Adaptational Processes in Affective Disorders :

Conceptual, Empirical and Clinical Perspectives

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Processus d'adaptation dans les troubles affectives:

Perspectives conceptuelles, empiriques et cliniques

Anpassungsprozesse in Affektiven Störungen :

Konzeptuelle, empirische und klinische Perspektiven

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Ueli Kramer

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PROLOGUE

"Science

is organized knowledge.

Wisdom

is organized life."

Immanuel Kant

When I started out the reflection on this dissertation, the first two components of its subtitle ("conceptual" and "empirical") have quite rapidly been defined from the literature at hand. I knew what I was looking for and I knew how I would like to go by in order to achieve this. However, it was not clear at all on which patient population(s) these hypotheses will be tested.

If one would have told me at the outset of this work in 2004 that a great part of my dissertation will be based on a sample of patients suffering from Bipolar Affective Disorder, I would have said plainly - at the time as a trainee-psychotherapist - that this disorder is not accessible to any psychotherapeutic conceptualization nor treatment. Images would have come up of my first clinical experience as a psychologist, right after the end of my undergraduate studies in 2001, at the psychiatric clinic of Burghölzli in Zurich: patients in manic states, loosing control over themselves, being aggressive or presenting with bizarre behaviors and attitudes. How would one be able to intervene effectively as a psychotherapist with such patients? Difficult or impossible, I thought like many others…

Six years after these first experiences, the work at hand should contribute to dispute in a constructive and creative way this wide-spread assumption I adhered for a long time. It will not answer completely the posed question, but question the underlying implications. Thus, this dissertation is a work aiming at questioning and interrogating, at researching and opening up, but not at answering nor finding the truth.

In my clinical experience as a psychotherapist, I find this attitude of quest very often the fundamental stance when entering a helping relationship with a patient. Also psychotherapy is not about offering the answer to the client's question, but understanding the posed question so fully and deeply in its premises that many possible options arise from the reflection.

In this sense, the third component in the subtitle merits fully to be added: "clinical". This component links practice, theory and research and acknowledges the therapist's and researcher's implication in the relationship with the client or the subject of study. I sincerely hope, this multi-faceted approach will make as much sense to the reader as it does to me.

INTRODUCTION

"The irrationality of a thing
is no argument against its existence,
rather a condition for it."
Friedrich Nietzsche

Conceptualizing and Measuring Adaptational Processes in Clinical Psychology

When formulating a general model for the prediction of therapeutic change, psychotherapy researchers generally distinguish between patient's characteristics, therapist's characteristics, process and relationship variables (Norcross, 2002; Clarkin, & Levy, 2004). These variables function as moderator or mediator variables in research designs, interacting with each other and influencing symptom change. Relationship variables, such as the quality of the therapeutic alliance, may be understood as one of the core mechanisms of change in psychotherapy – as a specific or unspecific variable – and are therefore investigated in various settings (Barber, Luborsky, Crits-Christoph, Thase, Weiss, Frank, Onken, & Gallop, 1999; Castonguay, Constantino, & Grosse Holtforth, 2006; Crits-Christoph, & Beth Connolly, 1999, 2003; Horvath, 2006; Martin, Garske, & Davis, 2000; Zuroff, & Blatt, 2006), whereas patient and therapist contributions to alliance processes and outcome are less systematically studied (Castonguay, Constantino, & Grosse Holtforth, 2006). Data exist as regards the influence of patient's functioning on alliance (Hersoug, Monsen, Havik, & Hoglend, 2002), as well as on the effect of the therapist's adapting technique to the patient's characteristics on alliance (Caspar, Grossmann, Unmüssig, & Schramm, 2005; Crits-Christoph, Cooper, & Luborsky,

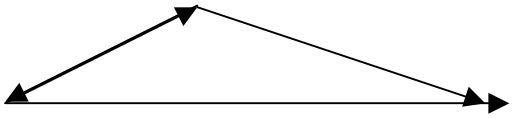
1988; Crits-Christoph, & Beth Connolly, 1999; Despland, de Roten, Despars, Stigler, & Perry, 2001; Hersoug, Hoglend, & Bogwald, 2004). These results suggest the importance of a better understanding of the influencing variables per se, and of the study of linkages among them, as well as their linkages with symptoms and symptom change.

In this dissertation, we will focus on adaptational processes as patient's characteristics. We noticed that patient's variables were very rarely studied in a theory-consistent way, and even when they were, the diagnosis usually served as operationalization. This is insufficient (Clarkin, & Levy, 2004), especially with regard to the enhancement of clinically relevant case conceptualizations for psychotherapeutic treatment planning, process monitoring and prospective mediator modeling. The advantage of using the diagnosis as sole patient characteristic is its consensual value and relative acceptance beyond the boundaries of psychotherapeutic approaches. Using theory-consistent concepts related to adaptation in psychoanalytic treatments for instance might weaken the relevance of such conclusions for other therapeutic approaches, and inversely, using theory-consistent concepts related to adaptation in cognitive-behavioral treatments alone yields results which do not necessarily apply to other approaches. It can be argued that cognitive-behavioral concepts are mostly related to the subject's *capacities* in adaptation, whereas psychoanalytic concepts mostly relate to *internal determinants* of adaptation. Their respective limitations become therefore evident, as competence-related concepts ignore aspects of internally determined reality-distortion and concepts which focus on internal determinants tend to ignore aspects of competence; consequently, these concepts need to be approached in an integrative perspective, for optimal benefit for scientific and clinical purposes (see Bateman, 2002; Castonguay, Newman, Borkovec, Grosse Holtforth, & Maramba, 2005; Power, 2002; Stricker, & Gold, 2005). Therefore, studies on patient's characteristics from a theory-consistent and integrative point of view are needed; the focus on adaptational processes in

psychiatric and psychotherapy patients is certainly a first step in this direction. Moreover, the focus on adaptational processes enables us to integrate data and models from fundamental psychology research into psychotherapy research, hence aiming at a research-informed practice (Grawe, 1997). Figure 1 depicts a general model of concepts and links as we understand the role of adaptational processes in the psychotherapeutic context. Since this dissertation does not lay the focus on therapist nor process variables in the narrower sense, we simplified the model (for recent empirical evidence focusing on therapist variables, see Barber, Gallop, Crits-Christoph, Frank, Thase, Weiss, & Beth Connolly Gibbons, 2006; Kramer, Despland, Drapeau, Currat, Beretta, & de Roten, in revision).

Figure 1

Simplified interaction model on potential moderators and mediators influencing therapeutic change



Adaptational processes, understood as the way the individual meets his/her need to adapt to external and internal constraints, involve the individual's affect regulation. Affects

and emotions are central in the process of the individual's adaptation to reality in that disturbing affects need to be avoided, contained or modulated, and what the individual might call in subjective terms "an emotion" may accompany such a process (Lazarus, 1991; Westen, 1998). Individual psychological processes involved in this respect are defense mechanisms and coping processes (Cramer, 1998a). Control concepts (e.g., Horowitz, Cooper, Fridlander, Perry, Bond, & Vaillant, 1992), concepts more narrowly related to emotion regulation (e.g., Garnefski, Kraaij, & Spinhoven, 2001; Znoj, 2006) or concepts related to other regulating processes (e.g., Sjöbäck, 1973) are not the main focus of this dissertation.

The question of the definition and width of the concept of adaptation is disputed (Hartmann, 1958; Sjöbäck, 1973; Vaillant, 1977; Wallerstein, 1967; White, 1974). In extremis, adaptation as the interaction between the individual and his/her environment may be considered as wide a concept as beauty, i.e., in the "eyes of the beholder" (Vaillant, 1977). Even if there is some truth in Vaillant's comparison – the eyes of the beholder or those of the external observer are indeed highly important for the evaluation of adaptation and adaptational processes -, we would add, consistent with a relativistic and pragmatic point of view of mental health (Sjöbäck, 1973), that adaptation to reality is a successful way of finding consensus between the normative societal imperatives and imperatives related to internal desires, wishes and conflicts. Furthermore, adaptation implies the two facets of phase-adequacy ("timing") and reality-appropriateness. Thus, adaptation in human life is above all *social adaptation* (Wallerstein, 1967).

Particularly within psychoanalytic theory, no consensus exists as regards the extent of the concept of adaptation. Defensive processes conceptualized in this context have either the function of an internal counter-cathexis of arousal related to unresolved inner conflicts or a reality-appropriateness with the external world (Wallerstein, 1967; Sjöbäck, 1973). Reality

appropriateness is related to mental health, whereas counter-cathexis not necessarily so, as this function has pathogenic effects in the sense of a "weakening of the Ego" (Freud, 1937). This is especially the case when these defenses are applied in a pervasive manner. Later, a hierarchical organization of defenses (Vaillant, 1977; Perry, 1990a) was put forward, as initially suggested by Freud (1926; Wallerstein, 1967). Needless to say, psychoanalytic theory considers not merely defenses, but also the resolution of internal conflicts and free communication within the mental apparatus (Sjöbäck, 1973) as related to the individual's adaptation to reality; in its turn, mature defensive functioning might itself contribute to conflict resolution. Within cognitive theory, adaptation to reality of coping may be operationalized as the short-term successful elimination of the stressor ("effectiveness") yielding a positive subjective experience, with no long-term negative effects (Skinner, Edge, Altman, & Sherwood, 2003). The latter concept is an important overlap between coping and defense theories; an individual's adaptation to reality is impeded – "his/her Ego weakened" - when adaptational processes are applied in a pervasive manner. Links with mental health are postulated in the sense that Ego strength and coping effectiveness correlate both with healthy functioning (Vaillant, 1977; for empirical evidence see Perry, 1993a). In this context, we need to differentiate between the adaptational process as the means the individual deploys in order to attain adaptation to reality, the state of adaptedness as the outcome of the adaptational process, also called "adaptation", and the degree of adaptiveness as the level of accuracy to reality of a specific adaptational process, based on its short- and long-term effects (Hartmann, 1958).

Two intertwined problems need to be clarified beforehand: (1) Possible confounding variables when studying adaptation; and (2) The construction of reality. (1) As suggested by Lazarus (2000), adaptational processes, such as defense and coping, may confound with input (i.e., appraisal) and output (i.e., outcome) variables of these same processes. We would argue

that some limited confound is unavoidable. Both models, psychoanalytic (Vaillant, 1977) and cognitive-behavioral (Lazarus, & Folkman, 1984), postulate a circular interaction between adaptational process and stress perception ("primary appraisal"; Lazarus, & Folkman, 1984). As level, intensity and type of stress are moderately related to the type of adaptational process and its adaptiveness, a slight overlap exists between the concepts, but is not considered substantial (see also for a discussion, Vaillant, 1977). (2) If the stress perception of reality (and appraisal of related stress level) is related to individual features such as adaptational processes, what exactly is reality? The definition of reality and its construction depend on the individual's characteristics and premises. We would argue, along with Clark, Beck and Alford (1999), that in normalcy, continuous negotiation between a constructivistic and an empiricistic stance takes place in the individual, yielding a reality construction that is always singular, but presenting sufficient overlap with reality constructions of other individuals in the same social structure. This dynamic view overlaps with Piaget's facets of adaptation as equilibration processes, assimilation and accommodation, in the construction of knowledge (Piaget, 1975). In the case of a "distorted" definition of reality, characterized by low adaptation in defenses and heightened levels of cognitive distortions (Clark, Beck, & Alford, 1999), the empiricist stance vanishes and individuals become pure constructivists in construing and defining reality. Such reality constructions are only minimally shared with other individuals of the same social structure, and potentially impede successful adaptation.

Our focus on affective disorders – a great part of this thesis being based on a sample of Bipolar Affective Disorder – has not come about by chance. Affective disorders in the broadest sense encompass any mental disorders characterized by disturbances in mood regulations. Psychological and biological processes are underpinnings of these dysregulations of inner affective life (see also the descriptive definition offered by the International Society for Affective Disorder; ISAD). Bipolar Affective Disorder is a particularly complex

diagnosis, encompassing at times unpredictable mood changes and loss of the function of reality-testing (see APA; 1994; Goodwin, & Jamison, 1990; Kraepelin, 1913). Emotion and affect dysregulating processes are of paramount importance in such patients (Goodwin, & Jamison, 1990; Greenhouse, Meyer, & Johnson, 2000; Lam, & Wong, 1997); understanding these processes better would help to improve psychological and psychotherapeutic treatments for these psychopathological conditions (for a single case study, see Kramer, 2006b; see also Mansell, 2007). Especially for long-term outpatient treatments of Bipolar Disorder (BD), - excluding the acute crisis situation - psychotherapy has proven to be highly effective as adjunct to pharmacological treatments (Jones, 2004; Kazvi, & Zaretzy, 2007; see also Jamison, 1995, for a personal account). However, literature on adaptational processes in these patients is sparse (Ablon, Carlson, & Goldwin, 1974; Greenhouse, Meyer, & Johnson, 2000; Perry, 1988; Perry, & Cooper, 1986). To our knowledge, no literature exists on links with psychotherapeutic contextual variables; no literature applying methods of individualized case conceptualizations for psychotherapy has been found (for a first attempt from an integrative-cognitive perspective, see Mansell, 2007; see also Kramer, 2006b). Another reason of our focus on BD patients is that there are very few structured psychotherapeutic concepts being proposed to this patient group. This enables to study adaptational processes per se, extraneous to the psychotherapeutic intervention context and, by the same token, to develop, adapt and enhance such interventions to these patients. Finally, when we as psychotherapists and clinical researchers work with this challenging group of patients, we should be humbly aware that the effects of a highly biologically-determined mental disorder (Faraone, Glatt, & Tsuang, 2003; Goodwin, & Jamison, 1990; McElroy, Altshuler, Suppes, Keck, Frye, Denicoff, Nolen, Kupka, Leverich, Rochussen, Rush, & Post, 2001; Smoller, & Finn, 2003) impose considerable limitations on long-term individual functioning, and at times on the psychotherapeutic process, as well. This should be part of any case conceptualization in BD.

Finally, we aim at understanding adaptational processes as patient characteristics in all types of patients, irrespective of their initial diagnosis. We believe that these processes differ slightly in different groups of patients – which is relevant information for further studies and clinical practice. Most importantly, the methods used for conceptualization of adaptational processes should prove to be accurate for all types of patients and almost all clinical situations. For these reasons, we will not hesitate to apply our hypotheses to a very different population: university students with Adjustment Disorder, undergoing short-term psychodynamic psychotherapy.

In-depth understanding of adaptational processes in inpatients suffering from significant mood swings and the tentative understanding of the same processes in a higher-functioning sample of psychotherapy patients will enable us to draw first conclusions with a heightened level of external validity and clinical usefulness. The focus on specificity of adaptational processes in different diagnostic groups is supported by the current important trend in psychotherapy to tailor conceptualization and treatment as a function of disorder-specific and approach-independent, i.e., integrative models, rather than to use disorder-non-specific techniques from a single therapeutic approach (Ambühl, 1998; Dammann, & Janssen, 2007; Grawe, 1998; McCollough, 2000; Sachse, 2003).

Clinical psychology, as we understand it, requires the use of high-quality, valid, reliable methodology, aiming at advances on conceptual, empirical and clinical levels and fully taking into account the inherent complex inter-relatedness of these three levels. When faced with the suffering of patients, as psychotherapist or clinical researcher, it is convenient for us to admit that we never make an observation within a theory-free zone. We may be reduced to using a loose juxtaposition or compulsive accumulation of data of multiple clinical trials; these observations are in reality embedded in a “clinically holistic” and meaningful understanding (Stiles, 2005). In this sense, our view is clearly opposed to the precept “let the

data speak for themselves", where research conclusions are supposed to be drawn free from any theoretical pre-conceptions (see Strauss, & Corbin, 1998). Clinically meaningful understanding implies (1) A level of inference based on systematic observation of (verbal and non-verbal) behaviors and experiences in context; (2) An attempt to integrate the observations into a coherent conception; (3) An attempt to draw practical conclusions for case conceptualization or treatment. Hence, using a clinical methodology in this narrower sense, the researcher's percept is influenced by the concept (sensu Kant). We will follow this principle and its three implications radically and apply methodology based on clinical theory - observer-rater methodology derived from clinical and theoretical background. The advantages of this radical clinical-theoretical stance will be high face-validity of the methods, the possibility of understanding the case by means of a case conceptualization, going beyond the mere description and approaching thus the explanation of the clinical phenomenon, the possible use of contextual information giving meaning to observed phenomena, i.e., contradictory information helping to reveal self-deceptions, interpersonally manipulative tendencies or lies, and, finally, the perspective of inherent and immediate clinical relevance of the gathered data with the aim to enhancing psychotherapeutic practice. Thus, such research presents high levels of external validity. Observer-rater methodology based on session-transcripts may be applied to either psychotherapy sessions or research interviews. For the main part of this dissertation, we have opted for the latter, using the research interview technique of dynamic interview (Perry, Fowler, & Semeniuk, 2005; for details see chapter B for example). This choice has been made for several reasons, in line with the above: (1) High external validity of the technique, since it offers a clinical situation very similar to a psychotherapy intake interview; (2) Internal coherence of the interaction, which enhances the quality of ratings done by external observers, because necessary contextual information is in the session-transcript; (3) Information is provided about the feasibility of a psychotherapy

with clinically challenging patients; (4) Non-directive interview approach which allows the optimal study of the patient's spontaneous discourse revealing adaptational processes; and finally, (5) Ethical acceptability, since it offers the patient support, the possibility of clarification and better understanding of him/herself by the therapist use of interpretation and synthesis techniques. The risk of the observer-rater methodology is the projection of the researcher's own subjective material onto the patient's material, in the form of session-transcripts. This risk, which one might call of "radical constructivism", needs to be avoided by the introduction of empiricism in the data analysis, in the form of control ratings by several independent observers, aiming at minimizing biases and at replicability of the trial (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005; Stiles, 2005).

Theory-embeddedness implies the use of "traditional" theories, those that have already developed a sufficient body of validating research, either conceptually, empirically or clinically, another reason why we will mainly concentrate on defense mechanisms and coping processes. In line with these, we will add as complementary strategies of conceptualization cognitive errors (Beck, 1976) and Plans (Plan Analysis, Caspar, 1995). Although defenses and coping as traditional concepts describing adaptational processes have been clinically and empirically validated, their mutual interactions, or possible integration, have not yet been the subject of much research. Therefore, our work will be inspired by several general models on defense and coping, in particular the one defined by Steffens and Kächele (1988). Although this model as a whole is more complex, we will present and apply here only some of its basic assumptions. These are consistent with Lazarus and Folkman's transactional conception of stress and coping and with the traditional psychoanalytic theory of defenses. Figure 2 depicts these assumptions in a graphical form.

Figure 2

General Model of Adaptational Processes (based on Steffens, & Kächele, 1988)

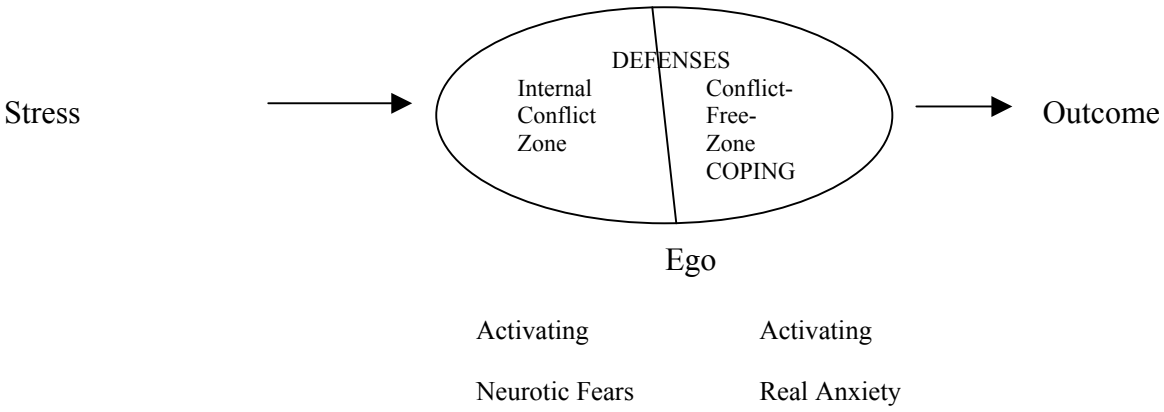


Figure 2 shows the basic assumptions with regard to the dynamic interplay between defenses and coping. External stress, but also stress resulting from internal constraints, e.g., internal conflicts due to contradictory desires, motives or Plans, elicit the Ego's adaptational potential. For patients presenting Bipolar Affective Disorder, one might imagine the stress to be the inpatient treatment situation, a "crisis" episode, possibly resulting from manic decompensation. This stressful situation encompasses internal and external stressors. These stressors might elicit unconscious conflicts in the subject: e.g., desires of subjugation based on childhood experiences controlled by a more rational and conscious desire for independence and self-control. Due to the uncomfortable arousal linked to the emerging awareness of such an internal conflict, the subject engages in a defensive process to contain the latter, e.g., he/she denies the desire for subjugation, or uses reaction formation by declaring to the clinician that he/she will always aim at total self-control in the future, in order to avoid future symptomatic decompensation. If the defensive process is sufficiently successful, the subject has an internal conflict-free zone at disposal in which, he/she might either seek help by trying to find a psychotherapist or object to inpatient treatment constraints: the subject thus engages in coping. Outcome in this model is conceived on the micro-level and understood as the result

of the dynamic-transactional interplay between defense and coping. It can be measured by the symptom level the subject displays during inpatient treatment or his/her overall functioning, more specifically social functioning, in inpatient treatment as indicators for adaptation to reality (Vaillant, 1977). More detailed theoretical elaborations will be found in the following chapters, in particular in chapter A.

While advocating this integrative model of adaptational processes, we are aware of the pitfalls and limitations of integrative tendencies in psychotherapy practice and research; Norcross (2005) has identified five: (1) Defense of "pure" psychotherapy orientations, (2) Inadequate training in integrative psychotherapy, (3) Possible antagonisms on epistemological levels between the models, (4) Different language for the same construct (the metaphor of the Tower of Babel; Messer, 1987) and (5) Omission of factors concerning multiculturalism. Although the second and fifth limitations are certainly not addressed by the model presented and remain clear limitations, we argue that this model responds to the defense of pure psychotherapies and the question of different languages (points one and four), because we use an integrative model that does not invent new concepts, but rather postulates links between established and validated concepts. Finally, the possibility of epistemological antagonisms cannot be completely ruled out by our approach, but we would consider it less important from a clinical-pragmatic perspective. This reflection leads to the question of the ontological status of the model outlined above. The model does not aim to be a fundamental scientific theory. Consistent with clinical theories on defense and coping, it corresponds to the level of an applied scientific theory (see also Clark, Beck, & Alford, 1999 for the same discussion with regard to the cognitive model in psychotherapy). Consistent with this ontological status, we have chosen clinical methodology (see above). Thus, the objective of our research is two-fold: to corroborate implications of the theoretical model by means of appropriate methodology and

to demonstrate by the same token clinical usefulness and relevance of the model and associated assumptions.

Outline of the Chapters of the Dissertation

Written in the form of seven chapters, and ultimately articles, numbered in alphabetical order, the main body of this dissertation addresses some of the issues related to the afore-mentioned integrative model on defense and coping, questions of measurement and conceptualization, stability and change of the processes and relations with psychotherapeutic contextual variables and outcome. Chapter A is a conceptual overview, chapters B through E are based on the patient sample presenting Bipolar Affective Disorder, and chapter G on the student sample undergoing psychodynamic psychotherapy. The individual chapters may be read independently. These chapters will be followed by a general discussion. All references are to be found at the end of the text. Several additional tables are provided under appendices, respecting the corresponding alphabetic order of the seven chapters.

Chapter A focuses on conceptual issues related to integrative models of defense and coping. It is based on Cramer's (1998a) discussion of the distinctiveness of underlying psychological processes. Particular emphasis will be given to the presentation and discussion of recent integrative models of defense and coping (Chabrol, & Callahan, 2004; Steffens, & Kächele, 1988; see Figure 2). Cramer's conclusions and these models will be discussed with regard to four aspects potentially differentiating defense from coping, consciousness, goal-directiveness, adaptiveness and the question of trait versus state. It appears that, unlike Cramer's conclusion (1998a; 2001), both defenses and coping probably have unconscious and conscious aspects, thus limiting the relevance of this criterion for differentiation. Similarly, both processes are characterized by some goal-directiveness. Adaptiveness may be described according to different criteria, namely qualitative for defenses and quantitative for coping. It

appears theoretically that a clear-cut differentiation can be found with regard to the state-trait debate: Coping is a state-variable, whereas defense encompasses trait- and state-aspects. Finally, the nature of the underlying fear may be differentiated: coping entails dealing with real anxiety and defenses neurotic anxiety. The latter assumption from the Steffens and Kächele model will not be tested empirically.

Chapter B focuses on the right-hand side of the general model (Figure 2): coping specificity in BD and its links with outcome on a micro-level, operationalized as symptom level. With this in mind, we will compare the mean coping profile of BD patients with the mean coping profile of matched controls. The latter are controlled with respect to gender, age and level of education. Focusing on specificity in BD should imply that coping is independent from symptom phase, but varies as a function of diagnostic group. These processes are investigated at a second measure point, as is the relationship with symptoms. Moreover, in line with the debate on the consciousness of coping processes (Cramer, 1998a; Lazarus, 2000), a multi-method comparison is applied, lending some support to the concept of coping as a partially unconscious process. Finally, relevant aspects from Figure 1 will be investigated; the influence of coping processes on the quality of the therapeutic alliance and on symptom change is tested. The unit of analysis will be the individual coping strategy.

Chapter C is twin to the preceding chapter, but focuses on the left-hand side of the general model depicted in Figure 2: specificities in defense mechanisms and their links with outcome of the adaptational process, operationalized as symptom level. Similarly as above, the mean defense profile of the BD patients is compared to the mean defense profile of the control group; in particular, the role of immature defenses is investigated, also by relating them to the symptom level (Perry, 1988). Again, specificity in BD implies that defense is independent from symptom phase, but varies as a function of diagnostic group. Defenses at a second measure point are tested. In the same way as in chapter B, a multi-method comparison

is applied, which aims at lending support for defenses as an unconscious process (Cramer, 1998a). Finally, as aspects drawn from Figure 1, mature defenses will be tested as regards the prediction of the quality of the therapeutic alliance. The unit of analysis will be the individual defense mechanism.

Chapter D concentrates on the complete model depicted in Figure 2: defenses and coping addressed from an integrative vantage point, linked to the clinical diagnosis of Bipolar Affective Disorder and to symptom level, as micro-outcome of the general model (Figure 2). In particular, we will investigate the core hypothesis related to stability and change in adaptational processes outlined in chapter A (Steffens, & Kächele, 1988). Furthermore, the assumption underlying Cramer's (1998a) review, which says that defenses and coping are underpinned by two different psychological processes, is tested and discussed within the context of previous studies. Finally, the clinical notion of "crisis" (Küchenhoff, & Manz, 1993) and particular intervention strategies are discussed based on the results. Units of analysis are respectively the coping category and the defense level.

Chapter E illustrates the links between cognitive errors on the one side and symptoms and the therapeutic alliance on the other. Overall and specific comparisons will be made. Consistent with Beck's negativity and universality hypotheses (Clark, Beck, & Alford, 1999), a specific focus is laid upon the differentiation between positively and negatively valenced cognitive errors and their links with either mania or depression as predominant symptoms. Finally, the influence of these errors on the therapeutic alliance is investigated, thus, this chapter focuses more particularly on aspects outlined in Figure 1.

Chapter F applies a valid methodology of psychotherapeutic case conceptualizations to the clinical diagnosis of BD: Plan Analysis (Caspar, 1995). Based on individualized Plan Analyses done on the entire sample of BD patients, this chapter proposes the establishment of a prototypical Plan structure for BD. Two subtypes are identified, described in terms of Plan

specificities, conflict constellations between Plans, prototypical emotions and coping Plans. Relations with symptoms are established. In this respect, Plans and the related hypotheses do not appear directly on either figure as presented in this introduction, but one aspect of the notion of "Plan" is the individualized conceptualization of adaptational processes. These results are discussed with regard to adapted psychotherapeutic attitudes useful when dealing with these patients, according to the principles of the motive-oriented therapeutic relationship (Caspar, Grossmann, Unmüssig, & Schramm, 2005).

Chapter G, finally, might be understood as twin to chapter D, but it will take into account more relevant aspects of the contextual model of psychotherapy than chapter D. This is the only one which focuses on the student patient sample presenting Adjustment Disorder with several co-morbidities and undergoing psychodynamic psychotherapy. This chapter also focuses on the complete model depicted in Figure 2: defenses and coping and their links with symptoms in patients in psychodynamic psychotherapy. In particular, we will investigate a core hypothesis elaborated in chapter A concerning stability and change in these processes in the context of early sessions of psychotherapy (Drapeau, de Roten, Perry, & Despland, 2003). Finally, we examine the role of the therapeutic alliance as a context variable influencing the dynamics of adaptational processes in patients undergoing time-limited psychotherapy. As suggested by Figure 1, the links between adaptational processes and therapeutic outcome will also be addressed.

In a final stage of this dissertation (*General Discussion*), we will discuss eleven core theses with regard to their empirical status, using the seven chapters as a basis and will illustrate some of these by means of patient verbatims from our data pool. The applied methodologies – along with the ensuing results - will be evaluated, compared among each other and criticized in the Discussion section. Further research on adaptational processes is

outlined. Finally, several chapters, but more fully the Discussion section, include clinical recommendations and perspectives for improving conceptualization and treatment practice.

Chapter A

Coping and Defense Mechanisms: What's the Difference? – Second Act

ABSTRACT

Research into adaptational processes has sometimes been confusing as regards differentiating coping and defense mechanisms. This theoretical discussion is based on Cramer's (1998a) highly inspiring effort to disentangle the two concepts concerning the psychological processes involved, as well as acknowledge their mutual overlapping. Although such an effort is needed, at the same time several issues should be re-addressed and further implications on the differentiation of coping and defense processes discussed, such as consciousness and intentionality, goal-directiveness, adaptiveness, and the question of trait v state. Recent integrative models of defense and coping yield a more differentiated picture with regard to these issues: coping includes conscious and unconscious efforts, coping and defense serve very similar functions, adaptiveness can be defined in qualitative (defenses) and quantitative (coping) terms and the question of stability of defenses and coping needs to be tested empirically. Furthermore, the nature of the underlying fear can be theoretically differentiated and related to the difference between coping and defense, as is the implication of competence-related aspects of functioning (coping) and of internal determinants of functioning (defense). Implications for research perspectives implying defense and coping concepts are proposed.

Key-Words: Coping, Defense Mechanism, Psychotherapy Integration, Adaptational Process

COPING AND DEFENSE MECHANISMS: WHAT'S THE DIFFERENCE? – SECOND ACT

When P. Cramer (1998a) wrote her paper on coping and defense mechanisms, the author chose an evocative subtitle: "What's the difference?". This simple phrase aiming at clarification reflects well the state-of-the-art knowledge about the issue: there are a host of empirical studies, based on a variety of conceptions, more or less theory-driven, leaving researchers and theoreticians somewhat overwhelmed. Confronted with so many ways to deal with adversity – from concrete behavioral strategies to emotion regulation and to intra-psychic counter-cathectic processes –, one might wonder "Does distinction really make a difference?"

The afore-mentioned paper makes it clear that the answer is at the same time yes and no, depending on the conceptual criterion applied. It also becomes evident that Cramer's (1998a) comparative view was greatly needed and is therefore very helpful for further studies and elaborations. Thus, our communication will be based on Cramer's review. For example, confusion surrounding the topic has been lessened by the introduction of the term of "adaptational process" (Cramer, 1998a, p. 920) encompassing coping and defense, based on the assumption that both serve the individual's need for adaptation to reality. Within this over-arching definition, we use the following definitions of coping and defense: "Defense mechanisms – i.e., mental mechanisms that alter veridical perception – [are] postulated to function so as to protect the person from excessive anxiety, whether the source of that anxiety be the perception of a disturbing external event or the presence of a disruptive internal psychological state (e.g., a wish, drive or fear)" (A. Freud, 1936, p. 43, cited by Cramer, 1998a, p. 920) and coping as "overt and covert behaviors that are taken to reduce or eliminate psychological distress or stressful conditions" (Fleishman, 1984, p. 229, cited by Holahan &

Moos, 1987, p. 946). However, several conceptual issues on integration of defense mechanisms and coping addressed by Cramer need to be re-addressed and re-evaluated. We think that more reflection is needed, in particular on consciousness and hierarchies of adaptiveness. A second act is needed.

With this article, we aim at maintaining, as far as possible, clear-cut definitions of defense mechanisms on the one hand and coping on the other and preparing hypotheses which can be empirically tested. We will first complete Cramer's review of models of defense and coping – both historical and recent – which will be evaluated according to their empirical and clinical usefulness, their integrative tendency, as well as regarding issues of conceptual overlappings, sequential links between defense and coping, and their inherent limitations. Finally, we will discuss several issues raised by Cramer – consciousness, aim-directiveness, adaptiveness and trait v state -, based on the models presented.

Historical Models of Defense and Coping

Two historical models have been documented by Cramer (1998a), Haan's and Plutchik's. We will re-examine them from a modern vantage point, in order to learn more about shortcomings and strengths of research in the field.

Haan's (1977) three-fold model is based on three levels of Ego functioning: (a) optimal functioning described by coping strategies, (b) non-optimal functioning by defense mechanisms and (c) Ego failure. Ten basic Ego processes have been defined: discrimination, detachment, means-end-symbolization, delayed response, sensitivity, time reversion, selective awareness, diversion, transformation and restraint. Associated to these processes are ten specific processes nested within the levels. The author suggests that a given Ego process in an individual is potentially pervasive on all three levels; facing adversity, the individual deploys a specific coping; if this is insufficient, the person uses the corresponding defense and, if

necessary, the corresponding Ego failure process. Thus, Haan formulates a model of psychopathology close to the Freudian conception of a continuum between normal and pathological states.

In this model, coping and defense are clearly differentiated (Haan, 1977; 1982), coping being defined as mechanisms eliciting secondary processes of thought allowing the individual deliberate and flexible choice and efficient affect modulation and expression; defense being defined as mechanisms referring to primary processes of thought deforming reality and putting the individual in a situation of non-voluntary and rigid functioning. No conceptual overlap is considered in Haan's model. The temporal sequence of coping preceding defense - emerging when coping fails - is postulated by the model.

The principal limitation of the three-fold theory is its definition of coping as optimal and defense as non-optimal processes (Parker & Endler, 1996; Perry, 1990a), reflecting the state-of-the-art definition of the time when N. Haan wrote her books. Later, the concept of defense encompasses adaptive mechanisms, inasmuch as the concept of coping describes maladaptive processes. Thus, the 30 processes described perfectly reflect the three-fold model, but account for neither current psychoanalytic conceptions nor behavioral theories.

Only very little empirical research has been conducted to test the model (see Haan, 1977 for an overview), all categories of coping and defense are theory-driven. The clinical relevance of the model is important, especially for diagnostic purposes of psychopathology.

With his psycho-evolutionary theory of emotion studying adaptation of organisms to emergency, Plutchik (1995) developed another integrative model of basic adaptational processes. According to this theory, ego defenses and coping styles are derivatives of eight basic emotions (depicted in subjective terms: fear, anger, joy, sadness, acceptance, disgust, expectation and surprise) in conflict with anxiety. A correspondence is established between each basic emotion and a specific defense mechanism and a specific coping style. Factor-

analytic methodology (Plutchik, Kellerman, & Conte, 1979) has confirmed these eight basic defenses; however, so far, no full replicative validation study confirming the complete model is known (Grebot, Paty, & Girard Dephanix, 2006 for a partial replication). Included as defenses are: repression, displacement, reaction formation, compensation, denial, projection, intellectualization and regression; and as coping: avoidance, substitution, reversal, replacement, minimization, fault finding, mapping and help seeking. Each couple of correspondence factors serves a specific function for survival, postulated as important for both humans and higher-order animals. In this model, defense and coping are clearly distinguished, ego defense being defined as "*unconscious*, rigid [processes] of limited adaptive value to an immature Ego" and coping styles as "*conscious* methods of solving problems, flexible and generally adaptive". (Plutchik, 1995, p. 30, italics by ourselves). No overlapping, but a clear correspondence between each defense and coping style in terms of a derivative is postulated. The main force – at the same time a limitation - of Plutchik's model is to simplify the list of defenses and coping. For the researcher on the one hand, this might be a welcome variable reduction. For the therapists on the other hand, it seems difficult to accept this reduced version of highly-developed theories of defense or coping; its implementation in clinical practice seems therefore limited. The question of consciousness of the processes, as defined by Plutchik (1995), will be addressed in the Discussion section.

Current Models of Defense and Coping

In Cramer's (1998a) review, at least two recent integrative attempts on defense and coping have not been included, due to the fact that at that point in time, no publication in English was available.

Chabrol and Callahan (2004) developed a conception describing the functional organisation of defense and coping. They postulate that defense and coping usually occur at

adjacent moments, but not simultaneously, in situations of everyday life or in the patient's narrative in psychotherapy. Temporal proximity has already intrigued other theorists, such as Haan (1977) and Vaillant (2000), who postulated a typical sequential order: first the individual tries to solve the problem associated with stress or conflict by engaging in coping processes, second, if they fail, the individual uses defenses which are conceived as less adaptive (see above). Chabrol and Callahan (2004) suggest that this approach is rather simplistic corresponding neither to clinical observations, nor to modern conceptions of coping and defense, and these authors propose a sequential model where defense mechanisms precede coping processes. Thus, defense remains a personality-related concept, very close to its Freudian definition (Freud, 1926), nevertheless dynamic, whereas coping processes are used once the individual's basic unconscious defensive stance (with several levels of adaptiveness) has been established. Within this model, coping processes can still be adaptive, even when preceding defenses are not necessarily adaptive, and inversely, adaptive defenses can also precede dysfunctional coping. This sequential hypothesis has several interesting clinical implications (see Ihilevich & Gleser, 1991); in particular it elicits potential limitations of coping enhancement training, as well as defense interpretation techniques. It might suggest that clinicians should be attentive to coping resources – in highlighting and activating them – at the same time formulating a defense interpretation, as the latter may be stressful for the patient. Inversely, working on enhancing coping presumes the related defense for the particular situation must be clarified (see also Grawe, 1998; Sachse, 2003, for the links between clarification and coping enhancement techniques in psychotherapy).

The model refers to the definition of defenses by A. Freud (1936) and the definition of coping by Holahan and Moos (1987). Overlappings between the two concepts seem possible, but are not substantial. An overall conceptual link is postulated in terms of synergetics between defense mechanisms and coping. Defense mechanisms facilitate or

impede the realisation of the cognitive- or behavior-oriented coping. Adaptive coping may be restricted by underlying immature defense mechanisms and potentialized by underlying mature defense mechanisms. A recent study realised on 190 psychology graduates yields moderate correlations between immature defenses (using the DSQ-40) and maladaptive coping processes (using the Brief COPE), as well as moderate correlations between mature defenses and adaptive coping (Callahan & Chabrol, 2004). So far, to our knowledge, the sequential link has only partially been confirmed by an unpublished study on 20 psychotherapy sessions using independent observer-rater methodologies. Only 36% of all rated defenses are immediately followed by a coping process, suggesting substantial loss of information on individual defensive and coping profiles when this sequential methodology is strictly applied to session-transcripts (Kramer, 2005b).

Yet another model has been proposed by Steffens and Kächele (1988), where the individual's need for adaptation to reality represents the missing link between coping and defense; both categories of processes serve this same function (see also Cramer, 1998a). A clear-cut distinction is made with regard to two criteria: the status of fear and the impact of novel situations to be faced by the individual. With reference to Freud (1926), realistic anxiety ("Realangst") is differentiated from neurotic fear (based on idiosyncratic conflict constellation; see also Hartmann, 1958); defenses operate in the case of the latter, whereas coping is the answer to the former. Thus, in novel situations, both processes are activated at the same time and have clearly distinctive functions, i.e., sub-functions of adaptation. In a stressful "novel" situation, both types of fears (realistic anxiety and neurotic fear) might be activated and these are neutralized by means of defenses and coping. We would develop this point by assuming the signal-anxiety as proximal cause for both defense and coping, and as distal cause only in defense the presence of neurotic fear related to inner conflict (see also Sjöbäck, 1973).

Steffens and Kächele give the following example: in a person given a diagnosis of chronic illness (e.g., cancer), (1) Defenses are activated in order to contain the resurgence of traumatic memories or fantasies related to death, loss, disintegration or castration and (2) Coping processes are activated to face the novel and threatening situation, in a so-called conflict-free zone of the Ego. Two basic coping processes are proposed: allo-plastic and auto-plastic (Hartmann, 1958; see also Perrez, & Reicherts, 1992, for an elaborated definition). Thus, the conflict-free zone of the Ego is only created, if the defensive process is sufficiently effective. We should note that this definition of conflict-free zone in the dynamics of the interplay between defense and coping does not completely overlap with Hartmann's (1958) definition of "conflict-free sphere", elaborated strictly on the basis of psychoanalytic theory.

Nevertheless, Steffens and Kächele's assumption is consistent with the traditional psychoanalytic definition of defenses (Freud, 1894; A. Freud, 1936; Hartmann, 1958; Moser, 1964) underlining the primacy of *internal* stressors, mainly traumatic memories and fantasies, as main triggers of defenses. Steffens and Kächele's (1988) conception is also consistent with the transactional theory by Lazarus (1991; Lazarus, & Folkman, 1984) emphasizing situation-dependency of coping. The assumption of simultaneity contradicts Chabrol and Callahan (2004), but is an argument in favor of parallel processing in facing adversity, underlined also by appraisal research (Scherer, 1984). The model does not exclude a dynamical shift from defenses to coping and vice-versa, thus partially undermining clear-cut boundaries between the two concepts. Hence, defenses, if induced by a situation, might be used as direct adaptation and thus, become coping for a given situation. On the other hand, if adaptational processes (defenses or coping) are used in a pervasive manner – the same process being implacably overused in many different situations -, one must assume the existence of an underlying internal conflict eliciting defensive manoeuvres (and not coping). This seems to contradict what Cramer (1998a; see also Skinner, Edge, Altman, & Sherwood, 2003) called

quantitative criteria of coping adaptiveness (versus qualitative for defenses). In our opinion, if overused coping characterized by stability across different situations is called coping or defense, this is a theoretical question which should be resolved for a particular clinical situation (with limited generalizability), based on empirical data available as to the presence of an internal conflict associated with the process.

In conclusion, according to the basic assumption by Steffens and Kächele, defense and coping are clearly distinguished. However, the authors do not exclude the dynamical transition, under specific conditions, between the two. This transition might account for what in other – more static – conceptions is called conceptual overlap between defense and coping. In Steffens et al.'s conception, the overlap phenomenon is clinically and theoretically accounted for, with a rationale of pervasiveness of adaptational processes related to internal conflicts being provided. The model postulates an overall link between defense and coping, where the creation of a conflict-free zone in the Ego is central, as well as different types of fears elicited by novel situations. So far, no empirical evidence supports the model, although, Küchenhoff and Manz (1993) have corroborated part of a derived model. From a clinical vantage point, however, this integrative conception is consistent with several clinical theories, above all Freud's defense theory and Lazarus' stress-coping model and therefore, thus both its clinical implementation and its empirical exploration seem promising.

DISCUSSION

As shown by the presentation of models of defense and coping, Cramer's (1998a) discussion of the question lacks several current references and thus, needs to be reviewed taking into account these modern conceptions of defense and coping. This is the aim of this second act. We will discuss the issues of consciousness, aim-directiveness, adaptiveness and

trait-state discussion, among others already raised by Cramer. Finally, we will argue in favor of theory-consistent methodology for assessment of defense and coping.

Consciousness

As suggested by Cramer (1998a), the question of consciousness is related to the question of intentionality, without both concepts being perfectly overlapped by each other. Unconscious processes may have conscious correlates, but the motive - or intention - of the adaptational process is generally concealed from consciousness, as may be the process as a whole. Therefore, we discuss the two questions together (for an opposing view, see Newman's reaction, 2001). Defenses, especially non-adaptive ones, are usually defined as processes with an important unconscious part (Freud, 1926; Perry, 1990a). The question is less clear for coping and adaptive defenses. Cramer refers to suppression, traditionally categorized as mature defense (Vaillant, 1977), but implying "a semiconscious decision to defer paying attention" (Vaillant, 1990, p. 262, cited by Cramer, 1998a, p. 925). Based on the argument that suppression thus involves "conscious intention to not allow some thought or event to create psychological disturbance", Cramer would suggest it be categorized as coping (see also Haan, 1977, for the distinction between suppression and repression). This argument needs to be challenged, since it is based on a static conception of adaptational processes. In line with Steffens and Kächele (1988), it can be argued that suppression might be understood as coping and as defense, depending on the type of fear to be contained in the subject and depending on its functionality in novel situations: the question would be: "does this process aim at direct adaptation to external reality – facing realistic anxiety - or at creating an internal conflict-free zone – facing neurotic fear?". Depending on the response to this question, suppression in a given situation would be classified as coping or as defense. A similar

argument might be advanced in answer to the question as to whether denial is a defense or a coping (Sjöbäck, 1973).

The second argument raised by Cramer is that the conscious status of coping is one of the main distinctive features of coping processes (as opposed to defenses). Paradoxically, Cramer (1998a) herself mentions divergent opinions of coping researchers on this tricky question. Certain do not exclude un- or pre-conscious coping (Erdelyi; 1985, 2000; Lazarus & Folkman, 1984), others claim that coping can only be conscious (Parker, & Endler, 1996; Singer, & Sincoff, 1990; Suls, & Harvey, 1996), but these opposing views are discussed neither with regard to theory nor to empirical data. Cramer (1998a, p. 924) concludes that "the majority of coping researchers see these processes as under the conscious control of the person". We would argue, along with Steffens and Kächele (1988, p. 41) that "(…) coping processes on the other hand may certainly occur automatically and thus, may be described as being unconscious, however, they are not - as Ego strategies – anchored within unconscious conflicts"[1]. The latter is reserved for defense mechanisms. Thus, we may have to admit that, at least theoretically, the non-conscious status of an adaptational process alone does not inform us if we are dealing with a defensive or a coping process (see also the discussion of Cramer's paper by Newman, 2001, Erdelyi, 2001; and Cramer's reaction, 2001). According to Steffens and Kächele (1988), we need to be able to identify an internal conflict in the individual in order to talk of a defense; coping does not require this type of adversity. This theory-driven conception is consistent with most conceptions on coping, as it is generally understood as a strategy against situation-related adversity, whether the strategy is conscious,

[1] „Bewältigungsvorgänge hingegen können zwar automatisiert und damit im deskriptiven Sinne unbewusst ablaufen, sie sind jedoch als Strategien des Ich nicht in unbewussten Konflikten verankert".

preconscious or unconscious for the individual (Lazarus & Folkman, 1984; Skinner, Edge, Altman, et al., 2003; Zeidner & Saklofske, 1996).

In conclusion, in order to be able to answer the question of the (un-) conscious status of coping, one needs to compare several methodologies of coping assessment, i.e., self-ratings and observer-ratings (see Tschuschke, Pfleiderer, Denzinger, Hertenstein, Kächele, & Arnold, 1994). Consistent and systematic overlap would be an argument in favor of conscious processes, whereas inconsistency in the results would argue in favor of the existence of unconscious coping; research into this question is therefore warranted.

Goal-directiveness

As suggested by Cramer (1998a), there is consistent overlap – or maybe even no difference - between the two main functions of coping and defense: (1) To reduce negative affect/ward off disruptive negative affect, and (2) Return to baseline functioning/restore a comfortable level of functioning. Thus, functions of defense and coping can be described as (1) Affect regulating, and (2) Maintaining homeostasis of the system. In this sense, the functionality of defense and coping is related to the concept of "Plan" in the Plan Analysis approach (Caspar, 1996), which we draw on to illustrate the afore-mentioned consistent overlap between defense and coping on an individualized level. Plan Analysis differentiates between interactive and intra-psychic goals – motives – and means, the latter being instrumentally related to these goals. For instance, a patient with traumatic memories of his childhood tends to "forget" these in a given current stressful situation and might use a repression. This defense, which might be described as a Plan (Caspar, 1996) "Do everything to forget the painful experience" or "Avoid thinking about the traumatic event", serves instrumentally a higher-order plan which might be called "Avoid upsetting emotions". Thus, the afore-mentioned function (1) of repression aiming at affect regulation is explained.

Moreover, these Plans might also serve another higher-order Plan, such as "Avoid talking in therapy about the trauma" or "Avoid engaging fully in therapy". Such Plans illustrate the afore-mentioned function (2) of repression as defense, which is the maintenance of homeostasis of the system. Moreover, the hierarchy of Plans illustrates the means-end relationships and thus, overlaps with the concept of aim-directiveness being inherent in defense and coping concepts.

Even if the Plan Analysis approach overlaps partially with defense and coping concepts, there are substantial differences, where Plan Analysis clearly surpasses the defense-coping concepts, such as the tailor-made description of Plans aiming at individualized case conceptualizations, the differentiation between intra-psychic and interpersonal regulation processes as Plans, the explicit instrumental links between behaviors, Plans and motives, as well as the instrumental function of emotions in relation with Plans (Caspar, 2007).

To sum up, goal-directiveness allows consistent overlap between defense and coping, and might even be the Achilles heel of adaptational processes – thus, the necessary condition for adaptiveness to be produced; without aim-directiveness of a process, the studied process ought not be adaptational, but embedded in a momentary adversity-free context requiring no adaptation. We therefore agree with Cramer (1998a): coping and defense cannot be differentiated on the sole criterion of aim-directiveness.

Adaptiveness

The question of hierarchy of defenses or coping, according to the criterion of adaptiveness, has been discussed (Cramer, 1998a). Adaptiveness might depend on at least three criteria, initially developed for the concept of coping, but certainly valid for all kinds of adaptational processes (Skinner, Edge, Altman, et al., 2003): the long-term developmental consequences of the process (a question being "What are the long-term costs?"), its

subjective experience ("What does it feel like to practice this process?") and the current qualities ("How can this process be described?").

