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A New Instrument to Assess Counterdependency, Evaluated in the Context of Postpartum Depression

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Counterdependency, a concept that describes defensive activity against dependent strivings, especially wishes to be taken care of, is gradually receiving increased clinical recognition. Clinical observation suggests its importance in many women with postpartum depression (PPD). In this article we report the development of a new self-report instrument to assess counterdependency, the SB Counterdependency Inventory (SBCI). We test the instrument in a population of women visiting websites concerning PPD. We find the instrument to have high reliability, good convergent validity, and that it discriminates between a population with PPD and a control population. Our results with the SBCI help to empirically establish the role of counterdependency as a psychological feature that is associated with PPD.

Keywords: counterdependency, counterdependence, postpartum depression, neonatal depression, defense mechanisms

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Counterdependency describes a defensive position against dependent strivings, especially wishes to be taken care of. It is a concept with broad implications for understanding human adaptation, psychology, and social relations. Counterdependent adaptation centers around a need not to be taken care of, often accompanied by a hesitation to ask for help, a need to deny the wish for help, a strong work ethic, and sometimes a degree of self-sacrifice. Helping others, rather than acknowledging one's own wishes to be helped, is often a part of the counterdependent picture. Counterdependency is a defense mechanism in the traditional sense, but at the same time can serve as a broader form of adaptation, a durable personality trait. It can be seen in individuals across a wide range of functional ability, and its presence can promote either a high level of function, or at times simply the appearance of it.

Empirical evidence of counterdependency as a potential risk factor for postpartum depression (PPD) will add it to a list of empirically observed factors that include prior depression, depression and anxiety during pregnancy, low levels of social support, unwanted pregnancy, problematic relationship between a new mother and her own mother, and mood reactivity in

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response to hormonal changes (see Blum, 2007, for references), as well as neuroticism (Martin-Santos et al., 2012).

The first clinical description of counterdependency, an early case of Freud's (1892/1953), did not use the term.[1] Compared with the defense mechanisms characteristic of hysteria, phobia, obsessive–compulsive phenomena, and borderline and narcissistic states, counterdependency has received limited attention in the psychoanalytic literature. Counterdependency has received some empirical attention in relation to chronic pain (Gregory & Berry, 1999; Gregory, Manring, & Berry, 2000; Gregory, Manring, & Wade, 2005), and more recently has clinically been observed as important in PPD (Blum, 2007). Despite these initial empirical and clinical reports, and apart from the occasional psychoanalytic reference, the concept of counterdependency remains relatively absent from the broader literature of psychology and psychiatry. In this study we report the development of a new self-report instrument to assess counterdependency, the Smith Blum Counterdependency Inventory (SBCI); conduct a preliminary assessment of its psychometric properties; and explore whether it discriminates between samples with and without PPD.

A Review of Counterdependency Literature

The modest but developing literature on counterdependency is scattered and diverse, but with few exceptions is consistent in how the concept is understood. Barbanell (1986) noted a high occurrence of counterdependent adaptation in people in the helping professions, but emphasized a view of counterdependency as "needing to be needed," rather than as a need to show that one does not need. Wilson, writing about severe depression, used the term counterdependency as "defending against the emergence of dependency wishes" (Wilson, 1986, p. 238), a definition similar to ours. Fowler, Hilsenroth, and Handler (1996) studied early memory and dependency strivings. They contrasted mature and anaclitic forms of dependency to counterdependency, which they described as "a highly conflicted state in which conscious and unconscious efforts are made to avoid and refute the need for closeness out of basic fear" (p. 403). Following Bornstein's (1993) earlier work on dependency, Bornstein et al. (2003) developed the Relationship Profile Test (RPT), which has subscales for Destructive Overdependence, Healthy Dependency, and Dysfunctional Detachment, the latter having some overlap with the concept of counterdependency. The RPT has now been validated and compared with other instruments in several different populations (Haggerty et al., 2016). Cooper (1992), in clinical observations of patients struggling with addictions, linked counterdependency to codependency (i.e., a drive to place others' needs and wants ahead of one's own), arguing that both result from deficient and pathological "early self-selfobject relations." Cooper sees counterdependent people as having had unmet needs and wishes to be taken care of in early childhood; they then engage in futile attempts to defend against dependency needs by turning attention away from those needs and instead focusing on the needs of significant others. She suggests that typical emotions felt by counterdependent people include shame, embarrassment, humiliation, and rage related to poor parental responsiveness.

