MIXED ANACLITIC–INTROJECTIVE PSYCHOPATHOLOGY IN TREATMENT-RESISTANT INPATIENTS UNDERGOING PSYCHOANALYTIC PSYCHOTHERAPY

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Utilizing data from the Riggs-Yale Project, 45 male and 45 female 18–29-year-old treatment-resistant inpatients undergoing intensive psychoanalytically oriented treatment were studied. Twenty-seven mixed-type anaclitic–introjective inpatients were compared with 29 “pure” anaclitic and 34 “pure” introjective inpatients. At intake, mixed-type inpatients were more clinically impaired (i.e., more symptomatic, cognitively impaired, and thought disordered) and more vulnerable (i.e., less accurate object representations and more frequently used maladaptive defense mechanisms) in comparison with clearly defined anaclitic and introjective patients. Mixed-type patients, however, improved significantly more in the course of psychoanalytically oriented treatment, in terms of clinical functioning (i.e., symptoms, cognitive functioning) and psychological vulnerability (i.e., utilization of more adaptive defense mechanisms).

Interpersonal relatedness and self-definition are two fundamental themes in many psychoanalytic and nonanalytic personality theories. In “Civilization and Its Discontents,” for example, Freud (1930/1961a) contrasted “the man who is predominantly erotic [and gives] first preference to his emotional relationships of other people” with “the narcissistic man,

Nonpsychoanalytic theorists such as Angyal (1951) and Bakan (1966) utilized a similar distinction in defining communion and agency as two fundamental personality dimensions. Communion represents the loss of self in merging with the other, while agency reflects the pressure toward individuation. McAdams (1980, 1985) and others (e.g., McClelland, Atkinson, Clark, & Lowell, 1953), in studies of life narratives, found that themes of intimacy and power were pivotal to understanding personality organization. Wiggins (1991), in a discussion of the Circumplex and The Five-Factor models of personality assessment, asserted that the various acts, traits and interpersonal behaviors assessed by these methods are derived from the metaconcepts of communion and agency (Blatt, 1998).

These two dimensions, relatedness and self-definition, evolve in normal development as a complex dialectic (Blatt & Blass, 1996; Blatt & Shichman, 1983). As theorized by Blatt (1974, 1998; Blatt & Shichman, 1983), various forms of psychopathology can emerge from disruptions of this normal dialectic developmental process. Some individuals, more often females, respond to these developmental disruptions by becoming preoccupied with issues of interpersonal relatedness in what can be called anaclitic disorders such as borderline and dependent personality disorders, anaclitic depression, and hysterical disorders. These disorders all reflect preoccupations with issues of interpersonal relatedness. Similarly, some individuals, more often males, respond to the disruption of the normal dialectic developmental process by becoming preoccupied with issues of self-definition in introjective disorders such as schizotypic or overideational borderline, paranoia, and obsessive–compulsive personality disorders, introjective (guilt-ridden) depression, and phallic narcissism. These disorders reflect preoccupations with issues of separateness, control, and concerns about self-worth.

The anaclitic–introjective distinction has facilitated the organization of personality disorders into two primary empirical supported clusters—anaclitic (Dependent, Histrionic, and Borderline) and introjective (Paranoid, Schizoid, Schizotypic, Antisocial, Narcissistic, Avoidant, Obsessive–Compulsive, and Self-Defeating) personality disorders (cf. Levy, Edell, Blatt, Becker, Kolligan, & McGlashan, 1994; Ouimette, Klein, Anderson, Riso, & Lizardii, 1994). This distinction has also informed depression research by identifying two relatively independent experiences of depression, one centered on disruptions of relatedness and the other on disruptions of self-definition (e.g., Beck, 1983; Blatt, 1974; Blatt, D’Afflitti, & Quinlan, 1976; Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982; Blatt & Zuroff, 1992). Furthermore, anaclitic and introjective outpatients and inpatients were shown to have differential patterns of improvement in various treatments, including psychoanalysis; supportive–expressive psychotherapy; psychoanalytically oriented psychotherapy; and brief, manualized treatments for depression (Blatt, 1992; Blatt & Ford, 1994; Blatt, Quinlan, Pilkonis, & Shea, 1995).

Despite the extensive impact of the anaclitic–introjective distinction on clinical theory and research, the possibility of individuals having both types of personality organizations has been largely unexplored (cf. Coyne & Whiffen, 1995). In recent theoretical formulations of the anaclitic–introjective distinction, Blatt and colleagues (e.g., Blatt & Blass, 1996; Blatt & Shichman, 1983; Blatt & Zuroff, 1992) indicated that in normal develop-
ment, the two dimensions of personality are relatively independent, or orthogonal, indicating the importance of individuals developing both of these central psychological dimensions of interpersonal relatedness and self-definition. In contrast, psychopathological conditions entail inverse relations between the two dimensions—individuals who manifest strong anaclitic tendencies are less likely to manifest strong introjective tendencies. The intense preoccupation with one dimension usually precludes investment in the other (Blatt & Zuroff, 1992). Arguably, this inverse relation between the personality dimensions in psychopathology accounts for the adequate reliability and validity with which anaclitic and introjective outpatients and inpatients are classified (Blatt, 1992; Blatt & Ford, 1994).

Some patients, however, are less amenable to the anaclitic–introjective binary categorization because they demonstrate intense preoccupations in both domains—with issues of both self-definition and interpersonal relatedness. Although this group of mixed-type patients is expected to be relatively small, it is by no means unimportant. Mixed-type patients may highlight an interesting quality of the personality organization of their anaclitic and introjective counterparts, namely, the importance of personality consolidation and its role in reducing vulnerability. The intense preoccupation of anaclitic and introjective patients, with focal concerns on issues of either interpersonal relatedness or on issues of self-definition, suggests that these patients seem to have established a consolidated personality organization and defensive structure. Thus, anaclitic and introjective patients are primarily vulnerable to only one set of concerns, and at the same time, relatively invulnerable or impervious to the other set of concerns. The mixed-type individuals, because they have not achieved a consolidated personality organization and defense structure, are vulnerable to both anaclitic and introjective concerns (Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982).

