non-clinical individuals who saw themselves as

having received less care in their childhood from one or both parents were more likely to suffer with depressive symptoms in adulthood. There was also a significant relationship between maternal overprotection and somatic scores on the BDI, indicating that negative affect is manifested in physical symptoms for those whose mothers were experienced as controlling and overprotective.

To systematically test the proposed model for the non-clinical group, the total BDI scores will be used for both paternal and maternal care, because both components (cognitive-affective and somatic) were found to be significantly related to parental style. However, only the somatic component will be used in relation to maternal overprotection as this (and not the cognitive-affective component) probably caused the total BDI score to be significant.

Using linear regression analysis to measure the sizes of the contributions made by these parental styles to the predictability of the relevant BDI scores, the results indicate that:

- Paternal care accounts for 19.6% ( $F = 16.12, p < .001$ ) of the variance in the overall BDI scores.
- Maternal care accounts for 14.1% ( $F = 10.81, p < .01$ ) of the variance in the overall BDI scores.
- Maternal overprotection accounts for 6.2% ( $F = 4.94, p < .05$ ) of the variance in the BDI somatic scores.



### **3.4.3. Research Question 2: Is there a link between core beliefs and parental style?**

Table 22 shows Pearson's correlations between core beliefs and parental style for the non-clinical group.

Care was significantly negatively related to eleven of the sixteen core beliefs for both parents, and only two core beliefs were not related in the case of either parent. The picture is very different for the PBI overprotection scores in this group. Maternal overprotection was found to be positively related to only three of the sixteen core beliefs, while none were associated with paternal overprotection.

To summarise, less care is associated with more dysfunctional core beliefs. Both parents play a significant role in the development of dysfunctional core beliefs for the non-clinical group.

*Table 22: Correlations between parental style and core beliefs in the non-clinical group.*

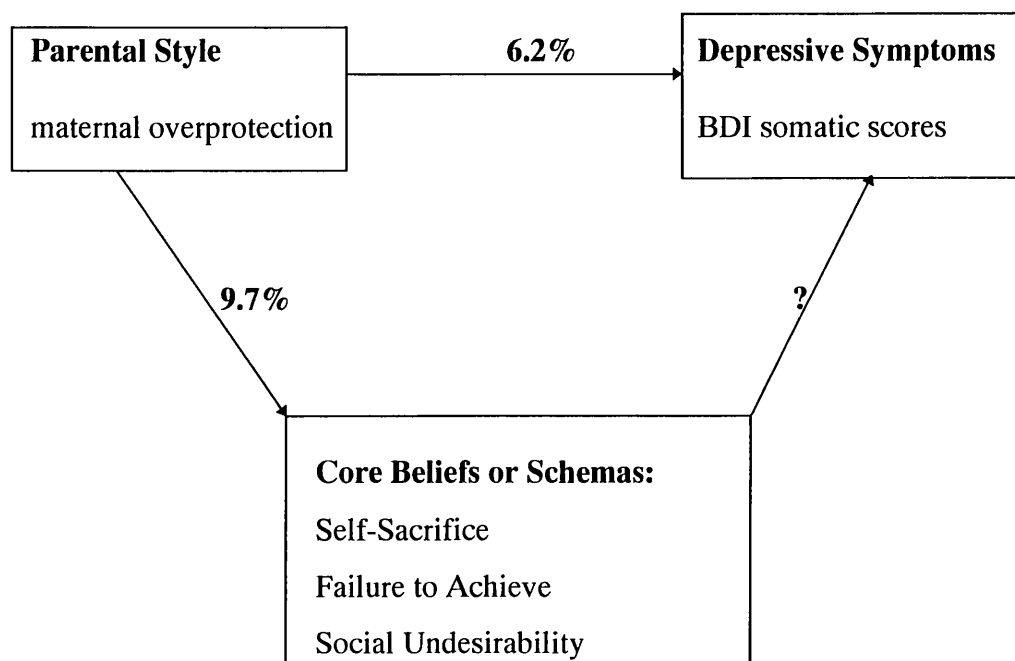
<b>Non-clinical Group</b>				
<b>Core Belief / Schema</b>	<b>PBI paternal care score</b>	<b>PBI maternal care score</b>	<b>PBI paternal overprotection score</b>	<b>PBI maternal overprotection score</b>
<b>Abandonment</b>	-.30* (N = 58)	-.28* (N = 55)	.11 (N = 58)	.13 (N = 55)
<b>Functional Dependence/ Incompetence</b>	-.33** (N = 62)	-.26* (N = 59)	.15 (N = 62)	.24 (N = 59)
<b>Defectiveness/ Shame</b>	-.43*** (N = 59)	-.66** (N = 57)	.13 (N = 59)	.25 (N = 57)
<b>Emotional Deprivation</b>	-.40** (N = 64)	-.34** (N = 61)	.02 (N = 64)	.03 (N = 61)
<b>Emotional Inhibition</b>	-.30* (N = 60)	-.31* (N = 57)	.07 (N = 60)	.24 (N = 57)
<b>Enmeshment</b>	-.18 (N = 63)	-.30* (N = 60)	.12 (N = 63)	.18 (N = 60)
<b>Entitlement</b>	-.25 (N = 60)	-.29* (N = 57)	.18 (N = 60)	.02 (N = 57)
<b>Failure to Achieve</b>	-.35* (N = 62)	-.25 (N = 59)	.18 (N = 62)	.32* (N = 59)
<b>Insufficient Self-Control/Self-Discipline</b>	-.10 (N = 59)	-.15 (N = 57)	.25 (N = 59)	.04 (N = 56)
<b>Mistrust/Abuse</b>	-.32* (N = 63)	-.38** (N = 60)	.10 (N = 63)	.21 (N = 60)
<b>Subjugation</b>	-.28* (N = 62)	-.37** (N = 59)	.16 (N = 62)	.24 (N = 59)
<b>Social Isolation</b>	-.44*** (N = 62)	-.32* (N = 59)	.15 (N = 62)	.13 (N = 59)
<b>Self-Sacrifice</b>	-.16 (N = 58)	-.26 (N = 55)	.10 (N = 58)	.37** (N = 55)
<b>Social Undesirability</b>	-.35** (N = 62)	-.40** (N = 60)	-.04 (N = 62)	.26* (N = 59)
<b>Unrelenting Standards</b>	-.27* (N = 55)	-.29* (N = 53)	-.14 (N = 55)	.22 (N = 53)
<b>Vulnerability to Harm and Illness</b>	-.43*** (N = 63)	-.37** (N = 60)	.20 (N = 63)	.20 (N = 60)

\*p<0.05, \*\*p<0.01, \*\*\*p<0.001

Again, using linear regression analysis to measure the size of the contributions made by core beliefs to the predictability of the relevant PBI scores, the results indicate that:

- The twelve core beliefs account for 10.6% ( $F = 1.44, p < NS$ ) of the variance in the PBI paternal care scores. Only the core belief of Social Isolation makes a significant contribution.
- The thirteen core beliefs account for 9.9% ( $F = 1.37, p < NS$ ) of the variance in the PBI maternal care scores. Only the core belief of Subjugation comes close to making a significant contribution.
- The three core beliefs account for 9.7% ( $F = 2.86, p < .05$ ) of the variance in the PBI maternal overprotection scores. Although this is a significant contribution, no particular core belief (or combination thereof) makes a significant impact in and of themselves.

To summarise, core beliefs do not make a significant contribution in accounting for PBI care scores for either parent. Therefore, it is not possible to continue with systematically testing the proposed model for these parental styles (paternal care and maternal care). However, the combined effect of three core beliefs (Self-Sacrifice, Failure to Achieve, and Social Undesirability) appear to make a small, but nevertheless, significant contribution in accounting for the variance in maternal overprotection scores. The information from sections 3.3.2. and 3.3.3. (with regard to maternal overprotection) can be incorporated into the diagrammatic representation of the proposed model:



*Figure 7: Proposed model incorporating parental style and core beliefs link in the non-clinical group.*

#### **3.4.4. Research Question 3: Are core beliefs related to depression?**

So far, for the non-clinical group, section 3.4.2. has shown a link between parental style and depression, and section 3.4.3. identified a relationship between parental style and core beliefs. The aim of this section is to find the link, if any exists, between core beliefs and depression (in order to saturate the proposed model and complete the preparation for testing it within a mediator framework). Table 23 shows the size and direction of these correlations (together with the levels of significance) for the clinical group. It is apparent that almost all of the sixteen core beliefs are significantly positively related to depression as measured by the BDI.

However, the focus here is to test the proposed model. The size of the contribution made by the three core beliefs pertinent to maternal overprotection

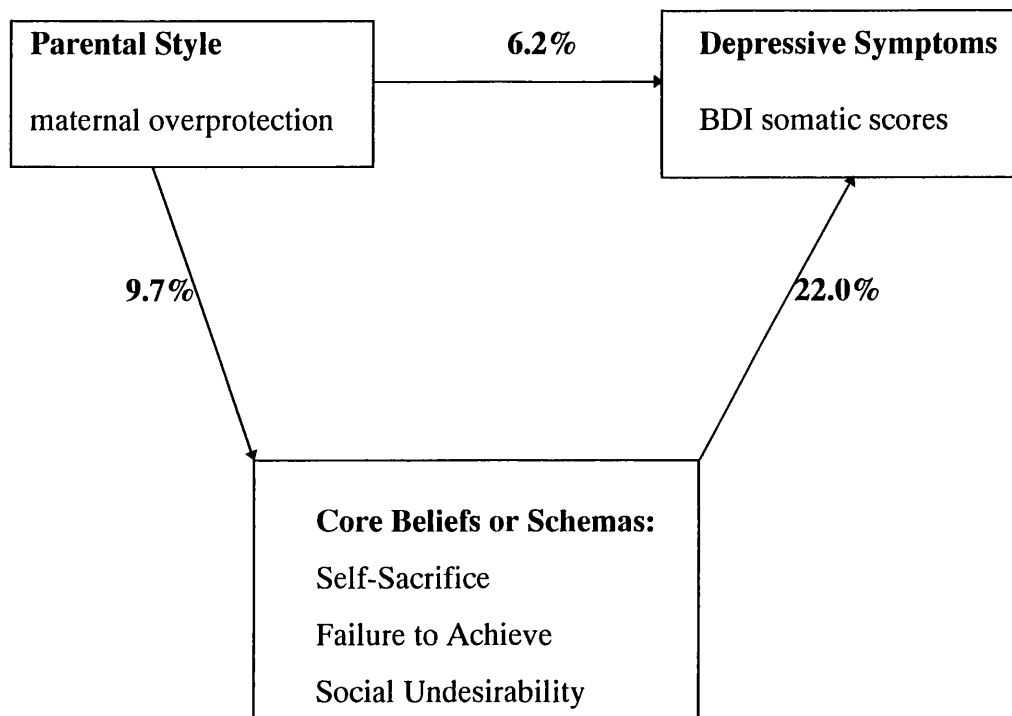
(Social Undesirability, Self-Sacrifice, and Failure to Achieve) to the predictability of the somatic BDI scores can be measured using linear regression analysis. The results indicate that 22.0% ( $F = 6.44, p < .001$ ) of the variance in BDI somatic scores is accounted for by the three core beliefs.

*Table 23: Correlations between core beliefs and depression in the non-clinical group.*

<b>Core Belief / Schema</b>	<b>BDI cognitive /affective score</b>	<b>BDI somatic score</b>	<b>Total BDI score</b>
<b>Abandonment</b>	.66 <sup>***</sup> (N = 60)	.32 <sup>*</sup> (N = 61)	.59 <sup>***</sup> (N = 60)
<b>Functional Dependence/ Incompetence</b>	.64 <sup>***</sup> (N = 65)	.48 <sup>***</sup> (N = 65)	.66 <sup>***</sup> (N = 64)
<b>Defectiveness/ Shame</b>	.71 <sup>***</sup> (N = 62)	.38 <sup>**</sup> (N = 62)	.66 <sup>***</sup> (N = 62)
<b>Emotional Deprivation</b>	.65 <sup>***</sup> (N = 66)	.31 <sup>*</sup> (N = 67)	.58 <sup>***</sup> (N = 66)
<b>Emotional Inhibition</b>	.66 <sup>***</sup> (N = 62)	.33 <sup>**</sup> (N = 63)	.60 <sup>***</sup> (N = 62)
<b>Enmeshment</b>	.52 <sup>***</sup> (N = 65)	.22 (N = 66)	.45 <sup>***</sup> (N = 65)
<b>Entitlement</b>	.27 <sup>*</sup> (N = 62)	.14 (N = 63)	.24 (N = 62)
<b>Failure to Achieve</b>	.67 <sup>***</sup> (N = 64)	.51 <sup>***</sup> (N = 65)	.68 <sup>***</sup> (N = 64)
<b>Insufficient Self-Control/Self-Discipline</b>	.48 <sup>***</sup> (N = 61)	.42 <sup>***</sup> (N = 62)	.52 <sup>***</sup> (N = 61)
<b>Mistrust/Abuse</b>	.64 <sup>***</sup> (N = 65)	.35 <sup>**</sup> (N = 65)	.61 <sup>***</sup> (N = 64)
<b>Subjugation</b>	.63 <sup>***</sup> (N = 65)	.37 <sup>**</sup> (N = 65)	.60 <sup>***</sup> (N = 64)
<b>Social Isolation</b>	.60 <sup>***</sup> (N = 64)	.31 <sup>*</sup> (N = 65)	.55 <sup>***</sup> (N = 64)
<b>Self-Sacrifice</b>	.59 <sup>***</sup> (N = 60)	.26 <sup>*</sup> (N = 61)	.53 <sup>***</sup> (N = 60)
<b>Social Undesirability</b>	.68 <sup>***</sup> (N = 65)	.50 <sup>***</sup> (N = 65)	.68 <sup>***</sup> (N = 64)
<b>Unrelenting Standards</b>	.36 <sup>**</sup> (N = 57)	.04 (N = 58)	.26 <sup>*</sup> (N = 57)
<b>Vulnerability to Harm and Illness</b>	.62 <sup>***</sup> (N = 66)	.44 <sup>***</sup> (N = 66)	.65 <sup>***</sup> (N = 65)

\* $p < 0.05$ , \*\* $p < 0.01$ , \*\*\* $p < 0.001$

The addition of this information to the proposed model saturates it (see Fig. 8):



*Figure 8: Saturated proposed model - non-clinical group data.*

In the next section, it will be possible to ascertain whether the link between this particular parental style (maternal overprotection) and depressive symptoms (particularly somatic symptoms) is mediated by the three core beliefs, or whether these relationships are independent of each other.

