The Anaclitic-Introjective Depression Assessment: Development and Preliminary Validity of an Observer-Rated Measure

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Abstract

Background: The two-configurations model developed by Blatt and colleagues offers a comprehensive conceptual and empirical framework for understanding depression. This model suggests that depressed patients struggle, at different developmental levels, with issues related to dependency (anaclitic issues) or self-definition (introjective issues), or a combination of both.

Aims: This paper reports three studies on the development and preliminary validation of the Anaclitic-Introjective Depression Assessment (AIDA), an observer-rated assessment tool of impairments in relatedness and self-definition in clinical depression based on the item pool of the Shedler–Westen Assessment Procedure (SWAP-II).

Method: Study 1 describes the development of the measure using expert consensus rating and Q-methodology. Studies 2 and 3 report the assessment of its psychometric properties, preliminary reliability, and validity in a sample of 128 patients diagnosed with treatment-resistant depression.

Results: Four naturally occurring clusters of depressed patients were identified using Q-factor analysis, which, overall, showed meaningful and theoretically expected relationships with anaclitic/introjective prototypes as formulated by experts, as well as with clinical, social, occupational, global, and relational functioning.

Conclusion: Taken together, findings reported in this paper provide preliminary evidence for the reliability and validity of the AIDA, an observer-rated measure that allows the detection of important nuanced differentiations between and within anaclitic and introjective depression.

Key Practitioner Message

- A multi-dimensional and hierarchical model of treatment-resistant depression might provide a better understanding than viewing it as a homogeneous syndrome that is particularly resistant to change.
- The AIDA, an observer-rated clinical assessment tool presented in this study, addresses the limitations of self-report questionnaires to detect more subtle and nuanced aspects of depression that clinicians are concerned with.
- The present findings, if further replicated, promise to provide practitioners with a tool to assess important distinctions in personality functioning among depressed patients.
- The AIDA might also be used to investigate possible differential treatment effects, allowing clinicians to tailor treatments in accordance with the individual's needs and capacities.

Keywords: Anaclitic, Introjective, Severe depression, Q-methodology, Q-factor analysis, levels of functioning

The 1980s heralded a sea-change in the conceptualization and assessment of mental disorders. A major shift was the assumption that clinical disorders are categorically distinct from subclinical disorders and personality. As such, depression has come to be understood as a unitary disease predominantly caused by biological and/or genetic abnormality (Spitzer, Williams, & Skodol, 1980). The emphasis on individuals' contextual factors that hitherto guided the understanding of its etiology, presenting clinical picture and treatment was replaced by an approach entirely focused on its manifest symptoms. However, we suggest there is a need for a return to a conceptualization of depression in which the focus is on the personal and social psychology of the individual (Blatt, 2004). Several authors have formulated theories aimed at explaining heterogeneity in depression. One important theoretical approach in this context has proposed a distinction between two dimensions in depression, one focused on relational issues and the other focused on self-definitional concerns. Most research in this area has focused on Blatt's (1974, 2004, 2008) two-configurations model as in integrates similar views advanced by Beck (1983), from a cognitive-behavioral perspective; Horowitz et al. (2006), from an interpersonal perspective; and Mikulincer and Shaver (2007), from a contemporary attachment perspective (see Luyten & Blatt, 2013, 2016, for a detailed summary).

The two-configurations model essentially proposes that normal personality development proceeds along two primary dimensions: One concerned with forming and maintaining mature and satisfying relationships (the *relatedness* dimension), and the other concerned with developing a stable, realistic, and positive sense of self (the *self-definition* dimension). Psychopathology is thought to occur when, as a result of interactions between biological, environmental, and psychological factors, the balance between the two is disrupted, leading to the overemphasis of one and the neglect of the other. Blatt used the terms *anaclitic* and *introjective* to describe the corresponding pathological expressions. As such, individuals with *anaclitic depression* would primarily express difficulties with dependency and need gratification in relation to others. Their depressive experience would be shaped by feelings of emptiness and loneliness, and intense fears of being abandoned and left unprotected. The experience of individuals with *introjective depression*, in contrast, would primarily be based on issues of self-definition, and includes an overemphasis on feelings of worthlessness, guilt, failure, blame, and extreme criticalness. Embedded within the model is the assumption that these exaggerated concerns are situated and expressed at different developmental levels. These reflect different types of concerns, which can range from basic to intermediate and then to more complex or advanced expressions of struggles with

interpersonal relatedness and self-definition, regardless of duration, severity and symptomatology (Blatt, 1995; Blatt, Zuroff, Hawley, & Auerbach, 2010).

Most research has largely relied on four widely used self-report measures to assess problems with self-definition and relatedness: the Depressive Experiences Questionnaire (DEQ; Blatt, D'Afflitti, & Quinlan, 1976); the Sociotropy-Autonomy Scale (Beck, Epstein, Harrison, & Emery, 1983), the Dysfunctional Attitudes Scale (Weissmann & Beck, 1974), and the Personal Style Inventory (Robins & Luten, 1991). Research using these instruments has in general provided strong empirical evidence for the assumption that anaclitic and introjective individuals show marked differences in their clinical expression of depression (e.g., Luyten, Blatt, Van Houdenhove, & Corveleyn, 2006), personality style (e.g., Blatt & Luyten, 2009), interpersonal problems (e.g., Dinger et al., 2015), and responsiveness to treatment and how they demonstrate therapeutic gain (e.g., Blatt et al., 1994, 2010). However, capturing the clinically observed hierarchical and multi-dimensional variations of expressions within each configuration has been much more difficult. Whilst available self-report measures may be useful for the assessment of broader issues in relation to *relatedness* and *self-definition* in subclinical depression, they may not be sensitive enough to detect subtle variations in disruptions of both, but which may be important in tailoring treatment. This calls for the need to develop an alternative assessment instrument.

The importance of acknowledging their heterogeneous nature and hierarchical structure has been stressed by several authors other than Blatt (e.g., Bagby and Rector, 1998; Birtchnell, 1999; Bornstein, 1994). Re-analysis of the DEQ, for example, has consistently revealed two sub-factors of the dependency scale (e.g., Rude & Burnham, 1995; Zuroff et al., 2004). The first sub-factor describes an immature and maladaptive reliance on others, while the second relates to a more mature intimacy-oriented relating in response to the potential or anticipated loss of a specific person. Morgan and Clarke's (2010) review of the available studies on dependency concluded that there was substantial evidence that it may be expressed at different levels of functioning. The Interpersonal Circumplex (IPC, Alden, Wiggins, & Pincus, 1990), a two-dimensional circular model of interpersonal problems that has been utilized frequently by researchers to explore the differential interpersonal patterns between individuals falling into either configuration, has revealed various variations in dependency ranging from more adaptive to maladaptive (e.g. Pincus & Gurtman, 1995; Pincus & Wilson, 2001). Similarly, Thompson and Zuroff (2004) identified two subscales in the DEQ self-criticism scale. The authors found that one subscale was positively associated with agreeableness and conscientiousness as well as with secure attachment, while the other

showed negative associations with adaptive functioning and was associated positively with fearful-avoidant attachment. While the above findings seem promising, they are limited in that these studies have mostly relied on nonclinical populations. Furthermore, research has not addressed the well-known biases to which self-report instruments are prone. These include their vulnerability to defensive and self-presentational bias, in particular with regard to undesirable symptoms or characteristics (Thomas, Turkheimer, & Oltmanns, 2003) and to individuals whose personality or pathology restricts access, such as patients who might be caught up in their own depression (Westen & Weinberger, 2004). An observer-rated measure assessing impairments in relatedness and self-definition might circumvent these limitations.