Contemporary versions of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (*DSM–III–R*, APA, 1987; *DSM–IV–TR*, APA, 2000; *DSM–5*, APA, 2013) have not recognized counterdependency as a distinct diagnostic category. However, the Psychodynamic Diagnostic Manual (PDM; PDM Task Force, 2006) designated "Counterdependent Personality Disorder" (CPD; p. 109.2) as a converse manifestation of "Dependent Personality Disorder" (DPD; p. 109), pointing to a hidden dependency of counterdependents as well as a predominance of the defensive tendencies to engage in denial, reversal, and enactment. The second edition of the PDM (Lingiardi & McWilliams, 2017) notes that "Counterdependent individuals may look askance at expressions of need and may regard evidence of emotional vulnerability in themselves and others with scorn" (p. 35). The PDM represents a significant step in bringing the concept of counterdependency into consistent clinical usage. We concur with the PDM's central, clinically derived meaning of the term counterdependency as an attempt to defend against, deny, and reverse dependent wishes to be taken care of, especially by attempting to show that one does not need help or care.

The lone empirical study in the counterdependency literature, merits further consideration. Gregory and Berry (1999) demonstrated counterdependency to be an important factor in a population with chronic pain. Starting from the idea that in some patients chronic pain conveys wishes to be taken care of that these patients regard as unacceptable (and are unable to directly communicate), Gregory and Berry developed a five item Counterdependency Scale (CDS). The five CDS items are designed to capture particular traits of chronic pain patients, specifically suppression of emotions, denial of relationship problems, work ethic, caregiver role, and self-reliance. In addition to distinguishing chronic pain and control populations, the CDS has acceptable and significant levels of item-to-scale correlation, and it has demonstrated acceptable test–retest reliability (Gregory & Berry, 1999, p. 343). However, the range of the CDS may be limited by its somatic orientation and its one-item-per-factor construction.

Postpartum Depression and Counterdependency

Women with postpartum depression appear to be a population for whom counterdependency is a frequent and important feature (Blum, 2007). Many women manage very well to take care of themselves, their partners, homes, jobs, and so forth, without asking for help, but when they have a baby, managing without help becomes impossible. Numerous clinical observations show that these women, unable to ask for help, can become depressed suddenly and unexpectedly, but that once they are able to ask for and accept sufficient help, many recover remarkably quickly (Blum, 2007). We regard counterdependency as a significant clin-

[1] In the period just before Freud began to formulate psychoanalysis, he was called upon to see a postpartum woman having difficulty nursing her baby. Finding that a typical hypnotic suggestion that all would go well brought only brief benefit, Freud intuited that the woman was struggling to feed her baby on account of unacknowledged wishes that she herself be taken care of. He tried a novel hypnotic suggestion: "I told the patient that five minutes after my departure she would break out against her family with some acrimony: what had happened to her dinner? did they mean to let her starve? how could she feed the baby if she had nothing to eat herself? and so on" (Freud, 1892/1953, p. 120). The patient did as suggested and had no further difficulties.

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ical matter that would benefit from empirical study, and women with PPD as an important population with whom to carry out such an investigation.

It is not surprising that conflicts concerning dependency and counterdependency should contribute to clinical problems such as PPD. Compared with most species, humans begin life after birth in an unusually ill-prepared, dependent state (Konner, 2010). Babies who are adequately cared for develop intense caring relationships with significant others (Gilmore & Meersand, 2014). In the course of development, dependent wishes (i.e., wishes to be taken care of, loved, held, and indulged) may be obscured by many other layers of thought, wish, and concern, but they never disappear. Anna Freud (1965), for example, regarded such dependency strivings as a significant focus in both child and adult analysis. She described a "developmental line" reflecting movement "from the infant's complete emotional dependence to the adult's comparative self-reliance and mature sex and object relationships (p. 63)." Dependent wishes and feelings, however, inevitably become a source of emotional conflict. All humans, faced with the need to grow up, must overcome dependent wishes and set some of them aside in favor of other pursuits.