### **3.4.5. Research Question 4: Is the link between parental style and depressive symptoms mediated by core beliefs?**

All the necessary pairwise relationships between the components of the proposed model have been tested, for the data collected from the non-clinical group. Within the mediator model, the next step is to ascertain whether the relationship between parental style and depression is independent of their associations with core beliefs, or whether core beliefs mediate this link. This is done by employing regression analysis block enter technique to test the mediation model.

The results indicate that maternal overprotection does not add anything to the degree of variance in BDI somatic scores accounted for, once the effect of the three core beliefs (see Figure 8) have been removed.

To summarise, in the non-clinical group, the data from this part of the study are consistent with the view that depression (more specifically, the somatic component of depression) appears to be caused by maternal overprotection in childhood. Moreover, this relationship is mediated by the three core beliefs (Failure to Achieve, Social Undesirability, and Self-Sacrifice). Therefore, (retrospectively perceived) maternal overprotection in childhood appears to cause depression in adulthood by causing the person to feel socially undesirable, incompetent and guilty. It is necessary to note that these findings, although reflect the proposed model in this way, are the results of an exploratory study. There are numerous other models which aim to explain depression, and it is beyond the scope of this study to describe them.

### **3.5. PART FOUR: Conclusions:**

Before concluding this chapter, the data from this study will be presented in such a way as to be able to identify which of these sixteen core beliefs are the best predictors of depression, as this is an important, clinically relevant finding in its own right.

#### **3.5.1. Which core beliefs are the best predictors of depression?**

Using the exploratory regression analysis technique, 68% ( $F = 5.94, p < .001$ ) of the variance in the total depression scores measured by the BDI was accounted for by the sixteen core beliefs identified by the YSQ. When this analysis was carried out on the component parts of the BDI (the cognitive-affective and somatic scores), the results were again significant [69% ( $F = 6.29, p < .001$ ) and 55% ( $F = 3.85, p < .01$ ) respectively].

Therefore, having established that core beliefs are significantly related to an individual's depression, the next step is to identify what is the most parsimonious set of core beliefs that will predict levels of depression. This is done by employing the stepwise method of regression analysis in which the core beliefs are ranked according to the amount of variance for which they account, in descending order (see Tables 24 and 25).



*Table 24: The most important core beliefs related to overall depression.*

Core Beliefs	Total BDI Scores			
	Non-clinical group		Clinical group	
	R <sup>2</sup>	F	R <sup>2</sup>	F
Emotional Inhibition			50%	52.01 <sup>***</sup>
Failure to Achieve	47%	54.04 <sup>***</sup>	7%	35.47 <sup>***</sup>
Vulnerability to Harm and Illness	14%	46.55 <sup>***</sup>		
Self-Sacrifice			3%	27.27 <sup>***</sup>
Emotional Deprivation	2%	34.94 <sup>***</sup>		
<b>Total Variance</b>	<b>63%</b>		<b>60%</b>	

<sup>\*\*\*</sup> p<0.001

*Table 25: Core beliefs related to cognitive-affective and somatic factors of depression.*

Core Beliefs	Cognitive-Affective				Somatic			
	Non-clinical group		Clinical group		Non-clinical group		Clinical group	
	R <sup>2</sup>	F	R <sup>2</sup>	F	R <sup>2</sup>	F	R <sup>2</sup>	F
Abandonment			54%	53.25 <sup>***</sup>				
Emotional Inhibition	50%	55.5 <sup>***</sup>	10%	41.0 <sup>***</sup>				
Failure to Achieve			3%	31.0 <sup>***</sup>				
Mistrust / Abuse							40%	36.1 <sup>***</sup>
Insufficient Self-Control / Self-Discipline					17%	11.9 <sup>***</sup>		
<b>Total Variance</b>	<b>64%</b>		<b>67%</b>		<b>17%</b>		<b>40%</b>	

<sup>\*\*\*</sup> p < .001

The findings indicate that 60% of the variance in the total BDI scores can be accounted for by just three of the core beliefs (Emotional Inhibition, Failure to Achieve and Self-Sacrifice) for the clinical group. Emotional Inhibition accounts for 50% of the variance in the clinical group and a comparable 47% of the non-clinical group's variance is accounted for by the Failure to Achieve core belief.

To summarise this section, there are five core beliefs (Emotional Inhibition, Failure to Achieve, Self-Sacrifice, Abandonment and Mistrust/Abuse) that will predict levels of depression. This is a useful finding in terms of clinical work because it enables therapy to become more focused.

### **3.5.2. Conclusion of the Results Chapter.**

At the outset, the aim of this chapter was to systematically test the proposed model using stringent statistical techniques. This has been achieved. The main findings of this study are that, for the clinical group, perceived paternal overprotection in childhood is related to depression in adulthood, and this relationship is mediated by the endorsement of a particular core belief or schema - Vulnerability to Harm and Illness. For the non-clinical group, maternal overprotection in childhood is associated with somatic symptoms of depression in adulthood, and this relationship is mediated by three core beliefs (Failure to Achieve, Self-Sacrifice, and Social Undesirability).

Finally, the most parsimonious set of core beliefs which predict depressive symptoms in adulthood are Self-Sacrifice, Failure to Achieve, Mistrust/Abuse, Abandonment and Emotional Inhibition. The implications of all these findings will be discussed in the next chapter.

## **4. CHAPTER FOUR: DISCUSSION**

### **4.5. Overview of Chapter Four:**

The main aim of this chapter is to summarise the results of this study in the light of the available literature. It will place the proposed model into the context of psychological theory. The anecdotal, qualitative information (collected from the participants) will be used to illustrate these findings.

The first section will outline the main and supplementary findings of this study. Then there will be some discussion on how to interpret the support obtained for the proposed model in both the clinical and non-clinical groups. Following a section on the clinical implications of these findings, this thesis will be concluded with some recommendations for further research.

### **4.2. Summary of Findings:**

The aim of this section is to summarise the main and supplementary findings of this study. The main findings are those directly related to the testing of the proposed model. However, the results pertaining to the individual hypotheses outlined in the Introduction are also discussed in some detail, with anecdotal illustrations. The supplementary findings are those that (on clinical analysis) appeared to be interesting and clinically relevant.

#### ***4.2.1. Main Findings:***

There were two main findings from this study, one related to the clinical group, the other to the non-clinical group:

- For the clinical group, the relationship between paternal overprotection and depression in adulthood was mediated by the core belief of vulnerability to harm and illness.
- For the non-clinical group, the relationship between maternal overprotection and depression in adulthood was mediated by three core beliefs (social undesirability, failure to achieve and self-sacrifice).

#### ***4.2.2. Hypothesis Testing:***

In this section, the answers to the individual research questions will be discussed. These findings will be illustrated with the anecdotal information collected from the participants.

##### ***4.2.2.1. Parental Style and Depression:***

###### **Hypothesis 1: Is there a link between parental style and depressive symptoms?**

For the clinical group, paternal overprotection was significantly positively correlated with cognitive-affective aspects of depression. This finding indicates that when fathers are perceived as controlling and authoritative in childhood, there is a greater level of depressive thoughts and feelings in adulthood. Anecdotal evidence (from the descriptions that participants provided) regarding their relationships with their parents demonstrates this. For example, a male member of Depression Alliance had this to say about his father:

*“...a violent alcoholic. I was terrified of him and hated him for how he treated us.”*

A female outpatient had this to say about her father:

*“My father was a drunk and a wife-beater. He had little or no respect for anybody. He never showed any affection towards me,*

*he only moaned. I loved my father, but at the same time wished him dead. When he did finally die in '92, I was very sad, but for my mother I was happy. She was finally free and I didn't have to worry about him hurting her anymore....I adored my mother, couldn't get close to her or dad would call her a lesbian."*

For the non-clinical group, care from both parents was negatively associated with all the different aspects of depression (cognitive-affective, somatic and total BDI scores). This suggests that non-clinical individuals (not receiving or having received help for depression) who saw themselves as having received less care in their childhood (from one or both parents), were more likely to suffer with depressive symptoms in adulthood. For example, a member of the non-clinical group (who scored in the moderate to severe range on the BDI) had this to say about her parents:

Father: *"Step-father, quite distant."*

Mother: *"I think she loved me, but would put up a front not to show how much. Mum was pregnant with me before marriage, also blamed me for how her life was."*

Conversely, a male member of the same group (whose BDI score indicated that he was not depressed) had this to say about his parents:

Father: *"He was reliable, secure and a good provider for the family. He was however, quite rigid and somewhat strict. His decisions were not negotiable. He was mainly supportive, and my relationship was open, if not very warm. He could be a stern figure, but did not instil an unhealthy fear in me."*

Mother: *"My mother cared for me extremely well, despite some*

*bouts of ill health. She was protective and sympathetic to my problems.”*

A significant relationship was also found between maternal overprotection and somatic scores on the BDI. This indicates that negative affect is manifested in physical symptoms for those whose mothers were experienced as controlling and overprotective. For example, a mildly depressed man in his thirties had this to say about his mother:

*“My mother is a strong, organised person who is quite dominant. As a result, I can’t really go to her when I’m in need. However, if things are fine we get on well as a family.”*

On the other hand, a mildly depressed woman (also in her thirties) said this about her relationship with her mother:

*“I do not remember liking my mother ever. I left home at 17 and refused to see my mother for 16 years. I saw her first 3 years ago which confirmed my early decisions to have left home was a positive move. My mother is manipulative, controlling and does not think beautifully in a spiritual way. Even now, I do not feel close to her, much to her sadness.”*

To conclude, only paternal overprotection was found to be associated with more severe depression in the clinical group, whereas care from both parents and maternal overprotection were found to be associated with the milder symptoms of depression found in the non-clinical group.

#### 4.2.2.2. Core Beliefs and Parental Style:

##### Hypothesis 2: Is there a link between core beliefs and parental style?

The second research question inquired about the relationship between core beliefs and parental style (i.e., the parental style(s) found to be associated with depression in the respective groups). For the clinical group, the findings revealed that four core beliefs (abandonment, mistrust/abuse, social isolation, vulnerability to harm and illness) were significantly related to paternal overprotection. Abandonment was negatively correlated, implying that the more the father figure was perceived to be overprotective, the less likely the individual was to feel the fear of abandonment in adulthood. The other three were positively correlated, suggesting that, having received controlling, overprotective fathering in childhood, one was more likely to feel lonely, mistrustful of others and vulnerable in the world. One female member of Depression Alliance had this to say about her father:

*“Very clingy towards him when I was very young. He had his own business and worked long hours, so I didn’t see a lot of him. Got on well with him and loved him, but felt I didn’t always get support with things e.g. when I was at school. My father did not believe in kissing and cuddling me which I found later that I missed. This was due to my mum having TB and my dad said you shouldn’t keep cuddling etc.”*

In the non-clinical group however, care was significantly negatively related to eleven of the sixteen core beliefs for both parents. Only two core beliefs were not related in the case of either parent. The picture was very different for the PBI overprotection scores in this group. Maternal overprotection was found to be positively related to only three of the sixteen core beliefs (self-sacrifice, failure to

achieve, and social undesirability), whilst none were associated with paternal overprotection. One non-depressed woman in her thirties said (about her mother) “she finds it difficult to say the right thing about what my life is like.” A man in his twenties said that his mother was “keen to see me happy and successful, and (is) very proud of my achievements.” It appears that some of the findings regarding core beliefs are borne out in the personal narratives people have about their lives (as found in the qualitative information collected).

#### *4.2.2.3. Core Beliefs and Depression:*

##### Hypothesis 3: Is there a link between core beliefs and depressive symptoms?

The findings in answer to the third research question showed that almost all of the sixteen core beliefs elicited by Young’s Schema Questionnaire are significantly positively related to depression (as measured by Beck’s Depression Inventory). This is true for both clinical and non-clinical groups. This result makes intuitive sense as one would expect, in line with cognitive theory and clinical practice, dysfunctional thoughts and beliefs to play a prominent role in negative affect. However, although one could argue that depressed mood influences one’s thoughts, core beliefs or EMSs (Young, 1990) are by definition, stable and enduring constructs developed in childhood and maintained despite contradictory evidence from experiences in later life. Therefore, although it is not possible to conclude causation relationships from correlational data, the diagrams representing the proposed model for this study do indicate accurately the direction of the relationships between parental style, core beliefs and depression in adulthood.



#### *4.2.2.4. Parental Style, Core Beliefs and Depression:*

Hypothesis 4: Is the link between parental style and depressive symptoms mediated by core beliefs?

The final result, however, for the clinical group indicated that only vulnerability to harm and illness mediates the relationship between paternal overprotection in childhood and depression in adulthood. It is also worth noting that this single core belief accounted for almost a quarter of the variance in paternal overprotection scores.

For the non-clinical group, on the other hand, less than ten per cent of the variance in maternal overprotection is accounted for by three core beliefs (social undesirability, failure to achieve, and self-sacrifice). However, this is a significant contribution, unlike those made by the core beliefs associated with care scores for both parents. Therefore, the relationships in question (as would be expected) are much 'weaker' in the non-clinical group.

#### *4.2.3. Supplementary Findings:*

This part will include a discussion about the nature of the sample population (particularly demographic and psychological characteristics) with an emphasis on gender issues. It will also identify the set of core beliefs which are found to be the best predictors of depression in adulthood.

##### *4.2.3.1. Quality of the Sample Population:*

Ideally, the two groups (clinical and non-clinical) would have shown no significant differences on factors such as age, gender, marital and family status, occupation, religion, ethnicity. However, in reality this is very difficult to achieve when using (as in this study) clinical populations and community samples. The

quasi-experimental design adopted in this study meant that it was not possible to strictly control the volunteers in each group. The completed questionnaires were subsequently analysed to assess severity of depression and other variables. However, the large number of participants obtained for each group enabled the analysis to be conducted with a degree of confidence that the populations were normally distributed. The unequal variances identified by Levene's test could most likely be attributed to differences in the shapes of the normal distributions between the two groups.

At this stage it is worth noting the nature of the samples used in this study. A student sample was not used for the non-clinical, comparison group, as this strategy has been shown to obscure gender differences in unipolar depression (Nolen-Hoeksema, 1987). A more representative cross-section of the community was recruited to participate in this study. As it was not possible to obtain such a large truly clinical sample, that is, 70 outpatients, the clinical group was more diverse than was preferable. Some members of Depression Alliance were receiving more attention from the services than others. This is also reflected in the range of severity of depression found in this group (see Table 10).

