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Observer-Rated Coping Associated with Borderline Personality Disorder: An Exploratory Study

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Observer-Rated Coping Associated with Borderline Personality Disorder: An Exploratory Study

Abstract

Background: Little is known about coping specificities, as operationalization of the concept of affect regulation, in Borderline Personality Disorder (BPD). It is most important to take into account methodological criticisms addressed to the self-report questionnaire approach, and to compare BPD coping specificities to the ones of neighboring diagnostic categories, such as Bipolar Disorder.

Sampling and Methods: The present exploratory study compared the coping profiles of N = 25 patients presenting BPD to those of N = 25 patients presenting Bipolar Disorder (BD) and to those of N = 25 healthy controls. All participants underwent a clinical interview which was transcribed and rated using the Coping Patterns observer-rater system (Perry et al., 2005).

Results: Results partially confirmed study hypotheses and showed differences between BPD patients and healthy controls in all coping domains (competence, resources and autonomy), whereas the only coping domain presenting a BPD-specific lack of skills, compared to the BD patients, was autonomy, a set of coping strategies facing stress appraised as challenge. These coping processes were linked to general and BPD-symptomatology.

Conclusions: These results extend conclusions of earlier studies on affect regulation processes in BPD and bear important clinical implications, in the context of Dialectical Behavior Therapy and other therapeutic approaches. Limitations of this exploratory study, such as the small sample size, are acknowledged.

Key-Words: Borderline Personality Disorder; Coping; Affect Regulation; Bipolar Disorder; Observer-Rated Methodology; Dialectical-Behavior Therapy

OBSERVER-RATED COPING ASSOCIATED WITH BORDERLINE PERSONALITY DISORDER: AN EXPLORATORY STUDY

Introduction

The capacity to regulate emotions and affects is a key-function in the psychopathology of patients presenting with Borderline Personality Disorder (BPD; APA, 1994; Bohus, 2002; Linehan, Bohus, & Lynch, 2007; Yen, Zlotnick, & Costello, 2002; Zittel Conklin, Bradley, & Westen, 2006). BPD is associated with high levels of negative and usually undifferentiated affect (Stiglmayr, Grathwol, Linehan, Ihorst, Fahrenberg, & Bohus, 2005), as well as with emotional dysregulation (Herpertz, 2011), along with higher sensitivity and reactivity to emotions and prolonged affective activation (Linehan, Bohus, & Lynch, 2007). From the treatment perspective, the capacity to regulate or tolerate negative emotions may be enhanced using specific skills training within the context of Dialectical Behavior Therapy (DBT; Linehan, 1993; Bohus, 2011). DBT has presented solid evidence of efficacy in the treatment of BPD symptoms related to affect dysregulation (*e.g.,* Linehan, Comtois, Murray, Brown, Gallop, Heard, et al., 2006; Neacsiu, Rizvi, & Linehan, 2010). However, to date, little is known about BPD-specific affect regulation processes taking into account current theoretical classifications of the latter, when compared with neighboring diagnostic categories, such as Bipolar Affective Disorder. Such data might (1) help to refine the psychopathological conception of BPD, irrespective of the specific treatment approach, (2) add data for diagnostic purposes differentiating BPD from Bipolar Disorder, (3) ultimately inform clinical treatment decisions, within the context of DBT, and other theoretical frameworks. BPD and BD share several common symptomatic features, such as affect instability (Koenigsberg, 2010) and impulsivity (Carpiniello, Lai, Pirarba, Sardu, & Pinna, 2011; Henry, Mitropoulou, New, Koenigsberg, Silverman, & Siever, 2001), but also present several clinical differences (see Paris, Gunderson, & Weinberg, 2007; Perugi & Akiskal, 2002). BD inpatients may serve as

relevant controls, as their coping profiles are more prototypical in inpatient treatment, compared to coping profiles at outpatient follow-up (Kramer, 2010/a); as such, the inpatient status of these patients increases the methodological rigor of the study, as the probability for false positives in this between-group (BPD vs. BD) comparison is reduced.

