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RUNNING HEAD: EARLY CHANGE IN DEFENSE AND COPING IN SHORT-TERM
DYNAMIC PSYCHOTHERAPY

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

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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 study includes 32 patients, mainly diagnosed with adjustment disorder and undergoing time-limited psychodynamic psychotherapy lasting up to 40 sessions, and will focus on early change in defense and coping. Observer-rater methodology was 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 corroborated the hypothesis, but only for coping, whereas for defenses, overall functioning remained 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 Short-Term Dynamic Psychotherapy:
Relations with Symptoms and Alliance

In psychotherapy research, in order to predict outcome, studies 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 as patient characteristics

Defense mechanisms and coping have aroused increasing research and clinical interest in recent years. This is due to greater conceptual and methodological maturity in this domain, as regards research on both coping and defenses (e.g., Cramer, 1998, 2000; Hersoug et al., 2002; Hilsenroth et al., 2003; Kramer, 2005; Lazarus, 2000; Perry, & Ianni, 1998; Seifert et al., 2006; Skinner et al., 2003; Steffens, & Kächele, 1988). We refer to classical definitions of defense by A. Freud, 1936 (cited by Cramer, 1998, p. 920¹) and coping by Fleishman, 1984 (cited by Holahan, & Moos, 1987, p. 946²). According to Cramer (1998), both can be called adaptational processes as overarching concept, they both serve the individual's need for adaptation to reality.

An important issue is the adaptiveness of specific defenses and coping. As regards defenses, the question was resolved with the suggestion of a hierarchical organization of defenses according to their adaptiveness, maturity or, inversely, degree of reality distortion (Perry, 1993; Vaillant, 1977). In the case of coping, adaptiveness is more complex: quantitative and qualitative criteria have been formulated. The first implies that the prolonged

¹ „Defense Mechanisms – i.e., mental mechanisms that alter veridical perception – were 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...”

² Coping defined as „overt and covert behaviors that are taken to reduce or eliminate psychological distress or stressful conditions“.

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 suggested the importance of disentangling defenses from coping (Cramer, 1998), not without admitting some overlap generally found according to the qualitative criteria of adaptiveness of the singular processes; Grebot, Paty and Girard Dephanix (2006) 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, 1998; Kramer, in revision). 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 alongside state-aspects. This assumption should result in 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.

Understanding adaptational processes as they are linked with psychopathology and psychotherapeutic outcome is a highly important objective. Maladaptive processes were moderately related to higher symptom levels and unfavorable outcome (Cramer, 1998, 2000; Hoglend & Perry, 1998; Maffei, Fossati, Lingiardi, & Maleddu, 1995; Noam & Recklitis, 1990; Perry, 1993). Inversely, the presence of mature defenses predicted positive long-term outcome (Vaillant, 2000). In neurotic disorders, such as adjustment disorder (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 or other severe psychopathology (Perry, 1993; Perry, 2001). Defenses were namely related to psychopathology in clinical samples with moderate to high disturbances (Hilsenroth et al., 2003; Hoglend & Perry, 1998) and change in defenses occurred after intense psychodynamic treatment of obsessive-compulsive disorder (Albucher et al., 1998).

Adaptational processes – whether coping or defense - have been examined in psychotherapy settings (Albucher et al., 1998; Cramer & Blatt, 1993; Drapeau, de Roten, Perry, & Despland, 2003; Perry, 2001; Perry, et al., 2007; Siefert, et al., 2006). Some studies have focused on the impact of psychodynamic interventions on adaptational processes (e.g., Hersoug, Bogwald, & Hoglend, 2003; Hoglend, et al., 1993; Siefert et al., 2006) or on the therapist responsiveness to the patient's defensive functioning (Despland et al., 2001). Over the course of brief psychotherapeutic crisis intervention in four sessions, Drapeau et al. (2003) showed a shifting effect in defenses from narcissistic (first session) to obsessional (fourth session). These changes were 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 were 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 tended to confirm the 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

Moderate effect sizes relate 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 tended to prefer the use of the clinically relevant description of evolution of alliance patterns (Castonguay, Constantino, & Grosse Holtforth, 2006; de Roten et al., 2004; Hayes et al., 2007; Kivlighan, & Shaughnessy, 1995; Kramer, de Roten, Beretta, Michel, & Despland, 2008; Stiles et al., 2004). 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). 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 et al. (2004).

This leads us to our research hypotheses: (1) Coping and defense are two different processes: there should be limited overall correlations; (2) Patterns of alliance construction operate as moderator variable for the early changes in defenses and coping in psychodynamic psychotherapy; (3) Coping is related to symptom level and change over therapy, whereas defenses are not.

Method

Participants

The patients ($N = 32$) 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 (First, Spitzer, Williams, & Gibbon, 2004). Patients presenting Psychosis, Addictions and Bipolar Disorder were excluded from this study. A total of 7 (22%) presented co-morbid Personality Disorders (cluster B). The patients' mean age was 24 years ($SD = 4.3$; range = 20-39); 26 (82%) were female. The subjects 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.

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.

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). Our study included psychotherapeutic treatments lasting up to 40 sessions, with a mean of 34 sessions ($SD = 7.67$; range 21 - 46). No therapist adherence measure was included in the study.

Instruments

Defense Mechanism Rating Scales (DMRS; Perry, 1990; 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; Perry, & Hoglend, 1998) score which can be computed by weighting the absolute frequency of the defenses by their level. It needs to be underlined that the DMRS may be understood as a assessment tool for defenses as they are defined in the appendix of DSM-IV (i.e., the

Defensive Functioning Scale DFS; APA, 1994; see also Hilsenroth, Callahan, & Eudell, 2003; Perry et al., 1998). For the current study, reliability coefficients on 36% (24) 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 .70 and .99 (Mean = .84; SD = .11) for the early session and varying between .71 and .99 (Mean = .84; SD = .11) for the middle session. For these reliability analyses, the defense level was the unit of analysis (7 categories; see table 1).

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 (submitted) for the French version used for this study. In the case of the current study, reliability coefficients on 36% (23) 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 .66 and .94 ($M = .84$; $SD = .09$) for the early session and varying between .65 and .88 ($M = .80$; $SD = .08$) for the middle session. These coefficients have been established on coping category as the unit of analysis (12 categories; see table 1). 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).

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, the mean RCI was -5.12 ($SD = 2.96$; range $-12.60 - .66$).

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 . 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) 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 ($n = 11$) and decreasing pattern ($n = 21$; Kramer, de Roten, Beretta, Michel, & Despland, 2008).

Procedure

All psychotherapy sessions were audio-taped. From each therapeutic process, two sessions were randomly chosen for DMRS and CAP ratings. The early session was chosen out of sessions 2 to 5, the middle one was chosen out of sessions 12 to 15. The rationale for these intervals was (1) To choose a session from the early alliance process, excluding the intake session; (2) To choose a session from mid-treatment, in order to study early change in STDP. This total of 64 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 first author; the reliability of these ratings was established with fully-trained colleagues on a randomly chosen 36% of all sessions (for the results see under Instruments). Initial training lasted four months and subsequent calibration of raters six months. All CAP ratings were done by the first author; reliability of these ratings were established with fully-trained Master's-level psychology students on a randomly chosen 36% of all sessions (for the results see under Instruments). Initial training lasted four months and subsequent calibration of raters four months.

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 early session), maximizing the possible links between the variables and controlling best for the multiplication of errors related to significance testing (Tabachnick, & Fidell, 1996). To validate the second 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 $OCF = \beta_{0j} + \beta_{1j} + \epsilon$; 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 early session between the CAP subscales and the DMRS levels yielded a non-significant overall effect ($r = .18$, ns). If specific correlation there was, immature defenses were correlated with coping when up against stress appraised as threat and mature defenses with coping when up against stress appraised as challenge. Pearson correlation between ODF and OCF yielded for the first interview $r = .31$ ($p = .08$) and for the second $r = .44$ ($p = .01$). Thus, a moderate to significant relationship between defense levels and coping processes was found on the level of overall functioning.

Alliance Construction Patterns Moderating Early Change of ODF and OCF

Using a mixed model (HLM), we did not find any main-effects for either the variable session (confirming the overall stability of ODF and OCF over time) nor the variable alliance pattern predicting ODF and OCF. However, there was a significant interaction effect (session x alliance pattern) for OCF: the increasing alliance construction pattern was associated with increasing OCF, whereas the decreasing alliance pattern with decreasing OCF ($p = .04$). No such interaction effect was found for ODF (table 2).

Coping, Defense, Symptom Level and Evolution

With regard to links with symptom level, linear regression analyses yielded a significant link between OCF and symptom level at intake ($p = .01$); no such link was found for ODF. The same pattern of links was found, when comparing ODF and OCF with regard to symptom change over the course of the entire psychotherapy (RCI); a significant relationship was found for OCF only ($p = .01$; see table 3).

Discussion

The results corroborate our hypotheses. First of all, the results suggested that defense and coping are probably two distinct psychological processes. In our sample, the moderate overlap was mostly related to maladaptive processes, as shown by correlational analyses and are in line with the results reported by Grebot, Paty and Girard Dephanix (2006). Overlap existed with regard to overall adaptiveness of defenses (ODF) and coping (OCF). These results add an argument in favor of convergent validity of general indices of adaptiveness, i.e., ODF and OCF, and relative divergent validity on the level of specific adaptational processes, i.e. specific defense and coping categories.

