

EXPLORING RELATIONSHIPS BETWEEN RECALLED PARENTING AND  
ANACLITIC AND INTROJECTIVE DEPRESSION

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This study related college students' remembered early relationships with parents to their depression symptoms and to dependent and self-critical subjective feelings. Undergraduates ( $N = 217$ , 118 female, 99 male) provided information regarding their current level of depression, overall functioning, subjective feelings of depression (Depressive Experiences Questionnaire), negative thoughts, interpersonal functioning, and recollections of their parents' behavior and attitudes. Depression symptoms were related to dependent and self-critical feelings and to recalled low parental care and high parental control. However, for women, paternal affection and, for men, paternal control, were unrelated to depression symptoms. Other results are inconclusive but, overall, provide evidence for the usefulness of Blatt's theory in assessing depression via dependent and self-critical subjective feelings.

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CHAPTER 1  
EXPLORING RELATIONSHIPS BETWEEN RECALLED PARENTING AND  
ANACLITIC AND INTROJECTIVE DEPRESSION

Introduction

Numerous studies have attempted to differentiate among the heterogeneous manifestations of depression. This literature has also focused on the antecedents and correlates of these different manifestations of depression (Blatt & Zuroff, 1992). Finally, assessment and treatment implications have been explored with the underlying assumption that individuals with a specific type of depression will respond better to treatment designed to address the nature of the difficulty underlying that particular manifestation of depression (Sotsky, Glass, Shea, Pilkonis, Collins, Elkin, Watkins, Imber, Leber, Moyer, & Oliveri, 1991; Blatt, 1992; Blatt & Felsen, 1993). Researchers interested in these topics have emphasized the need for further research to clarify findings linking types of depression to distal and proximal antecedents of depression and their clinical implications (Blatt & Zuroff, 1992).

The purpose of this thesis is to examine the associations between depressive symptoms, which are characterized by dependent and self-critical subjective feelings, and recollections of early interactions with parent figures. It is also an aim of this study to explore how males and females are differentially affected by parenting styles, which are described through ratings on dimensions of care and control. Also, this study will investigate how males and females are susceptible to developing depressive symptoms

characterized more strongly by either dependent or self-critical subjective feelings. Another goal is to explore the relationship between these two types of subjective feelings of depression and cognitive and interpersonal functioning. Finally, the findings are examined for consistency with the research literature and with theory. The ultimate goal of this study is to provide the foundation for the development of a more extensive project in which we hope to examine the different therapeutic contexts and processes that benefit specific types of depressed individuals.

In order to further introduce the topic of depression it is first necessary to provide a brief overview of the current literature on depression, including relevant measures, and to provide a rationale for choosing to focus on this particular mental disorder. Then, the literature on anaclitic and introjective depression is used to describe two types of depression characterized by dependent and self-critical subjective feelings. This section, in turn, is followed by a review of the parenting literature in order to link depression in adults with their recollections of being parented. We hope to link recollections of parenting behaviors with the subsequent development of anaclitic or introjective depression in adults. A brief summary of the expected gender interactions that exist among the different constructs being studied in this thesis is also presented.

This literature review concludes with a section discussing the current movement in psychotherapy research toward evaluating treatments and exploring patient characteristics that are predictive of success with those treatments. This section will guide the exploratory work done in this thesis.

## Depression: Overview and Rationale

Depression is a widespread disorder that causes emotional pain and significant disruption or impairment in functioning. The DSM and ICD classification systems describe depression as follows:

Broadly speaking, a depressive syndrome characterized by a cluster of signs and symptoms, including depressed mood; loss of interest; disturbances in sleep, appetite, and psychomotor activity; lack of energy; thoughts of worthlessness or guilt; and difficulties in concentrating. Depressive affect may occur independently of any other identified disorder, or it can occur in association with other forms of psychopathology...Depressive affect can occur acutely and remit; can occur in the absence of other alterations in affect...; or can occur in association with these other alterations. (Kaelber et al., p.5)

Blazer, Kessler, McGonagle, and Swartz (1994) estimated that the prevalence of current Major Depressive Disorder (MDD) in the population is 4.9% and the prevalence of lifetime depression is 17.1%. They reported that depression is quite prevalent in young adults and in persons with less than a college education. In addition, depression is not only prevalent in the general population, but it is a common presenting problem in the practices of medical physicians and mental health specialists (Burnam & Wells, 1990). The American Psychiatric Association (1994) reported that fifteen percent of individuals with MDD die by suicide, making it vital for psychologists to continue engaging in vigorous research with regard to the etiology, contributing factors, and treatments for this



disorder. This disorder affects not only the depressed individuals themselves, but also their families, and society-at-large by increasing mental health costs.

Past and current research findings indicate that depression is more prevalent in females; but Weissman and Klerman (1992), in reviewing recent advances in the understanding of depression, observed that there has been a narrowing of the gender difference due to the recently increased risk of depression in young men. Culbertson (1997) supported this finding and reported that currently, the rates of depression in men between twenty and thirty years of age are higher than for women. Weissman and Klerman also reported that depression does occur prepubertally, often begins in adolescence, and is two to three times more prevalent in the first degree relatives of depressed patients, as compared with controls. In addition, adolescents tend to have other disorders comorbid with depression such as eating disorders in females and conduct disorders and substance abuse in males (Petersen, Compas, Brooks-Gunn, Stemmler, Ey, & Grant, 1993). Petersen et al. also found that there is a greater risk for depression and suicide among Native Americans and in gay and lesbian youth. Altogether, these findings indicate that depression is a painful and debilitating disease that affects many people regardless of race and ethnicity, gender, and age.

There are well-established research studies about the treatment of depression (Jones & Pulos, 1993; Elkin, Parloff, Hadley, & Autry, 1985; Sotsky, Glass, Shea, Pilkonis, Collins, Elkin, Watkins, Imber, Leber, Moyer, & Oliveri, 1991; Shea, Pilkonis, Beckham, Collins, Elkin, Sotsky, & Docherty, 1990) With the exception of the Jones and Pulos study, the remaining three research studies mentioned above were based on the

National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program which was the first large-scale, multisite coordinated study in the area of psychotherapy research.

There are three predominant psychosocial approaches to the current psychological treatment of depression. These approaches are based on psychodynamic, cognitive, and interpersonal theories and techniques. Each approach emphasizes one or both of the following dimensions in therapy: the therapeutic relationship and/or the possibility of insight and understanding. There are patients who, given their background and personality, are more receptive and responsive to the therapeutic relationship, and there are patients who benefit more, and are more responsive to obtaining insight and understanding of their psychological difficulties.

The abundance of research on the etiology and treatment of depression highlight public and professional concern with these debilitating set of symptoms often called the “common cold” of mental disorders. This study adds to the literature on depression by focusing on factors that enable mental health professionals not only to assess and diagnose depression more accurately but to also develop individualized treatments to more effectively treat depressed clients.

### Assessment of Depression

Depression is a construct developed by psychiatric clinicians, epidemiologists, and investigators using a nomothetic approach. This approach to case description involves a process in which “...various persons’ clinical illnesses are examined for features that can be construed into putative lawful classifications and relationships

summarizing the type of illness across patients” (Kaelber, Moul, & Farmer, 1995, p.4). The current formal diagnostic systems, the 10th revision of the International Classification of Diseases (ICD-10) and the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), used the nomothetic approach to develop consensual diagnostic criteria for various forms of depression. However, despite these classification systems, depressive affect and functioning is assumed to exist on a continuum where a depressive disorder is distinguished from “normal” mood fluctuations by the severity, duration, and impact of symptoms on functioning (Kaelber et al.).

There are many generally accepted and reliable measures for diagnosing depression (Culbertson, 1997). Regardless of theoretical orientation or therapy technique, most mental health professionals, particularly researchers, rely on the use of similar assessment tools and measures of depression such as the Beck Depression Inventory, Hamilton Rating Scale for Depression, Social Adjustment Scale, and many others (Jones & Pulos, 1993; Elkin, Parloff, Hadley, & Autry, 1985; Sotsky et al., 1991). An assessment battery that uses several methods of measuring depression, such as self-report, projective, and structured interviews, is recommended to make the most accurate diagnosis possible (Katz, Shaw, Vallis, & Kaiser, 1995).

In choosing the best depression measure for this thesis, several criteria needed to be met. For example, the measure must be a self-report measure as it is not feasible to train people to administer interviews, or other measures, to each subject. In addition, the measure must have adequate psychometric properties, particularly high concurrent validity and adequate reliability, and must be relatively short (i.e. no more than 30 items).

The Beck Depression Inventory (BDI) meets all of the criteria cited above and is the most commonly used measure for this kind of study. It is a 21-item self-report scale that the participant can complete without assistance. In addition, the BDI has adequate psychometric properties. Katz et al. (1995) reviewed the validity and reliability of the BDI as part of a comprehensive description and critique of depression measures. They reported that the BDI has good concurrent validity as it has been found to correlate highly with other measures of depression including the Hamilton Rating Scale for Depression, the Zung Self-rating Depression Scale, and clinicians' ratings. In addition, the BDI has been found to be applicable across a variety of cultures and groups of people. It is particularly useful when gathering data from a nonclinical population because the BDI measures depression on a continuum and does not require the participants to meet a formal diagnosis based on a classification system of depression. Finally, the BDI has demonstrated moderate test-retest reliability, which is to be expected given the fact that depressive symptomatology tends to fluctuate during a depressive episode (Katz et al.).

#### Anaclitic and Introjective Depression

Research studies on the treatment of depression have reported findings that depression is not a homogeneous disorder and that patients with different subtypes of depression respond differently to treatment (Feinberg, 1992). A number of suggested subtypes of depressive disorders has been reported in the literature. "Among these have been the 'neurotic-psychotic,' the 'reactive-endogenous,' the 'primary-secondary,' and the 'unipolar-bipolar' distinctions" (Beckham, Leber, & Youll, 1995, p. 41). These distinctions have helped clinicians understand the uniqueness of the manifestation of

depression in each individual, and have assisted in selecting the most appropriate treatment for the particular manifestation of depression. In addition, the emergence of these distinctions has underscored the importance of making an accurate and in-depth assessment of depression (Beckham et al.).

Blatt (1974 unpublished manuscript, as cited in Zuroff, Moskowitz, Wielgus, Powers, & Franko, 1983) proposed two types of depression: an “anaclitic,” or dependent type of depression which is characterized by feelings of helplessness and weakness, by fears of being abandoned, and by wishes to be protected, loved, and cared for; and an “introjective,” or self-critical, guilty type of depression which is developmentally more advanced and is characterized by feelings of inferiority, guilt, worthlessness, and a sense of failure at living up to other’s expectations and standards. Blatt used these terms to refer primarily to normal feelings of depression experienced at subclinical levels in nonpatient populations. In other words, a normal person may experience feelings of depression without meeting the DSM criteria for major depression. Likewise, people with “depressive personalities” may also be differentiated by these two types of depression. However, Blatt indicated that these two types of depression, or depressive feelings, are not mutually exclusive and can be experienced simultaneously by an individual (Zuroff et al.).

As mentioned above, one of the ultimate goals in investigating subtypes of a disorder is to determine what kinds of treatment are most effective for individuals with specific symptoms. Blatt (1992) suggested that what is important in predicting effective treatment is not the disorder itself but the focus of the pathology within the disorder.

Using data from the Menninger Psychotherapy Research Project, Blatt's goal was to evaluate the differential effects of psychoanalysis and psychoanalytic psychotherapy with individuals having a variety of disorders (e.g. neurotic character disorders, borderline personality disorders, latent psychoses) classified as either "anaclitic" or "introjective" (Blatt, 1992).