Clinical experience with both adults and children generally, as well as with women suffering from PPD in particular, shows that dependent wishes may come to be experienced as embarrassing, humiliating, babyish, and anxiety-provoking. Many people then develop critical attitudes toward such wishes, and strong emotional avoidance of and antagonism toward them. These defensive reactions may manifest in denial of dependent wishes, a need to demonstrate that one does not need help, and/or an inclination to show that one takes care of others as a way of showing that one does not need help oneself, that is, counterdependency. Defensive positions such as these often contribute to personality traits such as tending to sacrifice one's own interests for someone else's, having a strong work ethic, and striving to be needed, all traits that are often seen clinically in PPD (Blum, 2007).

Present Study

Given the evident importance of counterdependency, and the relative lack of prior theoretical and empirical attention to it, we aim in the present study to develop a self-report instrument to assess counterdependency, the SBCI. Although we have designed the SBCI for potential applicability across a broad range of populations, given our view of the relation of counterdependency and PPD, we designed items to assess a range of commonly seen emotional features of PPD in addition to items focused on counterdependency per se. In particular, conflicts about the expression of anger, as well as aspects of self-sacrifice are often seen in depressed populations, and clinically, in PPD these are often intertwined with patients' counterdependent stances. In this study we test the SBCI in relation to PPD, following the clinical observation that counterdependency is common in that population. We assess the SBCI's reliability, convergent validity, and its ability to distinguish PPD and control populations.

Method

Participants

Participants in the present study were 159 women aged 19 to 59 years (M_{age} = 34.87 years, SD = 5.95 years) who were recruited from websites concerning postpartum depression. The sample was predominantly White (n = 147) and well-educated, with 76.8% of the sample obtaining a bachelor's degree or higher. Within the 159 participants included in this study, a total of 82 participants (52.2%) replied yes to a question asking if they felt depressed currently. Of these 82 participants who self-reported depression, 64 answered yes to a following question asking whether they attributed their depression to a postpartum reaction. These 64 participants are hereafter referred to as the clinical sample and the remaining 95 participants are referred to as the control sample.

Procedure

All study procedures were approved by the Institution Review Board at the University of Pennsylvania. Participants were recruited through advertisements placed on websites concerning postpartum depression, almost all from the Facebook page of The Postpartum Stress Center (postpartumstress.com). There were likely a few participants who found their way to our link via other sites, but we are unable to track them with certainty. Participants volunteered their time, provided informed consent, and then completed the battery of self-report questionnaires described below.

Measures

Demographics questionnaire. Participants completed a demographics questionnaire in which they were asked to report their birth year, sex, place of residence, language, race, education, occupation, and marital status.

Edinburgh Postnatal Depression Scale. The Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987) was used to assess severity of PPD. The EPDS is a 10-item, 4-point scale where items range from 0 = *normal* to 3 = *most severe*, with a higher score indicating a greater severity of symptoms. The EPDS is widely used as a standard measure of PPD. Although the EPDS was developed with cutoff scores indicating clinical depression, the total score has also been used as a continuous variable (Fredriksen, von Soest, Smith, & Moe, 2017). Thus, the EPDS composite score was used as a continuous variable. Cronbach's α was excellent (0.90), suggesting acceptable internal consistency.

Satisfaction With Life Scale. The Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985) was used to assess global life satisfaction. The SWLS has five items and is scored on a Likert-type scale from 1 = *strongly disagree* to 7 = *strongly agree* and higher scores indicate higher levels of life satisfaction. The SWLS has strong psychometric properties, including good convergent validity, discriminant validity, and reliability (Diener et al., 1985; Pavot & Diener, 1993). In the present study the internal consistency of the SWLS was good (α = .89).

Experiences in Close Relationships Scale. The Experiences in Close Relationships Scale (ECRS; Brennan, Clark, & Shaver,

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1998) is a 36-item self-report measure that assesses adult attachment. Factor analyses reveal two factors: avoidance and anxiety. Attachment anxiety refers to the fear of interpersonal rejection or abandonment and distress when another person is unresponsive or unavailable. Attachment avoidance involves a fear of dependence and intimacy. People who are high on either subscale are said to have insecure attachment whereas people who score low on both subscales have secure attachment (reviewed in Wei, Russell, Mallinckrodt, & Vogel, 2007). The ECRS has been shown to have a stable factor structure across populations, strong convergent validity, and good reliability (Wei et al., 2007). In our sample, the internal consistency of both subscales was excellent ($\alpha = .93$ for both).

