# THE ASSESSMENT OF ATTACHMENT STYLES AND DEFENSE MECHANISMS IN AN INPATIENT SAMPLE OF MAJOR DEPRESSIVE DISORDER

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# THE ASSESSMENT OF ATTACHMENT STYLES AND DEFENSE MECHANISMS IN AN INPATIENT SAMPLE OF MAJOR DEPRESSIVE DISORDER

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Ebru Erol Soy

## ABSTRACT

THE ASSESSMENT OF ATTACHMENT STYLES AND DEFENSE MECHANISMS IN AN INPATIENT SAMPLE OF MAJOR DEPRESSIVE DISORDER

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This study examined attachment styles and defense mechanisms among a sample of inpatients with Major Depressive Disorder (MDD). Forty-eight people participated in the study. The findings are discussed from a psychoanalytical perspective in order to understand the impact of attachment styles and defense mechanisms on the development of MDD and an effort is made to examine the possible relationship between these two variables. Inpatient group was randomly selected from Surp Pırgiç Armenian Hospital's Psychiatry Service ($n$ = 24) who were diagnosed with Major Depression Disorder as per DSM-V criteria. Comparison group ($n$ = 24) was selected from an accessible group among those individuals who completed the attachment styles and defense mechanisms questionnaires over SurveyMonkey. Attachment anxiety and avoidance was measured by using The Experiences in Close Relationships Revised (ECR-R). Mature, neurotic and

immature defense mechanisms were measured by using Defense Style Questionnaire (DSQ-40). Results showed that the inpatient group of MDD showed significantly higher levels of attachment related anxiety and attachment related avoidance than the comparison group. Additionally, there was a significantly higher use of neurotic and immature defenses and a significantly lower use of mature defenses among the inpatient group. When recording high neurotic and immature defense types, attachment related anxiety and avoidance increased, while mature defense types decreased. Furthermore, a correlation was found between neurotic, immature defense mechanisms and insecure attachment styles. Findings were particularly significant in the mature defense types of humor and suppression, in the neurotic defense type of undoing and in the immature defense types of projection, passive aggression, devaluation, splitting and somatization.

*Key words:* Attachment styles, Anxious attachment style, Avoidant attachment style, Defense mechanisms, Mature defenses, Neurotic defenses, Immature defenses, Major Depressive Disorder, ECR-R, DSQ-40

# ÖZ

MAJÖR DEPRESİF BOZUKLUK TANISI ALMIŞ BİR HASTA GRUBUNDA BAĞLANMA STİLLERİ VE SAVUNMA MEKANİZMALARININ DEĞERLENDİRİLMESİ

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Bu çalışma, Majör Depresif Bozukluk tanısı almış bir grup hastanın bağlanma stillerini ve savunma mekanizmalarını incelenmiştir. Çalışmaya kırksekiz kişi katılmıştır. Bağlanma stilleri ve savunma mekanizmalarının Majör Depresif Bozukluğa olan etkisine dair bulgular, psikanalitik bakış açısıyla tartışılmıştır. Yatan hasta grubu, Surp Pırgiç Ermeni Hastanesi Psikiyatri Servisi'nde, DSM-V kriterlerine göre Majör Depresif Bozukluk ($n$ = 24) tanısı almış hastalar arasından rastgele seçilmiştir. Karşılaştırma grubu ($n$ = 24) ulaşılabilirlik ilkesine göre, SurveyMonkey üzerinden bağlanma stilleri ve savunma mekanizmaları anketlerini dolduran kişiler arasından seçilmiştir. Bağlanmaya ilişkin kaygı ve kaçınma, Yakın İlişkilerde Yaşantılar Envanteri (YİYE-II) ile ölçülmüştür. Olgun, nevrotik ve immatür savunma biçimleri ise Savunma Biçimleri Testi (SBT-40) ile ölçülmüştür. Sonuçlar, depresyon tanısı almış hasta grubunun, bağlanmaya ilişkin kaygı ve

kaçınma seviyelerinin karşılaştırma grubuna kıyasla anlamlı biçimde yüksek olduğunu göstermiştir. Ayrıca, nevrotik ve immatür savunma biçimleri anlamlı derecede yüksek ve olgun savunma biçimleri anlamlı derecede düşük bulunmuştur. Bunun yanında, nevrotik, immatür savunma mekanizmaları ve güvensiz bağlanma stilleri arasında bir korelasyon bulunmuştur. Bulgular, olgun savunma mekanizmalarından mizah ve baskılamada anlamlı derecede düşük, nevrotik savunma mekanizmasından yapma-bozmada ve immatür savunma mekanizmalarından yansıtma, pasif saldırganlık, değersizleştirme, bölünme ve bedenselleştirmede anlamlı derecede yüksektir.

*Anahtar Kelimeler*: Bağlanma stilleri, Kaygılı bağlanma stili, Kaçıngan bağlanma stili, Savunma mekanizmaları, Olgun savunmalar, Nevrotik savunmalar, İmmatür savunmalar, Majör Depressive Bozukluk, YİYE-II, SBT-40

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pay more attention to him. He was not wrong, in his words; “normal mums did not go to school”.

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## LIST OF ABBREVIATIONS

| | |
|---|---|
| AAI | : Adult Attachment Interview |
| BPD | : Borderline Personality Disorder |
| CD | : Conduct Disorder |
| DSM | : Diagnostic and Statistical Manuel of Mental Disorders |
| DSQ-40 | : Defense Style Questionnaire |
| ECR-R | : Experiences in Close Relationships-Revised |
| ICD-9 | : Ninth version of the International Classification of Diseases |
| MDD | : Major Depressive Disorder |
| NIMH | : National Institute of Mental Health |
| OCD | : Obsessive Compulsive Disorder |
| PTSD | : Post-traumatic Stress Disorder |
| RAD | : Reactive Attachment Disorder |
| SBT-40 | : Savunma Biçimleri Testi-40 |
| YİYE-II | : Yakın İlişkilerde Yaşantılar Envanteri-II |

# CHAPTER 1

## INTRODUCTION

The aim of this study is to examine attachment styles and defense mechanisms among an inpatient sample of patients with Major Depressive Disorder (MDD). The findings are discussed from a psychoanalytical perspective in order to understand the way attachment styles and defense mechanisms each impact the development of MDD and in an effort to examine the possible relationship between these two variables. The participants of this study were selected among inpatients in Surp Pırgiç Armenian Hospital diagnosed with MDD by psychiatrists as per DSM-V criteria. The comparison group was formed by using SurveyMonkey and sample was matched considering demographic variables of clinical group. Attachment anxiety and avoidance was measured by using The Experiences in Close Relationships Revised (ECR-R). Mature, neurotic and immature defense mechanisms were measured by using Defense Style Questionnaire (DSQ-40).

More specifically, the first aim of this study is to investigate whether there is a difference in attachment related anxiety and attachment related avoidance between the inpatient group who are diagnosed with major depressive disorder and the comparison group.

The second aim of this study is to check differences between inpatient and comparison groups in terms of defense mechanisms used. In other words, the study will investigate if there is a significantly higher use of neurotic and immature defenses and a lower use of mature defenses among inpatient group than comparison group.

Finally, this study aims to serve as a preliminary investigation to see if there is a correlation among attachment styles, defense mechanisms and depression. The common denominators of object relations theory from psychoanalytic perspective and attachment theory will be reviewed and analytic perspective of defense mechanisms will be examined.

Results showed that, attachment related anxiety and avoidance increased when neurotic and immature defense types were highly used while low use of mature defense types were recorded. Additionally, there is a correlation between neurotic, immature defense mechanisms and insecure attachment styles especially significant findings in defenses of humor, suppression, undoing, projection, passive aggression, devaluation, splitting and somatization.

Before focusing on differences between inpatient group and comparison groups in terms of their attachment styles and defense mechanisms, a review of the relevant literature will be presented. Specifically, attachment theory, attachment styles, the place of affect regulation strategies in attachment theory and the link between the major depressive disorder and attachment theory will be introduced. Secondly, history of defense mechanisms, the hierarchy of defenses as they relate to psychopathology, the link between depression, distances and similarities between affect regulations will be reviewed. Thirdly, relationships between attachment styles and defense mechanisms will be discussed. Finally, the research hypotheses will be presented.

## 1.1. Attachment Theory

### 1.1.1. Definition

Attachment theory is one of the most considerable theoretical frameworks in psychology, with its important capacity to explain and predict human behavior based on early experiences with caregivers. John Bowlby (1973, 1980, 1982/1969) argued that attachment system is an inborn, evolutionarily adaptive regulatory device that adjusts the proximity of the infant with the attachment figure in order to ensure survival.

Bowlby (1969/1982) proposed that cognitive components, which are derived from mental representations of the attachment figure, environment and the self, supports the organization of the attachment behavioural system that are largely based on experience. At this point, his views differ from Freud who emphasized the

role of internal fantasies. According to Bowlby, these representations or *internal working models* allow individuals to make plans for their future (Davies & Bhugra, 2004).

According to Bowlby (1969), infants are born with a purpose of promoting proximity to a caregiver by the help of a biological and motivational system. From an evolutionary perspective, the infant increases the chance of survival by having a close relationship with the caregiver who provides protection and safety. When the bond is threatened or infant is separated from the caregiver, he or she features characteristic proximity-seeking behaviors like crying. A goal is set to develop a partnership between the caregiver and the child by the help of caregiver's responses (Lyddon & Sherry, 2001).

Bowlby (1973) described that, children experience their own worthiness by perceptions of caregiver's availability and passion to give protection and care. The intensity and level of emotion that is drawn depends on the relationship between the individual attached and the attachment object. Sooner or later, even in the absence of the caregiver, child can use the symbolic representations of attachment figure to feel safe. Personal-social development relies on the relationship between the inner models of self and others. The most central 'other' is the primary caregiver(s) (Bacon & Richardson, 2001).

All in all, attachment theory can be defined as an emotional bond between individuals shaped by seeking for closeness and display distress upon separation (Rathus, 2008).

### 1.1.2. Contributions to Attachment Theory

For Ainsworth (1989), attachment style is formed by the help of interaction with parent in early ages, which leads to the development of expectations in close relationships, belifes, needs and social behaviour patterns.

Ainsworth and her friends have an important contribution to attachment theory with the help of 'The Strange Situation Protocol'. Qualitative differences in the infant-mother relationship are thought to be reflected in the infant's behavior within the context of the Ainsworth and Wittig (1969) Strange Situation. This situation was a setup to reveal attachment behavior from infants in a controlled laboratory setting. The plan is a standardized short separations of infant and mother. They observed children's responses for the reunion with the primary caregiver which come just after a separation (Ainsworth et al., 1978). They defined and classified different types of attachment behavior as secure, insecure-avoidant and insecure-ambivalent/preoccupied. For the children whose care seeking behavior lacked a concordant strategy and could not be easily classified, a fourth item has been added as disorganized-disoriented attachment (Main and Solomon, 1986).

Bartholomew and Horowitz (1991) have proposed four group model attachment styles in adulthood. It is an important contribution which is based on Bowlby's (1973, 1980, 1982a) theory that postulates two types of internal working models as self and others and each model can be positive and negative. They combined two levels of self-image with the two levels of others which are positive vs. negative. Three ratings were used. Participants have been assessed through an interview, friend reports and their own self-reports have been included for a profile

identification. Styles are labeled as secure, preoccupied, fearful and dismissive avoidant.

Bowlby's focus was upon understanding the nature of child and caregiver relationship. He underlined the idea that attachment has an effect through whole life. Hazan and Shaver carried Bowlby's ideas in the context of romantic relationships. They argued that the emotional bond between adult romantic partners contains similar motivational system with infants and caregivers. They underlined the similarities as follows; (1)both feel safe when the other is nearby and responsive, (2)both engage in close, intimate, bodily contact, (3)both feel insecure when the other is inaccessible, (4)both share discoveries with one another, (5)both play with one another's facial features and exhibit a mutual fascination and preoccupation with one another, (6)both engage in "baby talk" (Fraley, 2010).

The importance of mother's affective responses and maternal care was also emphasized by early psychoanalytic theorists. Winnicott, D.W., and Fairbairn, W.D. have focused on the importance of early primary relationship in the development of self, relations to others and mental health. In the study of Heard, DH. (From object relations to attachment theory: A basis for family therapy, 1978), it is stated that, both in Winnicott's object relations theory and Bowlby's attachment theory provide a framework which underline the focus on psychological and interpersonal phenomena.

Sir Richard Bowlby who is the son of John Bowlby makes a speech in the second annual memorial lecture for Winnicott. It is known that they had a personal

relationship. [1]Richard Bowlby mentions about Winnicott's strong impression on John Bowlby (Bowlby, R. 2004). It is likely that Bowlby's work may have been influenced by Winnicott's ideas.

Winnicott emphasized that, infants are naturally dependent on their mothers which he defined as *absolute dependence*. Personality is unintegrated. Infant experiences the world provided by the mother in order to feel that he or she exists. Around 5 or 6 months, infant understands that objects have inside and outside. Baby starts to learn the other and becomes curious about moods of mother. Next phase involves integration, having the experience of collecting the parts together. Infant begins to feel a unity, a sense of self and other. If baby cannot receive *primary maternal preoccupation*, a *good enough mothering*, if he or she is ignored by the mother, has difficulty in finding a *holding* environment, then baby tries to defend against this experience and develop a *false self* which leads to feelings of abandonment, mistrust and hopelessness in relationships (Mikic &Terradas, 2014).

Fairbairn (1941) proposed a theory of development which makes a strong emphasis on early object relationships. For Fairbairn, identification with the object and later differentiation from the object is the healthy basis for a mature development and relationships. When the infant is completely dependent on the object, *splitting* occurs in an early phase. An infant who is rejected and neglected by the caregiver internalizes object as rejecting. Opposite feelings of good and bad

[1] There is an unpublished correspondence between the two men, housed partly in the Archives of Psychiatry in the Oskar Diethelm Library at the Institute for the History of Psychiatry, at the Joan and Sanford I. Weill Medical College of Cornell University, in New York City, and partly in the Pearl King Archives Trust, at the British Psychoanalytical Society in London (Bowlby, R., King, P. 2004).

toward the object is hard to integrate. Moreover, it is hard for the infant to see his or her parent as fearful or bad, because they are needed for survival. Therefore, infant introjects the parent inside and accepts it as a part of his or her own self. She feels that she is the one who is unlovable and bad. Fairbairn defined ego structure as formed by ego-nuclei and different parts which integrate during the development of the child. He suggested that, schizoid personalities have difficulty in this integration and attaining a mature stage which relies on mother-infant relationship. He described schizoid personalities that they feel love of theirs is a destruction of the object.