Blatt (1992) found that anaclitic patients have a more "constructive therapeutic response" to psychoanalytic psychotherapy. Blatt attributed this finding to the fact that patients that are dependent and interpersonally-oriented are more likely to benefit from a therapy that allows "face-to-face contact and personal interaction with the therapist" (Blatt, p. 715). Conversely, Blatt found that with introjective patients, psychoanalysis was more effective and beneficial. Blatt explained that "more ideational patients who stress their separation, autonomy, and independence should find the context of psychoanalysis more conducive to therapeutic progress" (Blatt, p. 715).

#### Assessment of Anaclitic and Introjective Depression

Blatt (1974 unpublished manuscript, as cited in Shaver & Brennan, 1991) defined an individual's tendency to develop anaclitic or introjective depression as "...a stable personality trait rooted in early development" (Shaver & Brennan, p. 219). Thus, Blatt, D'Afflitti, and Quinlan (1976, as cited in Shaver & Brennan) developed a measure, the Depressive Experiences Questionnaire (DEQ), to measure experiences associated with depression. In other words, the DEQ assesses subjective experiences that are not direct symptoms of depression but are frequently characteristic experiences of depressed patients (Shaver & Brennan).

Blatt (1974, as cited in Shaver & Brennan, 1991) conducted a factor analysis in order to create a scoring procedure for the hypothesized anaclitic and introjective dimensions of depression. Three factors emerged, two of which corresponded with his predictions of the two types of depressive experiences. He named these factors Dependency, or DEQ-A, for “anaclitic,” and Self-Criticism, or DEQ-I, for “introjective.” The third unpredicted factor, was named DEQ-E for “efficacy” as the items that loaded into this factor were related to “...a positive picture of secure goal striving, pride, etc., perhaps indicating invulnerability to depression” (Shaver & Brennan, p. 219).

Zuroff et al. (1983) reported a series of validation studies of the DEQ’s ability to measure normal individual vulnerabilities to each of the two types of depressive experiences (as opposed to studying a clinical population). Zuroff et al. described the DEQ as a measure that includes 66 Likert-type items that assess a broad range of feelings about the self and interpersonal relations. They found that the DEQ demonstrates high levels of temporal stability and that the phenomenological correlates of Dependency and Self-Criticism are consistent with Blatt’s descriptions of anaclitic and introjective depression.

The phenomenological correlates reported by Zuroff et al. were demonstrated by associations between high Dependency scores and conflict concerning the expression of hostility and, in males, feelings of helplessness. High Self-Criticism scores were found to be associated with low self-esteem and high levels of morality-conscience guilt. In addition, the researchers found support for Blatt’s claim to have identified stable personality traits in the DEQ’s high level of temporal stability.

Despite the evidence supporting Blatt's (1974) theory on anaclitic and introjective depression, Zuroff et al. (1983) found other results that were inconsistent with Blatt's theory. They found no support for the hypothesis that anaclitic depression represents a developmentally primitive response. Zuroff et al. nevertheless concluded that the data appears to be sufficiently consistent with the predictions to suggest that the distinction between anaclitic and introjective depression is "tenable and potentially important" (Zuroff et al., p. 239).

The DEQ is used for distinguishing among participants in the present study with self-critical and dependent subjective feelings of depression. This measure was chosen as the most appropriate for our purposes because its factors correspond directly to Blatt's theoretical constructs. Despite its relatively long length it is feasible and beneficial to use the DEQ in this study because it is a self-report scale with adequate psychometric properties.

#### Review of Parenting Literature

There is evidence in the literature that depression in adults can be linked to recollections of parenting. Burbach and Borduin (1986) reviewed the literature linking parent-child relations and the etiology of depression. Their goal was to summarize the major findings and to critique their methodologies in order to make recommendations for conducting future research. They found that, with regard to the link between parent-child relations and adult depression, many studies report a link between low maternal and paternal care, high maternal, but not paternal, overprotection, and the development of depression in adults. However, other studies report that some depressed patients



remember their mother as being overly permissive, not overprotective. Most of the research, in fact, has focused on relating depression to maternal characteristics, such as the ones mentioned above, as well as, low involvement, overintrusiveness, and high guilt induction (reviewed in Burbach and Borduin).

In their review of the literature, Burbach and Borduin (1986) also noted that past research has attempted to link paternal characteristics with the development of subsequent depression. The general theme within this realm of research is that depressed adults tend to recollect negative experiences in their childhood associated with their parents' level of involvement and types of child-rearing strategies (Burbach and Borduin).

Burbach and Borduin (1986) found one main problem with the studies linking depression in adults with recollections of parenting. They observed that most of these studies failed to report the reliability of the measures they used to assess the participants' depression and parent-child relations (Burbach and Borduin).

There is a component of the literature on perceptions of parenting that attempts to link anaclitic and introjective depression with parental representations (Blatt, Wein, Chevron, & Quinlan, 1979), family structure, parental conflict, decision-making power, and inconsistency of love (Schwarz & Zuroff, 1979), and other recollections of parenting (Whiffen & Sasseville, 1991). In addition, one study also links anaclitic and introjective depression with perceptions of socialization experiences which include relationships with parents and with peers (Rosenfarb, Becker, Khan, & Mintz, 1994). The latter two studies and the McCranie and Bass (1984) study, all of which will be described in more detail in

the following paragraphs, seem to support the idea that anaclitic and introjective depressive dimensions can be linked to parenting styles described along the dimensions of affection and control. In addition, males and females seem to be differentially affected by parenting styles and subsequently may be more likely to develop subjective feelings of depression along either an anaclitic or introjective dimension. Finally, independent of the anaclitic and introjective dimensions, differential vulnerability to depression in males and females has been linked with parenting styles, also along the dimensions of affection and control (Parker, 1983).

McCranie and Bass (1984) presented an “...etiologic model of how relationships with parents in childhood influence differential vulnerability to distinctive depressive experiences associated with issues of dependency or self-criticism” (p. 3). They found that individuals high on dependency recall their mothers as being the more dominant parent and as emphasizing strict control. These individuals also recall their mothers as expressing inconsistent affection and expecting conformity to authority rather than achievement. In contrast, McCranie and Bass found that individuals high on self-criticism recalled their father as the more dominant parent and both parents as emphasizing strict control, expressing inconsistent affection, and expecting conformity rather than achievement.

Whiffen and Sasseville (1991) conducted a study aimed at assessing “...the association between parenting practices and dependency and self-criticism, controlling for current depression levels, and to explore the possibility that parenting practices are differentially related to personality for females and males” (p. 121). The authors found

that depressive symptoms were correlated with dependency and self-criticism and with parenting scales. More significant was the finding that dependency was predicted by sex only. Females tended to demonstrate more dependency than males and none of the parenting variables helped in predicting dependency. In addition, the authors found three parenting variables that predicted self-criticism: maternal emphasis on achievement, paternal control, and, for males, paternal demands for conformity.

Rosenfarb et al. (1994) investigated the relationship between dependency and self-criticism in women, and perceptions of socialization experiences. They found that dependency appears to be related to recollections of having a distant relationship with their father during development. Dependency also appears to be marginally related to perceptions of increased parental attention and overindulgence. According to the authors' findings, self-criticism seems to be related to "...perceptions of difficulties in the quality of affective bonds with fathers and peers during childhood and ...related marginally to perceptions of increased paternal power and control during development" (Rosenfarb et al., p. 669). They also found that women who were both dependent and self-critical were likely to be severely depressed. (Note: although the Rosenfarb et al. study was conducted with women, theoretically, men who are both dependent and self-critical should also be more severely depressed.)

Parker (1983) conducted a study to explore parental "affectionless control" as an antecedent to adult depression. This study was prompted by an earlier study conducted by Parker (1979) in which he found that neurotic depressives, as opposed to manic depressives, reported less parental care and greater maternal overprotection. The term

“affectionless control” was used to describe parents who were rated by their children as being both low in care or affection, and high in control or protection (Parker, 1983).

In order to study the link between depression and these parental characteristics, Parker (1983) used the Parental Bonding Instrument (PBI). The PBI requires subjects to score their parents on 25 items as remembered in their first 16 years, and two scaled scores, care and protection are obtained for each parent. Parker used the PBI not only to assess the relationship between parenting styles and depression, but also to examine sex of parent-sex of child interactions in the development of depression. He found that depressive adults are more likely to perceive their parents as lacking in care and/or as having been overprotective, than nondepressive adults. He also showed that low paternal care scores were the best discriminators of those in the depressive group versus the control group. Parker also found that female depressives were most likely to report maternal “affectionless control” and men were most likely to report paternal “affectionless control” (Parker, 1983).

### Summary of Gender Interactions

This section will provide the reader with a brief summary of the gender interactions that as predicted by the research literature, may exist among the different constructs being studied in this thesis. In addition, links to psychoanalytic theory will be made to explain why males and females may be differentially affected by parenting styles and subsequently tend to develop anaclitic or introjective depression.

Depressed individuals, regardless of characteristic symptoms, are likely to recall both parents as providing little affection and emphasizing strict control. However,

perceptions of low paternal affection seem to be the best discriminators between depressed and nondepressed individuals. Also, depressed females are more likely to recall their mothers as being low in affection and high in control and men are most likely to recall their fathers as being low in affection and high in control (Parker, 1983).

According to the literature, individuals with depression characterized by anaclitic symptoms tend to recall their mothers as emphasizing strict control and expressing inconsistent affection (McCranie & Bass, 1984). According to Blatt's definition, anaclitic depression is associated with not having early developmental needs met (Rosenfarb et al., 1994). Psychoanalytic theory suggests that in a child's early, pre-oedipal development the central parental figure is the mother. Thus, the finding that individuals with anaclitic depression recall difficulties in the relationship with their mothers makes theoretical sense. Finally, females have been found to show more anaclitic symptoms than males regardless of parenting variables (Whiffen & Sasseville, 1991) and they also tend to recall their fathers as distant (Rosenfarb et al., 1994). This would also make theoretical sense as it appears that anaclitic females, in addition to recalling difficulties with their mother, also perceived their fathers as distant.

In contrast, individuals with depression characterized by introjective symptoms tend to recall both parents, regardless of gender, as emphasizing strict control and expressing inconsistent affection (McCranie & Bass, 1984). Blatt (1974 unpublished manuscript, as cited in Zuroff, Moskowitz, Wielgus, Powers, & Franko, 1983) defines introjective depression as being developmentally more advanced than anaclitic depression. This suggests that introjective depression may be developmentally related to

an Oedipal or post-Oedipal period where relationships with father figures become more important and the task is identification with the same-gender parent. Thus, the finding that individuals with introjective depression recall difficulties in the relationships with both parents makes theoretical sense.

Consistent with theory regarding the influence of paternal figures, females with introjective depression tend to recall their fathers as providing inconsistent affection and emphasizing strict control (Rosenfarb et al., 1994) and males with introjective depression tend to recall their fathers as emphasizing strict control (Whiffen & Sasseville, 1991). Finally, women who have depression characterized by both anaclitic and introjective symptoms are more likely to be severely depressed (Rosenfarb et al.).

Thus, there is consensus in the research literature about the existence of a relationship between the likelihood of developing depression and perceptions of parenting that is moderated by gender. Paternal control appears to be a strong factor in predicting the development of introjective depression in males and females, which is consistent with theoretical expectations. On the other hand, low parental affection and maternal factors in particular seem to predict the development of anaclitic depression in males and females. However, there is not enough information to achieve consensus about the parenting factors that differentially predict the development of anaclitic and introjective depression in males and females. In addition, there is some confusion about the manner in which the studies define the different types of affection (i.e. inconsistent affection, distant relationship; do these equal low affection?) For this thesis we will have

to make some assumptions regarding the meanings of the different types of affection as they are referred to in these studies.

