Presentation at the London Research Training Program

Ladies and gentlemen,
I am Mattias Desmet, I am working as a researcher at the university of Ghent, at the department of psychoanalysis. At this moment, I am in the final stage of a PhD in which I investigated empirically the associations between interpersonal characteristics and neurotic symptoms, in general, and more in particular, between the interpersonal and personality characteristics described by Blatt – thus dependency and self-criticism - and different types of depressive symptoms, with which I mean somatic and cognitive depressive symptoms. First, I will summarize shortly the research presented in my PhD, because the new research project that I will present here is based on it. The studies of my PhD were mainly conceived as validation studies of two questionnaires that are designed too measure the inter- and intrapersonal characteristics put forward by Blatt, namely the Depressive Experiences Questionnaire (thus the DEQ) and the Personal Style Inventory (PSI-II). In short, our studies suggested modest factorial validity for both questionnaires in clinical and student samples. Furthermore, we addressed the construct validity of these questionnaires by computing correlations between the scores on these questionnaires and scores on the Inventory of Interpersonal Problems – IIP-64, a questionnaire that measures interpersonal problems by means of eight scales that are organized as a circumplex – and different types of depressive symptoms – the cognitive and somatic symptom clusters of the BDI-II – and the different clusters of neurotic symptoms of the SCL-90-R.

First, we studied associations between the scores on DEQ-dependency and DEQ-self-criticism on the one hand and BDI-II symptom clusters and IIP-64 types of interpersonal problems on the other hand in a heterogeneous sample of 404 patients. As predicted, we found that dependency was associated with non-assertive, overly accommodating, and self-sacrificing interpersonal behaviour; and that self-criticism was associated with problems of being cold and distant in relationships. After having ipsatized both the scores on the DEQ and the BDI-II, we found, again as predicted, that dependency was associated with somatic depressive symptoms, while self-criticism was associated with cognitive depressive symptoms (see article 1 in attachment). However, when analysing associations of the DEQ scales with individual depressive symptoms, it was clear that it were those symptoms of the BDI-II that showed high content overlap with the items of the self-criticism scale of the DEQ that were responsible for the observed differential associations between the DEQ scales and the different types of depressive symptoms. For example, ‘worthlessness’ of the BDI-II shows content overlap with ‘If I fail to live up to expectations, I feel unworthy’ of the DEQ, ‘self-dislike’ of the BDI-II overlaps with ‘There is a considerable difference between how I am now and how I would like to be’, and ‘self-criticalness’ of the BDI-II is nearly identical to ‘I tend to be very critical of myself’ of the DEQ.

(Insert slide 1 in which these items of the DEQ are presented alongside the items of the BDI-II)

Based on this content overlap between the DEQ and symptom measures of depression, Coyne stated that the self-criticism scale probably does not measure a personality trait that predisposes for depression, but rather does not measure anything different from the intense self-denigration that is the hallmark of depression. Although we agree that the content overlap between both measures is problematic to study differential associations between the personality traits and depressive symptoms in an interesting way, a study in which we correlated the DEQ scales with clinicians’ ratings on hysterical/anaclitic and obsessional/introjective personality configurations showed that the scores on the self-criticism scale of the DEQ predicted clinicians’ ratings on introjective personality configuration in a significant way in a male clinical sample. The same was true for the dependency scale, which predicted the ratings of the clinicians on anaclitic personality organization. Over and above this, the ratings of the clinicians correlated in exactly the same way with interpersonal characteristics as measured by the IIP-64 as the scales of the DEQ did. Thus, Coyne’s assertion seems to be an overstatement. Nevertheless, we repeated the inquiry into the associations