The coping concept

Affect or emotion regulation may be understood as an over-arching functionality (Gross, 2001), encompassing several concepts and operationalizations (Lazarus & Folkman, 1984; Cramer, 1998; Kramer, 2010/b; Linehan, 1993). The present article focuses on the concept of coping as a specific operationalization of affect regulation (Cramer, 1998; Kramer, 2010/a). Fleishman (1984, p. 229) defines coping as globally as «overt and covert behaviors that are taken to reduce or eliminate psychological distress or stressful conditions». The notion of distress encompasses positive and negative emotions, whereas from a stress-coping perspective, as outlined before, the focus is laid on negative – "distressing" – emotions (Gross & Thompson, 2007).

In order to address some of the problems related to construct validity of the coping concept in clinical psychology, Skinner, Edge, Altman, and Sherwood (2003) put forward a synthesis of a limited number of general categories, based on a comprehensive literature review of the domain. These authors highlighted the *functionality* in the regulation processes, in accordance with Fleishman's (1984) definition and Gross' (2001) works. Skinner et al.'s (2003) review did not exclude the distinction between adaptive and non-adaptive processes. As such, helplessness coping may represent a potential developmental risk for the patient, albeit every coping process ultimately bears the potential of adaptation in specific situations (Lazarus, 2000; Lazarus & Folkman, 1984; Skinner et al., 2003). This discussion leads Skinner et al. (2003) to the major distinction in terms of the nature of appraisal. A stressor might be appraised by the individual using a frame of reference of challenge (*i.e.*, the

individual feels he has sufficient mastery in addressing the stress, the stress is perceived as controllable, the individual seeks help or information in order to solve the problem related with the stress) or of threat (*i.e.*, the individual feels overwhelmed by the stress or the emotion, the individual refuses to tackle the stress due to a perceived lack of skills). Importantly, this distinction is applicable irrespective of the nature or the objective intensity of the emotion/stress or the individual's objective capacities to cope, thus focusing on the presumed subjective appraisal. In conclusion, Skinner et al. (2003) underlined the importance of using a set of a dozen general categories for the conceptualization of coping, taking into account the nature of appraisal. These meta-categories are meant to encompass all the specific coping strategies discussed in the coping literature (Skinner et al. (2003). As such, 12 coping meta-categories may be distinguished on the basis of nature of the stress appraisal (see Table 1): six of the coping categories are conceived as coping with stress appraised as challenge (yielding adaptive coping) and the other six as coping with stress appraised as threat (yielding non-adaptive coping). The competence domain encompasses two coping categories where the stress is appraised as challenge, *i.e.*, problem-solving and information-seeking, as well as two categories where the stress is appraised as threat, *i.e.*, helplessness and escape. Similarly, for the relatedness domain, two categories imply stress appraisal as challenge, *i.e.*, self-reliance and support-seeking, two as threat, *i.e.*, delegation and isolation. Finally, the autonomy domain encompasses two challenge-coping categories, *i.e.*, accommodation and negotiation, and two threat-coping categories, *i.e.*, submission and opposition. Each coping category is broken down into three action levels, *i.e.*, affective, behavioral and cognitive, enabling the fine-grained rating of a total of 36 coping processes. The observer-rated Coping Action Patterns Rating Scale (Perry, Drapeau & Dunkley, 2005) used in the present study was developed based on this conception (see Method section).