The change model did not find any main effect for ODF nor OCF. However, when introducing alliance construction patterns into the model of early change in ODF and OCF, one noticed 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 or self-reliance coping (see the situation-dependent definition of coping by Whitty, 2003). 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 building patterns (Kramer et al., 2008), 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 is observed in the model. Hence, contextual variables, such as alliance 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 early sessions are linked to general symptomatology (GSI) at intake and symptom change (RCI). 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.

To sum up, coping and defense draw probably on two different psychological processes. By and large, defense and coping remain stable throughout the first half of short-term dynamic psychotherapy. Therapeutic alliance building processes operate as a moderator variable for change in coping, but not in defenses. Finally, coping is related to symptom level and change, whereas defenses are not. Clinically, these results suggest the potential benefit for therapy of coping and defense concepts when taken into account early in therapy for the therapist case and process conceptualization. The observed change and link with outcome of coping over the initial sessions of STDP points into the direction of its usefulness, alongside defense concepts, in the clinical work with patients suffering from adjustment disorder.

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 (see Siefert et al., 2006). This can be achieved in the future by drawing on the concept of therapist responsiveness (Despland et al., 2001; Stiles, Honos-Webb, & Surko, 1998; Norcross, 2002).

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Table 1

Defenses and Coping throughout Dynamic Psychotherapy ($N = 32$)

Defenses/Coping	Early Session		Middle Session		ICC (2, 1)	
	M	SD	M	SD	Early	Middle
DMRS						
<i>N</i> (defenses)	29.84	12.72	27.72	14.58		
ODF	4.45	0.55	4.35	0.55	.82	.80
Mature	9.80	10.43	8.06	8.22	.73	.76
Obsessional	27.28	12.95	27.11	11.15	.99	.91
Neurotic	15.78	13.35	15.18	12.03	.84	.73
Narcissistic	11.98	8.44	10.71	8.95	.96	.99
Disavowal	22.66	11.24	25.52	9.55	.95	.96
Borderline	5.05	5.23	6.40	6.92	.76	.82
Action	7.44	5.98	8.13	9.66	.70	.71
CAP						
<i>N</i> (coping)	15.24	5.52	15.29	4.09		
OCF	.47	.21	.47	.25	.84	.90
Problem-solving	1.43	3.54	1.55	4.47	.66	.65
Info-seeking	8.37	10.37	9.72	9.99	.92	.84
Helplessness	12.57	13.67	13.49	12.67	.91	.88
Escape	14.25	11.48	14.62	12.93	.84	.77
Self-Reliance	18.88	14.72	19.12	20.43	.88	.82
Support-Seeking	4.51	6.21	5.67	9.01	.73	.79
Delegation	7.08	10.27	8.04	12.04	.86	.69
Isolation	4.79	8.06	3.90	7.15	.70	.67

Accommodation	11.24	13.75	7.01	8.38	.89	.81
Negotiation	0.28	0.67	3.12	2.03	.88	.82
Submission	4.60	7.34	3.44	8.15	.84	.85
Opposition	10.18	11.21	9.83	10.99	.94	.87

Note. DMRS: Defense Mechanisms Ratings Scales; ODF: Overall Defensive Functioning;

CAP: Coping Action Patterns; OCF: Overall Coping Functioning

Table 2

Changes in ODF and OCF over the course of Dynamic Psychotherapy

Variable	Estimate	SE	Z	p-value
ODF				
Session	-0.28	0.16	-1.56	.16
Alliance pattern	0.13	0.22	0.45	.65
Interaction	0.02	0.45	0.11	.85
OCF				
Session	0.00	0.02	0.33	.81
Alliance pattern	-0.23	0.12	-1.45	.09
Interaction	0.34	0.13	1.99	.04

Note. Nested design (Hierarchical Linear Modeling; HLM); ODF: Overall Defensive

Functioning; OCF: Overall Coping Functioning; SE: Standard Error.

Table 3

Regression Analyses for ODF and OCF predicting GSI and RCI ($N = 32$)

Variable	B	SE B	β
Predicting Intake GSI			
ODF	-0.06	0.13	-.07
OCF	-1.24	0.34	-.57**
Predicting GSI-RCI			
ODF	-0.05	0.13	-.07
OCF	-0.87	0.33	-.45**

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

GSI: $R^2 = .60$; $p = .00$; RCI: $R^2 = .48$; $p = .02$; Bonferroni's correction applied (significance level $.05/2$)

** $p < .01$