### 1.1.3. Attachment Styles

In this study, secure and insecure attachment styles have been reviewed considering both adult attachment and child attachment literature due to the fact that attachment dimensions has tried to be understood by using an adult attachment scale.

*Secure Attachment:*

According to Hazan and Shaver's classification system (1987), adults whose attachment is classified as secure are the ones that give such answers when they are asked about their romantic relationships: "I find it relatively easy to get close to others. I am comfortable depending on them and having them depend on me. I don't worry about being abandoned or about someone getting too close to me."

For such a capacity, Bowlby underlines two important factors. First one is a representational model of others as available and responsive in times of trouble. Second factor is a representational model of the self as lovable and worthy of care. Similarly, Ainsworth reports upon her observations that secure infants who are upset and signal for comfort receive a supportive, accepting, cooperative, available, confronting and tender mothers (Cassidy, 2000). Because of this maternal sensitivity, secure children are thought to develop representations of the mother as loving, responsive and sensitive.

Adults attached securely in their childhoods feel comfortable and confident in seeking care. They have positive mental representations of others. They feel lovable. They are not engaged in destructive behaviors in a healthy relationship like in need of reassurance from the partner of his or her own worth, demanding excessive closeness, allowing himself or herself to be mistreated or insisting on continual proof of love and commitment. Secure adults described their mothers as caring, accepting and dependable (Hazan, & Shaver, 1987).

*Insecure – Avoidant Attachment:*

According to Hazan and Shaver (1987), adults classified as avoidant, describe themselves as follows: "I am somewhat uncomfortable being close to others; I find it difficult to trust them completely, difficult to allow myself to depend on them. I am nervous when anyone gets too close and often, love partners want me to be more intimate than I feel comfortable being." These adults are suspicious of the intentions of others, don't want to show their distress, limit their intimacy with others (Shaver and Hazan 1993).

Ainsworth's home observations for 1 year-old infants who were later classified as insecure-avoidant show that they had controlling mannered mothers. Moreover, these caregivers were described as having limited emotional expressiveness. They joined in play when infants were positive but withdrew when infants expressed negative affect. Some infants avoid the mother and focused playing with toys. Some of these babies showed no stress for separation from the mother or even interaction on reunion (Ainsworth et al., 1978). As per Spangler and Grossmann's (1993) heart rate measurement study, secure babies were truly interested in play and their heart rates were typically slowed down whereas avoidant babies were showing attention to toys but heart rates were not slowing down. They did not focused on the play truly. These children seemed away from their mothers while they pretend to play with toys. Bowlby (1973) described this behavior as *diversionary activity*.

These introjections are experienced in various ways in adulthood. Hazan and Shaver (1987) indicate that, avoidant adults are not comfortable depending on others. They are less likely to request care from others. They do not enjoy physical connection and hugging within romantic relationships. They are more hostile than the others. Avoidant adults report their mothers as cold and rejecting.

*Insecure – Anxious / Ambivalent Attachment:*

According to Hazan and Shaver (1987), adults classified as insecure-ambivalent describe themselves as follows: "I find others reluctant to get as close as I would like. I often worry that my partner doesn't really love me or won't want to stay with me. I want to merge completely with another person and this desire

sometimes scares people away." Cassidy (2000) points that these adults prefer incompetent closeness, commitment and affection. Ambivalent adults reported greater distress and hostility during a laboratory problem-centered discussion (Simpson et al., 1996).

In Hazan and Shaver's work (1987), they point at some characteristics of ambivalent adults. Ambivalent adults seek emotional closeness but do not find it satisfying. They describe their desires to merge with a partner. They report greater loneliness than others. They are particularly upset by relationship breakups.

As per Ainsworth's strange situation observations (1978), infants that classified as ambivalent were extremely distressed on separation and they did not easily calm down on reunion. These infants behaved angrily and resistant toward their parents. It could be a strategy to gain the mother's attention (Cassidy & Berlin, 1994; Main and Solomon, 1986). Their reactions might be exaggerated and chronic because they recognize that they only gain care in this way. Their attention were less focused during toy play (Cassidy, 2000).

### 1.1.4. Measurement of Attachment Styles

There are various scales that are used in attachment related measurement. These scales can be grouped mainly under two orientations; self-report measures and interview based assessments.

Interview based assessments are shown to be stronger in measuring defense strategies which are processed in subconscious level (Bartholomew & Moretti,

2002; Shaver & Mikulincer, 2002). One of the most well known one is Adult Attachment Interview (AAI) and it was developed by Main and her friends (George, Kaplan & Main, 1984; Main, Kaplan & Cassidy, 1985). Interview based assessments are thought to be more successful in representing underlying processes. On the other hand, in a study which was held with 135 participants by using AAI, Shaver and his friends (2000) found that, codings in likert-type scales are meaningfully correlated with interview based assessment of relationship questionnaire of Bartholomew & Horowitz (1991) (Sümer, 2006).

One of the most widely used likert-type scale is Experiences in Close Relationships-Revised (ECR-R) which was developed by Brennan et al., in 1998. The study takes its roots from Bowlby's (1979) belief in a model of continuous development. He predicted that a securely attached child will form a secure romantic attachment in adulthood. He argued that there is a strong cause and relationship between experiences with parents and the later capability to make affectional connections. New relationships are formed by the help of models of self and others. From this point of view, Hazan and Shaver (1987) suggested a possibility that romantic love is a kind of attachment process which contains affectional bonds similar to childhood like between mother and the infant. They designed a "love quiz" to be printed in a local newspaper in 1983. Brennan and her friends (1988) have a contribution for adult based attachment measurement by defining adult attachment related behaviors under two dimensions. These are attachment related anxiety and attachment related avoidance. Turkish form of the scale "Yakın İlişkilerde Yaşantılar Envanteri-II" (YIYE-II) has been used in the

measurement of adult attachment styles. It has higher measurement precision as compared to other scales (Selçuk et al., 2005) which is also used in this study.

One of the most well-known example for interview based assessments is Adult Attachment Interview (AAI) (George, Kaplan & Main, 1984). It is a structured interview that gets the description of childhood and focuses on the relationship with parents. It has twenty questions and many sub-questions related to the main ones. It has an administration procedure and special training is a precondition for interviews.

Main and Goldwyn (1984-1998) have also worked on *Adult Attachment Scoring and Classification System* which is used in research contemporary vastly. Study was published in 2008 (Main, Hesse & Goldwyn, 2008). Four patterns of adult discourse are observed; (a) secure-autonomus, (b) insecure-dismissing, (c) insecure-preoccupied and (d) insecure-unresolved. This classification is parallel to infant strange situation classification in the order of (a) secure, (b) insecure-avoidant, (c) insecure-ambivalent and (d) insecure-disorganized. (Allen & Hauser 1996).

There are various attachment related scales that are used for different needs. Some examples have been shared from the literature as follows: Properties of the Psychological Treatment Inventory Attachment Styles Scale (PTI-ASS) (Giannini et al., 2011) aims to see the link between attachment and psychotherapy integration. Attachment During Stress Scale (ADS) (Carcamo et al., 2014) detects insecure attachment behaviors in mother-infant interactions. The Attachment

Questionnaire for Children (AQC); (Muris et al. 2003) is an age-downward adaption of Hazan and Shaver's (1987) instrument for measuring attachment patterns in adults. The Brief Accessibility, Responsiveness, and Engagement (BARE) is a tool for measuring attachment behavior in couple relationships (Sandberg et al., 2012). Preliminary Development and Validation of the Supervisee Attachment Strategies Scale (SASS) measures counseling trainees' attachment orientations towards their clinical supervisors (Menefee et al., 2014). Adult Attachment in the Workplace (AAW) questionnaire (Scrima et al., 2014), Infatuation and Attachment Scales (Langeslag et al., 2013), The Adult Attachment Ratings (AAR) (Pilkonis et al., 2013), The Parental Bonding Instrument (PBI) (Parker et al., 1979) and Adult Attachment Style Scale (Hazan & Shaver, 1987; Mikulincer et al., 1993) are some examples for attachment scales.

## 1.2. Relationship Between Attachment and Psychopathology

Healthy development is based upon the quality of relationship between the infant and the caregiver (Bowlby, 1973, 1980). The interactive regulation between infant and caregiver inspires balance and regulation of the inner states of the infant which is the basis for affect regulation (Beebe & Lachmann, 2002; Beebe, Rustin, Sorter & Knoblauch, 2003). Secure attachment is a background for affect regulation that is associated with integrity which is needed for mental health throughout life (Bowlby, 1988; Fonagy, 1999).

Terms "affect regulation" and "emotion regulation" have been used in research within the larger framework of attachment theory (Kobak, 1987; Bartholomew, 1990; Grolnick et al., 1996). In 1987, Kobak uses the term "affect

regulation" while comparing secure and avoidant infants for their regulation of negative emotions. Bartholomew (1990) uses the frame "emotion regulation" while focusing on negative affect of adults. Emotion regulation is defined as set of processes that start both negative and positive emotional responsiveness (Grolnick et al., 1996).

Bowlby gives importance to affect in his theory and accepts internal working models as the ultimate goal for affect regulation. According to various studies, participants reporting different attachment styles who have probably different internal working models differentiate from each other about their emotional reactivity and what they do in accordance with these feelings. (Bartholomew & Horowitz, 1991; Carnelley et al., 1994).

When attachment figure is reachable in reality or symbolically, affect regulation is formed which is called security based strategy in the activation of attachment. (Mikulincer & Shaver, 2005). This strategy is to diminish anxiety and distress in a positive way and supports coping strategies with flexible mechanisms. Security based strategies are basic components for secure attachment and it is accepted to be an outcome of a positive interaction with the attachment figure. During this interaction, infant learns to cope with difficult situations exist in life (Mikulincer, Shaver & Pereg, 2003). This is accepted as a characteristic feature of securely attached people who have lower scores in anxiety and avoidance dimensions. Research show that, lower anxiety and avoidance scores are associated with positive beliefs in stress management, positive point of view to self and others and functionality under stressful events (Collins et al., 1994). People who are

securely attached do not need to use self-defeating or dissociative mechanisms and do not associate with strategies which configures affect regulation with self-esteem (Mikulincer, 1998).

On the other hand, if the attunement between the infant and the caregiver fails, the need of proximity seeking cannot be satisfied therefore child develops secondary attachment strategies which becomes a defensive result due to the inappropriate interaction with the caregiver. People having insecure attachment styles over-regulate or under-regulate their emotions (Mikulincer, Shaver & Preg, 2003).

People who have higher scores in avoidant attachment dimension avoid close relationships in order to minimize emotional involvement, maintain control, suppress disturbing thoughts and feelings and permanence of dissociative mechanisms. They use affect regulation to deny the idea to be the main source of their own distress, to ignore the personal incompetence to provide positive, strong and competent self-image which is an over-regulation of the affect. (Mikulincer, 1998).

People who have high scores in anxious attachment dimension cope with distress by minimizing the distance with attachment figure and get the secure base to the highest level (Bowlby, 1988). Their behavior pattern are observed to be adhesion and control to adjust proximity. They show excessive behaviors in the way reflecting personal weakness and rely on others for affect regulation (Mikulincer, 1998).

Worthlessness, desperation and the perception of being unlovable overlap with self-perception in depression. Correspondingly, early insecure attachment styles might be predisposition factors for depression. Additionally, the proximity need of the infant increase the chance of survival by having a close relationship with the caregiver which has impact on affect regulation strategies.

In summary, the literature indicates that, early interaction between the infant and the caregiver is a major determinant of the quality of the attachment and might be accepted as a predictor for the later development of mental health problems. In the following section, a detailed look to Major Depressive Disorder, links between attachment, psychopathology and depression will be reviewed.

### 1.2.1. Major Depressive Disorder

Depression is characterized by sadness, unhedonia, low energy level, pessimism, hopelessness, low mood, eating and sleeping problems, negative thoughts about the self, guiltiness and suicidal thoughts in Diagnostic and Statistical Manual of Mental Disorders (DSM-V). These symtoms have been described and classified under mood disorders in 1980 edition of American Psychological Association (APA). International Statistical Classification of Diseases and Related Health Problems (ICD-10) defines three typical depressive symptoms (depressed mood, anhedonia, and reduced energy) and for depressive disorder diagnosis, two of them should be present.

There are various reasons underlying the onset of depression. Fennell (1989) argues that, low self-esteem, lack of close relationships, lack of social

support, early parental loss, family neglect, depression history in the family and disturbances in neurotransmitters are known to be the major factors for depression.

Hamilton (1982), defines depression as vital activity reduction. It appears with the differences in cognitive, affective, physiological functionings. Most common symptoms are depressive mood, loss of interest and anxiety.

Beck (1961) hypothises that person who has vulnerability to depression has a general attitude of negative self critisizm. They exaggerate the unsuccessful results. He cathegorised symptoms of depression under three groups which are emotional, cognitive and physical symptoms.

In psychoanalytic literature, depression is interpreted as a response to loss. Depressive person strongly reacts to the loss because existing situation recalls the feeling of a previous loss (loss of parental love and interest). It causes the person to regress in a vulnerable position which was dependent and helpless like in the first loss (Atkinson et al., 1995). Therefore, the behavior of a depressive person partly represents a call for love and security need.

### 1.2.2. Research on the Link Between Attachment and Depression

Recent progresses in research propose that insecure attachment style is suggested as a risk factor in developing psychopathology.

National Institute of Mental Health (NIMH) has supported specific areas of attachment-related research. Factors like caregiving, parental psychopathology,

family processes are included into studies. Cummings & Cicchetti (1990) and Radke et al., (1985) have linked attachment process to depression. Moreover, they suggested that adult attachment style might have a role in mediating the transmission of psychopathology across generations. Greenberg et al., (1993), Lyons et al., (1993) and Lyons (1996) underlined the link with oppositional and conduct disorders. Reactive attachment disorder (Zeanah, 1996), abuse or maltreatment (Cicchetti & Barnett, 1991; Lynch & Cicchetti, 1991) and eating disorders (Cole-Detke & Kobak, 1996) are in correspondence with attachment styles (Carmen and Huffman, 1996).