These theoretical formulations can be translated into three empirically testable hypotheses. First, mixed-type individuals should manifest poorer clinical functioning in comparison to “pure” anaclitic and introjective individuals, as evidenced by a greater number of symptoms and greater impairment in thought processes, interpersonal behavior, and cognitive functioning. Second, irrespective of overt functioning, mixed-type individuals might be more psychologically vulnerable. This could be manifested in less mature self- and object representations and the use of more primitive defense mechanisms. Finally, mixed-type individuals should be less responsive to psychoanalytically oriented treatment because of the severity of their psychopathology and their heightened vulnerability.

These three hypotheses were examined in a sample of 90 seriously disturbed, treatment-resistant, young adults, who were the patients in the Riggs-Yale Project (Blatt & Ford, 1994). These inpatients had been in long-term, intensive, psychoanalytically oriented, inpatient treatment at the Austen Riggs Center, which included psychoanalytic psychotherapy at least four times a week. The Riggs-Yale Project utilized clinical records that had been routinely prepared to evaluate the patients’ clinical status at the beginning of treatment and after approximately 15 months of treatment, on average, approximately 10 months prior to discharge. In addition to these extensive clinical records, patients were also independently administered psychological tests (e.g., the Wechsler Adult Intelligence Scale, or WAIS [Wechsler, 1958], the Rorschach [Rorschach, 1921/1942], and the Thematic Apperception Test [Morgan & Murray, 1935]) at these two points in the treatment process. In prior research, 2 independent raters had reliably classified the entire sample into either anaclitic or introjective patients ($N = 42$ vs. $N = 48$, respectively). Several groups of independent raters had also reliably rated various dimensions in the clinical case records and the psychological test protocols. Blatt, Ford, Berman, Cook, and Meyer...
(1988) found that the total sample (N = 90) of these treatment-resistant patients had improved considerably in long-term psychoanalytically oriented treatment, as evidenced in both the clinical case records and psychological tests. Anaclitic and introjective patients, however, demonstrated a differential pattern of change across treatment. Anaclitic patients changed predominately in measures of interpersonal relations, whereas introjective patients changed primarily in the intensity of manifest symptoms and in their level of cognitive functioning (Blatt & Ford, 1994; Blatt et al., 1988).

An interesting and as-yet-unexplored feature of the data from the Riggs-Yale Project is the rankings made by the 2 independent raters of the degree of certainty with which they assigned each patient to the anaclitic and introjective groups. The personality organization of most patients seemed to emphasize either strong anaclitic features (i.e., extreme dependency, fear of abandonment) or strong introjective features (i.e., need for separation and isolation, unrealistic self-standards, and self-critical perfectionism). Thus, most patients could be classified with considerable reliability and certainty as either introjective or anaclitic. Some patients, however, were less easy to classify because their personality organization seemed to include both anaclitic and introjective features. These patients, although classified as either anaclitics or introjectives in the original study, received lower certainty scores from the judges. In the present study we identified these mixed-type individuals by utilizing the certainty rankings made by the judges in their original classification. Specifically, we defined mixed-group individuals as those patients who received lower certainty scores because of their having both anaclitic and introjective features. On the basis of this reclassification, we were able to reanalyze the Riggs-Yale data utilizing a three-group design (i.e., anaclitic, mixed-type, and introjective inpatients), instead of the two-group design (i.e., anaclitic vs. introjective inpatients) used by Blatt and Ford (1994) in their original analyses.

We hypothesized that at admission, mixed-type patients would manifest poorer clinical functioning than “pure” anaclitic and introjective patients, as evidenced by greater psychiatric symptoms and poorer cognitive functioning, including greater thought disorder. We further hypothesized that at admission, mixed-type patients would be more psychologically vulnerable, as evidenced by less mature object representation and the use of more primitive defensive mechanisms. Finally, we hypothesized that in comparison to “pure” anaclitic and introjective patients, mixed-type patients would be less responsive to psychoanalytically oriented treatment, as evidenced by less improvement in their clinical functioning (i.e., symptoms, cognitive functioning, and thought disorder) and in their psychological vulnerability (i.e., object representations and defense mechanisms).

Method

Participants and Procedures

Participants were 45 male and 45 female late-adolescent and young adult inpatients (ages 18 to 29 years at the time of admission, M = 20.94) at the Austen Riggs Center in Stockbridge, Massachusetts. As described in detail by Blatt and colleagues (Blatt & Ford, 1994; Blatt et al., 1988), the 90 patients were selected for the study because they were between the ages of 18 and 29 years at admission, had remained in treatment for at least a year, and had a set of psychological tests at both admission and again later in the treatment process.