For defense mechanisms, a hierarchical organisation ranging from maladaptive defenses to mature defenses is widely accepted in psychoanalytic thinking (Cramer, 1991; Perry, 1990a, 1993a; Vaillant, 1977, 1993). However, in coping research, coping processes are rarely ranked according to their degree of adaptiveness. Some researchers describe good news versus bad news coping (Aldwin, & Revenson, 1987), but critics of this dichotomic conception are frequent (Kramer, 2005a, Lazarus, 2000; Skinner, Edge, Altman, et al., 2003). Cramer (1998a) does not exclude a "horizontal hierarchy" describing coping processes as they unfold with time (sequential model: Aspinwall, & Taylor; 1997; Carver, & Scheier, 1981; Folkman & Lazarus, 1985; Rothbaum, Weisz, Snyder, 1982; Tennen, & Affleck, 1997). There are also several attempts to classify coping along a more complex hierarchy; for instance, within a three-level-model (Leventhal, Suls, & Leventhal, 1993). With some exceptions, it can be concluded that vertical hierarchy is associated to defense, whereas horizontal (sequential) hierarchy is linked to coping.

Along with Costa, Somerfield and McCrae (1996) and Cramer (1998a), qualitative differences in defenses account for adaptiveness (see also A. Freud. 1936, for a discussion) – meaning that some defenses are more mature than others -, whereas quantitative criteria might apply to the degree of adaptiveness of coping – meaning that any given coping is maladaptive if practiced ("overused") in a highly frequent manner. Therefore, for optimal adaptation, an individual should engage in mature – high-level – defense mechanisms and at the same time avoid practicing any coping too frequently (Skinner, Edge, Altman, et al., 2003). This hypothesis is theory-driven and needs to be tested empirically. Recent models of defense and coping (Steffens & Kächele, 1988) suggest an overused coping be called defense, due to the underlying internal conflict postulated. We would argue that as long as the underlying internal

conflict has not been reliably assessed in the given clinical situation, coping may be used recurrently, without it becoming a defense. Only empirical research might answer the question of internal conflict being associated with frequent use of a specific coping.

Trait v State

The question of trait v state of defense and coping has been tackled by several researchers (Cramer, 1998a). Underlying this distinction is the empirical question of stability over time of an adaptational process in a given individual. On a theoretical level, we differentiate between personality-driven processes (defense mechanisms) and situation-induced processes (coping processes) (Chabrol, & Callahan, 2004; Cramer, 1998a; Steffens & Kächele, 1988). In this respect, Cramer (1998a) concludes that we are facing mere tendencies, rather than a criteria yielding clear-cut differentiation between defense and coping. We only partially agree, in view of recent integrative models (Chabrol, & Callahan, 2004; Steffens, & Kächele, 1988) and empirical findings (Whitty, 2003). A closer look at the question yields the following: it is common to conceive defenses as personality-driven constructs (aspect of trait), elicited by intra-psychic or external conflicts (Bergeret, 1985; Cooper, 1998; Kernberg, 1984; Perry, 1993a); this would imply both a trait- and state-aspect of defenses (see also Drapeau, de Roten, Perry, & Despland, 2003, for the question of stability and fluctuation of defenses over psychotherapy). Facing the same unconscious conflict, the individual does not need to defend him-/herself by using the same defense across situations, but tends to use certain defenses more often than others, yielding a profile of typical defensive patterns, which undergoes only limited fluctuation over time (Cramer, 1998b; Perry, & Cooper, 1989; Perry, 1993a; see also Vaillant, 1976, for the long-term developmental course of defenses in adulthood). For coping, on the other hand, the particularities of the situation and its subjective appraisal by the individual (Lazarus & Folkman, 1984) determine the coping process

involved, not directly the individual's personality nor the nature of inner conflicts. This implies higher fluctuation for coping over time, compared to defenses. Of course, appraisal research shows links of coping with stable personality-variables (which are aspects of trait; Carver, Scheier, & Weintraub, 1989; Costa, & McCrae, 1990; Hewitt, & Flett, 1996; see also Beutler, Harwood, Alimohamed, & Malik, 2002), but theoretically, coping is conceived as situation-induced, thus rather reflecting the concept of state (Cramer, 1998a; Kramer, 2005a, Lazarus, & Folkman, 1984; Perrez, & Reicherts, 1992). This distinction implies the differentiation of determinants in adaptational processes: coping is essentially externally determined – a concept related to the individual level of competence in adaptation, whereas defenses are essentially internally determined – a concept implying a certain degree of reality-distorted perception. As a result, at least theoretically, clear-cut differentiation can be obtained, as defenses encompass trait- and state-aspects, whereas coping is associated to state. However, it is high time this conception is better understood by being tested empirically (see the conclusions by Whitty, 2003).

Research Perspectives into Defense and Coping

To sum up the research agenda related to adaptional processes, we would need to see the following questions addressed by empirical research (non-exhaustive).

(1) Are defenses and coping based on conscious or non-conscious processes, or both? Comparison between self-report and observer-rater methodology would shed light on this question.

(2) Is optimal adaptation, as operationalized, for instance, by symptoms or symptom change, associated to mature defenses and low frequencies of any coping? A clinical trial on defense and coping in patients undergoing psychotherapy or other treatment would help answer this question.

(3) Are defenses always related to internal conflicts; does coping always follows realistic anxiety? Concurrent assessment of conflicts, defenses and coping on the same clinical material would be of use.

(4) Are defenses best understood as state- and trait-dependent, whereas coping is after all state-dependent? Research into stability and change of defense and coping over time is needed.

Measurement of Coping and Defense in Clinical Psychology

The issue of accurate measurement has been addressed by several scholars and researchers, separately for coping (Carver, Scheier, & Weintraub, 1989; Lazarus, & Folkman; Endler, & Parker, 1990; Perrez, & Reicherts, 1996) and defenses (Cramer, 1991; Haan, 1977; Perry, 1990a). The clinical v research origins of the two concepts are generally reflected by the assessment strategies: clinician-rated evaluation systems of defenses, versus self-report measures, i.e., questionnaires, self-observational methodologies regarding coping. Whereas the former yield high external – clinical and theoretical - validity but may suffer from flaws in inter-rater reliability, the latter show high internal validity and reliability - on subscales produced by factor-analytic procedures - but potentially suffer from low external validity, low theory-consistency and limited usefulness for clinical psychology, due to the low level of complexity in the assessable concepts with such methods.

Related to this classical divergence in measurement is the differentiation between defense and coping in unconscious and conscious processes (see Discussion section). Assessment of coping by means of solely self-report measures is prone to distorted perceptions of self, manipulative tendencies or lies, which might be the consequence of unconscious adaptational processes. On the contrary, assessment of defenses and coping by means of clinician- or observer-rater systems would seem unnecessary for those researchers

who postulate that such processes are conscious for the individual; in this case, questionnaires or self-observation methodologies would suffice. Based on the afore-mentioned discussion, we should leave open the query as to whether coping is conscious or not, and thus, would opt for observer-rater methodology, in addition to self-report measures for assessing coping and defenses (Cramer, 2000; Kramer, 2005a; Lazarus, 2000; Perry, 1993a; Tschuschke, et al., 1994). Observer-rater methods are also perfect ways of controlling for biases due to social desirability, acquiescing, interpersonally manipulative and self-deceptive tendencies. Such methodology responds optimally to the complexity inherent in clinical psychology.

CONCLUSIONS

This paper aims to assess Cramer's effort to address confusion in the concepts of defense and coping and proposes further elaborations on several of the related topics. As such, recent integrative models on defense and coping are presented and discussed. Furthermore, the discussion shows that coping, as well as defense, can be – but need not be - unconscious for the individual. The criteria of goal-directiveness and adaptiveness do not fundamentally differentiate defenses from coping. However, the nature of the underlying fear theoretically differentiates defenses from coping. We may add more generally that competence-related functioning is reflected by coping, whereas internal determinants of functioning are related to defenses. Stability over time is theoretically related to defenses as a personality-related concept, whereas change is related to the concept of coping, due to the status of the latter as a situation-induced adaptational process. Measurement issues are discussed, the relevance and clinical validity of self-report measures for unconscious adaptational processes questioned and theory-consistent methodologies corresponding to the complexity of clinical research objects put forward.

Chapter B

Coping Specificities in Bipolar Affective Disorder: Relations with Symptoms, Symptom Evolution and Therapeutic Alliance

ABSTRACT

Ways to enhance research into coping have been suggested by Lazarus (2000). The issues of consciousness, adaptiveness and structure of coping (Cramer, 1998a; Skinner, Edge, Altman, & Sherwood, 2003) are particularly relevant in this regard; thus, they are addressed and applied in a clinical research setting. A total of 30 inpatients presenting with Bipolar Affective Disorder (BD) have been interviewed twice, as well as the participants of a matched control group ($N = 30$). Self-report and observer-rater methods of coping have been applied. Multi-method comparison adds an argument in favor of coping as unconscious processes. Coping specificities in BD have been identified: opposition and support-seeking are most frequently practiced by BD patients, in comparison with controls; the maladaptive character of opposition is confirmed by links with symptom evolution. No significant link has been found between coping processes and the therapeutic alliance. This study lends support for a quantitative definition of coping adaptiveness which is discussed further.

Key-Words: Coping, Bipolar Affective Disorders, Opposition, Observer-Rater Method, Cognitive-Behavioral Therapy

COPING SPECIFICITIES IN BIPOLAR AFFECTIVE DISORDERS: RELATIONS WITH SYMPTOMS, SYMPTOM EVOLUTION AND THERAPEUTIC ALLIANCE

Coping: Assets and Challenges

Ways of coping, understood as the individual's strategies to face stressful situations, is a central notion in cognitive psychology, research, and therapy. Coping is generally understood as a moderator variable between situational inputs and outcome (Holahan, & Moos, 1987; Lazarus, & Folkman, 1984; Skinner, Edge, Altman, & Sherwood, 2003). Fleishman (1984, p. 229, cited by Holahan, & Moos, 1987, p. 946) defines coping as "overt and covert behaviors that are taken to reduce or eliminate psychological distress or stressful conditions".

Beyond this minimal definition, little consensus exists in the literature on conceptualization, structure and measurement of coping (Skinner, Edge, Altman, et al., 2003). The great number of empirical studies on coping, aiming at the description of coping in cross-sectional designs, certainly yielded some insight into coping processes, but also contributed, paradoxically, to its threatening disintegration as a scientific concept (see Coyne, & Racioppo, 2000; Kramer, 2005a; Lazarus, 2000). Confounds with outcome variables (Coyne, & Racioppo, 2000), as well as issues of delimitation of the field (a difficulty due to a "bewildering richness" of behaviors related to coping; Pearlin & Schooler, 1978, p. 4) contributed to this confusing picture of coping research. In this article, several conceptual issues are addressed, aiming at reducing maximally these confusions (Lazarus, 2000): the degree of consciousness of coping processes, the question of good news v bad news ways of coping and the structure of coping. We will then apply the concept of coping to the specific clinical diagnosis of Bipolar Affective Disorder (BD). Systematic theory-driven coping

research is sparse in this clinical field, despite its high psychological relevance, according to current clinical conceptualizations of BD (e.g., Johnson & Leahy, 2004). We then present, test and discuss the ensuing hypotheses. Our objective is to describe coping specificities in BD, relate them to outcome (e.g., symptom level and change) and other process variables (e.g., therapeutic alliance).

With regard to consciousness of coping, as highlighted by Cramer (1998a), no consensus has been reached among researchers up till now. Certain studies argue in favor of coping being confined to conscious strategies (Parker, & Endler, 1996; Singer, & Sincoff, 1990), whereas others (Erdelyi, 1985, 1990; Lazarus, & Folkman, 1984) also accept the concept of unconscious coping. As argued by Steffens and Kächele (1988), referring to Lazarus and Folkman (1984), coping essentially responds to stress appraisal within a specific situation, generally in an automatized way. Thus, it can be at least *described* as unconscious, not always being under the individual's control. Conceptual overlap with unconscious action tendencies (Lazarus, 1991) support this argument. Furthermore, limitations of a pure questionnaire-approach on coping are well described by Perrez and Reicherts (1996), Tennen, Affleck, Armeli, and Carney (2000) and Lazarus (2000). Biases of social desirability, acquiescing and biases related to self-deceptive processes need to be taken into account. A multi-method approach, implying the comparison between self-report measures and observer-rater methodology (see also Tschuschke, Pfleiderer, Denzinger, Hertenstein, Kächele, & Arnold, 1994) may compensate for the drawbacks of self-report measures and is likely to supply empirical evidence with regard to consciousness of coping.

Another conflictual point of the coping concept is the question of adaptiveness (White, 1974). Are there "good news and bad news ways of coping" (Aldwin, & Revenson, 1987; Lazarus, 2000; Skinner, Edge, Altman, et al., 2003) or is any coping in any situation potentially adaptive? Lazarus (2000) argues in favor of situation-dependency of coping

adaptiveness, based on individualized patterns of stress management and heuristics. In line with this, objective rules have been defined in order to evaluate an individual's coping adaptiveness in a specific situation (Reicherts, & Perrez, 1992; Reicherts, 1999). While this position radically applies the situation-dependency of coping, it is doubtful that coping adaptiveness can be evaluated reliably without taking into account the specific context of the situation, including similar – or dissimilar - situations when the individual had to face adversity. Furthermore, the possibility of dismantling contradictions in the individual's narrative – essential for clinical assessment of coping adaptiveness - is not taken into account by this approach. However, the argument of situation-dependency of coping adaptiveness suggests that coping specificities exist as a function of specific clinical situations or diagnoses. These arguments imply that a quantitative criterion for coping adaptiveness may be applied, rather than qualitative (Costa, Somerfield, & McCrae, 1996; Cramer, 1998a): The more often a specific coping process is used by the same individual – thus becoming a "high-frequency coping" -, the less adaptive this same process becomes; one could talk of "rigidity" of coping patterns (see also the notion of coping inflexibility in personality disorders; Summerfeldt, & Endler, 1996), rather than the qualitative classification of coping processes into distinctly adaptive and maladaptive processes. Finally, Skinner, Edge, Altman, et al. (2003) combine both arguments – qualitative and quantitative - and point out that the prolonged use of certain ways of coping, such as helplessness, social withdrawal and opposition, indicates that the individual is "at developmental risk" (Skinner, Edge, Altman, et al., 2003, p. 231). Thus, coping processes dealing with adversity appraised as a threat, if overused, may be more harmful than other types of coping.

The question of the structure of coping refers to theory-driven classifications (yielded by confirmatory factor analyses or rationale sorting), as opposed to merely empirically-driven classifications (mainly based on exploratory factor analyses; Skinner, Edge, Altman et al.,

2003; see also Lazarus, Averill, & Option, 1974). A total of 100 attempts to structure the concept of coping have been found and criticized based on several desiderata for category systems, i.e., clarity, mutual exclusiveness, comprehensiveness, functional homogeneity and distinctiveness, generativeness and flexibility of the categories (Skinner, Edge, Altman, et al., 2003, p. 219). Instead of multiplying the number of low-level ways of coping or using merely higher-order categories, the authors propose a hierarchical system of the structure of coping, based on action regulation theories (Brandstätter, 1998). Twelve categories - or "families" - of coping, distinguishable according to the nature of primary appraisal of stress (stress appraisal as threat v as challenge), domain (relatedness, competence and autonomy) and orientation (self-directed v other-directed coping), encompass a host of lower level ways of coping (e.g., shouldering, help-seeking, rumination). This classification is the basis used in recent observer-rater methodology (Perry, Drapeau, Dunkley, & Blake, 2005, see Method section), which is characterized by high face validity, as it responds to desiderata formulated for category systems.

Coping Specificities in Bipolar Affective Disorders (BD)

Coping in BD has been addressed by only a few studies as yet. The instruments applied did not meet the high expectations of face and structure validity of coping, as defined by Skinner, Edge, Altman et al. (2003). In a general way, psychopathological states such as depressive or manic symptoms can be understood as either (1) Outcome of coping (Zeidner, & Saklofske, 1996), or (2) Input stressor which the individual has to deal with by means of coping (Summerfeldt, & Endler, 1996). In our study, we will focus on the former, even if some confounds with the latter exist in studies on coping in BD. Furthermore, particularly in BD, a highly biologically-determined mental disorder, a third possibility exists: absence of

direct conceptual link between psychological processes such as coping and occurrence of symptoms and presence of a biologically-determined mediator variable.

Lam, Wong and Sham (2001) and Wong and Lam (1999) base their conclusions on ad-hoc interview ratings developed for measuring coping with manic prodromes (Lam, & Wong, 1997): priority-setting prevented relapse, whereas extra-stimulation as coping increased the probability of relapse. Another study reports rumination and risk-taking as being associated with both depression and hypomania (Knowles, Tai, Christensen, & Bentall, 2005; see also Nolen-Hoeksema, 1991; Nolen-Hoeksema, & Morrow, 1993, as well as Rohde, Levinsohn, Tilson, & Seeley, 1990 and Uehara, Sakado, Sato, & Someya, 1999, for coping in unipolar depression). Greenhouse, Meyer and Johnson's (2000) study yields a correlation between acceptance and treatment compliance in BD, whereas denial is associated with treatment non-compliance. Denial is also reported by Krober (1993) as a specificity of BD, but only after a great number of inpatient treatments. According to Paykel (2001), the nature of primary stress appraisal – together with the absence of social support as secondary appraisal – predicts relapse in BD. When focusing on BD specificity, we assume that specific coping processes occur as a function of the clinical diagnosis as a whole, - as contextual input variable - independently from the current predominant symptomatology. Finally, in the case of BD inpatients, it is particularly important to address the question of lack of consciousness of coping, as the level of insight into their own functioning is generally low (Lam, & Wong, 1997).

This leads us to our hypotheses: (1) Comparison between self-report and observer-rating of coping: moderate or no relationships/correlations are expected; (2) Coping specificity in BD: specific coping processes are more frequently used by BD inpatients, what may be called "high-frequency coping"; (3) High-frequency coping is associated with higher levels of symptoms and negative symptom evolution; (4) Coping changes as a function of the

situation; less high-frequency coping should be observed after discharge; (5) Coping is related to therapeutic alliance during inpatient treatment: the more high-frequency coping, the lower the therapeutic alliance.

METHOD

Sample

A total of 30 inpatients with Bipolar Affective Disorders (BD) were included in the study. A total of 20 (67%) were female, with a mean age of 46.1 years (SD = 11.2 ; ranging from 21 to 60). Their socio-demographic level was assessed by means of the total number of years of education in any field. On average, the patients had 12.4 years of education (SD = 1.1 ; range from 10 to 16). All had a DSM-IV-R diagnosis of Bipolar Disorder I (either F30.x[296.x], F31.x[296.4x or .5x] or F31.6[296.6x]) and were included in the study irrespective of the nature of the most recent phase or of the level of chronicity. Some (13; 43%) presented co-morbid disorders, such as drug abuse (23% ; cannabis, alcool, cocaine), personality disorders cluster C (10%), compulsive-obsessive disorders (3%), acute suicidality (3%) and epilepsy (3%). Diagnoses were established by trained medical staff by means of DIGS (Diagnostic Interview for Genetic Studies; Preisig, Fenton, Matthey, Berney, & Ferrero, 1999). The number of inpatient treatments in psychiatry, including current treatment, varied between 1 and 29 (Mean = 7.7 ; SD = 7.0).

A strictly matched control group was introduced; matching criteria were gender, age and years of education, as these have an influence on coping (Labouvie-Vief, Hakim-Larson, & Hobart, 1987; Whitty, 2003). A total of $N = 30$ persons from a community sample were recruited for the study. Out of these, 20 (67%) were female, with a mean age of 41.9 (SD = 14.3 ; range from 23 to 65). Their mean number of years of education was 12.9 (SD = 1.4 ; range from 11 to 18), corresponding to intermediate education level. No inpatient treatment in

psychiatry is known for these participants and general symptomatology was in the normal range for all control participants. T-tests yielded no significant differences in the matching variables between the groups (see table 1). All participants gave written informed consent.

Instruments

Coping Action Patterns (CAP; Perry, Drapeau, Dunkley, & Blake, 2005; French translation by Kramer, & Drapeau, 2005; APPENDIX B1; APPENDICES B6 to B9). CAP is an observer-rating system assessing coping processes based on interview-transcripts (Drapeau, & Perry, 2005). The rating scale encompasses 12 categories of coping (based on Skinner, Edge, Altman, & Sherwood, 2003). Three general domains have been identified (relatedness, competence, autonomy) encompassing each four categories ("families") of coping. Moreover, six of the coping categories are conceived as coping with stress appraised as challenge (problem-solving, information-seeking, self-reliance, support-seeking, accommodation, negotiation) and the other six as coping with stress appraised as threat (helplessness, escape, delegation, isolation, submission, opposition). Each coping category is broken down into three action levels (affective, behavioral and cognitive). Therefore, 36 coping processes are assessed by this instrument. Relative frequencies are computed for all coping processes. Based on Skinner, Edge, Altman et al. (2003), an Overall Coping Functioning (OCF) score can be computed (relative frequency of challenge-coping). Preliminary empirical validation data have been presented by D'Iuso, Blake and Drapeau (2007), Drapeau and Perry (2005), Drapeau, Perry, Blake and D'Iuso (2007), Perry, Drapeau, Dunkley, Foley, Blake and Banon (2007) for the original English version and by Kramer (2006), Kramer, Drapeau, Perry, Bodenmann, Despland and de Roten (2007) and Kramer and Drapeau (in prep.) for the French version used for this study. For the current study, reliability coefficients on 20% of the ratings were established among fully-trained raters and yielded

satisfactory results in terms of intra-class correlation coefficients (2,1; Wirtz, & Caspar, 2002; APPENDIX B2) varying between .59 and .94 (M = .84; SD = .10; APPENDIX B3). These coefficients have been established on coping as the unit of analysis (36 categories). Intra-class correlation coefficients (2,1) with the CAP authors' group of raters vary between .51 and .83 (M = .71; SD = .11; the .51 score is the only one below .60; APPENDIX B4).

Coping Inventory for Stressful Situations (CISS; Endler, & Parker, 1988; 1990). This 48-item self-report questionnaire is empirically derived and assesses three basic dimensions of coping: task-oriented, emotion-oriented and avoidance (encompassing two factors distraction and social diversion); low correlations between the three factors are reported, internal and external validity, as well as test-retest reliability yield satisfying results (Endler, & Parker, 1990). Subjects report coping frequency using a Likert-type scale from 1 (not at all) to 5 (a lot). The French version has been validated (Endler, & Parker, 1998). Cronbach alpha for this patient sample is .95.

Symptom Check List SCL-90-R (Derogatis, 1994). This questionnaire includes 90 items addressing various somatic and psychological signs of distress. These items are scored using a Likert-type scale from 0 (not at all) to 4 (very much). Although the instrument is composed of 10 subscales, our study used only the General Symptomatic Index (GSI, score ranging from 0 to 4), which is a mean rated over all symptoms. Clinical cut-off score is 0.80. The French validation study has been carried out by Pariente and Guelfi (1990) and yielded satisfactory coefficients. Cronbach alpha for this sample was .98. Mean symptom level for patients is higher than for controls (see table 1; the range of the patients' scores is 0.12 to 3.17). Symptom change has been calculated according to Jacobson and Truax' (1991) recommendation by means of Reliable Clinical Change Index (RCI; see also Beretta, de

Roten, Drapeau, Kramer, Favre, & Despland, 2005)**.** Negative numbers indicate symptom decrease. In our sample, 38% presented no change, 31% symptom decrease and 31% symptom increase (M(RCI) = 1.15; SD = 4.25; see table 1).

Bech-Rafaelson Mania Scale (BRMS; Bech, Rafaelson, Kramp, & Bolwig, 1978). The BRMS is a clinician-rated scale for manic symptoms, based on 11 items tapping activity level, mood, and other characteristics of mania. The items are rated on a scale from 0 (normal) to 4 (extreme). Clinical cut-off score for mania is 15 (hypomania 6). The range of our patients' scores is 0 - 12. Inter-rater reliability has proven to be high (.80 - .95; Bech, Rafaelson, Kramp, &, Bolwig, 1978; Altman, 2004). BPRS is effective in assessing outcome in clinical trials on BD (Bech, 2002). The French translation has been realized by Chambon, Poncet and Kiss (1989). Cronbach alpha for our patient sample was .77.

Montgomery-Asberg Depression Rating Scale (MADRS; Montgomery, & Asberg, 1979). MADRS is a clinician-rated scale for depressive symptoms, including among others items on sadness, internal tensions, insomnia, appetite reduction, cognitive impairment and suicidal ideation. The 10 items are anchored on a scale from 0 (absence of symptoms) to 6 (invalidating presence of symptoms). Clinical cut-off score for depression is 15. The range of our patients' scores is 0 - 38. Several validation studies have reported satisfactory coefficients for the original version (Montgomery, & Asberg, 1979) and concurrent validity (Kearns, Cruickshank, McGuigan, Riley, Shaw, & Snaith, 1982; Maier, & Philipp, 1985). The French translation has been realized by Lemperière, Lepine, Rouillon, Hardy, Ades, Luauté and Ferrand (1984) and validation studies on this version yield satisfactory coefficients on specificity, homogeneity, internal consistency (Pellet, Decrat, Lang, Chazot, Tatu, Blanchon, & Berlier, 1987). Cronbach alpha for our patient sample was .89.

Working Alliance Inventory (WAI; Horvath, 1981; Horvath, & Greenberg, 1989). The WAI is originally a 36-item self-report measure assessing the quality of the therapeutic alliance according Bordin's conception (1975). Responses are reported on a 7-point Likert-type scale ranging from 1 (never) to 7 (always). Construct validity has been established by Malinckrodt and Nelson (1991), reliability for the whole scale ranges between .84 and .93 (Horvath, 1994). Concurrent and predictive validity have been established (Tichenor, & Hill, 1989; Shick Tryon, & Kane, 1993). A 12-item short version has been developed by Tracey and Kokotovic (1989), based on factor-analytic procedures. Its French translation has been validated by Corbière, Bisson, Lauzon and Richard (2006) who suggest one general score be considered for the evaluation of alliance. The 12-item-version has been used for this study. Cronbach alpha for this patient sample was .87.

Procedure

All patients and controls were asked to participate in a dynamic interview (Perry, Fowler, & Semeniuk, 2005) lasting 50 minutes. Dynamic interview (DI) as a research tool has been developed from clinical practice of psychodynamic psychotherapy; thus, the context of DI is comparable to the context of an intake psychotherapy interview (Perry, personal communication). It has been widely used in psychotherapy research (Perry & Cooper, 1989 ; Hoglend & Perry, 1998). As shown by Perry, Fowler and Semeniuk (2005) and Fowler and Perry (2005), high-quality dynamic interviews are associated with Interviewer's and Overall Dynamic Interview Adequacy (I-DIA and O-DIA). Five tasks of the interviewer compose the I-DIA : (1) Setting the interview frame : work-enhancing strategies ; (2) Offering support : questions, support strategies, associations ; (3) Exploration of affect : questions, reflections, clarifications, low-level defense interpretations ; (4) Trial interpretations : defense and transference interpretations; (5) Offering a synthesis. In particular, exploring affect and trial

interpretations are highly correlated with O-DIA, when the patient's contribution is controlled for (Perry, Fowler, & Semeniuk, 2005). The author completed an intensive one-week-training at Austen Riggs Center, Stockbridge, USA, and later underwent regular supervision with senior supervisors in Psychodynamic Psychotherapy. All interviews were conducted in French by the author.

All inpatients participated in the dynamic interview, as soon as their symptomatic state allowed it. This means that the patients were included in the final third of the duration of inpatient treatment, shortly before discharge. Only two patients had to be excluded from the study due to non-feasibility of the research interview; all other patients responding to the inclusion criteria and willing to participate were included. The patients were given treatment as usual, encompassing non-specific supportive therapy and medication. All patients were appointed for a second interview at a three-month interval. Only 18 patients respected this appointment, despite great efforts on the part of the researcher. At the second interview, the patients were all discharged from inpatient treatment. Along with the dynamic interview, the evaluation procedure encompassed clinician-ratings of depression and mania. The patients were given the questionnaires at the end of the interview and were asked to fill them in and send them back within two days. The study was endorsed by the expert ethical committee of the psychiatric hospital.

The control group was recruited by means of two local institutions : (1) School of Social Studies (n = 17) ; (2) Association promoting Community Activities and Service (n = 13). Matching criteria were transparently issued at the outset of the control group recruitment. Therefore, only nine participants had to be refused from participation due to failure to meet the matching criteria. The control participants, unlike the patients who were not paid, were given a contribution (the equivalent of USD 16). The study was endorsed by the expert ethical committee of the School of Social Studies.

All interviews were tape-recorded and transcribed by Master's-level psychology students, according to the method defined by Mergenthaler and Stigler (1997).

Interviews were rated based on the transcripts. In-depth training and supervision was organized for all raters. Four Master's-level psychology students were trained during four months by the author and reliability was established on a dyadic basis among the student raters, between the student raters and the trainer and between the student raters and the authors of the CAP-method. A randomly chosen 20% of all interviews was rated by two raters independently, in order to establish inter-rater reliability checks (results see under Instruments).

Data Analytic Strategy

Canonical correlations were carried out (only on the patient's first sessions) in order to test our first hypothesis. We avoided the use of a set of Pearson's correlations, due to the multiplication of errors ensuing from multiple hypothesis testing; according to Tabachnik and Fidell (1996), canonical correlations as multivariate statistics control optimally for such flaws and are known to maximize inter-correlations between the two sets of variables. MANOVAs were performed to test our second and fourth hypotheses, respectively on data from the first and second sessions. Linear regressions were carried out in order to test the relationship between coping, symptom level and change, as well as with the therapeutic alliance. Bonferroni's correction was introduced where necessary.

RESULTS

Comparison Between Self-Report and Observer-Rating of Coping

Canonical correlations on $N = 30$ BD patients between CAP (36 dimensions plus OCF) and CISS (5 dimensions), yielded an overall t-value of 0.81 (ns; APPENDIX B5). The

CISS subscale task-oriented coping correlated with four CAPs and with OCF (t = 2.29): information-seeking affective (t = -2.12), helplessness affective (t = -2.12), accommodation behavioral (t = -2.45), and negotiation cognitive (t = 2.45). Finally, CISS emotion-focused coping correlates with CAP opposition affective (t = 2.10) and CISS escape with CAP submission cognitive (t = -2.04). No other correlations were significant.

Coping Specificities in BD Patients

Multivariate statistics on the first session yielded five CAP and two CISS factors being different between BD patients and parallelized controls, thus lending support for coping specificities (see table 2). CAP self-reliance behavioral and CISS task-oriented coping are less often practiced by the patients, whereas CAP support-seeking both affective and behavioral and opposition both affective and behavioral, along with CISS distraction, are more frequently practiced by patients, compared to controls. Moreover, OCF has proven to be lower in patients, compared to controls. Thus, opposition, support-seeking (affective and behavioral) and distraction are the only high-frequency coping in BD. Effect sizes of these between-group differences are moderate to high (the latter is true for OCF, self-reliance behavioral, opposition affective and behavioral).

No effect for either of these variables was observed when we compared subgroups of patients according to their predominant symptomatology, mania or depression, at first session (median-split method applied). No effect was found with regard to the status of the patients (completers v non-completers).

Frequency of Coping, Symptom Level and Evolution, and Therapeutic Alliance

Regression analyses on coping predicting the symptom level for the first session, whether general symptomatic level (GSI) or specifically mania or depression, did not yield any significant links. However, with regard to change in symptom level (RCI on GSI after

three months), results are depicted in table 4 with regard to coping processes when stress is appraised as threat. Due to missing data, regression analyses were carried out on a sub-sample of n = 13 (43%) patients, diminishing the power of the results. To compensate for this shortcoming, Bonferroni's corrections were strictly applied. Nevertheless, there are two noteworthy predictive links: helplessness and opposition as a prediction of symptom change in the sense that higher frequency of these coping processes are related to less symptom reduction or greater deterioration. No significant link with symptom evolution was found between coping processes when stress is appraised as challenge.

No significant links were found with regard to coping processes predicting the therapeutic alliance at first session.

High-Frequency Coping at the Second Session

Multivariate statistics have been carried out on the second session (N = 18; see table 3), in order to control for the obtained results at the first session. Interestingly, it appears that all differences – based on self-report and observer-rater methods - which were noticed at the first session disappear, apart from support-seeking behavioral as high-frequency coping in BD also at the second session. This effect is only marginally significant on the multivariate level (p = .05), but presents a high effect size on an univariate level.

DISCUSSION

The results partially confirm our hypotheses. The first aimed at comparing self-report measure and observer-rater method: only a few moderate, otherwise low, correlations have been found between CAP and CISS; overall correlation is not significant. There seems to be limited overlap in the perception of coping frequency between the subject and the independent observer; the subject is probably unaware of parts of his/her functioning. This

conclusion is corroborated by the observation that specific CAPs (e.g., opposition and support-seeking) differ between the groups, whereas corresponding CISS (e.g., emotion-factor being conceptually and empirically close to opposition, see canonical correlation) do not differ. This lack of empirical correspondence can also be due to conceptual differences in the construction of the two scales.

As far as the question of the coping specificity in BD is concerned, we observed a between-group effect - with 1.20 the highest effect size found - on a general level of coping adaptiveness (OCF); patients present lower Overall Coping Functioning, compared to controls. In addition, we found three high-frequency coping: CAP opposition (affective and behavioral), CAP support-seeking (affective and behavioral) and CISS distraction, along with low frequencies in BD of several others (CAP self-reliance and CISS task). The high frequency of opposition suggests its maladaptive character in the dynamics of stress management (Cramer, 1998a; Skinner, Edge, Altman, et al., 2003). Opposition is related to symptom evolution, thus adding an argument in favor of its maladaptive quality in BD. The observation that CAP opposition, affective and behavioral, did not come out as significant at the second session – after discharge from inpatient treatment - , suggests that we might be dealing with specific coping reactions to inpatient treatment contexts which entails some degree of constraint. The observation that these effects disappear when comparing subgroups, as a function of predominant symptomatology, adds a strong argument in favor of coping specificity of BD as a whole, irrespective of symptomatic phase. Moreover, symptom increase (or low symptom decrease) tends to be associated with the patient's presenting helplessness in inpatient treatment. Along with opposition, this coping process is part of the category when stress is appraised as threat and thus partially confirms the maladaptive quality of these processes with regard to symptom reduction over time (Skinner, Edge, Altman, et al., 2003). However, there are several other threat-coping processes which are not related to symptom

evolution. Therefore, this interpretation should be seen as tentative and be replicated in other samples.

Overall, the absence of significant links between symptom level, alliance and coping processes in the first session suggests the presence of limited conceptual overlap and, thus, underlines a clear-cut distinction between coping and symptoms; we may conclude that there are very limited confounds in this study, occasionally observed between coping and outcome (Coyne, & Racioppo, 2000; Lazarus, 2000). The absence of link between coping and symptom level can also be explained by the presence of biological mediators in BD (see Goodwin, & Jamison, 1990). This implies also that opposition as BD *inpatient* specificity is a situation-dependent, and not person-dependent, process.

Coping specificities in BD in inpatient treatment generally vanish over the course of three months, attaining the range of the functioning of the control group. This conclusion is after all confirmed by the merely moderate effect size (.36) of OCF in the second session. This observation does not hold true for Support-Seeking where a difference, with a high ES (.96), in favor of high frequency in the second session of this coping process in patients is noticed. Two interpretations are possible: (1) While support-seeking is generally understood as an adaptive coping process, high-frequency of its behavioral aspect might also represent an "overused" coping expressing an exaggerated need for dependency on the therapist, partner or any other significant person. (2) Support-Seeking as CAP ratings might have been induced by the interview method, which prescribes the investigation of significant - helping - relationships in the subject; in dynamic interviews, patients might simply express the fact that they do need more support in dealing with symptoms than symptom-free controls.

Therapeutic practice might be improved if the clinician is aware that opposition can be high-frequency coping, particularly in inpatient treatment, when it is likely to be a vulnerability factor in BD. An adequate therapeutic attitude when confronted with

oppositional behaviors or stances in inpatients includes empathic limit-reminding, augmenting self-observational capacities, Socratic dialogue and eventually clarifying experiential and emotion-focused work on the underlying motives and contents related with opposition, aiming at decreasing the level of opposition, and ultimately leading to better adaptation to reality. Moreover, enhancement of capacities in self-reliance and task-oriented coping by means of effective training is warranted.

This study confirms the importance of fine-grained analysis of coping in specific clinical diagnoses (Lazarus, 2000), and supports not only the relevance of the quantitative conception of adaptiveness (Cramer, 2000), but also tentatively the basic distinction of stress-appraisal in terms of challenge and threat (Lazarus & Folkman, 1984; Skinner, Edge, Altman et al., 2003; Perry, Drapeau, Dunkley, & Blake, 2005). More studies using the same methodology on other psychopathological states, e.g., personality disorders, are needed in order to shed additional light on the conclusions drawn.

There are several limitations to this study. No firm conclusion can be drawn with regard to the consciousness of coping, since the two instruments used aimed at measuring different dimensions of coping. Ideally, both measures should be based on the same theoretical structure of coping; this was not the case in our research; the CAP was based on the confirmatory factor analysis by Skinner, Edge, Altman, et al. (2003), whereas CISS was based on Endler and Parker's (1990) empirical analysis. Results on specificity are somewhat limited, due to co-morbidity in the sample. Participants in the control group were not randomly chosen, which is due to matching procedure and the voluntary status of participation and as a result, their coping profiles are not respresentative of the general population; great care needs to be taken with generalizations. Low numbers in the second session - but also lower numbers of self-report questionnaires in the first interview - decreased

the statistical power of the applied analyses and prevented higher-order statistics being carried out, as was further subgroup comparisons such as a function of gender.

Table 1

Socio-Demographics and Symptoms for Patients and Controls

	Patients (N = 30)		Controls (N = 30)			
Criteria	Mean	SD	Mean	SD	T(1,58)	p
Age	46.14	11.20	41.90	14.33	1.28	.12
Education (N Years)	12.37	1.07	12.87	1.42	-1.59	.21
Gender (Female)	67%		67%			
Intimate relationship[1]	37%		40%			
Life situation						
With partner	30%		30%			
With partner & siblings	3%		7%			
Alone	43%		40%			
Alone with siblings	10%		10%			
With parents	7%		13%			
Institution	7%		0%			
WAI[2]	63.04	13.96				
GSI[2 3]	1.24	0.87	0.48	0.23	4.47	.00
RCI[3]	1.15	4.25	-0.10	1.81	1.00	.33
Mania (BRMS)[2]	3.10	2.94				
Depression (MADRS)[2]	12.87	10.40				

Note. WAI: Working Alliance Inventory; GSI : General Symptom Index of Symptom Checklist SCL-90-R; RCI: Reliable Change Index (Change on GSI between the two sessions)

[1]Considered as stable intimate relationship when lasting longer than 2 years

[2] Measured at first interview

[3]N(patients) = 13 ; N(controls) = 18

Table 2

Coping Specificities in Bipolar Affective Disorder: First Session ($N = 30$)

	Patients		Controls		$F(1, 58)$	ES
Coping	M	SD	M	SD		
CAP						
Total coping	19.60	7.04	22.80	9.36	2.24	0.38
OCF	.46	.17	.67	.18	22.34**	1.20
Problem-solving						
Affective	0.00	0.00	0.00	0.00	.	.
Behavioral	1.32	3.24	1.21	2.62	0.02	0.04
Cognitive	0.51	1.67	2.92	5.82	4.47	0.56
Info-seeking						
Affective	0.77	2.09	0.55	1.89	0.17	0.11
Behavioral	3.71	5.59	4.87	6.79	0.53	0.19
Cognitive	3.02	5.97	4.61	6.66	0.95	0.25
Helplessness						
Affective	3.04	5.25	2.60	4.60	0.12	0.09
Behavioral	1.16	2.04	0.99	2.27	0.10	0.08
Cognitive	2.42	3.68	1.51	2.16	1.39	0.31
Escape						
Affective	0.92	1.89	0.82	2.05	0.04	0.05
Behavioral	2.73	4.41	4.12	4.24	1.54	0.32
Cognitive	11.29	10.65	6.55	6.93	4.17	0.54
Self-Reliance						
Affective	1.13	2.19	2.48	4.87	1.93	0.36

Behavioral	4.72	7.93	13.40	10.39	13.23**	0.95
Cognitive	5.68	6.02	6.88	5.57	0.64	0.21
Support-Seeking						
Affective	3.37	5.02	1.26	3.06	3.87*	0.51
Behavioral	6.79	4.81	3.91	4.58	5.66*	0.61
Cognitive	1.94	3.84	4.61	12.58	1.24	0.29
Delegation						
Affective	3.12	4.99	1.70	3.17	1.75	0.34
Behavioral	2.64	4.25	1.73	3.80	0.77	0.23
Cognitive	0.51	1.62	0.37	2.03	0.09	0.08
Isolation						
Affective	1.08	2.81	0.34	1.09	1.77	0.35
Behavioral	1.64	2.73	1.83	3.57	0.05	0.06
Cognitive	0.44	1.75	0.69	2.28	0.22	0.12
Accommodation						
Affective	1.03	2.55	1.84	2.92	1.32	0.30
Behavioral	3.74	5.15	4.19	4.74	0.12	0.09
Cognitive	5.31	5.79	9.57	8.39	5.23	0.59
Negotiation						
Affective	0.17	0.91	0.42	1.34	0.74	0.22
Behavioral	1.27	3.25	2.10	3.99	0.78	0.23
Cognitive	1.38	3.09	2.54	3.15	2.05	0.37
Submission						
Affective	0.60	1.91	0.75	2.30	0.08	0.07
Behavioral	6.33	7.16	3.86	5.78	2.16	0.38

Cognitive	0.92	2.20	0.59	2.04	0.35	0.16
Opposition						
Affective	7.23	8.45	1.82	2.98	10.93**	0.85
Behavioral	5.71	6.63	0.75	1.54	15.86**	1.03
Cognitive	2.64	3.84	1.60	3.36	1.22	0.29
CISS[a]						
Task	38.7	19.9	48.9	8.1	6.30*	0.71
Emotion	56.6	16.2	49.6	9.6	3.70	0.54
Escape	53.2	14.9	47.4	7.9	3.20	0.51
Distraction	56.0	14.9	47.4	7.9	4.84*	0.75
Social Diversion	48.2	12.0	45.8	8.7	0.69	0.23

Note. MANOVA: Problem-solving: F (2; 57) = 2.38; p = . 10; Information-seeking: F (3; 56) = 0.56; p = .65; Helplessness: F (3; 56) = 0.52; p = .67; Escape: F (3; 56) = 1.83; p = .15; Self-Reliance: F (3; 56) = 5.24; p = .00; Support-Seeking: F (3; 56) = 3.69; p = .02; Delegation: F (3; 56) = 0.94; p = .43; Isolation: F (3; 56) = 0.68; p = .57; Accommodation: F (3; 56) = 1.95; p = .13; Negotiation: F (3, 56) = 1.28; p = .29; Submission: F (3, 56) = 0.79; p = .50; Opposition: F (3; 56) = 8.12; p =.00; CISS: F (5; 45) = 3.53; p = .01; Bonferroni's correction applied where necessary (significance level .01/12 or .05/12).

ES: Effect size; CAP: Coping Action Patterns; OCF: Overall Coping Functioning; CISS: Coping Inventory for Stressful Situations

[a] T-scores reported; n = 22 for patients; n = 29 for controls

* $p < .05$; ** $p < .01$

Table 3

Coping Specificities in Bipolar Affective Disorder: Second Session (n = 18)

Coping	Patients		Controls		$F(1, 35)$	ES
	M	SD	M	SD		
CAP						
Total coping	19.89	7.90	23.78	8.38	2.05	0.48
OCF	.55	.16	.61	.17	1.53	0.36
Problem-solving						
Affective	2.47	10.48	0.51	2.16	0.60	0.28
Behavioral	1.29	3.48	0.89	1.75	0.19	0.15
Cognitive	0.87	2.10	2.48	3.78	2.51	0.53
Info-seeking						
Affective	2.00	4.74	0.42	1.23	1.87	0.46
Behavioral	5.63	5.23	4.39	6.84	0.37	0.20
Cognitive	5.65	6.69	7.64	4.12	1.04	0.36
Helplessness						
Affective	4.88	8.86	5.75	10.11	0.08	0.09
Behavioral	0.92	2.12	1.11	2.19	0.07	0.09
Cognitive	0.74	2.15	2.25	3.06	3.33	0.57
Escape						
Affective	1.55	3.40	0.67	1.55	1.00	0.33
Behavioral	6.34	7.95	3.22	5.77	1.82	0.45
Cognitive	7.76	7.96	10.08	6.63	0.91	0.32
Self-Reliance						
Affective	1.81	3.22	2.42	4.06	0.25	0.17

Behavioral	6.44	4.13	8.30	8.32	0.72	0.28
Cognitive	2.04	3.10	6.14	7.11	5.04	0.75
Support-Seeking						
Affective	3.09	4.70	1.69	2.97	1.16	0.36
Behavioral	6.08	5.62	1.80	2.82	8.37**	0.96
Cognitive	4.03	4.94	3.55	3.86	0.10	0.11
Delegation						
Affective	4.87	10.00	2.08	2.73	1.30	0.38
Behavioral	2.06	3.92	0.66	1.52	2.02	0.47
Cognitive	2.03	4.14	1.13	2.77	0.60	0.26
Isolation						
Affective	0.17	0.74	0.23	0.98	0.04	0.07
Behavioral	1.95	3.71	2.12	3.96	0.02	0.04
Cognitive	0.89	2.15	0.18	0.76	1.75	0.44
Accommodation						
Affective	1.02	2.17	1.01	1.68	0.00	0.01
Behavioral	2.42	3.28	3.43	3.70	0.74	0.29
Cognitive	8.36	7.62	10.25	7.50	0.56	0.25
Negotiation						
Affective	0.14	0.62	1.16	3.27	1.67	0.43
Behavioral	1.60	3.11	2.13	3.09	0.27	0.17
Cognitive	1.66	2.89	3.56	4.91	1.99	0.47
Submission						
Affective	0.00	0.00	0.88	2.15	3.02	0.58
Behavioral	1.83	2.83	2.18	4.38	0.09	0.10

Cognitive	0.83	2.44	0.97	1.69	0.04	0.07
Opposition						
Affective	4.83	5.86	2.47	3.33	2.22	0.50
Behavioral	1.90	3.60	0.65	1.91	1.71	0.43
Cognitive	1.88	2.84	1.93	4.22	0.00	0.01
CISS[a]						
Task	42.86	17.54	50.00	9.84	2.14	0.52
Emotion	52.64	13.53	48.61	9.92	0.95	0.35
Escape	55.29	13.07	49.33	10.30	2.08	0.51
Distraction	52.50	12.94	47.61	9.00	1.59	0.45
Social Diversion	51.43	9.87	46.83	10.15	1.65	0.46

Note. MANOVA: Problem-solving: F (3; 32) = 1.41; p = .26; Information-seeking: F (3; 32) = 0.85; p = .48; Helplessness: F (3; 32) = 1.07; p = .37; Escape: F (3; 32) = 1.02; p = .40; Self-Reliance: F (3; 32) = 2.26; p = .10; Support-Seeking: F (3; 32) = 2.94; p = .05; Delegation: F (3; 32) = 0.83; p = .49; Isolation: F (3; 32) = 0.60; p = .62; Accommodation: F (3; 32) = 0.31; p = .82; Negotiation: F (3, 32) = 0.97; p = .42; Submission: F (3, 32) = 1.05; p = .38; Opposition: F (3; 32) = 1.04; p =.39; CISS: F (5; 26) = 1.03; p = .42; Bonferroni's correction applied where necessary (significance level .01/12 or .05/12).

ES: Effect size; CAP: Coping Action Patterns; OCF: Overall Coping Functioning; CISS: Coping Inventory for Stressful Situations;

[a] T-scores reported

** $p < .01$

Table 4

Regression Analyses for Threat-Coping of First Session predicting RCI (n = 13)

Variable	*B*	*SE B*	*β*
Helplessness			
Affective	0.27	0.14	.30
Behavioral	0.43	0.38	.19
Cognitive	1.58	0.28	.89**
Escape			
Affective	-0.83	0.89	-.33
Behavioral	0.40	0.43	.32
Cognitive	0.13	0.14	-.29
Delegation			
Affective	0.15	0.28	.16
Behavioral	0.15	0.28	.18
Cognitive	-0.69	0.84	-.27
Isolation			
Affective	-0.88	0.69	-.39
Behavioral	0.01	0.45	.01
Cognitive	-0.44	0.53	-.27
Submission			
Affective	0.35	0.51	.19
Behavioral	0.04	0.15	.07
Cognitive	0.90	0.43	.57
Opposition			
Affective	0.43	0.08	.66**

Behavioral	0.31	0.07	.55
Cognitive	0.83	0.14	.79**

Note. Helplessness : R^2 = .80; p = .00; Escape: R^2 = .19; p = .58; Delegation: R^2 = .16; p = .65; Isolation: R^2 = .19; p = .58; Submission: R^2 = .34; p = .27; Opposition: R^2 = .86; p = .00. RCI: Reliable Change Index on General Symptom Index from Symptom-Checklist-90-R. Bonferroni correction applied (significance level .05/6 or .01/6).

* $p < .05$; ** $p < .01$

Chapter C

Specificities of Defense Mechanisms in Bipolar Affective Disorders: Relations with Symptoms and Therapeutic Alliance

ABSTRACT

Defense Mechanisms as a central notion of psychoanalysis have inspired various levels of interest in research in psychotherapy and psychopathology. Defense specificities have only recently been investigated systematically with regard to several clinical diagnoses, such as Affective Disorders, and Personality Disorders. For the present study, 30 inpatients with the diagnosis of Bipolar Affective Disorder I (BD) were interviewed twice. Self-report and observer-rater methods, applied to session-transcripts, of assessment of defenses have been used. A matched control group was introduced. Multi-method comparison confirms defenses as unconscious processes. Defense specificities in BD encompass a set of five immature defenses, of which omnipotence is linked with symptom level. Stability of these defenses over three months is by and large confirmed. The level of the therapeutic alliance is predicted by mature defenses. These results are discussed with regard to the psychological vulnerability of BD and treatment implications for psychodynamic psychotherapy with such challenging patients are evoked.