between interpersonal characteristics and neurotic symptoms in a new clinical sample of 150 patients, this time making use of a questionnaire that shows little or no content overlap with symptom measures to measure dependency and self-criticism, namely the PSI-II, and making use of the Symptom Checklist (the SCL-90-R) to measure a wide variety of neurotic symptoms. We hypothesized that both personality traits would be associated with depressive symptoms. Additionally, we hypothesized that dependency would be associated with phobia's and somatic symptoms, while self-criticism would be associated with obsessive-compulsive symptoms and symptoms centred on aggressive urges. Our hypotheses with regard the associations with interpersonal circumplex scales of the IIP-64 remained the same as in the first sample.
Our results showed that indeed the interpersonal characteristics associated with the scales of the PSI-II were the same as those associated with the corresponding scales of the DEQ; the associations with the symptoms showed that the dependency scale of the PSI-II showed higher associations with all symptom clusters of the SCL-90-R in the heterogeneous clinical sample. However, when studying the same associations in subsample of depressed patients, the associations were in line with theoretical predictions, except the fact that depressive symptoms were only significantly associated with dependency and not with self-criticism. Moreover, although the symptom clusters showed the strongest associations with the predicted personality trait, we observed a lack of differentiation between the associations with the two traits.

(Insert slide with tables in which the associations were presented)

Correlations

		PSIsociotrIII	PSIautonIII
PSIsociotrIII	Pearson Correlation	1	,188
	Sig. (2-tailed)	.	,070
	N	94	94
PSIautonIII	Pearson Correlation	,188	1
	Sig. (2-tailed)	,070	.
	N	94	94
SCLago	Pearson Correlation	,535**	,205*
	Sig. (2-tailed)	,000	,048
	N	94	94
SCLang	Pearson Correlation	,553**	,359**
	Sig. (2-tailed)	,000	,000
	N	94	94
SCLdep	Pearson Correlation	,561**	,351**
	Sig. (2-tailed)	,000	,001
	N	94	94
SCLsom	Pearson Correlation	,439**	,254*
	Sig. (2-tailed)	,000	,013
	N	94	94
SCLin	Pearson Correlation	,445**	,332**
	Sig. (2-tailed)	,000	,001
	N	94	94
SCLsen	Pearson Correlation	,535**	,426**
	Sig. (2-tailed)	,000	,000
	N	94	94
SCLhos	Pearson Correlation	,208*	,557**
	Sig. (2-tailed)	,045	,000
	N	94	94
SCLsla	Pearson Correlation	,237*	,272**
	Sig. (2-tailed)	,022	,008
	N	94	94
SCLover	Pearson Correlation	,526**	,392**
	Sig. (2-tailed)	,000	,000
	N	94	94
SCLpsneur	Pearson Correlation	,583**	,418**
	Sig. (2-tailed)	,000	,000
	N	94	94

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

We tried to replicate these findings in a student sample and in a new clinical sample. In the student sample (N = 200), replication failed.

Correlations

		PSIsociotr	PSIauton
PSIsociotr	Pearson Correlation	1	,292**
	Sig. (2-tailed)	.	,000
	N	151	151
PSIauton	Pearson Correlation	,292**	1
	Sig. (2-tailed)	,000	.
	N	151	151
SCLago	Pearson Correlation	,203*	,350**
	Sig. (2-tailed)	,012	,000
	N	151	151
SCLang	Pearson Correlation	,289**	,392**
	Sig. (2-tailed)	,000	,000
	N	151	151
SCLdep	Pearson Correlation	,309**	,449**
	Sig. (2-tailed)	,000	,000
	N	151	151
SCLsom	Pearson Correlation	,211**	,290**
	Sig. (2-tailed)	,009	,000
	N	151	151
SCLin	Pearson Correlation	,325**	,418**
	Sig. (2-tailed)	,000	,000
	N	151	151
SCLsen	Pearson Correlation	,277**	,487**
	Sig. (2-tailed)	,001	,000
	N	151	151
SCLhos	Pearson Correlation	,231**	,407**
	Sig. (2-tailed)	,004	,000
	N	151	151
SCLsla	Pearson Correlation	,226**	,317**
	Sig. (2-tailed)	,005	,000
	N	151	151
SCLover	Pearson Correlation	,329**	,426**
	Sig. (2-tailed)	,000	,000
	N	151	151

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

(Insert slide with associations in student sample)

In the heterogenous clinical sample associations were investigated in a student sample