### Assessment of Parenting

There are several generally accepted and reliable measures for assessing recollections of parenting. The Inventory of Parent and Peer Attachment (IPPA) is a self-report instrument used in studies of parent attachment in adolescent depression to assess degree of mutual trust, quality of communication, and extent of anger and alienation (Armsden, McCauley, Greenberg, Burke, & Mitchell, 1990). Another measure used in studies of late adolescents and adults in reference to their own childhood is the Parent-Child Relations Questionnaire (PCR). This measure was originally devised as a measure of the characteristic behavior of parents toward their children, as experienced by the child (Roe & Siegelman, 1963). The Parent Behavior Form was used in the studies that linked dependency and self-criticism with parental behavior. This measure consists of 265 items that produce 13 subscales including the Conformity, Achievement, and Control scales (Whiffen & Sasseville, 1991).

The most appropriate measure for use in this thesis is the Parental Bonding Instrument (PBI). It is a 25-item, self-report measure which yields two scales that represent Parker's two dimensions of parenting: care and protection. The scales can be used separately, or together as a bonding instrument and may be administered twice, once for the father and a second time for the mother (Parker, Tupling, & Brown, 1979).

This measure will also allow us to investigate whether, and in what way, depression, characterized by dependency and/or self-criticism, is related to these two

dimensions of recollected parenting. Theoretically, we expect an association between anaclitic depression, which is characterized by wishes to be protected, loved, and cared for, and recollections of low parental care and possibly high parental control. Similarly, we expect a relationship between introjective depression, which is characterized by feelings of inferiority, guilt, worthlessness, and a sense of failure at living up to other's expectations and standards, and recollections of high parental control. Furthermore, we hypothesize that, for women, there is a unique relationship between feelings of dependency (anaclitic depression) and fathers seen as providing little care and control and, likewise, a relationship between self-critical feelings and recollections of fathers as controlling but low in care.

#### Treatment Outcome Research

There is a large movement in the field of psychology towards providing information about the success of psychological treatments. This type of research is commonly referred to as "treatment outcome research." The goal of this movement is to provide treatment information to influential third parties and the community about the most successful and cost effective treatments available to individuals in need of psychological help.

The National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program was the first large-scale, multisite coordinated study in the area of psychotherapy research. Their main goal was to study the differential effectiveness of two forms of psychotherapy with depressed patient populations. In selecting the two therapeutic approaches to be compared, the researchers set specific



criteria for the inclusion of the treatments in their study. These criteria included “(1) that the therapy had been developed or modified specifically for use with depressed outpatients; (2) that the therapy had been standardized in such a fashion that it could be transmitted to other clinicians and researchers...; and (3) that there must be some evidence of efficacy for the approach with depressed outpatients” (Elkin et al., 1985, p. 307). The two psychotherapies that met these criteria were cognitive behavioral therapy and interpersonal psychotherapy.

The researchers focused on four major questions: (1) Are there any differences among the four treatment conditions (cognitive behavior therapy, interpersonal psychotherapy, imipramine hydrochloride plus clinical management, and pill-placebo plus clinical management), at termination, with regard to patients’ depressive symptoms and general functioning? (2) Are the two types of psychotherapies more effective than the other treatments in bringing about change in their respective targeted areas? (3) Are there differences in the “temporal course of symptom reduction” (Elkin, 1994, p. 118)? (4) What patient characteristics predict outcome differentially among the four treatments (Elkin, 1994)? The latter question is directly relevant to this thesis as it corresponds with the purpose to explore depressed patient characteristics in detail, with the underlying goal of helping to predict successful response to different types of treatment.

### Interpersonal and Cognitive Treatment

Using data from the NIMH study, Sotsky et al. (1991) investigated depressed patient characteristics that are most likely to result in a positive response to interpersonal psychotherapy. They reported that a favorable response to interpersonal psychotherapy is

associated with good initial social adjustment, previous attainment of a marital relationship, higher satisfaction with social relationships, and interpersonal sensitivity. The authors theorize that these patient characteristics function as predictors of success in interpersonal psychotherapy because “...patients with good social function may be better able to take advantage of interpersonal strategies to recover from depression...” (Sotsky et al., p. 1006).

Sotsky et al. (1991) also investigated depressed patient characteristics that are most likely to result in a positive response to cognitive behavior therapy. They reported that a favorable response to cognitive behavior therapy is associated with “...lower initial cognitive dysfunction, briefer duration of the current episode of depression, absence of a family history of affective disorder, later age at onset, and a history of more previous episodes of depression” (Sotsky et al., p. 1000). In addition, if the patient is married there is a higher likelihood that he/she will respond positively to this type of therapy. The authors theorize that the reason why these patient characteristics function as predictors of success in cognitive behavior therapy, is that “...patients without severe dysfunctional attitudes may better utilize cognitive techniques to restore mood and behavior” (Sotsky et al., p. 1006).

These findings, from the NIMH study, are consistent with the results of Blatt’s Menninger Psychotherapy Research Project (discussed in the section on anaclitic and introjective depression), in which Blatt found that anaclitic patients have a more “constructive therapeutic response” to psychoanalytic psychotherapy while introjective

patients find psychoanalysis more effective and beneficial (Blatt, 1992). Blatt and Felsen (1993) summarized the findings from these studies as follows:

The fact that more ideational patients did better in psychoanalysis in the MPRP and in CBT in the NIMH TDCRP suggests that both short-term CBT and long-term psychoanalysis emphasize change in cognitive structures, in contrast to the interpersonal emphasis of short-term IPT and long-term psychotherapy which was more effective with more interpersonally-oriented patients (p. 253).

An aim of this thesis is to corroborate this statement by conducting exploratory analyses to determine whether there is, in fact, a connection between individuals' anaclitic depression scores and their interpersonal functioning and between individuals' introjective depression scores and their cognitive functioning. The answers to these questions may help to predict what type of therapy will treat these individuals more effectively.

#### Interpersonal and Cognitive Functioning Assessment

Van Denburg, Schmidt, and Kiesler (1992) reviewed the major instruments available to assess clients' interpersonal functioning. Among the instruments reviewed were the Interpersonal Check List (ICL), the Interpersonal Behavior Inventory (IBI), the Interpersonal Adjective Scales (IAS), and the Check List of Interpersonal Transactions (CLOIT). These instruments were designed to measure the sixteen theoretical constructs of Kiesler's Interpersonal Circle. Kiesler's theory is the most recent reconstruction of Leary's original circle model which proposes "...a distinct combination of two basic dimensions of interpersonal behavior: control (dominance-submission) and affiliation

(friendliness-hostility)” (Van Denburg et al., p. 84). These instruments measure the range of blends formed by combinations of the control and affiliation dimensions (Van Denburg et al.). Although they appear to have adequate psychometric properties (Van Denburg et al.), these instruments measure constructs unrelated to the theoretical concepts investigated in this study.

Horowitz, Rosenberg, Baer, Ureno, and Villasenor (1988) created the Inventory of Interpersonal Problems (IIP), based on their perceived “...need for an easily administered self-report inventory that describes the types of interpersonal problems that people experience and the level of distress associated with them before, during, and after psychotherapy” (Horowitz et al., p. 885). The IIP yields five subscales concerning compliance, aggression, intimacy, independence, and socializing and it has been shown to be sensitive to modification of clients’ interpersonal problems during counseling (Van Denburg et al., 1992). The psychometric data reported by Horowitz and colleagues suggest that the IIP has “...adequate test-retest reliability and convergent validity with counselors’ ratings of clients’ behaviors and other interpersonal measures” (Van Denburg et al., 1992, p.88).

Although the IIP is a relatively long scale (127 items), it meets other necessary criteria for use in this thesis; namely, it has adequate psychometric properties and it is a self-report scale.

Dobson and Breiter (1983) conducted a psychometric investigation of three cognitive assessment measures in the area of depression. They compared the Automatic Thoughts Questionnaire (ATQ), the Dysfunctional Attitude Scale (DAS), and the

Interpretation Inventory (IntI) in terms of their concurrent validity and internal reliability. They concluded that the ATQ was the most satisfactory instrument as it has “notably high” internal validity and “statistically significant” concurrent validity (Dobson & Breiter). The ATQ also meets the necessary criteria for use in this thesis. It is a relatively short (30 items), self-report scale with adequate psychometric properties.

### Summary of Literature Review

The goal of this literature review was to provide a rationale for the study and to familiarize the reader with the constructs to be compared and analyzed in this study. The organization of this review was prepared in such a way as to add complexity to the issues presented in the previous sections. Thus, an introduction to depression was followed by a distinction between two types of depression, anaclitic and introjective, which in turn was followed by a section linking these depression types to recollections of parental care and control. Adding complexity, research on gender interactions related to the aforementioned variables was presented. This section was followed by a final discussion on the potential relationships between types of depression and treatments designed to address the underlying difficulties manifested by the two types of depression.

Overall, the findings from the literature linking types of depression with recollections of parenting appear to be mostly consistent with psychoanalytic theory. However, there is a lack of consensus in the literature regarding a unified theory that underlies the research findings described in the above sections. Thus, the attempts made in this thesis at linking psychoanalytic theory with the research findings were tentative

and somewhat superficial. It is likely that the findings from this study will not fit as neatly with psychoanalytic theory.

The studies described in this literature review also varied widely in terms of measurement and research design issues. As mentioned in the section on Gender Interactions, researchers differ in the ways they measure and define parental affection and control. In addition, many of the researchers used clinical samples, as opposed to non-clinical student samples, in their studies. Furthermore, many of the self-report measures used in previous research, and in this study, are correlated with one another due partly to method variance which are easily influenced by certain response sets. Thus, the findings from this study may differ from the literature due to assumptions made in measuring parenting variables, and the use of self-report measures and a college student sample for the analyses.

In the following section, the research hypotheses, which were formulated to test the findings described in the section linking parenting variables to anaclitic and introjective depression, are presented. It is important to emphasize that these hypotheses were based on literature findings, not on theory. Whether the literature findings and the results from this study are consistent with theory will be addressed in the discussion section of this thesis.

### Research Hypotheses

1. Individuals with higher depression scores recall their parents as low in care and high in control.

2. Individuals with higher anaclitic depression scores recall their mother as emphasizing strict control.
3. Women with higher anaclitic depression scores recall their fathers as distant (low in affection and control).
4. Individuals with higher introjective depression scores recall their parents as emphasizing strict control.
5. Women with higher introjective depression recall difficulties in the affective bond with fathers (low in affection) and greater paternal power and control during development.
6. Individuals with more severe depression symptoms also have both anaclitic and introjective symptoms of depression.

## CHAPTER 2

### METHOD

#### Participants

The participants consisted of a voluntary sample of male and female undergraduates enrolled in Psychology courses at the University of North Texas located in Denton, Texas. The sample was composed of 217 individuals (118 female, 99 male). Minors, or individuals under the age of 18, were excluded from this study as they would need parental consent to participate in the research.

The sample's mean age was 22.18 years. This variable is markedly skewed (2.7) as would be expected in a college population; there were only 12 individuals, or 5.9% of the sample, over the age of 30. Regarding ethnicity, of the 217 participants, 156 individuals (71.9%) were Caucasian, 20 (9.2%) were African American/Black, 18 (8.3%) Hispanic/Latino, 16 (7.4%) were Asian/Pacific Islander; only 1 (.5%) was an American Indian/Alaskan Native, and 6 individuals (2.8%) indicated that they did not belong in any of the categories listed in the questionnaire.

In this sample, 160 participants (73.7%) reported that they were single, 33 participants (15.2%) indicated they were in a committed relationship, 19 (8.8%) said they were married, and 5 individuals (2.3%) were divorced. Of the 217 participants, only 13



individuals (6% of the sample) indicated having children, and, of those 13, 8 (61% of those with children) indicated having more than one child.