Most of the patients came from families of at least the middle socioeconomic class, were well educated, and had at least average intelligence. Approximately 30% of the
sample were diagnosed with psychotic conditions according to Diagnostic and Statistical Manual of Mental Disorders—Third Edition (DSM–III; American Psychiatric Association, 1980) criteria (e.g., schizophrenia or psychotic depression), 60% of the patients were diagnosed with severe personality disorders (e.g., borderline personality disorder), and 10% were diagnosed with severe (but not psychotic) depression. The average Global Assessment Score (GAS; Endicott, Spitzer, Fleiss, & Cohen, 1976) at admission of a comparable Riggs sample that included many of the patients investigated here was 34 (Plakun, 1989), indicating major impairments in work, family relations, judgment, thinking, mood, reality testing, communication, or a serious suicide attempt. The 90 inpatients had, on average, 28.5 months of previous outpatient therapy; 57% of these patients had been briefly hospitalized previously an average of 1.32 times for a mean length of 4.75 months before seeking treatment at the Austen Riggs Center. The average length of hospitalization of these 90 patients at the Austen Riggs Center was 26 months, with an average of 15 months between the initial evaluation (conducted during the first 6 weeks of hospitalization) and the second assessment which, on average, was conducted 10.9 months prior to discharge.

Two judges, blind to the hypotheses of the study and to other ratings, classified the patients into two groups—those with primary anaclitic or those with primary introjective personality organization. Each judge classified 45 randomly selected patients. Classification was based on information obtained from initial clinical case records established 4–8 weeks after admission. Data pertinent to the classification of the patients as either anaclitic or introjective were (a) patients’ developmental and family history, (b) their initial statement of their problem, and (c) the clinician’s psychodynamic case formulation and recommendations. This information was compared to a 1-page synopsis that had been prepared of the anaclitic and introjective configurations, in which the typical needs, wishes, concerns, preoccupations, relational style, and defense and coping mechanisms of these configurations were described (see Blatt & Ford, 1994, p. 277). Patients whose description in the initial clinical records was consistent with anaclitic psychodynamics were classified into the anaclitic group. Similarly, patients whose description on the initial clinical records was congruent with the introjective psychodynamic were classified into the introjective group. This process resulted in 42 of the patients being classified as anaclitic and 48 being classified as introjective. Judges were able to make this binary diagnostic distinction with high reliability (the two judges agreed on these ratings in 17 of 18 shared cases; see Blatt et al., 1988, p. 136). The validity of this diagnostic distinction was demonstrated by the findings of Blatt and colleagues (1988) regarding the above-described significant differences between anaclitic and introjective patients in terms of the nature of their therapeutic change.

In addition to the forced binary classification of the patients into the anaclitic and introjective groups, judges were asked to rate the certainty, or conviction, of their anaclitic–introjective classification on a one-dimensional, 100-point scale. Thus, a patient who had predominantly anaclitic features would be given, for example, a certainty rating as 90% anaclitic. Due to the one-dimensional nature of the certainty scale, this patient would necessarily receive a 10% certainty rating for being introjective. Conversely, a patient who had predominantly introjective features would receive a certainty rating of 90% for being introjective and, by implication, would be rated with 10% certainty as being anaclitic.

Even though some patients with both anaclitic and introjective features had been originally classified into one of the two groups based on the predominance of either of
these two sets of features, the assigned clarity or conviction rating for these patients was low—between 50% to 60% certainty. Thus, a patient who was considered by judges to have both anaclitic and introjective features, but who was also considered to be slightly more anaclitic than introjective, might have been eventually classified as anaclitic with 60% conviction, which also implied that the patient was rated as 40% introjective.

The interrater reliability of these clarity ratings was quite high; on the 18 cases evaluated by both raters, the correlation between their clarity ratings was .917. The mean level of certainty for the anaclitic patients was $M = 68.30\%$ ($SD = 9.90\%$, range = 52%-90%). The mean level of certainty for introjective patients was $M = 71.06\%$ ($SD = 12.86\%$, range = 55%-98%). Importantly, anaclitic and introjective patients did not differ in the level of clarity or conviction with which they had been classified, $t(88) = -1.12$, *ns.*

In the present study, we utilized these clarity or conviction ratings to identify a mixed-type group of patients characterized by both anaclitic and introjective features. Our initial aim was to include in this group one third of the anaclitic patients and one third of the patients in the introjective group who had received the lower clarity or conviction scores. Thus, we aimed to divide the 90 patients in this sample into three equal groups, with 30 patients in each group. We came as closely as possible to this objective by including in the mixed-type group 13 anaclitic patients and 14 introjective patients with the lowest scores of clarity or conviction. The clarity or conviction scores of these patients ranged up to 60%. The mean certainty of the 13 previously anaclitic, now mixed-group patients was $M = 57.53\%$ ($SD = 3.07\%$, range = 52%-60%). The mean certainty of the 14 previously introjective, now mixed-group patients was $M = 57.53\%$ ($SD = 2.49\%$, range = 55%-60%). These two groups did not differ in terms of the level of the clarity or conviction assigned to them, $t(25) = .16$, *ns.* Neither did the remaining 29 anaclitic and 34 introjective patients differ in the average of clarity or conviction assigned to them ($Ms = 73.13\%$ vs. 76.70%, $SDs = 7.85$ and 10.99, ranges = 63%-90% and 63%-98% for anaclitics and introjectives, respectively), $t(61) = 1.45$, *ns.* These findings rule out the possibility of bias toward either anaclitic or introjective patients in terms of certainty scores.

**Measures**

The pertinent variables in this study were derived from clinical case records and psychological test protocols. Extensive clinical case records available at Times 1 and 2 were reviewed by 2 raters who were blind to the hypotheses of the study and to other ratings and who previously achieved an acceptable level of reliability (see Blatt & Ford, 1994, p. 33) in doing these ratings. Rater A reviewed a randomly selected 45 cases at Time 1 and the other 45 at Time 2. Rater B reviewed the remaining cases. Thus, each case was rated by a different judge at Time 1 and at Time 2.