Blatt and Shichman (1983) turned the focus on two different personality configurations as *anaclitic* and *introjective* which are related to some types of disordered behavior. They argued that, anaclitic depression, characterized by fears of abandonment and compulsive care-seeking, dependent and borderline personality disorder and hysteria is related with distorted and exaggerated emphasis on interpersonal development. On the other side, guilty depression, characterized by fears of abandonment and loneliness, phallic narcissism, paranoid and obsessive-compulsive disorders and avoidant, schizotypal, schizoid and borderline personality disorders are linked with distorted introjective developmental line. It is noted that these two primary configurations are similar to insecure-ambivalent and insecure-avoidant attachment (Blatt and Levy, 2003).

Bateman and Fonagy (2004) propose that, destructive relationships with others, neglect, abuse and traumatic histories lead to complications and lay the groundwork for psychopathology. *Mentalization theory* combines developmental

research and psychoanalysis with the notion of attachment. The aim is to understand the development of self in relation to others and how poor early relationship influences the development of Reactive Attachment Disorder (RAD) (Mikic & Terradas, 2014).

RAD first took place in DSM-III in 1980 and criteria are primarily "a markedly disturbed and developmentaly inappropriate social relatedness, in most context beginning before 5 years of age, which is associated with pathogenic care. According to Kemph and Voeller, there are two main etiological factors in RAD. First one is disruption of normal brain development like exposure to drugs and toxins, maternal illness, prematurity or malnutrition. Second factor is poor mothering in giving care and nurturing. Several disorders diagnosed in childhood like attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD) and conduct disorder (CD), anxiety disorder like post-traumatic stress disorder (PTSD) also borderline personality disorder may be associated with RAD (Kemph & Voeller, 2007).

In the research of Morriss et al., (2009), security of adult attachment style have been examined among 107 participants diagnosed with mania, major depression and euthymic mood states in bipolar I (BP I) disorder. Insecure attachment style was 78% of BP I patients whereas healthy controls reported 32%. Healthy group's anxious and preoccupied attachment style scores were low in contrast to BP I. Although Morriss and his friends emphasized the limited research on attachment style in bipolar disorder, in terms of their empirical data and the study

of Bifulco et al., (2006), insecure attachment styles have appeared to be a vulnerability factor for the new episodes prospectively.

Research supports that, poor relationship with caregiver, feeling of misunderstood, connectedness, deprivation of love, overcontrol and overprotection are vulnerability factors for developing psychopathology.

It is thought that, insecure attachment styles are related with psychological symptoms especially with mood disorders (Bowlby, 1969, 1973) which might be a reflection of internal working models shaped in early relationships with self and others (Mikulincer & Shaver, 2007). Like the object relations theorists (eg. Fairbairn, 1954; Klein, 1940) and self psychologists (Kohut, 1977, 1984) who have a psychoanalytic point of view, Bowlby states that the source of abnormal behaviour bases on the early relationship with the caregiver (Mikulincer & Shaver, 2007).

The avareness and the response for the need of the baby determines babies' stress regulation capacity during the early relationships (Reels, 2011). Otherwise, unregulated stress might be a cause to develop depression, anxiety, PTSD, ADHD and psychosomatic disorders (Rees, 2011). Death of attachment figure or repetitive disorganizations in relational bond may cause depression in adulthood (Bowlby, 1980).

Some studies reveal that individuals who have secure attachments show lower signs of depression and anxiety. Additionally, some studies present that, individuals who have high scores in self-report scales measuring anxious attachment

style dimension show depression and anxiety symptoms higher compared to securely attached group. Moreover, individuals who have avoidant attachment style suffer from depression and anxiety more than securely attached ones (Mikulincer & Shaver, 2007).

Another study that points the relationship with attachment styles and depression belongs to Kesebir, Kavzoğlu and Üstündağ (2011). It is stated that, there is an association between depression, anxiety and anxious attachment style. Also similar relationship has been found between anxious attachment style and postpartum depression (McMahon, Barnett, Kowalenko & Tennant, 2005; Meredith and Noller, 2003).

There are many studies that deduce common points in between insecure attachment styles and child-parent relationships like poor connection with mother, feeling of being misunderstood, rejection by caregiver and low emotional warmth. The following studies suggest these common findings as a possibility of predisposing factors for MDD.

Abraham and Whitlock (1969) have examined the relationship between childhood bereavement, negative childhood experiences and development of adult affective illness among 152 depressed patients. Depressed patients reported unhappy past experiences compared to control group. Researchers found out that, child-parent relationships lead to affective disorder in adults, while physical loss of a parent does not necessarily have a role in developing adult depression. Jacopson, Fasman and Dimascio (1975) have examined depriving events of 461 depressed

woman both inpatient and outpatient. Like Abraham and Whitlock, they also found no parental death of separation but discovered a link with adult depression and negative childhood experiences.

Perris and his friends (1986) assessed parental rearing practices with depressed patients. They used the term ‘neurotic reactive patients’ in the place of dysthymic disorder. These patients reported earlier parental deprivation. They described their families as rejecting and less consistent than the groups with major depressive disorder. He reported the importance of low emotional warmth and overprotection. He supported his hypothesis that deprivation of love is a risk factor for depressive disorders.

Hallstrom (1987) has investigated 60 middle-aged women who were diagnosed with major depressive disorder. They reported a more unhappy childhood which meant a poor relationship with mother, feeling of misunderstood by parents and punishment. Hallstrom has also found out that, parents of these participants are in contact with psychiatry services more that the comparison group.

Cole-Detke and Kobak (1996) have reached some preliminary data in their study that, there is a relationship between depression and preoccupied attachment. In their study, Q-item analysis proposes that, working models of parents of participants, especially mothers who are incapacitated, incompetent and unhappy in their marriage life reveal more depressive symptoms.

The aim to understand the etiology of depression has a significant place in research. Although, insecure attachment oriented psychopathology which leads to depression has the biggest place in literature, childhood maltreatment like negative life events, sexual abuse, peer victimization, cognitive vulnerability and affectionless control are shown as some reasons in developing depression (Toth and Cicchetti, 1996; Gibb, Abramson & Alloy, 2004; Hankin, 2005; Gibb, Chelminski & Zimmerman, 2006).

Toth and Cicchetti (1996) have conducted a research with 92 participants. They have reached to 52 children through Department of Social Services recorded as maltreated children and 40 from comparison families with no history of maltreatment. Sexual abuse, which was a subtype of maltreatment was the highest factor for depressive symptomatology. They emphasized that later childhood problems were linked to parental psychopathology which was related with maltreatment that led to disorganized, avoidant and ambivalant attachments.

Affectionless control is a term that combines low parental care, high parental control and overprotection. Brewin et al., 1992 and Hall et al., 2004 have reported that although affectionless control from both parents have a major role in developing adult depression, maternal rearing is related to depressive symptoms stronger than paternal rearing. Overprotection or control are shown as risk factors for developing depression but parental poor caring has a stronger relationship with depressive symptomology (Chambers et al., 2001; Hall et al., 2004; Lloyd & Miller, 1997).

From the psychoanalytic literature, Vaillant (1985) searched for a relationship between attachment and psychopathology by considering separation, loss and internalization. He argued that separation and loss of those we love do not cause psychopathology. Rather, failure in internalizing those whom we have loved or never having loved at all, causes psychopathology. Internalization offers us a shorthand for discussing the *psychic metabolic process* which assimilates split objects and leads to object constancy. He believed that early object loss and incomplete mourning makes critical contributions to adult development and psychopathology. Indeed, the psychodynamic literature of the late 1950s suggested that early object loss might be the etiology of schizophrenia.

In a description of an empirical data of Vaillant's which he followed 268 men from adolescence until middle life, he focused on parental loss, on adulthood depression and oral dependence. He was surprised that the best and worst outcome groups did not differ in the extent of childhood parental loss, in their own lives or in that of their parents. He found that traits of orality and dependency made it difficult to grieve, rather than that separation and loss created the traits of orality and dependence. He gives an example from Rutter (1981) who makes a distinction between privation and deprivation. Privation, never having loved or being loved, leads to emotional disability. Deprivation, losing one we have loved, leads to emotional distress. To lose someone we have loved and been loved by produces grief, not psychopathology. Thus, what leads to future psychopathology is privation, rather than deprivation.

## 1.3. Defense Mechanisms

Defense mechanisms have significant place in psychoanalytic literature. Contributions of Anna Freud, 1937; Melanie Klein, 1952; Kernberg, 1975; Vaillant, 1977; Perry, 1992; Nancy McWilliams, 1994; Bond, 2005 and many other valuable researchers will be reviewed in this part of the study.

Affect regulation has an important role in attachment based studies. It was revealed in Fraley and his friends' work that (Fraley et al., 2000) negative emotions are regulated by suppressing unwanted thoughts with preemptive and postemtive defense strategies. On the other hand, suppression is accepted among mature defenses in defense mechanism literature. Therefore, can a link between attachment and defense mechanisms be considered which might lead to mental health problems?

In this part of the study, definition, history of defense mechanisms, hierarchy of defenses, link between affect regulation, psychopathology especially with depression will be discussed in detail.

### 1.3.1. Definition

Defense mechanisms have been defined from different perspectives and have an important role in psychoanalytic literature. American Psychological Association (APA, 1994; Perry et al., 1998) describes defense as automatic psychological responses to internal and external conflicts and stressors. There are healthy and psychopathologic types of defenses. They mostly operate out of awareness. According to Perry and Kardos (1994), defenses are unconscious

mechanisms that reduce cognitive incompatibility and moderate sudden changes perceived from internal and external environment. Wallerstein (1985) articulated defense as a construct that states a way of operation of the mind, assisted to explain affects, behaviors and ideas that serve to prevent unwanted impulse discharge.

The data provided by Vaillant (1977) as well as Meissner (1980) and Cramer (1991) laid the groundwork for including defense mechanisms to DSM-III (Diagnostic and Statistical Manuel of Mental Disorders). In 1980, the relationship between defense mechanisms and psychopathology took place in DSM-III for the first time and defined as automatic psychological processes against internal and external threats. Both DSM-III and ICD-9 (Ninth version of the *International Classification of Diseases*) give a place to defenses underlying Axis II disorders in the perspective of both psychodynamic, genetic and temperamental domains (Vaillant, 1994).

### 1.3.2. History of Defense Mechanisms

The notion "mechanism of defense" was first defined in the study 'The Neuro-Psychoses of Defense' Freud, S. (1894). He argued that repression takes its roots from conflict. Freud first mentioned about *repression* in the case report of Miss. Lucie R. He formulated that when the repression process occurs, it becomes like a nucleus and departs from the ego containing the incompatible ideas.

According to Freud, the mechanisms of defense are unconscious operations that are used if the realization of an instinctual wish is threatened by a danger in the external world such as loss of object, loss of the object's love or

castration (Freud, 1926, p. 137). Thus, the realization of instinctive wishes become the internal condition of the external danger that has as its consequence ‘‘an accumulation of amounts of stimulation which require to be disposed of (1926, p. 137).

For a period of time, Freud used repression as a general definition for defensive process. Later on, his definition changed its form. He used repression as keeping a material away from the conscious. He discovered most of defense mechanisms and identified their important properties. He underlined that they, are unconscious, they are different from one another, they have a managing role of affect and instinct, they are reversible, adaptive and might be pathological (Zepf, 2011).

Many additional theoretical contributions followed in the next decades. Anna Freud (1937/1966) brought up a systematic structure to describe ten defense mechanisms that has emerged from psychoanalytic literature by that time: Regression, repression, reaction formation, isolation, undoing, projection, introjection, turning against the self, reversal and sublimation. She turned the focus from psychopathology to adaptation. Defenses, she recognized, reduce or silence internal turbulence. However, they also help individuals cope with the demands and challenges of external reality (Hentschel et al., 2004). She classified defenses as per the source of anxiety like superego, external world and strength of instinctual pressures that cause them.

Melanie Klein expressed in her book *The Psycho-Analysis of Children* that the ego functions from the beginning and that among its first activities are defenses against anxiety and the use of processes of introjection and projection. She also suggested that the ego's initial capacity to tolerate anxiety depends on its innate strength, on constitutional factors. She also expressed the view that ego establishes object relations from the first contacts with the external world (Klein, 1952).

The psychoanalytic mainstream springed from classical psychoanalysis, and later ego-psychology brought out defenses in response to drives or impulses, super-ego or conscience and the conflicts between these. Sublimation, repression, isolation, undoing, reaction formation, denial, projection, and acting out were added in common defenses. Kleinian and British object relations analysts added that certain defenses were oriented toward handling conflicts presented by the activation of internalized object representations of self and other, including defenses such as splitting and projective identification. Self-psychology, the relational and inter-subjectivist approaches arose from a view that narcissistic disorders constituted a group between borderline and neurotic conditions. In narcissistic disorders, problems with an enfeebled self were associated with the use of self-objects and particular defenses which could play a reparative role in treatment (Kernberg, 2001; Kohut & Wolfe, 1978).

### 1.3.3. Hierarchy of Defenses as They Relate to Psychopathology

Freud made an early hierarchy that differentiated defenses under three groups. Denial, distortion and projection were defenses of psychosis, and the opposite end of the continuum, sublimation, altruism, humor and suppression were

defenses of maturity. Between them; splitting, hypochondriasis, turning-against-the-self, fantasy, dissociation, repression, isolation, undoing, displacement and reaction formation were defenses of neurosis (Vaillant, 1992).

George Eman Vaillant made a contribution in differentiating a developmental hierarchy of defenses. He emphasizes the creative, coping and healthy sides of defenses. He likened them to "an oyster which confronted with a grain of sand, creates a pearl" Vaillant (1977). It is thought that this metaphor has carried his study to a more structured form. His first book, *Adaptation to Life* (1977), included excellent literary case presentations of defenses. He grouped defense mechanisms at four levels;

I – Psychotic mechanisms (delusional projection, denial and distortion),

II – Immature mechanisms (projection, schizoid fantasy, hypochondriasis, passive aggressive behavior, acting out and dissociation),

III – Neurotic defenses (isolation/intellectualization, repression, displacement and reaction formation),

IV – Mature mechanisms (altruism, suppression, anticipation, sublimation and humor) (Hentschel et al., 2004, p. 7, 8).

DSM-III and ICD-9 have given place to classification of personality disorders in the aspect of classification domain in 1980. Axis II disorders have been shown in a table in the perspective of genetic temperament and psychodynamic domains. From the psychodynamic perspective, projection and schizoid fantasy have been on the same line with paranoid, schizoid and schizotypal diagnostic domain. Acting out, splitting, devaluation and dissociation have taken place with

antisocial, narcissistic, borderline, histrionic and explosive diagnostic domain. Lastly, passive aggression and hypochondriasis have been kept in-line with avoidant, dependent, compulsive, passive-aggressive, affective and anankastic diagnostic domain.