Patients with treatment-resistant depression are currently at a serious disadvantage due to the shortage of research evidence guiding their clinical management. A multi-dimensional and hierarchical model might provide a better conceptualization of these forms of depression than viewing them as a homogeneous syndrome that is particularly resistant to change. Thus, the aims of this study were: (a) to develop a new observer-rated measure assessing impairments in relatedness and self-definition in severe, treatment-resistant depression, which will be summarized in Study 1, (b) to investigate whether this measure is able to delineate anaclitic and introjective concerns at multi-dimensional and hierarchically organized levels, which will be tested in Study 2, and (c) to establish preliminary reliability and validity of the measure, which will be reported in Study 3. The hypotheses for each study are outlined in detail in the sections below.

Study 1

Development of the Anaclitic-Introjective Depression Assessment

The aim of Study 1 was to develop an observer-rated measure using expert consensus rating and Q-methodology (Stephenson, 1953; Block; 1961). This methodology has been extensively used in clinical psychology (e.g., Ablon & Jones, 1998; Block & Block, 1980; Bychkova, Hillman, Midgley, & Schneider, 2011; Cassibba, van Ijzendoorn, & D'Odorico, 2000; Shedler & Westen, 2007; Westen & Shedler, 1999). It entails asking raters to rank-order a set of statements as per their relevance or prototypicality in describing an individual, using a particular rating scale and following a fixed distribution to categorize these. It furthermore follows an ipsative approach in that defined personality descriptions are seen and

rated relative to each other. In completing this rank ordering, statements are combined to obtain a composite description of a prototypical personality (Westen & Shedler, 1999).

The development of the measure, which we called the Anaclitic-Introjective Depression Assessment (AIDA), proceeded in four steps. First, we used the well-established Shedler–Westen Assessment Procedure Q-sort (SWAP-II; Shedler & Westen, 2007) to develop the item set. The SWAP-II was chosen as it consists of 200 jargon-free statements covering a wide array of personality styles and problems, ways by which individuals regulate emotion, capacity for intimate relationships, coping strategies, and perceptions of self and others. Following an iterative process, two authors (FR and PL) identified a total of 62 out of the 200 SWAP-II items describing anaclitic and introjective depression features. Statements that were thought to capture more general physical and psychological symptoms of depression were excluded, as we wanted to avoid item-content overlap with measures of depression.

In a second step, 26 international experts who have published widely on Blatt's theory were approached. Twenty-two (85%) experts (10 female, 12 male), whose professional background was in clinical psychology, psychiatry, or psychotherapy, agreed to participate and were presented with the 62 selected SWAP-II items. Half of the experts were asked to rate each item in terms of how well it captured the characteristics and features of a prototypical individual with anaclitic depression; the other half were asked to do the same with regard to describing a prototypical introjectively depressed patient. Raters were given a Likert scale ranging from 1 (*Not at all prototypical*) to 7 (*Highly prototypical*) and the instructions to rate only eight statements as 7 (*Highly prototypical*) and ten statements as 6 (*Next most prototypical*). The remainder of the items could be given any score between 1 (*Not at all prototypical*) and 5 (*Somewhat prototypical*). To assist the rating process, a description of a prototypical patient with anaclitic or introjective depression was provided (included in the Appendix). Intraclass correlation coefficients (ICCs) were calculated to estimate the internal consistency and inter-rater agreement of the experts' prototype ratings. ICCs allow analysis of data with multiple response levels when rater agreement varies across the possible responses. ICC is a reliability coefficient between 0 and 1, with values closer to 1 indicating stronger agreement and values closer to 0 indicating weaker agreement. The item cut-off for determining the most prototypical items was a median ≥ 6. A two-way random consistency model was employed and average measures are reported (Shrout & Fleiss, 1979). Analysis revealed 14 statements that captured the prototypicality of anaclitic depression and

13 statements that captured the prototypicality of introjective depression using this criterion. The ICC for the expert anaclitic prototype was .71 (95% CI [.42, .90]; $F_{(11,638)} = 3.48$; $p < .0001$), indicating a moderate level of agreement. The ICC for the expert introjective prototype was .85 (95% CI [.69, .96]; $F_{(9,522)} = 6.85$; $p < .0001$), demonstrating a high level of inter-rater agreement (Landis & Koch, 1977). Overall, the results indicate a reliably shared understanding of the characteristics of a hypothetical prototypical anaclitic or introjective depressed patient.

In a third step, each ranked SWAP-II item was provided with a comprehensive definition and examples relevant to anaclitic and introjective depression. Following this procedure, and guided by experts' feedback, three items were removed, reducing the total set to 59 items. One of the three items was identified as a duplicate and two were discarded because they both captured aspects of anger, which was felt to dominate the overall item set.

In a final step, following a systematic piloting and revision procedure, an appropriate item distribution, including its shape and range, was determined. The ranking procedure was standardized by amending the partially fixed distribution utilized to elicit the experts' consensuses to a fixed distribution. The advantage of using a fixed over a partial distribution is its propensity to control for rater effect and minimization of error variance (Block, 2008). The finalized AIDA consists of a five-point rating scale with the following fixed distribution pattern: 20 items are to be sorted into category 1 = "*Not at all prototypical, or not enough information available,*" 14 items into category 2 = "*Slightly prototypical*," 11 items into category 3 = "*Somewhat prototypical*," 8 items into category 4 = "*Next most prototypical*," and 6 items into category 5 = "*Most prototypical*." Figure 1 provides a pictorial example. The numbers correspond to the SWAP-II items describing the personality.

Study 2

Identification of Naturally Occurring Depression Clusters using the AIDA

The aim of Study 2 was to examine the psychometric properties of the newly developed AIDA Q-sort. To that effect, the measure was used to rate a sample of 128 patients with severe, chronic depression, and exploratory Q-factor analysis was used to identify naturally occurring clusters. We expected to find clusters of patients defined by struggles with self-definition and dependency expressed at different developmental levels of functioning.

Materials and Methods

Participants

The sample consisted of 44 male and 84 female participants from the Tavistock Adult Depression Study (TADS; Fonagy et al, 2015; Taylor et al., 2012). The TADS is a pragmatic randomized controlled trial investigating the effectiveness of once-weekly psychoanalytic psychotherapy for treatment-resistant depression. All patients had a diagnosis of current major depressive disorder (MDD), and 76% had an additional diagnosis of early-onset dysthymia, as assessed by the Structured Clinical Interview for DSM-IV (SCID-I; First & Gibbon, 2004). The average length of years depressed was 25.4 years (*SD* = 12.42) and the average length of the current MDD episode was 3.7 (*SD* = 3.01) years. The majority of patients (82%) were white Caucasian and they ranged in age from 22 to 66 years (*M* = 44, *SD* = 10.31).