Ratings of the clinical case records were based on the following scales: (a) the Strauss-Harder clinical rating scales (Strauss & Harder, 1981), (b) the Fairweather Rating Scale of Ward Behavior (Fairweather et al., 1960), and (c) scales developed as part of the Menninger Psychotherapy Research Project (MPRP; Harty et al., 1981) to evaluate clinically significant dimensions. The Strauss-Harder scales provide information on four types of symptoms: psychotic symptoms (e.g., hallucinations, delusions), neurotic symptoms (e.g., depression, anxiety), labile affect (e.g., hypomanic and manic mood and behavior), and flattened affect (e.g., flat affect, retarded movement and speech). The Fairweather Rating Scale of Ward Behavior assesses patients’ participation in interpersonal communication, self-care, work, and recreational activities. Finally, the 5 Menninger scales formed two factors: Menninger Factor I (MI) assesses interpersonal behavior and Men-
ninger Factor II (MII) assesses impulsive behavior. All these clinical case record scales and their reliability and validity are described in detail by Blatt and colleagues (Blatt & Ford, 1994; Blatt et al., 1988).

The 90 patients were administered the WAIS, the TAT, and the Rorschach Inkblot Test at both Times 1 and 2. The WAIS protocols yielded scores on verbal, performance, and full-scale IQ. The TAT protocols were assessed for three defense mechanisms (denial, projection, and identification), using a system developed by Cramer (1991, 1996). The Rorschach protocols were scored with three independent scoring systems yielding three empirically established and theoretically based measures of thought disorder and object relations: (a) the Composite Thought Disorder, (b) the Mutuality of Autonomy, and (c) the Concept of the Human Object. The reliability and validity of these three measures had been demonstrated in prior cross-sectional studies. The Composite Thought Disorder is an overall index of thought disorder indicating various types of boundary disturbances (e.g., contamination, confabulation, and fabulized combination; see Blatt & Berman, 1984; Blatt & Ritzler, 1974; Blatt & Wild, 1976; Blatt, Wild, & Ritzler, 1975). The Mutuality of Autonomy Scales (MOA; Urist, 1977; Urist & Shill, 1982) assesses the quality of the interactions of human, animal, and inanimate figures in the Rorschach protocol. The MOA yields two scores: one assessing the most malevolent interaction (MOA–malevolent) and another assessing the most benevolent interaction (MOA–benevolent). Finally, the Concept of the Human Object (Blatt, Brenneis, Schimek, & Glick, 1976) assesses the developmental level of human responses in the Rorschach protocol. The authors distinguished between the developmental level of accurately perceived human responses (OR+) and inaccurately perceived human responses (OR−). A developmental index is the weighted sum of all responses that have humanoid features, based on the developmental level of differentiation, articulation, motivation, integration of object and action, and the nature of interaction of both accurately perceived (OR+) and inaccurately perceived (OR−) responses. In addition, a mean developmental level for both accurate and inaccurate responses assesses the average developmental level of these human responses. Thus, both OR+ and OR− are each assessed using two indicators: A Developmental Index (DI) and a Mean Developmental Level (MDL). Cross-sectional studies demonstrated the reliability and validity of these Rorschach variables (Blatt & Berman, 1984; Blatt & Ritzler, 1974; Blatt & Wild, 1976; Blatt et al., 1975; Blatt, Brenneis, et al., 1976; Urist, 1977; Urist & Shill, 1982) and TAT measures (Cramer, 1991, 1996).

Results

Our analyses were performed on three groups of patients: anaclitics (N = 29; 18 women and 11 men), introjectives (N = 34; 9 women and 25 men), and mixed-type (N = 27; 18 women and 9 men). We examined each of our three hypotheses in turn. First, we tested our hypothesis regarding the impaired clinical functioning of mixed-type patients in comparison to more clearly delineated anaclitic and introjective patients. This was done by conducting a series of analyses of variance (ANOVAs) and multivariate analyses of variance (MANOVAs) in which the dependent variables were (a) clinical symptoms (as measured by the Strauss-Harder scale), (b) thought disorder (measured by the Composite Thought Disorder Index of the Rorschach), (c) interpersonal behavior (as measured by the Fairweather and Menninger scales), and (d) cognitive functioning (as measured by the WAIS). The independent variables in these ANOVAs were patients’ personality organization (i.e., anaclitic, introjective, or mixed-type) and gender.
Next, we tested our hypothesis regarding the greater psychological vulnerability of mixed-type patients, in comparison to more clearly delineated anaclitic and introjective patients. To that effect, we conducted a series of ANOVAs in which the dependent variables were (a) object representations (measured by the Concept of the Object and Mutuality of Autonomy scales) and (b) defense mechanisms (measured by the TAT). The independent variables were patients’ personality organization and gender.

To reduce the number of statistical tests performed and thereby limit Type-I error, we combined dependent variables that belong to a certain category (e.g., the four Strauss-Harder symptoms scales) and conducted MANOVAs. Variables that could not be combined were subject to an ANOVA.

Note that in both sets of analyses we introduced patients’ gender as an independent variable, in addition to patients’ personality organization. We elected to treat gender as an independent variable based on previous analyses of this data set (Blatt & Ford, 1994) and other studies (e.g., Chevron, Quinnan, & Blatt, 1978; Smith, O’Keefe, & Jenkins, 1988) that suggested that the anaclitic men and introjective women (i.e., gender-noncongruent individuals) are particularly vulnerable to adaptation problems.

We then tested our third hypothesis, namely, that mixed-type patients would evidence smaller therapeutic improvement in comparison to anaclitic and introjective patients. This was done by conducting a series of repeated-measure ANOVAs to examine the differential therapeutic change of the three groups, as well as the moderating role played by gender in this change over the course of approximately 15 months of treatment. In these analyses, the dependent, repeated-measure variables were patients’ clinical functioning (i.e., clinical symptoms, thought disorders, interpersonal behavior, and cognitive functioning) and their psychological vulnerability (i.e., object representation and defense mechanisms). The independent variables in these analyses were patients’ personality organization and gender.