#### *4.2.3.2. Demographic Characteristics of the Sample:*

The clinical and non-clinical groups were different in age - the clinical group was older and the range was much wider than that for the non-clinical group. Indeed, there was one fifteen year old member of Depression Alliance, who felt that her mother was "a very patient and caring person, but she does not understand my depression and doesn't know how to help me, which can be frustrating". It is only recently that the mental health services have begun to accept that many children

warrant a formal diagnosis of major depression (Angold, 1988). This age difference may account for many of the other differences in the demographic details of the sample. For example, more people in the clinical group were divorced and widowed. There were more people in the clinical group with children, and with children who had grown up and left home. Although the same number of participants in each group had dependent children living with them, four times as many individuals in the clinical group had dependent children not living with them. This perhaps reflects the higher divorce and separation rates in the clinical group. This finding is consistent with Richards *et al.* (1997), who concluded that divorce and separation have a specific and long-term impact on mental health.

The gender differences in this sample reflect the prevalence of depression in the wider community. There were twice as many women in the clinical, depressed group, but the numbers of men and women in the non-clinical group were balanced. Gender issues in depression warrant a section devoted to them. However, the fact that the two groups in this study were not matched on the factors of age and gender may make them liable to the period and cohort effects discussed by Klerman (1988). Indeed, several members of the clinical group described the difficulties they had to face during the war:

*My relation (with my father) was very good, although I saw very little of him during the war years 1939 - 1945. I was four years old when war broke out. ... My father was a very intelligent man, quite introvert as he grew older. He was a prolific reader, and spoke very little. He provided for the family, but was not a family man. In fact, he became more and more solitary as the years*

*passed. He died of motor neurone disease.*

The significant differences between the two groups in terms of occupational status and types of occupation could again be seen to partially reflect the differences in age and gender. However, the data from this study are in keeping with numerous sociological studies (e.g., Brown & Harris, 1978), which highlight the fact that long-term unemployment maintains depressed mood. The ‘failure to achieve’ core belief (which would be expected to be associated with employment status) did indeed feature in the most parsimonious set of beliefs related to depression.

There was some attempt made in the design of this study to allow the participants to use their own words to express themselves, and thus obtain a combination of qualitative as well as quantitative data. This was not done extensively in the collection of the demographic information, due to the time constraints of the project. However, when information about the ethnicity and religious convictions of the participants was requested with open-ended questions, and subsequently categorised, there were some interesting findings. For example, twice as many members of the clinical group used the term “White” in describing their ethnicity. Also, the numbers of participants who described themselves as “Christian” or “Church of England” were almost exactly reversed for the two groups, with more “Christians” in the non-clinical group and more members of the clinical group assigning themselves to “Church of England”. One could speculate from these results that depression is associated with rigid, prejudiced and ‘religious’ or traditional beliefs, whereas non-clinical individuals are more labile in their thought processes. This would be in keeping with the developments in cognitive theory, but

perhaps also suggests that ‘political’ issues such as ethnicity and religion do have a place in the therapy room.

#### 4.2.3.3. *Gender Differences:*

In this study, there was a brief examination of gender differences for the total sample population across all the scales. Significant differences were found in all three BDI scales, as well as self-sacrifice on the Schema Questionnaire and the PBI maternal care scores. As there were twice as many females in the clinical group as males, the depression scores are not surprising. However, the need to please others at the expense of oneself is a stereotypically female trait. Pound (1996) suggests a reason why maternal care might be differentially experienced by boys and girls. She proposes that a depressed mother is likely to have differing relationships with her children: “boys are more prone to be the objects of irritability and criticism and girls of comfort seeking, predisposing the former to conduct disorders and the latter to being drawn into the mother’s depressive world”(pp 205). She (in her chapter about parental affective disorder and childhood disturbance) makes a case for a family approach to the treatment of affective disorders. Combining this information with the generally agreed finding that single men and married women have the highest rates of depression (McGuffin *et al.*, 1988), the perpetuating effect of passing depression down through the generations (via the women) seems inevitable.

However, maintaining a cognitive framework for evaluation, Hokanson and Butler (1992) considered Beck’s (1983) conceptualisations of sociotropic and autonomous depressives, which appear to be particularly relevant when considering gender differences. Sowa and Lustman (1984) have already suggested that there are qualitative differences in cognitive distortions for men and women. Sociotropic

individuals are described as overly dependent on others for safety, help and gratification. Their self-esteem is highly sensitive to even minor rejection, and their overall goal is to maintain closeness and goodwill with others. Interpersonally, these people would be expected to behave in a relatively passive, ingratiating, and dependent manner. Autonomous persons, on the other hand, are described as perfectionistic, action-oriented, dogmatic and authoritarian. They rely on social distancing strategies to facilitate the goals of freedom of action, control, and avoidance of interpersonal entanglements. Such individuals might be expected to behave in a relatively aggressive, competitive, controlling, and wary manner. However, in female survivors of childhood sexual abuse both these aspects can be clearly observed in different situations.

Gove and Tudor (1977) argue that the traditional female role as homemaker is becoming increasingly boring and undervalued as more modern conveniences are being introduced. They suggest that the gender differences in depression can be attributed to the lesser value put on the female role, and the resulting lesser gratification women receive from fulfilling that role. It is not so much the number of stressors that makes women more susceptible to low self-esteem and despair, but the conflicts or radical changes in the expectations for women and the society's devaluation of the stereotypical female role.

Kraemer (1995) make a bold and philosophical statement regarding the roles of men and women: "the fact is that men are just as necessary as women for keeping the species going, but that they do not have to be in charge. There is always a very fierce reaction to this sort of talk, and not only from men!" However, he also observes that any attempt to rebalance the genders seems to disturb the very

foundation of our thinking. This is so because notions of sex and gender *are* the foundation of much of our thinking, about roles, power, love, sexuality, social order; the very stuff of life and its meaning. Freud (1923) shocked the world with his observations that sexuality is part of everyone's life, even infants. Feminists, who have rarely been friends with Freud, have noted that our unconscious reliance on assumptions of gender are equally pervasive.

#### 4.2.3.4. *Psychological Characteristics of the Sample:*

There were significant differences found between the two groups on all the scales used in this study (BDI, PBI, YSQ). This is a necessary result in order to proceed with further data analysis. However, it is worth noting that six per cent of the non-clinical group did report to having been clinically depressed in the past. This highlights the fact that the non-clinical group was obtained from a representative community sample, and not screened to exclude depressed individuals.

The data presented in this study indicate that the majority of the participants (91%) had an appropriate understanding of 'clinical depression' as distinct from normal, transient feelings of misery. This lends some support to Kuyken *et al.*'s (1992) finding that there are similarities between lay persons' and clinical psychologists' views about the possible causes of depression. Unfortunately, only 23% of the total sample population reported to being "clinically depressed" (and this result was reflected in the BDI scores) as opposed to the expected 50%. As this is less than half the expected value for ideal experimental conditions, this may have had some bearing when testing the proposed model.

#### *4.2.3.5. The Core Beliefs that Predict Depression:*

The data from this study lends itself to identifying the most parsimonious set of core beliefs in adulthood depression. For the clinical group, 60% of the variance in the overall BDI scores for depression was accounted for by just three core beliefs (emotional inhibition, failure to achieve, self-sacrifice). In addition, the core belief of abandonment featured high on the cognitive-affective component of this group, whilst mistrust/abuse was predictive of somatic symptoms of depression.

In the non-clinical group, 63% of the variance in the overall BDI scores was accounted for by (a different) three core beliefs (failure to achieve, vulnerability to harm and illness, emotional deprivation). Emotional inhibition was most predictive of cognitive-affective aspects of depression, whilst insufficient self-control/self-discipline featured in the somatic component for this group. These results can be useful in developing treatment interventions and preventative measures for clinical practice (see section 4.4.).

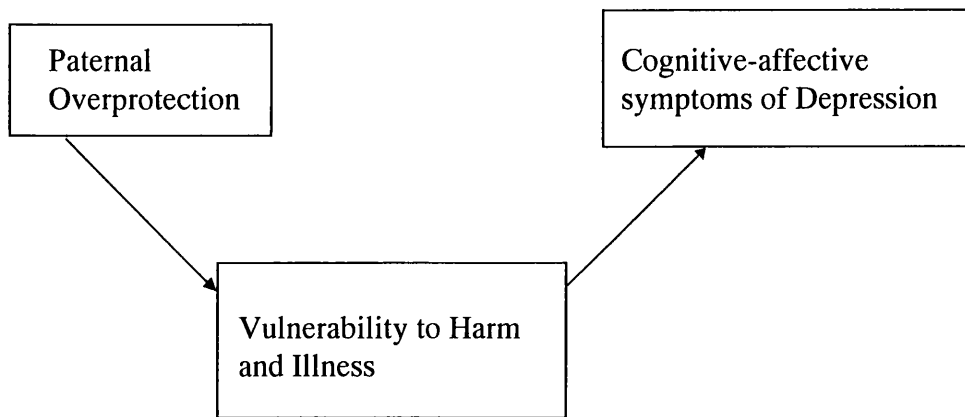
### **4.3. The Main Findings in Context:**

In this section, there will be a discussion on how the proposed model relates to the clinical and non-clinical groups in this study.

#### ***4.3.1. Model in relation to the Clinical Group:***

The data from the clinical group supported the proposed model. The findings indicate that the relationship between perceived paternal overprotection in childhood and depression in adulthood is mediated by the core belief of vulnerability to harm and illness. This can be summarised diagrammatically as:

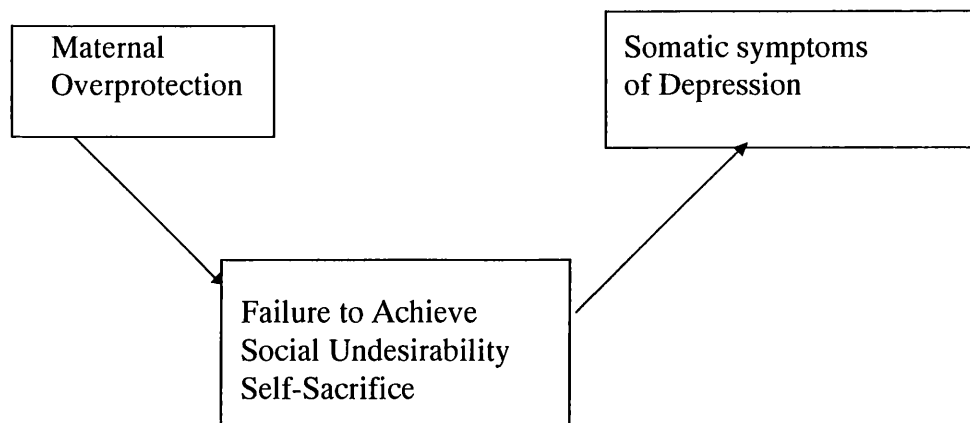




This finding is consistent with the suggestion that moderate to severely depressed individuals (those seeking help for their depression) are likely to feel vulnerable in the world if they experienced their fathers as controlling and overprotective in childhood. They will therefore be prone to depression in adulthood. This vulnerability to harm and illness is a key concept in Beck's cognitive model for anxiety (1976). Given that the high level of comorbidity between anxiety and depression is well established, and as comorbidity was not controlled for in this study, it may be more accurate to consider this finding as being related to neurotic/affective disorders, rather than depression specifically. Nevertheless, the finding still indicates that it is the paternal influence that is most significant in the development of depression in adulthood.

#### ***4.3.2. Model in relation to the Non-Clinical Group:***

The data from the non-clinical group also supported the proposed model, although (as would be expected) the relationships were not as remarkable. The finding from this group suggests that perceived maternal overprotection (experienced in childhood) is related to depression in adulthood, and that this link is mediated by three core beliefs. This finding can be summarised diagrammatically:



These data from the non-clinical group indicate that mild depression (not being treated) is linked to maternal overprotection. They suggest that mothers (or maternal figures) may be overly concerned with their children's achievement records and their presentability in public. They also suggest that the children may have learned (maybe through modelling the mother's role) to focus on meeting the needs of others (at the expense of one's own needs), either to gain in esteem or to avoid guilt.

Combining this finding with the fact that there were equal numbers of men and women in the non-clinical group, and also that mild depression in men usually goes unnoticed, one could speculate on this finding in terms of gender issues. For example, some psychoanalytic literature (e.g., Formaini, 1991) suggests that western society is structured such that little boys grow up knowing they have to be different from their mothers, but not knowing their fathers' roles in the family. One male member of the non-clinical group had this to say about his mother:

*A good and loving relationship - although as a child my mother was the parent who kept discipline in the home. ... Now I find it easier to talk to my mother than my father - but that is because my father doesn't talk about*

*his feelings very easily.*

Anecdotal information suggested that women struggle with how to be good mothers in the current changing climate and in the light of their own experiences, for example:

*My mother was not as strong a personality as my father, allowing him to make most major decisions. She had a lot of problems in her own childhood which affected how she treated us - she wasn't sure how to cope with us as young kids, particularly when we fought. She didn't show us a lot of affection when we were younger and then became very interested in us and our lives as we got older (in a sort of 'nosy' way). Because she tended to be very caught up in her own, sometimes trivial, problems, she rarely really talked to us or listened when we had problems.*

Therefore, it seems feasible to speculate that coming to terms with changes in the maternal role is causing individuals to reflect in different ways on their personal experiences in childhood.

#### **4.3.3. The Results in Context:**

These results are somewhat surprising for two reasons: (a) it has highlighted the importance of the paternal influence (rather than the maternal) in clinical depression, and (b) the controlling/overprotective parental style was found to have a greater impact on clinical depression in adulthood than the 'care' construct.