Brief Symptom Inventory. The Brief Symptom Inventory-18 (BSI-18; Derogatis, 2000) is an 18-item self-report measure that is a brief psychological screen for medical patients, but has also been used in community populations. The BSI-18 asks individuals to report on a Likert-type scale from 0 = *not at all* to 4 = *extremely* how distressed they have been in the past 7 days by various circumstances (e.g., feeling lonely, feeling blue, and feeling fearful). Although the BSI-18 has three subscales (depression, anxiety, and somatization) research on the psychometrics of these subscales reveals mixed results (e.g., Asner-Self, Schreiber, & Marotta, 2006; Zabora et al., 2001). Thus, we elected to only use the total score of the BSI-18 for this study. The total score had excellent internal consistency ($\alpha = .92$) in the present study.

Smith-Blum Counterdependency Inventory. We developed the initial item pool for the SBCI as a 35-item self-report measure that uses a 5-point Likert scale (see Appendix). We incorporated items from Gregory's and Berry's CDS and added items that we designed to be sensitive to counterdependency per se, such as needs and wishes to rely on one's self, avoid help, and take care of others. In addition, we added items to assess feelings and traits involving discomfort with anger, and the presence of shame, guilt, and self-sacrifice—features that clinically are often seen together with counterdependency and are commonly present in patients with other types of depression as well as in PPD. People can of course only report what they are conscious of, so we tried to design items reflective of conscious feelings that may indicate these underlying processes and dynamics.

Statistical Analyses

The current investigation evaluated the basic psychometric properties of the SBCI. We performed an exploratory factor analysis with oblimin rotation (given the expected nonorthogonality of factor scores) using an iterative process within SPSS Version 24. Factors for extraction were first selected by examining scree plots, and the percent of variance explained by and number of items loading onto each factor, from which a three-factor structure was determined to be optimal. Subsequent iterations eliminated items with factor loadings less than 0.30. Finally, we examined item-total correlations and Cronbach's α values if deleted for each remaining item on each of the three factors, and removed additional items for which values suggested the internal consistency of each factor would be improved if removed. Once we determined the final set of items comprising the SBCI, internal consistency reliability was calculated using Cronbach's α for each subscale and for the total score.

To assess the convergent validity of the SBCI, we calculated bivariate correlations between scores on the SBCI and scores on other measures that are theoretically related to the SBCI. *T* tests were used to examine differences between the clinical and control populations on all study variables, including the SBCI.

Results

Exploratory Factor Analysis and Internal Consistency of SBCI

We conducted an exploratory factor analysis with oblimin rotation using an iterative process within SPSS, starting with all 35 items from the SBCI. The initial exploratory factor analysis (EFA) yielded 12 factors with eigenvalues greater than 1; however, an investigation of the scree plots, the percent of variance explained by each factor, and the number of items loading on the 12 factors suggested that a three-factor structure would be more optimal (and more parsimonious). Subsequent iterations limited the number of factors to three. These models also indicated that several items should be reverse coded (as their strongest factor loading was negative: Items 14, 27, 30, and 34), or dropped from the model because of all factor loadings being less than 0.30 (Items 1, 3, 15, 23, and 31). The 30 remaining items loaded onto three factors that we labeled *Suffering* (the emphasis of these items seems to be suggestive of suffering, guilt, shame, and self-criticism), *Self-Sacrifice* (the items appear to center on more successful self-sacrifice, with less suffering), and *Claims of Strength* (the items suggest feelings that others look to the respondent for help and strength). Together these factors accounted for 32% of the variance in item responding. We then examined the item-total correlations and Cronbach's α values if deleted for each item on each of the three factors. These values suggested that the internal consistency of Factor 3, Claims of Strength, would be improved (from $\alpha = .59$ to 0.74) if two items (20, 34) were removed, so we removed these items. Thus, the final model contained 28 items across three factor subscales (see Table 1). Internal consistency of the final three factors ($\alpha = .74$–0.83) and total scale ($\alpha = .85$) were acceptable-to-good. For bivariate correlation analyses, we flipped the directionality of the SBCI score (described in the measures section above) to aid the interpretability of the correlations.

