Assessment of parents’ attitudes and symptoms of aggression in depression

Abstract

The aim of the study was to investigate whether in the clinical picture of unipolar depression we can find symptoms of abnormal ties in the generational family and their relationship with aggression, assessed during adulthood of patients. Problem questions concerned the following issue: Do patients with depression differ from healthy people in their assessment of the parental attitudes and the structure of aggression? What are the relationships between the attitudes of parents and aggression among ill and healthy people? The Questionnaire of the Retrospective Assessment of Parents Attitudes (KPR-Roc, author Plopa) and The Questionnaire of The Syndrome of Aggression (IPSA, author Gaś) were used.

Patients assessed mothers as more demanding, inconsistent and giving less autonomy in comparison to fathers. Patients were characterized by less than healthy people control of aggressive behavior. The attitude of acceptance and father’s autonomy was correlated with the reduction of overall aggression factor. Protective attitudes of mother and fathers seem to be associated with auto aggression in the group of patients. The associations of parental attitudes and aggression, illustrate the presence family factors present in the clinical picture of the unipolar depression among the patients.

Keywords: parents’ attitudes, depression,
factors and partly by negative life events (after: Auerbach et al., 2013). The developmental perspective assumes that specific and non-specific risk factors for depression and protective factors have different influential effects in certain phases of the development process. The behavioural processes that, next to neurobiological markers, would allow a fuller understanding of the mechanisms underlying cognitive determinants of depression and enable more effective treatment are less explored (Munoz et al. 2012). Relationships between the attitude of parents rejecting a child and aggression in children have been observed (Leary et al., 2006). Referring to a study conducted by Lefkowitz et al., McCrae and Costa (1988) claim that parental non-acceptance was associated with aggression in adolescents. Similarly, patients with depression more often assessed their parents as not accepting them, evoking feelings of guilt and anxiety, hostile and withdrawn from contact. Parenting styles characterized by emotional coldness and greater control proved to be particularly associated with depressive disorders (Crook et al., 1981; Hammen, 2006; Sheeber et al., 1997; Sheeber et al., 2007; Sheeber et al., 2007; Stark, 2012). Studies in the general population with the participation of people who were not patients, showed that healthy adults who perceived attitudes of their parents as overly controlling and non-accepting obtained higher scores in a depression questionnaire (Denollet et al., 2007). Some studies have also confirmed the correlation between inadequate parental care and an increased risk of severe depression (Parker, 1995; Sakado et al., 2000).

Research conducted by Malone, Haas, Sweeney and Mann (1995) showed that patients with severe depression, after suicide attempts, differed from patients without suicidal tendencies in a higher intensity of aggression, indirect hostility and impulsivity. Similar results were obtained in patients with bipolar depression (Oquendo et al., 2000).

The aim of the study is to investigate the quality of parental attitudes and identify their relationship with aggression assessed in the adulthood of patients. The problem questions are as follows: Do patients with depression differ from healthy subjects in their assessment of parental attitudes and symptoms of aggression? Are there any relationships between parental attitudes and aggression specific to the groups of patients and healthy subjects?

Material

The clinical group consisted of 30 patients of psychiatric hospitals (20 women and 10 men), diagnosed with unipolar depression. The selection criteria for the group included diagnosis in compliance with ICD-10-F33 and
being raised in a family of origin by both parents. The control group included 30 healthy subjects, also raised in complete families. The age of patients ranged from 27 to 63 years, $M = 50.37$, $SD = 5.85$, and the control group aged from 29 to 57 years, $M = 47.57$, $SD = 6.56$. There were no significant statistical differences between the clinical group and the control group with respect to age $U = 332; Z = 1.751; p = 0.08$ and the level of education $U = 353; Z = -1.527; p = 0.127$. In the group of patients, 5 people received primary education, 14 vocational education, 11 secondary education, while in the control group, 3 persons had primary education, 12 vocational education, 10 secondary education and 5 higher education.

The study was conducted in the Public Specialist Mental Health-Care Centre in Frombork, in the non-public health-care centre “Centre of Psychiatry” in Prabuty and the Hospital for Nervous and Mental Diseases in Starogard. Patients were informed that participation in the survey would be voluntary and anonymous, and that at any moment they would be able to refuse further participation. Subjects suffering from depression or other psychiatric disorders during the study and in the past were also excluded from the control group.