##### **4.3.3.1. The father not the mother:**

Much of the literature suggests that the relationship with the mother (as the primary caregiver) is most often predictive of depression in adulthood. Monick (1987) observed that "psychoanalytic theory, whether Freudian or Jungian, gives

singular primacy to the mother as the basis of life. This is an error.” Also, Earls (1976) wrote:

*“The physical needs of infants for nourishment and affection appear to be so obviously fulfilled by mothers that Western psychology has been able to comfortably ignore the relationship of men to infant. If fathers are considered at all, it is usually in relation to the extent that they provide a supportive environment generally, and contribute to a good marriage specifically. Direct interaction between fathers and young children is usually regarded as accessory to maternal behaviour and responsibility.”(pp. 209)*

The role of the father has been somewhat neglected in the psychological literature until recently. This difficulty with recruiting fathers in research is also reflected in clinical practice, especially family therapy. In the research that has been carried out on fatherhood, the dominant theme has been father *absence*. The implication then is that it takes this level of family insult to produce an emotional handicap in children. Even then, this concept of father absence is riddled with complications. For example, the father may be absent for socially acceptable reasons, such as military service or death. These are likely to have different consequences on family life than if the father’s absence is due to desertion or imprisonment.

Until recently, the proliferating literature on the effects of separation and divorce on children neglected the quality of the home environment just prior to the “loss of a parent”. Indeed, this loss may have been a welcome relief for the children if the alternative had been verbal, physical, sexual abuse or witnessing constant conflict. There are numerous confounding variables, such as the quality of the

marital relationship prior to divorce, developmental stage of the children, socio-economic changes and so on. Therefore, data on the effect of parental loss through separation, divorce and death are inconclusive. Tousignant *et al.* (1993) suggested that parental divorce may have a short-term effect, but not a lasting influence if good 'care' is present. However, research on parental behaviour and style has provided more conclusive evidence. An overview of ten countries has shown that many types of family problems are involved (chaotic family or marital relationships, violence and physical abuse, sexual abuse, alcoholism, drug abuse, suicidal behaviour, familial psychiatric disorder) which all contribute to child-rearing competence and reflect the quality of care for children (Peck *et al.*, 1985).

The importance of the role of the father was highlighted as early as 1966 by Paffenbarger and Asnes (cited in Earls, 1976), who investigated suicide in a student population. They considered a variety of familial, physical, sociological and psychological factors, and found that paternal death and deprivation emerged as one of the more striking correlates of suicide. Paternal influences had more apparent impact than maternal factors. A more recent study (Tousignant *et al.*, 1993) examined suicidal behaviour in adolescents. They found that a negative relationship between father and child plays a very important role in the suicidal behaviour of adolescents, and this effect lasts until young adulthood. Their conclusion was that more attention should be focused on the relationship with the father in residence. On the other hand, Adams *et al.* (1994) found that perceptions of mother (rather than those of father) were more consistently predictive of suicidal behaviour for both male and female adolescents. They suggested that their findings were generalisable to female adult populations. However, Silove *et al.* (1987) compared adult suicide

attempters with matched controls, and found that only paternal overprotection was statistically significant in predicting suicidal behaviour in adult offspring.

While both parasuicide and completed suicide are related to depressive experiences, parasuicidal behaviour appears to be related to affective experiences of anger, whereas suicide may be more related to apathy, or an absence of anger expression (MacLeod *et al.*, 1992). It is apparent that much research has been dedicated to suicidal ideation and behaviour in young people. It makes sense to concentrate finite research resources into such an important area. However, suicide is but one symptom of depression. Gaining a better understanding of the aetiology of the disorder may in turn inform clinical practice with ways to approach depression as a whole. Gotlib *et al.* (1988) conducted a longitudinal study on maternal parenting style and depression in women who exhibited relatively mild levels of depression. They found that only those participants who reported both low maternal care *and* high maternal overprotectiveness at the initial assessment were still depressed 30 months later. Those that had remitted in that time had only reported high overprotectiveness. Therefore, low maternal care was identified to be the most important factor in the chronicity of depression. Pedersen (1994) found that both care and control / overprotection (as measured by the PBI) showed a clear relationship to anxiety/depression and/or delinquency. Again, the relationship with the 'care' dimension was the strongest. Perceptions of low care by father were the strongest predictor of anxiety/depression. Perception of low care by mother was the strongest predictor of delinquency and a combination of the two conditions - anxiety/depression and delinquency.

Unfortunately, Gotlib *et al.* (1988) did not measure paternal parenting style. It is not possible to extrapolate these findings to paternal overprotectiveness because stereotypically the roles of fathers and mothers are very different (Gove & Tudor, 1977). Therefore the stereotypes are likely to cause variation in individuals' perceptions of such constructs, depending on the context. For example, a mother may be perceived as controlling, whilst the same characteristics demonstrated in a father may be perceived as "taking an interest" or "caring".

Therefore, to conclude, it appears that there is some evidence to suggest that a child's relationship with their father is an important one. This relationship has significant consequences on the affective/emotional development of the person into adulthood. However, the amount of evidence is greatly limited by the difficulties in obtaining male volunteers for clinical intervention and/or research purposes. The next section will examine the second reason why the main findings from this study were somewhat surprising.

#### 4.3.3.2. 'Care' versus 'Overprotection':

Contrary to the main findings of this study, much literature suggests that 'care' is the parental style most predictive of depression in adulthood. High overprotection has been associated with an external attributional style, interpersonal dependency, and low social support satisfaction, while 'affectionless control' has been found to be associated with neurotic / reactive depression in adults (Richman and Flaherty, 1987). However, MacKinnon *et al.* (1993) conducted a study to assess the claim that parental "affectionless control" (high overprotection, low care) predisposes a person to depression in adulthood. They used the PBI on 922 adult twins in their sample and concluded that it is the lack of 'care' (rather than

‘overprotection’) which is the primary risk factor to depression in adulthood. When only one of the two scales is used as a predictor, ‘care’ exhibits the strongest relationship with depression. Using further regression analyses, they conclude that (in statistical terms) the concept of “affectionless control” as a synergistic risk factor for depression is not supported. The two PBI scales are correlated, so that parents reported as being uncaring are likely also to be seen as highly controlling. Thus, at a phenomenological level, depressed individuals will be observed with low caring and high overprotection scores. This appears to be the basis on which previous reports have identified ‘affectionless control’ as a risk factor. For these reasons, the quadrant assignment method was not used in the present study.

These studies turn the focus to what is essentially a single dimension of parenting concerned with affection, caring and attachment, which was its original theoretical basis (Rutter, 1980). MacKinnon *et al.*’s (1993) study has cast some doubt over the role of protection or control in the relationship between depressive disorders and poor parenting, including the notion that the combined effects of low care and high overprotection are responsible for depression. However, before overprotective or controlling parenting is dismissed as a risk factor, alternative explanations for the lack of an independent effect should be considered. One avenue of explanation concerns the dimensionality of this second scale. Although a “care” factor can be identified in all inventories designed to assess memories of parenting (Perris *et al.*, 1980; Schaeffer, 1965) there is more diversity in the characteristics of the second and third factors. This is reflected in the item content of the questionnaires and the purpose for which they were developed. While notions of independence, control and discipline feature in most scales, it is not always with the



negative connotations that ‘overprotection / control’ has in the PBI. Loadings on the ‘overprotection / control’ factor of the PBI are generally lower than those for the care scale. Combining these facets into a single scale could attenuate any relationship between negative aspects of control and depression.

Parker *et al.* (1979) noted that high ‘overprotection’ and low ‘care’ are likely to be additive or interactive in their effects. Gotlib *et al.* (1988) postulated that overprotectiveness was only related to vulnerability to ‘general’ or ‘diffuse’ psychological symptoms, particularly during periods of stress. In the light of other research findings with adolescents, Pedersen (1994) concluded that the PBI predicts a heterogeneous spectrum of behaviour disorders rather than specific problems. Similarly, Parker (1983) contends that overprotectiveness is associated with various manifestations of psychological distress, including generalised anxiety and phobias, as well as depression. The conclusion appears to be that the PBI is a good measure of general risk factors for psychosocial problems.

#### 4.3.3.3. *Depression and Anxiety:*

The central notion in cognitive models of emotional disorders is the idea that it is not events *per se* but rather people’s expectations and interpretations of events which are responsible for the production of negative emotions such as anxiety, anger, or sadness. In depression, the interpretations which are considered important relate to perceived loss of a relationship, status, or efficacy. In anxiety, the important interpretations, or cognitions, relate to perceived physical or psychosocial danger. Cognitive models of generalised anxiety (Beck, Emery and Greenberg, 1985) propose that individuals experience pervasive anxiety because their beliefs about themselves and the world make them prone to interpret a wide range of situations in a

threatening fashion. This alludes to the fact that Young's 'vulnerability to harm and illness' core belief is a key principle construct underlying (and therefore more indicative of) anxiety rather than depression. This is contrary to the main finding in the present study, which suggests that the expectation of imminent disaster is associated with depression. However, had a measure of anxiety been included in the present study, then this issue would have been more clearly resolved. MacKinnon *et al.* (1993) failed to find a relationship between anxiety and parental style after controlling for comorbid depression. They argued that parenting does not have as substantial an effect on general neurotic tendency as that found in depression. They suggested that previous studies' findings of a relationship between anxiety and PBI scores could be attributed to the high rate of comorbidity between anxiety and depression.

#### 4.3.3.4. *Combined Parenting:*

The issue of the possible interactive effects of fathers' and mothers' parenting behaviours was also not addressed in the present study. Parker and Hadzi-Pavlovic (1992) confirm the logical assertion that two parents with anomalous parenting considerably increase the risk of depression for their offspring in adulthood. However, if one of the parents is able to offer optimal parenting, this was found to decrease the risk of depression. Although ratings of mothers and fathers have been found to be correlated, it may be that one caring parent provides a protective effect, regardless of the behaviour of the other. However, anecdotal evidence suggests that good enough parenting from one parent is not enough to protect against depression in adulthood, for example:

*“Very poor relationship with my father, never shows me affection*

*we hate each other. He physically and emotionally abused me as a child and still says negative things about me constantly. I am scared of him and I don't understand why he can't love me. I feel very sad because I would love to have a real dad to love me and give hugs to."*

*"Very good. My mum is my best friend and I know she is there for me whenever I need her. I love her more than anyone else and she loves me too. She would do anything for me and is desperate for me to be happy, which is why I hide my depression from her."*

#### *4.3.3.5. The PBI as a Measure of 'Actual' Parenting:*

A primary difficulty in carrying out research in the area of parental style is the long period between exposure to the risk factor (parental style) and the development and measurement of psychopathology (depression). The PBI retrospectively collects information from adults about their parents' behaviour. MacKinnon *et al.* (1989) tested the psychometric properties of the PBI in a general population sample. They reported that respondents who were parents themselves differed significantly from those who were not parents in relation to ratings on the protection scale. Both mothers and fathers were more likely to perceive their own fathers to have been less protective. On the maternal protection scores, the male and female respondents rated in opposite directions. One could speculate on this gender difference, but what seems more important to note here is that reports of parental behaviour has been found to differ significantly according to the events taking place some decades later. As it is implausible that the behaviours or attitudes tapped by the PBI will influence later fertility, it seems probable that the experience of having

children brings about a modest change in the reporting of protective behaviour of one's own parents.

On the other hand, there is some evidence to suggest that the PBI is a good measure of 'actual' parenting. A number of studies have shown that perceptions of early parenting (at least by depressed individuals) do not seem to be affected by transient depressed mood, and are, therefore, considered to be stable perceptions (Gotlib *et al.*, 1988; Parker, 1983). They reflect what parents were 'actually' like, not merely how they seemed to a particular individual. Thus, it is likely that depressed adults have indeed had more negative relationships with their parents than have non-depressed persons. These results add to a growing body of literature indicating that the social context of depression cannot be ignored aetiologically (e.g., Brown & Harris, 1978) or in treatment (Gotlib & Colby, 1987).

#### 4.3.3.6. *Conclusions:*

To conclude this section (aimed at placing the main findings of this study into the wider context of the psychological literature available) it is apparent that fatherhood has been somewhat neglected in research. The PBI is an accepted measure of perceived and actual parenting. It elucidates two factors, 'care' and 'overprotection / control'. Previous research indicates that 'care' is the prominent factor in predicting depression in adulthood. This is contrary to the finding of the present study. Beck's central principle with respect to anxiety (1976) suggests that the core belief of vulnerability to harm and illness (found to mediate the relationship between depression and paternal overprotection in the present study) would be particularly predictive of anxiety disorders. The issue of a high degree of comorbidity between anxiety and depression always poses difficulties for studies

such as this which use a heterogeneous clinical sample. However, the present study has highlighted the importance of the role of the father in the development of negative affective disorder. Cognitive theory does not directly explain this particular finding. Therefore, speculation about the importance of the fathers' role from a wider perspective may facilitate an understanding of the results and implications of this study.

Taking a broader view, Formaini (1991) makes a passionate statement about men and fathering, placing the problems into the political arena:

*“If any subject could be said to be underrated it is surely the subject of men and fathering. As fathers, men are best understood by their absence. In the psychological literature, one of the most popular themes today is the absentee father and his relation to the psychological development of his children. Twelve minutes is the amount of time most men spend with their children in the course of a day. But these men are not understood necessarily as “bad fathers”. It is just accepted that the role of parenting is the woman’s role, even if and when both parents work in full-time jobs. ... Western society gives scant attention to emotional and psychological needs: its basis and motivation stem from a concern with hierarchical power and personal and collective economic growth, even at the expense of half the world, or life itself.” (pp 156)*

#### **4.3.4. Good Parents, Bad Parents:**

The data from this study provide some evidence that a person's childhood relationship with his/her father is related to emotional well-being in adulthood, and

indeed that the quality of this relationship may influence later emotional stability.

However, it is important to note here that this is a preliminary exploratory study and, although the main findings do lend support to the proposed model, the risk of conducting numerous correlations is that one is subject to Type I errors.

The trends in society are contrary to the main finding of this study. There are high separation and divorce rates, where custody of children is usually awarded to mothers. Childhood sexual abuse is said to affect one in four women and one in seven men, and 50% of the “psychiatric” population (Kuyken 1995), with the father or father figure being high on the list of most likely perpetrators (Greenberg, 1979; Jones, 1982: both cited in Kuyken, 1995). The breakdown of the “community” has led to a lack of support and sharing of parenting skills. Indeed, Earls (1976) has summarised the ‘new’ requirements that men are being expected to meet: “With the emergence of new social patterns of family life and paternal responsibility, requiring a higher degree of male sensitivity and involvement than has been customary in this century, men may be expected to reveal more signs of stress related to paternity than the literature reflects to date.”(p 213).

Pacella (1989) has identified four important dimensions of fatherhood in early child development within a psychoanalytical, developmental framework:

1. The father enhances maturation by facilitating the separation-individuation process.
2. The father aids the imitative and internalisation processes in both boys and girls.
3. The father helps to modulate and regulate psychosexual development.
4. The father promotes the development of the sense of reality.