J. Christopher Perry defined four general defensive states of mind which are roughly synonymous with the four major categories of defenses with Mardi Horowitz (1992). He defined clues for defensive anomalies that are being observed in (1) affect, (2) behavior, (3) formal aspect of speech and (4) content of speech.

Perry divided 30 defenses into seven defense levels. Each defense level has a general function. Each level describes how they protect the person from internal or external sources or conflict. Defense levels are as follows:

- Level 0: Psychotic defenses; he omitted 6 defenses from this level and gave reference to Bernys, de Rotten, Beretta, Kramer and Despland (2014) for further discussion.
- Level 1: Action defenses; acting out, passive aggression and help-rejecting complaining.
- Level 2: Major image-distorting defenses; splitting of others' images, splitting of self images and projective identification.
- Level 3: Disavowal defenses and autistic fantasy; denial, rationalization and projection.
- Level 4: Minor image-distorting defenses; devaluation of self or others' images, idealization of self or object images and omnipotence.
- Level 5a: Hysterical defenses; repression and dissociation.

- Level 5b: Other neurotic defenses; reaction formation and displacement.
- Level 6: Obsessional defenses; isolation, intellectualization and undoing.
- Level 7: High adaptive defenses; altruism, suppression, anticipation, sublimation and humor (Perry, 2014).

Bond and Perry (2004) argue that immature defenses are heavily hypothesized to lead to personality disorders (PD). These are; isolation, intellectualization, undoing, repression, dissociation, reaction formation, minor image distorting, omnipotence/grandiosity, idealization, devaluation and denial. Since, there are extra causal factors that produces traits, it is hard to postulate a one-to-one correspondence between PD types and specific defenses. Rather, they hypothesize that there is some meaningful overlap between PD type and specific defense mechanisms.

Ruuttu et al., (2006) have categorized defenses in four groups; mature mechanisms help individual to deal with conflicting emotions while seeking for psychological balance which contain rationalization and anticipation. Neurotic defenses are shown as reaction formation and pseudo-altruism, those that have short-term advantages but might be problem in long term. Image distorting mechanisms are dissociation and devaluation that are used to manipulate reality in order to avoid conflict. Immature defenses are displacement and projection that is like an elimination of the need to deal with reality.

Nancy McWilliams (1994) indicated that there are many benign functions of defense. They start out as providing healthy creative adaptation that continues

throughout life. On the other hand, they have a role of defending against a threat. Person who is in a defensive behavior usually has one or two intentions in a subconscious level; to avoid threatening or strong feeling and maintain a strong sense of self-esteem.

Based on clinical observations, McWilliams argues that, using a defense or a defense team is the result of a multi-dimensional combination of four factors: (1) Person's inherent temperament, (2) the nature of the problems that person exposed in early childhood, (3) as models, things that caregivers transfer to the child and (4) experiential results of using certain defenses. She makes a categorization for defense mechanisms as “primary” and “secondary” defenses. She includes primitive withdrawal, omnipotent control, denial, primitive idealization (and devaluation), projection, introjection, projective identification, splitting of the ego and dissociation to primary defenses while, isolation, moralization, compartmentalization, repression, regression, undoing, reversal, reaction formation, turning against the self, intellectualization, rationalization, displacement, acting out, identification, sexualization and sublimation are listed under secondary defenses (McWilliams, 1994).

### 1.3.4. Research on Defense Mechanisms, Psychopathology and Depression

Psychological health, pathology and ego strength are being measured meaningfully by the help of recent empirical studies. Some specific defenses are shown to be related to certain personality disorders that associated with core psychopathology. In some studies of Perry, he proposes various links between

defense and psychopathology such as omnipotence and devaluation in antisocial and narcissistic personality disorders (Perry J.D., and Perry J.C., 2004; Perry 2001) or splitting and projective identification in borderline personality (Perry and Cooper 1986). Moreover, narcissistic defenses and were used to compare depressive and psychotic symptomatology between subjects with borderline, antisocial personality disorders and bipolar II disorders (Beck, S.M., 2010).

Kernberg (1975) suggested that, some defense mechanisms as projective identification and splitting might be helpful in diagnosing borderline personality organization. He argued that, there are distinguishable defense mechanisms which had diagnostic significance (Cooper, 1989).

In the study of Cramer (1999), he investigated the relationship between personality, personality disorders and defense mechanisms by using the longitudinal study of Block and Block (1980). He based the work on psychoanalytic literature (Kernberg, 1976; Millon, 1996; Svrakic & McCallum, 1991) to put syndromes in a developmental order. It was suggested that histrionic personality is in the highest level that is followed by narcissistic personality. Antisocial personality is at the lowest level of these three. Beneath this developmental hierarch is the borderline personality disorder which is hypothesized from an earlier developmental level basis. Results indicated that, immature denial was the strongest predictor for borderline prototype. The higher levels of development is respectively as follows; Psychopathic, Narcissistic and Histrionic personalities that are characterized by use of higher levels of projection in addition to denial. In contrast to the previous psychoanalytic theoretical expectation, Histrionic and

Borderline personalities showed the strongest overlap. Histrionic personality showed the use of lowest level defense. Cramer points to the possibility that Histrionic Personality Disorder might be at a lower developmental level then it is assumed to be.

If we look at depression more specifically, with the emphasis toward an integrative psychotherapy approach for depression, Kwon P. (1999) examined the influence of cognitive style and psychodynamic defense mechanisms considering levels of dysphoria in a non- clinical group. Attributional style and turning against self were found to be associated with dysphoria.

A year later, in Kwon and Lemon's (2000) study, there is an integration of cognitive and psychodynamic contributions and they argue that, an interactive effect of both have role in depressive symptoms. *Hopelessness theory of depression* (Abrahamson, Metalsky & Alloy, 1989) presumes that a negative attributional style serves as a weakness to depression. Psychodynamic perspective asserts that defense mechanisms are unconscious intrapsychic processes that are triggered by threatening events (Cramer, 1991; Vaillant, 1977). Under the light of these two approaches, Kwon and Lemon have used Defense Style Questionnaire (DSQ), which was also used in this study, in order to investigate defense style maturity and immaturity separately. Relation between attributional style and defense style immaturity suggested a mediational effect. High uses of mature defenses reduce the relation between a negative attributional style and depressive symptoms (Kwon & Lemon, 2000). Addition to this, Busch, Rudden and Shapiro (2004) presented some case examples of patients who are diagnosed with MDD using immature or

neurotic defenses shifted to mature defenses after an eclectic therapeautic process based on psychodynamic and cognitive behavioral therapies.

Hovanesian, Isakov and Cervellione (2009) underlined the significant relationship between suicide risk in Major Depression and image distorting mechanisms by using DSQ and clinical interview for diagnosis. Results reveal that, the best predictors among defense mechanisms for suicide attempt are dissociation and devaluation categorized under image distorting mechanisms.

Craşovan (2014) examined defense mechanisms associated with dysfunctional attitudes in a participant group diagnosed with Major Depressive Disorder among 103 adult patients. He used DSQ-60 (Thygeasen et al., 2008) which was adapted and validated to Romanian population by Craşovan & Maricutoiu in 2012. Denial, self-devaluation and withdrawal have positive correlations with dysfunctional attitudes for entire clinical group. For the subgroup of men, denial and repression have significant roles whereas self-devaluation shows a significance in subgroup of women for a positive correlation with dysfunctional attitudes.

Although, there is a considerable amount of psychoanalytic and cognitive based literature focused on depression, bipolar disorder did not received the same interest even in contemporary research. Freud (1917, pp.132) wrote: "We are without insight into the mechanism of the displacement of melancholia by a mania." Kramer, Roten, Perry and Despland (2009), have focused on defense mechanisms in Bipolar Affective Disorder in a study with 30 inpatients diagnosed

with BD. Five immature defenses were linked with diagnosis which are denial, projection, acting out, hypochondriasis and passive-aggression.

In the study of Sharma and Sinha (2010), they compared the use of defense mechanisms among ten bipolar manic, ten bipolar depressed and ten unipolar depressed patients. Both bipolar manic and depressed groups used denial, borderline level defenses and immature defenses significantly. Manic group significantly used narcissistic level defenses and denial compared to bipolar and unipolar depressed groups. Manic group scored lower on the defense mechanism of identification as compared to unipolar depression group. Unipolar depression group used neurotic level of defenses more frequently than bipolar depression group which is followed by manic group.

Before reviewing the literature to see the link between attachment and defense mechanisms, distances and similarities between affect regulation and defense mechanisms will be presented in order to constitute an easier connection between two theories.

Affect regulation consists of both conscious and not conscious processes which regulates positive and negative emotions. It is an implicated process perceived by the person in personality, social, emotional and cognitive development (Gross, 2002). Emotion regulation and defenses are both processes for the management of person's internal states (Sala et al., 2015). On the other hand, their arousal is from two very different theoretical backgrounds. Defense mechanisms have a significant place in psychoanalytic theory (Freud, 1936) and an

important usage in analytical based psychotherapy. Research on emotion regulation is originated in the field of developmental psychology (Thompson, 1994).

There is a distance between two perspectives like defenses focus on negative emotional experiences and unconscious processes whereas emotion regulation direction is upon both positive and negative emotions and can either take place both in conscious or unconscious (Gross, 1998, 2002; Cramer, 1998). Another difference might be shown as the regulation of impulses such as aggression and sex for defense mechanisms. However, emotion regulation strategies are oriented towards emotions like sadness, anger or happiness.

Despite the differences in presentation of two frameworks, they are similar in some points. They both have important role in mental health. Both of them have to do with the management of affect which is accepted to be a superordinate category including stress, moods, emotions and impulses. Both emotions and impulses have value and influence in directing behavior (Gross, 1998). Moreover, studies of Garnefsky et al., (2002) and Perry (1990) underline connections between emotion regulation and defenses. The emotion regulation strategy named rumination and defense mechanism named intellectualization could be an evidence for similarities (Sala et al., 2015).

### 1.4. Relationship Between Attachment Styles and Defense Mechanisms

While the literature demonstrates the relationship between attachment styles and depression as well as the relationship between use of defense mechanisms and depression, there are very few studies that investigate a direct link

between attachment styles and the use of defence mechanisms. Furthermore, there has been no research that has looked at the relationship among attachment styles, defence mechanisms and depression. However, the literature does contain a number of studies that indirectly suggest a link among these two variables, attachment styles and defense mechanisms as they relate to depression.

Fonagy emphasizes that secure attachment includes responsiveness, sensitivity and warmth which prepares a ground for greater awareness of the mental state of others (Atkinson & Zucker, 1997). On the other hand, in an experiment of Fraley and Shaver (1997) which was conducted in an insecurely attached adult group, they observed that, individuals who show attachment related avoidance deactivated psychological arousal to some degree and minimized attachment related thoughts. They suppressed their emotions. It might be an evidence for the relationship between insecure attachment and defense orientation.

In the study of Fraley and Shaver (2000), they underlined avoidant adults' suppression towards emotional events by using preemptive and postemptive defensive operations in order to limit the amount of information that is coded and deactivate memories that have already been encoded which serve for regulation of negative emotions (Gross & Levenson, 1993).

In the study of Finzy and his friends (2002), they reached to a result that physically abused children show long-term pathologic impairments with a demonstration of avoidant attachment style and use of immature defense mechanisms such as denial, splitting, isolation, identification with the aggressor and

projection. Significant differences in scores of depression, depressive anxiety, and negative affect between nonabused/nonneglected and physically abused group have been demonstrated in the research.

Brody project, begun in 1963, is a pioneer longitudinal study in mother-infant interaction. It was simply hypothesed that, mother's early close care would have a positive effect on child's psychological development. Children's first seven years were documented. Study occupied mother-child films, semi-structured parent interviews and school observations; followed by detailed assessments of the children at 1, 7, and 18 years (Brody and Axelrad, 1970, 1978; Brody and Siegel, 1992). 76 children have been followed from birth to age 30. Ten children were abused emotionally, physically and were exposed to verbal hostility. As per AAI findings, compared to a non-abused group, 20% have reported themselves as securely attached. 80% of the insecurely attached group were psychiatrically diagnosed with dysthymia, MDD - alcohol abuse, narcissistic personality - substance abuse, insomnia, anxiety headaches stomach distress and schizoid personality whereas psychiatric diagnoses ratio for non-abused group is 27.3%. Immature defense mechanisms were observed commonly among abused group like acting out, denial, passive-aggression, identification with the aggressor and apathetic withdrawal. Only one participant used mature defenses which are rationalization, intellectualization and humor in order to give positive value to his experience (Massie and Szajnberg, 2006).

In the study of Kalamatianos (2013), he examined defense mechanisms in people with Borderline Personality Disorder (BPD) diagnosis in relation to the

attachment type they adopt. He worked on 36 adult participants who were dignosed with BDP and in contact with psychiatry outpatient departments. He reported that results are congruent with literature due to the participants' high scores in insecure attachment types. Subjects diagnosed with BPD used neurotic and immature defenses more than non-diagnosed subjects. He found out significant correlations between attachment and defenses but no difference was scored in mature defenses.

Besharat and Khajavi (2013) have investigated the mediating role of defense mechanisms on the relationship between attachment styles and alexithymia. DSQ-40 was used for defense mechanisms, AAI was used to measure attachment styles and The Toronto Alexithymia Scale (TAS-20) for alexithymia. Their result showed that the relationship between attachment styles and alexithymia has been influenced by defense mechanisms which have a partial mediating role. Moreover, they argued about a possibility that defense mechanisms could explain a relationship between attachment styles and alexithymia.

## 1.5. The Present Study

The present study aimed to assess the attachment styles and the defense mechanisms in an inpatient sample of major depressive disorder. Inpatients in Surp Pırgiç Armenian Hospital's psychiatry service diagnosed with Major Depressive Disorder are asked for their permission to attend to the present study. The comparison group was randomly selected among those individual who completed the attachment and defense mechanisms questionnaires over SurveyMonkey. Then, sampling was matched with inpatient group's demographic data.

The research hypotheses are stated as below:

1. There is a significantly higher level of attachment related anxiety and attachment related avoidance among inpatient group than the comparison group.
2. There is a significantly lower use of mature defense mechanisms among inpatient group than the comparison group.
3. There is significantly higher use of neurotic and immature defense mechanisms among inpatient group than the comparison group.
4. There are statistically significant correlations between the attachment related anxiety, attachment related avoidance and the level of defenses used by the subjects in the inpatient group, comparison group, and the total group.