Key-Words: Defense Mechanisms, Bipolar Affective Disorder, Therapeutic Alliance, Observer-Rater Method, Psychodynamic Psychotherapy

SPECIFICITIES OF DEFENSE MECHANISMS IN BIPOLAR AFFECTIVE DISORDERS: RELATIONS WITH SYMPTOMS AND THERAPEUTIC ALLIANCE

Defense mechanisms have inspired various levels of interest in psychotherapy research (Cramer, 1998b). Since their first definition by Freud (1894), their conceptualisation, width, functionality, clinical and research usefulness have changed, reflecting almost perfectly the evolution of psychoanalytic theory. Nevertheless, defense mechanisms have always played a role of paramount importance in psychoanalysis, for Freud (1914, p. 16), it is "the cornerstone on which the whole structure of psychoanalysis rests". Freud's initial conception of defense as the repression of sexual drive seems too restrictive from today's vantage point (Cooper, 1998; Despland, Drapeau, de Roten, 2001). It was S. Freud himself who revised, in Freud (1926, later by A. Freud, 1936), his conception of defense mechanisms, by differentiating between several intra-psychic mechanisms, different from repression, all aiming at neutralizing unconscious drives and impulses by means of counter-cathexis. This solely intra-psychic function of impulse regulation has been criticized by Ego-psychologists (Hartman, 1958; Hartman, Kris, & Loewenstein, 1964; Schafer, 1968), suggesting defenses certainly had a counter-cathectic function, but at the same time express these underlying impulses and thus, allow gratification. These dynamics need to be hidden from the individual's awareness, to protect the self from internal conflictuality. Unacceptable aggression shown towards somebody close to the individual might be concealed by means of such defenses; for example, by turning the aggression into over-indulgence in using reaction formation, and, at the same time, by expressing the negative intention by the over-indulgent attitude (see Cooper, 1998; Perry, 1993a). This example also illustrates the conceptual shift in psychoanalysis from defenses as intra-psychic regulation to defenses encompassing, in addition, interpersonal regulation of conflicts and drives (Sullivan, 1953; Winnicott, 1965; Modell, 1975; Kohut,

1984; Sandler, 1976; Kernberg, 1975; Levenson, 1993). Hence, two main – and mutually overlapping - functions of defenses can be deduced from current psychoanalytic literature: (1) Counter-cathexis and (2) Protection of self-esteem (Cooper, 1998).

"Ups and downs" in research interest in defenses (Cramer, 2000, 1998b) might be due to defense concepts in particular and psychoanalysis in general being taboo during a certain time as a research paradigm. It might also be due to previously unsatisfying research methodology. As classical personality psychology is mainly based on questionnaire evaluation, it cannot assess reliably the complexity of the defense concept as an unconscious process. Limitations of self-report evaluation of defenses are reported elsewhere in detail (Perry, & Hoglend, 1998; Perry, 1993a); overlaps between questionnaire data on defenses and clinical evaluation of defenses are expected to be moderate to low, due to the predominantly unconscious status of defenses (Cramer, 2000; Perry, & Hoglend, 1998). Moreover, projective techniques are widely used in the assessment of defenses (for a review, see Perry & Ianni, 1998). For psychotherapy research in particular, several rating scales based on observer-rater methodology have been devised; reliability and face validity of the most widely-used methods are satisfactory to high (Perry, & Ianni, 1998; Hilsenroth, Callahan, & Eudell, 2003).

Vaillant (1971), based on Semrad's (1967) conception of defensive organization, defined a hierarchical organization of defenses, including four main levels of defensive functioning, ranging from the least to the most adaptive (see also S. Freud, 1926, p. 164, for the initial hint regarding defenses as a function of psychogenetic "stages of organization"; see also A. Freud, 1936; Wallerstein, 1967): psychotic, immature, neurotic and mature. Several studies have empirically corroborated this hierarchy of adaptiveness of defenses on various clinical diagnoses, mainly affective, anxiety, obsessional and personality disorders (Battista, 1982; Jacobson, Beardslee, Hauser, Noam, Powers, Houlihan, & Rider, 1986; Vaillant, 1976; Vaillant, & Drake, 1985; Perry, & Cooper, 1989; Perry, 1993b). In studies based on the

Defense Mechanisms Rating Scales (Perry, 1990a, see Method section), immature defense levels (action, borderline, disavowal, narcissistic) are associated with high levels of symptoms and poor social functioning (Perry, & Cooper, 1989; Perry, 1995, 1996; Perry, & Ianni, 1998). Stability of defenses over time has been confirmed by several studies across instruments (Perry, & Hoglend, 1998; Perry, 2001; for a review see Soultanian, Dardennes, Mouchabac, & Guelfi, 2005).

As far as affective disorders are concerned, Hoglend and Perry (1998) have shown that eight lower-level defenses are associated with poor outcome of unipolar depression after six months' follow-up. These defenses encompassed passive aggression, acting out, help-rejecting complaining, splitting of self and other's images, projective identification and devaluation, whereas the other six immature defenses did not predict outcome in depression. The importance of immature defenses in depression with suicidal tendencies has been partially confirmed by a study on self-reported data (Corruble, Bronnec, Falissard, & Hardy, 2004). With regard to manic and hypomanic symptoms, Perry (1990b, 1988) has shown the linkage between hypomania and mature defenses (e.g., affiliation, self-observation, self-assertion), as well as a negative association between mania and action defenses. Ablon, Carlson and Goldwin (1974) studied the change of defenses over the course of inpatient treatment in Bipolar Affective Disorder (BD) and found less denial, distorsions, and projection once the BD patient improved; patients coming to the end of a manic state tend to use more somatization and hypochondriasis at this point of evolution. According to Perry and Cooper (1986), Bipolar II Affective Disorder is related to obsessional defenses (isolation of affect, intellectualization, undoing). Moreover, in various patients, a manic defense as resistance to treatment - composed by denial and omnipotence (Angel, 1934; Deutsch, 1933; Klein, 1935; Lewin, 1932; Sjöbäck, 1973; Winnicott, 1935, 1965) - might appear throughout psychotherapeutic treatment and in analysis (Baruch, 1997). The function of the manic

defense is counter-cathectic of depressive affect, anxiety or guilt (Battegay, 1987; Clifford, & Scott, 1966), thus, Baruch (1997) calls it a reparation process aiming at the avoidance of slipping into negative affect through the regressive process of analysis. Paradoxically, this defensive process becomes the source of guilt and persecutory ideation, affects to be defended by using projective identification. Finally, several psychotherapy case studies report the relevance of psychoanalytic case conceptualization (including defensive functioning) and treatment for patients with BD (Deitz, 1995; Jackson, 1993, Kahn, 1993; Salzman, 1998; for a review, see Jones, 2004).

This leads us to our hypotheses: (1) Comparison between self-report and observer-rating of defenses: moderate or no relationships are expected; (2) Defense specificity in Bipolar Affective Disorder (BD): inpatients practice more immature defenses, in comparison with controls; (3) Immature defenses are associated with higher levels of symptoms; (4) Defenses specificities remain stable over time; (5) Defenses are related to therapeutic alliance during inpatient treatment: the more mature defenses, the higher the therapeutic alliance.

METHOD

Sample

A total of 30 inpatients with Bipolar Affective Disorders (BD) were included in the study. A total of 20 (67%) were female, with a mean age of 46.1 years (SD = 11.2 ; ranging from 21 to 60). Their socio-demographic level was assessed by means of the total number of years of education in any field. On average, the patients had 12.4 years of education (SD = 1.1 ; range from 10 to 16). All had a DSM-IV-R diagnosis of Bipolar Disorder I (either F30.x[296.x], F31.x[296.4x or .5x] or F31.6[296.6x]) and were included in the study irrespective of the nature of the most recent phase or of the level of chronicity. Some (13; 43%) presented co-morbid disorders, such as drug abuse (23% ; cannabis, alcool, cocaine),

personality disorders cluster C (10%), compulsive-obsessive disorders (3%), acute suicidality (3%) and epilepsy (3%). Diagnoses were established by trained medical staff by means of DIGS (Diagnostic Interview for Genetic Studies; Preisig, Fenton, Matthey, Berney, & Ferrero, 1999). The number of inpatient treatments in psychiatry, including current treatment, varied between 1 and 29 (Mean = 7.7 ; SD = 7.0).

A strictly matched control group was introduced; matching criteria were gender, age and years of education, as these have an influence on defensive functioning (Labouvie-Vief, Hakim-Larson, & Hobart, 1987; Whitty, 2003). A total of $N = 30$ persons from a community sample were recruited for the study. Out of these, 20 (67%) were female, with a mean age of 41.9 (SD = 14.3 ; range from 23 to 65). Their mean number of years of education was 12.9 (SD = 1.4 ; range from 11 to 18), corresponding to intermediate education level. No inpatient treatment in psychiatry is known for these participants and general symptomatology was in the normal range for all control participants. T-tests yielded no significant differences in the matching variables between the groups (see table 1). All participants gave written informed consent.

Instruments

Defense Mechanism Rating Scales (DMRS; Perry, 1990a; French translation: Perry, Guelfi, Despland, & Hanin, 2004). The DMRS is an observer-rater scale assessing 28 defense mechanisms, based on the hierarchical conception of defensive functioning by Vaillant (1992). Seven levels, ranged according to the criteria of adaptiveness, are included, from the least adaptive to highly adaptive: (1) Action (acting out, passive aggression, hypochondriasis), (2) Borderline (splitting of self/object images, projective identification), (3) Disavowal (denial, rationalisation, projection) and autistic fantasy (for further computation, this defense will be considered on level 3, even if conceptually distinct) (4) Narcissistic (omnipotence,

devaluation, idealization), (5) Neurotic (repression, dissociation, reaction formation, displacement), (6) Obsessional (isolation of affect, intellectualization, undoing) and (7) Mature (affiliation, altruism, anticipation, self-assertion, humor, self-observation, sublimation, suppression). Quantitative scoring has been used, yielding relative frequency scores per defense, as well as an Overall Defense Functioning (ODF) score which can be computed by weighting the absolute frequency of the defenses by their level. For the current study, reliability coefficients on 20% of the ratings were established among fully-trained raters and yielded satisfactory results in terms of intra-class correlation coefficients (2,1; Wirtz, & Caspar, 2002; APPENDIX B2) varying between .64 and .95 (Mean = . 83; SD = .10; APPENDIX C1). For these reliability analyses, the single defense was unit of analysis (28 categories).

Defense Style Questionnaire (DSQ ; Bond, Gardner, Christian, & Sigal, 1983). This self-report questionnaire encompasses 88 items in its original version and measures conscious derivatives of 24 defense mechanisms. These statements are to be rated on a nine-point Likert-scale from 1 ("Strongly disagree") to 9 ("Strongly agree"). The patient's score for a defense mechanism is the mean of the scores of the items attributed to this mechanism. A high score on any one defense measure indicates that the defense is used by the patient. Validity and reliability have been reported by Bond and Perry (1994; Bond, Perry, Gautier, Goldenberg, Oppenheimer, & Simand, 1989). A short version comprising 60 items has been created by Bond, Trijsburg, and Drapeau (2003) in order to ensure congruency of the operationalization with DSM-IV (APA, 1994). Cultural variability and French validation data have been presented (Thygesen, Hunter, Lecours, Trijsburg, & Drapeau, 2005; Thygesen, Drapeau, Trijsburg, Lecours, &, de Roten, submitted; Trijsburg, Bond, Drapeau, Thygesen, & de Roten, 2005). A three-factor solution was obtained (image-distorting, affect regulating,

mature) with sufficient validity coefficients; however, image-distorting factor had somewhat lower reliability (.64) and parts of the correlations between factors were high (between -.12 and .59; Thygesen, Drapeau, Trijsburg, et al., submitted). Encompassing all 60 items, an Overall Defensive Functioning (ODF-DSQ) score can be computed. Cronbach alpha for this patient sample was .87.

Symptom Check List SCL-90-R (Derogatis, 1994). This questionnaire includes 90 items addressing various somatic and psychological signs of distress. These items are scored using a Likert-type scale from 0 (not at all) to 4 (very much). Although the instrument is composed of 10 subscales, our study used only the General Symptomatic Index (GSI, score ranging from 0 to 4), which is a mean rated over all symptoms. Clinical cut-off score is 0.80. The French validation study has been carried out by Pariente and Guelfi (1990) and yielded satisfactory coefficients. Cronbach alpha for this sample was .98. Mean symptom level for patients is higher than for controls (see table 1; range for patients' scores 0.12 - 3.17). Symptom change has been calculated according to Jacobson and Truax' (1991) recommendation by means of Reliable Clinical Change Index (RCI; see also Beretta, de Roten, Drapeau, Kramer, Favre, & Despland, 2005)**.** Negative numbers indicate symptom decrease. In our sample, 38% presented no change, 31% symptom decrease and 31% symptom increase (M(RCI) = 1.15; SD = 4.25; see table 1).

Bech-Rafaelson Mania Scale (BRMS; Bech, Rafaelson, Kramp, & Bolwig, 1978). The BRMS is a clinician-rated scale for manic symptoms, based on 11 items tapping activity level, mood, and other characteristics of mania. The items are rated on a scale from 0 (normal) to 4 (extreme). Clinical cut-off score for mania is 15 (hypomania 6). Range for our patients' scores is 0 – 12. Inter-rater reliability has proven to be high (.80 - .95; Bech, Rafaelson, Kramp, &,

Bolwig, 1978; Altman, 2004). BPRS is effective in assessing outcome in clinical trials on BD (Bech, 2002). The French translation has been realized by Chambon, Poncet and Kiss (1989). Cronbach alpha for our patient sample was .77.

Montgomery-Asberg Depression Rating Scale (MADRS; Montgomery, & Asberg, 1979). MADRS is a clinician-rated scale for depressive symptoms, including among others items on sadness, internal tensions, insomnia, appetite reduction, cognitive impairment and suicidal ideation. The 10 items are anchored on a scale from 0 (absence of symptoms) to 6 (invalidating presence of symptoms). Clinical cut-off score for depression is 15. Range for patients' scores is 0 – 38. Several validation studies have reported satisfactory coefficients for the original version (Montgomery, & Asberg, 1979) and concurrent validity (Kearns, 1982; Maier, & Philipp, 1985). The French translation has been realized by Lemperière, Lepine, Rouillon, Hardy, Ades, Luauté and Ferrand (1984) and validation studies on this version yield satisfactory coefficients on specificity, homogeneity and internal consistency (Pellet, Decrat, Lang, Chazot, Tatu, Blanchon, & Berlier, 1987). Cronbach alpha for our patient sample was .89.

Working Alliance Inventory (WAI; Horvath, 1981; Horvath, & Greenberg, 1989). The WAI is originally a 36-item self-report measure assessing the quality of the therapeutic alliance according Bordin's conception (1975). Responses are reported on a 7-point Likert-type scale ranging from 1 (never) to 7 (always). Construct validity has been established by Malinckrodt and Nelson (1991), reliability for the whole scale ranges between .84 and .93 (Horvath, 1994). Concurrent and predictive validity have been established (Tichenor, & Hill, 1989; Shick Tryon, & Kane, 1993). A 12-item short version has been developed by Tracey, & Kokotovic (1989), based on factor-analytic procedures. Its French translation has been

validated by Corbière, Bisson, Lauzon and Richard (2006) who suggest one general score be considered for the evaluation of alliance. The 12-item-version has been used for this study. Cronbach alpha for this patient sample was .87.

Procedure

All patients and controls were asked to participate in a dynamic interview (Perry, Fowler, & Semeniuk, 2005) lasting 50 minutes. Dynamic interview (DI) as a research tool has been developed from clinical practice of psychodynamic psychotherapy; thus, the context of DI is comparable to the context of an intake psychotherapy interview (Perry, personal communication). It has been widely used in psychotherapy research (Perry & Cooper, 1989; Hoglend & Perry, 1998). As shown by Perry, Fowler and Semeniuk (2005) and Fowler and Perry (2005), high-quality dynamic interviews are associated with Interviewer's and Overall Dynamic Interview Adequacy (I-DIA and O-DIA). Five tasks of the interviewer compose the I-DIA : (1) Setting the interview frame : work-enhancing strategies ; (2) Offering support : questions, support strategies, associations ; (3) Exploration of affect : questions, reflections, clarifications, low-level defense interpretations ; (4) Trial interpretations : defense and transference interpretations; (5) Offering a synthesis. In particular, exploring affect and trial interpretations are highly correlated with O-DIA, when the patient's contribution is controlled for (Perry, Fowler, & Semeniuk, 2005). The author completed an intensive one-week-training at Austen Riggs Center, Stockbridge, USA, and later underwent regular supervision with senior supervisors in psychodynamic psychotherapy. All interviews were conducted in French by the author.

All inpatients participated in the dynamic interview, as soon as their symptomatic state allowed it. This means that the patients were included in the final third of the duration of inpatient treatment, shortly before discharge. Only two patients had to be excluded from the

study due to non-feasibility of the research interview; all other patients responding to the inclusion criteria and willing to participate were included. The patients were given treatment as usual, encompassing non-specific supportive therapy and medication. All patients were appointed for a second interview at a three-month interval. Only $N = 18$ patients respected this appointment, despite great efforts on the part of the researcher. At the second interview, the patients were all discharged from inpatient treatment. Along with the dynamic interview, the evaluation procedure encompassed clinician-ratings of depression and mania. The patients were given the questionnaires at the end of the interview and were asked to fill them in and send them back within two days. The study was endorsed by the expert ethical committee of the psychiatric hospital.

The control group was recruited by means of two local institutions : (1) School of Social Studies ($n = 17$) ; (2) Association promoting Community Activities and Service ($n = 13$). Matching criteria were transparently issued at the outset of the control group recruitment. Therefore, only nine participants had to be refused from participation due to failure to meet the matching criteria. The control participants, unlike the patients who were not paid, were given a contribution (the equivalent of USD 16). The study was endorsed by the expert ethical committee of the School of Social Studies.

All interviews were tape-recorded and transcribed by Master's-level psychology students, according to the method defined by Mergenthaler and Stigler (1997).

Interviews were rated based on the transcripts. All ratings were done by the author; reliability of these ratings was established with fully-trained colleagues and supervisors on a randomly chosen 20% of all interviews (for the results see under Instruments).

Data Analytic Strategy

Canonical correlations were carried out (only on patient's first session) in order to test our first hypothesis. We avoided the use of a set of Pearson's correlations, due to the multiplication of errors ensuing from multiple hypothesis testing; according to Tabachnik and Fidell (1996), canonical correlations as multivariate statistics control optimally for these flaws and are known to maximize inter-correlations between the two sets of variables. Multivariate statistics are performed to test our second and fourth hypotheses. Linear regression analyses are carried out in order to test the relationship between defenses, symptoms and alliance. Bonferroni's correction was introduced where necessary.

RESULTS

Comparison Between Self-Report and Observer-Rater Method

Canonical correlations on the patient group (first session) between DSQ-60 (3 factors plus ODF) and DMRS (7 levels plus ODF) yielded a non-significant overall effect (*t*-value: 1.51; ns). Furthermore, ODF (DSQ) correlates with self-assertion ($t = 2.17$), autistic fantasy ($t = -3.37$), splitter other ($t = -4.04$), splitting self ($t = -3.01$) and acting out ($t = -2.05$). The DSQ-factor image-distorting correlates with self-assertion ($t = -2.44$), self-observation ($t = -2.08$), intellectualization ($t = -2.57$), dissociation ($t = 2.09$), autistic fantasy ($t = 2.25$), splitting other ($t = 2.59$) and projective identification ($t = 2.12$). The DSQ-factor affect regulating correlates with self-âssertion ($t = -.260$) and acting out ($t = 2.39$). Finally, the DSQ-factor mature defenses correlates with altruism ($t = 2.20$), self-assertion ($t = 2.23$), intellectualization ($t = 2.28$), dissociation ($t = -3.40$), displacement ($t = -2.09$), splitting other ($t = -2.03$) and splitting self ($t = -2.73$; see APPENDIX C2).

Defense Specificities in BD

Multivariate statistics carried out on the first session yielded several results in terms of defense specificity (see table 2). Overall, ODF is lower in patients, compared to controls, a result confirmed by ODF as assessed by DSQ. At inpatient treatment, BD patients practice fewer mature (altruism, humor, self-assertion, self-observation), fewer obsessional (intellectualisation), fewer neurotic defenses (reaction formation, but more often displacement), whereas they use more often defenses which are narcissistic (omnipotence), more often disavowal (rationalization), more often borderline (splitting of others' images, projective identification) and more often action defenses (acting out). DSQ-factors differentiate the groups: BD patients display more image-distorting and affect-regulating defenses, but less mature ones, compared to matched controls. Effect sizes of the reported between-group differences are moderate, except for ODF, altruism, self-assertion, self-observation, intellectualization, rationalization and the DSQ-factors, where high ES have been observed.

With regard to defense specificities at second interview (see table 3), ODF of both DMRS and DSQ remain significantly lower than in controls. However, almost all between-group effects vanish after three months; only obsessional (intellectualization; a high effect size with 1.09) remains significant when comparing the two groups. On the contrary, DSQ-factors image-distorting and affect-regulate show similar between-group effects (and effect sizes) at the second interview as shown at the first interview.

No effect for either of these variables was observed when we compared subgroups of patients according to their predominant symptomatology, mania or depression, at first session (median-split method applied). No effect was found with regard to the status of the patient (completers v non-completers).

Immature Defenses and Symptom Level

Linear regressions (method enter) yielded specific significant coefficients between immature defenses and symptoms, especially manic symptoms (see table 4). Patients with higher levels of manic symptoms use more often narcissistic defenses (omnipotence and devaluation), whereas no relationship was found for depressive symptoms. General symptom level (GSI) was not related in any way to defenses.

Mature Defenses and Therapeutic Alliance

Linear regression (method Enter) yielded a significant effect between mature defenses and the therapeutic alliance at inpatient treatment (see table 5). In particular, self-assertion predicted the level of therapeutic alliance; the more assertive the patient, the better the therapeutic alliance.

DISCUSSION

The results corroborate parts of our hypotheses. First of all, they indicate that only a small overlap exists between self-report measure and observer-rater method of defenses, thus confirming the results on convergent and discriminant validity of overall defensive functioning (Perry, & Hoglend, 1998; Hilsenroth, Callahan, & Eudell, 2003). Once again, the theoretical assumption of defense mechanisms as potentially unconscious processes is confirmed (Perry, 1993a) and suggests that self-report measures tap into conscious derivatives of defenses – or their behavioral correlates - and do not assess the defensive process itself.

Our second hypothesis about defense specificities is confirmed; BD patients display a significantly lower Overall Defensive Functioning, a lower level of neurotic and mature defenses and a higher level of immature defenses; thus, these patients are particularly vulnerable due to BD defense specificity. This conclusion is corroborated by the relationship

between defenses and manic symptoms and underscored by the result when taking into account the patient's symptom phase: defense specificity is completely independent of the predominant symptomatology.

More specifically, our study yields in total five immature defenses as BD specificities, in comparison with matched controls: acting out, projective identification, splitting of others' images, rationalization and omnipotence; the latter predicts specifically the level of manic symptoms. There are no effects for idealization, devaluation, denial, projection, autistic fantasy, splitting of self images, help-rejecting complaining and passive aggression; furthermore, displacement is the only neurotic defense more often practiced by BD patients, in comparison with matched controls. Conversely, BD patients practice less often mature, obsessional and neurotic defenses. This clear picture confirms and enlarges Perry and Hoglend's (1998) conclusions on affective disorders indicating that a set of eight immature defenses are related to symptom level and evolution in depression, and sheds additional light on defensive processes in BD specifically. These are different from defensive processes in hypomania (Perry, 1990b; Perry, & Cooper, 1986), whose symptoms are associated either with mature or obsessional defenses, and negatively with action defenses. Thus, Bipolar type I Affective Disorder is consistently associated with lower-level (immature) defenses, unlike type II. The use of borderline and action defenses is associated with increased vulnerability for Recurrent Depression (Perry, 1990b) and symptom intensity in Borderline Personality Disorders (Perry, & Cooper, 1986); the use of narcissistic defenses is associated with higher symptom level in BD (see above) and Borderline Personality Disorder (Perry, & Cooper, 1986). Thus, a specific double defense vulnerability results for BD patients: (1) They are psychologically vulnerable to further episodes of depression, (2) They are psychologically unstable as regards personality features, i.e., borderline defenses, which contribute together – among other factors such as biological determinants - to explaining the substantial

symptomatic fluctuation in BD. The relevance of the double defensive vulnerability should be confirmed in longitudinal studies.

With regard to the hypothesis of defense specificity at the second session, it is confirmed on the level of Overall Defensive Functioning. However, on a specific defense level, only action and obsessional defenses show between-group differences, whereas all the others are in the range of the control group. Of course, a lower number of observations at the second session might have prevented mature, neurotic, action and narcissistic defense levels – all presenting multivariate *p*-values between .05 and .25 - from turning out to be significant in this statistical analysis. In addition, between-group differences have been observed for the second session in DSQ-factors, underscoring again the relevance of our fourth hypothesis. This mitigated picture draws our attention to the fact that defenses do not only depend on trait-variables, but are also directly induced by state-aspects (for fluctuating aspects of defenses see Perry, 2001; Drapeau, de Roten, Perry, & Despland, 2003). These are situational contingencies eliciting internal conflicts which call for the use of defense mechanisms (Steffens, & Kächele, 1988). As suggested above, the diagnosis, related contextual problems in functioning and underlying fears and wishes might act as such situational contingencies. In the case of our sample, symptoms are moderately present in the first session, but absent in the second, as are immature defenses, which is an argument in favor of state changes in these defenses.

Narcissistic defenses are an important aspect of BD functioning. These defenses serve to protect a positive self-concept in a crisis situation (Cooper, 1998; Gilliéron, 2004; Drapeau, de Roten, Perry, & Despland, 2003). Patients presenting narcissistic defenses have difficulty in fully accepting the self as being in need of help. However, this is exactly how they might perceive themselves when facing a crisis situation (Gilliéron, 2004) or are induced to reflect about themselves – as prescribed by the technique of dynamic interviewing (Fowler, & Perry,

2005) and in psychotherapy – which may elicit narcissistic defenses, such as omnipotence. In turn, this defensive attitude again leads to sub-manic manifestations or symptoms requiring more of the same defenses for the protection of narcissism; even more omnipotence is used, allowing full gratification of desires, maintaining therefore manic symptomatology (Sjöbäck, 1973). These dynamics explain why such patients might appear to the therapist as both "uncomfortable" and "discouraging". These countertransferential attitudes are not necessarily beneficial for the therapeutic process and need further reflection by the clinician. We may speculate that such dynamics, among others, might have been at stake when Fromm-Reichmann concluded that BD patients were "unrewarding" candidates for psychodynamic psychotherapy (Fromm-Reichmann, 1949), a position we are trying to overcome by this study.

The development of a positive therapeutic alliance is supported by the presence of self-assertion in the patient. This is an important result for clinical consideration and might help the clinician to perceive resources in this clinically challenging group of patients. It also suggests the probable undermining of alliance through heightened levels of immature defenses.

To sum up, in order to assess defenses reliably, especially in BD inpatients, a multi-method approach is preferable rather than a self-report approach, in view of high face-validity of observer-rater methodology (Perry, & Ianni, 1998) and the necessity of context-embedded assessment based on session-transcripts, due to the unconscious status of defenses. As for BD patients, a set of five immature defenses have been identified as specificities, along with lower frequencies in mature, obsessional and neurotic defenses. Their links with therapeutic outcome need to be clarified on a larger sample. We hypothesize a two-fold vulnerability result in BD patients - depression- and personality-related defensive vulnerability - due to heightened levels of action, borderline and narcissistic defenses. The positive relationship

between mature defenses and therapeutic alliance is encouraging in this clinically challenging patient group.

These results are inspiring for psychodynamic treatment of BD patients (see also the case reports by Deitz, 1995; Jackson, 1993; Kahn, 1993; Salzman, 1998). Especially the concept of the double defense vulnerability might help the clinician to be more attentive to defensive processes in BD patients, in particular to be attentive to narcissistic defenses on the one hand and to borderline on the other. The presence of immature defenses warrants specific psychotherapeutic interventions, such as supportive techniques and early-in-process defense interpretation, in order to increase the awareness in the patient of his or her way of functioning and its effects (see Perry, 1993a, for specific therapeutic attitudes as a function of the patient's predominant defensive level). These defenses tend to hinder the construction of a positive therapeutic alliance (Coughlin Della Silva, 1996); their early working-through seems, therefore, of paramount importance in the process of psychodynamic psychotherapy with BD patients (see also Yeomans, Clarkin, & Kernberg, 2002).

There are several limitations to this study. Whereas the sample size is certainly acceptable for the first interview, lack of data at the second interview prevents robust predictive analysis. The low numbers did not allow us to test our hypotheses as a function of gender. Co-morbidity in the patient sample reduces somewhat the internal validity of the trial. The lack of complete overlap between DMRS and DSQ might also be due to slight conceptual divergence between the measures which we did not completely control. Participants in the control group were not randomly chosen due to matching criteria and the voluntary status of participation and, thus, their defensive profiles are not representative of the general population; great care with generalizations need to be applied. Finally, psychotic defenses (or level of defensive dysregulation, Perry, 1993a; see also Piasentin, Vigano, Azzone, Verga, & Freni, 2001) are not assessed by the methodologies used, even if patients with Bipolar I

Affective Disorder do present such defenses, associated with momentarily inaccurate reality testing (Baruch, 1997).

Table 1

Socio-Demographics and Symptoms for Patients and Controls

	Patients (N = 30)		Controls (N = 30)			
Criteria	Mean	SD	Mean	SD	T(1,58)	p
Age	46.14	11.20	41.90	14.33	1.28	.12
Training (N Years)	12.37	1.07	12.87	1.42	-1.59	.21
Gender (Female)	67%		67%			
Intimate relationship[1]	37%		40%			
Life situation						
With partner	30%		30%			
With partner & siblings	3%		7%			
Alone	43%		40%			
Alone with siblings	10%		10%			
With parents	7%		13%			
Institution	7%		0%			
WAI[2]	63.04	13.96				
GSI[2] [3]	1.24	0.87	0.48	0.23	4.47	.00
Mania (BRMS)[2]	3.10	2.94				
Depression (MADRS)[2]	12.87	10.40				

Note. WAI: Working Alliance Inventory; GSI : General Symptom Index of Symptom Checklist SCL-90-R; RCI: Reliable Change Index (Change on GSI between the two sessions)

[1]Considered as stable intimate relationship when lasting longer than 2 years

[2] Measured at first interview

[3]N(patients) = 13 ; N(controls) = 18

Table 2

Defense Specificities in Bipolar Affective Disorder ($N = 30$)

Defense	Patients		Controls		F (1, 58)	ES
	M	SD	M	SD		
DMRS						
Number of defenses	32.77	9.32	31.20	10.12	0.39	0.16
ODF	3.77	0.38	4.80	0.57	67.36**	2.13
Mature :						
Affiliation	1.32	2.19	2.62	3.38	3.14	0.46
Altruism	0.29	1.26	2.75	3.26	14.87**	1.00
Anticipation	0.47	1.63	1.12	2.43	1.45	0.31
Humour	0.18	0.72	1.10	2.19	4.82*	0.56
Self-Assertion	1.39	2.18	8.25	7.29	24.39**	1.28
Self-Observation	0.95	2.11	4.50	4.85	13.52**	0.95
Sublimation	0.09	0.49	0.32	1.05	1.25	0.28
Suppression	0.00	0.00	1.22	2.61	6.55*	0.66
Obsessional :						
Isolation	1.87	3.20	2.17	4.57	0.09	0.08
Intellectual.	11.00	9.04	21.48	9.72	18.70**	1.12
Undoing	1.25	2.19	1.55	2.61	0.24	0.12
Neurotic :						
Repression	1.47	2.70	2.15	2.83	0.89	0.25
Dissociation	2.07	3.16	1.27	2.72	1.08	0.27
React. Formation	0.29	0.88	1.44	2.09	7.82**	0.72
Displacement	7.86	10.38	3.13	3.92	5.45*	0.60

Narcissistic:						
Omnipotence	6.32	9.70	1.02	2.24	8.53**	0.75
Idealization	6.66	5.27	5.07	5.71	1.27	0.29
Devaluation	5.95	5.29	6.76	6.56	0.28	0.14
Disavowal:						
Denial	10.62	7.12	11.24	6.67	0.12	0.09
Projection	3.54	4.30	3.22	2.74	0.12	0.09
Rationalization	18.38	7.78	9.81	6.45	21.57**	1.20
Autistic fantasy	0.82	1.72	0.16	0.87	3.55	0.48
Borderline:						
Splitting other	2.69	3.79	0.57	1.19	8.61**	0.75
Splitting self	0.82	1.60	0.20	0.77	3.58	0.49
Proj.identificat.	4.54	4.40	2.26	3.52	4.95*	0.57
Action:						
Acting out	4.15	3.96	1.46	2.99	8.80**	0.77
Help-rejecting	1.38	2.67	0.41	1.81	2.72	0.43
Passive-aggress.	3.61	3.66	2.73	4.11	0.76	0.23
DSQ-60[1]						
ODF	4.30	0.76	5.04	0.28	24.23**	1.37
Image-Distorting	4.72	1.81	2.73	0.72	29.01**	1.53
Affect-Regulate	4.91	2.19	3.14	1.45	11.86**	0.98
Mature	5.10	1.46	6.06	0.87	8.59**	0.83

Note. MANOVA: Mature: F (8; 51) = 6.90; p = .00; Obsessional: F (3; 56) = 6.62; p = .00; Neurotic: F (4; 55) = 3.51; p = .01; Narcissistic: F (3; 56) = 2.90; p = .04; Disavowal: F (4; 55) = 8.09; p = .00; Borderline: F (3; 56) = 3.84; p = .01; Action: F (3; 56) = 3.67; p = .02;

DSQ: F (3; 47) = 14.83; p = .00. DMRS: Defense Mechanism Rating Scales; ODF: Overall Defensive Functioning; DSQ: Defense Style Questionnaire; Bonferroni's correction applied where necessary (significance level .01/7 or .05/7).

[1] n = 22 for patients; n = 29 for controls

* $p < .05$; ** $p < .01$

Table 3

Defense Specificities in Bipolar Affective Disorder: Second Session (n = 18)

Defenses	Patients		Controls		$F(1, 35)$	ES
	M	SD	M	SD		
DMRS						
Number defenses	33.61	21.12	35.61	11.81	0.12	0.12
ODF	4.01	0.52	4.70	0.57	12.02**	1.27
Mature:						
Affiliation	3.48	3.34	2.85	3.25	0.32	0.19
Altruism	0.76	1.48	2.21	5.02	5.79	0.39
Anticipation	1.02	1.98	1.48	2.03	0.47	0.23
Humour	0.39	1.12	1.28	2.38	2.09	0.48
Self-Assertion	2.47	3.06	6.93	5.18	9.91	1.05
Self-Observation	1.45	2.61	4.02	4.27	4.72	0.73
Sublimation	0.00	0.00	0.19	0.81	1.00	.033
Suppression	0.98	3.42	0.34	1.43	0.55	0.24
Obsessional:						
Isolation	1.08	2.48	2.08	4.14	0.77	0.29
Intellectual.	10.45	10.86	20.94	8.21	10.68**	1.09
Undoing	2.42	3.46	1.15	1.59	1.99	0.47
Neurotic:						
Repression	1.83	2.82	1.02	1.52	1.15	0.36
Dissociation	2.66	5.29	1.99	2.72	0.23	0.16
React.Formation	0.47	1.15	0.88	1.35	0.95	0.33
Displacement	8.27	9.22	3.17	4.39	4.47	0.71

Narcissistic:						
Omnipotence	1.17	1.84	2.16	3.85	0.96	0.33
Idealization	5.67	5.16	3.94	4.19	1.22	0.37
Devaluation	6.21	6.95	4.36	5.38	0.80	0.30
Disavowal:						
Denial	11.48	5.87	13.82	9.33	0.82	0.30
Projection	2.80	3.09	2.93	4.13	0.01	0.03
Rationalization	19.24	8.54	14.52	5.49	3.89	0.66
Autistic Fantasy	0.94	2.55	0.17	0.74	1.50	0.41
Borderline:						
Splitting other	1.89	4.51	0.57	2.44	1.19	0.36
Splitting self	0.09	0.38	0.00	0.00	1.00	0.33
Proj. Identific.	4.81	4.12	3.83	5.81	0.34	0.19
Action:						
Acting out	2.28	2.82	0.86	1.50	3.55	0.63
Help-rejecting	2.79	5.19	0.08	0.38	4.84	0.74
Passive-aggress.	2.89	3.89	2.19	3.09	0.36	0.20
DSQ-60						
ODF	4.77	0.34	5.05	0.21	8.32**	0.99
Image-Distorting	3.89	1.46	2.68	0.72	9.38**	1.05
Affect-Regulate	4.86	1.61	3.14	1.58	9.12**	1.08
Mature	5.59	2.06	6.12	0.86	1.00	0.35

Note. MANOVA: Mature: F (8; 27) = 1.92; p = .10; Obsessional: F (3; 32) = 4.44; p = .01; Neurotic: F (4; 31) = 1.92; p = .13; Narcissistic: F (3; 32) = 1.42; p = .26; Disavowal: F (4; 31) = 1.23; p = .32; Borderline: F (3; 32) = .82; p = .50; Action: F (3; 32) = 2.57; p = .07;

DSQ: F (3; 28) = 4.94; p = .01. DMRS: Defense Mechanism Rating Scales; ODF: Overall Defensive Functioning; DSQ: Defense Style Questionnaire; Bonferroni's correction applied where necessary (significance level .01/7 or .05/7).

** $p < .01$

Table 4

Regression Analyses for Immature Defenses predicting Manic Symptoms : First Session

($N = 30$)

Variable	*B*	*SE B*	*β*
Narcissistic:			
Omnipotence	0.11	0.05	.36*
Idealization	-0.02	0.10	-.03
Devaluation	0.22	0.09	.40*
Disavowal:			
Denial	-0.12	0.09	-.29
Projection	-0.20	0.15	-.29
Rationalization	-0.10	0.08	-.27
Autistic Fantasy	-0.37	0.35	-.22
Borderline:			
Splitting other	0.08	0.16	.11
Splitting self	-0.16	0.38	-.09
Proj. Identific.	-0.06	0.13	-.09
Action:			
Acting out	0.04	0.15	.05
Help-rejecting	-0.12	0.22	-.11
Passive-aggress.	-0.10	0.16	-.13

Note. Narcissistic: $R^2 = .29$; $p = .03$; Disavowal: $R^2 = .13$; $p = .48$; Borderline: $R^2 = .02$; $p = .91$; Action: $R^2 = .04$; $p = .80$; Bonferroni's correction applied (significance level .05/4)

* $p < .05$

Table 5

Regression Analysis for Mature Defenses predicting Level of Therapeutic Alliance in First Session ($N = 30$)

Variable	*B*	*SE B*	*β*
Affiliation	1.41	0.10	.24
Altruism	-3.67	2.67	-.37
Anticipation	2.78	1.83	.34
Humour	0.61	2.81	.04
Self-Assertion	2.27	1.27	.32*
Self-Observation	3.04	2.38	.49
Sublimation	11.59	8.01	.43

Note. Suppression was excluded due to absence in this session

$R^2 = .67$; $p = .01$.

* $p < .05$

Chapter D

Defense and Coping in Bipolar Affective Disorder: Stability and Change of Adaptational Processes

ABSTRACT

Many studies on psychotherapy and psychopathology have investigated separately defense mechanisms and coping as adaptational processes. In recent years, several integrative models on adaptational processes have been proposed (see Cramer, 1998a) but only a few studies have attempted to validate these theoretical assumptions. Our study aims at comparing 30 inpatients presenting Bipolar Affective Disorder to 30 matched controls. All participants were interviewed twice, coping and defense were rated based on the session-transcripts by means of independent observer-rater methodology (DMRS and CAP). It appears that Overall Defensive Functioning remains stable over a three-month period, whereas Overall Coping Functioning increases over the same period in patients, as they are discharged from inpatient treatment. These results are discussed within the context of trait- and state-aspects of adaptational processes; further theoretical and clinical implications for crisis intervention with BD patients are presented.

Key-Words: Defense Mechanisms, Coping, Bipolar Affective Disorder, Crisis Intervention, Observer-Rater Method

DEFENSE AND COPING IN BIPOLAR AFFECTIVE DISORDER: STABILITY AND CHANGE OF ADAPTATIONAL PROCESSES

Defense mechanisms and coping processes have both aroused increasing interest in recent research on personality, psychopathology and psychotherapy (Cramer, 1998a; Lazarus, 2000; Skinner, Edge, Altman, & Sherwood, 2003). Even if they stem from different conceptual backgrounds, the question has been posed as to whether one can differentiate the underlying psychological processes (Cramer, 1998a). The question of one or two distinct underlying processes will be evoked in the introduction with regard to several criteria, then we will present empirical evidence on the question and finally apply these issues to the clinical crisis situation of Bipolar Affective Disorder cases undergoing inpatient treatment. We refer to classical definitions of defense by A. Freud, 1936 (cited by Cramer, 1998a, p. 920) and coping by Fleishman, 1984 (cited by Holahan, & Moos, 1987, p. 946). According to Cramer (1998a), both processes can be called adaptational, since they serve the individual's need for adaptation to reality.

Differences between Coping and Defense: A Case like Dr Jekyll and Mr Hyde?

The question of differentiation between defense and coping may be discussed with regard to several criteria: consciousness, adaptiveness, stability v change and degree of association with psychopathology (Cramer, 1998a).

The assumption of the unconscious status of defenses (A. Freud, 1936) has been discussed (Cramer, 1998a; Erdelyi, 2001; Newman, 2001; Perry, 1993a) and we may conclude that, although the defensive process is generally unconscious, there are conscious correlates of defenses, as well as the possibility of the subject's raised awareness of his/her defensive processes, e.g., after psychoanalytic treatment. This opposes Cramer's advocating

in favor of strictly unconscious status (Cramer, 1998a; 2001). Similarly, consciousness of coping processes has been discussed controversely (Lazarus, & Folkman, 1984; Erdelyi, 1990; Parker, & Endler, 1996; Cramer, 1998a). Steffens and Kächele (1988; Newman, 2001) do not exclude conceptually non-conscious coping processes, since they tend to occur in an automatized way. The presence of non-conscious aspects leads us to prefer the use of observer-rater methodology for the assessment of both defense mechanisms and coping processes, since they compensate optimally for limitations in self-report measures, such as social desirability and self-deceptive tendencies (Lazarus, 2000; Perry, 1993a; Tennen, Affleck, Armeli, & Carney, 2000; Tschuschke, Pfleiderer, Denzinger, Hertenstein, Kächele, &, Arnold, 1994), and take into account these non-conscious aspects of adaptational processes.

The question of adaptiveness of defense and coping has been addressed by several researchers (for coping: Carver, & Scheier, 1994; Costa, Somerfield, & McCrae, 1996; Lazarus, 2000; Reicherts, 1999; Skinner, Edge, Altman, & Sherwood, 2003; for defense: Perry, 1993a; Vaillant, 1977). Defenses are ranged according to a hierarchy of adaptiveness, from the least adaptive to the highly adaptive (see also the developmental perspective of defensive maturation: A. Freud, 1936; Labouvie-Vief, Hakim-Larson, & Hobart, 1987; Whitty, 2003), whereas for coping, adaptiveness is more complex: the use of certain types of coping, e.g., maladaptive coping, i.e., coping where the stress is appraised as threat, might put the individual “at developmental risk” (Skinner, Edge, Altman, et al., 2003, p. 231). The same is true for a rigidly prolonged use of any coping process across dissimilar situations (Summerfeldt, & Endler, 1996). Several researchers (Cramer, 1998a; Fenichel, 1945) do not exclude the quantitative criterion also being applied to defense mechanisms.

The question of stability and change over time of defenses and coping refers to the underlying question of trait- and state-aspects in defense and coping. Defenses, in line with

Cooper (1998) and Perry (1993a; see also the afore-mentioned definition by A. Freud), are generally elicited by intra-psychic or individual-related external conflicts, which means that there is a trait- as well as a state-aspect. Nevertheless, stability of overall defensive functioning – or of an idiosyncratic profile of defensive patterns across situations - is characteristic of the concept of defense (Bergeret, 1984; Kernberg, 1984); short-term changes being limited (Drapeau, de Roten, Perry, & Despland, 2003; Perry, & Cooper, 1989; Cramer, 1998b; Vaillant, 1976). With regard to coping, even if data and theoretical elaborations have appeared on the subject of personality variables influencing coping processes (Beutler, Harwood, Alimohamed, & Malik, 2002; Carver, Scheier, & Weintraub, 1989; Costa, & McCrae, 1990), coping is theoretically conceived as highly situation-dependent, thus referring more narrowly to the aspect of state in personality psychology (Cramer, 1998a; Lazarus, & Folkman, 1984; Steffens & Kächele, 1988; see also the afore-mentioned definition offered by Fleishman, 1984). Within behavior theory, "stable" coping processes in the same individual can be explained by the short-term benefits of a strategy, i.e., by referring to negative reinforcement. Empirical evidence encompassing coping and defense concepts using self-report measures supports the distinction between state- and trait-aspects (Whitty, 2003).

Much empirical work has already been realized separately on defenses and coping in clinical contexts. Thus, the association of both adaptational processes with psychopathology (on single measures and over time) is established; their clinical usefulness is also shown (Cramer, 1998a). Based on the conclusions regarding the state-trait-debate, we may assume that a specific clinical context, e.g., a symptomatic decompensation necessitating inpatient treatment as crisis intervention or a specific diagnosis function as situational variables inducing changes in adaptational processes, irrespective of the presence or efficacy of any therapeutic intervention. Since coping is conceived as state-dependent, compared to defenses,

it seems sensible to postulate that coping processes are more closely related to these situational parameters and change more rapidly than defenses.

To sum up, the metaphor used in the title of Dr Jekyll and Mr Hyde (R. L. Stevenson, 1886), where the same person has two very different appearances, does not apply, on a conceptual level at least, to the debate on the differentiation between defense and coping. We are probably dealing with two distinct underlying psychological processes in the form of two different – and certainly at times one single - manifestations (Chabrol, & Callahan, 2004; Cramer, 1998a).

Empirical Evidence concerning Defense and Coping

Thus far, only very few empirical studies have investigated potential linkages between defenses and coping, with respect to the afore-mentioned theoretical elaborations. Callahan and Chabrol's research (2004), based on the assumptions detailed in Chabrol and Callahan (2004), found in a questionnaire-study on a student sample ($N = 190$) moderate correspondence between mature defenses and adaptive coping, as well as between immature defenses and maladaptive coping (Callahan, & Chabrol, 2004). Similarly, Grebot, Paty, and Girard Dephanix (2006) have investigated specific relations between defense and coping in a questionnaire-study on a sample of psychology students ($N = 184$) and found partial confirmation of the link between mature defenses and adaptive coping (activity, self-control, responsibility) and partial confirmation of the link between neurotic, immature defenses and maladaptive coping (evasion, escape). Unfortunately, these results are based only on a series of Spearman correlations, which are sensitive to the multiplication of measurement errors, if Bonferroni corrections are not strictly applied. Since this has apperently not been done, it cannot be excluded that certain correlations were obtained by chance; Labouvie-Vief, Hakim-Larson, and Hobart (1987) controlled for this bias by using canonical correlations. No

observer-rater method has been applied in these studies, which is a serious disadvantage, due to the limited face-validity of questionnaires when non-conscious aspects of a individual's functioning are measured (Cramer, 1998a; the same criticism applies to the study on adolescents by Erickson, Feldman, & Steiner, 1997, as well as those on age-differences and maturation by Whitty, 2003 and by Labouvie-Vief, Hakim-Larson, & Hobart, 1987). Using the Defense Mechanism Rating Scales as observer-rater scale based on session-transcripts (DMRS; Perry, 1990a; see Method section), Hersoug, Sexton, and Hoglend (2002) found positive correlations between adaptive coping (measured by the questionnaire WCCL; Vitaliano, Russo, Carr, Maiuro, & Becker, 1985) and overall defensive functioning (ODF). Finally, Küchenhoff and Manz (1993) have conducted a study inspired by the Steffens and Kächele's (1988) integrative model on defense and coping. The authors devised their own model based on several layers of consciousness associated with coping (situated on a fully conscious level of the individual's functioning; measured by a self-report questionnaire) and defenses (situated on a fully unconscious level; measured by a observer-rater scale), as well as presumably pre-conscious derivates of defenses (situated in-between; measured by a questionnaire). The multi-layer model seemed confirmed on a sample of $N = 118$ patients presenting Morbus Crohn illness in the acute phase, but was not confirmed for the same patients in the rehabilitation phase.

While the differentiation in terms of consciousness is disputed (see above), Küchenhoff and Manz's study underlines the relevance of a clinical crisis situation for the application of research questions related to adaptational processes. In an acute crisis situation, the individual's habitual adaptational profile is overwhelmed – under stress – thus, old and new ways of facing the situation need to be recruited by the individual, in addition to those used in everyday life. It can be postulated that in crisis situations, such as depressive or manic decompensation necessitating inpatient treatment in Bipolar Affective Disorder, the subject's

defensive processes are used to regulate the individual's internal conflicts and coping processes are used to regulate situation-oriented behaviors and cognitions. These processes need to enter a dynamic transactional relationship in a synergistic manner (Küchenhoff, & Manz, 1993; see also Chabrol, & Callahan, 2004; Steffens, & Kächele, 1988). A prospective design, similar to the Küchenhoff and Manz (1993) study, should allow the investigation of the impact of crisis situation on adaptational processes. This would help to understand better and disentangle stability from change in these processes and their links with symptomatology. By doing this, we would admit that the predominant symptomatology per se (either mania or depression) has little influence on these psychological processes partly related with personality, but it is the diagnosis as a whole which influences adaptational processes. Finally, by investigating the psychological stakes of the crisis, clinically relevant data would be obtained on adaptational processes for patients presenting Bipolar Affective Disorder and psychological treatments as adjunct to pharmacological treatments would be improved.