This seems a lot to expect from someone who only has twelve minutes a day in which to achieve it. However, one person in the clinical group had this to say about her relationship with her father:

*“Marvellous - a very supportive and encouraging person and someone who always helped me find a positive aspect to any situation. The main person in my life to teach me to laugh, have faith in my own judgements and abilities, and the confidence to ‘have a go’ no matter what the outcome, win or lose.”*

Of course, the child too has a role to play in this process. In a somewhat radical but interesting paper about ‘integrative body psychotherapy’, Rand (1996) proposed that: (a) each child brings a unique essence of Self into the world; (b) that the child’s developing sense of Self-in-the-world is formed within the context of primary relationships; and (c) that this process begins well before the development of cognitive and intellectual capacities. She asserts that bonding is a biological need which occurs during a hormonally determined critical period and also that the manner in which the infant bonds forms the blueprint for all future relationships. Bonding is a two-way street. Parents who have not themselves formed a bond in childhood often find it difficult to be “there” for the new-born. One thing, at least, seems clear. People who do not become bonded in early infancy spend the rest of their lives looking for it, one way or another. On the whole, men to date have not been encouraged to ‘bond’ with their offspring, only provide for them. Indeed, a close relationship between father and child is often regarded with scepticism, and unfortunately, often not without good cause.

Many fathers have taken this bonding process as a licence to sexually abuse their children, with the 'aim' of educating them about the world (Greenberg, 1979; Jones, 1982; both cited in Kuyken, 1995). It is apparent that fathering is an important and delicate role to play. Kraemer (1995) has plotted the roles of men and women in history and concluded that "relative equality gave way to the inequality of the sexes in the historic world. Men's status, or prestige, was increased, but at great cost to their modesty, their capacity to love, and, of course, to women. As feminist scholars have shown, the political, intellectual and artistic achievements of women throughout history have largely been ignored. But because vulnerability and tenderness are projected into women, the definition of maleness becomes rather hollow, encouraging performance at the expense of genuineness." He goes on to quote Redfearn (1992) to make his point:

*It is as if the symbol of authority is a hard father who is not yet assured of loving and being loved, a narcissistically wounded or deprived person who, despairing of being loved, resorts to force and legalistic principles and reinforces this way of feeling secure by accentuating masculine-feminine polarities and subjugating females and female deities. (p 188)*

The implications of abusing the fathers' role are only just beginning to be acknowledged as women (and increasingly men) reveal histories of childhood abuse. Steele (1990) suggested that "probably the most tragic sequel to sexual abuse is the pervasive, depressive feeling that one can never enter into a comfortable adult life and that rewarding, intimate relationships are impossible to achieve. Any attempt to be close with another person is perceived as dangerous." Studies of student samples



support a connection between reporting a history of childhood sexual abuse and mental health and relationship problems (e.g., Finkelhor, 1984). Follow-up studies of victims of sexual abuse also point to behavioural difficulties, particularly in the area of anger control, and increased symptoms of depression and anxiety (e.g., Conte and Schuerman, 1987). Mullen *et al.* (1993) investigated the relationship between childhood sexual abuse and mental health in adult life in a random community sample of women. They reported that there was a positive correlation between reporting abuse and greater levels of psychopathology on a range of measures (suicidal behaviour, substance abuse, disrupted homes, inadequate parenting, and physical abuse). Using the statistical technique of logistic regression, Mullen *et al.* (1993) report that abuse directly contributes to adult psychopathology and that the severity of abuse is related to the degree of adult psychopathology. Finkelhor *et al.* (1986) reported that “In the clinical literature, depression is the symptom most commonly reported among adults molested as children, and empirical findings seem to confirm this” (pp 152). However, Kuyken (1995) notes that although many of the symptoms of depression have been associated with long-term effects of childhood sexual abuse (CSA), few studies have addressed the issue of whether CSA is associated with the syndrome of depression. Those depressed people who experienced severe abuse and/or abuse by a primary caregiver tend to report more concurrent levels of distress.

A subsample of the clinical group were indeed members of a group for survivors of childhood sexual abuse. Therefore, in considering these issues, it is small wonder that vulnerability to harm and illness is a core belief that mediates the relationship between depression and parental style in the present study. As the PBI

has been found to be an accurate measure of actual parenting, it can be confidently argued that these adverse childhood experiences have left a lifelong legacy in their wake.

It has already been suggested that chronic depressives often demonstrate features of personality disorder. It is commonly accepted that adult survivors of childhood sexual abuse also present with such features (Briere & Runtz, 1989). There is some evidence to suggest that the PBI is a good measure of general psychopathology, rather than specific disorders. In any case, the comorbidity of depression and anxiety is well established (Parker *et al.*, 1995). Therefore, given the prevalence of CSA in a 'psychiatric' population, the main finding from this study could be considered in terms of a link between paternal control / overprotection (i.e. abuse) causing an affective disorder in adulthood, by predisposing the individual to feel 'unsafe' in the world. To this end, recent research in Australia (Parker *et al.*, 1997) has led to the development of an instrument - MOPS (Measure of Parenting Style) - based on the PBI, but incorporating scales assessing parental abuse. This seems to be a valuable development, as clinical judgements in deciding when a relationship becomes 'abusive' are variable.

#### **4.3.5. Conclusions**

The findings from this study have highlighted the importance of the role of the father in the presentation of depression to psychology services. This is in keeping with personal clinical impression. It has been suggested that because vulnerability and tenderness have been projected into women, the definition of maleness has become rather hollow, encouraging performance at the expense of genuineness (Kraemer, 1995). Therefore, the father's role appears to be interpreted

by both genders as critical, demanding, controlling, overprotective, authoritative.

When he takes up the role assigned to him, he is experienced as powerful. If he abuses this role, he is experienced as abusive. When he hands over this role to his partner, he is judged as “weak”.

A theory that has long underpinned aetiological and clinical formulations is that certain parental behaviours and attitudes dispose the child to both psychiatric disorder as well as to dysfunctional social and emotional interactions in adulthood. Any research addressing such propositions must first define the salient at-risk parental characteristics and, secondly, seek to measure those characteristics validly (Parker *et al.*, 1997). There is recent interest in the role of fathers in the aetiology of adolescent psychopathology (Phares and Compass, 1992), but research in this area is significantly hampered by the problem of recruiting men to participate (Walters, personal communication).

Although research into childhood abuse, in general, has increased, interest in the role of parental psychiatric factors in child maltreatment has been sporadic. There is an on-going debate about the extent to which psychiatric factors cause or contribute to child maltreatment. Little is known about those children who experience non-fatal but inadequate care of a severity which significantly impairs physical, emotional and psychological development (Falkov, 1996). Therefore, a disparity exists between the extensive identification of psychopathology in children, and a scarcity of clinical studies assessing parental psychiatric disorder in relation to child care issues, in particular, significant harm and maltreatment. Pound (1996) claimed that “the child learns primarily from his parents (and most intensely from his or her mother) what it is to be human, and how people think, feel and behave in

general and respond to the self in particular” (pp 201). There is some evidence to suggest that depression in mothers is associated with child abuse and neglect (Zuravin, 1988). However, fathers are still underrepresented in such research, despite growing evidence of their contribution to the maladjustment of their children.

Unfortunately, Formaini (1991) has noted that in Western society the father has been socialised in such a way as to not be “in tune” with his own feelings, let alone those of his children. Therefore, it seems that fathers are expected to fulfil a role without the right tools. They are then excused from the role of fathering, for not being able to achieve the right balance for their children. However, in recent years, this notion of mother-infant exclusiveness has been challenged. Schaeffer and Emerson (1964; cited in Earls, 1976) demonstrated evidence of multiple attachments (primary paternal and primary maternal) and suggested that bonds to either parent are maintained by the amount of interaction and caretaking given by that parent. The question remains: under what circumstances do childhood experiences lead to depression, to anxiety, to a redoubling of efforts to overcome, to rage, or to physical illness. There is a need for further research aiming to distinguish the effects of paternal and maternal factors. Both men and women are seeking more complete and enriched lives in technologically advanced societies. Therefore, it might be that men will, of their own accord, seek more responsibility in infant and child care (Earls, 1976).

#### **4.4. Implications for Clinical Practice:**

The main findings from this study have implications for clinical practice, in the areas of both treatment/intervention and prevention. Health professionals must

achieve greater awareness of men's roles in the lives of their families and children (Earls, 1976) for two reasons. Firstly, they should promote "good" fathering by validating the important role of the father, and hence protecting children from a lifetime of depression. Secondly, they need to identify "bad" fathering at an early stage and intervene to protect the child (and therefore the adult person) from a lifetime of despair and abuse.

#### ***4.4.1. Treatment/Intervention:***

This study has shown that a set of core beliefs (particularly emotional inhibition, failure to achieve, self-sacrifice, abandonment, and mistrust/abuse) are likely to be relevant in the treatment of a depressed individual. However, if the depressed person reports having experienced an overprotective/controlling father in childhood, then the key target for treatment should be the core belief of vulnerability to harm and illness. The person holds a strong conviction that disaster is about to strike at any time and s/he won't be able to protect themselves. The results of this study indicate that this core belief is a strong mediator between paternal overprotection in childhood and depression in adulthood.

This result can be compared with the idea of reciprocal roles in cognitive analytic therapy (CAT) developed by Ryle (1991). This therapy aims to integrate cognitive and psychoanalytic ideas into a focused, collaborative, brief therapy. The concept of reciprocal roles is concerned with identifying the parent-derived role (e.g., overprotective/controlling) and the child-derived response to that (e.g., controlled, vulnerable, unable to make decisions for oneself). It is assumed that during childhood the person has internalised the parental role to some extent (maybe

through the process of modelling), and in adulthood re-enacts these roles in their subsequent relationships.

#### **4.4.2. Prevention:**

For those individuals who are prone to depression (but who do not necessarily seek help) the results of this study indicate that core beliefs exacerbate mood states. Knowing which core beliefs do this to a significant level can facilitate challenging the onset of an episode. The core beliefs which contribute to the experience of a depressive episode are failure to achieve, vulnerability to harm and illness, emotional deprivation and inhibition, and insufficient self-control/self-discipline. By making the person aware of these potential pitfalls in their lives, they may be able to exercise some control over the onset of a depressive episode. Of course, by exercising this control they will have immediate evidence which challenges their failure to achieve and insufficient self-control beliefs.

However, if the person is known to have experienced an overprotective / controlling maternal figure in the first sixteen years of their lives then the key core beliefs operating are likely to be social undesirability, self-sacrifice, and failure to achieve. If these are identified and the link with maternal overprotection made explicit to the client, they can again exercise some control over their depressed moods.

#### **4.5. Recommendations for Further Research:**

This was an exploratory study, conducted within strict time constraints and limited resources. However, its main strength was the use of a large community sample as this was more representative than more accessible student samples. Given more time, a “purer” clinical sample (all outpatients) would have been preferable, as

members of Depression Alliance were receiving varying amounts of help with their depression. The difficulties of obtaining a homogenous group in a clinical sample are renowned. Even if it were possible, the sample would not accurately reflect the situation in the clinical setting. However, it would be useful to compare this depressed outpatient group with other clinical groups (e.g., eating disorders, obsessive/compulsive, PTSD) in order to identify the patterns of core beliefs and relationships with parental figures that may characterise the type of disorders.

The data from this study could be further scrutinised to test the proposed model in terms of gender. There were enough male and female participants to carry out the stringent statistical analyses. Also, gender differences in depression are commonly reported as secondary to the main study, but there is some evidence to suggest qualitative differences which have clinical implications. The data from the present study could be further interrogated to replicate Parker and Hadzi-Pavlovic's (1992) findings with respect to the effects of combined parenting (i.e., the interactive effects of mothers' and fathers' parenting styles).

In Beck's cognitive theory (1976), vulnerability to harm and illness is the key concept in anxiety. However, the finding in this study of its mediating role in the link between parental style and depression brings this into question. It is well established that there is a high rate of comorbidity between anxiety and depression. Therefore, to delineate the strongest associations a replication of this study should include a measure of anxiety (e.g., the Beck Anxiety Inventory (BAI; Beck, 1990)).

There is some suggestion that becoming a parent affects how one retrospectively remembers one's own childhood. This is contrary to the assertions

that the PBI is a measure of “actual” parenting. A longitudinal study on a sample who become parents would be able to shed some light on this discrepancy.

Finally, the main finding has highlighted fathers as central figures in the development of depression in their offspring. However, the problem in research and clinical practice remains - gaining the attention of and recruiting men into psychological services is difficult. For those who have recognised the splits in which they live and have done something about them, they report “I used to feel on the outside if I wasn’t at the centre - crazy I know - whereas now I have the feeling of being attached to everything.” (Formaini, 1991; pp179).



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## **APPENDICES**

**Appendix 1:** DSM IV criteria for depression.

**Appendix 2:** Definitions of 16 EMSs.

**Appendix 3:** Letters granting ethical approval.

**Appendix 4:** Information sheets for three categories of participants.

**Appendix 5:** Consent forms for individual participants.

**Appendix 6:** Form for clinicians of outpatient group.

**Appendix 7:** Form for demographic and qualitative information.

**Appendix 8:** Beck Depression Inventory (BDI).

**Appendix 9:** Parental Bonding Instrument (PBI).

**Appendix 10:** Young's Schema Questionnaire (YSQ).

## **APPENDIX 1: DSM IV CRITERIA FOR DEPRESSION.**

### **Criteria for Major Depressive Episode - DSM IV:**

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

**Note:** Do not include symptoms that are clearly due to a general medical condition, or mood-congruent delusions or hallucinations:

- (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful).  
**Note:** In children and adolescents, can be irritable mood
- (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
- (3) significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.  
**Note:** In children, consider failure to make expected weight gains
- (4) insomnia or hypersomnia nearly every day
- (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
- (6) fatigue or loss of energy nearly every day
- (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e. after the loss of a loved one, the symptoms persist for longer than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

### **Diagnostic criteria for Major Depressive Disorder, Single Episode - DSM IV**

- A. Presence of a single Major Depressive Episode.
- B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode. **Note:** This exclusion does not apply if all the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

*Specify* (for current or most recent episode):

**Severity/Psychotic/Remission Specifiers**

**Chronic**

**With Catatonic Features**

**With Melancholic Features**

**With Atypical Features**

**With Postpartum Onset**

---

### **Diagnostic criteria for Major Depressive Disorder, Recurrent - DSM IV**

- A. Presence of two or more Major Depressive Episodes.  
**Note:** To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a Major Depressive Episode.
- B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode. **Note:** This exclusion does not apply if all the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

*Specify* (for current or most recent episode):

**Severity/Psychotic/Remission Specifiers**

**Chronic**

**With Catatonic Features**

**With Melancholic Features**

**With Atypical Features**

**With Postpartum Onset**

*Specify:*

**Longitudinal Course Specifiers (With and Without Interepisode Recovery)**

**With Seasonal Pattern**

## APPENDIX 2:

### DEFINITIONS OF 16 EARLY MALADAPTIVE SCHEMAS (EMSs)

#### IMPAIRED AUTONOMY:

*Expectations about oneself and the environment that interfere with one's perceived ability to separate, survive, and function independently.*

#### Functional Dependence / Incompetence:

Belief that one unable to handle one's everyday responsibilities in a competent manner, without considerable help from others (e.g. take care of oneself, solve daily problems, exercise good judgement, tackle new tasks, make decisions.)