Assessment strategies

Traditionally, coping processes are assessed using self-report questionnaires. Several limitations of this practice need to be acknowledged (see Shedler, Mayman and Manis, 1993). In general, biases of social desirability, acquiescence and self-deception are reported in relation with self-reports assessing psychological processes. For the assessment of cognitive processes, D'Iuso, Blake, Fitzpatrick, and Drapeau (2009) pointed out that a questionnaire assesses the representation a person has of his/her cognitive processes, but fails to assess these processes themselves, as they unfold over time in spontaneous speech (see also Nisbett & Wilson, 1977). These criticisms, along with the importance of moment-by-moment in session assessment, are particularly relevant when studying patients presenting with BPD. Indeed, some of these patients display relevant traumatic content from their early childhood encoded in implicit memory systems which might have an impact on explicit responses on questionnaires (Van der Kolk, Perry, & Herman, 1991; Korner, Gerull, Stevenson, & Meares, 2007). As adults, they possibly need to cope with these memories, in particular in the context of an affect-evoking therapy session. Such information on in-session coping with distressing memories may not be accessible to awareness and may be lost in a questionnaire approach. An observer-rated methodology using transcribed therapy sessions optimally addresses these concerns. A recent multi-method study that included a comparison of different assessment strategies of coping (self-report questionnaires vs observer-rated methodology; Kramer, Drapeau, Khazaal, & Bodenmann, 2009) reported an overall between-method canonical correlation of $r = .16$ (ns) for patients presenting with Bipolar Disorder (see also the similar results by Kramer and Drapeau, 2011). This non-significant correlation with regard to supposedly similar concepts may indicate that each assessment strategy may capture different, partially unrelated, aspects of the same construct.

Coping associated with Borderline Personality Disorder (BPD)

What do we know about coping processes associated with BPD? Whereas increased negative affect has repeatedly been shown to be related to psychopathology, *i.e.,* to Mood Disorders (Krueger, Hicks, Patrick, Carlson, Lacono, & McGue, 2002; Westen, Muderrisoglu, Fowler, Shedler, & Koren, 1997) and personality Ddisorders (Zittel Conklin, Bradley, & Westen, 2006), less is known about how specifically BPD patients cope with this increased negative affect. Overall failure in implementing effective coping strategies in patients with BPD, including emotion regulation and radical acceptance, was postulated by Linehan (1993) and shown in several studies (Gratz, Rosenthal, Tull, Lejuez, & Gunderson, 2006; Schroder, Sachsse, & Spies, 2003; Yen et al., 2002; Zittel Conklin et al., 2006), resulting in an ill-differentiated state of internal tension (Stiglmayr et al., 2005; Stiglmayr, Shapiro, Stieglitz, Limberger, & Bohus, 2001; Wolff, Stiglmayr, Bretz, Lammers, & Auckenthaler, 2007). Yen et al. (2002) showed an association between the level of affect control and BPD symptoms. High frequencies of stress avoidance strategies were reported for BPD (Kruedelbach, McCormick, Schulz, & Grueneich, 1993), as was for all PDs (Bijttebier & Vertommen, 1999). For patients with BPD, low frequences of problem-solving strategies (Kremers, Spinhoven, Van der Does, & Van der Dyck, 2006 ; Vollrath, Alnaes, & Torgersen, 1996) were found. Russ, Clark, Cross, Kemberman, Kakuma, and Harrison (1996) found high frequencies of cognitive reinterpreting as coping with painful sensations in BPD patients who tend to have increased thresholds of pain perception. Because the frequency of this coping strategy correlated with dissociation scores in these patients, the authors hypothesized that cognitive reinterpreting may have a similar function as dissociation in coping with painful sensations. Dissociation, as well as cognitive reinterpreting, is effective in distancing distressful contents from the individual's awareness. The use of coping processes related to problem-focused coping, *i.e.,* planning, suppression of competing activities, negatively predicted symptomatic evolution in BPD (Vollrath, Alnaes, & Torgersen, 1998). Finally, increased levels of