Validity of SBCI

The SBCI total score was significantly associated with all study measures. Specifically, as hypothesized, the SBCI total score (directionality reversed for interpretability) was associated with scores on the EPDS (i.e., greater counterdependency was associated with higher levels of PPD). The SBCI also was positively correlated with attachment avoidance (ECR Avoidance), attachment anxiety (ECR Anxiety), and recent distress (BSI Total). Additionally, the SBCI total score was negatively associated with satisfaction with life (SWLS) scores. Table 2 presents zero-order correlations between study measures and SBCI total and factor scale scores based on the final 28-item SBCI.

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Table 1
Factor Loadings for SBCI (Final 28 Items)

Item	Factor 1	Factor 2	Factor 3
Factor 1: *Suffering* (M = 44.33, SD = 9.61, α = *0*.83)			
16. I often doubt my friends and family really love me.	**0.750**	—	—
7. I often feel I disappoint others.	**0.719**	0.323	—
18. Emotional pain is a big part of my life.	**0.705**	—	—
6. I get angry easily.	**0.642**	—	—
25. There's no point in sharing my problems with others.	**0.639**	—	—
19. If I fail to live up to expectations, I feel unworthy.	**0.586**	0.343	—
17. I prefer to not show my feelings.	**0.554**	—	—
30. My relationships are perfectly fine.[a]	**0.525**	—	—
27. I am comfortable with depending on others.[a]	**0.483**	—	—
28. If I do not help my family, no one else will.	**0.428**	—	0.394
4. People who often ask others for help are weak and lazy.	**0.404**	—	—
29. If my physical condition were improved, I would have no emotional problems.	**0.397**	—	—
14. I like to spend my free time with others.	**0.383**	—	—
5. Physical pain is a big part of my life.	**0.338**	—	0.304
Factor 2: *Self-Sacrifice* (M = 27.84, SD = 6.43, α = .76)			
10. I'd rather be hurt than hurt someone else.	—	**0.684**	—
12. I find it difficult to say "no" to people.	—	**0.646**	—
8. I am nice to everyone, regardless of how they treat me.	—	**0.643**	—
9. I'd rather help others than help myself.	—	**0.604**	0.405
11. If I do more than others do, I don't mind.	—	**0.537**	—
22. I don't like to ask other people for help.	0.434	**0.526**	—
35. I am more likely to withdraw than to get angry.	—	**0.475**	—
21. I set my goals and standards as high as possible.	—	**0.445**	—
13. People say I'm a martyr.	0.409	**0.414**	—
24. I try hard not to hurt or offend other people.	—	**0.407**	—
33. I have no right to complain.	—	**0.385**	—
Factor 3: *Claims of Strength* (M = 4.08, SD = 1.59, α = *0*.74)			
2. Everyone looks to me for help.	—	—	**0.833**
32. People have always turned to me for strength and support.	—	—	**0.666**

Note. SBCI = Smith Blum Counterdependency Inventory. Highest factor loading in bold. Cross-loadings less than 0.30 are not printed.
[a] Items are reverse-coded.

Differences Between Clinical and Control Participants

T tests were used to compare scores on all study measures between the clinical (i.e., self-reported PPD) and control groups. Clinical participants had significantly lower SBCI total scores, indicating higher counterdependency, compared with the control participants (see Table 3). The clinical participants also had higher scores than control participants on the EPDS, ECR Avoidance, ECR Anxiety, and BSI Total. The clinical participants had significantly lower scores compared with the control participants on the SWLS. Mean scores on all study measures for clinical and control participants along with the p values associated with the mean differences between these two groups are presented in Table 3.

Given that the clinical and control populations are defined by self-reported post-partum depression, we conducted the t tests again using only those participants who reported being pregnant or having given birth within the last nine months and who scored ≥13 on the EPDS as the clinical group (n = 22), and all other respondents as the control group (n = 137). The results mirrored those that were found in the original comparisons, $t(157) = 2.77$, $p = .006$, $d = 0.67$, with the clinical participants reporting SBCI scores reflecting greater counterdependency compared with controls.

Discussion

The present study investigated the psychometric properties of the SBCI, a novel measure designed to assess counterdependency. The results of this study support the reliability and validity of the SBCI. Specifically, the SBCI (directionality flipped for interpretability) was positively associated with several measures of psychopathology: individuals higher in counterdependency tended to report higher levels of symptoms, reflected in higher scores on the BSI-18 and the ECR avoidance and anxiety scales, and lower life satisfaction, reflected in lower scores on the SWLS. The results also show that individuals who reported postpartum depression had SBCI scores reflecting greater counterdependency compared with individuals who did not report postpartum depression.