# CHAPTER 2

# METHOD

## 2.1. Design

Study was conducted with a quantitative methodology. Two groups have been set for the design: One inpatient group and one comparison group. Inpatient group was selected from the psychiatry service's current available inpatients. Comparison group was selected among those individuals who completed attachment and defense mechanisms questionnaires over SurveyMonkey. Sampling was matched considering demographic data of inpatient group. Two research questionnaire sets were used: Attachment questionnaire (ECR-R) and defense mechanisms questionnaire (DSQ-40). Independent T-Test analysis has been used in comparing the inpatient and comparison groups. In order to determine the relationship between ECR-R and DSQ-40 Pearson Correlation test has been used.

## 2.2. Participants

Participants were selected among patients of Yedikule Surp Pırgiç Armenian Hospital Psychiatry Service. Forty-nine people participated in this study. 25 participants were diagnosed with Major Depressive Disorder as per DSM-5 criteria. Since psychosis has been excluded from the study, 1 participant who was diagnosed with psychotic depression was left out of data. Sample was consist of 14 female and 10 male participants. Age range varied from 18 to 65: 7 subjects were in 18-27, 10 subjects in 30-41, 5 subjects in 42-53, and 2 subjects in 54-65 age range.

Comparison group ($n$ = 24) was randomly selected from an accessible population by using SurveyMonkey. Then, sampling was matched by considering demographic data of inpatient group. Attention was paid for the comparison group selection in hospitalization and medication subjects. Group was composed of participants who declared on self-report that they were out of psychiatric medication within last two years and who have not been inpatient due to any psychiatric disorder. 24 participants were selected out of 98. Selection was done by considering inpatient group's demographic characteristics. Sample was consist of 9 female and 15 male participants. Age range varied from 18 to 53: 3 subjects were in 18-27, 11 subjects in 30-41, 10 subjects in 42-53 age range.

## 2.3. Instruments

Both inpatient and comparison groups were asked to complete Experiences in Closed Relationships-Revised and Defense Style Questionnaire to

evaluate attachment styles and defense mechanisms. The reason for selecting mentioned scales is due to recommendation in proposal. Moreover, in reliability and validity study of ECR-R Turkish version, it is found that dimensions measured by ECR-R have higher test-retest reliability and internal consistency (Selçuk et al., 2005). Internal consistency of DSQ-40 is also found to be high as will be mentioned further in the next part. Significant differences were found in the expected direction between clinical and non-clinical groups (Yilmaz et al., 2007) which serves our purpose when sample of the study is considered. Demographic information and informed consent were included in the survey package.

### 2.3.1. Experiences in Closed Relationships-Revised (ECR-R)

The original form is Experiences in Close Relationships-Revised (ECR-R) scale which was developed by Brennan et al., in 1998 in the measurement of adult attachment styles. It has a two factor solution. Reliability and validity of ECR-R has been examined in a Turkish student sample by Selçuk et al., in 2005. "Yakın İlişkilerde Yaşantılar Envanteri-II" (YİYE-II) has also a two factor solution which are attachment-related avoidance and attachment-related anxiety. Cronbach's Alpha for avoidance factor was found as .90 and .86 for anxiety factor. It is a 7 point likert scale with 36 questions. Options are between (1) I totally disagree and (7) I totally agree.

### 2.3.2. Defense Style Questionnaire (DSQ-40)

Second scale is "Defense Style Questionnaire" (DSQ-40). The original form was developed by Bond et al., in 1983. It was a self-report scale consist of 88

questions. It was revised by Andrews et al., in 1989 and in 1993 and consist of 40 questions. Defense styles have been summarized under three cathegories; (1) immature defense styles: projection, passive–aggressive, acting out, isolation, devaluation, autistic fantasy, denial, displacement, dissociation, somatization, rationalization, splitting; (2) neurotic defense styles: pseudo-altruism, idealization, reaction formation, undoing; and (3) mature defense styles: sublimation, humor, anticipation, suppression. It is stated the most applied instrument is the Defense Style Questionnaire (DSQ), which is an easñy administrable and cost-effective self-report questionnaire (Bond et al., 1989; Andrews et al., 1993).

Reliability and validity studies were held by Yılmaz et al., in 2007. Turkish version of the study "Savunma Biçimleri Testi" (SBT-40) also keeps the same factor solution which are mature, neurotic and immature defense styles. It is a 9 point likert scale with 40 questions. Options are between; (1) It is definitely not convenient for me, (9) It is definitely convenient for me. The internal consistency of the mature, neurotic, and immature defense styles were 0.70, 0.61, and 0.83, respectively. Additionally, results revealed that the three defense styles had acceptable split-half reliability and test-retest reliability coefficients. Considering the concurrent validity, the mature defense style was negatively correlated with the symptoms of depression and anxiety, whereas the immature defense style was positively correlated with these symptoms. The neurotic defense style, on the other hand, had a positive correlation with anxiety symptoms, but did not reveal a significant correlation with depressive symptoms.

## 2.4. Procedure

The ethics committee approval was received from Bahçeşehir University Scientific Research and Publication commission before starting to data collection process. Special permission was received from psychiatry service of Yedikule Surp Pırgiç Armenian Hospital's foundation management. Information upon diagnoses have been obtained from each patient's psychiatrist, nurse and hospital records. Psychosis has been excluded. No patient has attended any psychotherapy sessions. Survey package was consist of demographic information form with an informed consent part and two questionnaires which are Turkish forms of Experiences in Closed Relationships Revised (ECR-R) and Defense Style Questionnaire (DSQ). It has been delivered to each patient in the second day of their hospitalization earliest due to their emotional and cognitive availability. Some participants' treatment occupied electroconvulsive therapy (ECT) as well as medication. Therefore ECT periods have also been considered like leaving the patient at least 4 hours before delivering the questionnaire set because of a side effect of short term confusion. Patients have been informed personally before delivering questionnaires.

Comparison group has filled the questionnaire upon written information. Like inpatient group, their names have not been recorded in order to protect personal information.

# CHAPTER 3

# RESULTS

## 3.1. Demographic Character of the Sample

Frequencies and percentages of sample characteristics were displayed in Table 3.1. Gender, age, education and marital status comparisons between inpatient and comparison groups have been shown separately in following tables. Chi square tests have been conducted for demographic characteristics of inpatient and comparison groups.

**Table 3.1 Demographic Character of the Sample**

| | Inpatient Group | | Comparison Group | |
|---|---|---|---|---|
| Characteristics | Frequencies ($n$ = 24) | % | Frequencies ($n$ = 24) | % |
| Gender | | | | |
| Female | 14 | 58.3 | 9 | 37.5 |
| Male | 10 | 41.7 | 15 | 62.5 |
| Marital Status | | | | |
| Single | 12 | 50.0 | 10 | 41.7 |
| Married | 11 | 45.8 | 11 | 45.8 |
| Divorced | 1 | 4.2 | 2 | 8.3 |
| Widower | 0 | 0.0 | 1 | 4.2 |
| Education | | | | |
| Primary school | 7 | 29.2 | 1 | 4.2 |
| Intermediate school | 3 | 12.5 | 6 | 25.0 |
| High school | 2 | 8.3 | 4 | 16.7 |
| University | 12 | 45.8 | 12 | 50.0 |
| Age | | | | |
| 18-29 | 7 | 29.2 | 3 | 12.5 |
| 30-41 | 10 | 41.7 | 11 | 45.8 |
| 42-53 | 5 | 20.8 | 10 | 41.7 |
| 54-65 | 2 | 8.3 | 0 | 0.0 |

The sociodemographic characteristics of the inpatient group shown in table 3.1 is as follows: In terms of Gender: 14 (58.3%) Females and 10 (41.7%) Males; in terms of Marital Status: 12 (50.0%) Single, 11 (45.8%) Married and 1 (4.2%) Divorced; in terms of Education: 7 (29.2%) Primary school graduate, 3 (12.5%) Intermediate school graduate, 2 (8.3%) High school graduate, 12 (45.8%) University graduate, and 1 (4.2%) Graduate graduate; in terms of Age: 7 (29.2%) 18-29 age group, 10 (41.7%) 30-41 age group, 5 (20.8%) 42-53 age group, and 2 (8.3%) 54-65 age group.

The sociodemographic characteristics of the comparison group on the same table is as follows: In terms of Gender: 9 (37.5%) Females and 15 (62.5%) Males; in terms of Marital Status: 10 (50.0%) Single, 11 (45.8%) Married, 2 (4.2%) Divorced and 1 (4.2%) Widower; in terms of Education: 1 (4.2%) Primary school

graduate, 6 (25%) Intermediate school graduate, 4 (16.7%) High school graduate, 12 (50%) University graduate, and 1 (4.2%) Graduate graduate; in terms of Age: 3 (12.5%) 18-29 age group, 11 (45.8%) 30-41 age group and 10 (41.7%) 42-53 age group.

**Table 3.2 Gender Comparison Between the Inpatient and Comparison Groups**

| | | | Gender | | Total |
|---|---|---|---|---|---|
| | | | Female | Male | |
| Groups | Comparison | Count | 9 | 15 | 24 |
| | | % within Groups | 37,5% | 62,5% | 100,0% |
| | Inpatient | Count | 14 | 10 | 24 |
| | | % within Groups | 58,3% | 41,7% | 100,0% |
| Total | | Count | 23 | 25 | 48 |
| | | % within Groups | 47,9% | 52,1% | 100,0% |

The gender comparison between the inpatient and comparison groups have been done by using the Chi-Square test. The result on table 3.2 showed that there is no significant difference between Inpatient and Comparison groups in terms of gender: $\chi^2_{(1)} = 2.09$, $p = 0.149$.

**Table 3.3 Age Comparison Between Inpatient and Comparison Groups**

| | | | Age | | | | Total |
|---|---|---|---|---|---|---|---|
| | | | 18-29 | 30-41 | 42-53 | 54-65 | |
| Groups | Comparison | Count | 3 | 11 | 10 | 0 | 24 |
| | | % within Groups | 12,5% | 45,8% | 41,7% | 0,0% | 100,0% |
| | Inpatient | Count | 7 | 10 | 5 | 2 | 24 |
| | | % within Groups | 29,2% | 41,7% | 20,8% | 8,3% | 100,0% |
| Total | | Count | 10 | 21 | 15 | 2 | 48 |
| | | % within Groups | 20,8% | 43,8% | 31,2% | 4,2% | 100,0% |

The age comparison between the inpatient and comparison groups have been done by using the Chi-Square test. The result on table 3.3 showed that there is

no significant difference between the Inpatient and Comparison groups in terms of age: $\chi^2_{(3)} = 5.31$, $p = 0.150$.

**Table 3.4 Education Comparison Between Inpatient and Comparison Groups**

| | | | Education | | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | | | Primary School | Intermediate School | High School | University | Graduate | |
| Groups | Comparison | Count | 1 | 6 | 4 | 12 | 1 | 24 |
| | | % within Groups | 4,2% | 25,0% | 16,7% | 50,0% | 4,2% | 100,0% |
| | Inpatient | Count | 7 | 3 | 2 | 11 | 1 | 24 |
| | | % within Groups | 29,2% | 12,5% | 8,3% | 45,8% | 4,2% | 100,0% |
| Total | | Count | 8 | 9 | 6 | 23 | 2 | 48 |
| | | % within Groups | 16,7% | 18,8% | 12,5% | 47,9% | 4,2% | 100,0% |

The education comparison between inpatient and comparison groups have been done by using the Chi-Square test. The result on table 3.4 showed that there is no significant difference between Inpatient and Comparison groups in terms of education: $\chi^2_{(4)} = 6.21$, $p = 0.184$.

**Table 3.5 Marital Status Comparison Between Inpatient and Comparison Groups**

| | | | Marital Status | | | | Total |
|---|---|---|---|---|---|---|---|
| | | | Single | Married | Divorced | Widow | |
| Groups | Comparison | Count | 10 | 11 | 2 | 1 | 24 |
| | | % within Groups | 41,7% | 45,8% | 8,3% | 4,2% | 100,0% |
| | Inpatient | Count | 12 | 11 | 1 | 0 | 24 |
| | | % within Groups | 50,0% | 45,8% | 4,2% | 0,0% | 100,0% |
| Total | | Count | 22 | 22 | 3 | 1 | 48 |
| | | % within Groups | 45,8% | 45,8% | 6,2% | 2,1% | 100,0% |

The marital status comparison between inpatient and comparison groups have been done by using the Chi-Square test. The result showed that there is no significant

difference between the Inpatient and Comparison groups in terms of marital status: $\chi^2_{(3)} = 1.51$, $p = 0.679$ which is shown on table 3.5.

## 3.2. Group Comparisons for Attachment Anxiety and Avoidance Scales (ECR-R)

Independent t-test was conducted to evaluate comparisons for attachment anxiety and attachment avoidance between inpatient and comparison groups. Mature, neurotic and immature defenses between inpatient and comparison groups have also been compared with independent t-test.

Results on table 3.6 and 3.7 indicated that, inpatient groups' total scores in attachment anxiety is significantly higher than comparison groups' attachment anxiety scores. There is a significant difference between inpatient and comparison group in terms of attachment anxiety ($t_{(46)} = 3.51$, $p < .01$) and attachment avoidance ($t_{(46)} = 2.83$, $p < .01$).

**Table 3.6 Group Comparisons for the Attachment Anxiety Scale (ECR-R)**

| *Variables* | *Groups* | *N* | *M* | *SD* | *t* | *df* | *p* |
|---|---|---|---|---|---|---|---|
| Attachment Anxiety Total | MDD | 24 | 69.67 | 16.65 | 3.505 | 46 | 0.001** |
| | Comp. | 24 | 53.17 | 15.95 | | | |

Comp.:Comparison group
*Note* * $p < .05$ ** $p < .01$

**Table 3.7 Group Comparisons for the Attachment Avoidance Scale (ECR-R)**

| Variables | Groups | *N* | *M* | *SD* | *t* | *df* | *p* |
|---|---|---|---|---|---|---|---|
| Attachment Avoidance Total | MDD | 24 | 56.17 | 17.10 | 2.832 | 46 | 0.007** |
| | Comp. | 24 | 44.21 | 11.65 | | | |

Comp.: Comparison group
*Note* * $p < .05$ ** $p < .01$

### 3.3. Group Comparisons for Mature, Neurotic and Immature Defenses Scale (DSQ-40)

Inpatient group scores for mature defense score was significantly lower ($t_{(46)}$ = -2.62, $p < .05$) than comparison groups' score as shown on table 3.8. On the other hand, data on tables 3.9 and 3.10 that are neurotic defense score ($t_{(46)}$ = 2.34, $p < .05$) and immature defense score ($t_{(46)}$ = 2.84, $p < .01$) were significantly higher than comparison groups' scores.