impulsivity and negative affects were found to be associated with BPD in a laboratory task (Dougherty, Bjork, Huckabee, Moeller, & Swann, 1999). Except the latter, most cited studies relied on self-reports of coping which may be seen as a severe shortcoming from a methodological point of view (see above). Another shortcoming of the field investigating coping with negative affect in BPD are the numerous measures applied which are only partially overlapping: none of the cited studies used a measure that was based on a comprehensive literature review of the coping concept, as performed by Skinner et al. (2003). Similar coping strategies have been associated with neighboring diagnostic categories, like Bipolar Disorder (BD; e.g., Greenhouse, Meyer, & Johnson, 2000). The literature review indicated that there is some overlap, along with some differences, between the coping profiles of BD and BPD patients. Therefore, BD is a relevant candidate as a clinical anchor of comparison, in particular BD inpatients considered to present with maximum levels of affect instability. Coping overlap between the two categories are expected particularly with regards to stress avoidance, denial and opposition (Greenhouse, Meyer, & Johnson, 2000; Kramer et al., 2009; Kramer, 2010/a; Krober, 1993). However, it needs to be noted that BPD patients tend to present with even more unproductive coping processes (*i.e.*, dissociation, dysfunctional problem-solving) than BD inpatients. A comparative study, aiming at disentangling BPD-specific coping processes from BD-specific ones and from healthy controls' ones is therefore warranted. Even if some overlap is expected, based on the literature review on BPD-specific coping processes, we expect more unproductive affect regulation strategies in BPD outpatients, compared with highly impaired BD inpatients (see above).

The present exploratory study aims at contributing to these questions, by using a reliable observer-rated system for asssessing coping. Observer-rated system for assessing coping has the advantage of being based on data gathering using a clinical interview with high external validity, even if standardized and manualized. The dynamic interview paradigm

(Perry, Fowler, & Seminiuk, 2005) was used in several studies (e.g., Kramer, Khazaal, & Bodenmann, 2009) as an interview technique that aims to evoke affective and coping processes which may not be evident in a highly structured therapy session, such as within the format of DBT. Therefore, the information gathered in the dynamic interview format may contribute to the understanding of BPD, from a narrative perspective (see Method section). In this sense, the extraction of quantitative assessment (*i.e.*, frequencies of in-session coping) from unstructured interview data is mostly consistent with mixed methods paradigms (Morse, 2003).

Using such observer-rated methodology, we aim at comparing the BPD coping profile to the ones of healthy controls and of Bipolar Affective Disorder I (BD). We assume that (a) BPD-patients present with lower scores on general coping functioning (*i.e*, higher scores on coping categories where the stress is appraised as threat), when compared with matched healthy controls; (b) BPD outpatients present with even lower scores on general coping functioning than matched BD inpatients; and (c) overall coping functioning relates to symptom level in BPD patients.

Method

Sample

A total of 25 outpatients presenting Borderline Personality Disorder (BPD) were included in the study. Fifteen (60%) were female; the patients had a mean age of 31.1 years (SD = 10.4; ranging from 19 to 55). All patients were French-speaking and had a DSM-IV (APA, 1994) diagnosis of Borderline Personality Disorder, as diagnosed by the Structured Clinical Interview for DSM-IV (SCID-II; First, Spitzer, Williams, & Gibbons, 2004). These diagnostic interviews were performed by trained staff; mean reliability of axis II diagnoses was satisfactory (κ = .76); these reliability analyses were performed on independent ratings of video-taped SCID-II interviews of randomly chosen 20% (5) of all cases. Some of the patients

(10; 40%) presented co-morbid disorders, such as on axis I major depression (4 ; 16%). Other disorders, each present in one patient, were agoraphobia, dysthymia, bulimia, anorexia, panic disorder, alcohol abuse, somatoform disorder and schizoaffective disorder, and on axis II one paranoid and one narcissistic PD. Mean number of BPD symptoms was 7.01 (SD = .05; range 5-9).

A matched clinical control group of $N = 25$ inpatients presenting with Bipolar Affective Disorder I (BD) was recruited for an earlier study (see Kramer, Drapeau, Khazaal, & Bodenmann, 2009); matching criteria were gender and age, as these may have an influence on coping functioning (Labouvie-Vief, Hakim-Larson, & Hobart, 1987; Segal, Hook, & Coolidge, 2001; Whitty, 2003). Out of these BD patients, 15 (60%) were female; the BD patients had a mean age of 36.6 years (SD = 10.3; ranging from 21 to 60). No difference was found with regard to the matching criteria (for age: $t(1, 48) = 3.49$; $p = .07$). The BD patients' mean Global Severity Index (GSI) from the Symptom Check-List - Revised (SCL-90-R; Derogatis, 1994) was 1.43 (SD = .85), which is in the clinical range. BD-diagnoses were assessed using the MINI (Sheehan, Lecrubier, Harnett-Sheehan, Janavs, Weiller, Bonara et al., 1997), however, no reliability checks were performed on these diagnoses.

A matched non-clinical control group was recruited; matching criteria were gender and age, as above. A total of $N = 25$ persons from a French-speaking community sample participated in the study. Out of these**,** 15 (60%) were female; the controls had a mean age of 33.7 (SD = 7.9; ranging from 23 to 50). Thus, no difference was found with regard to the matching criteria (for age: $t(1, 48) = -1.06$; $p = .30$). None of these participants had prior psychiatric treatment. Global symptomatology as assessed by the SCL-90-R (Derogatis, 1994) was in the normal range for all control participants (M = .47; SD = .23). No diagnostic interview assessment of symptoms were performed for the non-clinical control group. All

participants gave written informed consent. The study was approved by the Research Ethics Board of the specific institutions.

Instruments

Coping Action Patterns Rating Scales (CAP; Perry, Drapeau, & Dunkley, 2005; French translation and validation by Kramer & Drapeau, 2011). The CAP is an observer-rating system assessing coping processes based on interview-transcripts. It is based on Skinner, Edge, Altman, and Sherwood's (2003) hierarchical conception of the structure of coping and encompasses 12 categories of coping, nested within three general domains: competence, relatedness and autonomy (see Introduction section). For our study, we only used these three general domains, broken down into processes facing a stress conceived as threat vs challenge (6 categories ; see Table 1 for examples of excerpts from the current study sample). Relative frequencies were 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). Empirical validation has been presented by D'Iuso et al. (2009) for the original English version and by Kramer (2010/a), Kramer and Drapeau (2011; see also Kramer, de Roten, & Drapeau, 2011), Kramer and Drapeau (2009) and Kramer et al. (2009) for the French version used for this study. For the current study, reliability coefficients on 20% of the ratings were established among trained raters and yielded satisfactory results in terms of intra-class correlation coefficients (2, 1; Shrout & Fleiss, 1979**)** varying between .72 and .92 (M = .83; SD = .07). These coefficients have been established on coping as the unit of analysis (12 categories).

Outcome Questionnaire-45.2 (OQ-45; Lambert, et al., 1996). This self-report questionnaire encompasses 45 items addressing three main domains of distress: level of symptoms, interpersonal relations and social role. In this study, the general sum score computed from the three sub-scores was used. A Likert-type scale is used to assess the items,

from 0 (never) to 4 (almost all the time). The validation coefficients of the original English version are satisfactory, in particular for internal consistency and sensitivity to change over psychotherapeutic treatment (Vermeersch, Lambert, & Burlingame, 2000). The French validation study (for the version used in this study) was carried out by Emond, Savard, Lalande, Boisvert, Boutin, and Simard (2004) and yielded satisfactory results. Only the BPD-patients filled out this questionnaire. Cronbach's alpha for this BPD sample was .95. Mean of the BPD sample was 96.14 (SD = 21.22; range 68-124), which is in the clinical range.

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. The focus of the DI is the «patient's life in general» and five tasks of the interviewer compose a high quality DI: (1) Setting the interview frame: work-enhancing strategies; (2) Offering support: questions, support strategies, associations; (3) Affect exploration: questions, reflections, clarifications, defense interpretations; (4) Trial interpretations: defense and transference interpretations and (5) Formulating a synthesis. 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 control group was recruited by means of two local institutions: (1) School of Social Studies (n = 16) and (2) Association promoting Community Activities and Service (n = 9). Matching criteria were transparently issued at the outset of the control group recruitment. Nine participants failed to meet the matching criteria and were not included in the study. The control participants were given a financial compensation (the equivalent of USD 20).

All interviews were tape-recorded and transcribed by Master's-level psychology students, according to the method defined by Mergenthaler and Stigler (1997). Ratings were based on these transcripts and done by four Master's-Level students in psychology.