Procedure

Each of the 128 patients were rated with the AIDA by the first author using research and clinical material that was collected at study intake before randomization. This material included the audio-recording of the semi-structured Hamilton Rating Scale for Depression (HRSD; Hamilton, 1967), the SCID-I initial assessment interview, and the Tavistock Psychodynamic Interview (TPI; Carlyle, 2001). A detailed description of these measures can be found elsewhere (Taylor et al., 2012). The HRSD and SCID-I interviews allowed good insight to be gained of the patient's characteristics and experience of their depression on the basis of recorded elaborations and specific examples given during symptom assessment and detailed history-taking. The TPI, drawing on the Adult Attachment Interview (Main, Kaplan, & Cassidy, 1985) and the Quality of Object Relations Scale (Piper, McCallum, & Joyce, 1993), collects narrative data about the patient's representations of him/herself and key interpersonal relationships, along with important aspects of cognitive and emotional processing. After listening to this extensive assessment material, the first author rank-ordered the AIDA statements in accordance to their prototypicality of the respective patients, which took on average 20 minutes. An independent rater (a clinical psychology trainee) assessed 53 patients (41%) with the AIDA in order to establish inter-rater reliability. ICCs were calculated using the two-way random effects model and Spearman–Brown correction, presenting the mean reliability across two raters (Shrout & Fleiss, 1979). Mean single-rater ICC was .62 (range .37–.83). The ICC across both raters was .76 (range .53–.91), and .86

(range .69–.95) after correction. Both ICCs indicate good to excellent inter-rater reliability (Fleiss, 1981).

Statistical analysis

First, using the array of numerical data that was produced by the rank-ordered statements of the 128 AIDA Q-sorts, the data were subjected to Q-factor analysis, using the statistical analysis software SPSS version 22 (IBM, 2013). In line with Shedler and Westen (1999), principal component analysis was used for factor extraction, and, as there was no theoretical reason to assume complete independence of the characteristics of depressed patients, Promax with Kaiser Normalization was used to rotate the factors to produce a final oblique solution. The initial communalities for each AIDA Q-sort before rotation describe their representativeness of the group as a whole. In the present study, they ranged from .78–.96, indicating that the majority of the Q-sorts were highly representative. Following Brown's (1980) recommendation, the following criteria were used to determine the number of factors, which included using the scree plot, percentage of variance explained, and randomly splitting the dataset into two and repeating the analysis on both halves. Kaiser's Criterion, which is a frequent criterion in traditional factor analysis, was viewed with caution, as it has been found to often lead to the extraction of meaningless factors in Q-analysis (Brown, 1980). With regard to an acceptable percentage of variance explained, we followed Kline (1994), who suggested a variance in the region of 35–40% or above to be considered a sound solution. Overall, we implemented Brown's (1980) most important advice: that deciding which factor solution to accept requires judgment in relation to the meaning and significance of the theoretical criteria alongside statistical ones. Thus, we decided to compare all presenting factor solutions carefully, paying attention to both statistical indication and theoretical meaningfulness.

In the second stage of the analysis, the Q-sorts that loaded significantly on only one of the extracted factors were weighted and merged, revealing the level of agreement each statement carries within each of the identified depression clusters (Valenta & Wigger, 1997). Factor loadings represent each patient's association with each of the identified factors and can range from -1.0 to +1.0. A significant factor loading can be calculated for each particular dataset in accordance to a formula provided by Brown (1980, pp. 222–223). Following this formula, it was calculated that in the present study a factor loading needed to be $\geq .32$ to be significant at the .001 level. In order to facilitate cross-factor comparison, the significant factor scores were subsequently standardized (transformed into *z*-scores), and were applied to

the initial ranking system used during data collection (i.e., to the five-point ranking system of the AIDA with the fixed distribution described earlier). Finally, they were arranged in descending order to represent as factor arrays (Watts & Stenner, 2012). Items with negative *z*-scores were not considered. The final step consisted of an inspection and comparison of the patterns found in the items of each factor array and a name was chosen for each factor to denote the most defining and differentiating aspect in accordance with patients' phenomenological experience of their depression.

Results

The scree plot indicated a two-, a four-, and a seven-factor solution, explaining 31.5%, 46.5%, and 58.7% of the total variance, respectively. After careful exploration of all three possible solutions, we extracted four Q-factors as they produced the most theoretically meaningful and statistically acceptable solution.

Q-Factor 1, which was made up of 32 patients and explained 22.3% of the total variance, was labeled *Submissive Depression* because items with high loadings suggest a highly subservient manner through which these individuals seem to express their need gratification and preoccupation with others. A similar number of individuals made up the second Q-factor, which added 9.3% to the total variance. It was labeled *Self-Critical Depression* to connote the harsh self-criticism describing these individuals. Q-Factor 3, which was made up of 15 patients and explained 8.2% of the total variance, was labeled *Dismissive Depression*, indicative of the contemptuous manner through which their introjective issues are primarily expressed. The fourth Q-factor, which was also made up of 15 patients and added a further 6.7% to the total variance, was labeled *Needy Depression* because items with the highest loading emphasize these individuals' struggles with dependency and need gratification in an anxious or fearful way. This stands in contrast to those making up the *Submissive Depression* factor, whose struggles with issues of dependency appear much more extreme. Tables 1–4 list the statements that best describe the patients in each of the four Q-factors.

From the above item descriptions, it seems that the concerns of patients with Submissive Depression or Needy Depression are primarily centered on issues of relatedness, and thus fall within the anaclitic/relatedness domain, while those matching Self-Critical Depression or Dismissive Depression are largely centered on exaggeration of aspects of self-definition, and thus fall within the introjective/self-definition domain. Those with Submissive

or Dismissive Depression appear to express their respective needs and issues on a potentially more maladaptive developmental level, while those with Needy and Self-Critical depression express theirs on a seemingly higher developmental level. Whether this is the case will be tested empirically in Study 3.

Study 3
Initial Reliability and Validation of the AIDA

The aim of Study 3 was to test the initial reliability and validity of the model by examining (a) the AIDA's inter-scale reliability, and (b) the relationships of the four depression clusters with the expert anaclitic/introjective prototypes and various functioning indices, including clinical, social, occupational, global, and interpersonal functioning collected at study intake prior to randomization. Figure 2 presents the hypothesized model. More specifically, based on previous empirical studies and theoretical reviews and AIDA item descriptions outlined above, the following predictions were made:

1. Submissive and Needy Depression were expected to be positively associated with the expert anaclitic prototype and negatively with the introjective prototype, and the converse was expected to be found for Dismissive and Self-Critical Depression.

2. No differences in depression severity and length of depressive episode were expected, but individuals with Needy and Self-Critical Depression were predicted to be differentiated from those with Submissive and Dismissive Depression by higher levels of functioning, as indicated by higher global functioning scores, higher academic and professional achievement, and less suicidality, self-harm, and drug and alcohol abuse.

3. Finally, with regard to interpersonal functioning, Self-Critical Depression was expected to be associated with fewer interpersonal problems and more stable relationships, while Dismissive Depression was expected to be associated with difficulties in relating to others, as reflected in associations with primarily negative relating tendencies and the avoidance of close relationships specifically. Submissive Depression was expected to be associated with subservient and ingratiating relating tendencies, and a propensity to seek out and enter abusive romantic relationships, while Needy Depression was expected to be associated with more fearful and dependent relating tendencies, and thus show a more ambivalent or unstable relationship pattern.