This leads us to our research hypotheses: (1) Coping and defense are two different processes, with limited overlap; (2) If overlap there is, adaptive defenses are related to adaptive coping, and maladaptive defenses are related to maladaptive coping; (3) Patients presenting Bipolar Affective Disorder (BD) practice less adaptive coping and less adaptive defenses than matched controls; (4) Defenses are stable between inpatient treatment and after three months, whereas coping changes over time; (5) Coping is related to either symptom level (mania or depression), whereas defenses are not.

METHOD

Sample

A total of 30 inpatients with Bipolar Affective Disorders (BD) were included in the study. A total of 20 (67%) were female, with a mean age of 46.1 years (SD = 11.2 ; ranging

from 21 to 60). Their socio-demographic level was assessed by means of the total number of years of education in any field. On average, the patients had 12.4 years of education (SD = 1.1 ; range from 10 to 16). All had a DSM-IV-R diagnosis of Bipolar Disorder I (either F30.x[296.x], F31.x[296.4x or .5x] or F31.6[296.6x]) and were included in the study irrespective of the nature of the most recent phase or of the level of chronicity. Some (13; 43%) presented co-morbid disorders, such as drug abuse (23% ; cannabis, alcool, cocaine), personality disorders cluster C (10%), compulsive-obsessive disorders (3%), acute suicidality (3%) and epilepsy (3%). Diagnoses were established by trained medical staff by means of DIGS (Diagnostic Interview for Genetic Studies; Preisig, Fenton, Matthey, Berney, & Ferrero, 1999). The number of inpatient treatments in psychiatry, including current treatment, varied between 1 and 29 (Mean = 7.7 ; SD = 7.0).

A strictly matched control group was introduced; matching criteria were gender, age and years of education, as these have an influence on defensive functioning and coping (Labouvie-Vief, Hakim-Larson, & Hobart, 1987; Whitty, 2003). A total of N = 30 persons from a community sample were recruited for the study. Out of these, 20 (67%) were female, with a mean age of 41.9 (SD = 14.3 ; range from 23 to 65). Their mean number of years of education was 12.9 (SD = 1.4 ; range from 11 to 18), corresponding to intermediate education level. No inpatient treatment in psychiatry is known for these participants and general symptomatology was in the normal range for all control participants. T-tests yielded no significant differences in the matching variables between the groups (see table 1). All participants gave written consent.

Instruments

Defense Mechanism Rating Scales (DMRS; Perry, 1990a; French translation: Perry, Guelfi, Despland, & Hanin, 2004). The DMRS is an observer-rater scale assessing 28 defense

mechanisms, based on the hierarchical conception of defensive functioning by Vaillant (1992). Seven levels ranged according to the criteria of adaptiveness are included, from the least adaptive to the highly adaptive: (1) Action (acting out, passive aggression, hypochondriasis), (2) Borderline (splitting of self/object images, projective identification), (3) Disavowal (denial, rationalisation, projection) and autistic fantasy (for further computation, this defense will be considered on level 3, even if conceptually distinct) (4) Narcissistic (omnipotence, devaluation self/other, idealization self/other), (5) Neurotic (repression, dissociation, reaction formation, displacement), (6) Obsessional (isolation of affect, intellectualization, undoing) and (7) Mature (affiliation, altruism, anticipation, self-assertion, humour, self-observation, sublimation, suppression). Quantitative scoring has been used, yielding relative frequency scores per defense level, as well as an Overall Defense Functioning (ODF) score which can be computed by weighting the absolute frequency of the defenses by their level. For the current study, reliability coefficients on 20% of the ratings were established among fully-trained raters and yielded satisfactory results in terms of intra-class correlation coefficients (2,1; Wirz, & Caspar, 2002; APPENDIX B2) varying between .70 and .99 (Mean = . 86; SD = .09; APPENDIX D2). For these reliability analyses, the defense level was unit of analysis (7 categories).

Coping Action Patterns (CAP; Perry, Drapeau, Dunkley, & Blake, 2005; French translation by Kramer, & Drapeau, 2005). CAP is an observer-rating system assessing coping processes based on interview transcripts (Drapeau, & Perry, 2005). The rating scale encompasses 12 categories of coping (based on Skinner, Edge, Altman, & Sherwood, 2003). Three general domains have been identified (relatedness, competence, autonomy) encompassing each four categories ("families") of coping. Moreover, six of the coping categories are conceived as coping with stress appraised as challenge (problem-solving,

information-seeking, self-reliance, support-seeking, accommodation, negotiation) and the other half as coping with stress appraised as threat (helplessness, escape, delegation, isolation, submission, opposition). Therefore, 12 coping categories are assessed by this instrument. Relative frequences are computed for all coping processes. Based on Skinner, Edge, Altman, et al. (2003), an Overall Coping Functioning (OCF) score can be computed (relative frequency of challenge-coping). Preliminary empirical validation data have been presented by D'Iuso, Blake and Drapeau (2007), Drapeau and Perry (2005), Drapeau, Perry, Blake, and D'Iuso (2007) and Perry, Drapeau, Dunkley, Foley, Blake and Banon (2007) for the original English version, Kramer (2006), Kramer, Drapeau, Perry, Bodenmann, Despland and de Roten (2007) and Kramer and Drapeau (in prep.) for the French version used for this study. For the current study, reliability coefficients on 20% of the ratings were established among fully-trained raters and yielded satisfactory results in terms of intra-class correlation coefficients (2,1; Wirtz, & Caspar, 2002; APPENDIX B2) varying between .54 and .94 (M = .84; SD = .10; the .54 score is the only one below .60; APPENDIX D1). These coefficients have been established on coping category as the unit of analysis (12 categories). Intra-class correlation coefficients (2,1) with the CAP authors' group of raters vary between .51 and .83 (M = .71; SD = .11; the .51 score is the only one below .60; see APPENDIX B4).

Symptom Check List SCL-90-R (Derogatis, 1994). This questionnaire includes 90 items addressing various somatic and psychological signs of distress. These items are scored using a Likert-type scale from 0 (not at all) to 4 (very much). Although the instrument is composed of 10 subscales, our study used only the General Symptomatic Index (GSI, score ranging from 0 to 4), which is a mean rated over all symptoms. Clinical cut-off score is 0.80. The French validation study has been carried out by Pariente and Guelfi (1990) and yielded

satisfactory coefficients. Cronbach alpha for this sample was .98. Mean symptom level for patients is higher than for controls (see table 1; range of the patients' scores is 0.12 – 3.17).

Bech-Rafaelson Mania Scale (BRMS; Bech, Rafaelson, Kramp, & Bolwig, 1978). The BRMS is a clinician-rated scale for manic symptoms, based on 11 items tapping activity level, mood, and other characteristics of mania. The items are rated on a scale from 0 (normal) to 4 (extreme). Clinical cut-off score for mania is 15 (hypomania 6). The range of our patients' scores is 0 – 12. Inter-rater reliability has proven to be high (.80 - .95; Bech, Rafaelson, Kramp, &, Bolwig, 1978; Altman, 2004). BPRS is effective in assessing outcome in clinical trials on BD (Bech, 2002). The French translation has been realized by Chambon, Poncet and Kiss (1989). Cronbach alpha for our patient sample was .77.

Montgomery-Asberg Depression Rating Scale (MADRS; Montgomery, & Asberg, 1979). MADRS is a clinician-rated scale for depressive symptoms, including among others items on sadness, internal tensions, insomnia, appetite reduction, cognitive impairment and suicidal ideation. The 10 items are anchored on a scale from 0 (absence of symptoms) to 6 (invalidating presence of symptoms). Clinical cut-off score for depression is 15. The range of our patients' scores is 0 – 38. Several validation studies have reported satisfactory coefficients for the original version (Montgomery, & Asberg, 1979) and concurrent validity (Kearns, 1982; Maier, & Philipp, 1985). The French translation has been realized by Lemperière, Lepine, Rouillon, Hardy, Ades, Luauté and Ferrand (1984) and validation studies on this version yield satisfactory coefficients on specificity, homogeneity and internal consistency (Pellet, Decrat, Lang, Chazot, Tatu, Blanchon, & Berlier, 1987). Cronbach alpha for our patient sample was .89.

Working Alliance Inventory (WAI; Horvath, 1981; Horvath, & Greenberg, 1989). The WAI is originally a 36-item self-report measure assessing the quality of the therapeutic alliance according Bordin's conception (1975). Responses are reported on a 7-point Likert-type scale ranging from 1 (never) to 7 (always). Construct validity has been established by Malinckrodt, & Nelson, 1991), reliability for the whole scale ranges between .84 and .93 (Horvath, 1994). Concurrent and predictive validity have been established (Tichenor, & Hill, 1989; Shick Tryon, & Kane, 1993). A 12-item short version has been developed by Tracey, & Kokotovic (1989), based on factor-analytic procedures. Its French translation has been validated by Corbière, Bisson, Lauzon and Richard (2006) who suggest one general score be considered for the evaluation of alliance. Cronbach alpha for this patient sample was .87.

Procedure

All patients and controls were asked to participate in a dynamic interview (Perry, Fowler, & Semeniuk, 2005) lasting 50 minutes. Dynamic interview (DI) as a research tool has been developed from clinical practice of psychodynamic psychotherapy; thus, the context of DI is comparable to the context of an intake psychotherapy interview (Perry, personal communication). It has been widely used in psychotherapy research (Perry & Cooper, 1989 ; Hoglend & Perry, 1998). As shown by Perry, Fowler and Semeniuk (2005) and Fowler and Perry (2005), high-quality dynamic interviews are associated with Interviewer's and Overall Dynamic Interview Adequacy (I-DIA and O-DIA). Five tasks of the interviewer compose the I-DIA : (1) Setting the interview frame : work-enhancing strategies ; (2) Offering support : questions, support strategies, associations ; (3) Exploration of affect : questions, reflections, clarifications, low-level defense interpretations ; (4) Trial interpretations : defense and transference interpretations; (5) Offering a synthesis. In particular, exploring affect and trial interpretations are highly correlated with O-DIA, when the patient's contribution is controlled

for (Perry, Fowler, & Semeniuk, 2005). The author completed an intensive one-week-training at Austen Riggs Center, Stockbridge, USA, and later underwent regular supervision with senior supervisors in psychodynamic psychotherapy. All interviews were conducted in French by the author.

All inpatients participated in the dynamic interview, as soon as their symptomatic state allowed it. This means that the patients were included in the final third of the duration of inpatient treatment, shortly before discharge. Only two patients had to be excluded from the study due to non-feasibility of the research interview; all other patients responding to the inclusion criteria and willing to participate were included. The patients were given treatment as usual, encompassing non-specific supportive therapy and medication. All patients were appointed for a second interview at a three-month interval. Only N = 18 patients respected this appointment, despite great efforts on the part of the researcher. At the second interview, the patients were all discharged from inpatient treatment. Along with the dynamic interview, the evaluation procedure encompassed clinician-ratings of depression and mania. The patients were given the questionnaires at the end of the interview and were asked to fill them in and send them back within two days. The study was endorsed by the expert ethical committee of the psychiatric hospital.

The control group was recruited by means of two local institutions : (1) School of Social Studies (n = 17) ; (2) Association promoting Community Activities and Service (n = 13). Matching criteria were transparently issued at the outset of the control group recruitment. Therefore, only nine participants had to be refused from participation due to failure to meet the matching criteria. The control participants, unlike the patients who were not paid, were given a contribution (the equivalent of USD 16). The study was endorsed by the expert ethical committee of the School of Social Studies.

All interviews were tape-recorded and transcribed by Master's-level psychology students, according to the method defined by Mergenthaler and Stigler (1997).

Interviews were rated based on the transcripts. All DMRS ratings were done by the author; reliability of these ratings was established with fully-trained colleagues and supervisors on a randomly chosen 20% of all interviews (for the results see under Instruments). For CAP, in-depth training during four months and supervision was organized for all raters. Four Master's-level-psychology students were trained by the author and reliability was established on a dyadic basis among the student raters, between the student raters and the trainer and between the student raters and the authors of the CAP-method. A randomly chosen 20% of all interviews was rated by two raters independently, in order to establish inter-rater reliability checks (results see under Instruments).

Data Analytic Strategy

Pearson's and canonical correlations (Tabachnik, & Fidell, 1996) were carried out (on the patient's first interviews only) in order to test our first and second hypotheses. For a more detailed understanding, an exploratory factor analysis (EFA; method PCA, Principal Components Analysis, results after VARIMAX rotation) on both interviews taken as a whole, separately for patients and controls, was carried out. Multivariate statistics were performed in order to test our third and fourth hypotheses, applying Bonferroni correction. In addition, we implemented Hierarchical Linear Modeling (HLM; Bryk, & Raudenbush, 1987), to deal optimally with data dependency between the first and second session; sessions (level 1) are nested within participants (level 2). In assessing change, HLM avoids the limiting assumptions of exploratory repeated measures MANOVA by taking into account each individual's trajectory of scores over time. A mixed model (group as fixed factor) predicting alternatively ODF and OCF was carried out (for level 1: ODF or OCF = $\beta_{0j} + \beta_{1j} + \varepsilon$; for level

2: $\beta_{0j} = \gamma_{00} + \gamma_{01} + u_{0j}$; $\beta_{1j} = \gamma_{10} + \gamma_{11} + u_{1j}$). For computation, we used the program MixReg (Hedeker, & Gibbons, 1996). Finally, linear regression analyses were used to test the relationship between defenses and symptoms.

RESULTS

Comparison between Defense and Coping

Canonical correlations on the patient's first session showed a non-significant, however moderat, effect between DMRS-ODF and CAP-OCF ($t = 2.00$; $p = .06$; Pearson's correlation: $r = .45$, ns) and a non-significant overall effect on 7 DMRS-levels and 12 CAP categories ($t = 1.02$, ns; see table 2). Exploratory factor analytic procedures (after VARIMAX rotation) yielded for patients a first factor called "Maladaptive Processes" (significant item loadings for borderline defenses, helplessness coping; explaining 10.39% of the variance; Eigenvalue 2.61) and a second factor called "Coping" (significant item loadings for isolation CAP, problem-solving CAP, accommodation CAP, submission CAP; explaining another 10.06% of the variance; Eigenvalue 2.36). These first two factors account for 20.46% of the variance (see table 3). For controls, the same procedure yielded a first factor called "Adaptive Processes" (significant item loadings for mature defenses and support-seeking CAP; explaining 10.69% of the variance; Eigenvalue 2.79) and a second factor called "Coping" (significant item loadings for escape CAP, delegation CAP, and accommodation CAP; explaining another 10.36% of the variance; Eigenvalue 2.14). These first two factors account for 21.04% of the variance (see table 4).

Defense and Coping in BD

Multivariate statistics carried out on the first session yielded several results in terms of between-group differences for defense and coping (table 5). Overall, ODF and OCF are both

lower in patients, compared to controls. At inpatient treatment, BD patients practice fewer mature, fewer obsessional, but more neurotic, more narcissistic, more borderline and more action defenses. With regard to coping, BD patients practice less self-reliance, less accommodation and more opposition in inpatient treatment.

No effect for either of these variables was observed when we compared subgroups of patients according to their predominant symptomatology, mania or depression, at first session (median-split method applied). No effect was found with regard to the status of the patients (completers v non-completers).

Stability of Defense and Coping in BD

Multivariate statistics carried out on the second session (N = 18 per group, see table 6) yielded also several between-group differences. First of all, ODF remains significantly different, whereas there is no longer any difference in OCF. With regard to defenses at second session, mature and obsessional ones are less practiced by the patients, whereas neurotic and action are more practiced by the patients, compared to controls. For coping, support-seeking is more practiced by the patients, whereas self-reliance is less practiced by the patients, compared to controls. In exploratory MANOVA repeated measures (not reported in the tables) encompassing the same sets of variables, no session main (within-subject) effect was found, several between-group main effects were found (for all variables yielding an ES greater than .32, according to table 6) and only one interaction effect was found: Overall Coping Functioning (within-subject effect: $F(1, 34) = 0.08$, ns; between-group effect: $F(1, 34) = 8.80$, $p = .01$; interaction effect: $F(1, 34) = 2.98$, $p = .05$) . In order to deal with the potential shortcomings of MANOVA repeated measures, i.e., equivalence and non-correlatedness of error variances, a nested design as used in HLM is preferable for testing the evolution of coping and defensive functioning over time. Table 7 reports the results on sessions nested

within participants. It appears that there is, for both ODF and OCF, a highly significant group effect; patients present lower scores. Moreover, similar to the repeated measure statistic, OCF shows a significant interaction effect (group x session) meaning that, in the second session, the patients present similar OCF scores to the controls, unlike in the first session. This interaction effect was not found for ODF, meaning that the patients present invariably lower scores in both sessions, compared to controls.

Defense and Coping in BD and Symptom Level

Linear regression analysis (method enter) on ODF and OCF predicting general (GSI) and specific (BRMS and MADRS) symptomatology yielded no significant relationship whatsoever between the variables (GSI: $R^2 = .06$; $p = .60$; BRMS: $R^2 = .02$; $p = .81$; MADRS: $R^2 = .00$; $p = .94$).

DISCUSSION

The results corroborate parts of our hypotheses. First of all, as far as the links between defenses and coping are concerned, we have found marginal significance for overall adaptational functioning and a limited number of correlations between specific processes. If there are significant linkages, they all go in the direction postulated: immature defenses pertain to maladaptive coping, (e.g., action, borderline and narcissistic defenses with opposition coping); mature defenses with adaptive coping (e.g., with self-reliance and accommodation coping). Most importantly, there are many non-significant links suggesting that we are probably dealing with two separate underlying psychological processes (Cramer, 1998a; see also the results from the factor analysis), even if there is some limited overlap. By and large, these results tend to confirm convergent validity for general indices of adaptiveness (ODF and OCF) and tentative divergent validity for the specific adaptational processes.

The application of the adaptiveness concepts to the clinical diagnosis of Bipolar Affective Disorder has yielded several other noteworthy results. Immature defenses are convincingly associated with BD, compared to matched controls. Furthermore, maladaptive processes, such as borderline defenses and helplessness coping also had the highest item loadings for the patient's first factor (in EFA), unlike in controls, where adaptive processes define the first factor (e.g., mature defenses, support-seeking coping). However, only one coping category when stress is appraised as threat, opposition, was linked with the diagnosis. We hypothesize that this is an argument in favor of coping as a state-concept, implying situation-induced micro-fluctuations that we were not completely able to detect by means of our design.

Our hypothesis regarding stability and change in overall defensive and coping functioning is tentatively confirmed. The afore-mentioned picture regarding between-group differences is highly relevant for the crisis situation of inpatient treatment, but is less convincing for the second session. The importance of the symptomatic decompensation leading up to inpatient treatment as a moment of crisis for the patients, not only on a symptomatic level, but also on the level of adaptational processes, suggests a breakdown in habitual adaptational patterns (Chabrol, & Callahan, 2004; Küchenhoff, & Manz, 1993). Steffens and Kächele (1988; see also Hartman, 1958) would add that in such situations, the individual has a double agenda: (1) Contain negative affect related to internal conflicts based on the presence of neurotic fear; in other words, use defense mechanisms to create a conflict-free zone where the Ego can (2) Engage in concrete strategies to reduce the stress (elicited this time by realistic anxiety; "Realangst"), as a coping process. On the one hand, as also suggested by preliminary multivariate analyses, defensive functioning remains overall stable in BD patients, irrespective of the presence of a crisis. On the other hand, the level of coping functioning increases after the resolution of the crisis situation and once again comes within

the range of the controls' functioning at the second interview. Hence, stability is associated with defenses and change with coping in BD patients undergoing inpatient treatment. This probable validation of our fourth assumption leads to the distinction between trait- and state-aspects in adaptational processes (Cramer, 1998a). Coping as situation-induced competence variable is sensitive to input variables (such as type of stressor, context), whereas defenses as a personality-related variable depend mainly on the presence of internal idiosyncratic conflicts to be contained. Thus, parts of Steffens and Kächele's (1988) integrative model is corroborated by our data.

This study did not confirm our last hypothesis regarding relations between adaptational processes and level of symptoms. Two explanations might be at stake: (1) Adaptational processes and symptoms are linked on the contextual level in terms of group-differences, but not on the micro-level in terms of specific associations, suggesting independency and limited confounds between these variables; (2) Symptom level in BD is highly biologically determined and not related to psychological-adaptational processes as such. These explanations warrant further studies, especially by comparing with other clinical situations and diagnoses, e.g. personality disorders.

Finally, in what respect are these results useful for a clinician working on the ward to enhance inpatient crisis intervention for BD patients? It is noteworthy that opposition coping increases in the crisis situation. Dysphoric mood and aggression – such as related to opposition coping – are vulnerability factors associated with increased suicide risk in BD (Newman, 2004; see also for suicide prevention in BD: Ellis, & Newman, 1996; Rizvi, & Zaretsky, 2007). Thus, in-depth assessment of suicidality level is indicated in these oppositional inpatients. Moreover, for psychotherapy, it is important for the clinician to know about the stability of overall defensive functioning, irrespective of the crisis. It is also of relevance for the clinician to be aware that coping functioning changes more rapidly than

defensive functioning. Short-term treatment strategies should therefore focus on the former, with skills-training being proposed (Linehan, 1993), whereas defensive functioning would need long-term rehabilitative treatment strategies, with interpretative or clarification-oriented work being used (Yeomans, Clarkin, & Kernberg, 2002; Sachse, 2003).

There are several limitations to this study. Whereas the number of subjects in the first session is certainly acceptable for our analyses, the lower number in the second limits the validity of its results. In relation to this, EFA yielded a limited percentage of variance explained by the first two factors. Co-morbidity limits internal validity of the trial. Furthermore, participants in the control group were not randomly chosen due to matching criteria and the voluntary status of participation and thus, their adaptational profiles are not representative of the population; generalizations need to be applied with great care. Adaptational processes depend on the type and level of stress (Vaillant, 1977) which we did not completely control for, as we used an observer-rater methodology that takes into account all types of stress and conflicts, without further distinction. Finally, the data yielded by observer-rater methods applied on transcripts have been analysed on a session level; a sequential within-session micro-analysis of adaptational processes (Chabrol, & Callahan, 2004 for theoretical assumptions) has not been conducted.

Table 1

Socio-Demographics and Symptoms for Patients and Controls

	Patients (N = 30)		Controls (N = 30)			
Criteria	Mean	SD	Mean	SD	T(1,58)	p
Age	46.14	11.20	41.90	14.33	1.28	.12
Education (N Years)	12.37	1.07	12.87	1.42	-1.59	.21
Gender (Female)	67%		67%			
Intimate relationship[1]	37%		40%			
Life situation						
With partner	30%		30%			
With partner & siblings	3%		7%			
Alone	43%		40%			
Alone with siblings	10%		10%			
With parents	7%		13%			
Institution	7%		0%			
GSI[2] [3]	1.24	0.87	0.48	0.23	4.47	.00
Mania (BRMS)[2]	3.10	2.94				
Depression (MADRS)[2]	12.87	10.40				

Note. GSI : General Symptom Index of Symptom Checklist SCL-90-R

[1]Considered as stable intimate relationship when lasting longer than 2 years

[2] Measured at first interview

[3]N(patients) = 13 ; N(controls) = 18

Table 2

Canonical Correlations (*t*-values) between Defense and Coping ($N = 30$)

DMRS / CAP	Mat	Obses	Neur	Narc	Disav	Border	Act
PS	1.66	1.35	-1.53	0.21	-0.06	-1.34	2.52*
IS	0.77	0.64	-0.07	-1.03	-0.42	-0.32	0.34
H	-0.02	1.26	-0.35	-0.91	-0.57	0.66	0.21
E	-1.66	1.09	0.53	-0.90	0.58	0.39	0.78
SR	4.00**	1.19	-1. 58	-1.44	-0.42	-1.63	-2.01*
SS	-0.78	-0.69	-0.37	0.30	0.25	1.82	0.50
D	-1.08	-0.55	-0.42	1.14	0.15	0.51	0.85
I	-0.54	-0.55	0.29	-1.14	1.96	0.37	0.19
A	3.31**	-0.45	-1.11	-0.11	0.26	-1.37	-2.55**
N	1.92	1.06	-0.42	-1.16	-0.41	-1.52	-0.66
S	-0.16	-1.70	1.45	-0.17	1.24	-0.29	-0.12
O	-2.86**	-1.60	-0.36	2.33*	-1.27	4.15**	3.09**

Note. CAP: Coping Action Patterns; PS: Problem-solving; IS: Information-seeking; H: Helplessness; E: Escape; SR: Self-reliance; SS: Support-seeking; D: Delegation; I: Isolation; A: Accommodation; N: Negotiation; S: Submission; O: Opposition.

* $p < .05$; ** $p < .01$

Table 3

Exploratory Factor Analysis (EFA), Principal Component Analysis, both Sessions, after VARIMAX Rotation, on Patients

Items	Patients (N = 48)	
	I: Maladaptive	II: Coping
Obsessional Defenses	-.21	
Borderline Defenses	*.91*	
CAP Helplessness	*.84*	
CAP Negotiation	-.37	
CAP Opposition	.20	
CAP Accommodation	-.23	*-.58*
CAP Problem-solving		*-.72*
CAP Isolation		*.68*
CAP Info-seeking		.22
CAP Submission		*.64*

Note. Item loadings below |.20| not reported and item loadings above |.50| in *italics*.

Table 4

Exploratory Factor Analysis (EFA), Principal Component Analysis, both Sessions, after VARIMAX Rotation, on Controls

Items	Controls (N = 48)	
	I: Adaptive	II: Coping
Mature Defenses	*.81*	
CAP Info-seeking	-.29	
CAP Opposition	-.38	
Obsessional Defenses	-.40	.36
CAP Escape	-.36	*.64*
CAP Support-seeking	*.81*	.26
CAP Accommodation	.31	*-.56*
Neurotic Defenses		-.23
CAP Helplessness		.43
CAP Delegation		*.82*

Note. Item loadings below |.20| not reported and item loadings above |.50| in *italics*.

Table 5

Between-Group Differences with regard to Defense and Coping: First Session ($N = 30$)

Defense/Coping	Patients		Controls		F (1, 59)	ES
	M	SD	M	SD		
DMRS						
N (defenses)	32.77	9.32	31.20	10.12	0.39	0.16
ODF	3.77	0.38	4.80	0.57	67.36**	2.13
Mature	4.70	6.10	21.89	12.17	47.83**	1.79
Obsessional	14.12	9.38	25.20	12.29	15.42**	1.02
Neurotic	11.68	11.10	8.00	4.80	2.79	0.43
Narcissistic	18.94	12.91	12.84	8.73	4.59*	0.55
Disavowal	33.36	9.24	24.43	8.50	15.21**	1.01
Borderline	8.06	6.87	3.03	4.69	10.98**	0.86
Action	9.14	6.40	4.61	5.42	8.78**	0.76
CAP						
N (coping)	19.60	7.04	22.80	9.36	2.24	0.39
OCF	.46	.17	.67	.18	22.34**	1.20
Problem-solving	1.84	3.45	4.13	6.77	2.74	0.43
Info-seeking	7.49	7.60	10.04	9.01	1.40	0.31
Helplessness	6.63	5.91	5.10	6.21	0.95	0.25
Escape	14.94	11.68	11.49	8.81	1.67	0.33
Self-Reliance	11.53	9.41	22.76	12.57	15.37**	1.01
Support-Seeking	12.10	7.32	9.78	13.54	0.68	0.21
Delegation	6.28	6.48	3.80	5.71	2.47	0.41
Isolation	3.17	4.59	2.86	4.24	0.07	0.07

Accommodation	10.08	8.93	15.60	10.82	4.63*	0.56
Negotiation	2.82	4.25	5.06	5.71	2.97	0.45
Submission	7.84	8.06	5.21	6.86	1.86	0.35
Opposition	15.26	12.11	4.17	4.78	21.79**	1.20

Note. MANOVA: Defenses: F (7, 52) = 10.43; p = .00; Coping: F (12, 47) = 3.94; p = .00. DMRS: Defense Mechanisms Rating Scales; ODF: Overall Defensive Functioning; CAP: Coping Action Patterns; OCF: Overall Coping Functioning; Bonferroni's correction applied (significance level .05/2 or .01/2).

* $p < .05$; ** $p < .01$

Table 6

Between-Group Differences with regard to Defense and Coping: Second Session (n = 18)

Defenses/Coping	Patients		Controls		F (1, 35)	ES
	M	SD	M	SD		
DMRS						
N (defenses)	33.61	21.12	35.61	11.81	0.12	0.12
ODF	4.01	0.52	4.70	0.57	12.02**	1.27
Mature	10.55	9.48	19.30	12.27	4.77*	0.80
Obsessional	13.95	11.83	24.18	8.49	8.87**	0.99
Neurotic	13.23	8.19	7.07	5.49	7.04*	0.88
Narcissistic	13.06	7.75	10.46	7.96	0.99	0.33
Disavowal	34.45	8.44	31.45	10.09	0.94	0.32
Borderline	6.79	5.13	4.40	7.76	1.19	0.36
Action	7.96	7.95	3.14	3.57	5.50*	0.78
CAP						
N (coping)	19.89	7.90	23.78	8.38	2.05	0.48
OCF	.55	.16	.61	.17	1.53	0.36
Problem-solving	2.54	5.04	3.55	4.83	0.37	0.20
Info-seeking	13.28	6.84	12.35	7.52	0.15	0.13
Helplessness	6.54	10.14	9.21	11.55	0.55	0.25
Escape	15.65	10.06	13.98	9.22	0.27	0.17
Self-Reliance	10.29	6.20	16.86	10.31	5.37*	0.77
Support-Seeking	13.22	8.90	7.04	5.95	5.99*	0.82
Delegation	8.97	13.68	3.87	4.70	2.24	0.50
Isolation	3.02	4.72	2.52	4.03	0.11	0.11

Accommodation	11.81	9.21	14.68	9.22	0.87	0.31
Negotiation	3.41	4.46	6.84	8.67	2.24	0.50
Submission	2.65	4.00	4.04	5.40	0.76	0.29
Opposition	8.62	9.25	5.05	6.10	1.87	0.46

Note. MANOVA: Defenses: F (7, 28) = 4.33; p = .00; Coping-Challenge: F (6, 29) = 2.40; p = .05; Coping-Threat: F (6, 29) = 1.21; p = .33. DMRS: Defense Mechanisms Rating Scales; ODF: Overall Defensive Functioning; CAP: Coping Action Patterns; OCF: Overall Coping Functioning; Bonferroni's correction applied (significance level .05/3 or .01/3).

* $p < .05$; ** $p < .01$

Table 7

Mixed model predicting Changes in ODF and OCF between First and Second Session, as a function of Group

Variable	Estimate	SE	Z	*p*-value
ODF				
Session	-0.25	0.23	-1.05	.29
Group	-0.93	0.26	-3.59	.00
Interaction	0.38	0.34	1.12	.26
OCF				
Session	-0.05	0.05	-1.05	.30
Group	-0.19	0.05	-3.51	.00
Interaction	0.12	0.07	1.79	.05

Note. Nested design using Hierarchical Linear Modeling (HLM). ODF: Overall Defensive Functioning; OCF: Overall Coping Functioning; SE: Standard Error.

Chapter E

Too much Positive Thinking? Cognitive Errors in Bipolar Affective Disorder: Relations with Symptoms and Therapeutic Alliance

ABSTRACT

The construct of cognitive errors is clinically relevant for cognitive treatment of Mood Disorders. Beck's universality hypothesis postulates the relevance of negative cognitions in all subtypes of Mood Disorders, as well as positive cognitions for manic states. This hypothesis has rarely been empirically addressed for patients presenting Bipolar Affective Disorder (BD). Inpatients ($N = 30$) presenting BD were interviewed twice, as were 30 participants of a matched control group. Valid and reliable observer-rater methodology for cognitive errors was applied to the session-transcripts. Overall, patients make more cognitive errors than controls. When manic and depressive patients were compared, parts of the universality hypothesis were confirmed. Manic symptoms are related to positive and negative cognitive errors, whereas depressive symptoms hinder only the production of positive cognitive errors. Finally, the therapeutic alliance was impeded by the presence of selective abstraction errors. These results are discussed with regard to the main assumptions of the cognitive model for depression; thus adding an argument for extending it to the BD diagnostic group, by taking into consideration specificities in terms of cognitive errors. Clinical implications for cognitive therapy of BD are suggested.

Key-Words: Cognitive Errors, Bipolar Affective Disorder, Observer-Rater Method, Cognitive Therapy

TOO MUCH POSITIVE THINKING? COGNITIVE ERRORS IN BIPOLAR AFFECTIVE DISORDER: RELATIONS WITH SYMPTOMS AND ALLIANCE

Introduced in 1963 by A. T. Beck, the concept of cognitive errors (or more generally cognitive distorsion) has become one of the central features of cognitive theory and therapy for depression (J. Beck, 1995; Clark, Beck, & Alford, 1999). Beck (1963) observed that the main suffering in depressive patients is not caused by affective disturbances, but by pervasiveness of inaccuracy in interpreting reality – errors in logic - in such a way that the result is a generalized negative bias against themselves; this assumption was called "negativity hypothesis" (see also Beck, 1991; Peterson & Seligman, 1984). According to the constructivist cognitive theory (Clark, Beck, & Alford, 1999; Beck, 1991), normal functioning, on the contrary, would not mean complete accuracy to reality, the latter being always an individual's construction, but an "adaptive" way of information processing. Hence, theoretically, normal cognitive functioning is characterized by a slightly positive bias which, when the individual shifts into depressive mood (called "negative cognitive shift"; Beck, 1967), fades away and, little by little, is replaced by a negative bias. Finally, along with a series of other hypotheses, Beck (1967; 1976; 1991; Clark, Beck, & Alford, 1999) defines the "universality hypothesis" as follows: "Heightened negative cognition, reduced positive thinking, and self-referent negativity processing bias are evident in all subtypes of depression" (Clark, Beck, & Alford, 1999; p. 159). With more detail for Bipolar Affective Disorders, Beck (1991) postulates overly positive biases in individuals in manic episodes and overly negative biases when they are in depressive episodes (see also Leahy, 2003; Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2001). The present study aims at testing part of the universality hypothesis, by focusing on cognitive errors in Bipolar Affective Disorder

(BD). Empirical evidence on this hypothesis will be reviewed and methodological issues related to assessment of cognitive processes discussed, before we address our specific research questions related to BD.

Results from previous empirical work on cognitive errors (CE) confirm Beck's hypotheses (Clark, Beck & Alford, 1999) for patients presenting unipolar depression. Depressed persons show more CE than non-depressed (Hammen, 1978; Hammen & Krantz, 1976; Krantz & Hammen, 1979). More specifically, the category of selective abstraction (SA) yielded a particularly great between-group difference, greater than the category of personalization (P). For patients presenting low-back pain, overgeneralization (OG) is most often reported, compared to all other errors (Lefebvre, 1981). However, the author acknowledges that the latter result may possibly be induced by the formulation of the questionnaire, which focuses on contents related to low-back pain. As shown by Weintraub, Segal, and Beck (1974), CE are persistent across phases of unipolar depression and remission, and function thus as a vulnerability factor in relapse in depression-prone individuals. An experimental-mood-induction study on non-depressed subjects was conducted by Henriques and Leitenberg (2002), who found that the ratio of negative-to-positive CE predicted best the outcome variables (e.g., self-esteem, mood change). Focusing on information-processing underlying cognitive distortions, experimentally-controlled research designs using various tasks investigated mood biases in depressives: Matthews and Antes (1992) found a difference in eye fixations in dysphorics, who tend to fix the sad regions of a pictural stimulus longer and more often, compared to controls. A widely-studied argument for attentional biases in depression (and anxiety) is the Stroop inference effect, which has been replicated many times, although yielding contradictory results (inference effect found: see Williams, Watts, MacLeod, & Mathews, 1997 ; no inference effect found: Doost, Taghavi, Moradi, Yule, & Dalgleish, 1997; for a critical discussion see Eells, Fridhandler, Stinson, & Horowitz, 1993).

Mood-congruency between encoding and retrieval has also been found to be an important context-variable for the retrieval of words (Davis, 1979; Ingram, Partidge, Scott, & Bernet, 1994), supporting Beck's selective processing hypothesis (Clark, Beck, Alford, 1999). Even if these studies tend to confirm Beck's assumptions and more generally the cognitive model of unipolar depression, it is doubtful that the results of such laboratory studies are directly applicable to clinical contexts, such as enhancement of the cognitive case conceptualization and the psychotherapeutic intervention (see below).

With regard to patients presenting Bipolar Affective Disorder (BD) I or II, there is some tentative evidence that Beck's universality hypothesis concerning the presence of negative cognition across all subtypes of depression, holds true (Clark, Beck & Alford, 1999). A questionnaire has been devised aiming at assessing hypomanic cognitions (Mansell & Jones, 2006), which succeeded in differentiating BD patients from controls: the former present higher scores related to hypomania, compared to the latter. Weingartner, Miller, and Murphy (1977) conducted a word-encoding study on 8 BD patients and showed that the recall is better in the case of mood-congruency, compared to mood-incongruency. Eich, Macaulay, and Lam (1997) were unable to reproduce the congruency-effect on word-recall ($N = 10$ BD rapid-cyclers), but reproduced it on auto-biographical events. Although statistical power of these studies is limited, it can be tentatively concluded that there may be cognitive specificity in BD patients in terms of cognitive errors. However, especially in the case of hypomanic and manic symptoms, it is not clear if these symptom phases are characterized by an increased level of positive errors or a decrease in negative ones, or any other cognitive pattern. Consequently, the same doubt persists for depressive symptoms in BD.

Assessment of cognitive errors has traditionally been done by means of self-report measures (e.g., Lefebvre, 1981); these methods might be useful in some contexts, on condition that the individual is aware of his or her own errors in cognitive processing (for

other limitations of self-report measures, such as social desirability, tendency to acquiescing and self-deception, see Cramer, 1998a; Tschuschke, Pfleiderer, Denzinger, Hertenstein, Kächele, & Arnold, 1994). In highly disturbed patients, this is rarely the case. This has led recent researchers to devise standardized experimental testing procedures (see above, for depression see Jermann, Van der Linden, Adam, Ceschi, & Perroud, 2005). These tests, inspired by neuropsychological research paradigms, might be useful for testing a specific hypothesis in fundamental research, but suffer from a lack of external validity and are therefore of limited direct relevance for psychotherapeutic practice, also because they are based on aggregated data sets (see the limitations of application of neuropsychological research to psychotherapy practice outlined by Eells, Fridhandler, Stinson, & Horowitz, 1993 and by Clark, Beck, & Altman, 1999). Finally, the CE Rating Scale (Drapeau, Perry, & Dunkley, 2005) was devised, in order to compensate optimally for the shortcomings of the two afore-mentioned research paradigms, i.e., self-reports and neuropsychological tests, and to offer valid conceptualization of CE by using observer ratings of CE, based on transcripts of psychotherapy sessions (see Method section).

Taking Beck's negativity and universality hypotheses as a basis, we can formulate the following research hypotheses: (1) BD display more cognitive errors, in total and per category, than controls; (2) Patients with predominantly manic symptoms display more positive cognitive errors, whereas patients with predominantly depressive symptoms more negative cognitive errors; (3) A higher proportion of cognitive errors in patients is associated with higher symptom level and negative symptom evolution; (4) A higher proportion of cognitive errors in patients is associated with lower levels of therapeutic alliance.

METHOD

Sample

A total of 30 inpatients with Bipolar Affective Disorders (BD) were included in the study. A total of 20 (67%) were female, with a mean age of 46.1 years (SD = 11.2 ; ranging from 21 to 60). Their socio-demographic level was assessed by means of the total number of years of education in any field. On average, the patients had 12.4 years of education (SD = 1.1 ; range from 10 to 16). All had a DSM-IV-R diagnosis of Bipolar Disorder I (either F30.x[296.x], F31.x[296.4x or .5x] or F31.6[296.6x]) and were included in the study irrespective of the nature of the most recent phase or of the level of chronicity. Some (13; 43%) presented co-morbid disorders, such as drug abuse (23% ; cannabis, alcool, cocaine), personality disorders cluster C (10%), compulsive-obsessive disorders (3%), acute suicidality (3%) and epilepsy (3%). Diagnoses were established by trained medical staff by means of DIGS (Diagnostic Interview for Genetic Studies; Preisig, Fenton, Matthey, Berney, & Ferrero, 1999). The number of inpatient treatments in psychiatry, including current treatment, varied between 1 and 29 (Mean = 7.7 ; SD = 7.0).

A strictly matched control group was introduced; matching criteria were gender, age and years of education, as these have an influence on cognitive functioning (Labouvie-Vief, Hakim-Larson, & Hobart, 1987; Whitty, 2003). A total of $N = 30$ persons from a community sample were recruited for the study. Out of these, 20 (67%) were female, with a mean age of 41.9 (SD = 14.3 ; range from 23 to 65). Their mean number of years of education was 12.9 (SD = 1.4 ; range from 11 to 18), corresponding to intermediate education level. No inpatient treatment in psychiatry is known for these participants and general symptomatology was in the normal range for all control participants. T-tests yielded no significant differences in the matching variables between the groups (see table 1). All participants gave written consent.

Instruments

Cognitive Errors CE (Drapeau, Perry, & Dunkley, 2005; French translation by Kramer, & Drapeau, 2005; APPENDIX E1) is an observer-rating system assessing cognitive errors in interview transcripts (Drapeau, & Perry, 2005). It assesses 14 different cognitive errors, based on J. Beck (1995) and A. T. Beck (1976): (1) Fortune-telling, (2) Labeling, (3) Overgeneralizing, (4) All-or-nothing, (5) Discounting the positive/negative, (6) Emotional reasoning, (7) Magnification/minimization of positive/negative, (8) Mental filter, (9) Should and must, (10) Tunnel vision, (11) Jumping to conclusions, (12) Mind-reading, (13) Personalization, (14) Inappropriate blaming of self. All errors are broken down according to their valence: positive and negative. According to Lefebvre (1981), they can be classified in four higher-order categories: fortune-telling (error 1); overgeneralizing (errors 2 and 3); selective abstraction (errors 4 through 11); personalization (errors 12 through 14). According to Henriques and Leitenberg (2002), an overall ratio can be computed by dividing the proportion of negative CE by the proportion of positive CE. For all computations, relative frequencies are used, by weighting the absolute frequency of each error by the number of words emitted by the patient (excluding therapist interventions and patient's hesitations) yielding a score for each error per 1000 words. Preliminary empirical validation data have been presented by D'Iuso, Blake and Drapeau (2007), Drapeau and Perry (2005), Drapeau, Perry, Blake, and D'Iuso (2007) and Perry, Drapeau, Dunkley, Foley, Blake and Banon (2007) for the original English version, Kramer (2006a) and Kramer and Drapeau (in prep.; see APPENDICES E3 and E4) for the French version used for this study. For the current study, reliability coefficients on 20% of the ratings were established among fully-trained raters and yielded satisfactory results in terms of intra-class correlation coefficients (2,1; Wirtz, & Caspar, 2002; APPENDIX B2) varying between .48 and .95 (M = .80; SD = .12; the .48 ICC value being an exception, the second-lowest value in this distribution was .62;

APPENDIX E2). These coefficients were established on single errors broken down into positive and negative valence as unit of analysis (28 categories). Intra-class correlation coefficients (2,1) with the CE authors' group of raters vary between .51 and .83 (M = .71; SD = .11; the .51 rating is the only one below .60; APPENDIX B4).

Symptom Check List SCL-90-R (Derogatis, 1994). This questionnaire includes 90 items addressing various somatic and psychological signs of distress. These items are scored using a Likert-type scale from 0 (not at all) to 4 (very much). Although the instrument is composed of 10 subscales, our study used only the General Symptomatic Index (GSI, score ranging from 0 to 4), which is a mean rated over all symptoms. Clinical cut-off score is 0.80. The French validation study has been carried out by Pariente and Guelfi (1990) and yielded satisfactory coefficients. Cronbach alpha for this sample was .98. Mean symptom level for patients is higher than for controls (see table 1; range of our patients' scores is 0.12 – 3.17).

Bech-Rafaelson Mania Scale (BRMS; Bech, Rafaelson, Kramp, & Bolwig, 1978). The BRMS is a clinician-rated scale for manic symptoms, based on 11 items tapping activity level, mood, and other characteristics of mania. The items are rated on a scale from 0 (normal) to 4 (extreme). Clinical cut-off score for mania is 15 (hypomania 6). The range of our patients' scores is 0 – 12. Inter-rater reliability has proven to be high (.80 - .95; Bech, Rafaelson, Kramp, &, Bolwig, 1978; Altman, 2004). BPRS is effective in assessing outcome in clinical trials on BD (Bech, 2002). The French translation has been realized by Chambon, Poncet and Kiss (1989). Cronbach alpha for our patient sample was .77.

Montgomery-Asberg Depression Rating Scale (MADRS; Montgomery, & Asberg, 1979). MADRS is a clinician-rated scale for depressive symptoms, including among others

items on sadness, internal tensions, insomnia, appetite reduction, cognitive impairment and suicidal ideation. The 10 items are anchored on a scale from 0 (absence of symptoms) to 6 (invalidating presence of symptoms). Clinical cut-off score for depression is 15. The range of our patients' scores is 0 – 38. Several validation studies have reported satisfactory coefficients for the original version (Montgomery, & Asberg, 1979) and concurrent validity (Kearns, 1982; Maier, & Philipp, 1985). The French translation has been realized by Lemperière, Lepine, Rouillon, Hardy, Ades, Luauté and Ferrand (1984) and validation studies on this version yield satisfactory coefficients on specificity, homogeneity and internal consistency (Pellet, Decrat, Lang, Chazot, Tatu, Blanchon, & Berlier, 1987). Cronbach alpha for our patient sample was .89.

Working Alliance Inventory (WAI; Horvath, 1981; Horvath, & Greenberg, 1989). The WAI is originally a 36-item self-report measure assessing the quality of the therapeutic alliance according Bordin's conception (1975). Responses are reported on a 7-point Likert-type scale ranging from 1 (never) to 7 (always). Construct validity has been established by Malinckrodt, & Nelson, 1991), reliability for the whole scale ranges between .84 and .93 (Horvath, 1994). Concurrent and predictive validity have been established (Tichenor, & Hill, 1989; Shick Tryon, & Kane, 1993). A 12-item short version has been developed by Tracey, & Kokotovic (1989), based on factor-analytic procedures. Its French translation has been validated by Corbière, Bisson, Lauzon and Richard (2006) who suggest one general score be considered for the evaluation of alliance. The short version was used for our study. Cronbach alpha for this patient sample was .87.

Procedure

All patients and controls were asked to participate in a dynamic interview (Perry, Fowler, & Semeniuk, 2005) lasting 50 minutes. Dynamic interview (DI) as a research tool has been developed from clinical practice of psychodynamic psychotherapy; thus, the context of DI is comparable to the context of an intake psychotherapy interview (Perry, personal communication). It has been widely used in psychotherapy research (Perry & Cooper, 1989; Hoglend & Perry, 1998). As shown by Perry, Fowler and Semeniuk (2005) and Fowler and Perry (2005), high-quality dynamic interviews are associated with Interviewer's and Overall Dynamic Interview Adequacy (I-DIA and O-DIA). Five tasks of the interviewer compose the I-DIA : (1) Setting the interview frame : work-enhancing strategies ; (2) Offering support : questions, support strategies, associations ; (3) Exploration of affect : questions, reflections, clarifications, low-level defense interpretations ; (4) Trial interpretations : defense and transference interpretations; (5) Offering a synthesis. In particular, exploring affect and trial interpretations are highly correlated with O-DIA, when the patient's contribution is controlled for (Perry, Fowler, & Semeniuk, 2005). The author completed an intensive one-week-training at Austen Riggs Center, Stockbridge, USA, and later underwent regular supervision with senior supervisors in psychodynamic psychotherapy. All interviews were conducted in French by the author.

All inpatients participated in the dynamic interview, as soon as their symptomatic state allowed it. This means that the patients were included in the final third of the duration of inpatient treatment, shortly before discharge. Only two patients had to be excluded from the study due to non-feasibility of the research interview; all other patients responding to the inclusion criteria and willing to participate were included. The patients were given treatment as usual, encompassing non-specific supportive therapy and medication. All patients were appointed for a second interview at a three-month interval. Only $N = 18$ patients respected this

appointment, despite great efforts on the part of the researcher. At the second interview, the patients were all discharged from inpatient treatment. Along with the dynamic interview, the evaluation procedure encompassed clinician-ratings of depression and mania. The patients were given the questionnaires at the end of the interview and were asked to fill them in and send them back within two days. The study was endorsed by the expert ethical committee of the psychiatric hospital.

The control group was recruited by means of two local institutions : (1) School of Social Studies (n = 17) ; (2) Association promoting Community Activities and Service (n = 13). Matching criteria were transparently issued at the outset of the control group recruitment. Therefore, only nine participants had to be refused from participation due to failure to meet the matching criteria. The control participants, unlike the patients who were not paid, were given a contribution (the equivalent of USD 16). The study was endorsed by the expert ethical committee of the School of Social Studies.

All interviews were tape-recorded and transcribed by Master's-level psychology students, according to the method defined by Mergenthaler and Stigler (1997).

Interviews were rated based on the transcripts. CE ratings were done by fully trained raters, including the author. Four Master's-level psychology students were trained during four months by the author and reliability was established on a dyadic basis among the student raters, between the student raters and the trainer and between the student raters and the authors of the CE-method. A randomly chosen 20% of all interviews were rated by two raters independently, in order to establish inter-rater reliability checks (results see under Instruments).

Data Analytic Strategy

ANOVA and MANOVA statistics were carried out in order to answer the first two questions. For both hypotheses, univariate testing was used for number of words, number of CE and the ratio negative-to-positive. For the first hypothesis, patients were compared to controls, for the second, two subgroups of patients were compared among each other. These subgroups were obtained by median-split method of the ratio BRMS-to-MADRS (in order to be able to perform the variable transformation for all 30 cases, the MADRS score was transformed by adding 1 to the initial score, thus preventing the exclusion of two cases with the score of zero on MADRS). Multivariate statistics were applied to the four categories per error valence. In order to test hypotheses three and four, linear regression models (method Enter) were performed. For the first session for predicting symptoms, the error valence was broken down into the four categories, whereas for the second, we only tested one single model including both valences as predictors, due to lower sample size. Bonferroni's corrections were applied where necessary.

RESULTS

Preliminary Analyses

Total number of words was constantly higher for controls, compared to patients. For the first interview, the latter had a mean of 5955 words (SD = 1903), the former 7810 words (SD = 2514; F (1, 59) = 10.61; p = .00). For the second interview, patients had a mean of 4418 words (SD = 1927), controls 7116 words (SD = 1800; F (1, 35) = 18.84; p = .00). Comparing the depression subgroup to the mania subgroup (both n = 15, first session), the latter produced more words (mean = 6835; SD = 1903) than the former (mean = 5037; SD = 1207; F (1, 29) = 8.38; p = .01).

Cognitive Errors in BD Patients v Controls

After a control for the number of words produced, only one between-group effect remains significant: patients overall make more errors of any type than controls ($p < .05$). No effect was found with regard to the specific categories, nor the valence ratio negative-to-positive (see table 2).

Cognitive Errors in BD patients: Mania v Depression

When splitting up the patient group according to the predominant symptomatology, mania or depression, it appears that the valence ratio negative-to-positive is highly significant: BD patients with depressive symptoms have a higher ratio, compared to BD patients with manic symptoms. Moreover, in line with the first result, patients with manic symptoms display more positive errors, compared to patients with depressive symptoms. The category of selective abstraction, e.g., emotional reasoning, jumping to conclusions, magnification of the positive, is different in the two subgroups. However, no difference was found in negative errors (see table 3). These differences are not attributable to between-group differences as regards socio-demographic variables (gender: $\chi^2(1; n = 15) = 3.33$, ns; age: $t(1, 28) = -1.11$, ns; level of education: $t(1, 28) = 0.17$, ns).

CE and Level of Symptoms

Regression analysis on the first session yields a clear picture for manic symptoms: they are predicted by positive and negative errors. In particular, selective abstraction positive and overgeneralizing negative predict manic symptoms. Note that both links are positive, irrespective of the error valence. Depressive symptoms are predicted by positive errors, but not by negative ones. In particular, selective abstraction positive is inversely related to depression (see table 4).

In the second session, we were able to reproduce the afore-mentioned results on a restricted sample (n = 18). Mania is predicted by positive and negative errors, whereas depression is marginally inversely linked to positive errors (see table 5).

CE and Therapeutic Alliance

A linear regression analysis (method Enter) was performed on the first session predicting WAI by the four categories (fortune-telling, overgeneralizing, selective abstraction, personalization), irrespective of the valence. This method is used to avoid losing power due to lowered sample size for WAI (n = 23). We found that selective abstraction is inversely associated with WAI (R^2 = .44, p = .02).

DISCUSSION

Our hypotheses were partially confirmed by the results. By testing a first sub-version of the universality hypothesis, we have shown that patients presenting BD display more CE in their spontaneous in-session discourse than matched controls. However, no effect was found per error valence between the groups. These results indicate that a diagnosis does suffice for detection of an overall heightened level of CE, but not for the detection of a CE specificity (Clark, Beck, & Alford, 1999); potential effects are neutralized in such group comparisons by partially exclusive symptom patterns. The latter are particularly decisive in BD patients, as mania and depression fluctuate highly, sometimes rapidly; in consequence, such state-dependent parameters need to be entered analyses separately. In this way, the symptomatic subgroups being compared between themselves, the effect of overall frequency of errors disappears, but the valence ratio of negative-to-positive yields an effect which tends to confirm the universality hypothesis for bipolar depression (Henriques, & Leitenberg, 2002; see also Clark, Beck**,** & Alford, 1999). More specifically, selective abstraction positive is

more frequent in manic patients, but no between-group difference was found for negative CE, probably due to a relatively high level of negative CE in mania. This picture is confirmed by regression analyses, where mania is predicted by both types of errors (consistently in both interviews), whereas depression only yields marginal effects (mainly the inverse association with positive errors). Manic symptoms in BD patients are, therefore, not only characterized by cognitive-symptomatic interactions due to heightened positive thinking (i.e., selective abstraction), but may also be maintained by heightened negative thinking (i.e., overgeneralizing).

This result partially confirms Beck's universality hypothesis, in that it states the relevance of cognitive errors as correlates of BD symptomatology, whether mania or depression. It tends also to confirm Beck's exclusivity hypothesis for BD (Clark, Beck, &, Alford, 1999) stating that depression is characterized by the exclusion of positive self-referent thinking. However, the absence of effect related to negative CE in the depressive phase – probably due to heightened negative CE in mania rendering this likely effect insignificant – questions the generalizability to BD of Beck's negativity hypothesis. Biases towards particularly negative information processing and content are widely confirmed for unipolar depression, but negativity in depressive states in BD patients is not heightened when compared to mania, and also when compared to matched controls. Heightened negative valence errors in manic states might be due to persistence of negativity across phases, representing a vulnerability factor for relapse into depression (see also the comparable results on unipolar depression by Weintraub, Segal, & Beck, 1974). Finally, this study also indicates that controls make a significant amount of specific CE, probably also induced by the relatively stressful dynamic interview situation. The absence of symptoms in this group tends to confirm Beck's assumption of "adaptive" CE, generally conceived as a bias towards the positive in normalcy, but here also suggesting that the construction of reality in these

individuals is always slightly biased, positively or negatively, without it being an immediate vulnerability factor for manifest psychopathology.

With regard to the therapeutic alliance, we were able to confirm our hypothesis. In particular, the presence of higher levels of selective abstraction hinders the construction of a positive therapeutic alliance. This is important information for clinicians confronted with patients making this type of error. On the one hand, SA contributes to maintaining the BD symptomatology, on the other, it might impede the establishment of a constructive relational context with these patients. Of course, on the contrary, low levels of therapeutic alliance may also contribute to heightened levels of selective abstraction in the patient.

There are at least two clinical implications ensuing from the present study. First, clinicians should be aware of the occurrence of CE in their BD patients, since higher levels of symptoms are related to some types of CE. While the observation in manic patients of their discounting negative information is probably a truism for clinicians, the underlying presence, in the same patients, of a set of negative CE also related to mania, is certainly counter-intuitive and needs to be repeated in the training of cognitive psychotherapists, to avoid the latter remaining seduced by the positivity of the patient's narrative and making him-/herself positively valenced errors by discounting negative information! The second implication is the clinician's awareness of SA as a possible hindrance in the construction of a positive therapeutic alliance. Even if BD patients show many positive SA errors, including with regard to the therapeutic relationship, the clinician needs to address them systematically, i.e., by means of cognitive restructuring. It goes without saying that the latter procedure does not imply replacing positivity by negativity (or vice-versa), but it implies the collaborative therapeutic negotiation of a nuanced and adaptive view of the self and the self-in-interaction (Clark, Beck, & Alford, 1999).

To sum up, BD patients display a higher frequency of CE than controls. Manic symptoms are associated with more positive CE, as well as negative CE, compared to depressive symptoms where less positive CE has been found, thus adding an argument for corroboration of Beck's universality and exclusivity hypotheses. No effect was found for depressive symptoms in BD and negative CE. This study suggests therefore that the interrogation in the title of "too much positive thinking" is too simplistic and that a more complex cognitive pattern with regard to CE holds true in BD; further studies are needed in order to draw final conclusions with regard to cognitive errors in BD.

There are several limitations to this study. While the sample size is acceptable at the time of the first session, the lack of power in the second session limited further in-depth data analyses, i.e., robust predictive analyses. Co-morbidity in the patient sample limits somewhat internal validity of the trial. We found a high relevance of the CE rating scale for the BD population, but the question can be posed as to whether the high frequency of SA might be partially due to the number of item endorsements of this category, as it itself encompasses 8 of all 14 errors. Its variance might be partially "blown up" due to this irregularity within the scale, but our main conclusions are certainly not jeopardized by this eventuality, since the effects found for SA are sufficiently high; moreover, the same problem would arise for the control group which tends to neutralize this bias. The post-hoc median-split method for determining subgroups is bound to be biased; it would have been preferable to control initially for symptom subtype, e.g., by introducing a matching procedure within the patient group. It needs to be acknowledged that no patient presented full manic symptoms according to the clinical cut-off, thus confining the relevance of our results to patients in sub-manic or hypomanic states. Finally, participants in the control group were not randomly chosen, due to matching criteria and the voluntary status of participation and thus, their error profiles are not representative of the general population; much care with generalizations need to be applied.

Table 1

Socio-Demographics and Symptoms for Patients and Controls

	Patients (N = 30)		Controls (N = 30)			
Criteria	Mean	SD	Mean	SD	$t(1,58)$	p
Age	46.14	11.20	41.90	14.33	1.28	.12
Education (N Years)	12.37	1.07	12.87	1.42	-1.59	.21
Gender (Female)	67%		67%			
Intimate relationship[1]	37%		40%			
Life situation						
With partner	30%		30%			
With partner & siblings	3%		7%			
Alone	43%		40%			
Alone with siblings	10%		10%			
With parents	7%		13%			
Institution	7%		0%			
WAI[2]	63.04	13.96				
GSI[2] [3]	1.24	0.87	0.48	0.23	4.47	.00
Mania (BRMS)[2]	3.10	2.94				
Depression (MADRS)[2]	12.87	10.40				

Note. WAI: Working Alliance Inventory; GSI : General Symptom Index of Symptom Checklist SCL-90-R

[1]Considered as stable intimate relationship when lasting longer than 2 years

[2] Scores from first interview reported here

[3]N(patients) = 13 ; N(controls) = 18

Table 2

Cognitive Errors/1000 Words in Bipolar Affective Disorder

Errors	Patients (N = 30)		Controls (N = 30)		F (1, 59)	ES
	M	SD	M	SD		
Number Errors	15.87	6.60	12.50	4.88	5.04*	0.58
Ratio neg/pos	2.53	2.82	1.77	1.51	1.55	0.34
Positive Errors						
Fortune-Telling	0.17	0.46	0.27	0.58	0.54	0.19
Over-generalizing	5.54	7.43	8.45	8.67	1.95	0.36
Selective Abstraction	36.87	44.34	28.48	24.18	0.83	0.24
Personalization	1.02	2.75	0.53	2.05	0.62	0.20
Negative Errors						
Fortune-Telling	0.60	0.89	0.33	0.61	1.83	0.35
Over-generalizing	13.90	11.49	13.72	11.64	0.00	0.02
Selective Abstraction	35.61	17.38	27.79	31.22	1.44	0.31
Personalization	5.60	8.03	5.39	7.42	0.01	0.03

Note. MANOVA: Positive Errors: F (4; 55) = 1.44; p = .23; Negative Errors: F (4; 55) = 0.85; p = .50; Bonferroni's correction applied.

* $p < .05$

Table 3

Cognitive Errors/1000 Words as a function of Symptomatic Sub-Samples

Errors	Depression (n = 15)		Mania (n = 15)		$F(1, 29)$	ES
	M	SD	M	SD		
Number Errors	14.93	5.64	16.80	7.52	0.59	0.28
Ratio neg/pos	4.04	3.43	1.12	0.74	10.37**	1.18
Positive Errors						
Fortune-Telling	0.07	0.26	0.27	0.59	0.89	0.44
Over-generalizing	4.25	8.53	6.82	6.17	0.89	0.35
Selective Abstraction	15.56	12.30	58.18	54.30	8.79**	1.08
Personalization	0.97	2.71	1.07	2.89	0.01	0.04
Negative Errors						
Fortune-Telling	0.73	1.10	0.47	0.64	0.66	0.29
Over-generalizing	12.37	11.42	15.07	11.80	0.41	0.23
Selective Abstraction	28.93	10.70	26.66	22.55	0.12	0.13
Personalization	6.35	6.71	4.43	9.30	0.42	0.24

Note. MANOVA: Positive Errors: F (4, 25) = 2.29; p = .05; Negative Errors: F (4; 25) = 0.43; p = .78; Bonferroni's correction applied (significance level .01/2 or .05/2).

** $p < .01$

Table 4

Regression Analyses for Cognitive Errors predicting Symptomatology at First Session

($N = 30$)

Variable	*B*	*SE B*	β
Predicting BRMS			
Positive Errors			
Fortune-Telling	-0.35	1.06	-.06
Overgeneralizing	-.04	0.07	-.09
Selective Abstraction	0.04	0.01	.63**
Personalization	-0.13	0.18	-.12
Negative Errors			
Fortune-Telling	-0.74	0.55	-.22
Overgeneralizing	0.15	0.04	.59**
Selective Abstraction	0.02	0.03	.11
Personalization	-0.11	0.07	-.29
Predicting MADRS			
Positive Errors			
Fortune-Telling	-2.01	3.90	-.09
Overgeneralizing	0.00	0.26	.00
Selective Abstraction	-0.12	0.04	-.51**
Personalization	-0.57	0.64	-.15
Negative Errors			
Fortune-Telling	4.59	2.23	.40
Overgeneralizing	-0.24	0.18	-.27
Selective Abstraction	-0.01	0.13	-.01

Personalization	-0.04	0.27	-.03

Note. BRMS: Positive Errors: R^2 = .36; p = .02; Negative Errors: R^2 = .38; p = .02; MADRS: Positive Errors: R^2 = .31; p = .04; Negative Errors: R^2 = .18; p = .29; BMRS: Bech-Rafaelson Mania Scale; MADRS: Montgomery-Asberg Depression Rating Scale; Bonferroni's correction applied (significance level .01/2).

** $p < .01$

Table 5

Regression Analyses for Cognitive Errors predicting Symptomatology at Second Session ($N = 18$)

Variable	*B*	*SE B*	β
Predicting BRMS			
Positive Errors	0.05	0.01	.66**
Negative Errors	0.03	0.01	.39**
Predicting MADRS			
Positive Errors	-0.13	0.07	-.51±
Negative Errors	0.05	0.09	.14

Note. BRMS: $R^2 = .88$; $p = .00$; MADRS: $R^2 = .19$; $p = .20$; BMRS: Bech-Rafaelson Mania Scale; MADRS: Montgomery-Asberg Depression Rating Scale. Bonferroni's correction applied (significance level .10/2 or .01/2)

± $p < .10$; ** $p < .01$

Chapter F

Psychotherapeutic Case Conceptualization using Plan Analysis for Bipolar Affective Disorder

ABSTRACT

Valid individualized case conceptualization methodologies, such as Plan Analysis, are rarely used for the psychotherapeutic treatment conceptualization and planning of Bipolar Affective Disorder (BD), even if data do exist showing that psychotherapy interventions might be enhanced by applying such analyses for treatment planning for several groups of patients. We applied Plan Analysis as a research tool (Caspar, 1995) to $N = 30$ inpatients presenting Bipolar Affective Disorder, who were interviewed twice. Our study aimed at producing a prototypical Plan structure encompassing the most relevant data from the 30 individual case conceptualizations. Special focus was given to links with emotions and coping Plans. Inter-rater reliability of these Plan Analyses was considered sufficient. Results suggest the presence of two subtypes based on plananalytic principles: emotion control and relationship control, along with a mixed form. These subtypes are discussed with regard to inherent plananalytic conflicts, specific emotions and coping Plans, as well as symptom level and type. Finally, conclusions are drawn for enhancing psychotherapeutic practice with BD patients, based on the motive-oriented therapeutic relationship.

Key-Words: Plan Analysis, Case Conceptualization, Bipolar Affective Disorder, Emotion

PSYCHOTHERAPEUTIC CASE CONCEPTUALIZATION USING PLAN ANALYSIS FOR BIPOLAR AFFECTIVE DISORDER

In recent years, psychotherapeutic approaches began to offer theory-consistent clinical tools for practitioners to treat patients presenting Bipolar Affective Disorder (BD), as adjunct treatment to pharmacotherapy. Most of these tools are based on cognitive-behavioral and psychoeducation models (Basco & Rush, 2005; Lam, Jones, Hayward, & Bright, 1999; Leahy, 2003; Meyer & Hautzinger, 2004; Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2001; Scott, 1995; Scott, Garland, & Moorhead, 2001), on interpersonal and social rhythm therapy (Frank, 2007; Frank & Swartz, 2004) and on various other models as extensions of the afore-mentioned (group therapy: Bauer & McBride, 2003; Bock & Koesler, 2005; family therapy: Micklowitz, 2004; integrative-cognitive: Mansell, 2007). Recent reviews of treatment outcome studies confirmed overall efficacy for manual-based treatments (de Jong-Meyer, Hautzinger, Kühner, & Schramm, 2007; Jones, 2004; Rizvi, & Zaretsky, 2007; Scott, 2004), for some treatments in the acute phase with highly severe symptom levels, and for all treatments in the remission phase. While these recent developments are encouraging and the structure of manualized treatments highly meaningful for the treatment of this challenging group of patients, to our knowledge no systematic psychotherapeutic case conceptualization approach – based on the individual case - has yet been applied to this population. The objectives of this article are to contribute to the question of psychotherapeutic case conceptualization by using the Plan Analysis approach (Caspar, 2007; Caspar, 1996), more specifically, to (1) Enhance the psychotherapist's conceptualization of patients' problems presenting BD and (2) Optimize treatment planning, including effective

implementation of manualized treatment strategies and the construction of a tailor-made therapeutic relationship.

Plan Analysis

Plan Analysis is based on the works by Grawe & Dziewas in 1976 (Grawe, 1980) who observed in behavior group therapy that basic behavioral concepts were not sufficient to explain difficult interpersonal patterns presented by the patients. The patient's verbal and non-verbal behavior is not solely influenced by external contingencies, but also by internal determinants, such as intentions, motives, schemas of the self and the self-in-interaction leading the individual to actions and perceptions congruent with his/her basic assumptions (Grawe, 1998). The basic principle of Plan Analysis is the instrumental vantage point: the patient's behavioral (self-reported or in-session clinician-observed verbal and non-verbal) patterns are related to *Plans* and higher-order *motives* (or goals and needs) responding to the question: "Which purpose, conscious or unconscious, underlies an individual's behaviors and experiences?" (Caspar, 1997, p. 260). Generally, the presence of countless specific answers to this question, related to a patient's situation and interactional behavior, oblige the psychotherapist to prioritize, structure and hierarchize the information within a framework of instrumental connections, i.e., as a Plan structure. Later, developments of Plan Analysis drew on the schema concept and information-processing approaches (Caspar, 1984; 1995; 2007; Caspar, & Moix, 2006; Grawe, 1986; 1992b; 1998). Although complexity (and the correlating time investment) may be the price to pay for such detailed case conceptualizations, we would advocate, especially for clinical diagnoses such as BD, that a detailed case formulation might reflect in a reasonably accurate way the psychological and psychopathological complexity of such disorders. The payoff is certainly the adoption of a radical constructivist perspective, leading to – by means of reliable and valid single-case

qualitative methodology – a greater range of treatment possibilities (Caspar, 1997; Grawe, Caspar, & Ambühl, 1990; Kramer, & Caspar, 2007).

Emotions and Plans

The notion of Plan refers to the individual's adaptational processes and, as such, to the concepts of emotions and emotional processes from the instrumental perspective. Four cases are envisaged by the approach as regards the linkage between emotions and Plans (Caspar, 1997; 2007): (1) A negative emotion arises when Plans are threatened or blocked; (2) Plans shape emotions; (3) Plans are used as coping to face emotions; (4) Emotion has itself an instrumental function. We will focus more fully on the first and third aspect. (1) As long as the (internal and external) context allows the individual to act according to his/her main Plans, no negative emotional appraisal is noticed. However, the latter emerges when important Plans (e.g., related to life goals) are blocked – e.g., by life changes or internal conflicts. Negative emotional arousal might be observed in patients undergoing psychotherapy, either as a reaction to (internal or external) circumstances blocking Plans, or specifically as a reaction to therapeutic interventions blocking Plans. Inversely, positive emotions result from favoring important Plans or goals within the interaction or the release of blocked or threatened Plans. (3) Plans may function as coping with negative emotional arousal, which in its turn can be due to blocked or threatened Plans, but not necessarily. For example, a person who has just lost a loved one, to avoid confronting the emotions of sadness or anger caused by blocked Plans related to the need of companionship, might start to drink as emotion-soothing coping Plan. This means that adaptational processes – the way the individual aims at eliminating or avoiding unpleasant emotional arousal – are conceptualized by Plan Analysis.

Plans and Psychopathology

Since they are based on individual case studies, Plan structures may differ greatly from one individual to another within the same diagnostic category. Nevertheless, the notion of "prototypical Plan structure" has been offered by Caspar (1996), to assist the trainee-psychotherapist in learning to do case conceptualizations. The purpose of prototypical Plan structures is after all to give a general idea, by no means a constraint for Plan Analyses on individuals with the same diagnosis or clinical problem. These prototypical Plan structures aim at describing typical Plan and motive dynamics related to groups of patients. As such, the prototypical Plan structure for depression (Caspar, 1995) shows that these patients have difficulty in controlling aggression and anger; they produce many avoidance Plans (e.g., Plans like "Avoid further deceptions in relationships" and "Avoid social contacts"); they have high expectations (e.g., a Plan like "Be a perfect mother for your children"), which serve to replace certain needs (e.g., the need for proximity and affection), along with an argument for avoidance of the pursuit of related goals (e.g., resulting a conviction such as "I am too vulnerable to be a perfect mother, so I'd rather not even try to"). Depressives may also present Plans related to expressing vulnerabilities, to obtain from a significant other, including the therapist, particular consideration or attention (similar to patients suffering from psychosomatic difficulties; Caspar, 1996). Prototypical Plan structures are, inexhaustively, available for Anxiety Disorders (Caspar, & Tuschen, 1987), Borderline Personality Disorder (Ansmann, 2002) and child molesters (Drapeau, Körner, Brunet, Granger, de Roten, & Caspar, 2003).

METHOD

Sample

A total of 30 inpatients with Bipolar Affective Disorders (BD) were included in the study. A total of 20 (67%) were female, with a mean age of 46.1 years (SD = 11.2 ; ranging

from 21 to 60). Their socio-demographic level was assessed by means of the total number of years of education in any field. On average, the patients had 12.4 years of education (SD = 1.1 ; range from 10 to 16). All had a DSM-IV-R diagnosis of Bipolar Disorder I (either F30.x[296.x], F31.x[296.4x or .5x] or F31.6[296.6x]) and were included in the study irrespective of the nature of the most recent phase or of the level of chronicity. Some (13; 43%) presented co-morbid disorders, such as drug abuse (23% ; cannabis, alcool, cocaine), personality disorders cluster C (10%), compulsive-obsessive disorders (3%), acute suicidality (3%) and epilepsy (3%). Diagnoses were established by trained medical staff by means of DIGS (Diagnostic Interview for Genetic Studies; Preisig, Fenton, Matthey, Berney, & Ferrero, 1999). The number of inpatient treatments in psychiatry, including current treatment, varied between 1 and 29 (Mean = 7.7 ; SD = 7.0). All patients gave written informed consent.

Instruments

Plan Analysis (Caspar, 1996). Plan Analysis is an individual-based qualitative method yielding a complete case conceptualization for each patient. Data analysis for each patient follows a three-step procedure: (1) Conduct of tape-recorded clinical interviews (see under procedure), including post-session note-taking by the interviewer regarding the patient's in-session non-verbal behavior; (2) Establishment of chronologically-structured "extensions" on relevant instrumental manifestations (Breuer, 1985, cited by Caspar, 1996) for each patient, based on verbal and non-verbal cues in the recording and in the sessions notes (this intermediate step is specific to the research context and enhances transparency in the process of inferring Plans from concrete behaviors); (3) Construction of an individualized Plan Analysis based on the extensions, as well as of emotion frames for each rated emotion, encompassing the four aspects of emotion from an instrumental perspective (see Introduction section). At this point, reliability analyses were carried out by fully-trained Plan Analysis

raters, based on independent analyses on 10% of the cases (3 out of 30 cases; only the material detailed under step one was available for both raters) focusing on the 10 (judged by the rater) most important Plans in one structure, compared to all Plans in the second structure (Benkert, 1997; Ansmann, 2002). For each of the ten compared Plans, the following correspondence criteria and ratings were applied: 1 point for correspondence in the Plan itself, 2 points for correspondence in hierarchically superior Plans and 2 points for correspondence in hierarchically inferior Plans, yielding a possible total of 5 points. Percentages of the total correspondence of the ten main Plans between the two Plan structures were computed and averaged. An overall correspondence of 60% was defined as sufficient. For emotion frames, a similar procedure was applied: the total number of emotions submitted to reliability analysis for each case corresponded to the lower number of emotions rated between the two raters. Each component obtained a rating of 1 for perfect correspondence: type of emotion, blocked/threatened Plan and coping Plan (the aspects of emotion shaping Plans and of instrumentality of emotion were left aside for reliability analysis and also for further examination), yielding a possible total of 3 for each emotion. Percentages of total correspondence between each emotion of the two emotion frame structures were computed and averaged. An overall correspondence of 60% was defined as sufficient.

Symptom Check List SCL-90-R (Derogatis, 1994). This questionnaire includes 90 items addressing various somatic and psychological signs of distress. These items are scored using a Likert-type scale from 0 (not at all) to 4 (very much). Although the instrument is composed of 10 subscales, our study used only the General Symptomatic Index (GSI, score ranging from 0 to 4), which is a mean rated over all symptoms. Clinical cut-off score is 0.80. The French validation study has been carried out by Pariente and Guelfi (1990) and yielded

satisfactory coefficients. Cronbach alpha for this sample was .98 and General Symptom Index averaged on 1.24 (SD = .87; range 0.12 – 3.17).

Bech-Rafaelson Mania Scale (BRMS; Bech, Rafaelson, Kramp, & Bolwig, 1978). The BRMS is a clinician-rated scale for manic symptoms, based on 11 items tapping activity level, mood, and other characteristics of mania. The items are rated on a scale from 0 (normal) to 4 (extreme). Clinical cut-off score for mania is 15 (hypomania 6). Inter-rater reliability has proven to be high (.80 - .95; Bech, Rafaelson, Kramp, &, Bolwig, 1978; Altman, 2004). BPRS is effective in assessing outcome in clinical trials on BD (Bech, 2002). The French translation has been realized by Chambon, Poncet and Kiss (1989). Cronbach alpha for our patient sample was .77 and the mean of this sample 3.10 (SD = 2.94; range = 0 - 12).

Montgomery-Asberg Depression Rating Scale (MADRS; Montgomery, & Asberg, 1979). MADRS is a clinician-rated scale for depressive symptoms, including among others items on sadness, internal tensions, insomnia, appetite reduction, cognitive impairment and suicidal ideation. The 10 items are anchored on a scale from 0 (absence of symptoms) to 6 (invalidating presence of symptoms). Clinical cut-off score for depression is 15. Several validation studies have reported satisfactory coefficients for the original version (Montgomery, & Asberg, 1979) and concurrent validity (Kearns, 1982; Maier, & Philipp, 1985). The French translation has been realized by Lemperière, Lepine, Rouillon, Hardy, Ades, Luauté and Ferrand (1984) and validation studies on this version yield satisfactory coefficients on specificity, homogeneity and internal consistency (Pellet, Decrat, Lang, Chazot, Tatu, Blanchon, & Berlier, 1987). Cronbach alpha for our patient sample was .89 and the mean of the sample 12.87 (SD = 10.40 ; range = 0 - 38).

Procedure

All patients were asked to participate in a dynamic interview (Perry, Fowler, & Semeniuk, 2005) lasting 50 minutes. Dynamic interview (DI) as a research tool has been developed from clinical practice of psychodynamic psychotherapy; thus, the context of DI is comparable to the context of an intake psychotherapy interview (Perry, personal communication). It has been widely used in psychotherapy research (Perry & Cooper, 1989 ; Hoglend & Perry, 1998). As shown by Perry, Fowler and Semeniuk (2005) and Fowler and Perry (2005), high-quality dynamic interviews are associated with Interviewer's and Overall Dynamic Interview Adequacy (I-DIA and O-DIA). Five tasks of the interviewer compose the I-DIA : (1) Setting the interview frame : work-enhancing strategies ; (2) Offering support : questions, support strategies, associations ; (3) Exploration of affect : questions, reflections, clarifications, low-level defense interpretations ; (4) Trial interpretations : defense and transference interpretations; (5) Offering a synthesis. In particular, exploring affect and trial interpretations are highly correlated with O-DIA, when the patient's contribution is controlled for (Perry, Fowler, & Semeniuk, 2005). The author completed an intensive one-week-training at Austen Riggs Center, Stockbridge, USA, and later underwent regular supervision with senior supervisors in psychodynamic psychotherapy. All interviews were conducted in French by the author.

All inpatients participated in the dynamic interview, as soon as their symptomatic state allowed it. This means that the patients were included in the final third of the duration of inpatient treatment, shortly before discharge. Only two patients had to be excluded from the study due to non-feasibility of the research interview; all other patients responding to the inclusion criteria and willing to participate were included. The patients were given treatment as usual, encompassing non-specific supportive therapy and medication. All patients were appointed for a second interview at a three-month interval. Only $N = 18$ patients respected this

appointment, despite great efforts on the part of the researcher. At the second interview, the patients were all discharged from inpatient treatment. Along with the dynamic interview, the evaluation procedure encompassed clinician-ratings of depression and mania. The patients were given the questionnaires at the end of the interview and were asked to fill them in and send them back within two days. The study was endorsed by the expert ethical committee of the psychiatric hospital.

All Plan Analyses were done by the author; reliability was established with fully-trained colleagues and students on a randomly chosen 10% of all cases (for the results see under Results section). The establishment of a prototypical Plan structure respected the following 4 steps (inspired by Ansmann, 2002): (1) An inventory of all Plans was established, encompassing Plans and goals, excluding related observed behaviors. Clearly-overlapping Plan formulations were aggregated into one Plan and counted as such. Finally, a total of 198 different Plans were found (from a total of 483 Plans over the 30 patients; APPENDIX F3). (2) A threshold of absolute frequency of 5 occurrences in the whole sample per Plan was defined; a total of 26 Plans were found. These Plans were investigated concerning the relevant instrumental connections among them: we took into account only those instrumental linkages which presented at least 5 occurrences out of 30 cases. Finally, we composed an overall prototypical Plan structure. (3) For subtypes, an exploratory thematic analysis of the prototypical Plan structure allowed grouping based on frequency of instrumental links between the Plans and goals; two basic subtypes were found. Unlike Ansmann (2002) who performed a confirmatory study on theory-driven plananalytic subtypes of Borderline Personality Disorder, to our knowledge, BD has not been investigated with regard to subtypes. Thus, subtype formation in this study was exploratory and the strategy differed slightly from that used by Ansmann. For each subtype, in order to ensure non-ambiguous classification of all cases, one reference-Plan was defined, which was (a) present in all the

cases of the related subtype and (b) absent in all cases of the other subtype. The two subgroups taken together also had to cover more than 60% of all cases (at least 18 out of 30 cases). Two reference-Plans were found; the labels of the subtypes were derived from the labels of these two reference-Plans. Subjects presenting both reference-Plans were classified as mixed. (4) Inventories of emotion frames and specific coping Plans were established.

RESULTS

Reliability Analysis for Plan Analysis

Reliability analysis (Benkert, 1997) investigated two aspects of 3 randomly chosen Plan Analyses: (1) Plan structure; (2) Emotion frames. (1) For Plan Analyses, an overall acceptable average concordance between the author and three fully-trained raters was 64% (Case 1: 81%; Case 2: 64%, Case 3: 48%; APPENDIX F1). One case yielded insufficient reliability. However, since the overall average was higher than 60%, we decided to include this case. Furthermore, three other cases from this sample rated by the author were presented in supervision classes and were approved by the senior supervisor. Thus, we decided not to add a supplementary case for reliability. (2) For emotion frames, similar results were found: i.e., a sufficient average of 66% concordance (Case 1: 66%; Case 2: 77%; Case 3: 55%; APPENDIX F2).

Prototypical Plan Structures

The main prototypical Plan structure is shown in figure 1; figures 2 & 3 depict the subtypes. A drawn line depicts a direct instrumental relationship between Plans and goals in the order of hierarchy: lower-level Plans in the hierarchy serve higher-order Plans, goals, motives and needs; Plans are formulated in the imperative; specific behaviors at the service of low-level Plans are all left out of the presentation (Caspar, 1995). The two subtypes are each

related to a prototypical reference-Plan: (1) Figure 2 depicts the left part of the main structure and was called “(Internal) Emotion control” (reference-Plan 1: “Avoid being harmed”). A total of 10 patients presented reference-Plan 1, but not reference-Plan 2 in their Plan structure. (2) Figure 3 depicts the right part of the main structure and was called “Relationship control” (reference-Plan 2: “Control relationships”). A total of 8 patients presented reference-Plan 2, but not reference Plan 1 in their Plan structure. Finally, 12 patients presented both reference Plans and were classified as mixed (the main Plan structure representing this group best; see figure 1). The numbers in brackets in Figures 2 and 3 represent the occurrence of each Plan and the total number of subjects included in each subgroup.

Emotions and Coping Plans

With respect to emotions, which were all linked to specific Plans (to save space, these linkages will not be presented here), a total of 116 emotion events were rated in the whole sample, distributed into 27 distinct emotion categories. The three most frequently found emotions in the sample as a whole, as well as in both subgroups, are despair, fear and anger. In addition, in the subtype 1 emotion control, shame, guilt, joy, mistrust and disgust are more frequent than 5%, and in the subtype 2 relationship control the same can be said for sadness, shame, regret and hostility (see table 1). In terms of coping Plans, the inter-subject variability was very high: a total number of 126 different coping Plans were found in the sample as a whole. Because the frequencies per subtype were therefore all very low and the between-group differences not noteworthy, we present only the overall results. The main coping Plans used by BD patients are “Avoid talking about difficult events”, “Present yourself as competent” and “Search for help”. The remaining labels for coping Plans can be found in table 2.

Prototypical Plan Structures and Symptoms

Comparing subtype emotion control (n = 10) with subtype relationship control (n = 8), we found the following between-group differences: the former is associated with higher depressive symptoms and a higher general symptomatic level (GSI), than the latter. Both subgroups display the same clinically non-significant level of mania (see table 3). These differences are not attributable to between-group differences in socio-demographic variables (gender: $\chi^2(1; n = 8) = .22$, ns; age: $t(1, 16) = 0.55$, ns; level of education: $t(1, 16) = -1.83$, ns).

DISCUSSION

Our application of Plan Analysis as a method of psychotherapeutic case conceptualization to a sample of patients presenting Bipolar Affective Disorders yields an overall prototypical Plan structure. We will first discuss the characteristics and implications of this structure in detail, then elaborate on ensuing possible psychotherapeutic attitudes and interventions.

Prototypical Plan Structure for Bipolar Affective Disorder

The main Plan structure related to BD can reliably and meaningfully be divided into two parts, yielding two subtypes, emotion control and relationship control. These are abstractions of "pure" subtypes from a plananalytic perspective, represented by two rather small parts of our sample (respectively 10 and 8 patients), and a mixed type exists which presents Plan characteristics from both subtypes. Thus, all further considerations need to be interpreted with care within this context; the presence of two subtypes does certainly not suggest an all-or-nothing principle but rather a continuum between two abstracted and simplified extremes.

As positively formulated approach Plans, one can identify for the emotion subtype "Take care of yourself" and "Assert yourself", whereas for the relationship subtype "Realize yourself", "Be an achiever", "Search for help" and "Be close". As negatively formulated avoidance Plans, the emotion subtype presents many, e.g., "Avoid being hurt", "Avoid negative emotions", "Avoid conflict" and "Avoid mentioning difficult events", whereas there is only one for the relationship subtype "Avoid losing the other". Thus, the relationship control subtype presents more positively formulated Plans – resulting in more approach behavior generally known as resources - than emotion control patients, who may be qualified as "arousal avoiders". In our sample, this subtype yields higher levels of depression and general symptomatology which underlines the lower level of resources in these patients. Similar avoidance Plans (including the superior Plan of "Avoid negative emotions") have been found by Ansmann on a small sample of Borderline Personality Disorder (BPD), irrespective of the BPD subtypes (dependent v autonomous subtype; Ansmann, 2002). Avoidance of negative emotions in BD patients might also be more prevalent due to heightened levels of internal emotional arousal in these patients and the presence of more intense or subjectively more disturbing affects.

Several abstracted conflicts may be inferred based on the prototypical Plan structure. For patients from the emotion subgroup, the main conflict is situated between emotion activation (arousal) and avoidance of arousal (emotional distantiation; see also Zorn, Roder, Kramer, & Pomini, 2007). The first term of the conflict (emotion activation) is not directly mentioned in the Plan structure and is based on related emotion frames, where specific (external) situations or consequences of the Plan "Assert yourself " elicit unwanted emotions in the patient (e.g., guilt); the second term of the conflict (emotion distantiation) summarizes one of the goals of the prototypical Plans in this subtype (e.g., "Avoid being overwhelmed by emotion"). This might lead to a vicious circle which tends to affect symptom intensity, e.g.,

depressive symptoms, as shown by the higher levels of symptoms in the emotion control subgroup. For patients from the relationship subgroup, the main conflict is situated between proximity seeking and autonomy seeking. The former is represented by a Plan such as "Attract the other's attention", the latter by "Be yourself". Finally, for patients with mixed Plan structures, an additional conflict might arise between consequences of Plans such as "Transgress rules", which probably tend to elicit unwanted emotions (e.g., anger or guilt) and "Avoid negative emotions". As shown in table 3, these conflicts tend to influence differentially symptom intensity and might be assumed as psychological core determinants for symptomatic evolution in BD.

Compared to the study on BPD (Ansmann, 2002), invalidation of self was not found as a prototypical Plan in BD. Moreover, the goal "Maintain your self-esteem" was only present in 6 out of 30 BD cases (1 out of 8 for the relationship subtype). This relative absence of self-esteem Plans and goals (either expressed in a negative or positive sense) in a large part of the sample underlines the fragility of BD patients, self-esteem being generally one of the main resource aspects of human functioning (see Grawe, 1998). Compared to the prototypical Plan structure of Major Depression (Caspar, 1995), BD patients develop more Plans related to the fear of loss of control over oneself and one's emotions. Such fears find their expression in Plans such as "Avoid negative emotions". In such patients, these fears might be based on previous experiences of loss of control due to heightened levels of emotional arousal, i.e., in manic states, or when a significant other has lost self-control, e.g., a parent's violent behavior as traumatic childhood experience. High expectations and eliciting consideration from others are reserved to the prototypical Plan structure for unipolar depression and was not found in the BD sample. This emphasizes the importance of prototypical Plan structures indicating specific dynamics for each group of patients and, ultimately, of tailor-made disorder-specific interventions.

With regard to emotions, in addition to what one might call the "BD emotional triad" despair, fear and anger, the most frequently observed emotions irrespective of the subtype, several others are elicited in the patients in this context. Since no difference-testing was made, due to low frequencies, we will not interpret these scant between-group differences. However, it is remarkable that in BD, almost all rated emotions are negative, even if some patients present hypomanic symptoms. There are several exceptions, including joy. It can be hypothesized that the occasionally observed positive mood in these patients does not imply the presence of underlying positive affects and emotions; on the contrary, it might hide - defensively concealed - underlying emotion negativity in BD. This assumption can be exemplified by the two most frequently used coping Plans in BD: "Avoid talking about difficult events" and "Present yourself as competent". Both Plans might elicit positive emotions in the short term – or on the surface - but as shown by the instrumental embeddedness of these two Plans in the Plan structure (and related negative emotions when the Plans are blocked), their real long-term effects might not always be helpful for an individual presenting these Plans (see Skinner, Edge, Altman, & Sherwood, 2003, for a detailed definition of coping adaptiveness).

Motive-Oriented Therapeutic Relationship and Tailor-made Interventions

The motive-oriented psychotherapeutic relationship (Caspar, Grossmann, Unmüssig, & Schramm, 2006; Caspar, 2007) was introduced by Grawe (1992a) under the label of Complementary Therapeutic Relationship. The principle is based on Plan Analysis and allows the clinician to adopt a constructive and malleable stance to deal with the Plan dynamics in the specific patient. In a radically instrumental perspective, the clinician asks the following questions (1) "Which Plans and motives in the patient may I fully endorse within the therapeutic relationship?" (the response as Plan is generally found in the upper third of the

Plan structure, where more motive-related Plans are located) and (2) “How should I as the therapist behave in each clinical situation, to respect this Plan and underlying motive and to show the patient that I respect the Plan and motive?”

For the emotion control subtype, possible therapeutic attitudes include reassuring to the patient that the therapist will do everything to avoid for the patient being psychologically harmed during therapy (see the Plan “Avoid being harmed”), conveying to the patient that it is perfectly acceptable for him/her to want to protect him-/herself (see the Plan “Protect yourself”) and, finally, convey to the patient that therapy is a safe place (Reddemann, 2001). Motive-orientedness with the over-arching Plan “Avoid being harmed”, if it is realized by the therapist as avoidance of negative arousal in the patient, might be accurate in the initial sessions, but therapy would probably fail if aimed only at avoiding talking about negative events, since we assume with our case conceptualizations that there are real negative – in some cases probably traumatic (see also above) - events to work through with such patients. Hence, trauma-related interventions, such as imagination techniques and carefully planned exposure therapy (Reddemann, 2001; Foa, Rothbaum, Riggs, & Murdock, 1991 ; for a tailor-made application of such standardized methods, see Kramer, accepted for publication) might be indicated for this subgroup, as they would enable the patient to experience safely emotion activation related to trauma-related contents. Finally, a well-tailored skills-training focusing on emotion regulation (Linehan, 1993) is an important therapeutic ingredient for patients from this subtype.

For the relationship control subtype, with slightly higher resources, the therapist might adopt the following attitudes according to the principles of the motive-oriented therapeutic relationship: the therapist must show the patient that the latter can completely count on the former within the limitations of the therapeutic relationship (see the Plan “Avoid losing the other”). In addition, the therapist should show that it is possible to realize one’s own dreams

and ideas and yet be dependent on significant others (see the conflict between "Realize yourself" and "Avoid losing the other"). The therapist may also, where appropriate, pay great attention to the patient's discourse (e.g., by showing that he/she remembers what was said in the previous session). However, we also know from the Plan structure, that there are clinical situations where the patient tends to attract the therapist's attention by using unacceptable or less helpful means, e.g., by transgressing rules, by playing the role of a victim. If such behavior or low-order Plans are part of an "intransparent interactional play-structure" (Sachse, 2004), the therapist should point it out and, if the timing is correct, clarify it within the therapeutic relationship (Sachse, 2003). The therapist can at the same time reassure the patient of his/her presence as a therapeutic caregiver and a genuinely attentive listener, which would again be motive-oriented.

Finally, we mention several limitations of this study. First, by aggregating a host of individualized case conceptualizations into one single – broken down into two parts – prototypical Plan structure, we run the risk of ignoring clinically important information for individual cases, features that were observed rarely and which did not yield the significance level to be included the prototypical structure. Likewise, a complete case conceptualization and therapy planning for an individual patient needs to encompass far more detail in an individualized language adapted to the patient (see Caspar, 2007; for practical guidelines see Grawe, Grawe-Gerber, Heiniger, Ambühl, & Caspar, 1996; for a clinical example see Heiniger, Grawe-Gerber, Ambühl, Grawe, & Braun, 1996, and also Kramer, accepted for publication). As our aim is to apply Plan Analysis to an entire sample of BD patients and explore their similarities in terms of prototypicality, rather than their inter-individual differences, our suggestions for treatment planning can be understood as only a tentative illustration of the concept of motive-oriented therapeutic relationship. Our results of a prototypical case conceptualization based on individual clinical material may be particularly

useful in clinically challenging situations with BD patients, where a negative emotional reaction in the therapist (e.g., irritation) is involved, in situations when the manual-based set of interventions shows its limitations (Basco, & Rush, 2005) or when the therapeutic relationship with a patient is at stake. We believe these results are encouraging for the clinical work and we hope they may help clinicians to conduct even more efficient psychotherapeutic interventions as the adjunct to state-of-the-art pharmacological treatments for BD patients.

Table 1

Frequencies of Emotions in Total and per Subtype

Emotion	Total (N = 30)	Emotion Control (n = 10)	Relationship Control (n = 8)
Despair	20 (17%)	7 (19%)	5 (19%)
Fear	15 (13%)	5 (14%)	4 (15%)
Anger	14 (12%)	4 (11%)	5 (19%)
Sadness	11 (9%)	1 (3%)	4 (15%)
Shame	11 (9%)	2 (5%)	2 (7%)
Guilt	6 (5%)	3 (8%)	0
Joy	6 (5%)	4 (11%)	1 (4%)
Regret	5 (4%)	1 (3%)	2 (7%)
Mistrust	4 (3%)	2 (5%)	0
Hostility	3 (3%)	1 (3%)	2 (7%)
Pride	3 (3%)	0	0
Satisfaction	2 (2%)	0	0
Disgust	2 (2%)	2 (5%)	0

Note. The following emotions were found once in the whole sample: Anxiety, Self-pity, Discouragement, Embarrassment, Apprehension, Inhibition, Irritation, Enthusiasm, Vexation, Fear, Worry, Admiration, Resentment, Emotional Fatigue. Total for Emotion Control: 37 Emotions; Total for Relationship Control: 27 Emotions; Grand Total: 116 Emotions.

Table 2

Frequencies of Coping Plans

Coping Plan	Frequency
Avoid talking about difficult events	14 (11%)
Present yourself as competent	11 (9%)
Search for help	10 (8%)
Avoid remaining alone	9 (7%)
Accuse your environment of causing your problems	8 (6%)
Conform with rules	8 (6%)
Take your responsibility	8 (6%)
Distract yourself	7 (6%)
Do everything to satisfy other people	6 (5%)
Do everything to impress the therapist	5 (4%)
Seduce a loved person	3 (2%)
Do everything to avoid being asked uncomfortable questions	3 (2%)
Isolate yourself	3 (2%)
Present yourself as a victim	3 (2%)
Minimize your difficulties	3 (2%)
Avoid engaging in too close relationships	3 (2%)
Avoid stressful situations	2 (2%)
Provoke a dispute	2 (2%)
Emphasize your need of a special treatment	2 (2%)

Note. Only frequencies greater than 1 reported in the table. Total Coping Plans for the 30 patients: 126.

Table 3

Between-Group Differences with regard to Symptoms

Variable	*Emotion*		Relationship		*T*(1,17)	*ES*
	M	SD	M	SD		
GSI	1.69	0.98	0.91	0.38	2.91*	1.05
MADRS	19.10	12.64	12.00	7.19	1.99*	0.69
BRMS	2.30	2.05	4.13	3.44	1.96	0.65

Note. Emotion: Plananalytic subgroup characterized by internal stress regulation (n = 10); Relationship: Plananalytic subgroup characterized by stress regulation by using interpersonal relationships (n = 8); GSI: General Symptom Index from the Symptom Checklist 90-R; MADRS: Montgomery-Asberg Depression Rating Scale; BRMS: Bech-Rafaelson Mania Scale. Bonferroni's correction applied.

* $p < .05$

Figure 1

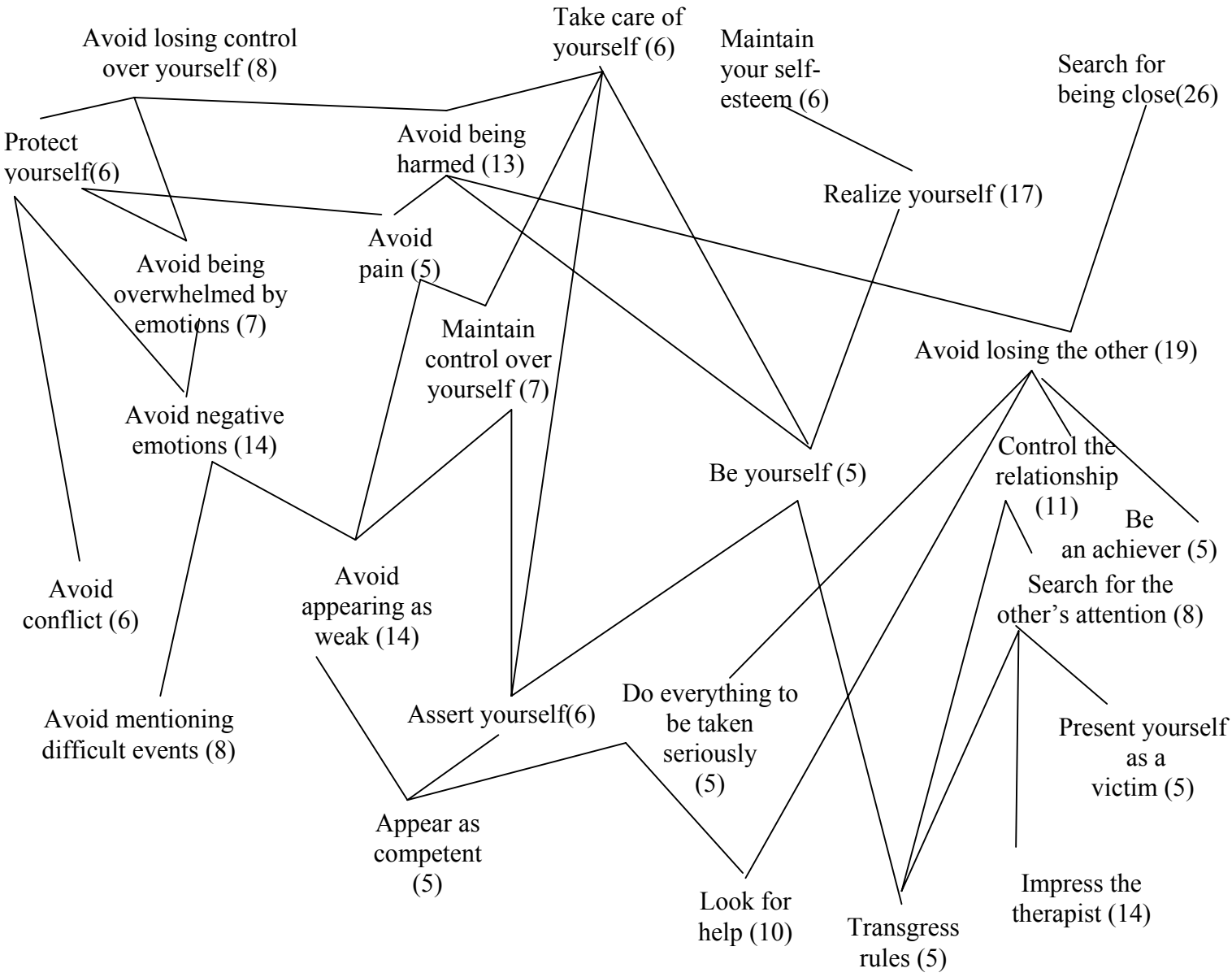

Avoid losing control over yourself (8)
Take care of yourself (6)
Maintain your self-esteem (6)
Search for being close(26)
Protect yourself(6)
Avoid being harmed (13)
Realize yourself (17)
Avoid being overwhelmed by emotions (7)
Avoid pain (5)
Maintain control over yourself (7)
Avoid losing the other (19)
Avoid negative emotions (14)
Be yourself (5)
Control the relationship (11)
Be an achiever (5)
Avoid conflict (6)
Avoid appearing as weak (14)
Search for the other's attention (8)
Avoid mentioning difficult events (8)
Assert yourself(6)
Do everything to be taken seriously (5)
Present yourself as a victim (5)
Appear as competent (5)
Look for help (10)
Transgress rules (5)
Impress the therapist (14)

Figure 2

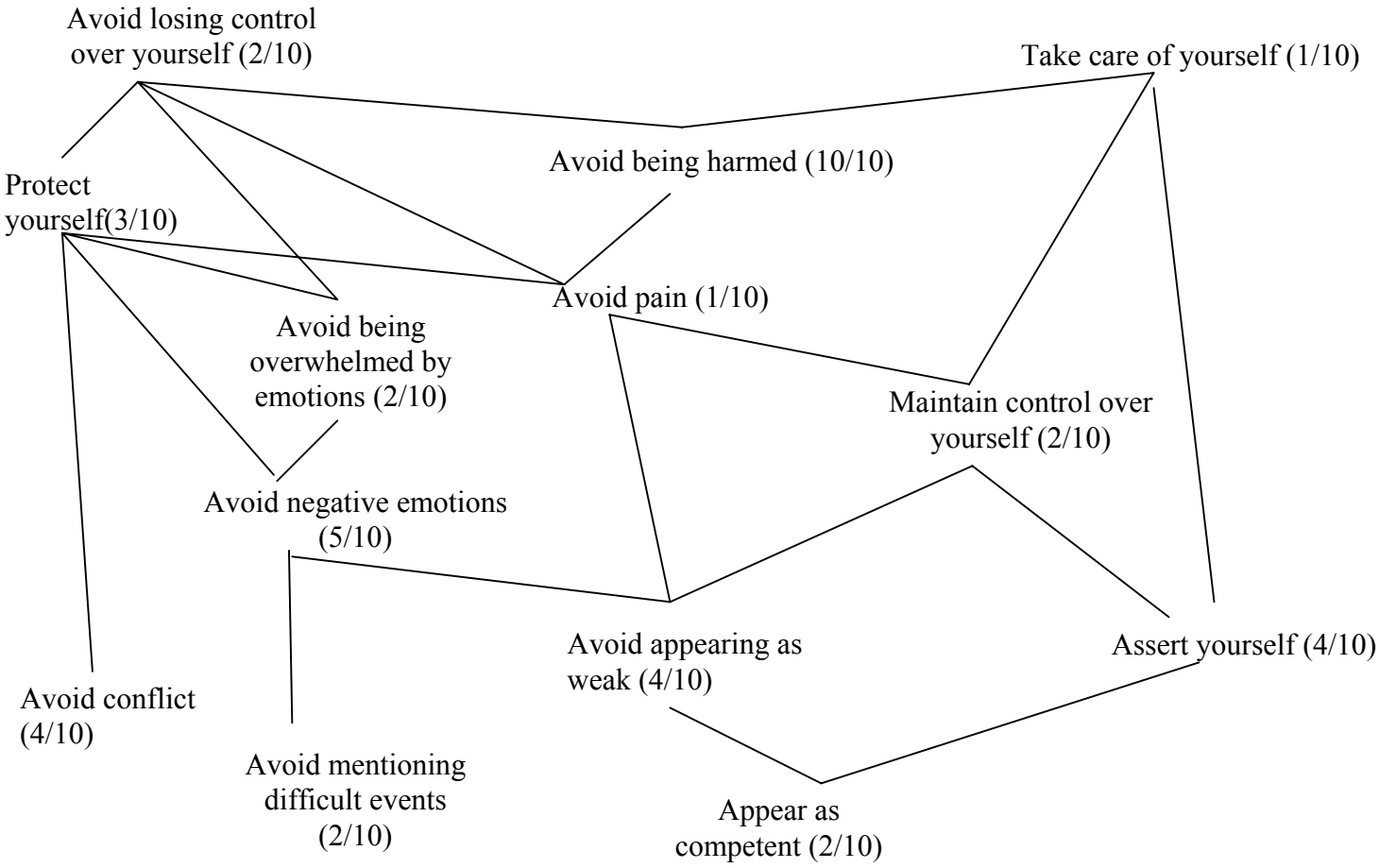

Avoid losing control over yourself (2/10)
Take care of yourself (1/10)
Avoid being harmed (10/10)
Protect yourself(3/10)
Avoid pain (1/10)
Avoid being overwhelmed by emotions (2/10)
Maintain control over yourself (2/10)
Avoid negative emotions (5/10)
Avoid appearing as weak (4/10)
Assert yourself (4/10)
Avoid conflict (4/10)
Avoid mentioning difficult events (2/10)
Appear as competent (2/10)

Figure 3

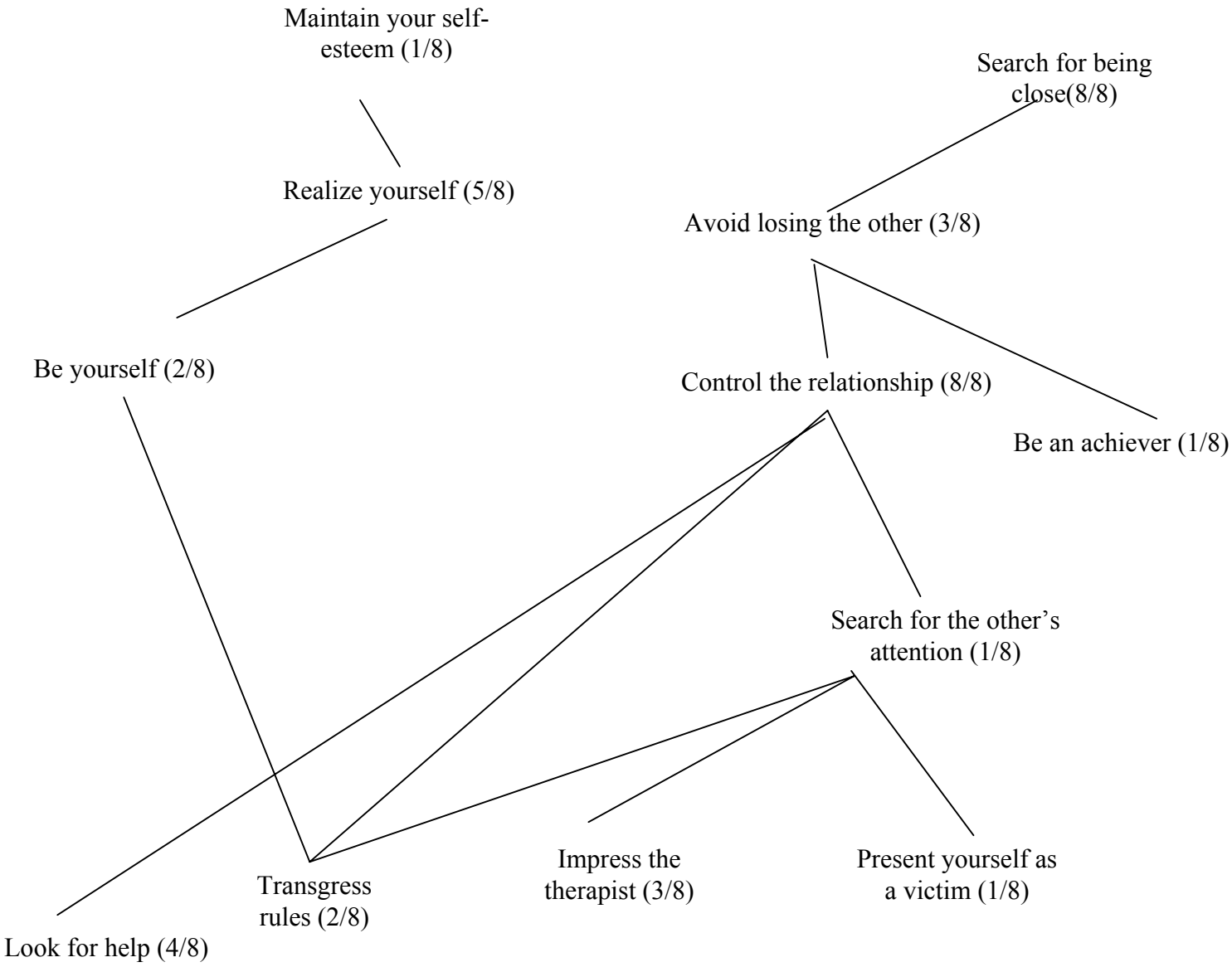

Maintain your self-esteem (1/8)
Search for being close(8/8)
Realize yourself (5/8)
Avoid losing the other (3/8)
Be yourself (2/8)
Control the relationship (8/8)
Be an achiever (1/8)
Search for the other's attention (1/8)
Impress the therapist (3/8)
Present yourself as a victim (1/8)
Transgress rules (2/8)
Look for help (4/8)

FIGURE CAPTIONS

Figure 1

Prototypical Plan Structure for Bipolar Affective Disorder (N = 30 patients)

Figure 2

Prototypical Plan Structure for the Subtype “Emotion Control” (n = 10 patients)

Figure 3

Prototypical Plan Structure for the Subtype “Relationship Control” (n = 8 patients)

Chapter G

Early Change in Defense Mechanisms and Coping in Successful Short-Term Dynamic Psychotherapy: Relations with Symptoms and Alliance

ABSTRACT

Several patient-related variables have already been investigated as predictors of change in psychodynamic psychotherapy. Defensive functioning is one of them. However, few studies have investigated adaptational processes, encompassing defense mechanisms and coping, from an integrative or comparative viewpoint. This pilot study includes 18 patients undergoing successful time-limited psychodynamic psychotherapy lasting up to 40 sessions and will focus on early change in defense and coping. Observer-rater methodology is applied to the transcripts of two sessions of the first part of the psychotherapeutic process. It is assumed that the contextual-relational variable of therapeutic alliance intervenes as moderator on change in adaptational processes. Results corroborate the hypothesis, but only for coping, whereas for defenses, overall functioning remains stable over the first 20 sessions of psychotherapy. These results are discussed within the framework of disentangling processes underlying adaptation, i.e., related to issues on trait- and state-aspects, as well as the role of the therapeutic alliance.

Key-Words: Defense Mechanism, Coping, Short-Term Psychodynamic Psychotherapy, Therapeutic Alliance

EARLY CHANGE IN DEFENSE MECHANISMS AND COPING IN SUCCESSFUL SHORT-TERM DYNAMIC PSYCHOTHERAPY: RELATIONS WITH SYMPTOMS AND ALLIANCE

In psychotherapy research, in order to predict outcome, studies generally distinguish between patient-related variables and context-related variables, among others (Lambert, 2004; Wampold, 2001). From among these groups of variables, we will concentrate on two facets of adaptational processes – defense mechanisms and coping – as patient-related characteristics, and on the therapeutic alliance as a contextual variable in psychotherapy.

Adaptational Processes

Defense mechanisms and coping – both serve the individual's need for adaptation to reality – have aroused increasing research and clinical interest in recent years. This is certainly due to greater conceptual and methodological maturity in this domain, as regards research on both coping and defenses (e.g., Cramer, 1998a; Kramer, 2005a; Lazarus, 2000; Perry, & Ianni, 1998; Skinner, Edge, Altman, &, Sherwood, 2003; Steffens, & Kächele, 1988). An important issue is the adaptiveness of specific defenses and coping. As regards defenses, the question has been resolved with the suggestion of a hierarchical organization of defenses according to their adaptiveness, maturity or degree of reality distortion (Perry, 1993a; Vaillant, 1977). In the case of coping, adaptiveness is more complex: quantitative and qualitative criteria have been formulated. The first show that the prolonged use of any coping process over dissimilar situations impede the individual's adaptation to reality (Summerfeldt, & Endler, 1996). Qualitative criteria, similar to defenses (Skinner, Edge, Altman, et al., 2003) differentiate maladaptive coping, as a reaction to stress appraised as threat, from adaptive, as a reaction to stress appraised as challenge. Previous studies suggest the importance of

disentangling defenses from coping (Cramer, 1998a), not without admitting some overlap, generally according to the qualitative criteria of adaptiveness of the singular processes. In this regard, Grebot, Paty and Girard Dephanix (2006) have found linkages between mature defenses and specific adaptive coping and between immature defenses and specific maladaptive coping.

An important question related to defense and coping is that of stability and change in these processes over time (Cramer, 1998a). Regardless of the presence or the efficacy of any therapeutic intervention, one can assume that defenses, as a personality-related concept (Bergeret, 1985; Kernberg, 1984), encompass stable trait-aspects along with some state-aspects. This allows minimal fluctuation of an established pattern of defense (Perry, 2001; Drapeau, de Roten, Perry, & Despland, 2003). Coping as a situation-determined concept (Lazarus, Averill, & Option, 1974; Lazarus, & Folkman, 1984; Steffens, & Kächele, 1988) is best described as a state-concept. Thus, theoretically and extraneous to the therapeutic intervention context, coping should be more prone to change over time than defenses.

The association of adaptational processes with psychopathology and psychotherapeutic outcome has already been investigated several times. Generally, maladaptive processes are moderately related to higher symptom levels and unfavorable outcome (Cramer, 1998a; Maffei, Fossati, Lingiardi, & Maleddu, 1995; Noam & Recklitis, 1990; Perry, 1993a). Especially in neurotic disorders, such as Adjustment Disorder, Panic Disorder, Major Depression – without the underlying presence of chronic Personality Disorders – , symptom level and evolution should be closely related to coping as state-dependent variable. Defenses should not vary greatly as a function of these symptoms, since the core personality structure, from which defensive functioning is a surface derivative, is less globally affected by this type of disorder, unlike in long-standing Personality Disorders (Perry, 1993a; Perry, 2001).

With regard to psychotherapy, adaptational processes – whether coping or defense - have been examined in several studies (Drapeau, de Roten, Perry, & Despland, 2003; Perry, 2001; Perry, Drapeau, Dunkley, Foley, Blake, & Banon, 2007). Over the course of brief psychotherapeutic crisis intervention in four sessions ($N = 61$ patients), Drapeau, de Roten, Perry and Despland (2003) have shown a shifting effect in defenses from narcissistic (first session) to obsessional (fourth session). These changes have been interpreted as state-changes in defenses due to the resolution of the crisis over the course of ultra-brief intervention - or the intellectualization of narcissistic stakes related to the crisis - rather than profound restructuring of defensive functioning in the patients. Long-term changes in defenses have been documented by means of a case study (Perry, 2001): a patient presenting passive-aggressive Personality Disorder undergoing psychodynamic psychotherapy for four years presented profound defensive restructuring, i.e., fewer action defenses, fewer narcissistic defenses, after treatment. This case study also confirms the clinical assumption of the patient's regression with regard to defenses at mid-treatment: Overall Defensive Functioning (ODF) decreased slightly in the first two years of treatment, before reaching healthier neurotic levels at third and fourth years, and moved up to adaptive and mature defensive functioning during follow-up. Hence, concentrating on short-term psychodynamic psychotherapy (STDP) and investigating early change in adaptational processes, we would hypothesize that if changes in defense and coping can be observed in the initial 20 sessions of STDP, they would be related to state-variables, i.e., be found in specific defense categories, and not represent profound restructuring of defensive functioning, as measured by Overall Defensive Functioning. In this early stage of therapy of predominantly neurotic patients, coping should be more closely related to symptom level and change and should change itself more rapidly, whereas symptom level and change should be independent from personality-related variables, such as defenses.

Therapeutic Alliance as Moderator

Theoretically, the therapeutic alliance intervenes as a contextual variable in influencing the effects of psychotherapy (Wampold, 2001). This is demonstrated by moderate effect sizes relating alliance to outcome across various treatment settings (Martin, Garske, & Davis, 2000; Horvath & Symonds, 1991). Whereas these meta-analyses are based on alliance measures at one point in time – or on mean alliance - , recent research tends to prefer the use of the clinically relevant description of evolution of alliance patterns (de Roten, Fischer, Drapeau, Beretta, Kramer, Favre, &, Despland, 2004; Kivlighan, & Shaughnessy, 1995; Kramer, de Roten, Beretta, Michel, & Despland, in revision). This may particularly hold true for time-limited treatments, where the process of relationship construction is at least as important as the technical aspects, due to the restricted time-frame potentially eliciting in the patient a high degree of emotionality and issues related to pre-transference and transference (Gilliéron, 1997). Thus, alliance may have an impact on the evolution of adaptational processes in patients undergoing short-term psychodynamic psychotherapy; we would postulate the presence of a moderator effect of alliance (Baron, & Kenny, 1986) in this regard. Consistent with our interest in early change in adaptational processes, we have concentrated on alliance construction processes taking place during approximately the first two months of treatment, i.e., the eight initial sessions. This time-frame is based on the study on alliance patterns by Stiles, Glick, Osatuke, Hardy, Shapiro, Agnew-Davies, Rees and Barkham (2004).

This leads us to our research hypotheses: (1) Coping and defense are two different processes; if overlap there is, mature defenses are related to adaptive coping and immature defenses are related to maladaptive coping; (2) Over the course of the initial sessions of psychodynamic psychotherapy, a) coping changes, whereas defenses remain stable, b) Overall Coping Functioning increases, whereas Overall Defensive Functioning remains stable; (3) Patterns of alliance construction operate as moderator variable for the early changes in

defenses and coping in psychodynamic psychotherapy; (4) Coping is related to symptom level and change over therapy, whereas defenses are not.

METHOD

Participants

The patients (N = 18) were self-referred university students at a French-speaking University Consultation Center, consulting for Adjustment Disorder, either with anxious or depressive mood. DSM-IV-diagnoses (APA, 1994) were established by using the SCID I and II (Spitzer, Williams, & Gibbon, 1997). Patients presenting Psychosis, Addictions and Bipolar Disorder were excluded from this study. A total of 7 (39%) presented co-morbid Personality Disorders (cluster B). Their mean age was 24 years (SD = 4.3; range = 20-39); 11 (61 %) were female. They were recruited for the study after their intake session by a member of the research staff. Upon approval, they were referred to one of the therapists. All participants gave written informed consent for their data to be used for research; the present study was approved by the ethical commission of the Department of Psychiatry involved. For our exploratory analysis on defense and coping, we selected 18 patients with clinically reliable symptom decrease on General Symptom Index (SCL-90-R; see below) over the course of short-term dynamic psychotherapy. For this exploratory study, we made a selection drawn from a larger sample encompassing N = 50 participants[2].

The therapists (N = 10) were experienced psychiatrists and psychotherapists, all with over 10 years of clinical experience in the field of psychodynamic psychotherapy. The therapists did not have access to research data until the whole set was completed.

[2] This study was supported by the FNRS Grant 3200BO-100706/1

Treatment

Short-term dynamic psychotherapy (STDP) is a manual-based (Gilliéron, 1997), time-limited form of psychotherapy based on psychoanalytic theory and developed in order to respond to the increasing demand for short-term efficient treatments in psychotherapy (Malan, 1976; Sifneos, 1987; Gilliéron, 1997). Its efficacy has been established by a number of studies (Leichsenring, & Leibing, 2003; Crits-Christoph, 1992; Beretta, de Roten, Kramer, Michel, & Despland, in revision). This study includes psychotherapeutic treatments lasting up to 40 sessions, with a mean of 24 sessions (SD = 10.0; range 15 – 40).

Instruments

Defense Mechanism Rating Scales (DMRS; Perry, 1990a; French translation: Perry, Guelfi, Despland, & Hanin, 2004). The DMRS is an observer-rater scale assessing 28 defense mechanisms, based on the hierarchical conception of defensive functioning by Vaillant (1992). Seven levels ranged according to the criteria of adaptiveness are included, from the least adaptive to the highly adaptive: (1) Action (acting out, passive aggression, hypochondriasis), (2) Borderline (splitting of self/object images, projective identification), (3) Disavowal (denial, rationalisation, projection) and autistic fantasy (for further computation, this defense will be considered on level 3, even if conceptually distinct) (4) Narcissistic (omnipotence, devaluation, idealization), (5) Neurotic (repression, dissociation, reaction formation, displacement), (6) Obsessional (isolation of affect, intellectualization, undoing) and (7) Mature (affiliation, altruism, anticipation, self-assertion, humour, self-observation, sublimation, suppression). Quantitative scoring has been used, yielding relative frequency scores per defense level, as well as an Overall Defense Functioning (ODF) score which can be computed by weighting the absolute frequency of the defenses by their level. For the current study, reliability coefficients on 10% of the ratings were established among

fully-trained raters and yielded satisfactory results in terms of intra-class correlation coefficients (2,1, Wirtz, & Caspar, 2002; APPENDIX B2) varying between .76 and .98 (Mean = . 90; SD = .12; APPENDIX G2). For these reliability analyses, the defense level was the unit of analysis (7 categories).

Coping Action Patterns (CAP; Perry, Drapeau, Dunkley, & Blake, 2005; French translation by Kramer, & Drapeau, 2005). CAP is an observer-rating system assessing coping processes based on interview-transcripts (Drapeau, & Perry, 2005). The rating scale encompasses 12 categories of coping (based on Skinner, Edge, Altman, & Sherwood, 2003). Three general domains have been identified (relatedness, competence, autonomy) each encompassing four categories ("families") of coping. Moreover, six of the coping categories are conceived as coping with stress appraised as challenge (problem-solving, information-seeking, self-reliance, support-seeking, accommodation, negotiation) and the other half as coping with stress appraised as threat (helplessness, escape, delegation, isolation, submission, opposition). Therefore, 12 coping categories are assessed by this instrument. Relative frequencies are computed for all coping processes. Based on Skinner et al. (2003), an Overall Coping Functioning (OCF) score can be computed (relative frequency of challenge-coping). Preliminary empirical validation data have been presented by D'Iuso, Blake and Drapeau (2007), Drapeau and Perry (2005), Drapeau, Perry, Blake and D'Iuso, 2007) and Perry, Drapeau, Dunkley, Foley, Blake and Banon (2007) for the original English version, Kramer (2006a), Kramer, Drapeau, Perry, Bodenmann, Despland, and de Roten (2007) and Kramer and Drapeau (in prep.) for the French version used for this study. In the case of the current study, reliability coefficients on 10% of the ratings were established among fully-trained raters and yielded satisfactory results in terms of intra-class correlation coefficients (2,1, Wirtz, & Caspar, 2002) varying between .73 and .88 (M = .79; SD = .08; APPENDIX G1).

These coefficients have been established on coping category as the unit of analysis (12 categories). Intra-class correlation coefficients (2,1) with the CAP authors' group of raters vary between .51 and .83 (M = .71; SD = .11; the .51 score is the only one below .60; APPENDIX B4).

Symptom Check List SCL-90-R (Derogatis, 1994). This questionnaire consists of 90 items addressing various somatic and psychological signs of distress. These items are scored using a Likert-type scale from 0 (not at all) to 4 (very much). Although the instrument is composed of 10 subscales, our study used only the General Symptomatic Index (GSI, score ranging from 0 to 4), which is a mean rated over all symptoms. Clinical cut-off score is 0.80. The French validation study was carried out by Pariente and Guelfi (1990) and yielded satisfactory coefficients. Cronbach alpha for this sample was .96. Mean GSI at intake for this sample is 1.24 (SD = 0.52; ranging from 0.52 to 2.69). Symptom change was calculated according to Jacobson and Truax' (1991) recommendation by means of Reliable Clinical Change Index (RCI; see also Beretta, de Roten, Drapeau, Kramer, Favre, & Despland, 2005). Negative numbers indicate symptom decrease. In our sample over the course of the whole psychotherapy**,** all patients included showed reliable symptom decrease (M(RCI) = -7.28; SD = 3.76; ranging from –14.04 to –2.02).

Helping Alliance questionnaire HAq-I (Alexander & Luborsky, 1986). This self-report 11-item questionnaire is rated by means of a 6-point-Likert scale (ranging from –3 "I strongly feel that this is not true" to +3 "I strongly feel that this is true"). The total score of HAq-I ranges theoretically between –33 and 33. Two factors have been identified in previous studies (Luborsky, 2000, for a review): the patient's experience of being helped and the patient's experience of making joint effort with the therapist to overcome difficulties. According to

Luborsky (2000), psychometric properties are as good as those of other current alliance questionnaires. The French validation study based on translation and back-translation was carried out by Bachelor and Salamé (2000). At the end of each psychotherapy session, the patient was asked to fill in the questionnaire. Cronbach alpha for the whole scale was .89. Mean alliance for our sample was 15.41 (SD = 9.11; ranging from –6.90 to 25.40). Recent research (de Roten, Fischer, Drapeau, Beretta, Kramer, Favre, & Despland, 2004; Kramer, de Roten, Beretta, Michel, & Despland, 2008, in press) has pointed out the relevance for outcome prediction of patterns of alliance construction over the course of psychotherapy. In the present sample over the initial eight sessions of therapy (corresponding to about the first two months of treatment), based on the methodology by Stiles, et al. (2004), the "Shape-of-Change", two distinct patterns of alliance construction were identified: increasing alliance pattern (n = 6) and decreasing pattern (n = 12; Kramer, de Roten, Beretta, Michel, & Despland, 2008, in press).

Procedure

All psychotherapy sessions were audio-taped. From each therapeutic process, two sessions were randomly chosen for DMRS and CAP ratings. The first was chosen out of sessions 2 to 5, the second was chosen out of sessions 12 to 15. The rationale for these intervals was (1) To choose a session from the alliance construction process, excluding the intake session; (2) To choose a session from mid-treatment, in order to study early change in STDP. This total of 36 sessions were transcribed according to the method defined by Mergenthaler and Stigler (1997).

The ratings were based on the transcripts. DMRS ratings were carried out by fully-trained raters, including the author; the reliability of these ratings was established with fully-trained colleagues on a randomly chosen 10% of all sessions (for the results see under

Instruments). All CAP ratings were done by the author; reliability of these ratings were established with fully-trained Master's-level psychology students, who were trained during four months by the author, on a randomly chosen 10% of all sessions (for the results see under Instruments).

Data Analytic Strategy

In order to respond to the first hypothesis, we conducted canonical correlations between the two sets of variables, defenses and coping (on the first session), maximizing the possible links between the variables and controlling best for the multiplication of errors related to significance testing (Tabachnick, & Fidell, 1996). Furthermore, we carried out exploratory factor analysis (method PCA, Principal Components Analysis; results after VARIMAX rotation) on defenses and coping on both sessions taken as a whole. In response to the second hypothesis, we conducted a series of Paired-Sample *t*-tests between the first and the second session on a) specific coping and defense processes and on b) Overall Coping Functioning (OCF) and Overall Defensive Functioning (ODF); Bonferroni's correction was applied. To validate the third hypothesis, a nested design offered only by Hierarchical Linear Modeling (HLM; Bryk, & Raudenbush, 1987; for computation the program MixReg, Hedeker, & Gibbons, 1997) is needed. This design takes optimally into account data dependency between the two sessions; sessions (level 1) are nested within patients (level 2). In assessing change, HLM avoids some limiting assumptions of Paired-Sample *t*-tests by taking into account each individual's trajectory of scores over time. A mixed model predicting alternatively ODF and OCF, introducing alliance pattern as fixed factor, was carried out (for level 1: ODF or OCF = $\beta_{0j} + \beta_{1j} + \varepsilon$; for level 2: $\beta_{0j} = \gamma_{00} + \gamma_{01} + u_{0j}$; $\beta_{1j} = \gamma_{10} + \gamma_{11} + u_{1j}$). Finally, linear regression analyses (method Enter) were conducted, including ODF and OCF predicting symptom level and change.

RESULTS

Difference between Coping and Defense

Canonical correlation on the first session the CAP subscales and the DMRS levels yielded a non-significant overall effect (*t*-value = 0.95; see table 1). Only a few moderate links between specific processes; if correlation there is, immature defenses are correlated with coping when up against stress appraised as threat and mature defenses with coping when up against stress appraised as challenge. Canonical correlation between ODF and OCF yields for the first interview a *t*-value of 2.06 (p = .06; Pearson's correlation r = .46; p = .06) and for the second a *t*-value of 2.15 (p = .05; Pearson's correlations r = .47; p = .05). Thus a moderate relationship between defense levels and coping processes has been found on the level of overall functioning. This result is corroborated by EFA (after VARIMAX rotation) where the first (bipolar) factor named "Maladaptive processes" yields high item loadings for borderline and action defenses, and opposition CAP (also with negative item loadings support-seeking CAP and accommodation CAP). This factor explains 16.23% of the total variance (Eigenvalue 3.08). The second factor is named "Defenses": obsessional and neurotic defenses show high item loadings (together with negative loading for disavowal; explaining 13.22% of the variance; Eigenvalue 2.51). Total variance explained by the two factors was 29.45%.

Early Change of Defense and Coping over the course of STDP

In a Paired-Sample *t*-test, where Bonferroni's correction was strictly applied, only one difference has been found for coping: negotiation CAP increases. This is also the only noteworthy category with a high effect size. Most importantly, both ODF and OCF remain stable (both ES in the moderate range).

Alliance Construction Patterns Moderating Early Change of ODF and OCF

Using a mixed model (HLM), we did not find any main-effects for either session (confirming the overall stability of ODF and OCF over time) nor alliance pattern predicting ODF and OCF. However, there is a significant interaction effect (session x alliance pattern) for OCF: the increasing alliance construction pattern is associated with increasing OCF, whereas the decreasing alliance pattern with decreasing OCF (p = .05). No such interaction effect was found for ODF.

Coping, Defense, Symptom Level and Evolution

With regard to links with symptom level and outcome, double linear regression analyses yield a significant predictive link between OCF and symptom level at intake (p = .05); no such link was found for ODF. Neither variable predicts symptom evolution, when comparing GSI at intake with GSI at discharge.

DISCUSSION

The results corroborate parts of our hypotheses. First of all, the results suggest that defense and coping are probably two distinct psychological processes, sharing some overlap. In our sample, the latter is mostly related to maladaptive processes, as shown by EFA (e.g., borderline and action defenses with opposition coping) and correlational analyses (see also the results reported by Grebot, Paty, & Girard Dephanix, 2006). Overlap exists with regard to adaptiveness of defenses (ODF) and coping (OCF): at both sessions, a marginally significant effect was found. These results add an argument in favor of convergent validity of general indices of adaptiveness, i.e., ODF and OCF, and divergent validity on the level of specific adaptational processes. Of course, these results are tentative, since the number of observations is very low for the conduct of exploratory factor analysis, as is the variance explained by the

first two factors; thus, the stability of these factors and the observed low item loadings need to be confirmed in larger samples.

The second hypothesis investigating early change of defense and coping in STDP has yielded one single significant effect, when Bonferroni correction is strictly applied. Overall coping and defense functioning both remain stable over the first part of STDP. OCF stability over the initial sessions of STDP contradicts our second, part (b), hypothesis. A more complex model including the effect of contextual variables such as the therapeutic alliance will be discussed below. No specific defense level changes – nor ODF change - were noted during the initial sessions of STDP, thus confirming our second hypothesis, part (a), as well as part (b). For coping, negotiation increases, which might be an early behavioral or cognitive benefit from therapy which also tends to corroborate our second, part (a), hypothesis. It can be assumed that, as well as gaining more insight into his/her own functioning over the course of therapy, the patient might become increasingly aware of others' wishes and he/she, even if contradicted, might be able to make a deal with anybody, without drawing on helpless or dominant interpersonal behaviors. In order to draw firm conclusions, coping changes in STDP should be investigated on larger samples.

When introducing alliance construction patterns into the model of early change in ODF and OCF, one notices an interaction effect in the case of OCF in the sense that increasing OCF is related to increasing alliance and vice-versa, but not for ODF. This confirms a differential moderating effect of alliance on OCF change and the relevance of alliance construction patterns in this regard. Patients constructing positive alliance over the initial sessions, do rapidly benefit from therapy in terms of a better overall state-dependent adaptation to reality, e.g. by the preferential use of negotiation coping, as shown above. In turn, the subject's awareness of this increase in adaptation might incite him/her to engage even more fully in therapy, and might thus lead to an even more solid therapeutic alliance. As

such, the relevance of alliance, and in particular alliance construction patterns (Kramer et al., 2008, in press), as a contextual variable for change in coping processes within the patient is tentatively confirmed. These hypothetical dynamics do not hold true for defenses (ODF), where no interaction effect has been observed in the mixed model. Hence, contextual variables, such as alliance construction patterns early in therapy seem to have a short-term effect on state-changes related to coping, but no such short-term effect on profound defensive functioning. In order to be able to observe the latter, we assume long-term psychotherapy or psychoanalysis to be the best treatment settings (Bond, & Perry, 2004; Perry, 2001). Alternatively, therapeutic effects on the defense level may only occur in the second half of short-term dynamic psychotherapy, as reported in a study by Hersoug, Sexton and Hoglend (2002). The effect of alliance on defensive functioning in these mid- to long-term processes is a necessary follow-up research question.

With regard to relations with symptom level and change, we were able to confirm our hypothesis that Overall Coping Functioning in the earliest sessions are linked to general symptomatology (GSI) at intake. Again, no such relationship was found for Overall Defensive Functioning. This is in line with the predominance of neurotic disorders in our sample producing symptoms which might be somewhat unrelated to defensive functioning. An argument against this surmise would be that the mean ODF is in the narcissistic range of defensive functioning, suggesting the presence of underlying immature defense patterns reflecting nevertheless a certain dysfunctionality in personality functioning. It becomes evident that immature defenses account for trait-aspects, in the same way as they might account for state-aspects. The absence of any relationship with symptoms would argue in favor of a complex interplay between therapeutic situation-induced - at times due to regression within the therapeutic context - defenses and personality-related defensive patterns remaining stable in the same individual in dissimilar situations. Finally, the absence of any

link between adaptational processes and therapeutic outcome might suggest that neither trait- nor state-aspects of adaptation in the patient suffice to explain the therapeutic results, but a mediator or moderator model, including context, therapist and technique variables, is probably warranted to explain a relevant amount of variance in symptom change (see Despland, de Roten, Despars, Stigler, & Perry, 2001). The low statistical power of this exploratory study prevented our conducting such analyses. In addition, the reliable symptom reduction observed in all patients as selection criteria, diminishes outcome variance and might thus account for the lack of any relationship between adaptational processes and outcome.

To sum up, coping and defense draw probably on two different psychological processes; further studies on their disentangling are greatly needed. At the same time, there exists a moderate overlap between the two concepts, especially with regard to maladaptive processes and the overall adaptiveness (see also Grebot, Paty, & Girard Dephanix, 2006). By and large, defense and coping remain stable throughout the first half of short-term dynamic psychotherapy; an exception is an increase in negotiation coping. Therapeutic alliance construction processes operate as a moderator variable for change in coping, but not in defenses. Finally, coping is related to the level of symptoms, whereas defenses are not. These results add an argument in favor of stability in defenses, as well as in favor of coping as a more situation-dependent concept (Whitty, 2003). Profound restructuring of defensive functioning would require a much longer time-frame of treatment.

Several limitations to this study have to be indicated. The small number of observations is certainly the main shortcoming; however, the data analytic strategy was adapted to the resulting low power and limitations are acknowledged. The sample presents a certain symptomatic heterogeneity, mainly neurotic disorders, such as adjustment disorder, but also several underlying personality disorders. While this is due to the naturalistic setting and increases external validity, it also limits the internal validity of the clinical trial, i.e., due

to the absence of a control condition. For adaptational processes, only two assessment points entered our analyses. To disentangle trait- and state-aspects completely, multiple measure points across the whole psychotherapy are needed (Perry, 2001; Drapeau, de Roten, Perry, & Despland, 2003). This would allow the conduct of full mediator or moderator analyses on indices of adaptational processes. Finally, our model focusing on early change in adaptational processes did not include the type, quality and level of therapeutic interventions. This can be achieved in the future by drawing on the concept of therapist responsiveness (Stiles, Honos-Webb, & Surko, 1998; Norcross, 2002).

Table 1

Canonical Correlations (*t*-values) Between Defense and Coping at First Session ($N = 18$)

DMRS CAP	Mat	Obses	Neur	Narc	Disav	Border	Act
PS	-0.53	0.39	-0.84	0.05	0.25	1.04	0.64
IS	0.38	-0.53	1.53	0.11	-1.00	-1.43	-0.21
H	-0.93	0.39	1.11	-1.44	-0.40	1.06	-0.14
E	-0.40	-0.26	-1.25	0.86	0.64	2.66*	0.07
SR	0.59	-0.27	-0.41	-0.03	1.15	-1.39	-1.18
SS	-0.67	0.72	2.90**	-0.10	-2.68*	-1.05	-1.35
D	-3.28**	-2.27**	-0.72	0.25	1.32	-0.94	0.09
I	-1.29	-0.71	1.32	0.19	-0.13	0.84	0.07
A	-0.46	1.91	0.83	-0.59	-1.61	-1.55	-0.59
N	-0.53	-0.94	-0.64	1.40	0.72	0.99	0.76
S	-0.39	0.11	-1.32	1.97	0.50	-0.85	0.81
O	-0.05	0.61	-2.67*	-0.06	0.72	2.22*	1.28

Note. CAP: Coping Action Patterns; PS: Problem-solving; IS: Information-seeking; H: Helplessness; E: Escape; SR: Self-reliance; SS: Support-seeking; D: Delegation; I: Isolation; A: Accommodation; N: Negotiation; S: Submission; O: Opposition.

* $p < .05$; ** $p < .01$

Table 2

Exploratory Factor Analysis on Defenses and Coping, Results after VARIMAX Rotation

	Patients (N = 36)	
	I:Maladaptive	II:Defenses
Borderline Defenses	*.63*	
Action Defenses	*.59*	
CAP Escape	.23	
CAP Support-Seeking	*-.65*	
CAP Isolation	.26	
CAP Opposition	*.74*	
Mature Defenses	-.31	-.34
Neurotic Defenses	-.24	*.58*
CAP Problem-solving	.39	.25
CAP Helplessness	.27	.48
CAP Self-Reliance	-.47	-.47
CAP Delegation	.44	-.40
CAP Accommodation	*-.63*	.32
Obsessional Defenses		*.77*
Disavowal Defenses		*-.72*
CAP Negotiation		-.30

Note. Item loadings below |.20| not reported and item loadings above |.50| in *italics*.

Table 3

Change in Defenses and Coping throughout Dynamic Psychotherapy ($N = 18$)

Defenses/Coping	First Session		Second Session		$t(1, 17)$	*ES*
	M	SD	M	SD		
DMRS						
N (defenses)	35.11	17.10	35.11	18.17	0.00	0.00
ODF	4.50	0.57	4.21	0.59	1.70	0.50
Mature	8.63	10.58	9.00	11.77	-0.11	0.03
Obsessional	29.88	14.08	24.87	10.62	1.55	0.40
Neurotic	18.38	14.39	13.52	8.70	1.36	0.41
Narcissistic	10.38	8.39	9.63	8.43	0.29	0.09
Disavowal	18.89	10.37	25.36	9.21	-1.85	0.66
Borderline	6.04	4.95	7.93	6.58	-0.95	.032
Action	7.79	6.05	10.59	9.30	-1.25	0.36
CAP						
N (coping)	14.22	6.53	16.28	7.09	-1.41	0.30
OCF	.36	.21	.46	.28	-1.59	0.40
Problem-solving	0.86	1.99	0.00	0.00	1.83	0.45
Info-seeking	6.97	9.96	7.73	7.83	-0.29	0.08
Helplessness	17.79	16.55	12.32	14.11	1.02	0.36
Escape	14.78	14.02	11.92	10.86	0.89	0.23
Self-Reliance	13.58	13.43	19.42	22.42	-0.92	0.32
Support-Seeking	2.91	6.18	6.34	8.65	-1.28	0.46
Delegation	9.42	12.87	12.68	14.70	-1.09	0.24
Isolation	4.32	6.44	3.61	5.81	0.45	0.12

Accommodation	11.30	14.36	9.29	9.50	0.48	0.17
Negotiation	0.21	0.87	3.42	5.27	-2.49*	0.85
Submission	5.62	7.79	3.95	10.33	0.75	0.18
Opposition	12.24	10.30	9.33	10.83	0.90	0.28

Note. Paired-Sample *t*-tests; DMRS: Defense Mechanisms Ratings Scales; ODF: Overall Defensive Functioning; CAP: Coping Action Patterns; OCF: Overall Coping Functioning; Bonferroni's correction applied (significance level 05/2).

* $p < .05$

Table 4

Changes in ODF and OCF over the course of Dynamic Psychotherapy

Variable	Estimate	SE	Z	p-value
ODF				
Session	-0.31	0.20	-1.51	.13
Alliance pattern	0.10	0.28	0.36	.71
Interaction	0.05	0.35	0.14	.89
OCF				
Session	0.02	0.07	0.34	.73
Alliance pattern	-0.18	0.11	-1.55	.12
Interaction	0.24	0.12	1.94	.05

Note. Nested design (Hierarchical Linear Modeling; HLM); ODF: Overall Defensive Functioning; OCF: Overall Coping Functioning; SE: Standard Error.

Table 5

Regression Analyses for ODF and OCF predicting GSI and RCI ($N = 18$)

Variable	*B*	*SE B*	β
Predicting GSI			
ODF	-0.09	0.20	-.09
OCF	-1.52	0.54	-.61*
Predicting RCI			
ODF	-0.52	1.85	-.08
OCF	6.25	5.43	.34

Note. ODF: Overall Defensive Functioning; OCF: Overall Coping Functioning; GSI: General Symptom Index from Symptom-Checklist-90-R at intake; RCI: Reliable Clinical Change Index based on GSI

GSI: $R^2 = .44$; $p = .02$; RCI: $R^2 = .10$; $p = .51$; Bonferroni's correction applied (significance level .05/2)

* $p < .05$

GENERAL DISCUSSION

"The important thing is

not to stop

questioning."

Albert Einstein

To make this set of chapters a coherent whole, we will discuss the results comprehensively. First, we will focus our attention on the theses ensuing from the material presented and discuss their theoretical and empirical validity. Some of these theses are illustrated by patient material (verbatims) from our samples chosen to support our theses. It was not our objective to choose and use clinical case material to challenge (Stiles, 2005), but to exemplify the assumptions. The reader mainly interested in conceptual issues may wish to skip these short illustrative paragraphs. We will discuss the methods used in our research and outline general limitations of the studies. Particular attention will be given to clinical implications ensuing from the conceptual and empirical results. Finally, we will outline several research perspectives and imperatives for future studies on adaptational processes in affective disorders and mental disorders in general.

Main Theses

A total of 11 theses have been drawn from the conclusions of this series of chapters, as they are depicted in Table 1. Their main theoretical underpinning is presented, as well as empirical evidence from the current series of chapters. Each will be discussed separately.

Table 1

Synopsis of the 11 Theses, including References, Chapters and Empirical Support

Thesis	References	Chapter	Empirical support
(1) Defense and coping are two distinctive psychological processes	Cramer (1998a)	A, D, G	**
(2) Defense and coping have both conscious and unconscious aspects	Perry (1993a) Lazarus (2000)	A, B, C	**
(3) Coping is understood as a state-concept, defense as state- and trait-concept	Cramer (1998a) Steffens & Kächele (1988)	A, D, G	***
(4) Coping adaptiveness is related to symptom level, whereas defense adaptiveness is not	Cramer (1998a)	B, C, D, G	*
(5) Only CAPs stress appraised as threat are prone to be high-frequency coping in BD	Skinner et al. (2003)	B, D	**
(6) Immature defenses are related to BD functioning	Perry (1988)	C, D	***
(7) Positive CE are related to manic symptoms, negative CE to depressive symptoms	Clark & Beck (1999)	E	**
(8) Internal regulation of stress yields less optimal adaptation than relationship regulation		F	***
(9) Coping and defense adaptiveness	Cramer (1998a)	B, C, D, G	*

are both related to symptom evolution			
(10) Adaptational processes are related to the therapeutic alliance	Zuroff, & Blatt (2006)	B, C, E	*
(11) The therapeutic alliance modulates the evolution of defense and coping over the course of treatment	Clarkin, & Levy (2004)	G	**

* sparse empirical support; ** moderate empirical support; *** clear empirical support; **** full empirical support

Thesis 1. Defense and coping are two distinctive psychological processes. As underlined in chapter A, this first assumption is the Achilles heel of our work, as well as of Cramer's (1998a) review and underlies the integrative conceptions of Chabrol and Callahan (2004) and Steffens and Kächele (1988). The moderate corroboration of this hypothesis, as suggested in chapters D and G independently, adds an empirical argument in favor of maintenance of a clear-cut conceptual distinction between defense and coping and opens the way to integrative conceptualizations as postulated in chapter A. Both data sets, the BD patients with the matched controls and the psychotherapy patients, yield low to moderate overall relationships between defense and coping. The strongest of the reported relationships, although only marginally significant, were consistently those between ODF and OCF, representing overall functioning and adaptiveness. This means that the overall level of adaptiveness, as operationalized by defenses v coping, is consistent, whereas consistency is low on the level of specificities (i.e., specific defense or coping profile). This result adds a fairly convincing argument in favor of the convergent validity of ODF and OCF, compared to an even more convincing discriminant validity on the specificity level. These empirical results

suggest that we are dealing with two specific psychological processes, both serving the same goal, the individual's adaptation to reality, as operationalized by the specific coping and defense concepts.

On the specific levels, there are some associations between defense and coping: In the BD sample, mature defenses correlate with CAP where the stress is appraised as challenge, inversely, action defenses are related to CAP-threat. The picture is less clear in psychotherapy patients, but there are still some significant correlations in this sense. In all three EFAs (BD patients, controls, psychotherapy patients), the first factor is a common defense-coping factor, labelled either immature or mature processes; the second is consistently a specific factor labelled either defense or coping. Thus, some data point in the direction underlined by Grebot, Paty and Girard Dephanix (2006) that, if overlap on the specific level, it will be found according to the hierarchy of adaptiveness inherent in the concepts of defense and coping. Specifically for BD, a patient presenting mature defenses is likely to present at the same time self-reliance and accommodation CAP and less likely to present opposition CAP. On the contrary, a patient presenting action defenses is likely to present opposition and problem-solving CAP and less likely to present self-reliance and accommodation CAP. Moreover, CAP opposition is linked with immature (narcissistic and borderline) defenses. For the psychotherapy patients, borderline defenses are linked with escape and opposition CAP; neurotic defenses are linked with support-seeking and negatively with opposition CAP.

For coping concepts, Skinner, Edge, Altman and Sherwood (2003) systematize the qualitative differentiation between stress appraised as challenge and as threat, but are hesitant as regards clear prediction in terms of adaptiveness. Quantitative differences in coping, "high-frequency coping", seem as promising an operationalization of coping adaptiveness as qualititative ones (see chapter B). Our data suggest the use of both conceptions for coping adaptiveness and advocate in favor of a clear qualitative conception ("hierarchy") for

adaptiveness of defenses (for an opposing view for defenses, see Fenichel, 1945). Overall, this first thesis is weakened by the small sample sizes and the observation that the factors in the EFAs are probably not stable; thus, further studies are needed on larger samples and other populations. However, if our hypotheses resist further empirical investigation, such research might be put forward as an argument in favor of the differentiation of defense and coping in the perspective of a separate dimension – encompassing two distinct subscales - in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM 4th ed., APA, 1994; Hilsenroth, Callahan, & Eudell, 2003; Perry, Hoglend, Shear, Vaillant, Horowitz, Kardos, Bille, & Kagan, 1998).

Thesis 2. Defense and coping have both conscious and unconscious aspects. Another important assumption of our work is the non-differentiation between coping and defense with regard to consciousness, thus opposing Cramer's view (1998a, 2001) and Küchenhoff and Manz's (1993). The clear confirmation of this hypothesis would argue in favor of multi-method comparison within each field separately – research on coping and on defenses – and questions the face-validity of self-report measures as regards the assessment of complex adaptational processes. This question has already been raised several times (Lazarus, 2000; Perry, & Ianni, 1998; Tschuschke, Pfleiderer, Denzinger, Hertenstein, Kächele, Arnold, 1994). The perspective of the evaluator on the process-to-be-evaluated is a methodological question that has been less discussed in fundamental psychology and psychotherapy research. Hoyt (2002) shows in an analogue study on the question that rater biases account for as much as 15% of the variance of a psychotherapy outcome measure (for a clinical study, see also Kramer, de Roten, Beretta, Michel, & Despland, 2008, in press). The idiosyncratic way the subject understands an item on a questionnaire needs to be controlled for by the systematic and in-depth training and subsequent ongoing calibration of raters, in the perspective of

observer-rater assessment, especially if the process-to-be-evaluated is complex (Perry, & Henry, 2004). Such training should reduce rater biases, due to the control of the perspective of the evaluator; these raters will have benefited from increased awareness of the concepts to be applied to clinical material. This effect is reflected by the rise in inter-rater reliability as a result of length of training in CE-CAP ratings, as reported by Drapeau, Perry, Blake and D'Iuso (2007), comparable training effects have been observed in the Lausanne group (Kramer, & Drapeau, in prep.). Unconscious adaptational processes in the rater him- or herself should become conscious during the training, which is the optimal control for rater biases. The latter are due to the unconscious status of idiosyncratic pre-conceptions in the rater. Such methodology also enables the dismantling of contradictions in the patient's discourse and of self-deceptive tendencies in the patient due to Plans related to self-concept motives. All these biases cannot possibly be controlled for when using self-report questionnaires. There might be exceptions, measuring closely-behavior-related concepts, where such biases impede less on the validity of the data reported: descriptive self-report of life events, general information about the subject's career and biographical data. We would conclude that data from self-report measures on defense and coping should therefore always be compared to observer-rater assessment, to control for such biases. Although our data tend to confirm the afore-mentioned, we should add that we did not use completely theory-driven self-report questionnaires, especially for coping. Low inter-correlations might therefore also be due to theoretical inconsistency between scales. Self-report assessment of exactly the same dimensions as in DMRS and CAP would add help drawing more firm conclusions regarding thesis 2.

Clinical example (3006.1, alinea 741 - 745). This female patient, 55 years of age, is at her 20th inpatient treatment in psychiatry, this time motivated by a suicide attempt by

means of medication overdose. A few years ago, her husband died unexpectedly, a loss she has not yet overcome. Furthermore, she lost contact with her only son leading her to predominantly use, at the first interview, disavowal defenses on DMRS (32%), her ODF-DMRS was clearly in the immature range (2.95); furthermore, zero mature defenses were observed. However, on theory-consistent questionnaire investigation (DSQ-60), this patient reported one of the highest scores on mature defenses (6.40). Excerpt (rated as autistic fantasy): “She [her deceased mother] will reserve for me a little nest over there in paradise, because…there is always someone to get help from, my Daddy [deceased], my brother [deceased] and my husband [deceased], this nest will be beautiful”. This case illustrates the limitation of self-report questionnaires in assessing defensive functioning.

Clinical example (3024.1, alinea 34 - 37). This female patient, 48 years of age, is at her second inpatient treatment in psychiatry, this time motivated by manic decompensation, predominantly with irritable mood. The patient feels threatened by the surrounding world and acts aggressively towards people she does not even know. Predominant coping processes at first interview are CAP escape and opposition; her OCF is .45. On CISS however, this patient scored rather high on task-oriented coping (t = 61) and in mid-range on emotion (t = 41) and escape (t = 47); CAP problem-solving appeared very rarely throughout the first interview (was rated once). Excerpt (rated as escape behavioral): “I’m not concerned anymore about these things [the subject is talking about the police tracking her down], I will live my little life very calmly. I don’t let anybody in, except my family, that’s all, and the owner of the apartment, that’s all,….I had a lot of stress with all this.” This case illustrates the limitation of self-report questionnaires in assessing coping functioning.

Thesis 3. Coping is understood as a state-concept, defense as a state- and trait-concept. This assumption refers to the debate on state- and trait-components in defenses and coping, based on Cramer's (1998a) review. If this assumption holds true, it is a corroboration of parts of Steffens and Kächele's (1988) dynamic model on defense and coping. It would help in arguing for defenses in favor of a personality-derived process, quite stable over time, but still elicited by the situational stressor on the one hand, and for coping in favor of a complete situation-dependent state-variable on the other. The latter is particularly controversial, as some research has been done on coping "styles" conceived as personality factors (for reviews see Costa, & McCrae, 1990; Beutler, Harwood, Alimohamed, & Malik, 2002). The assumption that coping is a pure state-variable would help to find a more clear-cut and empirically-based definition of the phenomenon as a situational-transactional process based on the interplay between the person and the environment (Lazarus, & Folkman, 1984). According to our data, this thesis is tentatively confirmed (chapters D and G). Therefore, we might argue that the field of adaptational processes would gain in clarity if personality-related aspects of adaptation were reserved for defensive functioning, and not called coping nor coping style, since this term should be reserved for situational-transactional processes. Change in coping as state-induced concept has only been confirmed on the BD patients, compared to controls; the psychotherapy patients show overall stability on both indices (chapter G). This result strongly confirms our hypothesis as regards a major crisis situation necessary for a breakdown in coping (Steffens, & Kächele, 1988; Küchenhoff, & Manz, 1993). This means that, in order to observe a significant state-change, it is necessary to see great changes in the level and the quality of the potential stressor(s) as contextual-situational variables. The psychopathological crisis in BD patients, either in the form of a depressive or a manic decompensation, and the subsequent dwindling of the crisis situation after three months were enough to produce the expected state-changes; no trait-change (i.e. on overall defensive

functioning) was observed. On the level of specificity, we can hypothesize that the fluctuating aspects in defenses in BD patients are due to the state-aspects of defenses (and not trait-aspects). This explanation is consistent with the results obtained by Drapeau, de Roten, Perry and Despland (2003) where a stability of ODF (as an operationalization of the trait-aspect) and fluctuation of the specific defense levels over the course of Brief Psychodynamic Intervention has been reported. In the psychotherapy patients (chapter G), we would argue that the level and quality of the stressor did not change as much as in the BD patients between the two investigated sessions of psychotherapy. At both times, the psychotherapy patients were still at an early stage of the treatment and presented the same type of symptoms on a comparable level. As a result, both sessions were comparable on an overall level in terms of quality and level of stress and no overall change in adaptational processes should be expected which was the case. Finally, the observation of relative low coping specificity for BD, compared to high defense specificity (see chapter D, and theses 5 and 6) might also be understood as an argument in favor of coping as a state-concept, as specificities linked to diagnoses are supposed to be rather stable over time.

> *Clinical example* (3017.1, alinea 66 and 3017.2). This female patient, 50 years old, has been hospitalized in psychiatry for the first time, due to manic decompensation. She lives in a house in the country with her enlarged family and is known as someone who does everything for others (i.e., cooking, cleaning, washing). Whereas ODF remains in the range of narcissistic defenses in both interviews (4.40, 4.44), OCF tends to rise to more adapted levels in the second interview (from .58 to .72). The most salient change in singular CAP is noted in submission (rated six times at the first interview and zero at the second), which is consistent with some of her main characteristics mentioned earlier. Excerpt (rated as submission behavioral): “I took everything out, and I sorted it

> all out, everything, everything. I sorted out the basement, to make room for stuff. I also sorted out everything in Nathan's room [her son], his clothing which has now got too small, so I gain more space. Because I would like Daddy to have his clothing in the other room." This case illustrates the important positive change in CAP when the stress is appraised as threat between inpatient treatment and the follow-up interview. CAP when stress is appraised as threat diminishes greatly between the two assessment points for this patient which accounts for better coping adaptiveness at the follow-up interview, whereas overall defensive functioning remains stable.

Thesis 4. Coping adaptiveness is related to symptom level, whereas defense adaptiveness is not. In relation to thesis 3, the linkage between OCF and symptoms should be higher than that between ODF and current symptom level. According to Steffens and Kächele (1988), the latter may be understood as an operationalization of outcome of the dynamic interplay between stress, defenses and coping – the transactional dynamics of the adaptational process (see Figure 2 in the Introduction section). Note that we are dealing here with symptom level as micro-outcome of adaptational processes (Vaillant, 1977), as opposed to (long-term) macro-outcome, i.e., symptom evolution over the course of treatment, discussed under thesis 9. Defenses should not be strongly related to the state-dependent symptom level, as ODF tends to remain stable over time. However, OCF as a state-related concept of adaptiveness should be related to state-dependent symptom level. For the sample of BD patients, this hypothesis was not confirmed, however, for the psychotherapy patients at intake, a significant link was found for OCF, as opposed to ODF (see chapter G). The absence of link in BD patients might reflect the limitations of psychological models when symptom levels associated with BD should be explained. The results suggest that overall symptom intensity in BD is completely independent from adaptational processes. Biological (i.e., endocrinological

or genetic; Faraone, Glatt, Tsuang, 2003; Smoller, & Finn, 2003) determinants are probably at stake which explains the absence of the link. This line of explanation is confirmed by the fact that this same link is found as regards psychotherapy patients presenting mainly Adjustment Disorder, a neurotic disorder for which a link between symptom level and coping adaptiveness is more plausible due to the probable absence of biological mediators.

Thesis 5. Only CAPs facing stress appraised as threat are prone to be high-frequency coping in BD. According to Skinner, Edge, Altman and Sherwood (2003) and Cramer (1998a), coping adaptiveness may be differentiated by using qualitative and quantitative criteria. The combination of both in a specific coping process would be a particular coping vulnerability for short- and long-term adaptation to reality ("developmental risk"; Skinner, Edge, Altman, & Sherwood, 2003, p. 231). The observation of high-frequency coping categories where stress is appraised as threat would cross-validate the qualitative and quantitative criteria of coping adaptiveness. Our results tend to confirm this hypothesis, but only with some reservation (chapter B). First of all, it is noteworthy that all CAP specificities found do not differ as a function of predominant symptomatology, we are thus dealing with BD specificity and not with specificities of either manic or depressive episodes. Whereas thesis 5 holds true for opposition as BD-high-frequency CAP where stress is appraised as threat, the inverse is true for support-seeking as BD-high-frequency CAP (where stress is appraised as challenge). CISS distraction is usually associated with negative coping outcome; its high frequency corroborates therefore our hypothesis. Finally, our hypothesis is not true for all the other CAPs where stress is appraised as threat; these categories did not appear as highly frequent in BD. Several explanations might be relevant in the context of this mitigated picture. As suggested in chapter B, CAP support-seeking, if overused, might have a maladaptive character. Greater proportions of support-seeking might also have been induced

by the interview technique, as it requires the investigation of helping relationships, which are simply very low-frequent in controls, whereas highly-frequent in BD patients. However, these specific assumptions regarding support-seeking do not explain the occurrence of only one threat-coping as highly frequent in BD (opposition) and the absence of between-group differences in the other five categories (which are helplessness, escape, delegation, isolation and submission). This limited result in terms of threat-coping might reflect a basic problem in the formulation of the fifth thesis, a more restrictive formulation in terms of opposition as BD high-frequency CAP is more accurate.

In addition to the complementary definitions of coping adaptiveness – in qualitative and quantitative terms -, we also need to acknowledge the great overlap between BD patients and control subjects in terms of adaptational processes. A heightened symptom level and a psychiatric diagnosis do not suffice for the complete corroboration of the hypothesis in terms of between-group differences. This underlines that overall coping specificity in BD is quite low which limits the relevance of thesis 5. Whether this pattern is related to the fact that coping adaptiveness is highly situation-dependent, at least more than defenses, and thus a radically individualized approach for the definition of adaptiveness is warranted (for a method, see Reicherts, 1999), or whether this pattern is a consequence of the fact that the diagnosis of Bipolar Affective Disorder has rather low specificity in terms of coping profile, remains to be tested by applying the same thesis with the same method to other psychiatry patients, ideally presenting some clinical characteristics of BD, such as Borderline Personality Disorder (Gunderson, Weinberg, Daversa, Kueppenbender, Zanarini, 2006). If it turns out that BD has rather low coping specificity, when compared to BPD, we may hypothesize that it is due to the important influence of biological determinants in BD, acting as mediators between stress and outcome (Faraone, Glatt, & Tsuang, 2003). This hypothesis is tentatively confirmed by the BD specificity of CAP opposition during inpatient treatment: this CAP is probably

related to specific stressors linked with inpatient treatment of the uncostumary crisis situation, and not with the BD diagnosis per se (see chapter D).

> *Clinical example* (3020.1, alinea 106 - 110). This female patient, 42 years of age, is at her 29th inpatient treatment in psychiatry. She has been forced to undergo the treatment, because of her aggressive behavior towards her boyfriend and her son. Her OCF is particularly low with .16. In the first interview, the patient predominantly used helplessness, escape and opposition. The patient did not respect the second appointment. When describing the situation which led to the hospitalization, she said (excerpt; rated as opposition behavioral): "Yes, because he [her son] didn't want me to have the key!! The key! So he took the key, so that it was impossible for me to lock myself in the bathroom! […] On this day, I wanted to lock myself in the bathroom and that's what I did!" This example shows the importance of opposition coping in this patient, not only possibly motivated by the contextual constraint of forced inpatient treatment, but by situational and internal constraints related to the interaction with her son.

Thesis 6. Immature defenses are related to BD functioning. The role of immature defenses in various groups of highly impaired individuals – and groups of individuals – has already been established (Perry, 1993a; Perry, 1988). Similar to thesis 5, for these patients, no specificity effect has been found when testing as a function of the predominant symptomatology, adding an argument in favor of BD defense specificity. The relevance of immature defenses in BD patients, as confirmed by the results in chapter C, adds a clear argument in favor of the psychodynamic vulnerability of this patient group. In particular, a set of five immature defenses have been identified: omnipotence, rationalization, splitting of

other's image, projective identification and acting out. Some of these defenses are known to be specificities in Recurrent Depression (e.g., acting out, narcissistic defenses), some others in Borderline Personality Disorder (e.g., splitting). Thus, we hypothesize two-fold psychological vulnerability - defenses typical of Recurrent Depression and Borderline Personality Disorder – because of the presence of these defenses at the time when the BD patient is almost over the crisis episode, as in the case of our first interview. Omnipotence is related to symptom level, thus adding an argument in favor of thesis 6. Long-term studies need to be conducted to test these implications.

> *Clinical example* (3018.1, alinea 56 - 57). This male patient, 60 years old, is at his second inpatient treatment in psychiatry, this time because of manic decompensation. While in mania, he threatened his wife with an axe; thus the police enforced hospitalization. The patient did not come back for the second interview. Previously, he had had to appear in court because of another threat. While narrating the details, he presented himself as in complete control of the situation. ODF is in the immature range on the level of disavowal defenses (3.76). Excerpt (rated as omnipotence): "I told him 'President of the Jury, may I tell you something. We live in a huge villa with seven rooms. We own cable-television, several cars, we have everything.'" This example shows the poor adaptation of the use of omnipotence within the situation of the clinical interview, as well as the probable poor long-term adaptation of the same defense when used in different situations, such as in a law court.

Thesis 7. Positive CE are related to manic symptoms, negative CE to depressive symptoms. As suggested by Beck (1976; Clark, Beck, & Alford, 1999), cognitive functioning associated with manic states is biased towards the positive, and cognitive functioning

associated with depressive states is biased towards the negative. Full corroboration of this hypothesis would enable us to extend the negativity hypothesis and to confirm the universality hypothesis for BD. Although our results tend to confirm parts of these assumptions, a more complex thesis holds true. Whereas the total number of CE is increased in BD patients, moderate manic symptoms are related to heightened positive and negative biases; only statistical tendencies have been found in depressive symptoms. The presence of negative biases, along with positive ones, in patients with some manic symptoms, is consistent with clinical observation. Underlying the bias towards positive information, a negative bias is also found, resulting from an increasing awareness of the effects of previous manic symptoms and the increase in negative affects such as shame, guilt and sadness. Negative views of the self and the world might indeed be evident at the end of manic decompensation (Basco, & Rush, 2005), without the symptoms of full depression. These negative cognitive errors might contribute to inducing and exacerbating the subsequent low-mood phase (depression). Unfortunately, our design did not allow the testing of this sequential hypothesis, which would require numerous assessment points. The absence of between-group effect regarding depressive symptoms (comparing the patients with predominantly manic symptoms to the patients with predominantly depressive symptoms) may be biased due to the post-hoc analyses and needs to be interpreted with care. Higher proportions of negative CE in the subgroup with manic symptoms (see above) might account for the non-significant effect. Thus, to confirm fully this particular thesis, we need to carry out a controlled trial, with patients from both subgroups being matched with each other, as well as with a control group. Furthermore, we must acknowledge that symptom levels were on average low to moderate, and do not represent the clinical situation of full decompensation, especially for mania.

Clinical example (3021.2, alinea 113 – 115). This male patient, 60 years old, is at his second inpatient treatment, this time for manic decompensation. The level of manic symptoms increases from a low at the first interview to a submanic level at the second interview (MAS = 10 at the second interview). However, he produces predominantly negative errors (in total 15; in particular selective abstraction) and some positive ones (in total 6). Excerpt (rated as all-or-nothing-thinking negative): "There are people who've got everything, they are young, they are beautiful, they are rich, they are famous, they are healthy, they've got everything. And there are others who do not have anything of all this!" Comparing in this way successful people with unsuccessful ones implicitly turns out to be unfavorable for the patient, which signifies all-or-nothing-thinking. Negative cognitive errors are thus part of BD functioning, even in case of heightened manic symptoms.

Thesis 8. Internal regulation of stress yields less optimal adaptation than relationship regulation. Two subtypes of stress regulation have been found by plananalytic methodology: internal emotion control and relationship control. At first glance, these two subtypes might be paralleled to Blatt's (2004) two subtypes for unipolar depression, introjective and anaclitic, on the one hand, and to Ansmann's (2002) two subtypes for Borderline Personality Disorder (BPD), autonomous and dependent, on the other. Blatt's (2004) proposal of differentiation between anaclitic and introjective subtypes implies that the psychogenetic evolutionary stage of the latter be higher than the former. The author also observed that the introjective subtype did better in psychotherapy or analysis, whereas the anaclitic subtype was characterized by dependency-patterns towards the therapist or analyst, which might take more time to resolve. However, after a closer look, whereas the BD subtype relationship control and unipolar anaclitic subtype share common features, this is not true for the BD subtype emotion control

and the unipolar introjective subtype. Emotion control patterns (such as found by our data on BD) are observed in both subtypes of BPD (Ansmann, 2002). These observations tend to confirm the double psychological vulnerability of BD from a plananalytic perspective, due to the same psychological specificities as for Recurrent Depression and Borderline Personality Disorder, similar to what has been found for defensive functioning (see thesis 6). Plan Analysis yielded a higher level of resources in the BD relationship control subtype and a higher level of vulnerability in the BD emotion control subtype. These observations are corroborated by significance testing on CAP (not reported in chapter F[3]), comparing the plananalytic subgroups: CAP opposition is more often practiced by emotion control individuals, than by relationship control individuals ($t(1, 16) = 2.68$; $p < .05$; Bonferroni corrections applied). In accordance with earlier considerations on the role of CAP opposition in BD dynamics, the higher levels of symptoms in the emotion control subtype (compared to the relationship control) is in line with our assumption. Thus, the presence of many avoidance Plans related to emotion control ("Avoid upsetting emotions", "Avoid being harmed", "Avoid talking about negative events"), as well as associated conflicts, are vulnerability factors for BD, and their role for prognostics, the course of illness and the treatment must be investigated and clinically monitored, keeping in mind the possibility of suicidality. These conclusions need to be confirmed by prospective studies within the context of psychotherapy; ours did not permit long-term within-subject comparison and follow-up. Finally, it would be interesting to investigate the above thesis for other patient groups, for instance by adopting a single case

[3] We are aware that the Discussion section should not comprehend data presentation. For this exceptional case, the structure of the dissertation in seven independent chapters made it impossible to report this piece of data in a coherent way elsewhere than in the Discussion section.

methodology using Plan Analysis (Kramer, accepted for publication; Kramer, 2006b; Kramer, & Caspar, 2007).

Thesis 9. Coping and defense adaptiveness are both related to symptom evolution. As predicted by the contextual model depicted in Figure 1 in the Introduction section, adaptational processes should be related to symptom change over time. Such a link may represent the long-term effects of defenses and coping over time and may indicate direct long-term vulnerability factors, which would be relevant clinical and research information. Both types of processes should be related, based on the hypotheses of long-term effects for adaptive coping (Skinner, Edge, Altman, & Sherwood, 2003) and of mature defenses (Perry, 1990a; Sjöbäck, 1973). In the case of the BD patients, we were able to partially confirm the hypothesis, but only for certain types of coping (chapter B), and not for defenses (chapter C). No links were found in successful psychotherapy patients with regard to therapeutic outcome after one year of treatment (chapter G). It should be pointed out that for such predictive analyses, the number of observations needs to be sufficiently high, which was not the case for the BD sample, nor the psychotherapy patients. Thus, underpowered analyses may partially be responsible for the absence of this link, but also sampling procedures centered on successful therapies for chapter G, diminishing outcome variance. In BD patients (chapter B), helplessness and opposition coping are related to symptom increase or less symptom decrease over three months, corroborating our hypothesis. Moreover, as opposition has previously been identified as high-frequency coping in BD (see thesis 5), we may conclude that its overuse is particularly prone to producing unfavorable outcome in the mid- and long-term.

The absence of links between overall adaptational indices (ODF and OCF) and symptom evolution in BD might again be due to the relative independence of symptom evolution in BD from adaptational processes, due to an important biological component

intervening as determining context variable (see above, thesis 4). In future studies focusing on adaptational processes in BD, these determinants should be taken into account. For the psychotherapy patients, the model presented in the Introduction section (Figure 1) might be too simple: it would mean that psychotherapy outcome might depend solely on the patient's and therapeutic relationship variables. However, therapist interventions, competence and personality (Beutler, Malik, Alimohamed, Harwood, Talebi, Noble, & Wong, 2004) intervene as one of the most promising mediator or moderator variables between the patient's characteristics and therapeutic outcome. Thus, in future studies on adaptational processes, the question of the accuracy of the therapist intervention to specific patient adaptational processes (from a psychodynamic perspective: Kramer, de Roten, Michel, & Despland, 2005; Stigler, de Roten, Drapeau, & Despland, 2007; Winston, Winston, Wallner Samstag, & Muran, 1994) needs to be elucidated and related to the therapeutic outcome. Such research, when the patient's characteristics are taken into account, allows the concept of therapist responsiveness to be operationalized (Stiles, Honos-Webb, & Surko, 1998; Norcross, 2002).

> *Clinical example* (3005.1 and 3005.2). This female patient, aged 40, is at her 8th inpatient treatment in psychiatry, this time for a suicide attempt in the context of a depressive phase. She suffers from co-morbid alcohol dependency. Her predominant coping process is submission, her OCF at the first interview is in the mid-range (.50 at the first interview, .40 at the second). The clinical change index between the two sessions (Reliable Clinical Change Index) is highly negative (-6.06), attesting the considerable decrease in general symptomatology over three months. At the first interview, she presents only one helplessness coping; this low score can be interpreted as a possible protective factor in subsequent symptom evolution.

Thesis 10. Adaptational processes are related to the therapeutic alliance. According to the basic assumption from the contextual model depicted in Figure 1 (Introduction section), adaptational processes should be related to the quality of the therapeutic alliance as a contextual variable of psychological treatment (Zuroff, & Blatt, 2006). In a psychotherapy setting, the meaning of the patient-rated alliance measure seems quite clear, i.e., the quality of the therapeutic alliance, the agreement with the therapist on goals, tasks and the quality of the bond with the therapist (Bordin, 1975); this alliance moderately predicts outcome (Martin, Garske, & Davis, 2000). However, with regard to the sample of BD patients undergoing treatment as usual (encompassing crisis intervention in inpatient treatment, pharmacological monitoring and supportive techniques in outpatient treatment), the question is more complex due to changing treatment contexts between the two assessment points. To ensure that the comparison is meaningful (the same treatment context for all patients) and to avoid underpowered analyses in the second session, results on alliance were analysed on only the inpatient (first) session. Whereas no links were found for coping (chapter B), mature defenses (in particular self-assertion; chapter C) are related positively to the quality of the therapeutic alliance, and, finally, a higher proportion of cognitive errors (in particular selective abstraction; chapter E) is inversely related to the quality of the therapeutic alliance. We might speculate, in view of these results, that high-quality alliance as self-reported by the patient, is fostered by minimal reality-distortion in the individual, as operationalized by mature defenses, and hampered by heightened reality-distortion, as operationalized by cognitive errors. Increased distortion in perception and interpretation of the reality has been related to a number of indices of psychopathology, as well as relationship variables (Vaillant, 1977). The absence of links between alliance and coping would corroborate this explanation, as coping processes as competence-related concepts are understood to be minimally reality-distorting; it

is cognitive and emotional appraisal that is more specifically prone to cognitive distortions, but not coping directly.

Of course, alliance in turn might also influence adaptational processes. Disentangling uni-directionality and ultimately causality in these linkages remains a research challenge which should be addressed by multiple measurement points of variables involved over the course of psychotherapy (Zuroff, & Blatt, 2006).

Thesis 11. The therapeutic alliance modulates the evolution of defense and coping over the course of treatment. As proposed indirectly by the contextual model of psychotherapy (Figure 1, Introduction section) and also by the previous discussion on links between adaptational processes and symptom change, the therapeutic alliance as contextual variable might influence the evolution of adaptational processes over the course of treatment and, ultimately, moderate therapeutic outcome. The focus is laid on the influence of alliance on adaptational processes within psychotherapy. Such a moderating influence might add an argument in favor of complex interactions between patient characteristics and contextual relationship variables in psychotherapy. Our results (chapter G) partially corroborate the thesis: OCF is predicted by the interaction-effect between session and alliance pattern, whereas no such effect was found for ODF. OCF appears more directly “responsive” to the early patient-therapist-relationship dynamics in psychodynamic psychotherapy. This result also tends to support thesis 3 of coping as a rapidly changing state-variable, when taking into account alliance patterns. It can be postulated that a similar effect should be found in ODF with regard to long-term treatments; defensive patterns need long-standing and intense psychotherapy or analysis in order to be restructured and at the same time this change depends also on relationship variables such as therapeutic alliance (Perry, 2001; see also Hersoug, Sexton, & Hoglend, 2002).

Clinical example (334.5 and 334.15, alinea 75 - 76). This female patient, 22 years old, consults for Adjustment Disorder related to the break-up of a romantic relationship. During therapy, she finds a new boyfriend, but hesitates to commit herself more fully. The alliance pattern of the initial eight sessions is classified as increasing. Her ODF is in the narcissistic and neurotic range (between 4.85 and 5.11) and thus remains stable over the first 15 sessions of STDP. However, her OCF rises significantly between the two sessions analyzed from .50 to .81. One of the specific CAPs responsible for the rise is accommodation, which she practices more often in session 15 (an absolute frequency of 5), compared to session 5 (an absolute frequency of 2). Excerpt (rated as accommodation cognitive): "And finally I am telling myself, OK then, there is no prince charming in this world, no man is perfect." This case example illustrates that in an increasing alliance construction pattern, Overall Coping Functioning rises, but Overall Defensive Functioning remains on the same level for the initial 15 sessions of short-term dynamic psychotherapy.

By and large, we can be quite confident about the satisfactory validity of the 11 theses examined. Some need more study, on larger samples or other patient groups, in order to be completely confirmed, some need more data measure points, to be completely valid or refined. It also needs to be underlined that no thesis found full empirical support.

Ultimately, if these theses resist further empirical investigation, it would mean that we should continue to refer to defenses and coping from an integrative viewpoint. By doing this, we may be able to explain more outcome variance and, ultimately, enhance psychotherapeutic practice. Along with Chabrol and Callahan (2004), we would assume that coping-enhancement trainings present inherent limitations, especially with regard to the conceptualization and treatment of internal determinants of adaptational processes. Similarly,

defense interpretations are not always helpful and need to be complemented by competence-oriented work in specific cases. Taking into account both competence-related concepts and internally-determined aspects of adaptation would permit a higher level of clinical precision and therapist flexibility in treatment planning and delivery. Competence-related aspects, i.e., coping, ask for training of stress management, whereas internally-determined aspects, i.e., defenses, ask for interpretative or clarification-oriented work with the patient's motives and internal conflictuality. Combining both in the same therapy as a function of the clinical situation is certainly a challenge within our reach. This distinction may be paralleled to the two main mechanisms of change in a heuristic model of psychotherapy, defined by Grawe (1998): problem-activation and clarification. Even if these concepts are much broader, to be understood on the level of general principles of psychotherapeutic change, this author suggests that the combination of both aspects, when applied with clinical competence and based on a coherent case conceptualization, within the same psychotherapy enables a comprehensive understanding of the patient and may enhance efficacy of the treatment. Data from comparative psychotherapy research tend to confirm these assumptions (Grawe, 2005)

With these general goals in mind, we will develop specific clinical implications based on our research so far.

Therapeutic implications

The simple fact that we are in the position of evoking therapeutic implications means that the second aim of the dissertation formulated in the Introduction section is fully attained: to demonstrate the clinical usefulness and relevance of our models for psychotherapeutic case conceptualization and treatment.

Even if this sub-section is more practice-oriented, it should not be understood as a complete treatment manual, but as an outline of treatment principles primarily focused on

Bipolar Affective Disorder, although certainly meaningful and effective, if applied with clinical competence and wisdom to various other psychiatric diagnoses, e.g., Borderline Personality Disorder and Major Depression. We will elaborate on the therapeutic relationship, on challenging of cognitive distortions, dealing with oppositional coping and defenses and the question of suicide prevention. Finally, we will give recommendations for particularities of inpatient treatment. Treatment implications will be deduced for the most part from the cognitive-behavioral model of psychotherapy in the broadest sense. Two reasons might be at stake: (1) The literature found for treatment strategies in BD stems mainly from CBT approaches, slightly less from other models, i.e., interpersonal, experiential and psychodynamic, and (2) The author is a psychotherapist with broad-spectrum CBT training, which biases the "clinical reflexes" proposed in this section. However, psychodynamic elements are also offered and should be implemented with these patients.

As described in chapter F, the principle of the motive-oriented therapeutic relationship is based on plananalytic conceptualizations and enables the therapist to creatively develop adequate therapeutic attitudes with each patient (Caspar, 1996; Caspar, 2007; Caspar et al., 2005; Grawe, 1998; Kramer, & Caspar, 2007). The therapist must be responsive to the motive "behind" the patient's behavior and circumvent the Plans that impede the creation of a collaborative relationship. Thus, for each clinical situation, it is essential to assess reliably the motives and distinguish them from low-level Plans and behaviors, because one should not, as therapist, react directly to the patient's observed behaviors and low-level Plans. Such behavioral strategies and coping Plans in the patient may be paralleled with the notion of interactional play-structure in the context of the double-action-regulation theory by Sachse (2003) implying specific interventions focusing on rendering explicit motives related to the interactional play-structure. For example, the motive of a patient presenting opposition (as part of his/her interactional play-structure) may be to maintain his/her autonomy. Related

Plans may have been blocked (i.e., by the constraints imposed by the inpatient treatment or by the increase of the symptomatology), thus opposition coping seems the only way to manifest his/her desire for autonomy. A motive-oriented therapeutic attitude would comprise the therapist's validating the autonomy motive and render explicit (sensu Sachse, 2003) the conflict in the patient between blocked Plans and underlying motives. It might also mean, in inpatient treatment, that alternative ways – expressed as Plans - of satisfying the autonomy-seeking motive can be explored or allowed, e.g., permission given for a day off, if the patient's clinical status allows it. An important therapeutic ingredient when dealing with opposition coping is certainly the collaborative stance of the therapist (see below, but also Basco, & Rush, 2005). Analogue reflections may be developed with regard to dealing with omnipotence for instance as BD defense specificity. For this reason, the following points should all be embedded within the principle of the tailor-made motive-orientedness of the therapeutic relationship offer.

Cognitive distortions are an important part of BD functioning (chapter E; Basco, & Rush, 2005); they are quite easily accessible in a therapeutic interview. If the timing is right, the therapist should point out these errors as they occur in the patient's discourse. A prominent technique in this regard is the Socratic dialogue developed for depression (Beck, Rush, Shaw, & Emery, 1979; Basco, & Rush, 2005). It implies questioning the veracity of an assumption, while at the same time completely validating the patient's own right to have a personal opinion (in the latter proposal, there is, of course, again an element of motive-orientedness). As the Socratic dialogue develops, the therapist helps the patient to construct an alternative cognition, not underpinned by cognitive distortions, but by so-called "adaptive" cognitions (Clark, Beck, & Alford, 1999). Especially the positive CE associated with mania should be restructured in this way (for an example of technique see Basco, & Rush, 2005). Positive CE may be considered by certain clinicians as "normal", since normal functioning is

characterized by a certain amount of positive CE (Beck, 1991). Informed clinicians, however, know about the negative effects of positive CE and question them in the early phases of hypomania. This questioning may elicit in its turn negative CE in the patient, who might start mistrusting – or accusing - the therapist when he/she is working on an obviously pleasant thought. Negative CE in BD, along with the afore-mentioned example, might occur in either phase of the disorder and must be addressed according to the principles of cognitive therapy in depression, to prevent the patient from slipping into profound hopelessness, and give him/her concurrently the right to feel sad, down or depressed. Generally, collaborative work on CE enhances the quality of the therapeutic relationship (for discussion of this question, see Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996) and the patient's confidence in the therapist, if the latter is genuine enough and shows that he/she truly understands – from "within the situation" - the patient's way of thinking, feeling and experiencing, instead of labeling from a distance the patient's utterances.

As shown in chapters B and D, oppositional coping is a particularly important feature of BD patients. It is of paramount importance that it is dealt with in a constructive way in therapy to maintain collaboration, enhance therapeutic adherence, ensure medication compliance, and prevent symptom recurrence. The motive-oriented therapeutic relationship offer might be a key principle in dealing with such "difficult" behavior, cognition and affect; it is thus indispensable to understand clearly its motive-related underpinning. An example is given at the beginning of this section. Furthermore, opposition might be tackled more globally according to stress management techniques used in cognitive-behavioral psychotherapy. First, self-observation techniques (e.g., files, diaries) may be applied to everyday situations where opposition is present. These situations are subsequently analysed and commented during therapy and the patient should be helped to construe alternative coping behaviors (see also skills training for BPD; Linehan, 1993) for similar future situations, which will be role-played

in the therapy session and the competence obtained transferred to reality. Such alternative coping includes, prior to the use of opposition on the micro-level of the situation, time-out techniques, cognitive distantiation techniques, self-assertive or negotiative cognitions and behaviors, support-seeking, behavioral isolation from the stressor, prioritizing and anticipating by imagining the negative consequences of opposition. A particular important technique for BD patients when they tend to be oppositional is relaxation. Relaxation helps the patient to find and connect momentarily with "an inner space" devoid of conflict. Such techniques may not only enhance cognitive and behavioral distantiation from the stressor on the micro-level of the situation, but also and most importantly have an effect on the psychobiological system of sleep. A relaxed body finds sleep more easily, which is extremely important for the manic phase, but also for depressive episodes, when the patients may engage in depressive rumination, leading potentially to hopelessness. Relaxation may be achieved by using classic progressive muscular relaxation or image-inducing techniques (Reddemann, 2001); in some cases, hypnosis might be indicated (Revenstorf, & Peter, 2005). Of course, the choice of the particular technique would depend on the individual case conceptualization and cannot be treated in this context.

In the perspective of long-term rehabilitation of seriously impaired psychiatry patients, working with defenses has proven to be promising (Perry, 2001). In BD patients, immature defenses may impede the establishment of a constructive therapeutic alliance. Thus, they need to be addressed as early as possible in the therapeutic process. Much care needs to be taken, since defense and transference interpretations are anxiety-provoking interventions and not always associated with positive outcome (Piper, Azim, Joyce, & McCallum, 1991; for a discussion see Hoglend, 2007). Thus, principles from transference-focused psychotherapy (Kernberg, 1984; Yeomans, Clarkin, & Kernberg, 2002), developed for Borderline Personality Disorders, may be applied in a variation to BD patients (Gunderson, Weinberg,

Daversa, Kueppenbender, Zanarini, Shea, et al., 2006). Most importantly in this setting, contract negotiation is a condition for further treatment. The authors underline that in highly disturbed individuals, this negotiation might take several sessions and should not be shortened for the sake of efficacy. Addressing the most-salient immature defenses might already be indicated in this preparatory phase, to enhance the accuracy of the patient's perception of reality (Coughlin Della Silva, 1996) and increase the chances of engaging fully in a solid therapy contract. Acting out or splitting might be candidates for such very-early-in-process defenses, which need to be treated with great care and competence. Later in the process, defenses are as important as in these early encounters, but the psychodynamic work may be – if timing is correct - more expressive and interpretative, aiming to give the patient a better insight into his/her psychological functioning. However, in these interpretations for BD patients much more than with other patients, the links between defensive functioning and symptom evolution should be established and reinterpreted on a regular basis. A purely psychodynamic understanding excluding symptom recurrence and its biological underpinnings risks denying psychiatric priorities. The psychodynamically-oriented psychotherapist, and, maybe to a lesser extent, the cognitive-behavioral psychotherapist run the risk of interpreting sexually-seducing behavior in hypomanic patients according to psychodynamic understanding and thus, may engage in a "folie à deux", kindling unintentionally the recurrence of manic symptoms in these patients by the use of interpretations. This might be one argument why Fromm-Reichmann (1949) discouraged clinicians from treating patients with manic-depressive symptoms by means of psychoanalytic therapy. Our research should help to offer clinical and empirical arguments in favor of such psychotherapies.

The question of suicide and suicide attempts is very important in the treatment of BD patients, as the prevalence numbers of suicide attempts for such patients are generally higher

than for other psychiatric patients (ranging between 15 and 50%; Newman, 2004; Goodwin, & Jamison, 1990). Psychotherapeutic interventions in this regard need to be based on an individualized understanding of the suicidal attempt, according to the functional analysis of behavior proposed by Linehan (1993) and according to Plan Analysis (Caspar, 1995). This complete conceptualization of suicidal behaviors and cognitions allows the therapist to understand functional and instrumental relationships. We know that the plananalytic subgroup emotion control is theoretically related to a higher risk for suicidal behavior, i.e., associated with higher levels of depressive symptoms and an aggressive potential (Newman, 2004), compared to the subgroup relationship control. Thus, if emotion control or psychological harm avoidance turns out to be a higher-order Plan or motive for suicidal behavior in a patient, the intervention would be – in line with the motive-oriented therapeutic relationship - to provide the patient with sufficient internal security and self-soothing capacities, i.e., by means of relaxation techniques or by enhancing distantiation capacities (see above and especially Linehan, 1993), in the form of skills training, to give the patient alternative coping Plans to deal with the stress. If relationship control, on the contrary, turns out to be a higher-order Plan or motive for suicidal behavior in a patient, the intervention would be very different: the therapist would need to reassure the patient that the therapist is someone the patient can count on in the therapeutic context, even when in a crisis situation. In addition, the therapist needs to convey convincingly that he/she will not abandon the patient. Clarification-oriented work (Sachse, 2003) is needed for such patients, as their degree of awareness of the motives related to their interactional play-structure by using suicidal threats and behaviors is low; thus, the intervention aims at overcoming alienation of the self (Sachse, 2003), which should reduce, ultimately, these threats and behaviors. In some countries, legal constraints impose the negotiation of a non-suicide-contract. This might help as well in planning crisis intervention, but will never suffice for treating suicidal thoughts and behaviors.

If the patient is in a crisis and inpatient treatment is necessary, some particularities may be of interest. The treatment focus for crisis intervention is on compliance assessment and enhancement and coping with acute symptomatology (Basco, & Rush, 2005). This means that a much more psycho-educational approach is indicated. This is also confirmed by outcome studies, where cognitive-behavioral treatments in the acute phases of BD yield only mitigating results (Scott, 2004; Rizvi, & Zaretsky, 2007). Psycho-education is an important part of psychotherapy irrespective of the approach used, but its effects might be underestimated. For personality disorders, for instance, we have found that a creative version of a psycho-educational group approach is more efficient, in comparison with a traditional problem-solving psychotherapeutic approach (Zorn, Roder, Kramer, & Pomini, in press). More specifically in BD patients, what needs to be emphasized is the importance of medication compliance, the enhancement of early detection of symptoms and stress management (see above). As shown in chapter D, a variety of coping and defenses are elicited in the crisis situation; they help the individual to adapt to the crisis situation. Thus, these patient's perceptions of reality might not be distorted due to only the presence of psychotic symptoms, but also due to underlying adaptational processes (e.g., immature defenses) in the patient's psychological functioning. Moreover, oppositional coping along with other BD specificities need to be understood within a comprehensive case conceptualization and the therapeutic attitude adjusted as a function of the motives and Plans involved (see above).

Other very important clinical domains at stake in such patients involve the treatment of co-morbidity (Gunderson, Weinberg, Daversa, Kueppenbender, Zanarini, Shea, et al., 2006), interpersonal aspects of the disorder and the work with the partner and the family (Morris, Miklowitz, & Waxmonsky, 2007; Weissman, Markowitz, & Klerman, 2000), long-term coping with life events (Bock, & Koesler, 2005) and finally, the prevention of recurrence

(Scott, 2001). We will not elaborate on these aspects; our research provides only marginal elucidation.

Finally, short-term dynamic psychotherapy may be enhanced with reference to coping concepts, as it is probably coping that changes in the short term, compared to defenses, which necessitates much more time to change profoundly. The use of Steffens and Kächele's (1988) integrative model on adaptational processes certainly does not mean that the psychoanalytic therapist needs to learn CBT, but helps to disentangle partially overlapping concepts with regard to their underlying psychological processes. As this model is consistent with psychoanalytic theories, for clinicians there should be only therapeutic and personal benefits if they refer to it, as well as to the conclusions of our work. More concretely, interpretative work may tap not only defensive processes, but also coping. The raised awareness of a possible overused coping in an individual, or of its maladaptiveness due to the stress appraised as threat, may help the patient to engage in more constructive coping behavior. Especially in an intense crisis situation, the psychodynamic psychotherapist should be aware that specific coping and defenses may be recruited by the individual (Küchenhoff, & Manz, 1993), to overcome the crisis, while overall defensive functioning should remain stable. Psychodynamic crisis intervention should take into account these ruptures in the course of the use of adaptational processes (see also Gilliéron, 1997); more supportive techniques, i.e., reflecting, acknowledging – as opposed to expressive ones - are indicated when the therapist is faced with such a breakdown of adaptation in a patient (Barber, Stratt, Halperin, & Beth Connolly, 2001).

Methodological Considerations and Limitations

When conceptualizing adaptational processes in a patient, as a clinical researcher or a psychotherapist, we have several options at hand: self-report questionnaires, observer-rater

methodologies and complete individualized case conceptualization methods. As we understand these three methodologies, they represent three levels of increasing complexity, clinical validity, depth and precision in conceptualizing a clinical situation of a patient. Their respective relevance and limitations will be discussed.

First, self-report questionnaires are relevant for measuring behavior-related constructs such as career, preferences, life choices, certain types of symptoms (when easily detectable in the behavior) and some aspects of biography (see also above, the discussion of thesis 2). Furthermore, questionnaires or computer-assisted evaluation may be accurate, should assessment need to be done very quickly and effectively, for example for the purpose of feed-back to the therapist (Lambert, 2007), or should assessment concentrate on adaptational processes in everyday life (Perrez, & Reicherts, 1996). Limitations in validity of self-report questionnaires have been cited several times (Fahrenberg, Myrtek, Pawlik, & Perrez, 2007; Lazarus, 2000; Perrez, & Wilhelm, 2000; Tschuschke, Pfleiderer, Denzinger, Hertenstein, Kächele, & Arnold, 1994). Thus, questionnaires need to be completed by using higher-order methodologies, especially when complex, partially unconscious, constructs, such as adaptational processes, are being measured. Therefore, our conclusions depended little on the self-reported measures of adaptational processes. A more thorough examination, item-per-item, would allow a valid comparison. This was however not possible due to different theoretical underpinnings of the methods used and potential loss of power and validity of the scales; thus, we limited the multi-method comparison to mean and subscales scores. Clinical research solely depending on self-report questionnaires does not allow the introduction of the rater perspective. The latter enhances reliability and clinical validity and controls for biases (Hoyt, 2002; see thesis 2).

Second, observer-rater methodologies are the core of this dissertation. Observer-rater methodology is needed in assessment of complex concepts, for example interpersonal

relationship patterns, internal conflicts and adaptational processes, as research objects of clinical psychology. They control for rater biases, self-deceptive tendencies in individuals, along with other limitations of self-report questionnaires (see above). Their use requires a certain level of competence and they are high-cost, since based on transcripts of clinical interviews or psychotherapy sessions. Consequently, data production is time-consuming and laborious. They also require continuous calibration of raters, in the form of in-depth case supervisions. Furthermore, such observer-rater scales are inherently limited as regards the number of categories they offer. The exhaustive list of defenses, coping and cognitive errors, as measured by DMRS, CAP and CE, are the result of many years of work aiming at a consensus concerning the number, labels and definitions of each category. Consensus is a constraint. For instance, DMRS has been criticized for it is not a comprehensive review of the defensive functioning in the individual (see Perry, & Ianni, 1998, for a review); in particular, psychotic defenses are not included. Studies are underway with regard to the inclusion of psychotic defenses in the current version of the DMRS (Piasentin, Vigano, Azzone, Verga, & Freni, 2001). However, they are not yet sufficiently advanced for our study to be included. With regard to coping, even if CAP is based on a comprehensive review, it is also based on consensual research strategies limiting the number of categories. Well-defined categories are a simplification of a highly complex individual functioning. For example, raters are confronted at times with the intriguing situation that an adaptational process has been identified in the transcript, but does not fit any category; in this case, of course, no rating was applied, in order to avoid rater drift (Perry, & Henry, 2004). In other cases, a variant of a known category was found, but the code applied of the category did not fully account for the nuance; in this case the rating of the category was applied when appropriate and after discussion with colleagues and supervisor. Moreover, because observer-rater methods are based on session-transcripts, i.e., the patient's narrative, strictly "covered" processes not

expressed in the interview are not assessable, unless there is sufficient information in the transcript for reliable inference. Finally, validity and reliability for the scales used have been established on a session-level, therefore we did not use them in micro-analyses on the situational level. Such analyses would help corroborating more fully the state-trait-assumption in adaptational processes and testing sequential hypotheses (Chabrol, & Callahan, 2004). These limitations of observer-rater methodology need to be kept in mind for future studies; some of them may be compensated by higher-order methodology.

Third, Plan Analysis as an individualized case conceptualization method was applied to the BD sample. Plan Analysis approaches adaptational processes in the broadest sense, without distinguishing between defensive and coping processes. As underlined by Caspar (1996), Plan Analysis is based on a "slim" and parcimonious theory and thus, corresponds to Foppa's (1984) criteria of a perspective theory. This means that it offers a concrete methodology and is not embedded in a specific theory in clinical psychology, even if Plan Analysis has been applied to Schema-Analysis according to Grawe (1998; Grawe, Grawe-Gerber, Heiniger, Ambühl, & Caspar, 1996; Heiniger, Grawe-Gerber, Ambühl, Grawe, & Braun, 1996). This characteristic may, with respect to adaptational processes, account for an advantage and a shortcoming at the same time. On the one hand, its relative theory-independency is a great advantage in the sense that it is compatible with many clinical theories, such as the psychoanalytic theory of defensive processes and the transactional theory of stress and coping. Moreover, it enables the conceptualization of individual-relevant concepts (Plans and motives) in an individualized language; thus, Plan Analysis in this regard is much closer to the specific person as he/she presents him-/herself in an interview and probably in daily life, compared to theory-laden concepts such as defenses and coping, implying a highly specialized language of conceptualization. The specialized language may yield a high accuracy of conceptualization in certain cases, but may also be less relevant for

other ones, for whom the assumptions of the theory do not completely correspond (see above for the limitations of the category systems approach; the individualized Plan Analysis approach compensates optimally for such flaws by adopting the individualized conception). On the other hand, the lack of theory in Plan Analysis may also prevent theory-driven hypothesis testing, such as our endeavor of disentangle coping from defenses, for which Plan Analysis would not be a suitable methodology. It must be noted, also, that Plan Analysis requires a great deal of training, in-depth case supervision and continuous rater calibration, placing it also among the high-cost methodologies. However, the high investment is paid off by the individualized case conceptualization, which neither self-report nor observer-rater methodology are capable of, especially with regard to assistance in psychotherapy treatment planning. Moreover, the openness of the approach would also permit the use of information from self-report or observer-rater methodology, if available to the plananalyst. This would have allowed us to relate defense or coping specificities in BD to higher-order Plans and motives on an individual basis. In order to control for confounds in our research setting, all Plan Analyses were carried out without the information from the defense and coping scales. However, in a clinical setting, all information available should be included and this would mean that the patient's functioning is understood in a truly comprehensive way.

Focusing on defense and coping at the same time also implies in itself limitations. While a specific approach, limited to either defense or coping concepts, enables to study in-depth specificity and relations with symptoms and outcome, the integrative approach allows to investigate comparatively different types of adaptational processes. The latter approach implies that the "zoom" is laid on a more comprehensive picture, which omits necessarily details. This may be exemplified by the fact that a big number of categories reduce power of the studies; thus, limitation to the higher-order categories, as done in chapter D and G, is necessary. A radically different approach to defense and coping would be the use of an

aggregated single-case methodology, where each case is conceptualized and presented in its singular specificity, independently of any group specificity (Stiles, 2005). In this paradigm, interactions between defense and coping would come out on the basis of individual case studies. Furthermore, unit of analysis was the session and we did not conduct fine-grained analysis on the situational micro-level of stress, coping and defenses. Such a study would enable to test more clearly some of our assumptions, i.e., on trait- and state-aspects of adaptational processes. It would also be interesting to try to assess adaptational processes *within* the crisis situation, however, we have to bear in mind that feasibility of the dynamic interview would be very low for patients presenting high levels of manic symptoms, a different setting would be necessary in these cases. Finally, after this first step in research on adaptational processes as patient's characteristics, it is high time the therapist be introduced in the model of therapeutic change.

Future Research Perspectives

Since our research is the beginning of a theoretical, empirical and clinical understanding of adaptational processes from an integrative viewpoint - in general and more specifically in patients presenting with Bipolar Affective Disorder - it is time to move on to the next step. Several research perspectives ensue from our studies and the limitations discussed above. We will very briefly outline the complete corroboration of the integrative model on adaptational processes, the relevance of these research questions for long-term psychotherapies, mediational models on adaptational processes, the application of these questions to the marital context, the application of these questions to the diagnosis of Borderline Personality Disorder, neurobiological underpinnings of defense and coping and, finally, enhancement of the instruments used.

The Steffens and Kächele's (1988) integrative model of defense and coping was not completely tested, as the link between defense and underlying neurotic conflict (v absence of such a conflict in coping) was not investigated. Such a question goes clearly beyond the scope of this dissertation, but could quite easily be tested in future research, by applying specific rating scales to our verbatim material, such as the Core Conflictual Relationship Theme Method by Luborsky and Crits-Christoph (1990; for a study on the relationship between defenses and conflicts, see de Roten, Drapeau, Stigler, & Despland, 2004) and testing linkages with adaptational processes.

One of the main disadvantages of our studies so far is, along with the small sample size, their short-term time-frame for all assessments (BD sample, matched controls, psychotherapy patients), as the interval between the assessment points is three months for all samples. The links between adaptational processes and therapeutic outcome were not sufficiently investigated by this study due not only to drop-outs which diminished power, but also to the time-frame. Changes in defenses did not go beyond state-changes, also due to the time-frame. The same holds true for the study of cognitive errors. Plans may theoretically remain fairly stable in an individual over time; schema-theoretical elaborations based on Plans (Grawe, 1998; Caspar, 1996) postulate schema- and emotion-fluctuation due to therapeutic activating strategies as important mediators for symptom change over the course of treatment for personality disorders (Zorn, Roder, Kramer, & Pomini, 2007). These considerations lead to the investigation of long-term psychotherapies (lasting at least two or three years), ideally in a comparative study design opposing different approaches, including adaptational processes and the therapeutic work on adaptational processes as mediator variables for symptom change. Such comparative analysis of mechanisms of change across therapeutic approaches has already been undertaken on a theoretical level for Borderline Personality Disorder (Kellogg, & Young, 2006; Levy, Clarkin, Yeomans, Scott, Wasserman, & Kernberg,

2006; Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). Between-approach comparison might give some indications about the process specificity of an approach and help disentangle common from specific change factors in these psychotherapies (Castonguay, Newman, Borkovec, Grosse Holtforth, & Maramba, 2005; Grawe, Caspar, & Ambühl, 1990; Kramer, de Roten, & Despland, 2005; Kramer, Vannotti, Pomini, de Roten, & Despland, 2005). Such a comparative study based on randomized clinical methodology on long-term psychotherapies regarding recurrent depression is currently underway at Lausanne University (Despland, de Roten, Pomini, & Zullino, 2004).

Changes in patients undergoing psychotherapy, either long-term or short-term, might be mediated by (1) Adaptational processes themselves; (2) Therapist responsiveness; (3) Interaction between adaptational processes, therapist responsiveness and therapeutic alliance. In order to investigate the first, the analysis of several time-points over the course of psychotherapy by means of our methods, testing mediator hypotheses of ODF and OCF, can be conducted. These analyses may be done on direct recorded session material or by using dynamic interviews at a three-month-interval carried out by an independent investigator. For the study of long-term therapies, preference is given to an independent investigator conducting clinical interviews, to control for specificities of the relationship variables inherent to the psychotherapeutic relationship (Perry, 2001; Perry, Fowler, & Semeniuk, 2005). Links with therapeutic change may be established, introducing the quality of the therapeutic alliance into the predictive model (see Figure 1, Introduction section). In order to test the second hypothesis, recorded psychotherapy sessions are a useful data source on the therapist responsiveness (Stiles, Honos-Webb, & Surko, 1998). Two models might be applied: (a) the level of therapist's motive-orientedness with regard to the patient's Plan structure (Caspar, Grossmann, Unmüssig, & Schramm, 2005) could be investigated by testing links with therapeutic change; (b) the level of accuracy of the therapist intervention as adapted to the

patient's defensive profile (or coping resources and deficits; Kramer, de Roten, Michel, & Despland, 2005; Stigler, de Roten, Drapeau, & Despland, 2007; Winston, Winston, Wallner Samstag, & Muran, 1994) could also be investigated by testing links with therapeutic change. Finally, for the third hypothesis, which is probably the most promising research perspective, a complex model implying adaptational processes, therapist responsiveness and therapeutic alliance (or patterns of alliance evolution) might account best for outcome variance in psychotherapy studies.

An important feature of clinical intervention is the focus on couple interaction, in BD patients (Morris, Miklowitz, & Waxmonsky, 2007) as in patients with Major Depression (Gollan, Friedman, & Miller, 2002). Especially with regard to enhancement of coping capacities in couples, Bodenmann's (2000; 2004) approach has shown convincing results for depressive patients and their partners in terms of treatment efficacy (Bodenmann, Plancherel, Widmer, Gabriel, Meuwly, Charvoz, Hautzinger, Schramm, & Beach, submitted) and enhancement of dyadic coping (Gabriel, Bodenmann, Widmer, Charvoz, Schramm, & Hautzinger, submitted). It would be interesting to adapt, apply and evaluate such couple interventions also to BD patients and their intimate partners. For this diagnostic group, to our knowledge, no such empirical data exist to date.

A better understanding from a comprehensive vantage point of adaptational processes involved in other mental disorders than BD or Adjustment Disorder is urgently needed. In particular, patients presenting Borderline Personality Disorders (BPD) are interesting candidates, as BPD may be considered an "affect regulating disorder" (Ansmann, 2002; Sachse, 2004), as may be considered BD, as well (see Introduction section). Coping and defense specificities in BPD and BD should overlap consistently, at least for the subtype emotion control. This overlap is in fact found with regard to defenses in BPD (Perry, 1993a); however, we do not have comparable data using the CAP (nor the CE) for BPD as yet.

The partially non-conscious and automatized status of adaptational processes may also be reflected by research on neuropsychological und biological underpinnings of defense and coping. We would hypothesize that patients undergoing dynamic interviews implying a moderate level of emotion activation might have more activation in the ventromedial prefrontal cortex associated with automatic (or "schematic") emotional processing of information (Schaefer, & Philippot, 2000; Schaefer, Collette, Philippot, Van der Linden, Laureys, Delfiore, Degueldre, Maquet, Luxen, & Salmon, 2003), as compared to the same people in situations without emotion activation (assessed by the substraction method in PET-SCAN, for example). One might also find concurrent activation with the pre-frontal cortex (along with activation in the right intraparietal sulcus and the left superior parietal gyrus) when the individual engages in strategizing, planning, inhibition or other resourceful cognitive activities related to coping (e.g., CAP problem-solving cognitive or CAP information seeking cognitive; Collette, Van der Linden, Laureys, Delfiore, Degueldre, Luxen, & Salmon, 2005). No studies are known to date which use concurrently such multi-level assessment of adaptational processes including observer-rater methods.

Finally, the quality of the self-report questionnaires on defense and coping should be improved in accordance with our conclusions and more vast cross-validating procedures with the observer-rater scales should be carried out (see Kramer, 2005a; Kramer, & Drapeau, in prep.). Questionnaires evaluating adaptational processes should measure exactly the same dimensions as DMRS, CAP and CE, which was not the case in our study, especially as regards the coping scale (CISS), and, to a lesser extent, also the defense scale (DSQ). If this were done, it would be possible to confirm fully the unconsciousness hypothesis of adaptational processes and would add an argument in favor of discriminant (and convergent) validity between observer-rater methodology and self-report measures. To ensure sound

norms for these scales, including the observer-rater methods, it would finally be helpful to conduct a study on a representative community sample, with high numbers of observation.

EPILOGUE

"I am not sick.

But I am happy

as long as I can paint."

Frida Kahlo

The initial question which has appeared in the prologue of this dissertation on the difficulty in doing psychotherapeutic conceptualizations and interventions with Bipolar Disorder patients has been addressed. As I come to the close of my dissertation, I am persuaded that my research will lead to even more extensive reflections on the subject, taking into account the fresh conclusions, as well as humbly acknowledging the inherent limitations. My earlier "resistances" – probably held by most psychologists and psychotherapists - concerning psychotherapy of BD have been dispelled. And more generally, the methodology applied to adaptational processes may certainly be beneficial to all groups of patients. Having said this, I would like to underline, finally, that theoretical conceptualizations and technical guidelines would certainly not completely suffice for grasping what may be called the essence of psychological treatments and in particular psychotherapy: the therapeutic relationship as a unique human encounter. The following anecdote is a good example of such a unique encounter and will allow this work to end on a more light-hearted note.

A female patient from the BD sample (3024) left a message on my answering-machine, cancelling her second interview. When I called her back to fix another appointment, she was extremely ambivalent as regards coming back to the clinic for the research session.

Instead, she invited me to her home for a cheese fondue, so that, as she said, "We could discuss everything calmly in a nice context … this would be much more pleasant than at the psychiatric clinic." I thought fast and, trying to respect complementarity, replied, "Thank you for your kind invitation. Of course, I can't accept the idea of a fondue, but would suggest that I could make an exception for once and come to your apartment just for the interview." The patient agreed and we fixed an appointment for the following week early in the morning. Her flat happened to be close to the clinic. Towards the end of this session, the following verbatim exchange took place (excerpt 3024.2, alinea 469-474) :

T : "On the phone, you invited me to have cheese fondue with you."

P : "Well, OK, I can't make cheese fondue anymore, but I can make raclette for you."

T : "You know perfectly well that I can't accept that, but at the same time….."

P : "Yes, I know that, I know it's impossible."

T : "But this also shows something about you, it shows you trust me."

P : "I trust you entirely." Then the patient went on talking about trust and distrust of other people, which is one of her major relationship themes.

This exchange and the preceding call show how important it is for the therapist to remain flexible, capable of adapting without any hesitation his own reactions to the patient's interactional behaviors and motives. It is noteworthy that the psychotherapist or clinical researcher should respond in a motive-oriented way to the patient, even if the patient's demands seem absurd or, as in this case, have a certain seductive element. Here the therapist managed to abate the latter problem by realising what lay "behind" the patient's words, what her true motive was. In fact, she was really checking whether she could actually trust the therapist and at the same time controlling her feeling of distrust.

Therefore, I reiterate that this dissertation would have been impossible without my adopting of a radically *clinical* stance in human encounters. This stance implies to constantly

keep in mind that each patient is unique within an individual situation, condition and suffering. Only in this respectful context, the patients will be able to reveal their intimate sufferings, become aware of their hidden resources and will, ultimately, change.

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Diplômes en bref	Juin 1994: Maturité Economie à Berne-Neufeld Juillet 1998: Demi-Licence en Psychologie (SSP), Université de Lausanne Octobre 2000: Licence en Psychologie (FPSE), Université de Genève Février 2003: Diplôme D'Etudes Avancées en Psychologie et Certificat Complémentaire Interfacultaire en Neurosciences Cognitives (FPSE), Université de Genève Décembre 2004 : Cambridge Proficiency in English (B), University of Cambridge, UK Mars 2007 : Psychothérapeute FSP Juin 2007 : Psychothérapeute SSTCC/SGVT Juin 2007 : Psychothérapeute DSAS - Canton de Vaud Avril 2008 : Docteur des. à la Faculté des Lettres de l'Université de Fribourg
Formation en psychothérapie	Septembre 2002 – Février 2007: Psychothérapie cognitive-comportementale et intégrative (AIM, Berne) Dès 2008 : Klärungsorientierte Psychotherapie (Prof. R. Sachse, Bochum, D)

Expérience clinique	Mai - juillet 2001: Psychologue-clinicien (100% ; Dr. J. Hättenschwiler) Psychiatrische Universitätsklinik (PUK) "Burghölzli", à Zurich Août - septembre 2001: Service civil (100%) dans le projet clinique Bulimia/Obesità/Anoressia (BOA) à l'Ospedale regionale della Beata Vergine à Mendrisio TI Avril - Septembre 2002: Psychologue-psychodiagnosticien (E. Maulaz) aux CPS du CPN, à Yverdon Novembre 2002 - septembre 2006: Psychologue-clinicien (50%, puis 10% ; Dr. V. Pomini), à l'Unité de réhabilitation au DP-CHUV, Lausanne Depuis 2004 : Pratique privée de psychothérapeute à l'Université de Lausanne (Prof. J.-P. Dauwalder)
Recherche clinique	Novembre 2002 – septembre 2003 : Unité de Réhabilitation au DP-CHUV (Dr. V. Pomini), Lausanne Juin 2003 – Décembre 2007: Psychologue-assistant (50%) à l'Institut Universitaire de Psychothérapie (Prof. J.-N. Despland) Octobre 2003 - avril 2004: Assistant-suppléant (50%) à l'Université de Genève (Prof. M. Van der Linden) Depuis septembre 2004 : Assistant-doctorant (50%) à l'Université de Lausanne (Prof. J.-P. Dauwalder) Depuis janvier 2008 : Chef de projet (50%) à l'Institut Universitaire de Psychothérapie (Prof. J.-N. Despland)
Enseignement clinique	2004 : Formateur au Certificat post-gradué « Traumatismes et enjeux de société », Université de Genève 2004-2007 : Co-animateur du cours-séminaire « Interventions Cognitivo-Comportementales », Université de Lausanne 2005-2006 : Formateur au CE-CAP, Université de Lausanne 2007 : Formateur en Psychologie Clinique Adulte « Diagnostic SCID I et II », Université de Genève 2007 : Intervenant dans le séminaire « Ecoute en psychothérapie », Université de Lausanne

	2007-2008 : Co-animateur du séminaire « Introduction à la Thérapie des Schémas selon J. E. Young », DP-CHUV 2007-2008 : Formateur à l'Analyse des Plans, Université de Lausanne
Expériences de travail	Février 1995 - juillet 1995: Enseignement spécialisé (100%) au Weissenheim, à Berne Octobre 2000 - avril 2001: Animateur d'ateliers (100% ; service civil) en pédagogie interculturelle au NCBI, à Thalwil
Distinction	Juin 2007 : Student Award de la Society for Psychotherapy Research, Madison, USA
Echange culturel	Juillet 1995 - juin 1996: Echange culturel à l'Up With People
Langues	Allemand et suisse-allemand: langue maternelle; Français: connaissances très avancées; Anglais: Cambridge Proficiency; Italien: connaissances avancées; Espagnol: connaissances de base
Informatique	Word, Excel, PowerPoint, s-plus, SPSS, MixReg (HLM)
Loisirs	Danse, lecture, théâtre, voyage
Affiliations	Société Suisse de Thérapie Cognitivo-Comportementale SSTCC/SGVT, membre du comité depuis avril 2006 Society for Psychotherapy Research SPR Fédération Suisse des Psychologues FSP Association Vaudoise des Psychologues AVP Société Suisse de Psychiatrie Sociale SSPS

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2004

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DECLARATION DU CANDIDAT

Je declare sur mon honneur que ma thèse est une oeuvre personnelle, composée sans concours extérieur non autorisé, et qu'elle n'a pas été présentée devant une autre Faculté.

Lausanne, le 19 mai 2008

Ueli Kramer

APPENDIX B

Appendix B1

Definitions of Coping Action Patterns according to the Manual CAP (Perry, Drapeau, Dunkley, & Blake, 2005, French Translation by Kramer, & Drapeau, 2005)

Résolution de problème (PS)

Définition : Gérer un stress en tentant à le comprendre et à le résoudre en tant que problème et à réaliser une solution désirée.

Fonction : La résolution de problème cherche à comprendre un événement stressant pour ensuite ajuster les réactions de la personne en développant des plans d'action et par ce moyen, réaliser un outcome désiré.

Recherche de l'information (IS)

Définition : La recherche de l'information gère un événement stressant en tentant de recueillir de l'information qui peut aider à la gestion du stress. Ceci inclut des informations concernant l'événement stressant, soi-même et tout ce qui est relié à la réalisation d'un outcome positif.

Fonction : La recherche d'information cherche à découvrir ou développer des possibilités supplémentaires pour la gestion du stress.

Impuissance (H)

Définition : L'impuissance gère un événement stressant en renonçant à affronter la situation et en même temps en exprimant de la souffrance par rapport à l'événement.

Fonction : L'impuissance cherche à exprimer de la souffrance au sujet de l'incapacité à gérer un événement stressant, au lieu d'une action directe sur la situation, quand l'individu pense qu'aucune action effective n'est possible pour la personne. Un objectif secondaire peut être dans certains cas d'avoir quelqu'un qui prend en charge la gestion du stress.

Fuite (E)

Définition : La fuite gère un événement stressant par le désengagement et l'évitement de l'affronter.

Fonction : La fuite cherche à protéger la personne de l'événement stressant et de son contexte, quand l'individu pense qu'aucune issue n'est ouverte qui permettrait de gérer favorablement l'événement stressant et permettrait d'éviter des conséquences négatives appréhendées.

Auto-détermination (SR)

Définition : L'individu utilise ses propres ressources pour gérer le stress et aller de l'avant pour se prendre en charge.

Fonction: L'auto-détermination cherche à protéger, préserver, augmenter ou actualiser des ressources personnelles pour gérer le stress. Régulation émotionnelle, régulation comportementale, expression des émotions, se rapprocher des émotions

Ceci peut impliquer de faire des choses pour autrui, si ceci entre dans les objectifs de la personne.

Recherche de soutien (SS)

Définition : La recherche de soutien social gère un événement stressant en cherchant, en trouvant ou en engageant des ressources sociales qui aident à atteindre un but désiré ou à éviter un but non-désiré.

Fonction : La recherche de soutien social utilise des ressources sociales pour remplacer ou compléter ses propres efforts pour gérer le stress.

Délégation (D)

Définition : La délégation gère un événement stressant en laissant sa gestion explicitement ou implicitement à autrui, au lieu de la gestion du stress par la personne elle-même.

Fonction : La délégation est utilisée quand la personne pense que ses propres ressources sont insuffisantes pour gérer le stress. L'individu renonce à des tentatives actives à gérer le stress et tente à convaincre autrui d'assumer la responsabilité pour la gestion de l'événement stressant.

Retrait social (I)

Définition : Le retrait social gère un événement stressant en se retirant de celui-ci ou en s'isolant socialement.

Fonction : Le retrait social cherche à retirer ou protéger la personne de l'événement stressant ou d'un entourage social ou matériel peu soutenant, ce qui permet à la personne d'éviter des dégâts ou de la souffrance (ou d'autres effets négatifs, comme les sentiments de honte ou de culpabilité).

Accommodation (A)

Définition : L'accommodation gère un événement stressant en construisant un compromis ou en acceptant ce qui peut être changé et ce qui ne peut être changé dans la situation stressante.

Fonction : L'accommodation ajuste flexiblement les préférences de la personne, par exemple en acceptant de recevoir moins de ce qu'on désire, en gérant les limites des options émergeant de l'événement stressant ou son contexte.

Négociation (N)

Définition : La négociation gère un événement stressant en tentant de développer de nouvelles options pour enrichir le répertoire des possibilités.

Fonction : La négociation cherche à élargir les possibilités d'action pour gérer le stress, en examinant les priorités de la personne ou en s'engageant avec autrui dans un échange réciproque. Elle peut inclure l'enlèvement des options avec moins d'importance pour maximiser les chances des options avec plus d'importance, si la situation impose de tels choix.

Soumission (S)

Définition : La soumission gère le stress en cédant à autrui et en renonçant à réaliser les préférences personnelles

Fonction : La soumission enlève la personne d'un conflit avec l'événement stressant en validant l'incapacité de surmonter l'événement stressant et en conséquence, en retirant la personne de tentatives actives de gérer le stress.

Opposition (O)

Définition : L'opposition gère un événement stressant en le confrontant et en tentant d'enlever toute contrainte imposée aux préférences de la personne.

Fonction : En confrontant un événement stressant et tentant d'éliminer ou éviter les contraintes imposées, l'opposition canalise la frustration en action pour élargir les options de la personne.

Appendix B2

Reliability Formula

$$\rho = \frac{\sigma_\alpha^2}{\sigma_\alpha^2 + \sigma_\beta^2 + \sigma_\varepsilon^2}$$

Note. According to Wirtz and Caspar, 2002; p. 171; Two-factors Random; Perfect Agreement

Appendix B3

Reliability Results CAP

Case	Rater	ICC (2,1)
3001.2	DD	.89
3003.1	DD	.79
3005.1	DD	.78
3006.1	DD	.80
3006.2	NP	.85
3007.1	NP	.91
3008.1	NZ	.82
3009.1	IR	.94
3010.1	DD	.84
3011.2	NZ	.59
3012.1	IR	.87
3012.2	NZ	.86
3013.1	IR	.90
3014.1	NZ	.60
3015.1	NP	.89
3016.1	UK	.88
3017.1	UK	.91
3020.1	UK	.86
3052.1	NP	.93
3060.1	UK	.91
Mean		.84
SD		.10

Note. ICC (2,1) on 36 categories of coping

Appendix B4

Reliability between Members of the Lausanne Group and the McGill Group Consensus for CE-CAP Ratings (English Ratings, including 12 CAP Categories and 14 Errors)

Rater nested within case	ICC (2,1)
Case 3002 RS2	
UK	.75
NP	.61
NZ	.70
IR	.51
DD	.76
Case 3002 RS3	
UK	.78
NP	.83
NZ	.83
IR	.72
DD	.60

Appendix B5: Canonical Correlations CAP-CISS (BD patients; $N = 30$)

CAP \ CISS	Task	Emotio	Escape	Distract	Soc Div
OCF	2.29*	-0.92	-0.54	-1.30	0.23
Problem-Solving					
Affective	.	.	.	.	.
Behavioral	1.74	-0.23	0.63	0.16	1.02
Cognitive	1.03	-0.29	-0.50	-1.39	0.74
Information-Seeking					
Affective	-2.12*	-0.71	-0.45	0.09	-0.82
Behavioral	1.40	0.89	1.67	1.21	1.28
Cognitive	0.53	-0.37	-0.60	-1.16	0.56
Helplessness					
Affective	-2.12*	-0.97	-0.66	-0.51	-0.53
Behavioral	-0.14	1.13	0.43	-0.44	0.99
Cognitive	0.10	1.44	-0.68	-0.41	-0.56
Escape					
Affective	0.86	0.55	0.23	-0.63	0.83
Behavioral	-1.33	-0.03	-1.11	-0.86	-1.10
Cognitive	-0.59	0.02	0.68	0.84	-0.01
Self-Reliance					
Affective	0.59	-1.68	-0.60	-0.94	-0.24
Behavioral	0.80	-1.36	-0.29	-0.85	0.06
Cognitive	0.71	1.08	-0.64	-0.38	-0.49
Support-Seeking					
Affective	-1.44	-0.87	-0.19	-0.16	0.06
Behavioral	-1.92	0.15	-0.38	-0.82	0.23
Cognitive	0.93	-0.20	-0.28	-0.79	0.46
Delegation					
Affective	-0.91	-1.53	0.54	0.76	0.26
Behavioral	-1.17	-1.39	-1.47	-1.01	-1.76
Cognitive	-0.02	-0.80	1.14	1.34	0.43
Isolation					
Affective	-1.33	-0.48	-0.79	-0.62	-0.89
Behavioral	-0.62	-0.24	-0.55	-0.72	-0.51
Cognitive	-0.56	-0.32	0.56	1.27	-0.37
Accommodation					
Affective	1.01	-0.43	-0.17	-0.61	0.54
Behavioral	-2.45*	-1.18	-1.73	-1.60	-1.27
Cognitive	-0.02	-0.05	-1.56	-1.95	-1.04
Negotiation					
Affective	-0.04	-1.29	0.51	0.38	0.48
Behavioral	-0.01	1.51	1.94	1.70	1.28
Cognitive	2.45*	-0.03	0.64	-0.22	1.24
Submission					
Affective	-0.91	-1.37	0.00	0.46	-0.48
Behavioral	-1.23	0.63	-0.02	0.49	-0.30
Cognitive	-1.67	0.11	-2.04*	-1.19	-1.71
Opposition					
Affective	-0.38	2.10*	1.76	1.92	1.27
Behavioral	-1.46	0.17	-0.40	-0.44	-0.07
Cognitive	0.56	0.74	1.00	1.18	0.88

Note. Overall $t = 0.81$, ns

Appendix B6

Mean Reliability per Category CAP (Control Group; *N* = 30)

	ICC (2,1)
Problem-Solving	.88
Information-Seeking	.88
Helplessness	.96
Escape	.84
Self-Reliance	.87
Support-Seeking	.90
Delegation	.71
Isolation	.77
Accommodation	.61
Negotiation	.81
Submission	.94
Opposition	.74

Note. Results from the French Validation Study CAP (Kramer, & Drapeau, in prep.)

Appendix B7

Canonical Correlations CAP-CISS (Control Group; $N = 30$)

CAP \ CISS	Task	Emotion	Avoidance	Distraction	So-Diversion
OCF	1.55	-1.01	-0.55	-1.59	0.13
PS-a	--	--	--	--	--
PS-b	1.62	-2.11*	-1.20	-1.48	-0.42
PS-c	0.20	0.55	-0.14	-0.28	0.18
IS-a	-0.26	0.62	0.77	1.33	-0.43
IS-b	1.33	0.16	0.98	0.80	0.38
IS-c	0.11	0.09	-2.58*	-3.06**	-1.00
H-a	-2.31*	2.12*	0.78	0.98	0.12
H-b	-1.13	1.50	2.00	0.64	2.31*
H-c	-0.17	0.76	-1.37	-1.79	-0.38
E-a	-0.24	-0.04	0.01	-0.90	0.92
E-b	-1.13	0.26	-0.81	-0.38	-0.56
E-c	-0.75	0.46	-0.37	0.29	-0.68
SR-a	0.97	-1.62	0.23	0.05	0.26
SR-b	-0.07	-0.76	1.37	1.28	0.40
SR-c	0.05	0.57	-1.16	-1.10	-0.64
SS-a	-1.95	-0.36	-1.62	-1.09	-0.92
SS-b	0.05	0.58	-0.02	-1.05	0.73
SS-c	1.21	0.18	0.25	-0.39	0.83
D-a	-0.54	-0.24	-1.11	0.09	-1.68
D-b	-0.73	-0.70	-1.02	-0.51	-1.19
D-c	0.01	-0.69	-0.68	0.25	-0.92
I-a	-0.75	0.88	1.21	1.71	-0.13
I-b	0.28	-0.55	0.96	0.41	0.74
I-c	0.64	-0.65	0.42	1.45	-0.64
A-a	-0.05	-0.81	-0.48	-0.67	0.22
A-b	-0.51	-0.66	-0.11	-0.39	0.26
A-c	0.61	-1.41	-1.28	-0.46	-1.78
N-a	-2.80**	1.51	0.06	0.50	-0.47
N-b	-0.24	0.82	1.35	0.68	0.85
N-c	0.63	-0.04	0.15	-0.65	0.52
S-a	-0.24	-0.01	-0.48	1.19	-1.27
S-b	0.08	0.30	2.21*	2.68*	1.63
S-c	-0.12	0.06	-1.12	-0.12	-1.19
O-a	-2.07*	1.97	0.74	0.94	0.43
O-b	0.53	1.11	1.13	1.21	0.87
O-c	1.45	-0.72	0.37	-0.15	0.75

Note. Overall $t = 0.80$, ns

Appendix B8

Canonical Correlations CAP-CE (Control Group; $N = 30$)

CE / CAP	Ratio	Positive Errors				Negative Errors			
		FT	OG	SA	P	FT	OG	SA	P
OCF	-1.46	2.17*	1.16	-0.77	0.80	1.13	-0.08	-3.50**	-0.26
PS	-1.06	-0.20	-0.00	-0.97	0.77	-0.64	0.15	-1.49	1.71
IS	0.41	0.93	1.44	1.15	-1.08	0.70	2.04*	1.23	-0.02
H	0.76	-1.09	-0.69	1.02	0.34	0.06	0.19	3.17**	0.08
E	1.45	-2.08*	-0.34	1.73	-0.33	-1.27	0.02	3.71**	0.73
SR	-0.71	-1.11	-0.17	0.64	0.68	-0.09	2.34*	0.19	0.17
SS	-0.07	-1.08	1.52	0.32	1.83	0.06	0.13	2.24*	0.08
D	1.63	-0.58	-1.70	-0.84	0.07	-1.66	-0.58	2.47*	-0.91
I	2.08*	-0.73	-1.58	0.36	0.24	0.57	-0.27	3.35**	-0.31
A	1.51	-0.45	-0.33	-0.93	-0.05	-0.62	-0.01	0.14	0.27
N	-0.54	-0.18	2.53*	1.22	0.49	0.43	1.03	-0.01	-0.80
S	0.49	-0.41	-0.25	-0.18	-0.09	-0.67	0.45	1.28	-0.26
O	0.43	-2.33*	0.12	1.06	1.13	-0.53	3.07**	1.39	2.45*

Note. Overall $t = 0.90$, ns

Appendix B9

Canonical Correlations CAP-GSI-SCL-90 (Control Group; *N* = 30)

CAP	GSI
Overall Coping Functioning	-2.63*
Problem-Solving	-0.97
Information-Seeking	0.79
Helplessness	2.53*
Escape	1.43
Self-Reliance	-0.37
Support-Seeking	0.64
Delegation	0.22
Isolation	1.80
Accommodation	-1.39
Negotiation	-0.66
Submission	2.18*
Opposition	0.52

Note. Overall $t = 1.13$, ns

APPENDIX C

Appendix C1

Reliability results DMRS

Case	Rater	ICC (2,1)
3005.1	MB	.78
3006.2	MB	.81
3007.1	YdeR	.89
3007.2	GA	.64
3010.2	GA	.50
3011.1	YdeR	.85
3011.2	MB	.78
3019.1	MB	.85
3022.1	GA	.95
3022.2	YdeR	.86
3051.1	VB	.88
3052.1	VW	.85
3053.1	VB	.95
3054.1	MB	.79
3056.1	VW	.83
3057.1	NT	.95
3058.1	VW	.94
3059.1	GA	.87
3060.1	VW	.73
3065.1	VW	.94

3070.1	VW	.81
Mean		.83
SD		.10

Note. ICC(2,1) on 28 singular defenses

Appendix C2

Canonical Correlations between DMRS and DSQ-60 (BD Patients; *N* = 30)

Defenses	ODF (DSQ)	Image-D (DSQ)	Affect-R (DSQ)	Mature (DSQ)
DMRS				
ODF	0.26	-0.50	-1.08	0.09
Mature:				
Affiliation	-0.44	-1.15	-0.62	0.49
Altruism	1.36	-1.52	-0.76	2.20*
Anticipation	1.51	-1.82	-0.88	0.70
Humour	1.67	-1.29	-0.63	1.42
Self-Assertion	2.17*	-2.44*	-2.60*	2.23*
Self-Observation	1.77	-2.08*	0.58	1.93
Sublimation	0.76	-0.72	-0.42	0.84
Suppression	1.43	-1.58	-0.96	1.09
Obsessional:				
Isolation affect	1.23	-1.26	-1.64	-0.06
Intellectualization	1.44	-2.57*	-1.44	2.28*
Undoing	0.30	-0.78	-0.20	0.31
Neurotic:				
Repression	1.00	-0.97	-0.07	0.47
Dissociation	-1.94	2.09*	0.43	-3.40**
Reaction formation	1.15	-1.05	-0.79	0.87
Displacement	-0.43	1.66	0.42	-2.09*
Narcissistic:				
Omnipotence	-0.86	1.43	1.44	-1.04
Idealization	-1.33	-0.44	0.67	-0.99
Devaluation	-0.45	-0.55	-0.22	-1.17
Disavowal:				
Denial	-0.22	0.44	0.29	-0.31
Projection	0.02	-1.28	-0.86	0.14
Rationalization	1.95	-1.59	-0.89	0.86
Autistic Fantasy	-3.37**	2.25*	-0.99	-1.75
Borderline:				
Splitting others	-4.04**	2.59*	-0.44	-2.03*
Splitting self	-3.01**	1.72	-0.80	-2.73**
Projective identification	-1.52	2.12*	-0.21	-0.69
Action:				
Acting out	-2.05*	0.93	2.39*	-1.39
Passive-aggression	-0.16	1.00	0.22	0.15
Help-rejecting complaining	0.70	0.33	1.95	0.64

Note. Overall $t = 1.51$, ns

APPENDIX D

Appendix D1

Reliability results CAP

Case	Rater	ICC global	ICC per coping
3001.2	DD	.84	.90
3003.1	DD	.88	.66
3005.1	DD	.83	.65
3006.1	DD	.85	.84
3006.2	NP	.92	.91
3007.1	NP	.91	.85
3008.1	NZ	.84	.84
3009.1	IR	.91	.89
3010.1	DD	.95	.94
3011.2	NZ	.90	.54
3012.1	IR	.84	.86
3012.2	NZ	.84	.88
3013.1	IR	.89	.89
3014.1	NZ	.79	.87
3015.1	NP	.83	.92
3016.1	UK	.93	.90
3017.1	UK	.90	.91
3020.1	UK	.84	.84
3052.1	NP	.94	.83
3060.1	UK	.89	.88

Mean	.88	.84
SD	.04	.10

Note. ICC global: CE and CAP together (26 categories); ICC per coping: CAP on 12 categories

Appendix D2

Reliability results DMRS

Case	Rater	ICC per level
3005.1	MB	.70
3006.2	MB	.76
3007.1	YdeR	.92
3007.2	GA	.89
3010.2	GA	.85
3011.1	YdeR	.82
3011.2	MB	.80
3019.1	MB	.82
3022.1	GA	.91
3022.2	YdeR	.96
3051.1	VB	.73
3052.1	VW	.86
3053.1	VB	.99
3054.1	MB	.71
3056.1	VW	.84
3057.1	NT	.99
3058.1	VW	.96
3059.1	GA	.82
3060.1	VW	.76
3065.1	VW	.95
3070.1	VW	.95
Mean		.86

SD	.09

Note. ICC per level: 7 levels of defenses

APPENDIX E

Appendix E1

Definitions Cognitive Errors according to the Manual Cognitive Errors (Drapeau, Perry, & Dunkley, 2005), French Translation by Kramer, & Drapeau (2005)

Pensée anticipatrice (FT)

La pensée anticipatrice assume que le pire ou le meilleur des résultats se produira dans une situation. Une pensée anticipatrice négative s'appelle aussi Catastrophisation, qui prédit que le résultat futur d'une situation spécifique est négatif, sans tenir compte des résultats plus probables qui peuvent être moins négatifs. La pensée anticipatrice positive prédit que le résultat futur d'une situation spécifique sera positif ou favorable, sans tenir compte des résultats moins positifs qui sont plus probables.

Sur-généralisation (OG)

La sur-généralisation assume que si un résultat négatif se produit dans un cas, il se re-produira dans un autre, si celui-ci est un peu similaire. Il y a deux formes : étiquettage et sur-généralisation.

Etiquettage

L'individu pose une étiquette globale et fixe sur soi-même ou autrui, sans tenir compte que la réalité peut mener plus raisonnablement à une conclusion moins désastreuse (ou moins positive). Il peut s'agir d'un adjectif (« Je suis un perdant », « C'est un mauvais type ») ou

une phrase (« Je suis le genre de personne qui échoue, peu importe ce que je fais »).
Distinction étiquettage et utilisation d'un adjectif : on peut décrire le comportement de quelqu'un à l'aide d'un adjectif, sans nécessairement recourir à de l'étiquettage, par ex. « c'était malpoli » est descriptif et adjectival, tandis que « il est malpoli, c'est pour ça qu'il ne m'écoutera pas ».

Abstraction sélective (SA)

Pensée en tout-ou-rien

Cette erreur est aussi appelée pensée en noir et blanc, polarisée, ou pensée dichotomique. L'individu perçoit une situation appartenant exclusivement à l'une ou l'autre catégorie opposée, au lieu d'une perception en termes de mélange ou de continuum entre les deux extrêmes.

Ignorance des aspects positifs ou négatifs

L'individu ignore sélectivement des aspects positifs ou négatifs de l'information, pour cela, il ne retient qu'une valence d'information en tant que vraie ou pertinente.

Raisonnement émotionnel

L'individu pense que quelque chose doit être vrai parce qu'il ou elle sent et croit que c'est vrai, ignorant des arguments en faveur du contraire.

Magnification des aspects négatifs ou minimisation des aspects positifs

Quand la personne évalue quelqu'un, soi-même ou une situation, elle gonfle les aspects négatifs, sans raison, ou minimise les aspects positifs, ou fait l'inverse.

Discrimination : La magnification a souvent deux parties : x démontre y, et non seulement l'énoncé « y est vrai », dans ce cas, il s'agirait d'étiquettage.

Filtre mental

L'individu fait seulement attention à un seul aspect d'un individu ou d'une situation, sans reconnaisssance des autres côtés du thème qui compléteraient l'image globale.

A. Filtre mental négatif : Ceci est probablement la forme la plus fréquente : voir les aspects négatifs sans reconnaître les aspects positifs. Par exemple, voir les coûts, mais pas les bénéfices d'une idée.
B. Filtre mental positif : La personne voit tout en rose, se centrant sur les caractéristiques positives et ne pas reconnaissant les aspects négatifs. Ceci donne une image unilatéralement positive, au lieu d'une image globalement nuancée.

Pensée impérative

L'individu a une idée précise et fixe sur comment les autres et soi-même devraient se comporter. Comme résultat, quand ces attentes ne sont pas remplies, l'individu surestime les conséquences négatives.

Vision rétrécie

L'individu se centre sur les aspects négatifs d'une situation. (Tunnel vision).

Raccourci vers conclusions

L'individu prend un ou deux faits et en tire des conclusions insolites.

Personnalisation (P)

Lecture de pensée

La lecture de pensée permet à l'individu de croire qu'il sait ce que les autres pensent, ignorant d'autres possibilités plausibles.

Personnalisation

L'individu prend les choses personnellement de manière excessive, en croyant que les autres se comportent de manière positive ou négative à cause de lui, sans considérer des explications plus plausibles pour leurs comportements qui n'impliquent pas sa personne.

Auto-accusation inappropriée, tout en ignorant le rôle des autres

Dans cette erreur, l'individu s'auto-accuse pour quelque chose de négatif qui lui est arrivé, pendant qu'ils laisse de côté les contributions des autres à ce même problème. L'individu se met dans la position de victime.

Appendix E2

Reliability Results CE

Case	Rater	ICC (2,1)
3001.2	DD	.48
3003.1	DD	.76
3005.1	DD	.75
3006.1	DD	.76
3006.2	NP	.89
3007.1	NP	.62
3008.1	NZ	.73
3009.1	IR	.93
3010.1	DD	.79
3011.2	NZ	.83
3012.1	IR	.73
3012.2	NZ	.73
3013.1	IR	.83
3014.1	NZ	.89
3015.1	NP	.64
3016.1	UK	.95
3017.1	UK	.94
3020.1	UK	.83
3052.1	NP	.94
3060.1	UK	.88
Mean		.80
SD		.12

Note. ICC (2,1) on 28 categories of errors

Appendix E3

Mean Reliability per CE Category (Control Group)

	ICC (2, 1)
Positive Errors	
Overgeneralization	.57
Selective Abstraction	.91
Personalization	.99
Negative Errors	
Overgeneralization	.90
Selective Abstraction	.85
Personalization	.82

Note. Results from the French validation study CE (Kramer, & Drapeau, in prep.)

Appendix E4

Canonical Correlations CE-GSI (Control Group ; $N = 30$)

CE	GSI
Ratio	0.42
Positive Errors	0.51
Overgeneralization	-1.06
Selective Abstraction	0.82
Personalization	-0.76
Negative Errors	0.68
Overgeneralization	1.05
Selective Abstraction	1.12
Personalization	0.03

Note. Overall $t = 0.75$

APPENDIX F

Appendix F1

Reliability for Plan Structures

Cas No 3006

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Garde 1 place importante à ton fils	Evite de perdre ton fils	1	3.5	70
Plans sup	Aie du contact	Sois proche de l'autre	2.5		
Plans inf	Contrôle les finances Fâche-toi quand thérap pose question	Fais tout pour ton fils Evite de te plaindre			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Isole-toi	0	0	0	0
Plans sup	Evite de souffrir	0	0		
Plans inf	Evite de répondre aux appels Coupe le contact	0			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Ne déçois pas les autres	Evite de déranger les autres	1	4	80
Plans sup	Fais-toi apprécier	Sois proche de l'autre	3		
Plans inf	Accueille bien beau-frère	Evite de t'affirmer			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Evite le conflit	Montre-toi poliment	1	2	40
Plans sup	Evite de souffrir	Evite de t'affirmer	1		
Plans inf	Coupe le contact Donne de l'argent Evite état des lieux	Excuse-toi Accomode-toi en entretien			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Sois appréciée pour autre chose que l'argent	0	0	2	40
Plans sup	Fais-toi apprécier	Sois 1 St-Bernard	2		
Plans inf	Ne te fais pas marcher dessus	0			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Donne de ta personne aux autres	Fais tout pour les autres	1	4	80
Plans sup	Fais-toi apprécier	Sois 1 St-Bernard	3		
Plans inf	Donne ton argent Sois serviable	Fais tout pour ton fils			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	0	Fais que l'autre apitoie	0	1	20
Plans sup	Aie du contact	Evite de perdre 1 relation Sois 1 St-Bernard	1		
Plans inf	0	Montre-toi faible			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	0	Sois proche de ta mère	0	3	60
Plans sup	Aie du contact	Evite de perdre 1 relation	3		
Plans inf	Tente de se suicider	Rêve d'1 paradis Fais tentamen			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Donne ton argent	Fais ce qui plaît à l'autre	.5	.5	10
Plans sup	Donne de ta personne	Evite de te plaindre	0		
Plans inf	Fais ménage gratuitement	Fais semblant en sexualité			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Aie du contact	Evite de perdre 1 relation	1	4	80
Plans sup	Obtiens l'affection des autres	Sois proche des autres	3		
Plans inf	Fréquente beau frère Garde 1 place importante pour fils	Fais que l'autre t'apitoie Sois proche de ta mère Evite de perdre ton fils			

Note. Moyenne (%) = (70+0+80+40+40+80+20+60+10+80)/10 = **48%**

Plans sup : Plans (hierarchiquement) supérieurs; Plans inf : Plans (hierarchiquement) inférieurs; Valeur corr : Valeur de correspondance; Valeur c total : Valeur de correspondance totale

Cas No 3007

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Evite des pertes	Evite de perdre 1 relation	1	3	60
Plans sup	Réalise ton besoin d'attachement	Sois proche	2		
Plans inf	Cache ta dépression Evite le changement	Evite de perdre la famille Fais tout pour les autres			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Reste digne	Evite de te montrer faible	1	5	100
Plans sup	Montre 1 image pos de toi-même	Evite des émotions négatives	4		
Plans inf	Cache ta dépression	Pleure en cachette			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Présente-toi comme victime	Fais tout pour les autres	.5	3	60
Plans sup	Attire l'attention	Evite de perdre 1 relation Evite de perdre ta famille	2.5		
Plans inf	Montre que tu n'as pas le choix	Pense devoir donner tout			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Rends-toi indispensable aux autres	Sois superwoman	1	3.5	70
Plans sup	Evite les pertes Réalise ton besoin d'attachement	Réalise toi-même Evite les émotions difficiles	2.5		
Plans inf	Sois superwoman	Affirme-toi			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Evite le conflit	Retire-toi des autres	1	2	40
Plans sup	Sauvegarde ton couple	Protège-toi des autres	1		
Plans inf	Utilise épilepsie comme prétexte Sois redevable	Evite de parler de l'enfance Isole-toi			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Valorise-toi	Améliore-toi	1	3	60
Plans sup	Préserve ton identité	Réalise toi-même	2		
Plans inf	Montre tes compétences	Cherche psy			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Fais en sorte que le thérapeute te prenne au sérieux	Recherche de l'aide	1	2	40
Plans sup	Evite de nouvelles déceptions	Sois proche Améliore-toi	1		
Plans inf	Sois attirée par les médicaments	Laisse-toi aller			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Montre tes compétences	Evite d'avoir honte	1	4	80
Plans sup	Valorise-toi	Evite les émotions difficiles	3		
Plans inf	Sois superwoman	Evite de te montrer faible			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Evite le changement	Protège-toi	1	3	60
Plans sup	Préserve ton identité Evite des pertes	Evite la blessure psychologique	2		
Plans inf	Idéalise sa vie	Protège-toi des autres			

Note. Total = (70+60+100+60+70+40+60+40+80+60)/10 = **64%**

Cas No 3011

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Reste dépendante de tes parents	Sois 1 bonne fille	1	5	100
Plans sup	Fais en sorte que l'on s'occupe de toi Occupe-toi des parents	Fais en sorte que tes parents t'aiment	4		
Plans inf	Ne laisse pas tomber la mère	Soucis-toi de ta mère			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Aie 1 relation intime	Cherche 1 copain	1	5	100
Plans sup	Obtiens de l'affection	Evite d'être seule	4		
Plans inf	Imagine l'amour d'1 chanteur	Rêve de B.			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Rejette ta mère	Mets une distance avec ta mère	1	5	100
Plans sup	Détache-toi de tes parents	Evite d'être dépendante	4		
Plans inf	Doute de l'identité de la mère	Méfie-toi de la mère			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Garde le contrôle	Contrôle l'interaction	1	4	80
Plans sup	Evite la souffrance	Sois proche Maintiens le contrôle	3		
Plans inf	Lutte contre le sentiment d'impuissance	Fais en sorte que le thérapeute ait pitié Séduis le thérapeute			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Montre-toi comme victime	Montre-toi maltraitée	1	4.5	90
Plans sup	Evite que le thérapeute exige trop de toi	Fais en sorte que le thérapeute ait pitié	3.5		
Plans inf	Apitoie sur toi-même	Plains-toi			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Evite les prises de consciences sur l'origine des difficultés	Evite les surprises négatives	.5	2.5	50
Plans sup	Evite le changement	Isole-toi des autres	2		
Plans inf	Fais en sorte que l'entretien se termine	Evite de vérifier l'identité de B.			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Attire l'attention des autres	Séduis le thérapeute	.5	2.5	50
Plans sup	Fais en sorte qu'on s'occupe de toi	Contrôle l'interaction	2		
Plans inf	Montre-toi déprimée à la sorte de l'hôpital	Dis 1 chose pour la première fois			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Occupe-toi des parents	Sois proche des parents	1	4.5	90
Plans sup	Obtiens de l'affection	Sois proche	3.5		
Plans inf	Reste dépendante des parents	Respecte les normes Fais en sorte que les parents t'aiment			

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Plans	Sois autonome	Isole-toi des autres	.5	2.5	50
Plans sup	Réalise toi	Evite d'être trop près des autres	2		
Plans inf	Aie davantage de liberté	Evite d'avoir des surprises négatives			

Note. Total = (100+100+100+100+80+90+50+50+90+50)/10 = **81%**

Appendix F2

Reliability for Emotion Frames

Cas No 3006

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Emotion	Tristesse	Tristesse	1	3	100
Plan bloqué	Evite de perdre 1 relation	Recherche des liens solides	1		
Plan Coping	Sois 1 St. Bernard	Occupe-toi des autres	1		

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Emotion	Joie	0	0	0	0
Plan bloqué	Recherche expériences agréables	0	0		
Plan Coping	0	0	0		

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Emotion	Colère	Découragement	0	2	66
Plan bloqué	Contrôle la relation	Evite de perdre 1 relation	1		
Plan Coping	Sois prudente	Evite de faire confiance	1		

Note. Total (100 + 0 + 66)/3 = **55%**

Cas No 3007

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Emotion	Angoisse	Angoisse	1	3	100
Plan bloqué	Protège-toi	Evite la blessure	1		
Plan Coping	Retire-toi des autres	Isole-toi	1		

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Emotion	Culpabilité	Culpabilité	1	2	66
Plan bloqué	Sois superwoman	Présente-toi comme superwoman	1		
Plan Coping	Recherche de l'aide	Evite de te montrer faible	0		

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Emotion	Désespoir	Désespoir	1	2	66
Plan bloqué	Améliore-toi	Sois proche	0		
Plan Coping	Evite de perdre ta famille	Fais tout pour éviter d'être seule	1		

Note. Total (100 + 66 + 66)/3 = **77%**

Cas No 3011

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Emotion	Tristesse	Tristesse	1	2	66
Plan bloqué	Détache-toi de tes parents	Sois proche de tes parents	0		
Plan Coping	Isole-toi des autres	Isole-toi des autres	1		

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Emotion	Désespoir	Désespoir	1	2	66
Plan bloqué	Sois autonome	Evite d'être seule	0		
Plan Coping	Réalise tes désirs	Cherche 1 copain	1		

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Emotion	Désespoir	Désespoir	1	2	66
Plan bloqué	Séduis le thérapeute	Garde le contrôle	0		
Plan Coping	Montre-toi maltraitée	Attire l'attention des autres	1		

	Structure 1	Structure 2	Valeur corr	Valeur c total	%
Emotion	Colère	Colère	1	2	66
Plan bloqué	Sois une bonne fille	Evite les prises de conscience	0		
Plan Coping	Mets une distance face au thérapeute	Fais en sorte que l'entretien se termine	1		

Note. Total (66 + 66 + 66 + 66)/4 = **66%**

Appendix F3

Exhaustive List of all Plans (N = 30 Patients)

Plans	Frequency
Prototypical Plans	
Search for being close	26
Avoid losing the other	19
Realize yourself	17
Impress the therapist	14
Avoid appearing as weak	14
Avoid negative emotions	14
Avoid being harmed	13
Control the relationship	11
Look for help	10
Search for the other's attention	8
Avoid losing control over yourself	8
Avoid mentioning difficult events	8
Avoid being overwhelmed by emotions	7
Maintain control over yourself	7
Maintain your self-esteem	6
Avoid conflict	6
Protect yourself	6
Take care of yourself	6
Assert yourself	6
Avoid pain	5
Be yourself	5

Do everything to be taken seriously	5
Appear as competent	5
Transgress rules	5
Present as a victim	5
Be an achiever	5
Other Plans	
Avoid being ignored	4
Avoid undergoing a manic crisis	4
Appear as weak before the therapist	4
Respect the norms	4
Avoid taking responsibility	4
Avoid being asked bothering questions	3
Avoid fully engaging in therapy	3
Minimize your difficulties	3
Appear knowledgeable	3
Do everything in order to provoke particular consideration	3
Do everything in order to provoke pity	3
Improve yourself	3
Search for better understanding	3
Be autonomous	3
Do things your way	3
Distance yourself from difficult themes	3
Approach the therapist	3
Appear as motivated	3
Appear as strong	3

Appear as special	3
Complain about your situation	3
Provoke a dispute	2
Appear as not being in need of help	2
Avoid making confidences	2
Avoid losing your son	2
Avoid complaining	2
Avoid shameful experiences	2
Avoid being a psychological case	2
Avoid admitting the gravity of your crisis	2
Be like the others	2
Be close to your father	2
Avoid being confronted with your failure	2
Avoid being too close to the others	2
Avoid being dependent	2
Seduce the opposite sex	2
Explain your story by means of anecdotes	2
Be close to the community	2
Avoid depression	2
Do everything that suits the other person	2
Show yourself as being correct	2
Let yourself go	2
Impose yourself	2
Do everything for the others	2
Be a good daughter	2

Note. *N* = 198 different Plans are found ; in total 483 Plans

APPENDIX G

Appendix G1

Reliability results for CAP for STDP

Case	Rater	ICC (2,1)
LONG	DD	.75
COQS	UK	.88
STUD	NP	.73

Note. ICC (2,1) for 12 coping categories

Appendix G2

Reliability results for DMRS for STDP

Case	Rater	ICC (2,1)
LARD	UK	.95
FORZ	UK	.76
STUD	UK	.98

Note. ICC (2,1) for 7 levels of defenses.