Data Analytic Strategy

Univariate and multivariate statistics were carried out to test our first and second hypotheses stating that (a) there is a lower coping functioning in BPD than in controls and (b) BPD outpatients present with even lower coping scores, compared with BD inpatients. Bonferroni's corrections were applied in these analyses. In order to test the third hypothesis stating that (c) overall coping functioning relates to symptom level as assessed by the OQ-45 and the number of BPD-symptoms on SCID-II in BPD patients, Pearson's correlation analyses were carried out.

Results

With regard to the first hypothesis (a), between-group difference testing between BPD and healthy controls as anchor yielded a clear picture in terms of coping. Overall Coping Functioning (OCF) differed with a large effect size between the groups (see Table 2); the BPD patients presented lower levels of coping adaptiveness. A MANOVA analysis was conducted where the between-subjects effects was F (5, 44) = 5.39; $p < .001$).

More specifically, as a results on the univariate levels, in the autonomy domain, the BPD patients more frequently used coping processes that appraise stress as threat (submission, opposition) and less frequently used processes that appraise stress as challenge (accommodation, negotiation), compared to healthy controls. The frequency of challenge-coping related to competence (problem-solving, information-seeking) did not differ between the groups, but the threat-coping related to competence (helplessness, escape) was more frequently employed by BPD patients, compared to controls. Finally, the relatedness domain yielded between-group differences: BPD patients more often used processes related to stress

appraised as challenge (self-reliance, support-seeking), compared to controls. No between-group difference (BPD vs healthy controls) was found for relatedness coping when the stress was appraised as threat (isolation, delegation).

Betweeen-group difference testing comparing BPD outpatients with BD inpatients yielded a less clear picture (hypothesis b). Overall Coping Functioning (OCF) did not differ between the two groups (see Table 2). Whereas the multi-variate analysis yielded a between-group difference (F (5, 44) = 2.64 ; p = .05), on the univariate level, only one coping domain significantly differed between BPD and BD patients: it was the autonomy domain facing the stress appraised as challenge. The BPD patients used less of these coping processes (negotiation and accommodation), compared to the BD inpatients. No between-group difference was found for any other domain on the univariate level.

For hypothesis c), the correlational analyses performed on the BPD-sample between the categories of the CAP and symptom level did not yield any significifant results for the self-report of general symptomatology (OQ-45), but several links with the number of BPD symptoms assessed using the SCID-II were found. In particular, negative correlations with OCF, challenge-coping (resources and autonomy) and positive correlations with threat-coping (competence and autonomy) were found (see Table 3).

Discussion

The results indicated that our first hypothesis stating a significant lower coping functioning of BPD, as compared to healthy controls, was confirmed. However, these results should be interpreted with caution, as the number of observations per cell was small. BPD outpatients presented with lower scores on coping functioning, both overall and for specific categories, compared to matched healthy controls. Overall Coping Functioning, defined as the relative frequency of adaptive coping strategies, *i.e.*, problem-solving, information-seeking, self-reliance, support-seeking, accomodation and negotiation, was significantly lower in BPD,

compared to healthy controls. This result is in line with theoretical assumptions on the overall lack of capacities, or «skills», in emotion regulation in patients with BPD (Linehan, 1993) and consistent with previous empirical findings (Gratz et al., 2006; Schroder et al., 2003; Yen et al., 2002; Zittel Conklin et al., 2006). However, the second hypothesis - positing that BPD outpatients present with even lower coping functioning scores, compared with BD inpatients - , was not supported, as the OCF index scores for the two samples did not differ.

On the univariate levels, the autonomy domain presented a clear picture when comparing BPD to healthy controls: BPD patients made less frequent use of productive autonomy coping patterns, such as negotiation and accomodation, whereas they use, or over-use, much of the unproductive autonomy coping patterns, such as submission and opposition. The autonomy domain was the only one that yielded a between-group difference with the patients presenting with BD. Thus, autonomy seems to be a coping domain specific to BPD.

The competence domain yielded significant between-group differences in terms of increased levels of unproductive coping pattens, such as helplessness and escape, when comparing BPD to healthy controls. The productive coping patterns are preserved (problem-solving and information seeking). Helplessness and escape have a common underlying functionality (Skinner et al., 2003): both aim at experiential avoidance of stressful stimuli. Experiential avoidance has repeatedly been related to BPD functioning (Bijettebier et al., 1999; Kruedelbach et al., 1993; Linehan, 1993; Linehan et al., 2007; Watson et al., 1999-2000). However, the preservation of productive competence-related coping, as shown by our results, has not been reported so far; on the contrary, Kremers et al. (2006) found problem-solving to be less frequently used, which was associated with BPD symptoms. Different methodologies might account for the different results: Kremers et al. (2006) used self-report focusing on general (everyday life and out-of-session) coping capacities, whereas the present study focused on the assessment of the in-session process. In session, BPD patients might

benefit from the presence of the interviewer and be able to produce problem-solving and information-seeking skills, whereas the implementation of these competencies in everyday life might be more difficult, as reported on the questionnaire. Another explanation for the in-session presence of productive competence-related coping might be the display of competence known as interaction pattern in patients presenting with BPD (Linehan, 1993). Similar comments apply to the questionnaire-study by Vollrath et al. (1996) who found a negative correlation between BPD and problem-solving.

Finally, in the relatedness domain, it appears that specific coping skills, such as self-reliance and support-seeking, are less often used in these patients. These results are in accordance with the literature (Bijttebier et al., 1999; Linehan, 1993). Only a small and non-significant effect was found for the unproductive relatedness-coping strategies isolation and delegation. It is important to note that these effects are not specific to BPD, as the results for these domains did not differ from the BD sample.

The third hypothesis on the relationship between coping functioning and symptoms was partially confirmed. Whereas on the self-report measuring general symptomatology, no significant correlation was found, the number of BPD symptoms relate negatively to OCF and a number of categories, such as both aspects of the autonomy domain. This result underlines even more the importance of coping vulnerability in the autonomy domain (see above). The absence of finding with regard to general symptomatology may be due to the non-specificity of OQ-questionnaire; specific problems related to BPD symptoms are not directly assessed by this measure.

Several clinical implications of the results found can be noted. Facing a patient presenting with BPD, it seems important for the clinician to assess on the micro-process level in-session coping processes, with a particular attention to the lacking coping skills in the autonomy domain. Low frequencies of accomodation may be enhanced by teaching the

patient the DBT skill of radical acceptance, as well as the set of Mindfulness skills (Linehan, 1993; Linehan et al., 2007). Equally important seems the training of social skills in order to overcome the low levels of negotiation coping in these patients. These interventions seem specifically useful for patients with BPD. Higher frequencies of opposition and submission (as threat-coping associated with autonomy stakes) need to be addressed by raising awareness in the clinician about his/her interpersonal «pulls» (Kiesler, 1982) in reaction to the patient's in-session expressed coping to stress. In order to constructively overcome, understand and address the motivational underpinnings of such non-productive coping processes, Caspar (2007) suggests conceptualization in terms of hypothetical Plans and motives related to in-session behaviors and experiences. Such a conceptualization may help the clinician to produce a different - more constructive - interactional stance than the ones immediately linked to the interpersonal pulls. Experiential avoidance may be treated by skills training using Mindfulness techniques (Linehan, 1993), or radical acceptance strategies, or by clarifying the underlying motives or emotions of the avoidance (Breil & Sachse, 2011; Greenberg, 2002; Pos & Greenberg, 2012; Sachse et al., 2009; Warwar, Links, Greenberg, & Bergmans, 2008). Finally, for the enhancement of support-seeking and reliance deficits, self-assertive training may be proposed in the context of a skills training (Linehan, 1993). The latter proposals may apply to BPD as well as BD patients.

Several research implications stem from the results presented. This is the first step of applying observer-rated methodology to coping, or more generally emotion regulation, concepts. Even if time-consuming, the present study attests its feasibility and clinical and scientific interest. In particular, in-session processes, otherwise overlooked and discarded as noise, are reliably assessable for highly disturbed patients. Their comparison with healthy controls, but also bipolar inpatients reveiled clinically meaningful results. Further steps include the more rigorous mixed method approach (Morse, 2003), combining this frequency-

based quantative assessment with the qualitative interview data at hand. Such a paradigm may help to differentiate between sub-categories otherwise conflated within the CAPRS-structure. This more discovery-oriented endeavour might help define even more specifically the coping deficits, as well as particular resources, of patients presenting with Borderline Personality Disorder.