#### Subjugation:

Excessive surrendering of control over one's own decisions, preferences, and emotional expression to others - usually to avoid anger, retaliation, or abandonment. Involves the perception that one's own feelings and desires are not valid or important to others. Often leads to difficulty establishing goals and direction, and to anger at the subjugation.

#### Vulnerability to Harm and Illness:

Exaggerated fear that disaster is about to strike at any time (natural, criminal, medical, or financial), and that one is unable to protect oneself.

#### Enmeshment:

Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development.

#### DISCONNECTION:

*Expectation that one's needs for nurturing, stable, trustworthy, and empathic relationships - social and intimate - will not be met in a predictable manner.*

#### Emotional Deprivation:

Expectation that one's desires for a normal degree of emotional support will not be adequately met by others.

- a) *Deprivation of Nurturance:* Absence of affection (physical or emotional) or warmth from others.
- b) *Deprivation of Protection:* Absence of strength, direction, or guidance from others.

c) *Deprivation of Empathy*: Absence of understanding, listening, self-disclosure, or mutual sharing of feelings from others.

**Abandonment / Instability:**

The perceived *instability* or *unreliability* of those available for support and connection.

Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable, unpredictable, unreliable, or erratically present; because they will die imminently; or because they will abandon the person in favour of someone else. Significant others may, to an exaggerated degree, be considered essential for survival or for life to have meaning.

**Mistrust / Abuse:**

The expectation that others will intentionally hurt, abuse, cheat, lie, manipulate, or take advantage.

**Social Isolation / Alienation:**

The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.

**UNDESIRABILITY:**

*The expectation that one will not be desirable to other people in terms of any of the following: physical attractiveness, social skills, inner worth, moral integrity, interesting personality, career accomplishments, etc.*

**Defectiveness / Shame / Unlovability:**

The feeling that one is *inwardly* defective, flawed, or invalid; or that one would be fundamentally unlovable to significant others if exposed.

**Social Undesirability:**

The belief that one is *outwardly* undesirable to others (e.g., ugly, sexually undesirable, low in status, poor in conversational skills, dull).

**Failure to Achieve:**

The belief that one has failed, or is inadequate relative to one's peers, in areas of achievement (school, career, sports, etc.). Often involves the belief that one is stupid, inept, untalented, ignorant, and so on.

## **RESTRICTED SELF-EXPRESSION:**

*Inordinate restriction or suppression of one's emotions, impulses, natural inclinations, or daily preferences, in order to gain the respect of others or avoid guilt.*

### **Emotional Inhibition:**

Excessive inhibition of emotions or impulses, especially anger, because one expects their expression to result in the loss of esteem or in harm to others.

### **Self-Sacrifice:**

Excessive voluntary focus on meeting the needs of others, at the expense of one's own needs and preferences, either to avoid guilt or because one expects a gain in esteem. Usually leads to a sense that one's own needs are not being adequately met and resentment of those who take.

### **Unrelenting Standards:**

The relentless striving to meet extremely high expectations of oneself - or excessive emphasis on status, money, achievement, order, or recognition - at the expense of happiness, pleasure, health, sense of accomplishment, or satisfying relationships.

## **INSUFFICIENT LIMITS:**

*Deficiency in internal limits leading to difficulty meeting others' expectations or one's personal goals.*

### **Entitlement / Self-Centredness:**

Insistence that one should be able to have whatever one wants, regardless of what others consider reasonable or the cost to others.

### **Insufficient Self-Control / Self-Discipline:**

Extreme difficulty exercising sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression of one's emotions and impulses. (May include addictive behaviours or criminality.)

**APPENDIX 3:**  
**LETTERS GRANTING ETHICAL APPROVAL**





**Essex Rivers Healthcare**

A NATIONAL HEALTH SERVICE TRUST

Date 10th December 1997  
Our reference PED/pmg/Ethics P63  
Your reference  
Department Medical Personnel, Postgraduate Medical Centre

Direct Line: 01206 832147  
Fax No: 01206 851231

Ms Rajshree Shah  
36 Hiliary Gardens  
Stanmore  
Middlesex  
HA7 2NQ

Dear Ms Shah

**INVESTIGATING THE RELATIONSHIP BETWEEN PARENTAL STYLE,  
CORE BELIEFS AND DEPRESSIVE SYMPTOMS**

Thank you for attending the meeting of the Ethics Committee on Thursday  
4th December 1997.

Approval to proceed has been granted.

Yours sincerely

Dr Paul E Dixon  
Chairman  
**Research Ethics Committee**



## The University College London Hospitals

### The Joint UCL/UCLH Committees on the Ethics of Human Research

Committee A Chairman: Dr F D Thompson

Please address all correspondence to:

Mrs Iwona Nowicka  
Research & Development Directorate  
9th Floor, St Martin's House  
140 Tottenham Court Road, LONDON W1P 9LN  
Tel. 0171- 380 9579 Fax 0171-380 9937  
e-mail: inowicka@academic.uclh.nthames.nhs.uk

Ms A Cooke  
Lecturer in Psychology  
Sub-department of Health and Clinical Psychology  
UCL  
Gower Street

25 September 1997

Dear Ms Cooke

**Study No:** 97/0309  
**Title:** Investigating the relationship between parental style, core beliefs and depressive symptoms

Thank you for sending us the above ethics proposal which was discussed and approved at the last meeting of the 18th September.

Please note that it is important that you notify the Committee of any adverse events or changes (name of investigator etc) relating to this project. You should also notify the Committee on completion of the project, or indeed if the project is abandoned. **Please remember to quote the above number in any correspondence.**

Yours sincerely

  
Dr F D Thompson  
Chairman

**APPENDIX 4:**  
**INFORMATION SHEETS FOR THREE CATEGORIES OF**  
**PARTICIPANTS.**

1. NON-CLINICAL CONTROL GROUP
2. MEMBERS OF DEPRESSION ALLIANCE
3. CLINICAL OUTPATIENTS

INFORMATION SHEET  
Confidential

Date.....

Dear Participant,

I am training to be a Clinical Psychologist at University College, London. As part of this course I have to carry out a research project. Therefore, I am inviting you to participate in this study which is investigating the relationships between parental styles, core beliefs and depressive symptoms.

I am looking at the patterns between how people have been brought up, what they believe now and whether these are related to their moods and emotions. In order to do this, I need to recruit a non-clinical “control” group (people who do *not* have a history of depression and are not currently depressed), to compare the results I obtain from other groups. Therefore, I would be grateful if you could participate in this study as a member of this “control” group. The information from this study will in turn enable psychology departments to provide a better service for clients suffering from depression.

If you choose to take part, and you are under no obligation to do so, please complete the consent form and questionnaires enclosed and return them to me in the SAE provided, *as soon as possible*.

Thanking you in advance for your co-operation. I look forward to hearing from you in the near future.

Yours faithfully,

Rajshree Shah  
Clinical Psychologist in Training

Anne Cooke  
Clinical Psychologist

**INFORMATION SHEET**  
**Confidential**

Date.....

Dear Participant,

I am training to be a Clinical Psychologist at University College, London. As part of this course I have to carry out a research project. Therefore, I am inviting you to participate in this study which is investigating the relationships between parental styles, core beliefs and depressive symptoms.

I am looking at the patterns between how people have been brought up, what they believe now and whether these are related to their moods and emotions. In order to do this, I need to recruit individuals who have a history of depression and who may or may not be depressed now. As a member of Depression Alliance, you would clearly be eligible for this study, and therefore, I would be grateful for your participation. The information from this study will in turn enable psychology departments to provide a better service for clients suffering from depression.

If you choose to take part, and you are under no obligation to do so, please complete the consent form and questionnaires enclosed and return them to me preferably now, but otherwise in a SAE which can be provided, *as soon as possible*.

Thanking you in advance for your co-operation.

Yours faithfully,

Rajshree Shah  
Clinical Psychologist in Training

Anne Cooke  
Clinical Psychologist

INFORMATION SHEET  
Confidential

Date.....

Dear Participant,

I am training to be a Clinical Psychologist at University College, London. As part of this course I have to carry out a research project. Therefore, I am inviting you to participate in this study which is investigating the relationships between parental styles, core beliefs and depressive symptoms.

I am looking at the patterns between how people have been brought up, what they believe now and whether these are related to their moods and emotions. In order to do this, I need to recruit individuals who are depressed. As you are currently receiving treatment as an outpatient by a Psychologist, clearly you would be eligible for this study, and therefore, I would be grateful for your participation. The information from this study will in turn enable psychology departments to provide a better service for clients suffering from depression.

If you choose to take part, and you are under no obligation to do so, please complete the consent form and questionnaires enclosed and return them, *as soon as possible*, either to your Psychologist, who will ensure they reach me in the sealed envelope, or directly to me by post. You may wish to discuss any aspect of this in your session, but confidentiality is guaranteed as I will not receive any identifying information about you.

Thanking you in advance for your co-operation. I look forward to hearing from you in the near future.

Yours faithfully,

Rajshree Shah  
Clinical Psychologist in Training

Anne Cooke  
Clinical Psychologist

**APPENDIX 5:**  
**CONSENT FORMS FOR INDIVIDUAL PARTICIPANTS.**

**CONSENT FORM**  
Confidential

**Investigating the relationships between parental styles, core beliefs and depressive symptoms.**

Anne Cooke, Lecturer in Psychology, University College London  
Rajshree Shah, Clinical Psychologist in Training, University College London

To be completed by the participant:

- |   |        |
|---|--------|
| 1. Have you read the information sheet about the study?   | YES/NO |
| 2. Have you had an opportunity to ask questions and discuss this study?   | YES/NO |
| 3. Have you received satisfactory answers to all your questions?  | YES/NO |
| 4. Have you received enough information about the study?  | YES/NO |
| 5. Do you understand that you are free to withdraw from this study<br>*at any time? *without giving a reason for withdrawing? | YES/NO |
| 6. Do you agree to take part in this study?   | YES/NO |

Signed:.....Date:.....

Name in block letters:.....

**APPENDIX 6:**  
**FORM FOR CLINICIANS OF OUTPATIENT GROUP.**

Id. Number \_\_\_\_\_

November 1997

Dear Clinician,

**Research Project 1997/98 - Rajshree Shah**  
**INFORMATION SHEET FOR CLINICIANS**

Thank you for agreeing to administer questionnaires for my research project to your clients. The following guidelines should help you to decide which clients are suitable and which are not. If in doubt, and the client is willing to spend an hour or so completing the questionnaires, and you feel this is not going to adversely affect your work with them, then please do administer them.

The criteria for Major Depressive Disorder (Single Episode and Recurrent) from DSM IV are the most clinically relevant for this study. Please find them enclosed for your information. If your client meets these requirements to the best of your knowledge, and they are over 18 years old, then they are suitable for this study.

Is this your client's first depressive episode?      Yes / No

Depression is rarely found as a sole problem in most clinical cases, thus raising the issue of co-morbidity. Does this client also have any of the problems listed below? Please specify:

- Substance misuse      Yes / No
- Alcohol misuse      Yes / No
- General Anxiety Disorder (GAD)      Yes / No
- Phobia: Please specify type:.....      Yes / No
- Obsessive-Compulsive Disorder (OCD)      Yes / No
- Post Traumatic Stress Disorder (PTSD)      Yes / No
- Personality Disorder      Yes / No
- Eating Disorder:      Yes / No
- Other? Please specify:.....      Yes / No

Please would you also complete this information sheet at the front of each questionnaire pack you administer, and **do not** give this to the client. Check that the Id. numbers on the information sheet and the questionnaire pack match. I would be grateful if you could match the Id. numbers on return of the questionnaires, and keep them for my collection. If the questionnaires are not returned to you, please give me your completed information sheets anyway, as the client may have decided to post the questionnaires back to me. Also, this will enable me to monitor the response rate for my study, i.e. how many people take, but do not complete questionnaires.

I hope all this makes sense, but if you have any queries please do not hesitate to contact me on (0181) 909 3258 (answerphone) or on (01206) 765350 on a Monday, Tuesday or Wednesday.

Thank you again for your co-operation. I have left myself very little time for this phase of the project, so I would be very grateful if you could fit as many in before Christmas as possible.

Kind regards.

Yours sincerely,



**APPENDIX 7:  
FORM FOR DEMOGRAPHIC AND QUALITATIVE  
INFORMATION.**

Id. Number: \_\_\_\_\_

**General Information:**

Gender:        male                                  female

Age: 18 - 20                                  31 - 40                                  51 - 60                                  71 - 80  
      21 - 30                                  41 - 50                                  61 - 70                                  81 - 90

Marital Status:        single (never married)                                  married  
                                 divorced    co-habiting  
                                 separated    in stable relationship  
                                 widowed

Occupation:    self-employed                                  unemployed                                  How long?  
                                 employed (full-time)                                  made redundant                                  How long?  
                                 employed (part-time)                                  retired                                  How long?

Please state what your occupation is: \_\_\_\_\_

How would you describe your ethnicity? \_\_\_\_\_

How would you describe your religion? \_\_\_\_\_

Sexual orientation:        heterosexual                                  homosexual  
                                 bisexual    not willing to answer this question

Are you a parent:        Yes                                  No

If so, do you live with your children?        Yes                                  No                                  They have grown-up and left home

Id. Number: \_\_\_\_\_

Have you ever been clinically depressed?    Yes    No    Don't know

What type of treatment did you receive? .....