Materials and Measures

Anaclitic and Introjective Prototypes

These were derived from the expert consensus rating described in Study 1.

Hamilton Rating Scale of Depression

The HRSD (Hamilton, 1967) is the most widely used interview-based measure of depressive severity and has acceptable psychometric properties (Bagby, Ryder, Schuller, & Marshall, 2004). It consists of 17 items, which yield a range of scores from 0–53. All ratings were carried out by two independent blinded assessors. Inter-rater reliability was excellent, with an ICC of 0.89.

Beck Depression Inventory

The Beck Depression Inventory II (BDI-II; Beck, Steer, & Brown, 1996) is the most commonly used self-report instrument to assess depression. The BDI-II consists of 21 items, which yield a range of scores from 0–63. It has been shown to have excellent reliability (coefficient alpha of .92 for an outpatient population) and diagnostic efficiency (Nezu, Ronan, Meadows, & McClure, 2000).

Indices of Functioning

These included clinical, occupational, and relational functioning as indicated by suicidal ideation (present, absent), self-harm (present, absent), drug and alcohol abuse (present, absent), educational achievement (postgraduate degree, university degree, no formal education), employment status (unemployed, employed), relationship status (single, separated/divorced, married/cohabiting), romantic relationship pattern (unstable, unfaithful, abusive). The data was collected at study intake using (a) an adapted version of the Client Service Receipt Inventory (Beecham & Knapp, 1992), a self-report measure that collects demographic data, social and health service utilization, (b) the SCID-I assessment, and (c) the TPI, which provided information on romantic relationship patterns and was categorized by two independent research assistants and verified by the first author (FR) in the few cases of a discrepancy.

Global Assessment of Functioning Scale

The Global Assessment of Functioning (GAF; Hilsenroth et al., 2000) is a widely used observer-rated instrument that evaluates psychological, social, and occupational functioning positioned on a hypothetical 0–100 continuum of mental health. The following severity indicators were applied: <40 impairment in reality testing, 41–50 serious impairment, 51–60 moderate impairment, 61–70 mild impairment, >70 healthy functioning.

The GAF was rated as part of the SCID-I assessment interview and double-rated by an independent assessor. Inter-rater reliability was excellent, with an ICC of .91.

Person's Relating to Others Questionnaire

The Person's Relating to Others Questionnaire (PROQ-2a; Birtchnell and Evans, 2004), which bears similarities to the Interpersonal Circumplex, was used to assess interpersonal relating styles. The PROQ-2a is a 96-item self-report measure that consists of eight relating scales (octants similar to the circular model of the IPC). These are defined within two intersecting axes: a horizontal axis concerning the need for separation (distance; D) versus seeking involvement with others (closeness; C), and a vertical axis, concerning relating from above downwards (upperness; U) versus relating from below upwards (lowerness; L). Items are scored on a 0–3 scale and each person receives a score ranging from 0–15 for each octant. Figure 3 provides a summary definition of each and the corresponding initials, which indicate their place within the two axes. In accordance with the author, these initials will be used throughout this paper. Birtchnell and Evans (2004) have demonstrated that all scales have high internal validity.

Procedure and Statistical Analysis

Q-factors can be expressed both categorically and dimensionally (Asendorpf, 2015). The validation was therefore conducted using both discrete prototypes and continuous prototypicality scores. Dimensional scores were created by correlating each participant's AIDA Q-sort rating with each of the four derived depression factors. These correlations signify the match between each participant's AIDA profile and the empirically derived Q-factors and can subsequently be used in analyses with external (normative) criterion variables to test the measures reliability and validity (Block, 1961). Pearson's correlation coefficients were calculated to assess bivariate associations between the AIDA profile scores and the three sets of external criterion variables described above.

Categorical allocations were made by assigning participants to the subtype for which they received the highest Q-score, provided the correlation was ≥.40 and that the loading was at least .10 higher than on other factors (Bradley, Heim, & Westen, 2005). Using this method, 120 of the 128 participants were classified (94%). Patients who had positive correlations on more than one factor (n = 27) were categorised as the "heterogeneous group". 8 patients showed nonsignificant correlations with any of the factors and were thus removed from the analysis. These grouped patients were compared on demographic variables and in terms of the various functioning and clinical indices. Mean differences were analyzed using

analyses of variance with Games-Howell post-hoc tests to take unequal variance and unequal sample size into account (Field, 2009); the criterion for statistical significance was .05. Differences with regard to categorical data were analyzed using chi-square statistics. Post-hoc tests included the comparison of specific cells and calculation of adjusted residuals. Group differences were explored even if the omnibus *F* test was nonsignificant (Hancock and Klockars, 1996). A post-hoc *z*-score of ±1.96 was significant at the $p < .05$ level.

Results

Reliability Assessment

As shown in Table 5, the internal consistency and the correlations between the four depression factors suggested that the factors were reliable and relatively independent of each other.

Correlations with the Expert Prototypes

As expected, Submissive Depression and Needy Depression were significantly positively associated with the expert anaclitic prototype, and Self-Critical Depression and Dismissive Depression with the expert introjective prototype (see Table 6). Furthermore, Submissive and Needy Depression were significantly negatively correlated with the expert introjective prototype, and Self-Critical and Dismissive Depression were significantly negatively correlated with the expert anaclitic prototype.

Depression Severity and Clinical, Occupational and Global Functioning

Frequencies and mean scores of characteristics, clinical and functioning indices are shown in Table 7. As expected, no significant differences were found in depression severity, as measured by the HRSD ($F_{(4, 115)} = 2.163$, $p = .078$) and BDI-II ($F_{(4, 115)} = .526$, $p = .717$), and length of depressive episode ($F_{(4, 115)} = .092$, $p = .985$). Contrary to expectations, however, there were no significant differences with respect to current self-harm ($\chi^2_{(4, 1)} = 4.355$, $p = .363$). Suicidal ideation was frequent in all groups, and the chi-square test just failed to reach statistical significance ($\chi^2_{(4, 1)} = 7.533$, $p = .107$). Comparison, however, showed that individuals with Self-Critical Depression reported less suicidal ideation than those in the other groups (53% compared with 69–88%; $z = -2.4$). With regard to drug and alcohol abuse, similarly, chi-square test did not yield a statistical significant difference overall, ($\chi^2_{(4, 1)} = 7.065$; $p = .117$). However, comparisons showed that individuals with Submissive Depression reported higher frequencies of drug and alcohol abuse ($z = 2.1$). With

regard to occupational, social and global functioning, as hypothesized, important differences between groups emerged. A significantly higher number of individuals with Needy and Self-Critical Depression had achieved a university degree compared with those categorized having Submissive and Dismissive Depression or those falling into the heterogeneous group ($\chi^2_{(4, 1)} = 10.792$, $p = .028$). Similarly, as expected, the majority of the those with Needy and Self-Critical Depression were employed, while the majority of those individuals with Submissive and Dismissive Depression, and those categorised as heterogeneous were unemployed ($\chi^2_{(4, 1)} = 32.456$, $p = .000$). Finally, as expected, individuals with Submissive and Dismissive Depression had statistically significantly lower GAF scores than those with Self-Critical and Needy Depression ($F_{(4, 115)} = 7.294$, $p = .000$). Whereas individuals with Submissive and Dismissive Depression fell within the serious functional impairment range, those with Self-Critical and Needy Depression fell within the moderate functional impairment range. Individuals in the heterogeneous group showed moderate functioning impairments and showed significantly lower GAF scores than those with Self-Critical Depression ($p = .012$).