Regarding education levels and current academic and employment activity, 28 individuals (12.9%) reported achieving a high school diploma as their highest degree of academic achievement, 159 (73.3%) completed some college or an associate's degree, 23 (10.6%) indicated having a bachelor's degree, and 4 (1.4%) said they had a master's or doctoral degree. Of the 217 participants, 4 (1.8%) are enrolled in school full-time and work full-time. In total, 122 individuals (56.2%) reported that they are enrolled in school full-time, of whom also 34.4% work part-time and 62.3% did not report additional work. Of the 217 individuals, 95 (43.8%) indicated that they are enrolled in school part-time, of whom 12.6% work full-time, 66.3% work part-time, 1.1% are self-employed, 2.1% are homemakers, 16.8% did not report additional work, and 1.1% reported that they are retired or disabled. As would be expected for a college population, 62 participants (21.2%) are employed in semiskilled positions and 46 (28.6%) are employed in sales/tech. positions. These types of positions represent jobs accessible to college students such as waitressing and counter-sales.

For this study, we also asked participants to report about their current and past psychological and medical functioning. Twenty-three participants (10.6%) reported having psychosomatic problems, 26 (12.0%) said they had physical problems, and 8 (3.7%) indicated having psychological problems. In addition, 34 participants (15.7%) are currently taking medication that has no side effect of depression, 18 (8.3%) are taking

medication with a possible side effect of depression, and 6 (2.8%) reported that they are taking medication for psychological symptoms.

When the participants were asked if they ever had a period in their life when they were feeling depressed or down most of the day nearly every day for at least two weeks, 109 (50.2%) said that they had experienced such a period of depressed affect. When they were asked whether they had more than one or two times like that (depressed for at least two weeks), 47 (21.7%) indicated that they had not experienced depression more than one time, 57 (26.3%) had experienced depression more than once, and 21 (9.7%) said they had experienced depression several times.

Of the 217 participants, 39 (18.0%) reported having received a clinical diagnosis of depression, 30 (13.8%) had received outpatient treatment for depression, 18 (8.3%) had received outpatient treatment but not for depression, 9 (4.1%) said that they had received inpatient treatment for depression, and 2 (.9%) reported having received inpatient treatment but not for depression.

## Measures

### Background Information Form

This questionnaire asks the client to provide basic demographic information, including Hollingshead S.E.S., and information regarding previous mental health outpatient/inpatient treatment received, parental history of depression and substance abuse, current and past substance use, past medical treatment and current medical problems, and current use of prescription and over the counter drugs (See Appendix).

### Parental Bonding Instrument (PBI)

This is a brief questionnaire that measures two principal characteristics of reported parental behavior and attitudes: a care dimension and a dimension of psychological control over the child (Parker, 1979). The PBI provides information regarding an individual's perceptions of his/her parents including their behaviors, attitudes of care, affection, sensitivity, cooperation, accessibility, indifference, strictness, punitiveness, rejection, interference, control, overprotection, and encouragement of autonomy and independence. However, the PBI yields only two scales, Care and Overprotection, based on the theoretical dimensions described above (Parker, Tupling, & Brown, 1979).

The PBI consists of 25 items comprised of 12 "care" items and 13 "overprotection" items. Two identical versions were given to participants; one to describe the mother and one to describe the father. The items are rated using a Likert scaling from 0 to 3. Each item is weighted according to the degree of Care and Overprotection reported by the individual (high Care = 3, high Overprotection = 3). The Care Scale yields a maximum score of 36 and the Overprotection Scale yields a maximum score of 39 (Parker, Tupling, & Brown, 1979).

The psychometric properties of the PBI, as reported by Parker, Tupling, and Brown (1979), are as follows: .76 and .63 test-retest reliability over three weeks, .88 and .74 split-half reliability, and .77-.78 and .48-.51 concurrent validity for the Care and Overprotection Scales respectively.

### Automatic Thoughts Questionnaire (ATQ)

This questionnaire measures the frequency of automatic negative thoughts associated with depression. The 30-item ATQ measures the following facets of depression in one scale: personal maladjustment and desire for change, negative self-concept and negative expectations, low self esteem, and helplessness.

Participants are asked to rate the frequency with which they recall 30 different thoughts occurring during the previous week. These ratings range from 1 (not at all) to 5 (all the time). The ATQ items are scored “positively” for depression so that high frequency ratings indicate depression. ATQ scores range from 30 (little or no depression) to 150 (maximum depression) (Shaver & Brennan, 1991).

The psychometric properties for the ATQ, as reported by Shaver and Brennan (1991) in a review of the literature, are as follows: .97 odd-even split-half reliability, .96 alpha coefficient, and .56 to .91 item-total correlations. There is also evidence for the ATQ’s convergent validity as shown by its high correlation with the BDI and the MMPI-D and by its ability to reliably discriminate between depressed and nondepressed individuals; unfortunately, these authors did not provide exact figures for these results (Shaver & Brennan, 1991).

### Inventory of Interpersonal Problems (IIP)

This is a self-report inventory that assesses interpersonal problems and the degree of distress related to those problems. The IIP yields the following 6 subscales: 1) Assertive, 2) Sociable, 3) Submissive, 4) Intimate, 5) Responsible, 6) Controlling (Horowitz, 1988). These scales provide information concerning the individual’s

level/degree of intimacy, aggression, independence, compliance, and socializing (Van Denburg, Schmidt, & Kiesler, 1992).

The IIP consists of 127 items that participants rate on a 5-point scale ranging from 1 (not at all) to 5 (extremely). To obtain a score for each subscale it is only necessary to add the items within that subscale and divide by the total number of items. Thus, a mean score is obtained for each subscale. To obtain an overall mean score for all 127 items of the IIP all IIP items are simply added and divided by 127 (Horowitz, 1988).

The psychometric properties of the IIP, as reported by Horowitz, Rosenberg, Baer, Ureno, and Villasenor (1988), are as follows: .82-.94 alpha coefficients, .80 -.90 test-retest reliability, and .57-.64 convergent validity. These authors also suggest that the IIP is sensitive to modification of client's interpersonal problems during counseling (Horowitz et al., 1988).

#### Depressive Experiences Questionnaire (DEQ)

The Depressive Experiences Questionnaire (DEQ; Blatt, D'Afflitti, & Quinlan, 1979) is a 66-item questionnaire that is rated on a 7-point Likert-type scale. When Blatt et al. conducted a series of factor analyses on this questionnaire, three orthogonal factors emerged. These were Dependency, Self-Criticism, and Efficacy. Dependency and Self-Criticism correspond with Blatt's concepts of Anaclitic and Introjective depression respectively. The Efficacy factor is not addressed in this study because it is not related to Blatt's theoretical model of psychopathology. The subjective feelings assessed by this measure have been linked to feelings experienced by individuals that meet DSM-IV criteria for major depression.

To score the DEQ "...the raw score for each item must be standardized according to the item means and standard deviations ... [reported by Blatt and colleagues in 1976]. The standard score is then multiplied by the appropriate factor weights from the original factor analysis, which can be different for males and females" (Shaver & Brennan, 1991). A computer program for scoring the DEQ was provided by Blatt, D'Affliti, and Quinlan (1979) for use in this study.

An alternative, unit-weight scoring system for the DEQ was proposed by Welkowitz, Lish, and Bond (1985). This new system was developed by assigning each item of the DEQ to one of the three subscales (dependency, self-criticism, or efficacy) by reexamining the factor coefficients for Blatt's 1976 samples of males and females. Each item was assigned to one of the three scales if "(a) its factor loading on that subscale for either gender was greater than .40, (b) it had the highest factor loading for that item and (c) it had the highest factor loading for both genders even if for one gender the criterion of .40 was not met" (p. 90). Using this rule, 21 items were assigned to the dependency scale, 15 to the self-criticism scale, and 8 to the efficacy scale. The remaining 22 items were dropped as they did not meet the inclusion criterion. To score this revised or unweighted DEQ, one must simply obtain a mean rating of the items on each scale (1985). Welkowitz et al. (1985) reported .81, .86, and .72 Cronbach's alphas for the dependency, self-criticism, and efficacy scales, respectively. These authors did not provide the exact figures for the correlations between the original and revised scorings of the DEQ (Welkowitz, Lish, & Bond, 1985).

Blatt, D'Afflitti, and Quinlan (as cited in Shaver & Brennan, 1991) have reported alpha coefficients ranging from .72 to .86 for each of the scales that compose the DEQ. In addition, test-retest reliabilities for the DEQ range from .64 to .89.

#### Symptom Check List-90- Revised (SCL-90-R)

The SCL-90-R is a brief, multidimensional self-report inventory designed to screen for a broad range of current psychological problems and symptoms of psychopathology. The SCL-90-R is scored and interpreted in terms of 9 symptom dimensions and 3 global indices of distress. The nine dimensions of the SCL-90-R and the 3 global indices are labeled as follows: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, Psychoticism, Global Severity Index (GSI), Positive Symptom Distress Index (PSDI), and Positive Symptom Total (PST) (Derogatis, 1983).

Each of the 90 items of the SCL-90-R is rated on a 5-point scale of distress (0-4), ranging from "not-at all" to "extremely." To score the SCL-90-R one must calculate the Global Severity Index (GSI) by adding all item scores and dividing by 90 (Derogatis, 1983).

The psychometric properties of the SCL-90-R, as reported by the research literature, are as follows: .77 to .90 internal consistency for each symptom dimension, .80 to .90 test-retest reliability for each symptom dimension, and .36 to .75 concurrent validity for each symptom dimension. In addition, construct validity data suggest that the SCL-90-R demonstrates high correlations with real clinical data (Derogatis, 1983).

#### Beck Depression Inventory (BDI)

This questionnaire measures the intensity of depression in terms of 21 symptom-attitude categories. The following symptoms of depression are measured by the BDI items: mood, pessimism, sense of failure, lack of satisfaction, guilt feelings, sense of punishment, self-dislike, self-accusation, suicidal wishes, crying, irritability, social withdrawal, indecisiveness, distortion of body image, work inhibition, sleep disturbance, fatigability, loss of appetite, weight loss, somatic preoccupation, and loss of libido (Shaver & Brennan, 1991).

Each of the 21 items on the BDI has four alternative responses ranging from 0 (none/low depression) to 3 (maximum/severe depression). To score the BDI it is only necessary to add up the numbers associated with each item. The total score can thus range from 0 to 63. The following cut-off scores have been identified by the research literature: no depression or minimal depression, scores less than 4; mild, between 5 and 13; moderate, between 14 and 20; and severe, 21 and above (Shaver & Brennan, 1991).

The psychometric properties for the BDI, as reported by Shaver and Brennan (1991) in a review of the literature, are as follows: .86 odd-even split-half reliability, .70 test-retest reliability, and .60 to .90 convergent validity. There is also evidence for the BDI's discriminant validity as shown by its high correlation with clinical ratings of depression versus low correlations with clinical ratings of anxiety and other psychiatric diagnoses (Shaver & Brennan, 1991).

#### Procedure

Participants were offered extra credit in their undergraduate psychology courses in exchange for completing a packet of self-report questionnaires. Group and individual



administrations were scheduled during various time slots to accommodate as many participants as possible. During each of the several group sessions conducted, participants were given a pre-numbered depression assessment packet, which included all of the questionnaires mentioned above, and asked to complete the questionnaires in the order they were given. In addition, an informed consent statement was attached to each packet that was administered. All packets and respective measures were assigned a study identification number to keep the participants' identities anonymous and to assist in keeping each participant's materials together.

Throughout the first months of data collection, several modifications were made in the data collection procedure in order to bring this about in a timely manner.

Researchers began by visiting undergraduate psychology classes and passing out depression screeners in order to recruit students who were experiencing at least minimal depression symptoms. However, the screener proved restrictive to sample size because few people were meeting this inclusion criterion. Thus, the depression screeners were omitted from the procedure. We did not believe this omission would be harmful to this study's design because Blatt's theory on anaclitic and introjective depression suggests that these traits are present in individuals within the entire continuum of depression. Furthermore, upon a review of Blatt's research, we found that he did not use depression screeners when working with an undergraduate population.