## Method

The questionnaire of retrospective assessment of parental attitudes (KPR-Roc) developed by M. Plopa (2007) was used in the study. The instrument enables to assess parents in retrospect in the field of parental attitudes. It is characterized by good psychometric properties. The structure of the questionnaire is based on theoretical assumptions supporting the validity of five dimensions that describe the parent-child relationships, and at the same time form the corresponding scales of the questionnaire: Dimension I – Acceptance/Rejection, Dimension II – Excessive demands, Dimension III – Autonomy, Dimension IV – Inconsistency, Dimension V – Excessive protection. The second research tool was the Inventory of Psychological Aggression Syndrome (Polish: IPSA), developed by Z. Gaś (1980). The inventory is used to study the aggressiveness of adults. It includes 10 scales: S I – Emotional self-aggression, II – Physical self-aggression, III – Hostility towards the environment, IV – Unconscious aggressive tendencies, V – Displaced aggression, VI – Indirect aggression, VII – Verbal aggression, VIII – Physical aggression, Scale K – Control of aggressive behaviour, Scale O – A tendency to retaliate. The questionnaire also allows the calculation of the overall severity of the aggression syndrome and a self-aggression indicator S (the sum of raw scores
1 and II) U – a covert aggression indicator (the sum of raw scores III and IV) Z – an outward aggression indicator (the sum of raw scores V, VI, VII and VIII).

The structured interview took into account basic clinical and sociodemographic factors.

The distribution of variables was analysed using the Shapiro-Wilk test. The Student’s t-test was applied for independent groups where the variables were normally distributed and the U-Mann-Whitney test was used where the distribution of variables was not normal. Due to the fact that this test does not calculate the significance of differences with respect to means, but to ranks, the analyses were performed according to the nature of the distribution of variables. Mean values and standard deviations have been presented in tables to better illustrate the results. In correlation tests, were the assumed parameters of variable distribution were met, the Pearson’s $r$-test was used, in other cases, the nonparametric Spearman’s $\rho$ test was applied to calculate statistical values.

## Results

Patients assessed maternal attitudes as more demanding, inconsistent, and giving less autonomy, while paternal attitudes as more protective compared to the control group of healthy persons. Other differences proved to be statistically insignificant (Table 1).

**Table 1.** Differences in perceptions of parental attitudes between the group diagnosed with depression and the control group

<table>
<thead>
<tr>
<th>Maternal attitude</th>
<th>Clinical group</th>
<th>Control group</th>
<th>Test for the significance of differences – results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Demands</td>
<td>30.90</td>
<td>9.63</td>
<td>24.43</td>
</tr>
<tr>
<td>Autonomy</td>
<td>36.13</td>
<td>7.20</td>
<td>39.07</td>
</tr>
<tr>
<td>Inconsistency</td>
<td>28.53</td>
<td>11.14</td>
<td>20.60</td>
</tr>
</tbody>
</table>

Paternal attitude

Protection

| Protection | 33.67 | 9.74 | 27.27 | 9.64 | t(58)=2.558; p=0.013 |

Source:

A statistical analysis showed that patients with depression scored significantly higher levels of emotional and physical self-aggression and general
self-aggression than healthy individuals. Patients showed a higher degree of hostility towards the environment as well as covert aggression and displaced aggression. The intensity of outward aggression proved to be higher in patients as compared to controls. Patients with depression also demonstrated significantly less control of aggressive behaviour and greater overall severity of the aggression syndrome than healthy subjects. There were no differences between the groups in terms of other forms of aggression (Table 2).

In the group of patients, the maternal attitude of acceptance negatively correlated with hostility to the environment ($\rho = -0.51$), and the demanding attitude was associated with indirect aggression ($\rho = 0.63$) and outward aggression ($r = 0.60$). The autonomy attitude of mothers was associated with slightly lower physical aggression ($r = -0.38$). The inconsistent attitude of mothers revealed a negative correlation with the score on the scale for aggressive behaviour ($r = -0.59$), and positive correlation with the overall level of aggression ($r = 0.50$). The protective attitude revealed no more significant correlations with aggression. In contrast, the demanding attitude of fathers positively correlated with general self-aggression ($r = 0.71$), and thus with its constituent dimensions: emotional self-aggression ($r = 0.67$) and physical self-aggression ($\rho = 0.54$). It also showed a positive correlation with outward aggression ($r = 0.51$) and verbal aggression ($r = 0.51$), and was associated with an increased score for the overall level of aggression ($r = 0.58$).

In the case of fathers, inconsistency was connected with increased general self-aggression ($\rho = 0.53$). Similarly, it showed a positive correlation with displaced aggression ($\rho = 0.56$), verbal aggression ($\rho = 0.54$) and outward aggression ($\rho = 0.50$).

In the control group, the maternal attitude of acceptance was associated with lower levels of physical aggression ($\rho = -0.59$), a tendency to retaliate ($\rho = -0.50$) and the overall score for the aggression syndrome ($\rho = -0.51$), while the acceptance of fathers revealed a negative correlation with a tendency to retaliate ($\rho = -0.52$). The demanding attitude of mothers was associated with general self-aggression ($\rho = 0.55$) and covert aggression ($r = 0.52$). Increasing demands of mothers were also correlated with increased outward aggression ($r = 0.60$) and its individual factors, i.e. displaced aggression ($\rho = 0.58$) and physical aggression ($\rho = 0.70$). This was due to a positive correlation with the overall score for the aggression syndrome ($\rho = 0.69$) and a negative correlation with control of aggressive behaviour ($\rho = -0.63$).

The demanding attitude of fathers was associated with an increase in physical aggression ($\rho = 0.52$), a tendency to retaliate ($\rho = 0.60$) and the overall intensity of aggression ($\rho = 0.52$).
Table 2. Differences in the aggression syndrome between the group diagnosed with depression and the control group

<table>
<thead>
<tr>
<th></th>
<th>Clinical group</th>
<th>Control group</th>
<th>Test for the significance of differences – results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional self-aggression (I)</td>
<td>12.10 4.09</td>
<td>3.53 2.81</td>
<td>U=44; Z=-6.019; p&lt;0.001</td>
</tr>
<tr>
<td>Physical self-aggression (II)</td>
<td>4.00 3.20</td>
<td>0.87 1.48</td>
<td>U=174.5; Z=-4.27; p&lt;0.001</td>
</tr>
<tr>
<td>Hostility towards the environment (III)</td>
<td>7.93 4.06</td>
<td>5.2 3.07</td>
<td>t(58)=2.943; p=0.005</td>
</tr>
<tr>
<td>Unconscious aggressive tendencies (IV)</td>
<td>4.63 3.60</td>
<td>3.03 2.57</td>
<td>U=345; Z=-1.572; p=0.116</td>
</tr>
<tr>
<td>Displaced aggression (V)</td>
<td>5.73 4.96</td>
<td>2.67 3.28</td>
<td>U=289; Z=-2.442; p=0.015</td>
</tr>
<tr>
<td>Indirect aggression (VI)</td>
<td>2.87 2.74</td>
<td>2.83 2.68</td>
<td>U=444; Z=-0.9; p=0.928</td>
</tr>
<tr>
<td>Verbal aggression (VII)</td>
<td>8.50 4.73</td>
<td>6.6 4.40</td>
<td>t(58)=1.611; p=0.113</td>
</tr>
<tr>
<td>Physical aggression (VIII)</td>
<td>2.50 2.81</td>
<td>1.27 1.84</td>
<td>U=330; Z=-1.894; p=0.058</td>
</tr>
<tr>
<td>Control of aggressive behaviour (K)</td>
<td>11.60 6.33</td>
<td>18.03 8.21</td>
<td>U=229; Z=-3.282; p=0.001</td>
</tr>
<tr>
<td>A tendency to retaliate (O)</td>
<td>6.33 5.88</td>
<td>5.57 5.22</td>
<td>U=415.5; Z=-0.513; p=0.608</td>
</tr>
<tr>
<td>General aggression (S)</td>
<td>16.10 6.37</td>
<td>4.4 3.46</td>
<td>U=45.5; Z=-5.991; p&lt;0.001</td>
</tr>
<tr>
<td>Covert aggression (U)</td>
<td>12.57 6.27</td>
<td>8.23 4.69</td>
<td>t(58)=3.031; p=0.004</td>
</tr>
<tr>
<td>Outward aggression (Z)</td>
<td>19.63 12.10</td>
<td>13.37 9.79</td>
<td>t(58)=2.205; p=0.031</td>
</tr>
<tr>
<td>Overall score for aggression (WO)</td>
<td>65.03 30.13</td>
<td>36.53 23.96</td>
<td>t(58)=4.055; p&lt;0.001</td>
</tr>
</tbody>
</table>

The autonomy attitude of mothers was associated with lower levels of physical aggression (ρ = 0.60), and in the case of fathers, it negatively correlated with the level of physical aggression (ρ = -0.50).

The inconsistent attitude of mothers showed a positive correlation with covert aggression (ρ = 0.52), outward aggression (ρ = 0.58) and its individual components, i.e., displaced aggression (ρ = 0.54) and physical aggression (ρ = 0.72). The growth of maternal inconsistency was accompanied by a tendency to retaliate (ρ = 0.61) and the general level of aggression (ρ = 0.72) as well as lower levels of aggressive behaviour control (ρ = -0.64).

Paternal inconsistency was associated with an increase in covert aggression (r = 0.50) and physical aggression (ρ = 0.50), a tendency to retaliate (ρ = 0.61), and the overall intensity of the aggression syndrome (r = 0.58).
Discussion

Patients with depression were characterized by a higher level of emotional and physical self-aggression, which turns out to be consistent with the assumptions of the psychodynamic theory, according to which depression is inward aggression. It can be also evidenced by the number of 16 people in the clinical group who attempted suicides (data from the history of the disease). The patients also revealed higher levels of covert aggression and hostility towards the environment.

The study has also showed that people with depression demonstrate higher levels of outward aggression. Reference literature usually does not present people with depression as aggressive, but the result obtained in this study seems to confirm the externalization of anger by depressed individuals, signalled by the authors. In this study, this has been also confirmed by the lower-than-normal control of aggressive behaviour, and the lack of differences in a tendency to retaliate, which requires planning, taking certain measures and some effort leading to acts of aggression, which suggests that in the case of patients they are purely impulsive (Berkowitz, 1989; Painuly et al., 2005).

In principle, in the context of depressive disorders, externalized aggression should not be interpreted in its ordinary meaning – as harmful interaction with the environment taking the form of, for instance, a physical attack (even though some studies seem to deny it), but in relation to certain forms of depression (Florkowski, 2006). In the present study, the absence of the classical understanding of outward aggression in patients is confirmed by the analysis of individual components. Patients with depression do not differ in terms of physical, indirect and verbal aggression, yet they have higher levels of displaced aggression.

The mechanism of displacement could indicate, among other things, susceptibility to the disease, which is associated with both the psychodynamic approach and the frustration-aggression theory, because the fear of punishment for an attack on the source of frustration causes displacement of aggression onto surrounding objects or onto oneself, and self-aggression occurs in particular when acts of outward aggression are heavily punished (Augustyniec, 2001). In this paper, the mechanism of displacement appears to be linked with the patients’ parents, whose improper attitudes might have helped to internalize aggression.

As for the assessment of parental attitudes, no difference in the area of acceptance-rejection relating to both mothers and fathers seems to be
surprising. In the presented typologies, the meaning of acceptance (love) is strongly emphasized as the most important factor impinged on the personality of a child, and later an adult. This is reflected even in the results cited in the Introduction, relating to patients with depression who evaluated their parents, first of all, as less accepting and more rejecting. In this study, the existence of improper relationships with a child can be found in the evaluation of the other attitudes, and more significant differences emerged in the evaluation of maternal attitudes. Patients rated their mothers as more demanding, inconsistent and giving less autonomy, while fathers as more protective. A configuration of such attitudes can evoke in an adolescent feelings of anxiety and tension, as well as a sense of excessive control and interference in their personal life, which is likely to be one of the pathomechanisms involved in the development of depressive disorders.

In the clinical group, emotional self-aggression, which is important in depression, was correlated with the protective attitude of both mothers and fathers. Presumably, excessive protection may be associated with decreased resistance to stress, which can increase the risk of emotional disturbances.

In both groups, demanding and inconsistent attitudes have proved to be the most significant factors, showing correlation with aggression. They also correlate positively with self-aggression, outward aggression, as well as physical and displaced aggression, and the overall intensity of the aggression syndrome.

The attitude of acceptance-rejection was indeed significant for the mothers of healthy subjects and the fathers of patients. This dimension shows a moderate, negative strength of relationship with outward aggression and with the overall intensity of the aggression syndrome, but still the acceptance of patients’ fathers was associated with lower levels of physical self-aggression and displaced aggression, which may be important for the treatment of depressive disorders.

The autonomy attitude of fathers turned out to be significant for people with depression and correlated with lower levels of overall aggression.

■ Conclusions

Differences between patients with depression and healthy subjects in the assessment of parental attitudes illustrate that abnormalities in their family environments consisting of improper relationships with parents might have occurred in the group of patients.
In the examined groups, the correlation between abnormal parental attitudes and various symptoms of aggression illustrates the importance of these early relationships for emotional disturbances, which may worsen the clinical condition of depressed patients.

**References**