Relational Functioning

First, no statistically significant differences were found between the groups in terms of their relationship status (single: $\chi^2_{(4, 1)} = 4.528$, p = .346; married: $\chi^2_{(4, 1)} = 5.654$, p = .21; separated: $\chi^2_{(4, 1)} = 1.931$, p = .767) (see Table 7). However, confirming expectations, a significantly higher frequency of individuals with Self-Critical Depression were married (z = 2.3). Furthermore, a higher percentage (37.5% vs. 6.7–6.9%) of those with Dismissive Depression reported never having had a significant relationship, although structural zeroes in the contingency table violated assumptions to carry out chi-square analysis. Exploring the romantic relationship patterns of those who reported having a partner or spouse, the majority are best described as following an unstable and unfaithful pattern. No significant differences between the groups were found with regard to either pattern (unstable: $\chi^2_{(4, 1)} = 2.436$, p = .676; unfaithful: $\chi^2_{(4, 1)} = 5.919$, p = .201). Structural zeroes in the contingency table of abusive relationships violated assumptions to carry out chi-square analysis; however, percentages show that 37% of individuals with Submissive Depression entered abusive relationships, compared with 11% of those with Needy and Self-Critical Depression, 26% of those in the heterogeneous group and none of those with Dismissive Depression.

Second, Pearson's correlations were computed for the AIDA factor scales and the eight PROQ-2a octants (see Table 8). As hypothesized, Self-Critical Depression was not associated with any of the incompetent relating styles with the exception of demonstrating a

statistically significant negative association with UD (r = -0.295, p = 0.001). Dismissive Depression, on the other hand, demonstrated statistically significant negative associations with most of the octants, consistent with the hypothesized propensity for these individuals to avoid contact with others. The significant positive association with ND (r = 0.192, p = 0.034) provides further support. As expected, Needy Depression was significantly positively associated with NC (r = 0.462, p = 0.000) and negatively with ND (r = -0.291, p = 0.001), while Submissive Depression was significantly positively associated with LD (r = 0.228, p = 0.011) and significantly negatively with UN (r = -0.192, p = 0.033) and UD (r = -0.328, p = 0.000) (see Table 8 and Figure 3).

General Discussion

The aim of the present study was to develop and provide initial validation of a new observer-rated measure to assess levels of anaclitic and introjective depression. To that effect, a 59-item Q-sort instrument (the AIDA) based on SWAP-II item set (Shedler & Westen, 2007) was developed, and was subsequently utilized to describe a sample of 128 severely and chronically depressed patients. Results yield four distinct naturally occurring prototypes, which, in accordance with patients' phenomenological experience, were named *Submissive Depression*, *Needy Depression*, *Dismissive Depression*, and *Self-Critical Depression.* Examining item loadings revealed that the former two were primarily characterized by preoccupations and problems with relatedness and thus fell under the anaclitic domain, whilst the latter two were characterized by preoccupations with the development of a stable and realistic sense of self and thus fell under the introjective domain. Expected relationships between the AIDA factor scales and the expert anaclitic/introjective prototypes provided reasonable convergent and discriminant validity of these affiliations. Moreover, consistent with Blatt's (1974, 1995) theory, patients were found not to differ with regard to symptom severity and length of illness, but distinct differences emerged when they were compared on various levels of functioning and relating tendencies, providing overall support for the hypothesized model depicted in Figure 2.

In summary, those with Needy and Self-Critical Depression seemed to function significantly better than those with Submissive and Dismissive Depression. The majority of patients in the more adaptive clusters had obtained a university degree, most were in employment, and fewer reported self-harm and substance abuse. Self-Critical Depression was not associated with problematic relating tendencies and individuals in this category reported the highest percentage of being married. Although it was surprising that individuals with

Needy Depression did not report higher levels of cohabitation/being married, Needy Depression was associated with more fearful and dependent relating tendencies. Overall, individuals with Self-Critical and Needy Depression showed moderate impairments in functioning as measured by the GAF. Among those with Submissive or Dismissive Depression, by contrast, the majority of patients had no formal education and were unemployed. On the GAF they showed serious functional impairment, which was substantiated by the finding that those with Dismissive Depression reported avoiding relationships and those with Submissive Depression reported the highest percentage of engaging in abusive relationships. Although the preliminary nature of these findings needs to be stressed, they converge with studies suggesting that issues with dependency and self-definition can be expressed at different levels of (mal)adaptiveness (e.g. Bagby & Rector, 1998; Birtchnell, 1999; Bornstein, 1994; Rude & Burnham, 1995; Zuroff et al., 2004; Morgen & Clarke, 2010; Pincus & Gurtman, 1995; Pincus & Wilson, 2001; Thompson & Zuroff, 2004).

Comparing the AIDA item description and associations with the PROQ-2a octants of the two anaclitic prototypes, it appears that Needy Depressed individuals seek care and attention from others primarily out of fear of abandonment and rejection. Submissive Depressed individuals, on the other hand, appear to be driven by a strong belief that the self is bad, damaged, and unworthy of nurture and care. They relate primarily in a subservient and self-denigrating way to others, potentially making themselves vulnerable to abusive behavior and exploitation. Present findings are in line with findings by Pincus and Gurtman (1995) and Pincus and Wilson (2001), who identified one sub-factor of dependency that is associated with a more neurotic fear of conflict and worry of losing appreciation, and one that is associated with a much more pathological compulsion to seek instrumental support from others as well as with a maladaptive belief that the self is weak. Thus, in similar ways, the two anaclitic configurations in the present study could be distinguished from each other by their level of relatedness. As Blatt (1974, 2004) and Blatt and Blass (1992) have argued, anaclitic individuals functioning at higher levels may manage and negotiate their intense dependency needs better and in conjunction with being more cognizant of the more nurturing aspects of themselves and others. This might allow them to achieve and function better compared with those with Submissive Depression. These latter individuals seem to struggle much more with the integration of the various opposing ambivalent aspects of the self and others, perhaps most akin to individuals with borderline personality organizations (Kernberg, 1967). The more destructive aspects of the Submissive Depressed individuals found in the

present study have as such not been identified by previous studies. This particular result may be a consequence of the severe, treatment-resistant nature of the sample in this study, although several other studies have implicated dependency issues in borderline personality disorder (Levy, Edell, & McGlashan, 2007).