It is also notable that some individuals in the control group exhibited symptoms of depression that they did not attribute to a postpartum reaction, which may suggest that the differences in counterdependency scores observed between the clinical and control groups may be more specific to postpartum depression than to nonpostpartum depression. Though we were underpowered to examine the comparison between individuals with self-reported PPD and those with nonpostpartum depression, future research into the specificity of counterdependency in postpartum depression is warranted. These results also

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Table 2
Bivariate Correlations Between SBCI Total and Factor Scale Scores and Scores on Other Measures

Scale	SBCI total[a]	SWLS	EPDS	ECR Anx	ECR Avd	BSI total
SWLS	−0.33***	—	—	—	—	—
EPDS	0.55***	−0.68***	—	—	—	—
ECR Anx	0.63***	−0.41***	0.54***	—	—	—
ECR Avd	0.51***	−0.31***	0.47***	0.62***	—	—
BSI total	0.57***	−0.47***	0.77***	0.45***	0.31***	—
SBCI-Suffering[a]	0.89***	−0.46***	0.68****	0.61***	0.55***	0.63***
SBCI-Self-Sacrifice[a]	0.77***	−0.05	0.22	0.45***	0.30***	0.27**
SBCI-Claims of Strength[a]	0.24**	0.17*	−0.04	0.08	−0.05	0.08

Note. SBCI = Smith Blum Counterdependency Inventory; SWLS = Satisfaction With Life Scale; EPDS = Edinburg Postnatal Depression Scale; ECR Anx = Experience With Close Relationships Anxiety Subscale; ECR Avd = Experience With Close Relationships Avoidance Subscale; BSI total = Brief Symptom Inventory Total Scores.
[a] To aid interpretability of bivariate correlations, SBCI factor and total scores multiplied by −1, so that higher scores indicate higher levels of counterdependency).
* $p < .05$. ** $p < .01$. *** $p \leq .001$.

suggest that comparison of a clinical PPD population with a less depressed control group might yield even more substantial differences on the SBCI than can be demonstrated with this initial study.

Further examination of the EFA leads to several additional relevant observations. While the factors appear distinct from each other (Factor 1, Suffering; Factor 2, Self-sacrifice; and Factor 3, Claims of Strength), it is clear that items reflective of counterdependent adaptation are distributed across all three factors. Items such as "People who often ask others for help are weak and lazy," and the reverse-scored "I am comfortable depending on others," along with "There's no point sharing my problems with others" aggregated to Factor 1. (The last of these has more of that sense of disappointment and suffering running through most items in this factor.) Similarly in Factor 2, the items "I don't like to ask other people for help," "If I do more than others do, I don't mind," and "I'd rather help others than help myself" are all demonstrative of counterdependency, with the latter two items also suggestive of self-sacrifice and close to other self-sacrificial items in Factor 2 such as "I'd rather be hurt than hurt someone else" and "I find it difficult to say "no" to people." The two items in Factor 3, Claims of Strength, are "Everyone looks to me for help" and "People have always turned to me for strength and support." These reflect a common stance in counterdependent adaptation, but one that is not always easily maintained. That this factor does not distinguish the clinical from the control population is not surprising, given that in the clinical population, to the extent that its members have tried to take this attitude, it has failed in the face of the underlying dependent needs. The fact that Factor 3, unlike Factors 1 and 2, has a positive correlation with the Satisfaction With Life Scale, is also consistent with the tendency of many who are counterdependent, as part of eschewing any need for help, to report not only that they are strong, but that all is well.

Items suggestive of conflicts over anger and its expression, as well as aspects of self-sacrifice, are likewise present in both Factors 1 and 2. Factor 1, however, is marked by signs of suffering, while the self-sacrificial trends suggested in Factor 2 appear to have more success and less suffering (and less guilty self-criticism) in them. The SBCI results closely reflect clinical experience, in which counterdependency is an important, prevalent psychological factor in PPD, but one that is typically highly intertwined with related defensive struggles with anger, and with efforts to resolve these struggles in a self-sacrificial direction, with varying degrees of success. These results provide initial empirical support for the importance of counterdependency among individuals with postpartum depression. We imagine that in an abstract,

Table 3
Means and Standard Deviations of Study Variables for Clinical and Control Groups