Initial recruitment also involved asking students to stay after class to complete the questionnaires. This proved unsuccessful because few students wished to stay after class, without previous warning, for forty-five minutes. Furthermore, difficulties arose

regarding the occupation of classroom space for an additional hour. Often other classes were scheduled in the same classroom after the targeted psychology class was over.

We then tried reserving our own room in the psychology building and posting times during the week in which students could sign up to complete the questionnaires. This proved more successful than earlier efforts but data collection still proceeded at a slower rate than was originally anticipated. Data collection was also slowed due to difficulty in obtaining a sufficient number of male participants. Thus, selective recruitment of males was initiated. The final modification to the procedure involved combining two of the aforementioned steps. We visited undergraduate classes to advertise our study and provide information about how to participate and, in addition, we posted available times to participate in the psychology building.

## CHAPTER 3

### RESULTS

#### Descriptive Analyses

Before analyzing the data to evaluate the hypotheses, it was first necessary to determine whether our sample was typical or atypical. Each measure used in this study was expected to yield means and standard deviations similar to those previously reported by studies using the same measures with similar populations. The expected and observed means and standard deviations for each measure used in this study are shown in Table 1. The results of these comparisons suggest that this sample is typical in that the mean scores yielded by this sample were not significantly different from the mean scores yielded by similar populations tested in other studies.

Table 1

#### Expected and Observed Means and Standard Deviations

Measure/Scale	Expected Mean	Expected St. Dev.	Observed Mean	Observed St. Dev.	Sig. Diff.
<u>PBI Care</u>					
Maternal	19.9	<sup>a</sup>	28.3	7.4	NS
Paternal	14.7	<sup>a</sup>	21.9	9.5	NS
<u>PBI Overprotection</u>					
Maternal	19.1	<sup>a</sup>	13.4	7.7	NS

Paternal	16.4	<sup>a</sup>	13.0	7.9	NS
ATQ	79.6	22.3	54.6	18.5	NS
IIP (Mean Total)	1.5	.6	1.2	.6	NS
DEQ Dependent <sup>b</sup>	4.3	.9	4.3	.8	NS
DEQ Self-Critical <sup>b</sup>	4.2	.9	3.9	1.0	NS
SCL-90 (GSI)	1.3	.7	.8	.7	NS
BDI Males <sup>b</sup>	6.9	5.4	9.5	8.0	NS
BDI Females <sup>b</sup>	8.4	6.1	11.5	9.7	NS

Note. Sources of expected means and standard deviations were outpatient samples reported by Parker (1979) for the PBI, Shaver & Brennan (1991) for the ATQ, Horowitz (1988) for the IIP, Viglione, Lovette, Gottlieb, & Friedberg (1995) for the DEQ, Derogatis (1983) for the SCL-90, and BDI Dobson & Breiter (1983) for the BDI.

<sup>a</sup> No standard deviations were reported in the literature for this measure.

<sup>b</sup> These are means and standard deviations gathered from nonpatient populations.

In addition to comparing the sample's parameters to previous studies using the same measures, it was also necessary to determine whether the sample's scores were normally distributed. Frequency distributions were examined to determine whether the distribution of scores for each measure represented a normal or non-normal distribution. We found that most of our measures were approximately normally distributed. However, the ATQ, the PBI Maternal Scale, and the BDI were not.

The ATQ was positively skewed (1.47) and leptokurtic (2.52). Modal values for this measure were 43-44, and these scores included 12% of the sample. These individuals' scores, in terms of the rating scale, were comparable to answering half of the items "not at all" and half "sometimes." This positive skew may be due to the underlying influence of social desirability which may have caused the majority of individuals in our sample to minimize their cognitive symptoms.

The PBI Maternal Care scale was negatively skewed (-1.45) and platykurtotic (2.22). Modal score for this measure was 33, which included 12%. Overall, these individuals tend to see their mothers positively in terms of care and affection and not especially controlling. Although not as markedly non-normal, fathers are also seen as positive in terms of care and not especially controlling.

Finally, the BDI was also positively skewed (1.58) and platykurtic (3.59). Modal scores for this measure were 6-7, which included approximately 14% of the sample. Most people rated themselves equivalently to "0" on half of the items meaning "absence of symptoms" and "1" on the other half of the items meaning "a small amount of symptoms." Thus, the average participant in our sample would be described as having no or minimal depression. Only approximately 12% of the sample scored in the severe range of depression. Some researchers have reported that the BDI suffers from social desirability (Shaver & Brennan, 1991), which may lower mean scores. Thus, the BDI may correlate with other self-report measures used in this study, such as the ATQ, that also suffer from social desirability response sets. This correlation may be misleading if

one assumes that the entire relationship between the two measures is due to the expected theoretical correlations between the constructs.

We also calculated the Cronbach's Alpha for each of the following measures: PBI, ATQ, IIP, and DEQ. The Cronbach's Alpha for each measure is presented in Table 2. All the measures in this study have high internal consistency.

Table 2

Internal Consistency Reliability: Cronbach's Alpha

Measure	Cronbach's Alpha
PBI Care Maternal	.91
PBI Care Paternal	.93
PBI Overprotection Maternal	.85
PBI Overprotection Paternal	.86
ATQ	.96
IIP	.98
DEQ Dependent	.83
DEQ Self-Critical	.85

Before testing the hypotheses it was also necessary to first determine whether the measurements were confounded. In order to examine whether confounding associations existed among the measures, a triangular matrix of intercorrelations was examined for any unexpected correlations. There were significant correlations between age of participant and number of children,  $r(71) = .75, p < .001$ , level of education,  $r(211) = .33$ ,

$p < .001$ , and Hollingshead S.E.S.,  $r(172) = .19$ ,  $p = .01$ ; and also between level of education and Hollingshead S.E.S.,  $r(170) = .15$ ,  $p = .05$ . These correlations, however, were to be expected given that the mean age of this college student sample is 22.2. Individuals of this age tend not to have children, and have achieved lower levels of education and employment. Likewise, individuals with lower levels of education are expected to have lower levels of S.E.S.

Finally, to further detect confounded measurements, we conducted t-tests between the continuous and categorical demographics used in this study. We found a significant association between gender of the participant and number of children. According to our analyses, there is a significant difference between the mean number of children reported by females,  $M = .59$ , and by males,  $M = .08$ ;  $t(40.61) = -2.77$ ,  $p < .01$ . We found no other significant associations among the continuous and categorical demographics used in this study.

Significant correlations among the predictor variables in our study are presented in Table 3.

Table 3

Unhypothesized Correlations Among Predictor Measures

	PBI	PBI	PBI	PBI	IIP
	Care	Care	Overprot.	Overprot.	
	Maternal	Paternal	Maternal	Paternal	

PBI Care

Maternal

Paternal .20\*\*

PBI Overprotection

Maternal -.46\*\* -.15\*

Paternal -.31\*\* -.38\*\* .47\*\*

IIP -.22\*\* -.09 .24\*\* .18\*\*

ATQ -.29\*\* -.17\* .31\*\* .23\*\* .53\*\*

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\*  $p < .05$

\*\*  $p < .01$

The correlations reported in Table 3 are not unexpected. We observe that individuals who see their parents as high in affection (Care) tend to also see them as not controlling (Overprotection). Interestingly, both parents appear to be grouped together in terms of the PBI scales; maternal and paternal scales are positively correlated when rated in terms of affection and control. Also individuals who describe their parents as caring tend to report fewer interpersonal problems and less frequent negative thoughts. On the other hand, individuals who rate their parents as high in control tend to report more interpersonal problems and more negative thoughts.

Significant correlations were also found among the outcome variables. There were significant positive correlations between the DEQ Self-Critical and Dependency scales,  $r(214) = .53, p < .001$ , between the DEQ Self-Critical and Dependency scales and the SCL Global Severity Index,  $r(207) = .43, p < .001$  and  $r(207) = .34, p < .001$



respectively, and between the SCL Global Severity Index and the BDI,  $r(192) = .67$ ,  $p < .001$ . The correlations among the outcome variables are moderately high and statistically significant. This is to be expected as they all measure degree of distress and presence of psychological symptoms.

In addition to examining the data for confounding associations among the variables, unhypothesized associations between the measures used in the hypotheses and the major demographics that are not used in the hypotheses were examined. In order to examine whether confounding associations exist between the measures and the demographic variables collected, a rectangular correlation matrix was examined for any unexpected correlations. There were significant correlations between number of children reported by participants and mother recalled as being controlling/overprotective,  $r(72) = .23$ ,  $p = .05$ , and between level of education and father seen as controlling/overprotective,  $r(206) = .15$ ,  $p = .03$ . It was also found that Hollingshead S.E.S. is significantly correlated with number of negative thoughts reported by the participant,  $r(173) = .16$ ,  $p = .04$ , and with subjective feelings of self-critical depression,  $r(172) = .17$ ,  $p = .02$ . Although, as reported in the Method section of this thesis, age is correlated with Hollingshead S.E.S and with level of education, age is not correlated with any of the parenting factors, negative thoughts, or self-critical subjective feelings.

Finally, to further detect any unhypothesized associations, we conducted t-tests between the continuous measures used in our hypotheses and the major categorical demographics not used in our hypotheses. We found a significant association between gender of the participant and reports of subjective feelings of dependency. According to

our analyses, there is a significant difference between the mean number of subjective feelings of dependency reported by females,  $M = 4.48$ , and mean number reported by males,  $M = 4.13$ ;  $t(213.4) = -3.38$ ,  $p < .01$ . No other significant associations were found between the continuous measures used in this study and the major categorical demographics not used in the hypotheses.

Significant correlations between the predictor variables and the outcome variables in our study are presented in Table 4. Most associations between the predictor variables and the outcome variables are significant. The strongest relationships appear to be between negative thoughts endorsed by an individual and self-critical subjective feelings and depressive symptomatology. Recollections of the father as high in affection seem to be unrelated to overall distress.

Table 4

Correlations Between Predictor and Outcome Measures

	DEQ Dependency	DEQ Self- Critical	BDI Depression	SCL Global Severity
<u>PBI Care</u>				
Maternal	-.14*	-.32**	-.37**	-.30**
Paternal	-.09	-.20**	-.18*	-.13
<u>PBI Overprotection</u>				
Maternal	.16*	.27**	.35**	.33**
Paternal	.20**	.23**	.29**	.27**
IIP	.42**	.48**	.46**	.57**

ATQ	.45**	.67**	.68**	.61**
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\*  $p < .05$

\*\*  $p < .01$

Finally, before testing the hypotheses it was necessary to evaluate the possible consequences of choosing the unit-weighted DEQ scoring system. We compared Blatt's factor-weighted scoring system with the unweighted scoring system developed by Welkowitz, Lish, and Bond (1985), which was more user-friendly. We compared the two scoring systems by creating a rectangular correlation matrix. The results from this analysis indicate that the two scoring systems are highly correlated. The correlations are presented in Table 5.

Table 5

Comparison Between Weighted and Unweighted DEQ Scoring Systems

	Blatt's Weighted Dependency Scale	Blatt's Weighted Self-Critical Scale
Unweighted DEQ Dependency Scale	.92**	.35**
Unweighted DEQ Self-Critical Scale	.29**	.92**

\*\*  $p < .01$

The following table, Table 6, compares the unweighted and weighted scales with each other. According to the analyses, Blatt's weighted dependency and self-criticism

factors are orthogonal whereas the unweighted versions are highly correlated with one another.

Table 6

Comparisons Within Weighted and Unweighted DEQ Scoring Systems

	Unweighted DEQ Self-Critical Scale	Blatt's Weighted Self-Critical Scale
Unweighted DEQ		
Dependency Scale	.92**	.35**
Blatt's Weighted		
Dependency Scale	.29**	.92**

\*\*  $p < .01$

On rational grounds, for parsimony and conceptual clarity, and for the convenience of researchers it seemed better to use the unweighted scoring system. In addition, the present hypotheses will be tested using correlations, and thus the findings will be little affected by the use of orthogonal factors, whereas the use of highly correlated scales in multivariate statistics or comparisons among high and low scorers on each scale would likely affect the results. Furthermore, the weights used in Blatt's scoring system are specific to his sample and will vary in other samples, and thus, not exactly apply to the sample used in this study.

However, the results that follow did yield different correlations. Table 7 includes the overall analyses using both systems of scoring the DEQ. The largest difference

occurred for most variables when comparing the weighted and unweighted forms of the Dependency Scale for maternal variables and the BDI.

Table 7

Relationships Between Recollections of Parenting and Subjective Feelings of Depression

	Unweighted DEQ Dependency	Blatt Dependency	Unweighted DEQ Self-Critical	Blatt Self- Critical
<u>PBI Care</u>				
Maternal	-.14*	.01	-.32**	-.36**
Paternal	-.09	-.02	-.20**	-.22**
<u>PBI Overprotection</u>				
Maternal	.16*	.08	.27**	.27**
Paternal	.20**	.13	.23**	.23**
BDI	.40**	.24**	.58**	.55**

\*  $p < .05$

\*\*  $p < .01$

Hypothesis-testing Analyses

Hypothesis 1. Individuals with higher depression scores recall their parents as low in care and high in control

The BDI correlated negatively with the PBI Paternal and Maternal Care scales for men,  $r(84) = -.28, p = .01$  and  $r(85) = -.48, p < .001$  respectively, and positively with their

Maternal Overprotection scale scores,  $r(85) = .30$ ,  $p < .01$ . However, for men, the BDI did not correlate with higher Paternal Overprotection scores,  $r(83) = .09$ ,  $p = .44$ .

For women, the BDI correlated negatively with Maternal Care scale scores,  $r(105) = -.31$ ,  $p < .01$ , and positively with Maternal and Paternal Overprotection scale scores,  $r(107) = .37$ ,  $p < .001$  and  $r(105) = .39$ ,  $p < .001$  respectively. However, for women, the BDI was uncorrelated with lower Paternal Care scale scores,  $r(103) = -.12$ ,  $p = .22$ .

Thus, the first hypothesis was mostly supported except that, for men, recollections of Paternal Control/Overprotection, and, for women, recollections of Paternal Affection/Care were unrelated to the presence of depressive symptoms.

Hypothesis 2. Individuals with higher anaclitic depression scores recall their mother as emphasizing strict control.

For women only, the DEQ Dependency scale correlated positively with Maternal Overprotection scale scores,  $r(114) = .20$ ,  $p = .03$ . However, for men, no relationship was found between the DEQ Dependency scale and Maternal Overprotection scale scores,  $r(97) = .05$ ,  $p = .61$ .

Thus, the hypothesis was only partially supported. It appears as though, for women only, there is a relationship between anaclitic depression and recollections of maternal control.

Contrary to the prediction, for men there is no such effect. However, for men, the DEQ Dependency scale correlated positively with Paternal Overprotection scale scores,  $r(96) = .20$ ,  $p < .05$ , whereas, for women, no significant relationship was found between

the DEQ Dependency scale and Paternal Overprotection scale scores,  $r(114) = .17$ ,  $p = .07$ .

Hypothesis 3. Women with higher anaclitic depression scores recall their fathers as distant (low in affection and control).

For women only, no significant relationship was found between the DEQ Dependency scale and Paternal Care and Overprotection scale scores,  $r(110) = -.10$ ,  $p = .29$  and  $r(112) = .17$ ,  $p = .07$  respectively. Thus, this hypothesis was not supported; for women, there is no relationship between anaclitic depression and paternal distance.

For men, there is also no relationship between the DEQ Dependency scale and Paternal Care ( $r(97) = -.11$ ,  $p = .30$ ), but, as mentioned above, the DEQ Dependency scale was correlated positively with Paternal Overprotection scale scores.

Hypothesis 4. Individuals with higher introjective depression scores recall their parents as emphasizing strict control.

For men and women, the DEQ Self-Criticism scale correlated positively with Paternal and Maternal Overprotection scale scores, for men,  $r(94) = .27$ ,  $p < .01$  and  $r(97) = .22$ ,  $p = .03$  respectively, for women,  $r(112) = .21$ ,  $p = .02$  and  $r(114) = .32$ ,  $p < .001$  respectively. Thus, the hypothesis was supported and, for men and women, there does appear to be a relationship between self-critical subjective feelings and recollections of parents as controlling or overprotective.

Hypothesis 5. Women with higher introjective depression recall difficulties in the affective bond with fathers (low in affection) and paternal power and control during development.

For women, no significant relationship was found between the DEQ Self-Criticism scale and the Paternal Care scale scores,  $r(110) = -.15$ ,  $p = .12$ . Thus, contrary to the prediction, for women, there is no relationship between self-critical subjective feelings and recollections of problems in the affective bond with fathers. Interestingly, however, for men, a significant unhypothesized relationship was found between the DEQ Self-Criticism scale and the Paternal Care scale scores,  $r(97) = -.25$ ,  $p = .01$ .

Hypothesis 6. Individual with severe depression also have both anaclitic and introjective symptoms of depression.

For men and women, the BDI correlated positively with both the DEQ Dependency scale and the DEQ Self-Criticism scale scores, for men,  $r(85) = .32$ ,  $p < .01$  and  $r(85) = .60$ ,  $p < .001$  respectively, for women,  $r(107) = .44$ ,  $p < .001$  and  $r(107) = .60$ ,  $p < .001$  respectively. Thus, the hypothesis was entirely supported and there appears to be a relationship between the presence of both dependent and self-critical subjective feelings and the degree of depressive symptomatology in men and women.

#### Exploratory Analyses

Some additional analyses were performed which might provide useful peripheral contributions to the literature. For example, a correlation matrix was constructed to determine the presence of associations among the DEQ scales and the IIP and ATQ. It was believed that testing these additional hypotheses would possibly provide useful information regarding the construct validity of Blatt's anaclitic and introjective depression.



Associations between introjective depression and the presence of dysfunctional attitudes and between anaclitic depression and interpersonal distress were expected and supported by our analyses. The DEQ Self-Criticism scale was positively correlated with ATQ scores,  $r(213) = .67, p < .001$  and IIP scores,  $r(209) = .48, p < .001$  and the DEQ Dependency scale was also positively correlated with ATQ scores,  $r(213) = .44, p < .001$  and with IIP scores,  $r(209) = .42, p < .001$ .

Despite the support for this general expectation, the relationship between introjective depression and the presence of dysfunctional attitudes was expected to be stronger than the relationship between introjective depression and the presence of interpersonal distress. Likewise, the correlation between anaclitic depression and interpersonal distress was expected to be stronger than the correlation between anaclitic depression and the presence of dysfunctional attitudes. When looking at the analyses conducted on males and females together, the results indicate that these expectations were supported only for the relationship between introjective depression and the presence of dysfunctional attitudes and interpersonal distress. See Table 8 for a summary of these correlations.

Table 8

Relationships Between Subjective Feelings of Depression and Interpersonal and Cognitive Functioning

	IIP	ATQ
<u>Males and Females</u>		
DEQ Dependency	.42*	.44*

DEQ Self-Critical	.48*	.67*
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Males

DEQ Dependency	.48*	.40*
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DEQ Self-Critical	.43*	.66*
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Females

DEQ Dependency	.38*	.48*
----------------	------	------

DEQ Self-Critical	.53*	.69*
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\*  $p < .001$

For men, these patterns do hold true for the DEQ Self-Critical scale and minimally for the Dependency scale. For women, the pattern holds true only in the case of a stronger association between self-critical depression and dysfunctional attitudes,  $r(114) = .69, p < .001$  than between self-critical depression and the presence of interpersonal distress,  $r(112) = .52, p < .001$ , but this difference is smaller than it is for men.

## CHAPTER 4

### DISCUSSION

#### Discussion of Hypotheses

The primary purpose of this thesis was to test the hypothesis that depressive symptoms, which are characterized by dependent and self-critical subjective feelings, are associated with recollections of early interactions with parent figures. Furthermore, we wished to see whether males and females may be differentially affected by parenting styles and therefore may subsequently tend to develop depressive symptoms characterized more strongly by either dependent or self-critical subjective feelings. Psychoanalytic theory suggests that individuals with anaclitic depression are more likely to recall difficulties in their relationships with their mothers. However, individuals with introjective depression are likely to recall difficulties in their relationships with both parent figures.

The results of this study are inconclusive in that some significant findings support the research literature but are inconsistent with theory, and vice versa for other results. In the following paragraphs the purpose of this study is addressed by considering each hypothesis in detail and discussing limitations and implications for research and clinical practice.

Based on Parker's (1979) theory that "affectionless control" is an antecedent to adult depression, it was first hypothesized that there would be a correlation between the

level of depression reported by the participants and their perceptions of overall low parental care and high parental control. Indeed, we found support for Parker's theory except that, for men, recollections of paternal control and, for women, recollections of paternal care seem unrelated to the presence of depressive symptoms.

The finding that paternal control is unrelated to depression in males is not surprising as most studies have found that recollections of maternal control are most predictive of depression in adults (reviewed in Burbach and Borduin, 1986). Likewise, the finding that paternal care is unrelated to depression in females is intriguing but it does support Parker's finding that depressed women are more likely to report maternal than paternal "affectionless control" (Parker, 1979).

However, these findings do not support Parker's (1979) theory. Parker (1979) reported that care is the major parental dimension influencing the development of depression in adults. This would support the finding that paternal control is unrelated to depression in males, except that for women this is not the case. One could further speculate that this finding would support psychoanalytic theory for the males in our sample who may have anaclitic depression, and thus may have been influenced more strongly by maternal factors. If that was the case, then paternal care would also be expected to have no relationship with the development of depression in males. However, our results show that the anaclitic males in our sample do tend to recall controlling fathers, and there is no indication that the male sample used to test this hypothesis has anaclitic depression.

For females, the finding that paternal care is unrelated to depression also does not appear to support theory. It is inconsistent with the theoretical and empirically-tested statement that low parental care is the major predictor of depression in adults (Parker, 1979). However, this finding would make sense, according to psychoanalytic theory, for those women in our sample who may have anaclitic depression. The results indicate that, indeed, women with anaclitic depression do not recall difficulties in their relationships with their fathers in either dimension of care or control. However, like men, there is no indication in our analyses that the female sample used to test this hypothesis has predominantly anaclitic depression.

Finally, in interpreting this hypothesis one must also consider that we used a non-clinical sample where the average participant would be described as having no depression or minimal depression. This hypothesis was based on findings from studies which used clinical samples (Parker, 1979, 1983). In addition, most individuals view their mothers positively in terms of care and affection, and not especially controlling. Fathers also tended to be seen as positive in terms of care and also not especially controlling. Also, results from these analyses yielded small to moderate effect sizes (significant correlations ranged from .28 to .48).

The second hypothesis stated that, for men and women, a correlation was expected between anaclitic depression and the mother seen as emphasizing strict control. This hypothesis was based partly on theory and on findings by McCranie and Bass (1984) who found that individuals high on dependency recall their mothers as dominant and emphasizing strict control. This hypothesis was only partially supported. There is a

relationship between anaclitic depression and recollections of maternal control for women, but not for men. This contradicts the findings by McCranie and Bass but supports Whiffen and Sasseville's (1991) finding that none of the parenting variables helped in predicting dependency.

For additional comparison it is interesting to note that, for males only, there was a significant relationship between anaclitic depression and paternal control. Contrary to psychoanalytic theory, which predicts that paternal influence is important only in later, post-Oedipal development, this finding suggests that, in terms of paternal control and its relationship with anaclitic depression, it is the parent of the same gender who is recalled as having the most influence and correlates with the development of depression in adults.

Although this finding applied to females only, it is consistent with psychoanalytic theory which states that maternal figures may be central to the development of anaclitic depression. For males, there is no relationship between anaclitic depression and maternal control, which is inconsistent with psychoanalytic theory. However, interestingly there is a relationship between anaclitic depression and maternal care for males. This does support psychoanalytic theory as well as Parker's (1979) statement that low parental care is most predictive of depression in adults. Despite the partial support of the research literature and theory, the effect size of the relationship found between dependency and maternal control for women was small and may not be clinically relevant.

As a final note on this issue, there is a possibility that the use of Blatt's weighted scoring system for the DEQ would have yielded non-significant results for both sexes with regard to the relationship between anaclitic depression and maternal control.

According to our analyses, Blatt's version of the Dependency scale is uncorrelated with maternal control for males and females together. However, if Blatt's version was used then the findings would be inconsistent with theory.

Our third hypothesis was not based on theory but was used to test the Rosenfarb et al. (1994) finding that dependency is related to recollections of having a distant relationship with their father in their childhood. Following this finding we expected, for women only, a correlation between anaclitic depression and fathers seen as distant (low in affection and control). We found no support for this hypothesis. According to our analyses, for women there appears to be no relationship between feelings of dependency and recollections of paternal distance. This finding is consistent with psychoanalytic theory but does not support the research finding that women are more likely than males to report anaclitic depression because of the added difficulty in the perceived relationship with the father.

Looking closer at Rosenfarb et al.'s (1994) finding we discovered that they also found no relationship between dependency and self-reported recollections of paternal distance. Their finding of a relationship between dependency and paternal distance was derived primarily from associations between anaclitic depression and nonverbal measures which assess degree of closeness between subjects and their parents at various developmental stages through the use of drawings. Citing McCranie and Bass (1984) who state that dependent individuals tend to deny problems with parental figures for fear of disrupting these relationships, Rosenfarb et al. suggested that "dependent women may

tend to verbally report having been spoiled or overindulged by their parents but may not readily report the absence of love or attachment.” (p. 673).

Despite the possible validity of this argument, if Rosenfarb’s et al. (1994) argument is supported by research, it would be inconsistent with psychoanalytic theory which predicts that fathers become influential only in later developmental phases in the child’s life. According to Blatt’s definition, anaclitic depression is associated with not having early developmental needs met (Rosenfarb et al., 1994). Psychoanalytic theory suggests that in a child’s early, pre-oedipal development the central parental figure is the mother. Thus, if recalled difficulty in the relationship with fathers using nonverbal measures is found to be related to the development of anaclitic depression, then these findings would not support either psychoanalytic theory or Blatt’s theory that anaclitic depression is related to relational difficulties in early development.

Based on the McCranie and Bass (1984) finding that parental control predicted self-criticism, our fourth hypothesis stated that, for men and women, a correlation should exist between introjective depression and both parents seen as emphasizing strict control. We found support for McCranie and Bass’s finding; there does appear to be a relationship between self-critical subjective feelings and recollections of parents as controlling or overprotective for both men and women.

This finding also supports the literature and theory on the relationship between parenting and the development of self-critical subjective feelings. Whiffen and Sasseville (1991), for example, also found that maternal emphasis on achievement and paternal control and demands for conformity predicted self-criticism. Also, Rosenfarb et al.



(1994) found that, for women, self-criticism appears to be marginally related to recollections of paternal power and control.

This finding is also consistent with theory. As discussed in the introduction, Blatt (1974 unpublished manuscript, as cited in Zuroff, Moskowitz, Wielgus, Powers, & Franko, 1983) defined introjective depression as being developmentally more advanced than anaclitic depression. This suggests that introjective depression may be developmentally related to an Oedipal or post-Oedipal period where, according to psychoanalytic theory, relationships with father figures become more important and the task is identification with the same-gender parent. Thus, the finding that self-criticism is related to recollections of both parents as controlling or overprotective for men and women, supports Blatt's theory.

It is unclear, however, how clinically significant this finding is. The correlations yielded by our analyses indicate small effect sizes across the board for both genders. However, when examining the correlations between self-criticism and parental control for men and women separately, we found some differences in effect sizes that may prove to be clinically relevant. A larger effect size was found for women in the relationship between maternal control and self-criticism, when compared to that for paternal control and self-criticism, explaining about twice as much variance in the Self-Criticism scale of the DEQ. Although not as pronounced, for men also a stronger effect size occurred between paternal control and self-criticism compared to the effect size for maternal control and self-criticism, explaining about 7% of the variance in the Self-Criticism scale of the DEQ compared to 4% of the variance. Overall, it appears as though for women,

maternal control and, for men, paternal control is more influential or critical than that of the other parent in the development of self-critical feelings. This is consistent with psychoanalytic theory, since the task associated with later development, which is, in turn, related to introjective depression, is identification with the same-gender parent. Thus, the influence of this same-gender parent on childhood development, and the correlation of this influence with depression, might be more significant than the influence of the other parent.

The fifth hypothesis stated that, for women only, we expected a correlation between introjective depression and difficulties in the affective bond with fathers (low in affection). This hypothesis was based on the Rosenfarb et al. (1994) finding that self-criticism in women is related to recollections of problematic affective bonds with fathers. Contrary to prediction, for women, there appears to be no relationship between self-critical subjective feelings and recollections of problems in the affective bonds with fathers. This finding would support psychoanalytic theory rather than Rosenfarb's et al. results; in this sample the influence of the same-gender parent seems to be more significant than the influence of the other parent in the development of introjective depression.

In our hypothesis we inferred that recollections of difficulties in the affective bonds with fathers could be translated to mean that fathers were seen as being low in affection. However, Rosenfarb et al. (1994) indicate that there is a difference between the relative absence of an affective "bond" and low affection. Rosenfarb et al. go on to suggest that this disruption of the affective bond is directly related to perceptions of

fathers as controlling. Thus, our lack of support for this hypothesis may be due to our incorrect assumption that affection is an orthogonal construct, with regard to control, and that low affection has the same meaning as “disruptions in the quality of the affective bond.”

In examining our data, we find possible support for this argument. Although the finding was not significant and accounted for only 2% of the variance in the Self-Criticism scale of the DEQ, the correlation between self-criticism and low paternal affection was in the predicted direction. An interaction with paternal control might have increased the effect size of the correlation between paternal affection and self-criticism, thus making it significant.

Our sixth hypothesis was based on the Rosenfarb et al. (1994) finding that women who were both dependent and self-critical were likely to be severely depressed. Theoretically, we assumed that the same would be true for men. Thus, we expected to find more severe depression to correlate with the presence of both anaclitic and introjective symptoms of depression for both men and women. This hypothesis was entirely supported and there does appear to be a relationship between the presence of both dependent and self-critical subjective feelings and the degree of depressive symptomatology in men and women. In addition, this hypothesis was also supported when using Blatt’s weighted scoring of the DEQ. However, the effect size for the correlations between the dependency scale of the weighted version of the DEQ and the BDI was slightly smaller than the one between the unweighted version and the BDI.

Thus, the findings using the unweighted version of the DEQ yielded results that are more consistent with theory.

This finding makes theoretical sense as the DEQ, which measures quantity of self-critical and dependent feelings, is a measure of depression and is thus expected to correlate with other measures of depression. Indeed, our findings indicate moderate effect sizes ranging from .3 to .6 which indicate clinical relevance for this finding. However, these moderately high correlations may be due partly to method variance as they are both self-report measures. In addition, the correlations between self-criticism and depression were consistently stronger than the ones between dependency and depression. This may also be related in part to the BDI's content validity because the BDI emphasizes the assessment of cognitive as opposed to interpersonal functioning, and thus would be expected to correlate higher with the Self-Criticism scale than the Dependency scale of the DEQ, as the former measures cognitions (thoughts) and the latter measures interpersonal distress.

These theoretical associations between the DEQ Self-Criticism and Dependency scales and measures that emphasize cognitive and interpersonal functioning were tested in exploratory analyses. These associations were based on Blatt's (1991) description of individuals with anaclitic depression as being dependent and interpersonally-oriented whereas individuals with introjective depression are more ideational and stress their separation and autonomy. Following this description, one might infer that anaclitic individuals may have more interpersonal difficulties when compared to introjective individuals, who would have more ideational or cognitive concerns. It was thus

hypothesized that there would be a correlation between anaclitic depression and reports of higher degrees of interpersonal distress, and also introjective depression and the presence of dysfunctional attitudes. The predictions were entirely supported. However, contrary to our conceptual predictions, the DEQ Self-Criticism scale was also correlated quite highly with interpersonal functioning, although the correlation between self-criticism and dysfunctional attitudes was much greater than the one between self-criticism and interpersonal functioning ( $r = .67$  vs  $.48$ ). Similarly, we found that the DEQ Anaclitic scale was correlated with the measure of cognitive functioning. However, this correlation was not much different than the correlation between dependency and interpersonal functioning.

A possible explanation for this finding is that all of these measures are theoretically expected to correlate with each other as they are all measures associated with depression. Indeed, our results show that the measures of introjective and anaclitic depression, as well as the measures of interpersonal distress and dysfunctional attitudes, are all correlated significantly with depression symptoms. In addition, upon closer examination of the consistently higher correlations between introjective depression and the presence of dysfunctional attitudes, it was clear that the content of the dysfunctional attitude items also measures self-critical attitudes. This connection is not as clear-cut in the relationship between the measures of anaclitic depression and the presence of interpersonal distress.

Overall, these findings tentatively support Blatt's (1991) theory and research regarding treatment effectiveness for individuals with anaclitic and introjective

depression as well as the findings from the NIMH study on characteristics of depression which are most predictive of positive response to cognitive and interpersonal therapy (Sotsky et al., 1991). It may be useful to separate depressed clients along dimensions of interpersonal and cognitive dysfunction in order to choose a treatment that will be appropriate for addressing the core difficulties experienced by depressed individuals. However, more conclusive statements regarding the usefulness of this theory require measurements that more clearly represent the underlying interpersonal and cognitive factors present in anaclitic and introjective depression.

#### Summary of Findings

In discussing the findings from the analyses, the success and failure of each hypothesis was considered in terms of consistency with the research literature and theory, and also measurement or research design factors. It is difficult to make one conclusive statement regarding the findings because some were consistent with the research literature and inconsistent with theory, whereas others supported theory but contradicted previous findings. What can be said conclusively is that the results of this study provide further evidence for the usefulness of Blatt's theory in assessing depression via dependent and self-critical subjective feelings. Furthermore, the relationships found between recollections of parenting and depressive symptoms support psychodynamic/object-relations and other interpersonal theories of depression with their emphasis on the influence of early interactions with parental figures on the development of psychopathology. Finally, the results provide support for the literature on the existence of gender differences in the manifestation of depression and recollections of parenting.

### Weighted and Unweighted Versions of the DEQ

As part of this study, the two scoring versions of the DEQ were compared. The results indicated that the two scales of the unweighted DEQ were highly correlated with the corresponding scales comprising the weighted DEQ. However, the unweighted dependent and self-critical scales are moderately and significantly correlated with one another whereas the weighted scales appear to be orthogonal (not significantly correlated with one another).

Klein's (1989) findings are consistent with the results of this study. He reported that the unweighted version of the DEQ is valid, reliable, and mostly comparable to the weighted version of the DEQ. However, he goes on to say that the two versions are not interchangeable when relationships between the subscales are important, as in using multivariate statistics or using a median split procedure to select individuals that score high on one scale and low on the other.

The present analyses did not require the use of multivariate statistics or median splits. Correlations were used to test the hypotheses to preserve the useful scale variability. A median split would have changed the DEQ scales from continuous to categorical variables and thus, would not have been easily comparable to the other scales used in this study. Thus, the unweighted version of the DEQ was more appropriate for this study. The only apparent impact of this choice on the hypotheses tests may have been for Hypothesis 2 which was support for the existence of a relationship between anaclitic depression and maternal control, for women but not for men. As mentioned previously, if

Blatt's weighted version was used the results may have contradicted previous research findings and been inconsistent with psychoanalytic theory.