**Table 3.8 Group Comparisons for Mature Defenses Scale (DSQ-40)**

| Variables | Groups | *N* | *M* | *SD* | *t* | *df* | *p* |
|---|---|---|---|---|---|---|---|
| Mature Defenses Total | MDD | 24 | 38.71 | 11.30 | -2.624 | 46 | 0.012* |
| | Comp. | 24 | 46.96 | 10.47 | | | |

Comp.: Comparison group
*Note* * $p < .05$ ** $p < .01$

**Table 3.9 Group Comparisons for Neurotic Defenses Scale (DSQ-40)**

| Variables | Groups | *N* | *M* | *SD* | *t* | *df* | *p* |
|---|---|---|---|---|---|---|---|
| Neurotic Defenses Total | MDD | 24 | 43.04 | 8.68 | 2.340 | 46 | 0.024* |
| | Comp. | 24 | 36.71 | 10.02 | | | |

Comp.: Comparison group
*Note* * $p < .05$ ** $p < .01$

**Table 3.10 Group Comparisons for Immature Defenses Scale (DSQ-40)**

| Variables | Groups | *N* | *M* | *SD* | *t* | *df* | *p* |
|---|---|---|---|---|---|---|---|
| Immature Defenses Total | MDD | 24 | 108.96 | 27.17 | 2.835 | 46 | 0.007** |
| | Comp. | 24 | 88.63 | 22.28 | | | |

Comp.: Comparison group
*Note* * $p < .05$ ** $p < .01$

**Table 3.11 Sub-defenses of Mature Defenses Scale**

| Variables | Groups | *N* | *M* | *SD* | *t* | *df* | *p* |
|---|---|---|---|---|---|---|---|
| Mature Defenses Total | MDD | 24 | 38.71 | 11.30 | -2.624 | 46 | 0.012* |
| | Comp. | 24 | 46.96 | 10.47 | | | |
| Sublimation | MDD | 24 | 9.96 | 4.42 | -.071 | 46 | 0.944 |
| | Comp. | 24 | 10.04 | 3.70 | | | |
| Humor | MDD | 24 | 10.04 | 4.35 | -2.742 | 46 | 0.009** |
| | Comp. | 24 | 13.25 | 3.73 | | | |
| Anticipation | MDD | 24 | 10.25 | 3.92 | -1.653 | 46 | 0.105 |
| | Comp. | 24 | 12.00 | 3.41 | | | |
| Suppression | MDD | 24 | 8.46 | 4.33 | -2.754 | 46 | 0.008** |
| | Comp. | 24 | 11.67 | 3.71 | | | |

Comp.: Comparison group
*Note* * $p < .05$ ** $p < .01$

Comparisons for DSQ-40 Mature Defenses Scale between the inpatient and comparison groups is done using the T-Test analysis. The results on table 3.11 showed that there are significant differences between the MDD and comparison groups in the following scores: Mature Defenses Total ($t_{(46)} = -2.62$, $p = 0.012$), Humor ($t_{(46)} = -2.74$, $p = 0.009$), Suppression ($t_{(46)} = -2.75$, $p = 0.008$). In all cases MDD group received lower scores compared to the comparison group.

**Table 3.12 Sub-defenses of Neurotic Defenses Scale**

| Variables | Groups | *N* | *M* | *SD* | *t* | *df* | *p* |
|---|---|---|---|---|---|---|---|
| Neurotic Defenses Total | MDD | 24 | 43.04 | 8.68 | 2.340 | 46 | 0.024* |
| | Comp. | 24 | 36.71 | 10.02 | | | |
| Undoing | MDD | 24 | 11.08 | 4.15 | 2.416 | 46 | 0.020* |
| | Comp. | 24 | 8.46 | 3.34 | | | |
| Pseudo-Altruism | MDD | 24 | 12.21 | 3.68 | 1.327 | 46 | 0.191 |
| | Comp. | 24 | 10.67 | 4.34 | | | |
| Idealization | MDD | 24 | 10.96 | 4.38 | 1.050 | 46 | 0.299 |
| | Comp. | 24 | 9.54 | 4.95 | | | |
| Reaction Formation | MDD | 24 | 8.79 | 4.17 | 0.674 | 46 | 0.504 |
| | Comp. | 24 | 8.04 | 3.51 | | | |

Comp.: Comparison group
*Note* * $p < .05$ ** $p < .01$

Comparisons for the DSQ-40 Neurotic Defenses Scale between the inpatient and comparison groups is done using the T-Test analysis. The results showed that there are significant differences between the MDD and comparison groups in the following scores shown on table 3.12: Neurotic Defenses Total ($t_{(46)} = 2.34$, $p = 0.024$), Undoing ($t_{(46)} = 2.42$, $p = 0.020$). In all cases MDD group received higher scores than comparison group.

**Table 3.13 Sub-defenses of Immature Defenses Scale**

| Variables | Groups | *N* | *M* | *SD* | *t* | *df* | *p* |
|---|---|---|---|---|---|---|---|
| Immature Defenses Total | MDD | 24 | 108.96 | 27.17 | 2.835 | 46 | 0.007** |
| | Comp. | 24 | 88.63 | 22.28 | | | |
| Projection | MDD | 24 | 10.54 | 4.57 | 3.679 | 46 | 0.001** |
| | Comp. | 24 | 6.42 | 3.05 | | | |
| Passive Aggression | MDD | 24 | 8.92 | 3.51 | 2.452 | 46 | 0.018* |
| | Comp. | 24 | 6.29 | 3.90 | | | |
| Acting Out | MDD | 24 | 8.63 | 5.01 | 0.605 | 46 | 0.548 |
| | Comp. | 24 | 7.79 | 4.51 | | | |
| Isolation | MDD | 24 | 10.04 | 4.13 | 1.617 | 46 | 0.113 |
| | Comp. | 24 | 7.96 | 4.77 | | | |
| Devaluation | MDD | 24 | 9.04 | 3.96 | 2.130 | 46 | 0.039* |
| | Comp. | 24 | 6.67 | 3.76 | | | |
| Autistic Fantasy | MDD | 24 | 7.58 | 5.26 | 0.783 | 46 | 0.437 |
| | Comp. | 24 | 6.58 | 3.39 | | | |
| Denial | MDD | 24 | 8.33 | 4.58 | 1.089 | 46 | 0.282 |
| | Comp. | 24 | 7.00 | 3.88 | | | |
| Displacement | MDD | 24 | 8.71 | 5.02 | 1.663 | 46 | 0.103 |
| | Comp. | 24 | 6.71 | 3.09 | | | |
| Dissociation | MDD | 24 | 7.08 | 4.12 | -1.009 | 46 | 0.318 |
| | Comp. | 24 | 8.42 | 5.00 | | | |
| Splitting | MDD | 24 | 10.99 | 4.10 | 2.053 | 46 | 0.046* |
| | Comp. | 24 | 8.46 | 4.34 | | | |
| Rationalization | MDD | 24 | 7.92 | 3.35 | -0.776 | 46 | 0.442 |
| | Comp. | 24 | 8.58 | 2.55 | | | |
| Somatization | MDD | 24 | 11.21 | 4.26 | 2.875 | 46 | 0.006** |
| | Comp. | 24 | 7.75 | 4.07 | | | |

Comp.: Comparison group *Note* * $p < .05$ ** $p < .01$

Comparisons for the DSQ Immature Defenses Scale between the inpatient and comparison groups is done using the T-Test analysis. The results on table 3.13 showed that there are significant differences between the MDD and comparison groups in the following scores: Immature Defenses Total ($t_{(46)} = 2.84$, $p = 0.007$), Projection ($t_{(46)} = 3.68$, $p = 0.001$), Passive Aggression ($t_{(46)} = 2.45$, $p = 0.018$), Devaluation ($t_{(46)} = 2.13$, $p = 0.039$), Splitting ($t_{(46)} = 2.05$, $p = 0.046$), Somatization ($t_{(46)} = 2.88$, $p = 0.006$). In all cases MDD group received higher scores than comparison group.

### 3.4. Correlations Between Variables

**Table 3.14 Correlation Between Attachment and Defense Mechanism Variables in the Total Sample (*N*=48)**

| | 1. | 2. | 3. | 4. | 5. |
|---|---|---|---|---|---|
| 1. Attachment-Anxious | 1 | | | | |
| 2. Attachment-Avoidant | .44*** | 1 | | | |
| 3. Mature Defenses | -.28* | -.22 | 1 | | |
| 4. Neurotic Defenses | .59*** | .34** | .17 | 1 | |
| 5. Immature Defenses | .52*** | .43*** | -.14 | .50*** | 1 |

*Note* *$p < .10$ ** $p < .05$ *** $p < .01$

In the total sample ($N = 48$) correlations between the attachment and defense mechanism variables are investigated using Pearson correlation analysis. The results showed as on the table 3.14 that there are significant correlations between the following variables: Attachment-Anxious and Mature Defenses ($r = -0.28$, $p < 0.10$), Neurotic Defenses ($r = 0.59$, $p < 0.01$), Immature Defenses ($r = 0.52$, $p < 0.01$); Attachment-Avoidant and Neurotic Defenses ($r = 0.34$, $p < 0.05$), Immature Defenses ($r = 0.43$, $p < 0.01$).

Those who has Attachment-Anxious style show less Mature Defenses ($r = -0.28$, $p < 0.10$) and more Neurotic Defenses ($r = 0.59$, $p < 0.01$) and Immature Defenses ($r = 0.59$, $p < 0.01$). Attachment-Avoidance is not much related with the Mature Defenses and more related with Neurotic Defenses ($r = 0.34$, $p < 0.05$) and Immature Defenses ($r = 0.43$, $p < 0.01$). In general, Attachment-Anxious style is related with more defensive operations within the person.

**Table 3.15. Correlation Between Attachment and Defense Mechanism Variables in the Inpatient Group (*n* = 24)**

| | 1. | 2. | 3. | 4. | 5. |
|---|---|---|---|---|---|
| 1. Attachment-Anxious | 1 | | | | |
| 2. Attachment-Avoidant | .42** | 1 | | | |
| 3. Mature Defenses | .01 | -.08 | 1 | | |
| 4. Neurotic Defenses | .58*** | .29 | .32 | 1 | |
| 5. Immature Defenses | .47** | .52*** | .20 | .53*** | 1 |

*Note* *$p < .10$ ** $p < .05$ *** $p < .01$

In the inpatient sample ($n = 24$) the correlations between the attachment and defense mechanism variables are investigated using Pearson correlation analysis. The results showed that there are significant correlations between the following variables: Attachment-Anxious and Neurotic Defenses ($r = 0.58$, $p < 0.01$), Immature Defenses ($r = 0.47$, $p < 0.05$); Attachment-Avoidant and Immature Defenses ($r = 0.52$, $p < 0.01$) as shown on table 3.15.

**Table 3.16 Correlation Between Attachment and Defense Mechanism Variables in the Comparison Group (*n* = 24)**

| | 1. | 2. | 3. | 4. | 5. |
|---|---|---|---|---|---|
| 1. Attachment-Anxious | 1 | | | | |
| 2. Attachment-Avoidant | .25 | 1 | | | |
| 3. Mature Defenses | -.27 | -.10 | 1 | | |
| 4. Neurotic Defenses | .47** | .22 | .32 | 1 | |
| 5. Immature Defenses | .37* | .23 | -.14 | .36* | 1 |

*Note* *$p$ < .10 ** $p$ < .05 *** $p$ < .01

In the comparison sample ($n$ = 24) on table 3.16, the correlations between the attachment and defense mechanism variables are investigated using Pearson correlation analysis. The results showed that there are significant correlations between the following variables: Attachment-Anxious and Neurotic Defenses ($r$ = 0.47, $p$ < 0.05), Immature Defenses ($r$ = 0.37, $p$ < 0.10).

# CHAPTER 4

# DISCUSSION

The main objective of the present study was first to examine whether there was a significant difference in attachment related anxiety and attachment related avoidance between an inpatient group diagnosed with Major Depressive Disorder and the comparison group. The second aim of this study was to examine the types of defense mechanisms used among the inpatient group. Our prediction was that, people diagnosed with MDD present higher anxious and avoidant attachment styles and higher neurotic and immature defense mechanisms than comparison group.

The findings of the study support the hypotheses. Inpatient group of MDD showed significantly higher levels of attachment related anxiety and attachment related avoidance than the comparison group. As far as defense mechanisms, there was a significantly higher use of neurotic and immature defenses and a significantly lower use of mature defenses' among the inpatient group. Specifically, there was a significant difference in the use of humor and suppression among mature defenses;

undoing among neurotic defenses; and projection, passive aggression, devaluation, splitting and somatization among immature defenses between the inpatient group and the comparison group.

Finally, in the total sample, there is a negative correlation between mature defenses and both attachment related anxiety and avoidance. On the other hand, data showed a positive correlation between attachment styles and both neurotic and immature defense mechanisms.

In other words, according to the findings of this study, it can be stated that attachment related anxiety and avoidance increases when neurotic and immature defense types are highly used while low use of mature defense types are recorded.

In this section, the literature supporting the results will be discussed with a particular focus on the psychoanalytic relevance of attachment theory as it relates to defense mechanisms and the development of MDD. Lastly, limitations and further suggestions will be presented.

### 4.1. Attachment Styles and Depression

Our data revealed that clinical group had significantly higher scores of attachment related anxiety and avoidance who were diagnosed with MDD. This relationship displays that insecure attachment has a relationship with depression which was our basic prediction.

Security based strategies are components for secure attachment (Mikulincer, Shaver & Pereg, 2003). This is accepted as a characteristic feature of securely attached people who have lower scores in anxiety and avoidance dimensions. Results in our study showed that, non-clinical group have significantly lower attachment related anxiety and avoidance when compared to inpatient group which is congruent with relevant research.

Infants who have secure style are observed as more confident when their mothers available; those with an anxious/ambivalent style have a history of neglect and poor maternal responsiveness (Cassidy & Berlin, 1994); and infants with avoidant style are reacting to extended unresponsiveness to maternal needs (Bowlby, 1988), hostility and rejection (Crittenden & Ainsworth 1989). These internalized patterns form the cognitive representation on which all their following social transactions are based (Bowlby, 1988).