Correlations

		PSIsociotr	PSIauton
PSIsociotr	Pearson Correlation	1	,102
	Sig. (2-tailed)	.	,315
	N	99	99
PSIauton	Pearson Correlation	,102	1
	Sig. (2-tailed)	,315	.
	N	99	100
SCLago	Pearson Correlation	,455**	,337**
	Sig. (2-tailed)	,000	,001
	N	99	100
SCLang	Pearson Correlation	,483**	,281**
	Sig. (2-tailed)	,000	,005
	N	98	99
SCLdep	Pearson Correlation	,469**	,244*
	Sig. (2-tailed)	,000	,015
	N	98	99
SCLsom	Pearson Correlation	,290**	,307**
	Sig. (2-tailed)	,004	,002
	N	98	99
SCLin	Pearson Correlation	,426**	,260**
	Sig. (2-tailed)	,000	,009
	N	98	99
SCLsen	Pearson Correlation	,517**	,341**
	Sig. (2-tailed)	,000	,001
	N	98	99
SCLhos	Pearson Correlation	,190	,352**
	Sig. (2-tailed)	,059	,000
	N	99	100
SCLsla	Pearson Correlation	,218*	,098
	Sig. (2-tailed)	,031	,335
	N	98	99
SCLover	Pearson Correlation	,469**	,323**
	Sig. (2-tailed)	,000	,001
	N	99	100

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

When selecting the depressive patients, we also were not able to replicate the previous findings.

Correlations

		PSIsociotr	PSIauton
PSIsociotr	Pearson Correlation	1	,112
	Sig. (2-tailed)	.	,457
	N	46	46
PSIauton	Pearson Correlation	,112	1
	Sig. (2-tailed)	,457	.
	N	46	46
SCLago	Pearson Correlation	,555**	,378**
	Sig. (2-tailed)	,000	,010
	N	46	46
SCLang	Pearson Correlation	,465**	,244
	Sig. (2-tailed)	,001	,106
	N	45	45
SCLdep	Pearson Correlation	,584**	,282
	Sig. (2-tailed)	,000	,061
	N	45	45
SCLsom	Pearson Correlation	,386**	,352*
	Sig. (2-tailed)	,009	,018
	N	45	45
SCLin	Pearson Correlation	,449**	,301*
	Sig. (2-tailed)	,002	,044
	N	45	45
SCLsen	Pearson Correlation	,538**	,371*
	Sig. (2-tailed)	,000	,012
	N	45	45
SCLhos	Pearson Correlation	,089	,401**
	Sig. (2-tailed)	,555	,006
	N	46	46
SCLsla	Pearson Correlation	,342*	,187
	Sig. (2-tailed)	,021	,220
	N	45	45
SCLover	Pearson Correlation	,493**	,408**
	Sig. (2-tailed)	,001	,005
	N	46	46

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Our overall conclusion thus is that replication failed and that we were not able to demonstrate specific associations between dependency and self-criticism on the one hand and neurotic symptoms on the other hand, not with the DEQ, and not with the PSI-II. We also tried to investigate the association between interpersonal characteristics and symptoms straightforwardly by computing correlations between the IIP-64 and the SCL-90-R. However, just as was the case with the PSI-II, we did not succeed in demonstrating specific asscociations between these two types of variables.

Now, I will present some plans for a follow-up project. As is often the case in research, the most interesting findings were those that happened by accident, that were not intended. Although we will continue investigating the association between interpersonal characteristics and neurotic symptoms, we will pay attention to some characteristics in depressive patients' perception of their parents. In

the previous project, we interviewed a diagnostically heterogeneous group of 56 patients. Interviews took on average two hours and were unstructured. It was striking that those patients that were diagnosed as having a major depression and that scored high on the Beck Depresion Inventory, all described their parents in a typical way: the parent that serves as the love object of the patient was almost without exception described as a passive victim of the other parent, which is on the contrary described as a dictator, as a merciless tyrant that is responsible for the suffering of both the parent-love object and of the patient. I give some examples from the interviews:

Patient 1 (2DO):

'My father has never … yes, he never talked to us, no, … he walked around, he earned money and came home and went working in the garden ..We had little or no contact with him … because of my mother … who has always depicted my father as bad and as a bogyman … and his family was bad and nothing and they were the dregs of the society … as a child you believe what your mother tells you. And since it started from when I was small, you don't know better. And since he never tried to get in touch with us, and, and, … we thus never sought to get in touch with him neither.'
'My mother was somenone, euh: everything that was outside the family was, was always good: the neighbours were better, the children were much better, they all studied better, euh … And we could never do something good. Never. It was euh … I still remember when I … I think I must have been ten years old or something … and it was the birthday of my mother. It was around Christmas and we got up early, and we decorated the whole kitchen with festoons and we set the table and everything … En we let her sleep because she usually had to get up early … it was vacation anyway so we did not have to … And suddenly, she ran down the stairs and she started yelling: "Why did you wake me up with all your noise!' en more of that. And there was a serious quarrel … And she came in the kitchen and said nothing about the things we had done. And we really did our best … and then I thought: "Never again! I will never do something for her again!" And I never *did* something for her again!'

Patient 2 (3DO):

'In my youth, in fact, I got little or no contact with my father, I mean, as father and doughter … My father was physically present … It was my mother that arranged everything. I mean, in fact, my mother is a tyrant. Euhm, my father always stayed in the background'.

'My father has had an operation because of eye cancer… This has been the first time that I really was able to get in touch with him, I mean, that he allowed me, no, before that too … Euh … I got in touch with him when … But my mother was enormously jealous, so euh, there is always the struggle between her and my father … because euh … she wants to receive all attention …'

There are numerous ways in which one can try to explain depression starting from these observations:

-One could say that depression is the effect of being humiliated by the dictatorial parent;
-Or that depression is a type of revenge, not directed at the parent-dictator, but at the parental love object, which did nothing to prevent the dictator from offending the patient when he/she was a child; but instead stayed passive, pretending that he/she was afraid, was to weak to protect against the dictator … In this interpretation, the real humiliation was not inflicted by the dictatorial parent, but by the loved parent, which did nothing but watching passively while the patient suffered. In fact, the depressive phenomenology is in this interpretation nothing different than the patient taking revenge on the love object by mirroring the passivity and the helplessness of the love object. Thus, according to the principle 'An eye for an eye and a tooth for a tooth', depression is a way to take revenge for the passivity of the love object by being passive itself. This is about what Freud concluded in 'Mourning and melancholia': Depression is a narcissistic identification with a love object, this identification is motivated by (unconscious) aggression towards the love object.

Besides the more general investigation of the associations between interpersonal characteristics and neurotic symptoms, we additionally want to investigate this mechanism of the narcissistic identification in depression.

More in concrete, we are planning to investigate a heterogeneous clinical sample of 100 inpatients by means of questionnaires and structured and unstructured interviews. Thus, instead of gathering large samples and studying them relatively superficial by means of questionnaires, we want to study a smaller number of patients more in depth. On the one hand, we want to address the same research questions as in the previous project, namely, are there specific interpersonal characteristics that are associated with specific types of interpersonal problems?
Since we did not really succeed in the previous project to demonstrate these specific associations, we will try to investigate them in a slightly different way. First, instead of measuring neurotic symptoms only by means of questionnaires, like for example the BDI-II and the SCL-90-R, we will also investigate them by means of a structured interview on neurotic symptoms like the SCID. The major types of neurotic symptoms will be coded by clinicians' and subsequently, we will study the convergence between these codings and the scores of the patient on the SCL-90-R. This is the first part of the project: mapping neurotic symptoms based on both interviews and questionnaires and checking whether or not there is convergence between these two different sources of information. Subsequently, we will do the same for the interpersonal characteristics. However, instead of only measuring interpersonal characteristics in general, as was the case in the previous project, we will differentiate between different persons and types of persons. For example, we will registrate the characteristics of the relationship with the mother, the father, and the romantic partner both by means of questionnaires as well as by means of the semi-structured interviews. For the questionnaires, we will make use of adapted versions of the Inventory of Interpersonal Problems, as semi-structured interview, we use the Clinical Diagnostic Interview of Drew Westen.