As described in the above summary of findings, there seems to be a lack of consistent connection between theory and research findings in this area. Multivariate analyses may be useful in developing a more appropriate theory to explain the relationships between anaclitic and introjective depression, recollections of parenting, and gender interactions. Part of this process might involve clarifying the descriptions of anaclitic and introjective individuals by making conceptually clearer distinctions between these two types of depression. These suggestions for future research may be more adequately tested with the use of Blatt's weighted version of the DEQ.

#### Limitations of This Study

One main limitation of our study was the use of a non-clinical sample in an exploration of depression. Although Blatt used introjective and anaclitic dimensions in reference to normal feelings of depression experienced at subclinical levels, the hypothesized associations between these terms and parental care and control were based on findings from clinical populations. This may explain some of the findings which were inconsistent with the literature but also has implications regarding the generalizability of the findings to clinical populations.

Another limitation of our study was the use of one measure of parental attachment. This measure was used for its theoretical compatibility with the measure of anaclitic and introjective depression. However, it is difficult to capture the complex and dynamic relationships between children and parents with a measure that yields



information about only two dimensions or qualities of this relationship. In our hypotheses we inferred that recollections of paternal distance could be translated to mean that fathers were seen as low in affection and control. As the findings by Rosenfarb et al. (1994) suggest, “paternal distance” may be a construct that, in its complexity, can only be captured nonverbally, through a drawing. However, the definition of “paternal distance” remains unclear and may interfere with the interpretability of findings that relate this construct with dependency. Finally, another significant limitation of the parenting measure used in this study is that it does not attempt to capture the distinction between Oedipal and pre-Oedipal memories; it may tap different levels of maturation for different people or what is most emotionally salient.

A further limitation of this study was the use of relatively simple statistics in the evaluations of our hypothesis. The relative influence of the variables on one another was not explored and could yield more specific information regarding the relationships between our variables. In addition, it is likely that complex interactions among the variables in this study were undetected as a result of these simple analyses. Multiple regressions are recommended for future research exploring such variables as gender and parenting.

A related limitation of this study may explain the reason why there were gender differences that did not support theory. It is likely that the division of the theoretical “parental influence” into care and control dimensions may have influenced the results by interacting in ways which were not discovered by our simple analyses. Research studies suggest that lack of parental care is a predominant factor in depression and “criticism or

intrusive parental control is a second but somewhat less frequent factor” (Blatt & Zuroff, 1992, p. 544). In addition, according to the literature, there are complex interactions between care and control that influence the development of anaclitic and introjective depression (Blatt & Zuroff) and which also may be more influential, and thus cancel out any potential finding on gender differences.

A final limitation of this study is also related to the reason for gender differences in this study that did not support the literature or theory. The definition of “gender” is more complicated than research and theory has led us to believe. Today, it is becoming increasingly difficult to categorize men and women according to traditional gender roles. Twenge (1999) emphasizes the importance of “...a framework for studying individual differences in masculine and feminine attributes as they occur within the *within* the sexes” (p. 486). Thus, a limitation of this study was the assumption that gender is a construct that yields two orthogonal categories, when, in reality the categories are not independent of one another and there are males with “feminine” attributes and females with “male” attributes. A more effective way of testing the hypotheses would have been to specify which attributes are related to the constructs studied in this thesis.

#### Implications for Research and Clinical Practice

How can psychologists work to best serve those in need of psychological treatment? The best answer is to provide specific information about the etiology and symptoms of mental disorders. Assessment is vital to this process as it provides professionals with the information they need to aid them in developing an appropriate and individualized treatment strategy for each client. Following this argument, the larger

purpose of this thesis was to provide more detailed information about the etiology and manifestation of depression and the foundation for a more extensive study on the different types of therapeutic contexts and processes that may benefit specific types of depressed individuals. Although the results from our study were inconclusive, there are implications for research and clinical practice.

The inconsistent findings from this study highlight one major implication for research: the need for a unifying theory that consistently explains the findings linking anaclitic and introjective depression with recollections of parenting. Although Blatt has attempted to provide a theoretical model of depression by differentiating between depression focused on interpersonal issues (dependency) and depression focused on self-definition (self-criticism), his theory does not effectively explain the inconsistent findings.

A more refined and parsimonious theoretical model, in turn would have implications for clinical practice. As mentioned above, a more thorough understanding of depression can enable practitioners to choose treatments that are more likely to be effective with their clients.

APPENDIX  
BACKGROUND INFORMATION FORM

## BACKGROUND INFORMATION FORM

Id# \_\_\_\_\_

Please answer the following questions before reading further:

1. Have you ever been depressed? \_\_\_\_\_ 1) No, Never  
\_\_\_\_\_ 2) Yes, once or twice  
\_\_\_\_\_ 3) Yes, several times  
\_\_\_\_\_ 4) Yes, fairly often
  
2. Please describe what the experience of being depressed is like for you. Compared to times when you are not depressed, how do you know that you are depressed?

## Demographics

Please answer these questions by marking one line:

1. Gender: \_\_\_\_\_ 0) Male \_\_\_\_\_ 1) Female

2. Years of age: \_\_\_\_\_

3. In which group do you mostly place yourself?

\_\_\_\_\_ 1) African-American/Black

\_\_\_\_\_ 4) Caucasian

\_\_\_\_\_ 2) American Indian/Alaskan Native

\_\_\_\_\_ 5) Hispanic/Latino

\_\_\_\_\_ 3) Asian/Pacific Islander

\_\_\_\_\_ 6) Other \_\_\_\_\_

4. What is your current marital status?

\_\_\_\_\_ 1) Single (never married)

\_\_\_\_\_ 4) Widowed

\_\_\_\_\_ 2) Married

\_\_\_\_\_ 5) Divorced

\_\_\_\_\_ 3) In committed relationship

\_\_\_\_\_ 6) Separated

5. Do you have any children? \_\_\_\_\_ 0) No

\_\_\_\_\_ 1) Yes (including step or

adopted)

6. How many children? \_\_\_\_\_

4. How far did you go in school?

\_\_\_\_\_ 1) Less than 10<sup>th</sup> grade

\_\_\_\_\_ 5) Bachelors degree

\_\_\_\_\_ 2) Completed 10<sup>th</sup> grade

\_\_\_\_\_ 6) Masters degree

\_\_\_\_\_ 3) High school graduate or GED

\_\_\_\_\_ 7) Ph.D., doctorate, M.D.,

J.D.

\_\_\_\_\_ 4) Some college, associate degree

\_\_\_\_\_ 8) Other \_\_\_\_\_

5. Current employment:

- |   |                             |
|---|-----------------------------|
| _____1) Employed full time or more                          | _____4) In school full time |
| _____2) Employed part-time (less than<br>35 hours per week) | _____5) Homemaker           |
| _____3) Self-employed                                       | _____6) Unemployed          |
|   | _____7) Retired or disabled |

6. Job title and description (currently or when you were last employed):

7. In this job, do you or did you supervise other employees? \_\_\_\_0) No \_\_\_\_1) Yes

### Social Perceptions and Activities

1. Would you say that you have a confidant—someone with whom you have a close, confiding relationship and with whom you can share your private feelings? (Please check one.)  
\_\_\_\_\_0) \_\_\_\_\_1) sometimes, about some things \_\_\_\_\_2) usually, about most things
2. What is that person's relationship to you? \_\_\_\_\_
3. How often do you see or talk with friends? (Please check one.)  
\_\_\_\_\_0) never or rarely \_\_\_\_\_1) less than once a month \_\_\_\_\_2) 1-4 times per month  
\_\_\_\_\_3) 1-4 times per week \_\_\_\_\_4) almost every day \_\_\_\_\_5) more than once a day
4. How often do you see or talk with relatives? (Please check one.)  
\_\_\_\_\_0) never or rarely \_\_\_\_\_1) less than once a month \_\_\_\_\_2) 1-4 times per month  
\_\_\_\_\_3) 1-4 times per week \_\_\_\_\_4) almost every day \_\_\_\_\_5) more than once a day
5. How often do you attend meetings of clubs or organizations (including work-related, service, fraternal, civic, or recreation organizations)?  
\_\_\_\_\_0) never \_\_\_\_\_1) rarely \_\_\_\_\_2) 3-6 times per year  
\_\_\_\_\_3) every month or two \_\_\_\_\_4) 1-4 times per month \_\_\_\_\_5) more than once  
a week
6. How often do you meet with informal groups of people who often see each other but are not organizations with official rules? (For example, to play games or hang out.)  
\_\_\_\_\_0) never \_\_\_\_\_1) rarely \_\_\_\_\_2) 3-6 times per year  
\_\_\_\_\_3) every month or two \_\_\_\_\_4) 1-4 times per month \_\_\_\_\_5) more than once  
a week



7. How often do you go to religious services?

- \_\_\_\_\_0) never \_\_\_\_\_1) rarely or holidays only \_\_\_\_\_2) 3-6 times per year  
\_\_\_\_\_3) every month or two \_\_\_\_\_4) 1-4 times per month \_\_\_\_\_5) more than once  
a week

## Medical Background

1. Please list any medical problems that you have:

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2. Are you currently taking any medication prescribed by a medical professional?

\_\_\_\_\_0) No \_\_\_\_\_1) Yes—What medication(s)?

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3. Have you ever had a period in your life when you were feeling depressed or down most of the day nearly every day for at least two weeks? \_\_\_\_\_0) No \_\_\_\_\_1) Yes

4. Have you ever had a period in your life when you were feeling a lot less interested in most things or unable to enjoy the things you used to enjoy, and felt that way most of the day on most days for two weeks or more? \_\_\_\_\_0) No—skip to Question 11 if you

said “no” to #4

\_\_\_\_\_1) Yes

5. Have you had more than one time like that? \_\_\_0) No \_\_\_1) Yes \_\_\_2) Several times

6. Please describe how these depressed periods are different from normal periods of sadness.

7. Just before this period or periods began, were you physically ill, pregnant, or had just given birth? \_\_\_0) No \_\_\_1) Yes, but not every time \_\_\_2) Yes, each time (or the only time)

8. Just before this period or periods began, were you taking any medications or street drugs? \_\_\_0) No \_\_\_1) Yes, but not every time \_\_\_2) Yes, each time (or the only time)
9. Did this begin soon after someone close to you died? \_\_\_0) No \_\_\_1) Yes, but not every time \_\_\_2) Yes, each time (or the only time)
10. For any of those times, did you have serious problems at home, at school, or at work because of how you were feeling? \_\_\_0) No \_\_\_1) Yes, At least once
11. Have you ever been diagnosed with depression by a physician or mental health professional? \_\_\_0) No \_\_\_1) Yes
12. Have you ever received outpatient psychotherapy?  
\_\_\_0) No \_\_\_1) Yes, for depression \_\_\_2) Yes, but not for depression
13. Have you ever been an inpatient in a psychiatric hospital or unit?  
\_\_\_0) No \_\_\_1) Yes, for depression \_\_\_2) Yes, but not for depression
14. Do either of your parents have a history of depression?  
\_\_\_0) No \_\_\_1) Maybe \_\_\_2) Yes \_\_\_3) Don't know
15. Have you ever had a problem with drinking alcohol too much, or has anyone else ever told you that you did?  
\_\_\_0) No, I never drink alcohol \_\_\_1) No, no problem \_\_\_2) Yes
16. Have you ever had a problem with using street drugs too much, or has anyone else ever told you that you did?  
\_\_\_0) No, I never use drugs \_\_\_1) No, no problem \_\_\_2) Yes

17. Do either of your parents have a history of alcoholism or drug abuse?

\_\_\_0) No \_\_\_1) Maybe \_\_\_2) Yes \_\_\_3) Don't know

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