With regard to the two identified introjective clusters, results differ somewhat from Thompson and Zuroff's (2004) sub-factors, where their first factor stresses feelings of inferiority toward others and the second factor highlights individuals' self-punitive responses to perceived failings. In the present sample, the characteristic introjective criticalness is directed either outward toward others for those with Dismissive Depression, or inward toward the self for those with Self-Critical Depression. Dismissive Depressed individuals seem to be governed by an intense denial of the need for relatedness, which manifests in distant, unemotional, and extremely critical behavior toward others, while the self may appear to be regarded as confident, superior, and privileged. In comparison, Self-Critical Depressed individuals do not seem to take flight into a narcissistic denial of the need to form relationships; they appear to direct their criticalness inward and seem more fearfully avoidant may appear to be than submissively avoidant (Bartholomew, 1990). Indeed, there seems to be a striking similarity between these two depressed prototypes and the two groups of individuals described by Bartholomew (1990) - those who are more dismissive avoidant versus those who show a more fearful avoidant pattern of attachment. In this respect, results of this study converge with the findings of Levy and colleagues (Levy, 2000; Levy, Blatt, & Shaver, 1998), showing that whilst individuals with dismissive attachment patterns show highly polarized representations of others, those with fearful avoidant patterns were able to acknowledge their felt ambivalence towards others. Moreover, the authors found that fearful attached individuals were able to describe their emotional experience in similarly sophisticated and differentiated ways as securely attached individuals. A recent meta-analysis examining the relationship between attachment and internalizing symptomology in childhood found that avoidance was significantly associated with internalizing symptoms ($d = 0.17$), but not resistance ($d = 0.03$) or disorganization ($d = 0.08$); the possible congruence of this meta-analytic finding with the current study's finding that in the introjective category, individuals with Dismissive Depression tend to function less well is intriguing. Overall, however, research findings on the relationship between depression in adulthood and attachment states of mind (as measured by the Adult Attachment Interview (AAI)) have been inconsistent (Stovall-McClough & Dozier, 2016). This may partly reflect the limitations of the AAI in capturing the full social cognitive sequelae of attachment insecurity; it also reflects the

complexity and nuance that contemporary attachment research findings are now throwing up – that the relationship between attachment status in infancy and later outcomes is perhaps less straightforward than early studies in this area indicated (Fearon, Shmueli-Goetz, Viding, Fonagy, & Plomin, 2014). We would suggest that the more significant clinical implication of the current study in relation to the question of the extent to which depression does or does not follow on from insecure attachment lies in the reinforcement of Blatt's (2004) idea that there are different categories of depressive presentation, which may be associated to some degree with different forms of early developmental experience (as well as other factors) in ways that need further exploration. Thinking about depression in less monolithic terms, accommodating early developmental etiology as well as the individual's current social cognitive style, may be key to developing therapeutic approaches that are more appropriately tailored to meet individual needs (Fearon et al., 2014). Although a link between these contemporary attachment theories and Blatt's formulations has been made (e.g. Luyten et al., 2006), further research investigating these assumptions is needed.

Finally, the categorical allocation used in the present study revealed a group of patients who shared characteristics of one or more of the AIDA depression clusters and thus formed a distinct sub-group. Shahar, Blatt, and Ford (2003) found that mixed anaclitic-introjective patients were significantly less able to function and were much more clinically impaired than "purely" anaclitic or introjective patients. This was not the case in the present study; results did not yield any statistically significant differences or distinguishing features on the chosen variables of the "heterogeneous group" compared to the other groups. However, in contrast to previous studies, the mixed group in our study is rather complex and currently difficult to make sense of as it is made up of 7 different constellations (5% Submissive/Needy; 2% Dismissive/Self-Critical; 10% Submissive/Self-Critical, 2% Submissive/Self-Critical, 1% Needy/Self-Critical, 1% Needy/Dismissive, 2% Self-Critical/Submissive/Dismissive) instead of a binary anaclitic/introjective composition. For any meaningful analysis of this group, a larger sample size would be required and future research should aim to do this.

Limitations

The present study has a number of limitations. The first pertains to the size and nature of the sample used. Although a considerable advantage of Q-methodology is that it does not need large numbers of participants (Smith, 2001), the sample size was relatively small for the subsequent taxonomic work. Therefore, findings have to be considered preliminary,

especially with regard to the statistical comparisons between the prototypes as the power to detect group differences may have not been sufficient, and thus chance findings cannot be ruled out. Additionally, the sample consisted of a group of very severely depressed individuals. Thus, the generalizability of the results to patients with other, especially milder, forms of depression remains open for discussion. While it is indeed an advantage that Q-factors can be treated as both dimensions and categories, the question of adequate cut-offs remains to be answered. We utilized a conservative test of between-group comparisons following Bradley et al. (2005); however, further research is needed to investigate whether the categorical distinctions made are indeed valid and reliable. The most noteworthy limitation was the lack of an alternative measure that assesses the dimensions of relatedness and self-definition. Inclusion of the DEQ, for example, would have allowed assessment of construct validity more directly. Assessing incremental validity is a crucial next step in further establishing the validity and utility of the AIDA. That the AIDA has been embedded within the well-known and well-utilized SWAP-II has several advantages. Not only are studies that have included the SWAP-II to assess personality disorder well positioned to further evaluate the validity of the AIDA, but, should further research prove the AIDA measure to be reliable and valid, clinicians who already use the SWAP-II in their practice, or for research purposes, will gain the benefit of also having a measure of different levels of anaclitic and introjective concerns at their disposal.

Conclusion

Blatt and colleagues have demonstrated that anaclitic and introjective patients show differential responses to the therapeutic process and outcome (Blatt, 2004; Blatt et al., 2010), which highlights the need to tailor therapeutic treatment in accordance with individuals' characteristics, needs and capacities (Fonagy, 2010; Piper et al., 2002). The newly developed AIDA appears to be a promising observer-rated measure. The present findings, if replicated, have important implications for the future conceptualization, assessment, and treatment of severe depression. They emphasize the importance of the assessment of explicit and implicit aspects of patients' depressive experiences that are not readily accessible to consciousness and therefore may be missed by current self-report measures. Moreover, the suggested multi-dimensional and hierarchical model provides an etiologically based account of the clinically observed heterogeneity of depressed patients (Blatt, 2004). It might provide a more precise conceptualization with which to study treatment-resistant depression and guide future clinical research to better address the question of adequate therapeutic help for these individuals.

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Table 1

Q-Factor 1, "Submissive Depression"

SWAP-II Item	Factor score
Tends to be ingratiating or submissive (e.g., consents to things s/he does not want to do, in the hope of getting support or approval).	1.951
Seems unable to settle into, or sustain commitment to, identity-defining life roles (e.g., career, occupation, lifestyle, etc.).	1.630
Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things s/he deserves.	1.494
Has a deep sense of inner badness; sees self as damaged, evil or rotten to the core (whether consciously or unconsciously).	1.439
Tends to be suggestible or easily influenced.	1.418
Tends to get drawn into or remain in relationships in which s/he is emotionally or physically abused, or needlessly puts self in dangerous situations (e.g., walking alone or agreeing to meet strangers in unsafe places).	1.108
Has a pervasive sense that someone or something necessary for happiness has been lost forever, whether consciously or unconsciously (e.g., a relationship, youth, beauty, success).	1.080
Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.	0.890
Is suspicious; tends to assume others will harm, deceive, conspire against, or betray him/her.	0.846
Tends to become attached to, or romantically interested in, people who are emotionally unavailable.	0.321

Note. The factor score is the normalized factor estimate, which describes the items' rank or centrality in defining the Q-factor. The items are arranged in order of importance.