We must acknowledge several limitations of our study. Beyond the limited power of the present exploratory study, the BPD sample presents quite low co-morbidity, both on axis I and II, which is consistent with the specialized center where the BPD patients were recruited; thus, we need to use great care with generalizations to samples with higher co-morbidity. In order to optimally understand coping dynamics, - where "timing is everything" (Gross, 2001) - several assessments over time may be necessary; this was not the objective of this cross-sectional study. Finally, the absence of any self-report assessing coping processes prevents multi-method analyses from being conducted; such analyses might help acknowledging both the assets and limitations of each methodological strategy.

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Table 1

Structure of the CAP with excerpts from patients diagnosed with BPD (Perry et al., 2005)

Domain	Categories	Excerpt
Challenge :		
Competence	Problem-Solving (PS)	IS-b : « May I tell you here about my symptoms? »
	Information-Seeking (IS)	
Resources	Self-Reliance (SR)	SS-b : « I was getting worse and worse and then
	Support-Seeking (SS)	decided to consult emergency services »
Autonomy	Accomodation (A)	A-c : « Yes, I accept it now ; I am unable to pass
	Negotiation (N)	my driver's licence under these circumstances. »
Threat :		
Competence	Helplessness (H)	H-a : « I've lost all direction here, I've lost my
	Escape (E)	place, all my energy is gone. »
Resources	Delegation (D)	D-c : « So I waited for the effect of the
	Isolation (I)	antidepressants ; these help me to cope. »
Autonomy	Submission (S)	O-b : « She told me, yes, she's dead, then I took
	Opposition (O)	everything on my way and destroyed it »

Note. Each category is broken down into three action levels: affective (a), behavioral (b) and cognitive (c). To save space, we do not provide this distinction in the table and only provide one example per domain.

Table 2

Coping in Borderline Personality Disorder (*N* = 25), compared to Bipolar Affective Disorder (*N* = 25) and Controls (*N* = 25)

Coping	BPD		BD		CONTR		BPD-BD		BPD-CONTR	
	M	SD	M	SD	M	SD	*F*	*ES*	*F*	*ES*
OCF	.44	.21	.44	.18	.67	.18	.00	.00	17.08**	1.18
Challenge										
Competence	12.52	12.13	9.41	7.33	13.04	8.93	1.20	.31	.03	.04
Resources	24.64	12.45	22.88	11.76	32.22	15.36	.27	.15	3.68*	.54
Autonomy	7.26	8.98	12.43	9.95	21.50	13.65	3.71*	.55	19.00**	1.23
Threat										
Competence	26.16	12.81	22.29	13.82	16.59	11.44	1.05	.29	7.76**	.79
Resources	10.18	11.35	8.46	7.29	6.81	8.21	.41	.18	1.45	.34
Autonomy	19.24	18.11	24.53	13.79	9.83	8.45	1.35	.33	5.55*	.67

Note. BPD-BD: MANOVA: F (5, 44) = 2.64; p = .05; BPD-CONTR : MANOVA: F (5; 44) = 5.39; p = .00; BPD : Borderline Personality Disorder; BD: Bipolar Affective Disorder; CONTR: Controls; *F*: F(1, 49); OCF: Overall Coping Functioning; ES: Effect size (Cohen's *d*)

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

Table 3

Pearson's correlations between symptom level (OQ-45, number of BPD symptoms according to SCID-II) and Coping Patterns (N = 25)

Coping	OQ-45	BPD
OCF	-.22	-.48**
Challenge-Coping		
Competence	-.05	.03
Resources	-.31	-.28**
Autonomy	-.03	-.51**
Threat-Coping		
Competence	-.11	.28*
Resources	.12	.18
Autonomy	.23	.35**

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