Are you depressed now?    Yes    No    Don't know

What type of treatment are you receiving now?.....

Please describe briefly your relationship with your father or father figure:  
(If there was no one in your life who fulfilled the role of a father to you, please describe your circumstances below and do *not* fill in the PBI-Father questionnaire.)

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Please describe briefly your relationship with your mother or mother figure:  
(If there was no one in your life who fulfilled the role of a mother to you, please describe your circumstances below and do *not* fill in the PBI-Mother questionnaire.)

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**APPENDIX 8:**  
**BECK DEPRESSION INVENTORY (BDI).**

**BDI:** Date: \_\_\_\_\_

Id. Number: \_\_\_\_\_

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the *one* statement in *each* group which best describes the way you have been feeling during the *past week, including today!* Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

- |   |   |
|---|---|
| <b>1</b> 0 I do not feel sad.<br>1 I feel sad.<br>2 I am sad all the time and I can't snap out of it.<br>3 I am so sad or unhappy that I can't stand it.  | <b>11</b> 0 I am no more irritated now than I ever am.<br>1 I get annoyed or irritated more easily than I used to.<br>2 I feel irritated all the time now.<br>3 I don't get irritated at all by the things that used to irritate me.  |
| <b>2</b> 0 I am not particularly discouraged about the future.<br>1 I feel discouraged about the future.<br>2 I feel I have nothing to look forward to.<br>3 I feel that the future is hopeless and that things cannot improve. | <b>12</b> 0 I have not lost interest in other people.<br>1 I am less interested in other people than I used to be.<br>2 I have lost most of my interest in other people.<br>3 I have lost all of my interest in other people.   |
| <b>3</b> 0 I do not feel like a failure.<br>1 I feel I have failed more than the average person.<br>2 As I look back on my life, all I can see is a lot of failures.<br>3 I feel I am a complete failure as a person.           | <b>13</b> 0 I make decisions about as well as I ever could.<br>1 I put off making decisions more than I used to.<br>2 I have greater difficulty in making decisions than before.<br>3 I can't make decisions at all any more.   |
| <b>4</b> 0 I get as much satisfaction out of things as I used to.<br>1 I don't enjoy things the way I used to.<br>2 I don't get real satisfaction out of anything anymore.<br>3 I am dissatisfied or bored with everything.     | <b>14</b> 0 I don't feel I look any worse than I used to.<br>1 I am worried that I am looking old or unattractive.<br>2 I feel that there are permanent changes in my appearance that make me look unattractive.<br>3 I believe that I look ugly.   |
| <b>5</b> 0 I don't feel particularly guilty.<br>1 I feel guilty a good part of the time.<br>2 I feel quite guilty most of the time.<br>3 I feel guilty all of the time.   | <b>15</b> 0 I can work about as well as before.<br>1 It takes an extra effort to get started at doing something.<br>2 I have to push myself very hard to do anything.<br>3 I can't do any work at all.  |
| <b>6</b> 0 I don't feel I am being punished.<br>1 I feel I may be punished.<br>2 I expect to be punished.<br>3 I feel I am being punished.  | <b>16</b> 0 I can sleep as well as usual.<br>1 I don't sleep as well as I used to.<br>2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.<br>3 I wake up several hours earlier than I used to and cannot get back to sleep.   |
| <b>7</b> 0 I don't feel disappointed in myself.<br>1 I am disappointed in myself.<br>2 I am disgusted with myself.<br>3 I hate myself.  | <b>17</b> 0 I don't get more tired than usual.<br>1 I get tired more easily than I used to.<br>2 I get tired from doing almost anything.<br>3 I am too tired to do anything.  |
| <b>8</b> 0 I don't feel I am any worse than anybody else.<br>1 I am critical of myself for my weaknesses or mistakes.<br>2 I blame myself all the time for my faults.<br>3 I blame myself for everything bad that happens.      | <b>18</b> 0 My appetite is no worse than usual.<br>1 My appetite is not as good as it used to be.<br>2 My appetite is much worse now.<br>3 I have no appetite at all any more.  |
| <b>9</b> 0 I don't have any thoughts of killing myself.<br>1 I have thoughts of killing myself, but I would not carry them out.<br>2 I would like to kill myself.<br>3 I would kill myself if I had the chance.                 | <b>19</b> 0 I haven't lost much weight, if any, lately.<br>1 I have lost more than 5 pounds. <i>I am purposely trying to</i><br>2 I have lost more than 10 pounds. <i>lose weight by eating</i><br>3 I have lost more than 15 pounds. <i>less. Y/N</i>  |
| <b>10</b> 0 I don't cry any more than usual.<br>1 I cry more now than I used to.<br>2 I cry all the time now.<br>3 I used to be able to cry, but now I can't cry even though I want to.   | <b>20</b> 0 I am no more worried about my health than usual<br>1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.<br>2 I am very worried about physical problems and it is hard to think of much else.<br>3 I am so worried about my physical problems that I cannot think about anything else. |
|   | <b>21</b> 0 I have not noticed any recent change in my interest in sex.<br>1 I am less interested in sex than I used to be.<br>2 I am much less interested in sex now.<br>3 I have lost interest in sex completely.   |

**APPENDIX 9:**  
**PARENTAL BONDING INSTRUMENT (PBI).**

1. PBI FOR FATHERS
2. PBI FOR MOTHERS

**PBIF:** Date: \_\_\_\_\_

Id. Number: \_\_\_\_\_

This questionnaire lists various attitudes and behaviours of parents. Please read the following statements carefully thinking about your own *father* in the first 16 years of your life. Then rate each one by marking, within the brackets on the scale below, the response which best represents your relationship with your father. Please note that there are no right or wrong answers and, as this exercise is completely confidential, no one will know *your* responses, so it would be helpful if you could be as honest as possible.

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

PBIM: Date: \_\_\_\_\_

Id. Number: \_\_\_\_\_

This questionnaire lists various attitudes and behaviours of parents. Please read the following statements carefully thinking about your own *mother* in the first 16 years of your life. Then rate each one by marking, within the brackets on the scale below, the response which best represents your relationship with your mother. Please note that there are no right or wrong answers and, as this exercise is completely confidential, no one will know *your* responses, so it would be helpful if you could be as honest as possible.

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



**APPENDIX 10:  
YOUNG'S SCHEMA QUESTIONNAIRE (YSQ).**

## Schema Questionnaire

Date: \_\_\_\_\_

Id. Number: \_\_\_\_\_

Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it fits you. When you are not sure, base your answer on what you emotionally feel, not what you think to be true.

If you desire, reword the statement so that the statement would be even more true of you. Then indicate the extent to which the statements relate to you by checking the appropriate box. The scale includes "*Completely Untrue of me*", "*Mostly Untrue of me*", "*Slightly More True than Untrue*", "*Moderately True of me*", "*Mostly True of me*" and "*Describes me Perfectly*".

	Comp Untrue	Mostly Untrue	Slightly True	Moder. True	Mostly True	Describe Perfectly
1. People have not been there to meet my emotional needs.	( )	( )	( )	( )	( )	( )
2. I haven't gotten love and attention.	( )	( )	( )	( )	( )	( )
3. For the most part, I haven't had someone to depend on for advice and emotional support.	( )	( )	( )	( )	( )	( )
4. Most of the time, I haven't had someone to nurture me, share themselves with me, or care deeply about anything that happens to me.	( )	( )	( )	( )	( )	( )
5. For much of my life, I haven't had someone who wanted to get close to me and spend a lot of time with me.	( )	( )	( )	( )	( )	( )
6. In general people have not been there to give me warmth, holding and attention.	( )	( )	( )	( )	( )	( )
7. For much of my life, I haven't felt that I am special to someone.	( )	( )	( )	( )	( )	( )
8. For the most part, I have not had someone who really listens to me, understands me, or is tuned into my true needs and feelings.	( )	( )	( )	( )	( )	( )
9. I have rarely had a strong person to give me sound advice or direction when I'm not sure what to do.	( )	( )	( )	( )	( )	( )
10. I worry that the people I love will die soon, even though there is little medical reason to support my concern.	( )	( )	( )	( )	( )	( )
11. I find myself clinging to people I'm close to because I'm afraid they will leave me.	( )	( )	( )	( )	( )	( )
12. I worry that the people I feel close to will leave me or abandon me.	( )	( )	( )	( )	( )	( )
13. I feel that I lack a stable base of emotional support.	( )	( )	( )	( )	( )	( )
14. I don't feel that important relationships will last; I expect them to fail.	( )	( )	( )	( )	( )	( )

		Comp Untrue	Mostly Untrue	Slightly True	Moder. True	Mostly True	Describe Perfectly
15.	I feel addicted to partners who can't be there for me in a committed way.	( )	( )	( )	( )	( )	( )
16.	In the end, I will be alone.	( )	( )	( )	( )	( )	( )
17.	When I feel someone I care for pulling away from me, I get desperate.	( )	( )	( )	( )	( )	( )
18.	Sometimes I am so worried about people leaving me that I drive them away.	( )	( )	( )	( )	( )	( )
19.	I become upset when someone leaves me alone, even for a short period of time.	( )	( )	( )	( )	( )	( )
20.	I can't count on people who support me to be there on a regular basis.	( )	( )	( )	( )	( )	( )
21.	I can't let myself get really close to other people because I can't be sure they will always be there.	( )	( )	( )	( )	( )	( )
22.	It seems that the important people in my life are always coming and going.	( )	( )	( )	( )	( )	( )
23.	I worry a lot that the people I love will find someone else they prefer and leave me.	( )	( )	( )	( )	( )	( )
24.	The people close to me have been very unpredictable; one moment they're available and nice to me; the next, they're angry, upset, self-absorbed, fighting, and so on.	( )	( )	( )	( )	( )	( )
25.	I need other people so much that I worry about losing them.	( )	( )	( )	( )	( )	( )
26.	I feel so defenceless if I don't have people to protect me that I worry a lot about losing them.	( )	( )	( )	( )	( )	( )
27.	I can't be myself or express what I really feel, or people will leave me.	( )	( )	( )	( )	( )	( )
28.	I feel that people will take advantage of me.	( )	( )	( )	( )	( )	( )
29.	I often feel that I have to protect myself from other people.	( )	( )	( )	( )	( )	( )
30.	I feel that I cannot let my guard down in the presence of other people, or else they will intentionally hurt me.	( )	( )	( )	( )	( )	( )
31.	If someone acts nicely towards me, I assume that he/she must be after something.	( )	( )	( )	( )	( )	( )
32.	It is only a matter of time before someone betrays me.	( )	( )	( )	( )	( )	( )
33.	Most people think only about themselves.	( )	( )	( )	( )	( )	( )
34.	I have a great deal of difficulty trusting people.	( )	( )	( )	( )	( )	( )

		Comp Untrue	Mostly Untrue	Slightly True	Moder. True	Mostly True	Describe Perfectly
35.	I am quite suspicious of other people's motives.	( )	( )	( )	( )	( )	( )
36.	Other people are rarely honest; they are usually not what they appear.	( )	( )	( )	( )	( )	( )
37.	I am usually on the lookout of people's ulterior motives.	( )	( )	( )	( )	( )	( )
38.	If I think that someone is out to hurt me, I try to hurt them first.	( )	( )	( )	( )	( )	( )
39.	People usually have to prove themselves to me first before I can trust them.	( )	( )	( )	( )	( )	( )
40.	I set up "tests" for other people to see if they are telling me the truth and are well intentioned.	( )	( )	( )	( )	( )	( )
41.	I subscribe to the belief: "Control or be controlled".	( )	( )	( )	( )	( )	( )
42.	I get angry when I think about the ways I have been mistreated by other people throughout my life.	( )	( )	( )	( )	( )	( )
43.	Throughout my life, those close to me have taken advantage of me or used me for their own purposes.	( )	( )	( )	( )	( )	( )
44.	I have been physically, emotionally, or sexually abused by important people in my life.	( )	( )	( )	( )	( )	( )
45.	I don't fit in.	( )	( )	( )	( )	( )	( )
46.	I'm fundamentally different from other people.	( )	( )	( )	( )	( )	( )
47.	I don't belong; I'm a loner.	( )	( )	( )	( )	( )	( )
48.	I feel alienated from other people.	( )	( )	( )	( )	( )	( )
49.	I feel isolated and alone.	( )	( )	( )	( )	( )	( )
50.	I always feel on the outside of groups.	( )	( )	( )	( )	( )	( )
51.	No one really understands me.	( )	( )	( )	( )	( )	( )
52.	My family was always different from the other families around us.	( )	( )	( )	( )	( )	( )
53.	I sometimes feel as if I am an alien.	( )	( )	( )	( )	( )	( )
54.	If I disappeared tomorrow, no one would notice.	( )	( )	( )	( )	( )	( )
55.	No man/woman I desire could love me once he/she saw my defects.	( )	( )	( )	( )	( )	( )
56.	No one I desire would want to stay close to me if he/she knew the real me.	( )	( )	( )	( )	( )	( )
57.	I am inherently flawed and defective.	( )	( )	( )	( )	( )	( )

	Comp Untrue	Mostly Untrue	Slightly True	Moder. True	Mostly True	Describe Perfectly
58. No matter how hard I try, I feel that I won't be able to get a significant man/woman to respect me or feel that I am worthwhile.	( )	( )	( )	( )	( )	( )
59. I'm unworthy of the love, attention, and respect of others.	( )	( )	( )	( )	( )	( )
60. I feel that I'm not lovable.	( )	( )	( )	( )	( )	( )
61. I am too unacceptable in very basic ways to reveal myself to other people.	( )	( )	( )	( )	( )	( )
62. If others found out about my basic defects, I could not face them.	( )	( )	( )	( )	( )	( )
63. When people like me, I feel that I am fooling them.	( )	( )	( )	( )	( )	( )
64. I often find myself drawn to people who are very critical or reject me.	( )	( )	( )	( )	( )	( )
65. I have inner secrets that I don't want people close to me to find out.	( )	( )	( )	( )	( )	( )
66. It is my fault that my parent(s) could not love me.	( )	( )	( )	( )	( )	( )
67. I don't let people know the real me.	( )	( )	( )	( )	( )	( )
68. One of my greatest fears is that my defects will be exposed.	( )	( )	( )	( )	( )	( )
69. I cannot understand how anyone could love me.	( )	( )	( )	( )	( )	( )
70. I'm not sexually attractive.	( )	( )	( )	( )	( )	( )
71. I'm too fat.	( )	( )	( )	( )	( )	( )
72. I'm ugly.	( )	( )	( )	( )	( )	( )
73. I can't carry on a decent conversation.	( )	( )	( )	( )	( )	( )
74. I'm dull and boring in social situations.	( )	( )	( )	( )	( )	( )
75. People I value won't associate with me because of my social status (e.g. income, educational level, career).	( )	( )	( )	( )	( )	( )
76. I never know what to say socially.	( )	( )	( )	( )	( )	( )
77. People don't want to include me in their groups.	( )	( )	( )	( )	( )	( )
78. I am very self-conscious around other people.	( )	( )	( )	( )	( )	( )
79. Almost nothing I do at work (or school) is as good as what other people can do.	( )	( )	( )	( )	( )	( )
80. I'm incompetent when it comes achievement.	( )	( )	( )	( )	( )	( )
81. Most other people are more capable than I am in areas of work and achievement.	( )	( )	( )	( )	( )	( )

	Comp Untrue	Mostly Untrue	Slightly True	Moder. True	Mostly True	Describe Perfectly
82. I'm a failure.	( )	( )	( )	( )	( )	( )
83. I'm not as talented as most people are at their work.	( )	( )	( )	( )	( )	( )
84. I'm not as intelligent as most people when it comes to work (or school).	( )	( )	( )	( )	( )	( )
85. I am humiliated by my failures and inadequacies in the work sphere.	( )	( )	( )	( )	( )	( )
86. I often feel embarrassed around other people because I don't measure up to them in terms of my accomplishments.	( )	( )	( )	( )	( )	( )
87. I often compare my accomplishments with others and feel that they are more successful.	( )	( )	( )	( )	( )	( )
88. I do not feel capable of getting on on my own in everyday life.	( )	( )	( )	( )	( )	( )
89. I need other people to help me get by.	( )	( )	( )	( )	( )	( )
90. I do not feel I can cope well by myself.	( )	( )	( )	( )	( )	( )
91. I feel that other people can take care of me better than I can take care of myself.	( )	( )	( )	( )	( )	( )
92. I have trouble tackling new tasks outside of work unless I have someone to guide me.	( )	( )	( )	( )	( )	( )
93. I think of myself as a dependent person, when it comes to everyday functioning.	( )	( )	( )	( )	( )	( )
94. I screw up everything I try, even outside of work (or school).	( )	( )	( )	( )	( )	( )
95. I'm inept in most areas of my life.	( )	( )	( )	( )	( )	( )
96. If I trust my own judgement in everyday situations, I'll make the wrong decision.	( )	( )	( )	( )	( )	( )
97. I lack common sense.	( )	( )	( )	( )	( )	( )
98. My judgement cannot be relied upon in everyday situations.	( )	( )	( )	( )	( )	( )
99. I am not confident in my ability to solve everyday problems that come up.	( )	( )	( )	( )	( )	( )
100. I feel I need someone to rely on to give me advice about practical issues.	( )	( )	( )	( )	( )	( )
101. I feel more like a child than an adult when it comes to handling everyday responsibilities.	( )	( )	( )	( )	( )	( )
102. I find the responsibilities of everyday life overwhelming.	( )	( )	( )	( )	( )	( )

	Comp Untrue	Mostly Untrue	Slightly True	Moder. True	Mostly True	Describe Perfectly
103. I can't seem to escape the feeling that something bad is about to happen.	( )	( )	( )	( )	( )	( )
104. I feel that a disaster (natural, criminal, financial, or medical) could strike any moment.	( )	( )	( )	( )	( )	( )
105. I worry about becoming a street person or vagrant.	( )	( )	( )	( )	( )	( )
106. I worry about being attacked.	( )	( )	( )	( )	( )	( )
107. I feel that I must be very careful about money or else I might end up with nothing.	( )	( )	( )	( )	( )	( )
108. I take great precautions to avoid getting sick or hurt.	( )	( )	( )	( )	( )	( )
109. I worry that I will lose all my money and become destitute.	( )	( )	( )	( )	( )	( )
110. I worry that I am developing a serious illness, even though nothing serious has been diagnosed by a physician.	( )	( )	( )	( )	( )	( )
111. I am a fearful person.	( )	( )	( )	( )	( )	( )
112. I worry a lot about the bad things happening in the world: crime, pollution, and so on.	( )	( )	( )	( )	( )	( )
113. I often feel that I might go crazy.	( )	( )	( )	( )	( )	( )
114. I often feel that I'm going to have an anxiety attack.	( )	( )	( )	( )	( )	( )
115. I often worry that I might have a heart attack, even though there is little medical reason to be concerned.	( )	( )	( )	( )	( )	( )
116. I feel that the world is a dangerous place.	( )	( )	( )	( )	( )	( )
117. I have not been able to separate myself from my parent(s), the way other people my age seem to.	( )	( )	( )	( )	( )	( )
118. My parent(s) and I tend to be over-involved in each other's lives and problems.	( )	( )	( )	( )	( )	( )
119. It is very difficult for my parent(s) and I to keep intimate details from each other, without feeling betrayed or guilty.	( )	( )	( )	( )	( )	( )
120. My parent(s) and I have to speak to each other almost everyday or else one of us feel guilty, hurt, disappointed or alone.	( )	( )	( )	( )	( )	( )
121. I often feel that I do not have a separate identity from my parent(s) or partner.	( )	( )	( )	( )	( )	( )
122. I often feel as though my parent(s) are living through me - I do not have a life of my own.	( )	( )	( )	( )	( )	( )

	Comp Untrue	Mostly Untrue	Slightly True	Moder. True	Mostly True	Describe Perfectly
123. It is very difficult for me to maintain a distance from the people I am intimate with; I have trouble keeping any separate sense of self.	( )	( )	( )	( )	( )	( )
124. I am so involved with my partner or my parent(s) that I do not really know who I am or what I want.	( )	( )	( )	( )	( )	( )
125. I have trouble separating my point of view or opinion from that of my parent(s) or partner.	( )	( )	( )	( )	( )	( )
126. I often feel that I have no privacy when it comes to my parent(s) or partner.	( )	( )	( )	( )	( )	( )
127. I feel that my parent(s) are, or would be very hurt about my living on my own, away from them.	( )	( )	( )	( )	( )	( )
128. I let other people have their way because I fear the consequences.	( )	( )	( )	( )	( )	( )
129. I think, if I do what I want, I'm only asking for trouble.	( )	( )	( )	( )	( )	( )
130. I feel that I have no choice but to give in to other people's wishes, or else they will retaliate or reject me in some way.	( )	( )	( )	( )	( )	( )
131. In relationships, I let the other person have the upper hand.	( )	( )	( )	( )	( )	( )
132. I've always let others make choices for me, so I really don't know what I want for myself.	( )	( )	( )	( )	( )	( )
133. I feel the major decisions in my life were not really my own.	( )	( )	( )	( )	( )	( )
134. I worry a lot about pleasing other people, so they won't reject me.	( )	( )	( )	( )	( )	( )
135. I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account.	( )	( )	( )	( )	( )	( )
136. I get back at people in little ways instead of showing my anger.	( )	( )	( )	( )	( )	( )
137. I will go to much greater lengths than most people to avoid confrontations.	( )	( )	( )	( )	( )	( )
138. I put other people's needs before my own, or else I feel guilty.	( )	( )	( )	( )	( )	( )
139. I feel guilty when I let other people down or disappoint them.	( )	( )	( )	( )	( )	( )
140. I give more to other people than I get back in return.	( )	( )	( )	( )	( )	( )
141. I'm the one who usually ends up taking care of the people I'm close to.	( )	( )	( )	( )	( )	( )



	Comp Untrue	Mostly Untrue	Slightly True	Moder. True	Mostly True	Describe Perfectly
142. There is almost nothing I couldn't put up with if I loved someone.	( )	( )	( )	( )	( )	( )
143. I am a good person because I think of others more than of myself.	( )	( )	( )	( )	( )	( )
144. At work, I'm usually the one to volunteer to do extra tasks or put in extra time.	( )	( )	( )	( )	( )	( )
145. No matter how busy I am, I can always find time for others.	( )	( )	( )	( )	( )	( )
146. I can get by on very little because my needs are minimal.	( )	( )	( )	( )	( )	( )
147. I am only happy when those around me are happy.	( )	( )	( )	( )	( )	( )
148. I'm so busy doing things for other people that I care about that I have little time for myself.	( )	( )	( )	( )	( )	( )
149. I've always been the one who listens to everyone else's problems.	( )	( )	( )	( )	( )	( )
150. I'm more comfortable giving a present than receiving one.	( )	( )	( )	( )	( )	( )
151. Other people see me as doing too much for others and not enough for myself.	( )	( )	( )	( )	( )	( )
152. No matter how much I give, it is never enough.	( )	( )	( )	( )	( )	( )
153. If I do what I want I feel very uncomfortable.	( )	( )	( )	( )	( )	( )
154. It's very difficult for me to ask others to take care of my needs.	( )	( )	( )	( )	( )	( )
155. I worry about losing control of my action.	( )	( )	( )	( )	( )	( )
156. I worry that I might seriously harm someone physically or emotionally if my anger gets out of control.	( )	( )	( )	( )	( )	( )
157. I feel that I must control my emotions and impulses or something bad is likely to happen.	( )	( )	( )	( )	( )	( )
158. A lot of anger and resentment has built up inside of my that I don't express.	( )	( )	( )	( )	( )	( )
159. I am too self-conscious to show positive feelings to others (e.g. affection, showing I care).	( )	( )	( )	( )	( )	( )
160. I find it embarrassing to express my feelings to others.	( )	( )	( )	( )	( )	( )
161. I find it hard to be warm and spontaneous.	( )	( )	( )	( )	( )	( )
162. I control myself so much that people think I am unemotional.	( )	( )	( )	( )	( )	( )

	Comp Untrue	Mostly Untrue	Slightly True	Moder. True	Mostly True	Describe Perfectly
163. People see me as uptight emotionally.	( )	( )	( )	( )	( )	( )
164. I must be the best at most of what I do; I can't accept second best.	( )	( )	( )	( )	( )	( )
165. I strive to keep almost everything in perfect order.	( )	( )	( )	( )	( )	( )
166. I must look my best most of the time.	( )	( )	( )	( )	( )	( )
167. I try to do my best; I can't settle for "good enough".	( )	( )	( )	( )	( )	( )
168. I have so much to accomplish, that there is almost no time to really relax.	( )	( )	( )	( )	( )	( )
169. Almost nothing I do is quite good enough; I can always do better.	( )	( )	( )	( )	( )	( )
170. I must meet all my responsibilities.	( )	( )	( )	( )	( )	( )
171. I feel there is a constant pressure for me to achieve and get things done.	( )	( )	( )	( )	( )	( )
172. My relationships suffer because I push myself too hard.	( )	( )	( )	( )	( )	( )
173. My health is suffering because I put myself under so much pressure to do well.	( )	( )	( )	( )	( )	( )
174. I often sacrifice pleasure and happiness to meet my own standards.	( )	( )	( )	( )	( )	( )
175. When I make a mistake, I deserve strong criticism.	( )	( )	( )	( )	( )	( )
176. I can't let myself off the hook easily or make excuses for myself.	( )	( )	( )	( )	( )	( )
177. I'm a very competitive person.	( )	( )	( )	( )	( )	( )
178. I put a good deal of emphasis on money or status.	( )	( )	( )	( )	( )	( )
179. I always have to be "Number One", in terms of my performance.	( )	( )	( )	( )	( )	( )
180. I have a lot of trouble accepting "no" for an answer when I want something from other people.	( )	( )	( )	( )	( )	( )
181. I often get angry or irritable if I don't get what I want.	( )	( )	( )	( )	( )	( )
182. I'm special and shouldn't have to accept many of the restrictions placed on other people.	( )	( )	( )	( )	( )	( )
183. I hate to be constrained or kept from doing what I want.	( )	( )	( )	( )	( )	( )
184. I feel that I shouldn't have to follow the normal rules and conventions other people do.	( )	( )	( )	( )	( )	( )

	Comp Untrue	Mostly Untrue	Slightly True	Moder. True	Mostly True	Describe Perfectly
185. I feel that what I have to offer is of greater value than the contributions of others.	( )	( )	( )	( )	( )	( )
186. I usually put my needs ahead of the needs of others.	( )	( )	( )	( )	( )	( )
187. I often find that I am so involved in my own priorities that I don't have time to give to friends or family.	( )	( )	( )	( )	( )	( )
188. People often tell me that I am very controlling about the ways things are done.	( )	( )	( )	( )	( )	( )
189. I get very irritated when people don't do what I ask of them.	( )	( )	( )	( )	( )	( )
190. I can't tolerate other people telling me what to do.	( )	( )	( )	( )	( )	( )
191. I have great difficulty getting myself to stop drinking, smoking, overeating, or other problem behaviours.	( )	( )	( )	( )	( )	( )
192. I can't seem to discipline myself to complete routine or boring tasks.	( )	( )	( )	( )	( )	( )
193. Often I allow myself to carry through on impulses and express emotions that get me into trouble or hurt other people.	( )	( )	( )	( )	( )	( )
194. If I can't reach a goal, I become easily frustrated and give up.	( )	( )	( )	( )	( )	( )
195. I have a very difficult time sacrificing immediate gratification to achieve a long-range goal.	( )	( )	( )	( )	( )	( )
196. It often happens that, once I start to feel angry, I just can't control it.	( )	( )	( )	( )	( )	( )
197. I tend to overdo things, even though I know they are bad for me.	( )	( )	( )	( )	( )	( )
198. I get bored very easily.	( )	( )	( )	( )	( )	( )
199. When tasks becomes difficult, I usually can't persevere and complete them.	( )	( )	( )	( )	( )	( )
200. I can't concentrate on anything for too long.	( )	( )	( )	( )	( )	( )
201. I can't force myself to do things I don't enjoy, even when I know it's for my own good.	( )	( )	( )	( )	( )	( )
202. I lose my temper at the slightest offence.	( )	( )	( )	( )	( )	( )
203. I have rarely been able to stick to my resolutions.	( )	( )	( )	( )	( )	( )
204. I can almost never hold back from showing people how I really feel, no matter what the cost may be.	( )	( )	( )	( )	( )	( )
205. I often do things impulsively that I later regret.	( )	( )	( )	( )	( )	( )