To control for a possible regression to the mean, we supplemented the repeated-measure ANOVAs that yielded statistically significant results with Analyses of Covariance (ANCOVAs), in which the independent variables were personality organization and gender and the dependent variable was patients’ clinical functioning and psychological vulnerability at Time 2, and the covariates were patients’ functioning and vulnerability at Time 1.1

**Hypothesis 1: Mixed-Type Patients Would Manifest Poorer Clinical Functioning in Comparison to Anaclitic and Introjective Patients**

Conducting a MANOVA in which the four Strauss-Harder symptom scales (i.e., Neurotic Symptoms, Psychotic Symptoms, Labile Affect, and Flattened Affect) served as dependent variables, we found a main effect for personality organization, Wilk’s $\Lambda(8, 162) = .79, p < .05$. Results of this analysis are presented in Figure 1. Univariate comparisons yielded significant effects for neurotic symptoms ($p < .01$), psychotic symptoms ($p < .05$), and flattened affect ($p < .05$), and a nearly significant effect for labile affect ($p = .07$).

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1 A comprehensive information of the means, standard deviations, and correlations among the study variables is available from the authors. Also available are figures will all the statistically significant interactions.
Post hoc comparisons were consistent with our hypothesis. Mixed-group members demonstrated significantly more neurotic and psychotic symptoms and flattened affect than both the anaclitic and introjective group and significantly more labile affect than introjective, but not anaclitic, patients.

Another ANOVA examined thought disorder on the Rorschach. Consistent with our hypothesis, the main effect of personality organization approached significance, $F(2, 84) = 2.74, p = .07$. Mixed-group patients evidenced significantly more thought disorder than introjective patients and tended to evidence more thought disorder than anaclitic patients. In addition, we found a significant main effect for gender, $F(1, 84) = 4.16, p < .05$; men scored higher than women.

An additional ANOVA that addressed the Fairweather Interpersonal Communication Scale yielded nonsignificant effects. Another ANOVA on Menninger Factor I also yielded nonsignificant effects. In contrast, an ANOVA on Menninger Factor II (Impulsivity) yielded a significant interaction effect, $F(2, 84) = 3.45, p < .05$. Post hoc comparisons demonstrated that gender-congruent patients (anaclitic females and introjective males) had higher scores on impulsivity than gender-incongruent patients.

A MANOVA on the two IQ scales (i.e., Verbal and Performance IQ) yielded a main effect for personality organization, Wilks’s $\Lambda(4, 166) = .86, p < .05$, and gender, Wilks’s $\Lambda(2, 83) = .89, p < .01$; men scored higher than women on Verbal IQ, but not on Performance IQ. Univariate analyses demonstrate a significant effect of personality organization on Performance IQ, $p < .05$, and a nearly significant effect of personality organization on Verbal IQ, $p = .08$. Post hoc tests were consistent with our hypothesis, demonstrating that the mixed-group patients scored significantly lower on Performance IQ than both the anaclitic and introjective groups. Regarding Verbal IQ, introjective patients scored significantly higher than anaclitic patients; mixed-group patients scored in the middle, but significantly lower than, the introjective patients.

An additional ANOVA was conducted using the Full-Scale IQ scores. Results yielded a main effect for gender, $F(1, 84) = 8.66, p < .01$ (men scored significantly higher than women); and for personality organization, $F(2, 84) = 4.21, p < .05$. Post hoc comparisons

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*Figure 1. Personality organization differences in Time 1 symptoms.*
revealed that the mixed-group patients scored significantly lower than the introjective group and tended to score lower than the anaclitic group (although the difference was not statistically significant). The anaclitic group scored significantly lower than the introjective group.

The above results largely support our hypothesis regarding the poorer clinical functioning of mixed-type patients. In comparison to anaclitic and introjective patients, mixed-type patients exhibited more psychiatric symptoms and thought disorder (as measured by the Strauss-Harder scales and the Composite Thought Disorder Index of the Rorschach, respectively), as well as poorer cognitive performance (as measured by the Performance scale and Full scale of the WAIS). Nevertheless, this pattern was not evident with respect to patients’ interpersonal behavior, as measured by the Fairweather and Menninger scales.

Hypothesis 2: Mixed-Type Patients Would Manifest Greater Psychological Vulnerability in Comparison to Anaclitic and Introjective Patients

Two MANOVAs addressed the Concept of the Object on the Rorschach. An initial MANOVA was conducted on the two indices of appropriate object relations (OR+), namely, the Mean Developmental Level (OR+MDL) and the Developmental Index (OR+DI) of accurately (F+) perceived responses. Although the main effects in this analysis were nonsignificant, a significant interaction effect emerged, $F(4, 166) = 2.81, p < .05$. Univariate analyses demonstrated that the source of this interaction is the OR+MDL ($p < .05$).

Post hoc comparisons revealed differential patterns of personality organization differences among men and women. Although personality organization differences among women were nonsignificant, men in the mixed group scored lower than anaclitic and introjective men, although only the difference between mixed and introjective patients reached statistical significance. An equivalent MANOVA on the two indicators of Inappropriate Object Relations (OR−MDL and OR−DI) yielded nonsignificant effects.

Two additional ANOVAs were conducted on the Mutuality of Autonomy scales derived from the Rorschach (i.e., MOA Most Malevolent score and MOA Most Benevolent score). All effects of these analyses were nonsignificant.

A MANOVA was conducted on the three defense mechanisms (Denial, Projection, and Identification; Cramer, 1991, 1996) that were rated on stories told in response to TAT cards. This analysis yielded a significant personality organization by gender interaction, Wilk’s $\Lambda(6, 164) = .85, p < .05$. As demonstrated by the univariate tests, the source of this interaction is the Projection and Identification scales. For both scales, differential group differences were found for men and women. The pattern of these differences is presented in Figure 2. Projection scores of mixed-group men were significantly higher than for introjective men and tended to be higher than for anaclitic men. Conversely, projection scores of mixed-group women were in the middle range, with introjective women scoring significantly higher than anaclitic women. Additionally, identification scores of mixed-group men were in the middle range, with anaclitic men scoring significantly higher than introjective men. Conversely, identification scores of mixed-group women were significantly higher than those for anaclitic women and tended to be higher than those for introjective women.

The above results provide support for our hypothesis that mixed-type patients would demonstrate greater psychological vulnerability, in that mixed-type male patients dem-
onstrated less mature object representations (as measured by the OR+MDL). In addition, mixed-type male patients demonstrated greater usage of projection, and mixed-type women showed greater use of identification, as measured by the TAT.

**Hypothesis 3: Mixed-Type Patients Would Demonstrate Less Improvement in the Course of Treatment, in Comparison to Anaclitic and Introjective Patients**

In this section, we first evaluated change in the clinical functioning variables (i.e., psychiatric symptoms, thought disorder, interpersonal behavior, and cognitive functioning). Then, we addressed change in the psychological vulnerability variables (i.e., object representations and defense mechanisms).

**Clinical functioning.** A repeated-measure $3 \times 2 \times [2 \times 4]$ ANOVA on the Strauss-Harder symptom scales yielded the following statistically significant effects: (a) main effects for personality organization, $F(2, 84) = 3.42, p < .05$; time, $F(2, 84) = 7.26, p < .01$; and symptoms, $F(3, 252) = 194.71, p < .001$; (b) two-way interactions between personality organization and time, $F(2, 84) = 9.19, p < .001$; and gender and symptoms, $F(3, 252) = 2.95, p < .05$; and (c) a three-way interaction between personality organization, gender, and time, $F(2, 84) = 4.37, p < .05$.

This latter three-way interaction is of special importance because it accounts for most of the obtained lower-order effects obtained (i.e., the main effect of time and the two-way interaction between personality organization and time). This interaction is plotted on Figure 3. Computing the mean scores of the four Strauss-Harder symptom scales at both Times 1 and 2 and conducting dependent-sample $t$ tests, we found that only mixed-type men had a significant change in level over time, Mean symptoms at Time 1 = 1.66 versus mean symptoms at Time 2 = 1.18; $t(8) = 4.19, p < .01$. 

![Figure 2. Thematic Apperception Test (TAT; Morgan & Murray, 1935) scores at Time 1 by personality organization and gender.](image-url)
A repeated-measure ANOVA, conducted on the Menninger Factors I and II and on the Fairweather Interpersonal Communication scales, did not yield significant effects for personality organization, gender, or their interactions. Null results were also obtained when the Composite Thought Disorder Index was subjected to a repeated-measure ANOVA.

A repeated-measure $3 \times 2 \times [2 \times 2]$ ANOVA (Group $\times$ Gender $\times$ Time $\times$ IQ scale) was conducted for Performance and Verbal IQs. This analysis yielded the following three types of significant effects: (a) main effects for personality organization, $F(2, 84) = 3.46, p < .05$; gender, $F(1, 84) = 10.45, p < .05$; and the IQ scales, $F(1, 84) = 65.60, p < .001$; (b) a two-way interaction between time and the IQ scale variable, $F(1, 84) = 13.58, p < .001$; and (c) a three-way interaction between personality organization, time, and the IQ scale variable, $F(2, 84) = 3.11, p < .05$. We focused on the interpretation of the latter three-way interaction because it includes the other significant effects. Utilizing dependent-sample $t$ tests, we found that both mixed-group and introjective patients increased in Performance IQ in comparable ways. None of the three groups changed significantly on the Verbal IQ scale.

A complementary repeated-measure ANOVA conducted on the Full-scale IQ yielded three main effects for personality organization, $F(2, 84) = 3.26, p < .05$; gender, $F(1, 84) = 11.33, p < .01$; and time, $F(1, 84) = 3.99, p < .05$; as well as a nearly significant interaction between personality organization and time, $F(1, 84) = 2.57, p = .08$. Dependent-sample $t$ tests revealed that anaclitics and introjectives did not change over time, whereas mixed-type individuals improved significantly in terms of their full-scale IQ, $t(26) = -2.78$.

**Psychological vulnerability.** Analysis with the object representation indices of the Rorschach (i.e., the two OR+ measures, the two OR− measures, and the Mutuality of Autonomy variables (i.e., benevolence and malevolence) did not yield statistically significant interactions.

In contrast, a repeated-measure ANOVA conducted on the three TAT variables (De-
nial, Projection, and Identification) yielded the following statistically significant effects: (a) a main effect for time, \( F(1, 84) = 6.60, p < .05 \); (b) a two-way interaction between gender and personality organization, \( F(2, 84) = 6.48, p < .01 \); and (c) a nearly significant four-way interaction between personality organization, gender, time, and TAT defenses, \( F(4, 168) = 2.30, p = .060 \). Because the four-way interaction includes the former significant effect, we focus on the understanding of this interaction.

Although four-way interactions can be disentangled in numerous ways, our main interest was in examining the differential change of men and women with different personality organizations across the three TAT defense scales. To that effect, we conducted three separate ANOVAs in which each of the three TAT scales served as a repeated measure and gender and group served as independent variables. Only in the case of Projection did we find a nearly significant interaction between group and gender, \( F(2, 84) = 2.61, p = .08 \). Plotting this interaction and conducting post hoc comparisons, we found that neither anaclitic men nor anaclitic women changed in the level of projection on the TAT, both mixed-type men and women decreased in their TAT projection level, and introjective women, but not introjective men, decreased in their TAT projection level.

Overall, these results stand in contrast to our hypothesis regarding less clinical improvement of mixed-type patients in comparison to anaclitic and introjective ones. Specifically, mixed-type patients showed greater improvement than anaclitic and introjective patients in terms of symptoms, performance and Full-scale IQ, and on TAT Projection. However, we were concerned that these results could be misleading, because mixed-type patients differ significantly from anaclitics and introjectives on Time 1 levels of these variables. Hence, the greater differential improvement of mixed-group patients might be attributed to the statistical phenomenon of “Regression to the Mean” (i.e., extreme observations that are assessed at one point in time tend to regress to the mean more than less extreme observations, when assessed again at Time 2). To address this concern, we performed ANCOVAs on the variables that indicated greater improvement of mixed-type individuals. Adjusted means of Performance and Full-scale IQ, and of symptoms and TAT Projection among anaclitic, mixed-type, and introjective men and women are presented in Table 1. This table also includes the \( F \) values and significance levels of the comparisons made.

As shown in Table 1, a similar pattern of results was found in the ANCOVA analyses. Time 2 means of mixed-type men, adjusted for Time 1 levels of symptoms and TAT Projection, were lower than adjusted means of their anaclitic and introjective counterparts. Time 2 adjusted mean of Performance IQ of mixed-type patients (i.e., men and women) tended to be higher than the means of anaclitics and introjectives. Group differences in Time 2 adjusted means of Full-scale IQ were nonsignificant.\(^2\)

\(^2\)We repeated our analyses comparing “previously” anaclitic inpatients (\( N = 13 \)) to previously introjective inpatients (\( N = 14 \)) in terms of clinical functioning, psychological vulnerability, and therapeutic improvement. The purpose of these analyses was to address the possibility of differences between mixed-type patients who tended to be more anaclitic (i.e., were ultimately classified as anaclitics) and those who tended to be more introjective (i.e., were ultimately classified as introjectives). Results indicate that these groups did not differ from each other. Of the myriad of tests performed on patients’ clinical functioning and psychological vulnerability at admission, only a single statistically significant difference emerged. “Previously introjective” inpatients utilized projection as a defense mechanism more than “previously anaclitic” ones. Of the multiple tests performed on patients’ improvement, none were statistically significant. This pattern is consistent with the treatment of mixed-type patients as an identifiable, cohesive group.
<table>
<thead>
<tr>
<th>Table 1</th>
<th>Adjusted Means of Performance and Full-Scale IQ and of Mean Symptoms and TAT Projection Among Anaclitic, Mixed-Type, and Introjective Women and Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Anaclitics</td>
</tr>
<tr>
<td></td>
<td>Women</td>
</tr>
<tr>
<td>Performance IQ</td>
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<tr>
<td>Full-scale IQ</td>
<td>114.27</td>
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<tr>
<td>Symptoms</td>
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</tr>
<tr>
<td>TAT Projection</td>
<td>1.68</td>
</tr>
</tbody>
</table>

*Note.* ANCOVA = analysis of covariance; PO = Personality Organization (anaclitics, mixed-type, introjectives); G = Gender (women, men); TAT = Thematic Apperception Test (Morgan & Murray, 1935). For ANCOVA F values, df = (1, 83).

*p < .05, two-tailed.

*p = .06, one-tailed.
Discussion

In an attempt to investigate mixed-type individuals who are preoccupied with both anaclitic and introjective concerns, we analyzed additional data from the Riggs-Yale study of therapeutic change in long-term, intensive treatment of severely disturbed, treatment-resistant patients. We compared anaclitic, introjective, and mixed-type inpatients in terms of their initial clinical functioning and psychological vulnerability as well as their responses to psychoanalytically oriented, inpatient treatment.

Results were consistent with our first two hypotheses, namely, that mixed-type inpatients are initially more distressed and vulnerable than their anaclitic and introjective counterparts. Poorer clinical functioning on the part of these mixed-type patients was evident in terms of more psychiatric symptoms, greater thought disorder, and lower Performance and Full-scale IQ. Greater psychological vulnerability was evident in terms of less accurate object representations (among men) and increased utilization of maladaptive defense mechanisms such as projection (among men), and identification (among women).

Results, however, were contrary to our third hypothesis regarding the negative therapeutic response of these mixed-type individuals. Specifically, we found that mixed-group men were the only subgroup improving significantly in terms of psychiatric symptoms. Moreover, mixed-group patients (men and women) improved significantly more in terms of Performance IQ and in terms of less frequent utilization of projection as a defense mechanism. As demonstrated in the ANCOVA analyses, these patterns of improvement go beyond what could be attributable to regression to the mean.

Our findings regarding the impaired initial clinical functioning and increased psychological vulnerability of mixed-type individuals illuminate an interesting, but relatively overlooked, quality of the personality organization of anaclitic and introjective individuals. The intense preoccupations of anaclitic and introjective individuals either with issues of interpersonal relatedness or self-definition suggests that these two types of personality organization reflect a capacity to construct a relatively coherent mode of adaptation. This focal adaptive style enables these clearly defined anaclitic and introjective individuals to function more effectively at admission to the hospital than less clearly defined patients. The mixed-type patients appear not to have achieved the same level of personality consolidation as either of the “pure” type of individuals. Hence, they are more vulnerable to a wide range of symptoms (neurotic and psychotic symptoms, as well as labile and flattened affect), have considerably greater difficulties in cognitive functioning and reality testing (as manifested by lower Performance IQ scores and more thought disorder and less capacity for accurate object representation on the Rorschach), and they tend to use less mature defense mechanisms (i.e., projection on the TAT).

Freud (1931/1961b), in his discussion of the role of various libidinal types in the genesis of the neuroses, noted that pure libidinal types “seem to have a better prospect of manifesting themselves as pure character-formations, while . . . mixed types would provide a more fruitful soil for the conditioning factors of neurosis” (p. 219). Consistent with Freud’s speculations, our findings indicate that clearly organized anaclitic and introjective patients appear to have achieved a defensive consolidation that facilitates their apparent adaptation but that also seems to limit their capacity to respond to therapeutic intervention. Mixed-type individuals, in contrast, seem to have a less consolidated defensive structure and therefore are initially more symptomatic but are also more accessible to intervention and change. Although mature psychological functioning also involves investment in issues of both relatedness and self-definition (Blatt & Blass, 1990, 1996; Blatt & Shichman,
1983), these concerns are at a high developmental level involving an interest in intimacy and efforts to achieve a consolidated identity and a sense of integrity. Furthermore, these concerns are coordinated and reciprocally organized, such that development occurs in a mutually facilitating, dialectic interaction between issues of relatedness and self-definition (Blatt & Blass, 1990, 1996; Blatt & Shichman, 1983). In contrast, when these two sets of concerns occur in seriously disturbed patients, the issues are at lower developmental levels, involving issues of neediness and dependency as well as concerns about separateness and control, and are relatively unintegrated, leading to increased vulnerability and impairment.

Despite significantly greater impairment at admission, our findings suggest that the mixed-type individuals had greater improvement in psychoanalytically oriented treatment, in comparison with their clearly defined anaclitic and introjective counterparts. Specifically, decrease in symptomatic behavior and utilization of projection as a defense mechanism and improvement in cognitive functioning was more pronounced among mixed-group inpatients than it was in the clearly delineated anaclitic and introjective patients. These findings raise the interesting possibility that the consolidated mode of adaptation or defenses of clearly defined anaclitic and introjective inpatients may impair their accessibility to treatment and limits the extent of their therapeutic gain. The lack of consolidation of a well-articulated defensive organization may make the mixed-type inpatients more accessible to therapeutic intervention. Subsequent research is needed to confirm and elaborate this interpretation.

These results with mixed-type inpatients illuminate two counterintuitive patterns that were found in previous analyses of this data set (Blatt & Ford, 1994; Blatt et al., 1988). The first pattern is the lack of almost any statistically significant differences between anaclitic and introjective patients in their clinical case record and psychological test variables at Time 1 (with the sole exception of introjective patients’ having more psychotic symptoms than anaclitics at Time 1). As demonstrated in the present study, when a mixed-type group was identified, numerous statistically significant differences emerged, not only between that third group and the other two groups, but also between the “pure” anaclitic and introjective groups (e.g., regarding impulsivity and verbal IQ). The finding of greater therapeutic responsiveness of the initially more disturbed mixed group also clarifies the findings of the prior path analyses (Blatt & Ford, 1994; Cook, Blatt, & Ford, 1995) that indicate that more disturbed patients (e.g., those with greater initial thought disorder) make greater therapeutic gain (e.g., fewer symptoms).

Several qualifications and suggestions for further research should be noted. First, although some of our findings suggest that gender plays a moderating role in the relationship of personality to vulnerability and impaired functioning, as well as therapeutic responses, these findings should be interpreted with caution. Interaction effects involving the mixed group are particularly difficult to interpret, as very little is known about this group. Even further, effects involving the more clearly defined anaclitic and introjective groups are not always consistent with prior findings on gender congruence. Although some effects (e.g., those found when using the TAT defense-mechanisms scales) supported the hypothesis regarding poorer functioning among gender noncongruent individuals, other effects (e.g., that found when using the Menninger Impulsivity scale) contradict this hypothesis. Hence, the exact role played by gender in the development of anaclitic, introjective, and mixed-type tendencies should be investigated systematically in future research with a larger sample.

Second, although the assessment strategy employed in the present study yielded reliable and valid estimates of the anaclitic–introjective dimensions, the strategy used in this
study is by no means the most optimal one. Limited resources required our utilizing only two raters of the clinical material. Conceivably, utilization of additional raters may have increased reliability and validity of the variables.\(^3\) Nevertheless, the present study illustrates that the raters’ assessment strategy is not only reliable and valid, but is also particularly well suited for psychoanalytically oriented data.

Despite these limitations, the unique features of the Riggs-Yale Project render these data particularly important in the empirical investigation of psychoanalytically oriented treatment. These features include (a) a clinically relevant sample of severely disturbed and treatment-resistant inpatients who could be reliably classified in terms of their personality organization; (b) a diverse assessment protocol that included reliable ratings of both clinical functioning and psychological vulnerability; (c) a treatment regime that is long-term and psychoanalytically oriented; and (d) a longitudinal study design that facilitated the comparison of anaclitic, introjective, and mixed-type individuals on therapeutic change, as well as the initial ratings of their behavioral and psychological functioning. It is our hope that other psychoanalytic investigators will explore additional dimensions of this data set, providing further insight into the course of psychoanalytically oriented treatment of seriously disturbed, treatment-resistant inpatients.

\(^3\)As indicated by one of the reviewers of this article, an optimal assessment strategy would include three pairs of judges to rate the clinical case records. One pair would independently rate all 90 patients for personality (i.e., anaclitics, introjectives, and mixed type). The second pair would rate the clinical material at Time 1, and the third pair would rate the clinical material at Time 2.

References