Mikulincer and Shaver (2007) proposed that, people who had both avoidant and anxious attachment styles had difficulty in regulating interactions with others. Both anxious and avoidant individuals were unable to overcome interpersonal conflicts and regulate negative emotions that were activated in relationships.

Disruption of interpersonal functioning in early relationships is thought to have a negative impact for gaining and protecting self-esteem which might be a predisposing factor for depression (Roberts, Gotlib, Kassel, 1996). Literature is considerably rich showing the relationship between attachment styles and

depression that were also included in this study (Abraham & Whitlock, 1969; Bowlby, 1969, 1973, 1980; Cole-Detke & Kobak, 1996; Toth & Cicchetti, 1996; Mikulincer & Shaver, 2007; Morriss et al., 2009; Reels, 2011; Kesebir, Kavzoğlu & Üstündağ 2011).

Individuals who are diagnosed with MDD are more likely than the normal population to present anxious attachment styles (Sümer et al., 2009; Kesebir et al, 2011). Besides, anxious attachment style is found to be more related with MDD than avoidant attachment style (Mikulincer & Shaver, 2007). In our study, results show that inpatient group's anxious attachment style score is higher with a slight difference when compared to avoidant attachment style score. This finding is consistent with the relevant literature.

Avoidant attachment style is also a significant factor that determine to pathology. Mikulincer & Shaver (2007) states that, people having avoidant attachment style are predisposed to MDD more that securely attached people which is also supported in our study. Bowlby (1973) defines avoidance as a blockage in the capacity to make deep relationships. As Sümer et al., (2009) stated that, families' blocking or suppressing feelings of their children might be a factor to develop an avoidant attachment style. Moreover, Kesebir et al., (2011) points that avoidant attachment is associated with behavior disorder and other pathologies.

Based on previous research, insecure attachment is associated with psychopathology in later periods of life whereas secure attachment is associated

with a healthier process (Nakash et al., 2000). This study focuses specifically on an inpatient population, indicating that inpatients diagnosed with MDD, have significantly higher levels of anxious and avoidant attachment styles compared to non-diagnosed participants.

While these results are in line with previous research, it might be helpful to conceptualize them from a psychoanalytic perspective, in an effort to integrate attachment theory into a psychoanalytic framework. This also makes it possible to theoretically examine the links between attachment styles and use defense mechanisms and the ways possible causal relationship among attachment, defense mechanisms and the development of MDD.

As mentioned in a previous section, early psychoanalytic theorists have not coined the term "attachment theory" or operationalized its definitions, however, it can be claimed that psychoanalytic literature contributes to the foundations of attachment theory. Winnicott, D.W., and Fairbairn, W.D. have underlined the importance of early primary relationship in the development of self, relations to others and mental health.

Winnicott emphasized that infant is dependent on mother with an *absolute dependence*. If primary maternal occupation is enough to create a *holding environment*, then inside and outside of the object experience integrate and infant begins to feel a unity of self and other. If holding environment is missing, then baby tries to defend against this experience and develop a *false self* which leads to feelings of abandonment, mistrust and hopelessness in relationships (Mikic &Terradas,

2014). Winnicott's object relations theory and Bowlby's attachment theory provide a similar framework which underline the focus towards psychological and interpersonal phenomena (Heard, 1978). Moreover, definitions for the path going to psychopathology is alike. Winnicott mentions about a development of false self whereas Bowlby names the term as secondary attachment strategy which both leads to failure in relationships as they create a base for various pathologies.

Fairbairn (1941) also focuses on early object relationships. Identification with the object and later differentiation from the object is the healthy basis for a mature development and relationships. An infant who is rejected and neglected by the caregiver internalizes object as rejecting and introjects the parent inside, accepts it as a part of his or her own self. She feels that she is the one who is unlovable and bad.

Additionally, Bion (1962) underlined the significance of maternal environment. *Containing* function of the mother is critical especially for intolerable negative emotions of the infant. The negative affect should be transformed and turned into a tolerable form. Then, infant reintrojects the regulated and contained feeling. Like Winicott and Bion, Kohut (1998) also drew the attention to mirroring function of the mother and importance of maternal environment. This function could be processed as maternal attunement of infant's affective needs.

Attachment theory could be viewed as an operationalized way of examining and understanding the child's response to the particular maternal environment and the ways in which it impacts future relational patterns. Secure attachment involves a

capacity to establish affective bonds and tolerance for separation. In addition, establishing mature levels of interpersonal relatedness, a positive and realistic sense of self is the representation of the integrated two major developmental lines. Thus, integrated representations of self and others allow for a diverse understanding of self, others and the social world (Blatt & Levy, 2003). On the other hand, insecure attachment styles indicate an impaired capacity for affective connection and separation tolerance. In other words, the individual, who was deprived of the containing function of the mother (as termed by Bion) or the positive maternal introject (as termed by Fairbairn), displays high levels of anxiety and/or avoidance in the way he/she manages relationships. As shown by the results of this study as well as previous research, this insecure attachment style can create a significant diathesis for depression, both in the way that it hinders the development of a cohesive sense of self (as termed by Winnicott) and because it leads to maladaptive ways of relating to others, thereby depriving the individual from an effective support system.

### 4.2. Defense Mechanisms and Depression

The findings of this study show that an inpatient sample of individuals diagnosed with MDD present a lower use of mature defenses and a higher level of both neurotic and immature defenses compared to non-diagnosed individuals. These findings are consistent with the theoretical literature as well as previous empirical studies.

High uses of mature defenses reduce the relation between a negative attributional style and depressive symptoms (Kwon & Lemon, 2000) whereas neurotic and immature defense mechanism are accepted to be predisposing factors

for MDD as having a considerable place in literature and in this review (Vaillant, 1977; Abrahamson, Metalsky & Alloy, 1989; Crammer 1991; Kwon, 1999; Kwon & Lemon, 2000; Hovanesian, Isakov & Cervellione, 2009, Kraşovan, 2014). Clinical studies demonstrate that depressed patients use maladaptive defenses and recovery from depression is closely related with improvement of defense mechanisms (Akkerman et al., 1999; Kneepkens & Oakly, 1996; Defife et al., 2005; Bloch et al., 1993). Patients with a recurrent depression have less mature defense styles (Henricus et al., 2009). Similarly, in this study, it is found that, mature defense mechanisms of inpatient group is significantly lower than non-diagnosed people.

A more specific result worth nothing is the significantly lower usage of the two specific mature defenses; suppression and humor, among the inpatient population. Even though it is thought that suppression is ineffective for most people due to an ironic increase in unwanted thought while endeavoring to manage control mechanisms (Wagner, 1989, 1994) and it is observed within over-regulation strategies in avoidant attachment style (Fraley & Shaver, 1997; Mikulincer, 1998), studies also show that the suppression of unwanted thoughts for regulation of negative emotions can be highly functional in adaptiveness of social functioning (Wagner, 1989, 1994; Gross & Levenson, 1993; MacGregor et al., 2003). Thus, individuals who are not able to effectively use this defense can be more prone to developing MDD.

Humor is accepted as another valuable psychological maneuver for dealing with pain. (Massie, H., Szajnberg, N. (2006). In our study, the use of humor was significantly lower than the comparison group, again suggesting that the

absence of this valuable psychological maneuver leaves an individual more vulnerable to depression. Overall, mature defenses indicate an ego strength (Meissner, 1980), and it was inline with our expectations that, our inpatient group showed a lower use of mature defenses than the comparison group.

Another finding in the present study was that, individuals with MDD show a higher use of neurotic and immature defenses compared to non-diagnosed people. Similarly, in the study of validity and reliability of DSQ-40 Turkish form (Yılmaz et al., 2007) which was used in this study, it was stated that the clinical group, composed of MDD and OCD participants, used mature defenses less frequently compared to neurotic and immature defenses. Parallel findings were recorded in various validity and reliability studies of DSQ that was held among different clinical groups like MDD, OCD, BPD and Eating Disorder diagnosed participants. Results demonstrated that, mature defense mechanisms were used poorer in clinical groups than healthy comparison groups (Yılmaz, Gençöz & Ak 2007). Our data shows that neurotic and immature defense mechanisms are significantly higher as expected. Findings of the present study is consistent with the literature.

While the overall use of neurotic defenses was higher among the inpatient MDD groups, undoing in particular, was found to be used significantly higher compared to the non-diagnosed group. Undoing is accepted as a common mechanism in compulsion neurosis. It is defined as an attempt whereby a person tries to change the past in order to hide or avoid a complexity by use of thought or behaviour having the opposite meaning (Laplanche, J. & Pontalis, J. B. 1973). The

significantly high usage of this defense among the inpatient MDD group is remarkable as its well-known link to compulsions and obsessional neurosis (Freud, 1926). Therefore, it would be interesting to understand this common point between depression and obsessive compulsive disorder. It would also be a remarkable point for further research.

Similarly, the overall use of immature defenses was found to be higher among the inpatient MDD group. Among those projection, passive aggression, devaluation, splitting and somatization were specific defenses that revealed significantly high usage.

Projection is an ego defense imposing to others what is unacceptable in unconscious level. In another words, it is an operation which is a strong refusal of wishes and feelings rejected in the person himself but expelled to another person or a thing (La Planche & Pontalis, 1973). Klein proposed that infant splits off unwanted elements and projects them into the mother (Klein, 1955). In later development, process turns out to project good feelings and parts of the self.

Buchholz & Wolf (1991) introduced an addition to Winnicott's concept of the holding environment called the "negative holding environment" based on their qualitative study done among depressed patients. Maternal abuse is common historical background of all participants. Projection, splitting and humor are three major defenses that were determined in assessments. Projection of rage on surroundings or internalization of the same negative affect and viewing oneself

as evil is another common mechanization of immature defense (Blizard & Bluhm, 1994; Hodges & Steele, 2000).

The most noticeable significant defense in this study is somatization which is positively related with depression parallel to literature (Montesinos et al., 2012). Psychological inflexibility is uniquely and positively associated with somatization and depression in Asian American population (Akihiko et al., 2014). In a study of WHO, somatic symptoms are shown as core component of depressive episode but regardless of cultural background (Simon et al., 1999) opposing to the suggestion of non-western cultures' being more somatic. It has been repeatedly indicated in the literature that somatic symptoms are important aspect of depression (Silveira & Ebrahim, 1998; Kijamer, 2001; Montesinos, 2012) as it is found in our study.

In the study of Perry et al., (2004), defense levels are positioned on a continuum of desired social and psychological adaptability from least adaptive to most adaptive. Passive aggression takes its place at the bottom of the hierarchy, which is significant among immature defense mechanisms in our study.

Worthlessness, desperation and the perception of being unlovable overlap with self-perception in depression. Immature defenses mediate many of the most maladaptive ways of handling stress and conflict in depression. Dysfunctional attitudes are strongly linked with devaluation (Craşovan, 2014) among depressive patients that is also another significant immature defense in our data.

Overall, these results propound that, highly neurotic and immature defense usage is significantly linked to psychopathology, namely MDD. Hypothesis three that put forward the significantly higher use of neurotic and immature defenses by inpatient group is supported.

### 4.3. Attachment Styles, Defense Mechanisms and Depression

A final finding of this study is the existence of a negative correlation between mature defenses and both attachment related anxiety and avoidance and a positive correlation between insecure attachment styles and both neurotic and immature defense mechanisms. In other words, it can be stated that attachment related anxiety and avoidance increases when there is a high use of neurotic and immature defense types and a low use of mature defense types.

Healthy development is based upon the quality of relationship between the infant and the caregiver (Bowlby, 1973, 1980). The interactive regulation between infant and caregiver inspires balance and regulation of the inner states of the infant which is the basis for affect regulation (Beebe & Lachmann, 2002; Beebe, Rustin, Sorter & Knoblauch, 2003). Considering the similarities of affect regulation and defense mechanisms which are both processes for the management of person's internal states (Sala et al., 2015), a connection between attachment styles and defense mechanisms might be considered in the later development of depression.

While previous literature does not contain empirical studies that directly investigate this correlation, the findings can still be conceptualized through several theoretical frameworks. Secure attachment includes responsiveness, sensitivity and

warmth which prepares a ground for greather awareness of the mental state of others (Atkinson & Zucker, 1997). Several studies have supported the central role that, early sensitive and responsive maternal preoccupation is significant in development of functional defense mechanisms (Perry, 1990; Garnefsky et al., 2002). It is known that if the attunement between the infant and the caregiver fails, the need of proximity seeking cannot be satisfied therefore child develops secondary attachment strategies which becomes a defensive result due to the inappropriate interaction with the caregiver. People having insecure attachment styles over-regulate or under-regulate their emotions (Mikulincer, Shaver & Preg, 2003). If defense cannot protect the child from anxiety, pathology occurs (Fonagy et al., 2002).

The results of this study can serve as preliminary empirical evidence for this theoretical discussion. Based on our findings, there is a significant positive correlation between insecure attachment styles, both anxious and avoidant and immature defense mechanisms, and a negative correlation between insecure attachment and mature defenses in the present study. Within insecure attachment styles, anxious attachment showed a significant positive correlation with both neurotic and immature defense mechanisms whereas avoidant attachment showed a significant positive correlation only with immature defense mechanisms. All these findings constitute an initial step in forming an empirical link between attachment theory and defense mechanisms, thereby serving as an additional contribution to the literature.

Finally, the hypotheses and the results of this study contain the theoretical question of whether defense mechanisms serve as a mediating factor in the development of depression following insecure attachment. While it is not possible to reach an empirically valid answer to this question through our methodology, all the findings discussed above as well as the relevant theoretical literature, suggest the probable mediating impact of defense mechanisms in the development of depression among individuals with insecure attachment styles. In other words, there is a question of a causal relationship between insecure attachment and the use of neurotic and immature defense mechanisms, which in turn contributes to the forming of depressive tendencies. This important final question derived from our findings can be further investigated in future research.

### 4.4. Clinical Implications

The findings of this study reveal that inpatients who are diagnosed with MDD have anxious and avoidant attachment styles significantly higher than non-diagnosed people and these dynamics are accompanied by neurotic and immature defenses. This, once again empirically confirms the importance of developmental history in understanding MDD. Furthermore, the evaluation of certain types of defense mechanisms might be kept in mind by the clinicians to see the link between related attachment style retrospectively. As is known, the basis for attachment is first developed between caregiver and the infant. If the relationship is healthy, infant would develop a secure attachment (Bowlby, 1973). Understanding the dynamics of the attachment type by the clinician might be helpful for a corrective experience for the patient. Moreover, if it is considered that insecure attachment is linked with depression and transgenarational transference has a role in this process, the

importance of studies towards women about psychological support becomes clear one more time.