Scale	$M_{Clinical}$ (*SD*)	$M_{Control}$ (*SD*)	*p*-value of difference	*Cohen's d*
SBCI total	69.67 (13.25)	80.69 (12.53)	<.001	0.85
SBCI-Suffering	38.73 (8.32)	48.11 (8.54)	<.0001	1.11
SBCI-Self-Sacrifice	26.94 (7.11)	28.45 (5.88)	0.145	0.23
SBCI-Claims of Strength	4.00 (1.69)	4.13 (1.53)	0.596	0.08
EPDS	17.79 (5.00)	9.75 (5.33)	<.001	1.55
SWLS	20.31 (6.35)	25.14 (6.56)	<.001	0.75
ECR Anx	3.98 (1.47)	3.23 (1.40)	0.003	0.52
ECR Avd	3.09 (1.27)	2.54 (1.10)	0.007	0.46
BSI total	44.30 (12.93)	33.32 (11.60)	<.001	0.89

Note. SBCI = Smith Blum Counterdependency Inventory (original direction of measure, with lower scores indicating higher counterdependency); SWLS = Satisfaction With Life Scale; EPDS = Edinburg Postnatal Depression Scale; ECR Anx = Experience With Close Relationships Anxiety Subscale; ECR Avd = Experience With Close Relationships Avoidance Subscale; BSI total = Brief Symptom Inventory Total Scores.

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ideal world, a factor would emerge that would bespeak counterdependency per se, but our results appear more consistent with clinical reality. That it is difficult to get a "pure culture" of counterdependency may help to explain why this important contributor to PPD has been overlooked for as long as it has.

The etiology of PPD has often been discussed from a preponderantly biomedical viewpoint (e.g., Zonana & Gorman, 2005; Massachusetts General Hospital Center for Women's Mental Health, 2017), and biomedical and psychosocial approaches to understanding have remained relatively separate (Yim, Tanner Stapleton, Guardino, Hahn-Holbrook, & Dunkel Schetter, 2015). The results reported here call attention to significant psychological factors in this disorder. In addition to such factors as whether the mother has social support, and whether the child is wanted, we can add counterdependency, along with associated conflicts concerning anger and self-sacrifice, to the psychological factors to be considered in PPD. These results also add to the expanding list of psychoanalytically derived concepts which now have empirical standing (e.g., unconscious conflict and repression [Shevrin et al., 2013], primary and secondary process thinking [Brakel, Shevrin, & Villa, 2002], and a broad range of defense mechanisms [Bond, 2004]).

Limitations and Future Directions

The present study is not without limitations. Our sample size was small for an EFA. The sample was entirely self-selecting, mainly White, and well-educated, which may limit the generalizability of findings to the population as a whole. Further, the sample self-reported experiencing PPD rather than receiving a formal diagnosis via semistructured interview; that our results are unchanged when the clinical population is limited to those with EPDS scores $\geq$ to a cut-off of 13, however, suggests limited reason for this concern. The lack of other validated measures of counterdependency for the assessment of convergent validity is an additional limitation.

Testing the SBCI in a larger population would facilitate the replication of these results with a confirmatory factor analysis, provide further information about the latent factor structure of the measure, and, hopefully, also about counterdependency more generally. Further research might examine the SBCI's relation to attachment style (anxious and avoidant), as well as with Blatt's anaclitic and introjective depression types (Blatt & Zuroff, 1992). It would also be beneficial to compare the SBCI with Bornstein's Relationship Profile Test (RPT). We would expect there to be a significant correlation between SBCI scores and the RPT's scale for dysfunctional detachment, which we regard as a related, overlapping, but different concept. Counterdependency, as we see it, can occur in people who are avoidantly attached and who keep an emotional distance from others, but the counterdependent need to do things for oneself and not to ask for help can also be seen in many people who are securely attached and who in general relate well to others. This latter group includes a significant number of health professionals. It would also be useful to compare the SBCI with the Rorschach Oral Dependency (ROD) scale, (Bornstein, 1996), as that measure provides an assessment of covert dependency, in contrast to the self-reported responses of the SBCI. Additional suggestions for further research include testing the SBCI in other clinical populations, such as patients with chronic pain, as well as exploring its potential use in cross-cultural study of attitudes concerning counterdependency.

Empirical evidence for the role of counterdependency in PPD also leads back to the question of clinical applications. It would be desirable to administer the SBCI to pregnant women to see if it can be used prospectively to predict risk of developing PPD. While clinical observation has suggested that prompt efforts to assist women with PPD to tolerate the need for help can greatly facilitate recovery, empirical corroboration of the potential benefits of clinical interventions to address counterdependency in this population would be a logical next step.

Finally, and most broadly, it is important to note that culture strongly influences the acceptance of, or defense against, dependent strivings. We regard the United States, for example, as having substantial counterdependent trends in its mainstream culture, exemplified by a "pull yourself up by your bootstraps" ethos, with intense opposition to social safety nets (that take care of people in dependent positions), as compared with other developed countries. Compared with the emphasis in the United States on personal independence, some cultures cultivate more interdependence (Rothbaum, Weisz, Pott, Miyake, & Morelli, 2000). The SBCI has potential use in cross-cultural, as well as clinical, studies, which should be examined in future research.

Conclusions

The SBCI is an instrument to assess counterdependency with good convergent validity with other measures, as well as a compelling factor analysis that correlates well with clinical experience. It distinguishes between a clinical sample of self-reported postpartum depression and a control sample, furnishing empirical evidence for the role of counterdependency specifically in postpartum depression. Our results suggest that counterdependency merits broader clinical and empirical attention than it has thus far received. The SBCI provides a basis for both further empirical research and potential clinical applications.

摘要

反依赖性描述的是对抗依赖努力的防御行为,特别是对抗想要被照顾的愿望,这一概念正逐渐得到越来越多的临床重视。临床观察提示它在很多产后抑郁症(PPD)女性中都很重要。在本文中,我们报告了一个新的评估反依赖性的自我报告工具的开发,即SB反依赖性量表(SBCI)。我们在访问PPD相关网站的女性人群中测试了该工具,这是一种模拟设计,其中女性自我认定是产后抑郁而不是有正式的PPD诊断。我们发现该工具有较高的信度、很好的会聚性效度,并且可以区分患有PPD的人群和正常人群。依据SBCI我们得出的结果可以帮助循证确立作为与PPD相关的心理特征的反依赖性的作用。

关键词: 反依赖性, 反依赖, 产后抑郁症, 新生儿抑郁, 防御机制

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(*Appendix follows*)

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Appendix

SBCI

Below is a list of questions about yourself and others. Please read each question carefully. There are no right or wrong answers. Different people feel differently about themselves and other people. Your answers should reflect how you feel right now. For each question, indicate how much you agree or disagree with each statement by placing the number indicating your level of agreement on the line next to the question.

1. Agree very much
2. Agree somewhat
3. Neither agree nor disagree
4. Disagree somewhat
5. Disagree very much

_____1. Working hard and well is most important to me.
_____2. Everyone looks to me for help.
_____3. I can handle things myself.
_____4. People who often ask others for help are weak and lazy.
_____5. Physical pain is a big part of my life.
_____6. I get angry easily.
_____7. I often feel I disappoint others.
_____8. I am nice to everyone, regardless of how they treat me.
_____9. I'd rather help others than help myself.
_____10. I'd rather be hurt than hurt someone else.
_____11. If I do more than others do, I don't mind.
_____12. I find it difficult to say "no" to people.
_____13. People say I'm a martyr.
_____14. I like to spend my free time with others.
_____15. I get lonely when home by myself.
_____16. I often doubt my friends and family really love me.
_____17. I prefer to not show my feelings.
_____18. Emotional pain is a big part of my life.
_____19. If I fail to live up to expectations I feel unworthy.
_____20. I have many responsibilities I must meet.
_____21. I set my goals and standards as high as possible.
_____22. I don't like to ask other people for help.
_____23. When I am disappointed in those closest to me, I tell them right away.
_____24. I try hard not to hurt or offend other people.
_____25. There's no point in sharing my problems with others.
_____26. I get angry when people hurt me.
_____27. I am comfortable with depending on others.
_____28. If I do not help my family, no one else will.
_____29. If my physical condition were improved, I would have no emotional problems.
_____30. My relationships are perfectly fine.
_____31. Working has helped me feel worthwhile as a person.
_____32. People have always turned to me for strength and support.
_____33. I have no right to complain.
_____34. I like to be taken care of.
_____35. I am more likely to withdraw than to get angry.

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