Table 2
Q-Factor 2, "Self-Critical Depression"

SWAP-II Item	Factor score
Tends to feel s/he is inadequate, inferior, or a failure.	2.474
Is invested in seeing and portraying self as emotionally strong, untroubled, and emotionally in control, despite clear evidence of underlying insecurity, anxiety, or distress.	2.120
Tends to deny or disavow own need for nurturance, caring, comfort, etc. (e.g., may regard such needs as weakness, avoid depending on others or asking for help, etc.)	1.901
Expects self to be "perfect" (e.g., in appearance, achievements, performance, etc.).	1.652
Is excessively devoted to work and productivity to the detriment of leisure and relationships.	1.439
Is self-critical; sets unrealistically high standards for self and is intolerant of own human defects.	1.417
Tends to see self as logical and rational, uninfluenced by emotion; prefers to operate as if emotions were irrelevant or inconsequential.	1.382
Tends to seek out or create interpersonal relationships in which s/he is in the role of caring for, rescuing, or protecting the other.	1.188
Tends to express anger in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.).	0.889
Appears conflicted about experiencing pleasurable emotions; tends to inhibit excitement, joy, pride, etc.	0.803
Tends to be conscientious and responsible.	0.739
Tends to be overly concerned with rules, procedures, order, organization, schedules, etc.	0.644
Is able to use his/her talents, abilities, and energy effectively and productively.	0.596
Has moral and ethical standards and strives to live up to them.	0.517

Note. The factor score is the normalized factor estimate, which describes the items' rank or centrality in defining the Q-factor. The items are arranged in order of importance.

Table 3

Q-Factor 3, "Dismissive Depression"

SWAP-II Item	Factor score
Lacks close friendships and relationships.	2.185
Appears to have little need for human company or contact; is emotionally detached or indifferent	2.071
Tends to be critical of others.	1.845
Tends to have extreme reactions to perceived slights or criticism (e.g., may react with rage, humiliation, etc.).	1.391
Tends to be self-righteous or moralistic.	1.161
Tends to hold grudges; may dwell on insults or slights for long periods.	1.154
Tends to get into power struggles.	1.110
Tends to be conflicted about authority (e.g., may feel s/he must submit, rebel against, win over, defeat, etc.).	0.952
Tends to blame own failures or shortcomings on other people or circumstances; attributes his/her difficulties to external factors rather than accepting responsibility for own conduct or choices.	0.910
Tends to be dismissive, haughty, or arrogant.	0.818
Has little empathy; seems unable or unwilling to understand or respond to others' needs or feelings.	0.779
Has an exaggerated sense of self-importance (e.g., feels special, superior, grand, or envied).	0.759
Tends to be oppositional, contrary, or quick to disagree.	0.694
Appears to feel privileged and entitled; expects preferential treatment.	0.661
Has fantasies of unlimited success, power, beauty, talent, brilliance, etc.	0.423
Tends to believe s/he can only be appreciated by, or should only associate with, people who are high-status, superior, or otherwise "special."	0.351

Note. The factor score is the normalized factor estimate, which describes the items' rank or centrality in defining the Q-factor. The items are arranged in order of importance.

Table 4

Q-Factor 4, "Needy Depression"

SWAP-II Item	Factor score
Tends to be needy or dependent.	2.768
Tends to fear s/he will be rejected or abandoned.	2.265
Appears to fear being alone; may go to great lengths to avoid being alone.	2.132
Tends to feel misunderstood, mistreated, or victimized.	1.860
Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship.	1.341
Is unable to soothe or comfort him/herself without the help of another person (i.e., has difficulty regulating own emotions).	1.328
Fantasizes about ideal, perfect love.	0.375
Tends to be competitive with others (whether consciously or unconsciously).	0.374
Is prone to idealizing people; may see admired others as perfect, larger than life, all wise, etc.	0.164
Tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc.	0.161

Note. The factor score is the normalized factor estimate, which describes the items' rank or centrality in defining the Q-factor. The items are arranged in order of importance.

Table 5

Reliability Statistics and Inter-correlations of the Four AIDA Q-Factors

	Q Factor 1: Submissive Depression	**Q Factor 2: Self-critical Depression**	**Q Factor 3: Dismissive Depression**	**Q Factor 4: Needy Depression**
Cronbach's alphas	0.95	0.95	0.88	0.84
Inter-correlations				
Submissive Depression	1	0.064	-0.331**	-0.013
Self-critical Depression	0.064	1	-0.166*	-0.244**
Dismissive Depression	-0.331**	-0.166*	1	-0.363**
Needy Depression	-0.013	-0.244**	-0.363**	1

Note: *$p \leq .05$; **$p \leq .001$

Table 6

Correlations between Derived AIDA Depression Clusters and Expert Prototypes

Expert Prototype	Q Factor 1: Submissive Depression	Q Factor 2: Self-critical Depression	Q Factor 3: Dismissive Depression	Q Factor 4: Needy Depression
Anaclitic	0.706**	-0.197*	-0.744**	0.500**
Introjective	-0.630**	0.344**	0.705**	-0.324**

Note. Pearson Correlation Coefficient *r* * Significant at 0.05 level (1-tailed); ** Significant at 0.01 level (1-tailed)

Table 7

Frequencies and mean scores of characteristics, clinical and functioning indices of the grouped AIDA Depression clusters

	Submissive Depression (*n* = 29)	**Self-Critical Depression (*n* = 30)**	**Dismissive Depression (*n* = 16)**	**Needy Depression (*n* = 18)**	**Hetero-geneous Group (*n* = 27)**
Depression Severity					
HRSD *M* (*SD*)	22.34 (4.68)	19.30 (4.28)	20.38 (5.30)	18.89 (5.31)	19.30 (5.37)
BDI-II *M* (*SD*)	38.55 (10.76)	37.67 (8.98)	35.38 (9.49)	35.89 (9.84)	35.63 (9.01)
Years Depressed					
Range	5 – 50	5 – 52	4 – 49	4 – 46	5 – 48
M (SD)	25.14 (12.06)	24.57 (12.61)	25.75 (14.97)	26.12 (12.49)	24.56 (12.19)
Clinical Indices					
Suicidality	69.0%	53.3%	87.5%	83.3%	66.7%
Self-harm	50.0%	34.5%	62.5%	35.3%	50.0%
Drug and alcohol abuse	41.4%	20.0%	37.5%	11.1%	22.2%
Functioning					
University degree	37.0%[t]	65.5%[t]	37.5%	76.5%	42.3%
Postgraduate degree	0%	30.0%	12.5%	22.2%	7.4%
No formal education	17.2%	0%	12.5%	0%	3.7%
Employment	13.8%	70.0%	31.3%	77.8%	25.9%
GAF *M (SD)*	45.03 (6.85)	52.67 (3.32)	48.19 (5.79)	51.11 (5.99)	49.15 (6.49)
GAF median	45	50.50	51	50.50	50
Relation Indices					
Single	60.0%	46.7%	56.3%	44.4%	63.0%
Separated/ divorced	20.7%	20.0%	31.3%	33.3%	22.2%
Married/ cohabiting	10.3%	33.3%	12.5%	22.2%	14.8%
Never significant relationship	6.9%	6.7%	37.5%	0%	22.2%
Unstable pattern	88.9%	78.6%	78.6%	72.2%	74.1%
Unfaithful pattern	14.8%	21.4%	42.9%	27.8%	37.0%
Abusive pattern	37.0%	10.7%	0%	11.1%	25.9%

Note. *M* = mean; *SD* = standard deviation; HRSD = Hamilton Rating Scale for Depression; BDI-II = Beck Depression Inventory II; GAF = Global Assessment of Functioning Scale. Underlined percentages indicate significant adjusted residuals; [t] Trend observed.

Table 8

Correlations between Derived AIDA Depression Clusters and Negative Relating Styles

	Q Factor 1: Submissive Depression	**Q Factor 2: Self-critical Depression**	**Q Factor 3: Dismissive Depression**	**Q Factor 4: Needy Depression**
UN - Pompous, boastful, dominating, insulting	0.228**	0.094	0.041	0.053
UC - Intrusive, restrictive, possessive	0.115	0.049	-0.254**	0.042
NC - Fear of separation and of being alone	0.024	0.152	-0.382**	0.483**
LC - Fear of rejection and disapproval	-0.078	0.046	-0.131	0.083
LN - Helpless, shunning responsibility, self-denigrating	0.185*	0.093	-0.281**	-0.020
LD - Acquiescent, subservient, withdrawn	0.257**	0.145	-0.211*	-0.057
ND - Suspicious, uncommunicative, self-reliant	0.126	0.083	0.208*	-0.328**
UD - Sadistic, Intimidating, Tyrannizing	-0.327**	-0.285**	0.101	0.080

Note. Pearson Correlation Coefficient *r* * Significant at 0.05 level (2-tailed); ** Significant at 0.01 level (2-tailed), [t] Trend observed

Figure 1. The AIDA Q-sort Response Grid and Item Distribution

Figure 2. The Depression Dimensions of the AIDA

Figure 3: The PROQ Negative Forms of Relating, adapted from Birtchnell and Evans, 2004

Appendix

Prototype of a Patient with Anaclitic (Dependent) Depression:

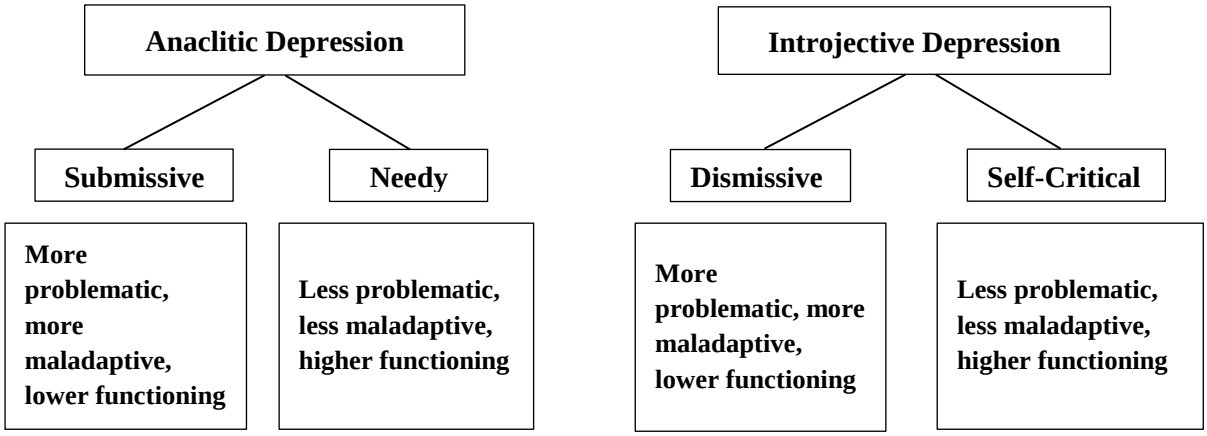
Patients with anaclitic depression are characterized by feelings of loneliness, helplessness, weakness, and fears of abandonment. Anxiety and agitation often color the clinical picture ("anxious depression") and these patients may seek refuge in the use of alcohol, drugs, or excessive eating. Depression is often masked by or expressed in somatic complaints. Suicidal ideation is often less violent or more "passive" in these individuals. In addition, their mood is also more reactive to both positive and negative events (e.g. a new relationship may ameliorate symptoms). Anaclitic depressed patients are also often very sensitive to even minor frustrations or signs of rejection and abandonment. However, aggression is denied or inhibited for fear of losing the care and love of others on whom one is dependent. Hence, they may have considerable difficulty expressing anger directly for fear of disrupting a relationship. They are often readily willing to accept (professional) help, although in a clinging and claiming way. They may be optimistic about treatment, resulting in a fast, but often temporary, relief of symptoms. Their depression is typically provoked by experiences of loss and abandonment, with which they deal with defense mechanisms such as denial, or overly demanding and clinging behavior, increasing the probability of experiences of loss and abandonment.

Prototype of a Patient with Introjective (Self-critical) Depression:

Patients with introjective depression are characterized by high levels of self-criticism, guilt, shame, worthlessness, and often a chronic fear of being criticized or disapproved. There is constant self-scrutiny, often together with a feeling of having failed to live up to expectations. They often have the feeling that they are constantly being watched and criticized, and have strong needs for control. Self-criticism and guilt can become psychotic (e.g., delusion of poverty, delusional feelings of immortal sin, etc.). Obsessive-compulsive symptoms and paranoid-like symptoms can be present (e.g. distrust, feeling of being constantly evaluated, delusions of punishment etc.). Suicidal ideation is often more active and violent in these individuals. When depressed, they often withdraw from personal contact, seek isolation, and are less likely to seek (professional) help. Moreover, they are often pessimistic about being helped (e.g. about psychotherapy), despite the fact that they often have a relatively good

capacity for introspection. Their depressed mood is often less reactive to positive and negative events but events that precipitated the onset of depressive episodes can sometimes be difficult to identify. These patients typically become depressed when confronted with failure. They make use of defense mechanisms like over-compensation to deal with their depression, which then results in more experiences of failure, leading to a more extensive and lasting depression. These patients are often considered by many to be very successful and accomplished, but find little meaning and satisfaction in their accomplishments and in life generally.

Not At All Prototypical 1 (20)	Slightly Prototypical 2 (14)	Somewhat Prototypical 3 (11)	Next Most Prototypical 4 (8)	Most Prototypical 5 (6)
1	7	5	2	25
3	8	9	13	17
6	10	12	21	22
11	15	14	24	29
16	19	4	32	41
18	20	27	36	43
23	31	42	44	
26	33	46	54	
28	39	48		
30	47	51		
35	55	57		
37	59			
38	60			
40	61			
49				
50				
52				
53				
56				
58				


Anaclitic Depression
Submissive
Needy
More problematic, more maladaptive, lower functioning
Less problematic, less maladaptive, higher functioning
Introjective Depression
Dismissive
Self-Critical
More problematic, more maladaptive, lower functioning
Less problematic, less maladaptive, higher functioning

Upperness

UN

UD

UC

Pompous
Boastful
Dominating
Insulting

Sadistic
Intimidating
Tyrannising

Intrusive
Restrictive
possessive

Distance

ND

Suspicious
Uncommunicative
Self-reliant

NC

Fear of
separation and
of being alone

Closeness

Acquiescent
Subservient
Withdrawn

Helpless
Shunning
responsibility
Self-denigrating

Fear of
rejection and
disapproval

LD

LC

LN

Lowerness