### 4.5. Limitations

There are some limitations in the study. The aim was to understand the relationship between attachment styles and defense mechanisms over a depressed sample with a dynamic point of view but since focus was on acute depression instead of character typologies, literature search was compelling due to need to get information from descriptive studies and harmonizing two perspectives.

Another limitation was the number of sample size. On the other hand, in order to reach to an acceptable and a clean data, patients were carefully selected in 8 months. Psychosis was excluded, medication and electroconvulsive therapy effects leading short term confusion were considered before delivering the questionnaire set.

Self-report scales were used to measure attachment styles and defense mechanisms. There were 76 questions in total. Although eventual confusion or lack of concentration due to medication was considered, internal consistency could be still a questionable point.

Patients who have acute depression showed significantly higher anxious and avoidant attachment styles compared to non-diagnosed group. Although the relationship among anxious, avoidant attachments, defense mechanisms and

depression was discussed, findings are results of correlation analysis which do not constitute a direct evidence for causal relationship (Sümer et al., 2009).

Kwon and Lemon (2000) defines in their study that, defense mechanisms are unconscious intrapsychic processes which are activated by stressful events. On the other hand, DSQ-40 assesses conscious manifestations. Although, the questionnaire has been associated with defense functioning and psychological problems (Andrews et al., 1989; Bond et al., 1983), there might be still uncontrollable points depending on the subjectivity of inpatients.

### 4.6. Areas for Further Research

Study could be repeated by composing groups with equal number of participants with various pathologies. The relationship between insecure attachment and defense mechanisms might be examined in a more specific way.

Similar study could be held with a regression analysis by measuring depression with a questionnaire.

To support the external validity, Adult Attachment Interview and clinical measures of defensive activity (e.g., Cramer, 1991) or Rorschach might be suggested to be included for future studies.

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## APPENDIX A

## INFORMED CONSENT FOR INPATIENTS

Bahçeşehir Üniversitesi Sosyal Bilimler Enstitüsü, Klinik Psikoloji Yüksek Lisans Bölümü öğrencisi Ebru Erol Soy tarafından yapılmakta olan bu çalışma, Surp Pırgiç Ermeni Hastanesi Psikiyatri Servisi'nde yatan hastalarda bağlanma stillerinin rolü ve savunma mekanizmalarının aracılık faktörlerini incelemeyi amaçlamaktadır. Katılım gönüllülük esasına dayanmaktadır. Çalışmaya katılan kişilerin cevapları ve bilgileri gizli tutulacaktır.

Katılmak İstiyorum.

İmza :

Tarih :

Yaşınız :

Cinsiyetiniz :

Öğrenim Durumu : Eğitimsiz__ İlk Öğretim__ Orta Öğreti__ Lise____ Üniversite__

Mesleğiniz : Yok__ Öğrenci__ Memur__ İşçi__ Ev kadını__ Serbest__ Diğer__

Medeni Durumunuz : Bekar__ Evli__ Boşanmış__ Dul__

## APPENDIX B

## INFORMED CONSENT FOR COMPARISON GROUP

Değerli Katılımcı,

Bu çalışma, Bahçeşehir Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi olan Ebru Erol Soy tarafından, Dr. Mia Medina danışmanlığında, yüksek lisans tezi kapsamında yürütülmektedir. Çalışmanın amacı, psikiyatri servisinde yatan duygudurum bozukluğu tanısı almış hastaların savunma mekanizmalarının, bağlanma stilleri üzerinde aracı faktörü olup olmadığının araştırılmasıdır.

Çalışma iki farklı grubun karşılaştırılması sonucunda elde edilecektir. İlk grubu, Surp Pırgiç Ermeni Hastanesi Psikiyatri servisinde yatan hastalar, ikinci grubu ise, psikiyatri servisinde yatarak tedavi görmemiş, sağlıklı grup oluşturmaktadır. Ekte yer alan iki envanterde 76 soruya ek olarak 7 tane demografik veri toplama amaçlı soru bulunmaktadır ve cevaplaması yaklaşık 20 dakika sürmektedir.

Bu çalışmada, kişisel bilgilerinizin gizlilik esaslarına uygun şekilde saklanabilmesi adına kimlik bilginizi girmeniz gereken bir alan bulunmamaktadır. Verecek olduğunuz tüm bilgiler tamamen gizli kalacaktır. Çalışma, gönüllülük esasına dayalıdır.

Değerli zamanınız için şimdiden teşekkür ederim.

Saygılarımla,
Ebru Erol Soy

Katılmak İstiyorum.

İmza :

Tarih :

Yaşınız :

Cinsiyetiniz :

Öğrenim Durumu : Eğitimsiz__ İlk Öğretim__ Orta Öğreti__ Lise__ Üniversite__

Mesleğiniz : Yok__ Öğrenci__ Memur__ İşçi__ Ev kadını__ Serbest__ Diğer__

Medeni Durumunuz : Bekar__ Evli__ Boşanmış__ Dul__

Daha önce hiç yatarak psikiyatrik tedavi gördünüz mü? Evet_____ Hayır_____

Son iki yıl içinde ilaçla psikiyatrik tedavi gördünüz mü? Evet_____ Hayır_____

## APPENDIX C

## YAKIN İLİŞKİLERDE YAŞANTILAR ENVANTERİ (YİYE-II)

Aşağıdaki maddeler romantik ilişkilerinizde hissettiğiniz duygularla ilgilidir. Bu araştırmada sizin ilişkinizde yalnızca şu anda değil, genel olarak neler olduğuyla ya da neler yaşadığınızla ilgilenmekteyiz. Maddelerde sözü geçen "birlikte olduğum kişi" ifadesi ile romantik ilişkide bulunduğunuz kişi kastedilmektedir. Eğer halihazırda bir romantik ilişki içerisinde değilseniz, aşağıdaki maddeleri bir ilişki içinde olduğunuzu varsayarak cevaplandırınız. Her bir maddenin ilişkilerinizdeki duygu ve düşüncelerinizi ne oranda yansıttığını karşılarındaki 7 aralıklı ölçek üzerinde, ilgili rakam üzerine çarpı (X) koyarak gösteriniz.

1----------2----------3----------4----------5----------6----------7

Hiç katılmıyorum — Kararsızım/ fikrim yok — Tamamen katılıyorum

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. Birlikte olduğum kişinin sevgisini kaybetmekten korkarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. Gerçekte ne hissettiğimi birlikte olduğum kişiye göstermemeyi tercih ederim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. Sıklıkla, birlikte olduğum kişinin artık benimle olmak istemeyeceği korkusuna kapılırım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. Özel duygu ve düşüncelerimi birlikte olduğum kişiyle paylaşmak konusunda kendimi rahat hissederim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. Sıklıkla, birlikte olduğum kişinin beni gerçekten sevmediği kaygısına kapılırım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. Romantik ilişkide olduğum kişilere güvenip inanmak konusunda kendimi rahat bırakmakta zorlanırım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 7. Romantik ilişkide olduğum kişilerin beni, benim onları önemsediğim kadar önemsemeyeceklerinden endişe duyarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. Romantik ilişkide olduğum kişilere yakın olma konusunda çok rahatımdır. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. Sıklıkla, birlikte olduğum kişinin bana duyduğu hislerin benim ona duyduğum hisler kadar güçlü olmasını isterim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. Romantik ilişkide olduğum kişilere açılma konusunda kendimi rahat hissetmem. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. İlişkilerimi kafama çok takarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. Romantik ilişkide olduğum kişilere fazla yakın olmamayı tercih ederim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 13. Benden uzakta olduğunda, birlikte olduğum kişinin başka birine ilgi duyabileceği korkusuna kapılırım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14. Romantik ilişkide olduğum kişi benimle çok yakın olmak istediğinde rahatsızlık duyarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 15. Romantik ilişkide olduğum kişilere duygularımı gösterdiğimde, onların benim için aynı şeyleri hissetmeyeceğinden korkarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 16. Birlikte olduğum kişiyle kolayca yakınlaşabilirim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 17. Birlikte olduğum kişinin beni terk edeceğinden pek endişe duymam. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18. Birlikte olduğum kişiyle yakınlaşmak bana zor gelmez. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 19. Romantik ilişkide olduğum kişi kendimden şüphe etmeme neden olur. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 20. Genellikle, birlikte olduğum kişiyle sorunlarımı ve kaygılarımı tartışırım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 21. Terk edilmekten pek korkmam. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 22. Zor zamanlarımda, romantik ilişkide olduğum kişiden yardım istemek bana iyi gelir. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 23.Birlikte olduğum kişinin, bana benim istediğim kadar yakınlaşmak istemediğini düşünürüm. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 24.Birlikte olduğum kişiye hemen hemen her şeyi anlatırım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 25.Romantik ilişkide olduğum kişiler bazen bana olan duygularını sebepsiz yere değiştirirler. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 26.Başımdan geçenleri birlikte olduğum kişiyle konuşurum. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 27.Çok yakın olma arzum bazen insanları korkutup uzaklaştırır. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 28.Birlikte olduğum kişiler benimle çok yakınlaştığında gergin hissederim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 29.Romantik ilişkide olduğum bir kişi beni yakından tanıdıkça, “gerçek ben”den hoşlanmayacağından korkarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 30.Romantik ilişkide olduğum kişilere güvenip inanma konusunda rahatımdır. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 31.Birlikte olduğum kişiden ihtiyaç duyduğum şefkat ve desteği görememek beni öfkelendirir. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 32.Romantik ilişkide olduğum kişiye güvenip inanmak benim için kolaydır. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 33.Başka insanlara denk olamamaktan endişe duyarım | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 34.Birlikte olduğum kişiye şefkat göstermek benim için kolaydır. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 35.Birlikte olduğum kişi beni sadece kızgın olduğumda önemser. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 36.Birlikte olduğum kişi beni ve ihtiyaçlarımı gerçekten anlar. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

## APPENDIX D

## SAVUNMA BİÇİMLERİ TESTİ (SBT-40)

Lütfen her ifadeyi dikkatle okuyup, bunların size uygunluğunu yan tarafında 1 den 9 a kadar derecelendirilmiş skala üzerinde seçtiğiniz dereceyi çarpı şeklinde (X) işaretlemek suretiyle gösteriniz.

1----------2----------3----------4----------5----------6----------7----------8----------9

Bana hiç uygun değil Fikrim yok Bana çok uygun

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. Başkalarına yardım etmek hoşuma gider, yardım etmem engellenirse üzülürüm. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 2. Bir sorunum olduğunda onunla uğraşacak vaktim olana kadar o sorunu düşünmemeyi becerebilirim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 3. Endişemin üstesinden gelmek için yapıcı ve yaratıcı şeylerle uğraşırım.(resim, el işi, ağaç oyma vs…) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 4. Arada bir bu gün yapmam gereken işleri yarına bırakırım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 5. Kendime çok kolay gülerim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 6. İnsanlar bana kötü davranmaya eğilimliler. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 7. Birisi beni soyup paramı çalsa onun cezalandırılmasını değil ona yardım edilmesini isterim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 8. Hoş olmayan gerçekleri, hiç yokmuşlar gibi görmezlikten gelirim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 9. Sanki Süpermenmişim gibi tehlikelere aldırmam. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10. İnsanlara, sandıkları kadar önemli olmadıklarını gösterebilme yeteneğimle gurur duyarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 11. Bir şey canımı sıktığında, çoğu kez düşüncesizce ve tepkisel davranırım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 12. Hayatım yolunda gitmediğinde bedensel rahatsızlıklara yakalanırım.. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 13. Çok tutuk bir insanım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 14. Hayallerimden gerçek hayatta olduğundan daha çok tatmin sağlarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 15. Sorunsuz bir yaşam sürdürmemi sağlayacak özel yeteneklerim var. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 16. Seçimlerde bazen haklarında çok az şey bildiğim kişilere oy veririm. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 17. Birçok şeyi gerçek yaşamımdan çok hayalimde çözerim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 18. Hiçbir şeyden korkmam. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 19. Bazen bir melek olduğumu, bazen de bir şeytan olduğumu düşünürüm. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 20. Kırıldığımda açıkça saldırgan olurum. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 21. Her zaman, tanıdığım birinin koruyucu melek gibi olduğunu hissederim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 22. Bana göre, insanlar ya iyi ya da kötüdürler. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 23. Patronum beni kızdırırsa, ondan hıncımı çıkarmak için ya işimde hata yaparım ya işimi yavaşlatırım . | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 24. Her şeyi yapabilecek güçte, aynı zamanda son derece adil ve dürüst olan bir tanıdığım var. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 25. Serbest bıraktığımda, yaptığım işi etkileyebilecek olan duygularımı kontrol edebilirim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 26. Genellikle, aslında acı verici olan bir durumun gülünç yanını görebilirim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 27. Hoşlanmadığım bir işi yaptığımda başım ağrır. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 28. Sık sık, kendimi kesinlikle kızmam gereken insanlara iyi davranırken bulurum. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 29. Hayatta, haksızlığa uğruyor olduğuma eminim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 30. Sınav ya da iş görüşmesi gibi zor bir durumla karşılaşacağımı bildiğimde, bunun nasıl olabileceğini hayal eder ve başa çıkmak için planlar yaparım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 31. Doktorlar benim derdimin ne olduğunu hiçbir zaman gerçekten anlamıyorlar. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 32. Haklarım için mücadele ettikten sonra, girişken fazla davrandığım için özür dilemeye meyilliyimdir. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 33. Üzüntülü veya endişeli olduğumda yemek yemek beni rahatlatır. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 34. Sık sık duygularımı göstermediğim söylenir. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 35. Eğer üzüleceğimi önceden tahmin edebilirsem, onunla daha iyi baş edebilirim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 36. Ne kadar yakınırsam yakınayım, hiçbir zaman tatmin edici bir yanıt alamıyorum. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 37. Yoğun duyguların yaşanması gereken durumlarda, genellikle hiçbir şey hissetmediğimi fark ediyorum. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 38. Kendimi elimdeki işe vermek, beni üzüntülü veya endişeli olmaktan korur. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 39. Bir bunalım içinde olsaydım, aynı türden sorunu olan birini arardım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 40. Eğer saldırganca bir düşüncem olursa, bunu telafi etmek için bir şey yapma ihtiyacı duyarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |