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Defense functioning in Depressed Patients treated with Medication and Group Psychotherapy

by

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A dissertation submitted to the Graduate Faculty in Psychology in partial fufillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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ABSTRACT

Defense Functioning in Depressed Patients Treated with Medication and Group Psychotherapy

Advisor: Professor Diana Diamond

This dissertation investigated defense functioning in 30 outpatients treated for DSM-III-R Dysthymic Disorder. Defense mechanisms were conceptualized on a developmental (immature-mature) continuum (Cramer, 1991), reflecting corresponding levels of psychopathology. The study of defense use elucidates psychological factors that promote or forestall symptom recurrence, as well as nosological questions concerning the status of depression as a primary (Axis I) disorder or (Axis II) form of personality. It was hypothesized that brief group therapy, augmented by medication, would effect a greater change in use of defense mechanisms (Denial, Projection, and Identification) than medication alone, and that such change would be associated with positive clinical outcome. It was also hypothesized that initial level of defense would predict clinical improvement, regardless of treatment group.

In this 24-week open label treatment study, patients received 8 weeks of Fluoxetine and were randomized to one of two treatment groups: (1) Medication alone and (2) Combined Medication and Group therapy. Assessments were conducted at intake and termination. Subjects were administered two symptom-based inventories (Beck Depression Inventory; Hamilton Depression Rating Scale), two personality measures (Inventory of Interpersonal Problems, Depressive Experiences Questionnaire), and a projective narrative task, the Thematic Apperception Test, to assess use of defense mechanisms.

As predicted, results showed significantly greater change on Denial for the

Combined Medication-Group patients. A significant negative relationship was found between Identification and depressive symptoms at intake, and a positive relationship between improved interpersonal functioning and reduced symptom distress over time. Depressive personality subtypes (Blatt, 1990) predicted use of specific defense mechanisms, with anaclitic (Dependent) depression positively associated with Projection, and introjective (Self-Critical) depression predicting less improvement on Identification over time. Axis II pathology, particularly Cluster C personality disorders, also affected defense use.

This study suggests that change on defenses can occur in brief group treatment, and that type of depressive experience, compared with symptom distress, is a more robust predictor of how much change a patient will show on mature defenses. These findings support a view of depression as a heterogenous disorder with trait-like personality features. The clinical implications of these findings are discussed, with recommendations for more effective treatment designs.

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INTRODUCTION

Chronic depression (dysthymia) affects at least 3-5% of the American population (Weissman et al., 1988). Epidemiological studies cite depressive disorders to be among the most common forms of mental illness in this country, with lifetime prevalence rates reaching as high as 17% (Kessler et al., 1994). Dysthymia, in particular, has been associated with impaired psychosocial functioning, over-utilization of medical services, increased suicide risk, high rates of recidivism, and increased psychiatric comorbidity (Howland, 1993a; 1993b; Friedman, 1993; Markowitz et al., 1992; Stewart et al., 1988), as well as excessive economic burden in the workplace (Conti & Burton, 1994). Medical outcome follow-up studies (Wells et al., 1992; Hays et al., 1995) confirm that, even after treatment, depression remains associated with a degree of psychological morbidity in multiple domains of functioning equal to or greater than that observed in chronic medical illnesses. In light of its exacting toll, the need to develop more efficacious treatments and assessment procedures for dysthymia is paramount.

This dissertation investigates changes in the use of defense mechanisms in outpatients prior to and following psychotherapy and pharmacological treatment for DSM-III-R Dysthymia. It explores whether the type and degree of defense use changes as a result of specific treatment interventions. And it asks whether these changes are related to improvements in measures of symptom response and interpersonal functioning. It is argued that such questions have important implications for the clinical assessment and treatment of chronic depression.

The rationale and impetus for studying defense mechanisms in a clinically

depressed patient population is fourfold:

(1) The chronic nature of depressive illness and its debilitating effect on psychosocial functioning supports the view that specific vulnerability factors, such as defensive style, may impede (or facilitate) recovery from this condition.

(2) The persistence of interpersonal deficits (e.g., social withdrawal, dependency) after completion of medication treatment (Hellerstein et al., 1993; Keller et al., 1994) suggests that depressed patients use defense mechanisms to avoid, negate, or subvert experiences that promote healthy relatedness and emotional well-being.

(3) The potential biasing effect of depressed mood on patients' self-administered questionnaires (Widiger, 1993; Segal, 1988), and discrepancies documented in medication trials between depressed patients' self-reports and clinician-based observations (Hellerstein et al., 1993), indicates that assessment of the depressed patients' unconscious defense use may be a more valid measure of personality functioning than self-descriptions.

(4) Investigating defense mechanisms as mediating variables could clarify the relation between depression and character pathology, and elucidate differential diagnosis of dysthymia and depressive personality.

Chronic depression, or dysthymia, is a clinically heterogeneous disorder, with multiple biological, genetic, and environmental pathways. Although personality variables are thought to be important in the aetiology of depressive illness, their precise role remains unclear. The reconceptualization of dysthymia from a

characterological condition to a mood disorder in DSM-III (1980) led to attenuated interest in defense functioning associated with this illness. But the early onset of dysthymia, coupled with its perniciously chronic, often lifelong course, has been cited by some as evidence for retaining this condition as a personality disorder (Frances, 1980; Frances & Cooper, 1981; Philips et al., 1990), in keeping with earlier formulations of neurotic depression, in which defense had a prominent aetiological role. The strong association between depression and various dysfunctional personality traits (e.g., introversion, negativism, dependency) continues to be a focus of research (Hirschfeld et al., 1983; Klein et al., 1993). An examination of defense functioning could help elucidate some of the conceptual confusions concerning such variables as state and trait, personality and mood, and their roles in depressive illness. Indeed, systematic study of defense functioning can help elucidate or resolve ongoing questions over whether a depressive type of personality disorder should be regarded an axis II disorder linked to an axis I depressive disorder (Phillips et al., 1990).

Few empirical studies have systematically examined defense use in clinically depressed patients (Kneepkens et al., 1996; Bloch et al., 1993; Akkerman et al., 1992). A review of the literature shows that, to date, no published research study has investigated whether defensive functioning in depressed patients is more responsive to antidepressant medication or to a combined medication-psychotherapeutic approach, nor whether defense use in such patients predicts their treatment response.

Although the emergence of a new class of antidepressant medication, the

Selective Serotonin Reuptake Inhibitors, brought renewed interest in the pharmacological treatment of depression (Hellerstein & Little, 1994, 1996), clinical trials have shown that despite the effectiveness and favorable side effect profile of the SSRIs residual symptoms and other sequelae of this chronic disorder do persist even after the completion of medication treatment (Hellerstein et al., 1993; Keller et al.,1994). Such symptoms (among them, hopelessness, social withdrawal, poor communication skills, negativistic thinking) suggest there may be disruptions in some patients' sense of self and relationships that are not adequately treated by pharmacological therapies, and may interfere with full recovery. These findings, buttressed by empirical research on the social skills deficits of depressed people (Gotlib & Asaranow, 1979; Coyne, 1976) have made interpersonal problems more focal in the treatment of chronic depression (Markowitz, 1993; Klerman et al., 1984; Gotlib & Hammen, 1992). Additionally, it has highlighted the need to test the efficacy of combined (medication + psychotherapy) approaches, particularly in cases of refractory dysthymia.

Little empirical literature to date exists on the relationship between depression and defense. However, an important psychological construct common to both domains is self-esteem. Psychoanalytic and social-cognitive theorists view defense mechanisms as cognitive strategies used to protect the self or self-concept (Cramer, 1987,1990; Fenichel, 1945; Sullivan, 1953), preserve self-cohesiveness (Haan, 1977, Kohut, 1977;1984), and promote self-enhancement in the face of external adversity or challenge (Taylor, 1983; Taylor & Brown, 1989). In contrast, the persistence of negative thoughts and feelings about the self (poor self-esteem) is part of the

phenomenology of depressive experience, and one feature which distinguishes it from other affective disorders. In psychoanalytic theory, depression is thought to be a form of pathological mourning in response to actual or imagined loss (Freud, 1917; Abraham, 1911/1985; Fenichel, 1945). Different views -- introjection, retroflexed anger, ambivalence, guilt -- have been proposed to explain how depressed people deal with such loss, but the pervasive subjective feeling in these accounts is one of profound devaluement. Similarly, cognitive and behavioral theorists (Abramson et al., 1978; Beck, 1967) have underscored loss of self-esteem as being central to the cognitions and attributional style of depressed persons, and correlated with feelings of helplessness and despair. If defense mechanisms are intrinsically self-protecting, and depressed people typically complain of inferiority and inadequacy, it would appear that the defense mechanisms depressed patients tend to use do not sufficiently buffer them. But it is also possible that depression constitutes a special, or paradoxical, form of defense, and that depressed individuals use defenses depending on predisposing factors, such as cognitive vulnerability, ego strength, or aversive experiences with early caretakers, which affect the quality not only of their self-views but their relations with others.

Following Cramer (1987, 1996), this study will use a projective measure, the Thematic Apperception Test, to examine changes in three unconscious defense mechanisms --denial, projection, and identification -- in depressed patients undergoing treatment. A substantial literature supports the use of projective tests to study the affective quality and cognitive structure of internal representations (Blatt & Lerner, 1983; Mayman, 1967, 1968), and the TAT in particular has been a traditional

test of interpersonal and object relational issues because it facilitates access to underlying, rather than manifest, meanings about self and others (Weston, 1991).

A second rationale for using projective testing with depressed patients is that traditional self-report measures of change, although easy to administer, have been problematic with this population. Reports from some medication efficacy trials suggest that clinicians rate higher improvement in depressive symptomatology over the course of treatment than patients do in their self-reports (Hellerstein et al., 1993). This discrepancy may reflect weaknesses in the measures used to track shifts in depressive symptomatology. But the lower rate of improvement reported by patients could also reflect a negative response styles (Teasdale & Russell, 1983). The need for alternatives to self-report methodologies when assessing clinical outcome was addressed at a 1994 NIMH research workshop on chronic anxiety and mood disorders, and is additionally supported by a research literature on the distorting effect of negative cognitions on patients' self-perceptions. Empirical studies on memory, for example, show that negative mood states (including depression) increases recall of negative information (Bower, 1981; Kuiper & McDonald, 1983; Teasdale & Russell, 1983). Given their potential bias effect, the validity of assessments based on patient self-descriptions or other symptom-based paper-and-pencil inventories has been called into question (Segal, 1988; Segal & Muran, 1993; Widiger, 1993). By using projective testing, researchers can tap the unconscious representations of patients, which are qualitatively different from readily available schematic contents, and thus may shed more light on the cognitive-affective processes that mediate depression.

Two theoretical models guide this investigation. The first, grounded in ego psychology (A. Freud, 1936; Vaillant, 1971, 1976, 1977; 1986, Vaillant et al., 1986) and empirical studies of chronological defense use (Chandler et al., 1978; Cramer, 1987, 1988, 1990, 1991), which posits a developmental conception of defense: It argues that defense mechanisms are adaptive ego functions which arise under normative conditions, and become more complex and integrated across the life span, consistent with Piaget's stage model of cognitive development..

Theorists propose that defense mechanisms operate on a chronological (age) continuum or on dimensions that involve some kind of hierarchy, such as lower-higher, simple-complex, immature-mature, successful-unsuccessful. In Cramer's model, the emergence and use of a particular defense mechanism is contingent upon level of ego development and available cognitive capacities. Chronological studies show that denial, projection, and identification first appear, respectively, in early childhood, adolescence, and adulthood (Cramer, 1979, 1987, 1991). They are not unitary constructs but function at varying levels of cognitive complexity, manage affect in different ways, and impede (or facilitate) adjustment to reality. In addition, they reflect increasingly differentiated views of self and other, which will have consequences for capacities of self-reflection, affect regulation, and interpersonal relatedness.

A second, related model draws from theories of social cognition and mental representation in which meaning structures (schemas) function as organizers of thoughts and feelings about self and other. How individuals view themselves and their relationships illuminates understanding of their potential vulnerability to

psychological dysfunction. Piaget's concept of assimilation (1952), by which new data are fitted to pre-existing schemas, without allowance for reality-based modifications, offers one view on how representations are subject to defensive biases. Extending Piaget's general notion of schema, contemporary theorists have stressed individual differences in thought style and patterns, and the role of affectivity and motivation in the making of personal meaning. This work has been anticipated, to some degree, by ego psychoanalytical conceptions of characterlogical defense (Reich, 1936; Shapiro, 1965), which describe diagnostically significant variants of cognitive and perceptual style.

Several empirical researchers have drawn on schema theory to elucidate self-protective and defensive mechanisms in affective conditions, including depression: Blatt's (1974) object relations model focuses on internalized forms of depressive experience, and avoidant and counteractive defense mechanisms which correspond to specific depressive personality subtypes; Beck's (1967,1983) cognitive theory views depression as the consequence of faulty information processing and negative self-schemata; Horowitz (1988a, 1998b; Horowitz et al., 1990, 1994) provides a study of maladaptive self-schemas, person schemas, and defensive control processes in various states of mind, including pathological grief; and Bowlby (1969, 1976, 1977, 1980) examines maladaptive aspects of internal working models in the context of disrupted attachment and disordered mourning.

The persistence of negative thoughts and feelings about the self is a seemingly intractable aspect of depressive experience, and a major obstacle to successful

therapeutic outcome. Unconscious defense mechanisms likely perpetuate negative self-views, which keep dysthymic individuals from developing the feelings of worth, social competence, and healthy patterns of behavior that might otherwise allow them to lead satisfactory and productive lives. Paradoxically, these defensive efforts may be the depressed individual's most effective means of preserving self-esteem. As Andrews (1989) argues, the prime motivating factor in maintaining depressive behavior may be the need for a stable self-concept, even one that is maladaptive. This study draws on the developmental model of Cramer, along with the theoretical contributions of Blatt, Horowitz, Bowlby, and Beck, to assess whether specific defense mechanisms, and the depressogenic schemas or representational schemes they might engender, can be modified by therapeutic intervention.

The following questions will be addressed: What kinds of defense mechanisms do depressed patients use? How resistant are these defense mechanisms to change? Is a measure of defense mechanism use sensitive enough to differentiate between treatment groups -- combined medication-therapy or medication alone?

Another set of questions asks whether defense use in depressed people, when assessed prior to clinical intervention, dictates treatment response, and whether specific defense mechanisms are associated with different outcomes.

A third set of questions investigates the relationship between defense functioning and other measures of symptom and interpersonal change, including assessments of depressive personality subtypes and interpersonal problems frequently encountered by depressed patients.

By raising these issues I hope to advance understanding of how depressed patients

respond differentially to standard treatments for dysthymia. A systematic study of defense mechanism use may help to differentiate patients who derive benefits from treatment from those who fail to show significant symptom improvement despite clinical intervention, and thus who may be at greatest risk for refractory depression and possibly relapse.

I. DEFENSE

Defense mechanisms are mental processes which mediate between an individual's impulses, affects, cognitions, on the one hand, and internalized prohibitions and external reality on the other (Hauser, 1986). Although traditional psychoanalytic theory conceptualizes the defense mechanism as a means of avoiding intrapsychic conflict pertaining to issues of sex and aggression, contemporary academic theorists maintain that psychological defense, in its broadest sense, involves the process of regulating painful emotions, including anxiety, depression, and loss of self-esteem (Paulhus et al., 1997). The current definition in the DSM-IV, the official psychiatric diagnostic system, stresses the role of anxiety and perceived psychological danger in triggering a defensive reaction:

> *Defense mechanisms (or coping styles) are automatic psychological processes that protect the individual against anxiety and from the awareness of internal or external dangers or stressors* (American Psychiatric Association, 1994, p.751).

In general, contemporary psychoanalytic theorists investigating defense mechanisms concur that: (1) anxiety over a perceived threat to one's safety or sense of well-being motivates defensive behavior (A. Freud, 1936; Fenichel, 1945); that (2) defense mechanisms are involuntary, reflexive responses which tend to function without conscious awareness (Vaillant, 1971; Perry, 1990); that (3) cognitive or perceptual distortion, or some sort of compromised cognition, is a common consequence of using defense mechanisms (Vaillant, 1971); and that (4) individuals seem to use certain defense mechanisms repetitively, suggesting that defense is a manifestation of an underlying characterological disposition (Perry, 1994). Indeed,

psychoanalytic character diagnosis is predicated on a comprehensive understanding of defense mechanisms. As McWilliams (1994) notes, "the major diagnostic categories used by analytic therapists to denote personality types refer implicitly to the persistent operation in an individual of a specific defense or constellation of defenses." A diagnostic label functions as "a kind of shorthand for a person's habitual defense pattern" (p. 96). This notion that ego defenses are differentially linked to specific psychiatric illnesses is evident in Freud's early aetiological considerations of paranoia, hysteria, and other neuro-psychoses.

Many theorists have attempted to classify defense mechanisms (A. Freud, 1936/1966), Fenichel, 1945; Bibring et al., 1961; Vaillant, 1977, Kernberg, 1975, Meissner, 1985, P. Kernberg, 1994). Anna Freud described ten mechanisms -- denial, repression, reaction formation, displacement, rationalization, intellectualization, regression, reversal, turning against the self, sublimation -- according to their source of anxiety (1936). Valenstein and his colleagues (Bibring et al., 1961), classified defenses as first-order, "basic," mechanisms, consistent with A. Freud's ego mechanisms, and second-order, "complex," behaviors, such as clowning or compliance, which they speculated were admixtures of defense mechanisms and other ego functions (Bibring et al., 1961). The DSM-IV (American Psychiatric Association, 1994) has proposed 31 defense mechanism contained in a Defensive Functioning Scale that groups defenses into seven levels on the basis of optimal adaptation:

- High adaptive level (e.g., humor)
- Compromise formation level (e.g., displacement)
- Minor image-distorting level (e.g., devaluation)

- Disavowal level (e.g., denial)
- Major image-distorting level (e.g., autistic fantasy)
- Action level (e.g., acting out)
- Defensive dysregulation (e.g., failure of defensive regulation to contain one's reaction to stressors, leading to delusional projection or psychotic distortion)

A rating scale based on these defense mechanisms, the Defensive Functioning Scale, has been proposed for inclusion in a future DSM as an additional "axis" of diagnosis (1994).

In an important contribution to the empirical study of defense, Wallerstein (1985), prompted to clarify a conceptual confusion inherent in Valenstein's taxonomy, distinguished between defense mechanisms as theoretical constructs "that denote a way of functioning of the mind" and defenses as overt behavioral phenomena. Defense mechanisms, as theoretical abstractions, can only be inferred from the behaviors or affects that they produce. Excessive sympathy, for example, is a defense against the impulse to cruelty, which can be explained by reaction formation, the particular defense mechanism which, in this case, is used to repress the individual's cruelty urge (Wallerstein, 1985). This crucial distinction between defense mechanism and defensive behavior has enabled researchers, such as Vaillant, Hauser, Bond, Cramer, to operationalize defenses as observable actions which can then be measured as correlates of intrapsychic processes, thus making the study of defense functioning more systematic and rigorous.

In this selective overview, I address (1) psychoanalytic theories of defense (principally the work of Freud, A. Freud, Fenichel, Sullivan, and Melanie Klein), (2) the social-cognitive literature on coping and varieties of self-deception. Finally (3), I

examine important empirical research on defense mechanisms by proponents of hierarchical models, most notably the work of George Vaillant, which evaluates the relationship between defense and positive psychosocial adjustment. Although defenses as coping mechanisms are thought to play a significant role in both normal and pathological development (Elkind, 1976; A. Freud, 1946, 1965; Vaillant, 1978), there is some disagreement as to the degree to which their intrinsically distorting effects impede healthy functioning. Vaillant, in particular, has vigorously tested the idea that defenses can be normal, constructive processes, correlated with levels of higher and lower adaptation.

A. Psychoanalytic Theories:

Psychoanalytic theories emphasize different aspects of defensive functioning: the management of intrapsychic conflict; affect regulation, and protection of self-esteem. Ego psychologists, notably Anna Freud (1936), describe the role of defenses in dealing with anxiety and guilt; colleagues Fenichel (1946) and Bibring (1953), also working within a structural framework, argued that some defenses are motivated by the need to protect self-esteem, a perspective supported by self-psychologists, such as Kohut (1984), who believe normative defenses help maintain a positively valued sense of self (McWilliams, 1994). In a similar vein, the interpersonal psychoanalyst Henry Stack Sullivan (1953) introduced the term "security operations," and the notion of "good me," "bad me," and "not me," to explain how distortions in the self-concept fend off socially-generated anxiety. And object relations theorists, beginning with Klein, have stressed more primitive mechanisms of defense as they manifest in infantile fantasies and internal

representations.

Defense in Freud's writing

The concept of psychological defense is pivotal to Freud's understanding of mental life, psychopathology, and therapeutic resistance. In "The Neuropsychoses of Defense" (1894), Freud described the conscious and unconscious mechanisms with which patients ward off unpleasurable ideas. He recognized that affects and ideas could become separated from one another in distinct ways to serve defensive aims -- affects could be dislocated or transposed from ideas, by dissociation, repression, or isolation, or reattached to other ideas, through displacement. His fundamental realization that one can alter the expression of a conflict by changing or distorting an affect or idea remains at the crux of psychoanalytic conceptualizations of defense (Vaillant, 1993).

Freud thought that defense operated according to an economic (energic) principle that follows the laws of constancy -- the natural tendency for organisms to return to a state of minimal stimulation (quiescence). This tendency of the nervous system to rid itself of stimuli and reduce levels of tension by energic discharge (constancy principle) is the basis for gaining pleasure and minimizing pain (Meissner, 1997). When Freud formulated his early theories of neurosis (1894, 1896), he believed that many of his hysterical patients suffered from sexual traumata, and that the mechanism of repression operating in hysteria served to banish from memory excessive libido related to sexual conflict.

Although Freud did not contribute a fully formulated theory of defense, several

psychoanalytic writers (Bellak et al., 1973; Rapaport, 1959; Hauser & Safyer, 1995) contend that the construct is integral to his conception of ego, which he delineated in three theoretical stages.

Freud's (1894-1900) initial notion of ego (das ich) involved the act of keeping memories of traumatic events (e.g., unwanted sexual seduction) from entering awareness. Defense mechanisms (projection, isolation, undoing, etc.) ensured that the pent-up emotional energy associated with the traumatic memory was redirected or kept from forcing its way back into consciousness. In hysterical neurosis, the undischarged energy was converted into a somatic symptom; in phobias or obsessions, it was displaced onto innocuous ideas (Meissner, 1997). Defense, in this early view, was a direct response to the impact of adverse external reality; Freud thought of it as a general function of mind, representing one of several psychic properties or faculties, such as memory and consciousness (Van Der Leeuw, 1971).

With the introduction of the topographical model in the second stage (1900-1923), Freud conceived of the mental apparatus in terms of levels of consciousness. To accommodate his new idea that unconscious mental processes prevailed over external reality in psychic life, his focus shifted from the ego to the instinctual drives. The ego, synonymous with the conscious part of the psyche, used repression to remove unacceptable sexual drives. But the psyche was also thought to comprise an unconscious portion of mind which contained the repressed elements.

In this model, then, repression (motivated forgetting) became synonymous with defense. Rapaport (1959) attributed Freud's new emphasis on the drives to his discovery that unconscious sexual fantasies (rather than actual traumatic events) accounted for many patients' reports of childhood seductions (cited in Hauser &

Safyer, 1995). During this period Freud had expanded the term repression so much that it obscured his original concept of differentiated ego mechanisms (Vaillant, 1971).

Freud ultimately abandoned the drive model because the conscious-unconscious distinction in his topographical theory could not explain how the repressing forces of the ego, not merely repressed ideas, were unconscious. He proposed a model of psychic functioning which allowed for parts of the ego to be unconscious: He differentiated "between the coherent ego and the repressed which is split off from it" (1923).

In this third phase, the ego emerged as a psychic agency that mediated between the id and the super-ego in a tripartite model of mind. Abandoning his earlier view that defenses were deployed simply to censor awareness of traumatic experiences, Freud now argued that the ego actively mobilizes defenses in response to anxiety signals. Signal anxiety became, for Freud, an autonomous ego function. It triggered a defensive reaction to mental conflict, such as an incestuous wish or a fear of loss, by transforming passively experienced anxiety into active mastery.

Ultimately, Freud returned to his original view of defense mechanisms. After the publication of Inhibitions, Symptoms, and Anxiety (1926), he reinstated defense as a generic category, of which repression was just one form. Despite theoretical modifications over the years, Freud's formulation remained rooted in a drive metapsychology that characterized conflict in impulse-defense terms. It was Anna Freud (1936) who, while never abandoning her father's instinctual emphasis, stressed the role of defense mechanisms as "ego functions" which can foster adaptation to reality, thereby bringing these mechanisms into the realm of general

psychological activity.

Ego Psychology: Anna Freud, O. Fenichel

Anna Freud (1936) wrote *The Ego and The Mechanisms of Defense*, to demonstrate the diverse ways in which defense mechanisms assist "the ego in its struggle with its instinctual life" (p. 69). Her book, which investigated specific defenses, their modes of operation, and role in normal and pathological development, was a critical contribution to the larger study of ego functioning, as well as to the emerging therapeutic technique of ego analysis (Blum, 1985). Ego psychology is a theory of psychic balance and equilibrium in the midst of an ongoing struggle between intrapsychic life and external reality. Anna Freud demonstrated that it is the defense mechanism that enables the ego to mediate the demands of conscience (super-ego) and desire (id). Defense mastery, in her view, leads to mature ego development and increased capacity for reality testing, both prerequisites for psychological adjustment.

Anna Freud's monograph elaborated upon her father's (1926) proposition that the ego mobilizes defenses in response to anxiety signals. She argued that anxiety did not come solely from endogenous sources (e.g., instinctual anxiety), but also from reactions to real, external situations and factors, such as fear of parental punishment (objective anxiety), or internal prohibitions to do with matters of conscience (super-ego anxiety). Defense mechanisms did not merely signify the ego's attempt to ward off instinctual impulses, but also affects associated with those impulses, such as love, longing, and mourning which accompany sexual wishes, and hatred and rage which accompany the impulses of aggression (1936). "If we know how a particular

person defends himself against the emergence of his instinctual impulses...we can form an idea of his probable attitude towards his own unwelcome affects," she wrote (1936, p. 33). She based her theory, in part, on clinical observations of therapeutic resistance, manifested by specific defensive maneuvers in the consulting room, thus introducing the idea that resistance is not merely to be overcome but represents a form of communication by the patient (Pumpian-Mindlin, 1967).

Although A. Freud did not provide a chronological classification of defense mechanisms, she did speculate that they followed a developmental course. "All defense mechanisms serve simultaneously drive restriction and external adaptation," she wrote (1936).

> *There is no antithesis between development and defense, since the strength of the ego and its defensive organization is in itself an essential part of the child's growth and comparable in importance to the unfolding and maturing of the drives.*

Some defenses, such as ego restriction, or various forms of denial, respond to "external stimuli" -- they arise out of the need to respond to an actual dangerous situation, and were not in themselves neurotic: "The efforts of the infantile ego to avoid unpleasure by directly resisting external impressions belongs to the sphere of normal psychology. Their consequence may be momentous for the formation of the ego and of character, but they are not pathogenic" (1936, p. 71).

Denial in fantasy, for example, which A. Freud called a pre-stage of defense, represents the child's refusal to become aware of a disagreeable reality, either by denying it altogether or by reversing the facts in imagination. If the transformation succeeds, the child avoids the disturbing reality, and "...the ego saved from anxiety ...has no need to resort to defensive measures against its instinctual impulses..."

Anna Freud considered denial to be a normal mechanism in childhood which is gradually discarded with the inevitable maturing of the capacity for reality-testing, but she emphasized that recurrence of denial in adult life is a sign of advanced neurosis (1936). She also introduced a new defense mechanism, sublimation (the successful displacement of instinctual aims). She considered sublimation a mature defense, which "pertains rather to the study of the normal than to that of neurosis." Underlining that point, Blum (1985) asserts that sublimation was perhaps her most important contribution because it provided "a bridge" to studies of the nondefensive functions of the ego as well as to developmental achievement.

A. Freud's contributions to defense analysis led to a new theory of therapeutic change. Structural (personality) change, she maintained, is largely accomplished through a modification or change in the choice, flexibility, and intensity of defense that allows for unconscious conflicts and fantasies to be admitted into consciousness for reexamination (Blum, 1985).

> *The ego is modified so that other ego functions can operate with greater strength, freedom, harmony, and reduced reliance on and interference from defense. New integration leads to personality reorganization with taming of infantile drives and affects, and defense becoming subordinant to mature ego-super-ego regulation* (p. 15).

Anna Freud wrote very little about depression, but concurred with classical formulations of melancholia as a conflict between ego and super-ego stemming from introjection of the lost loved object for the purposes of narcissistic identification. She did stress, consistent with classical theory, that an insufficiently developed ego and lack of evocative object constancy in the young pre-Oedipal child precluded him from mourning [1965], a view challenged by Bowlby (1968). In describing

introjective processes in complex defense behaviors -- altruism and identification with the aggressor -- she touched on defensive elements (e.g., masochism, self-criticalness) that directly relate to depressive experience. For example, she speculated that altruistic surrender of one's own instinctual impulses in favor of other people, a defensive behavior that utilizes both introjection and projection, represents a compromise formation with masochistic components that shield against the pain of narcissistic mortification. And she thought that identification with the aggressor, which involved the mechanisms of introjection and reversal, represented the incomplete internalization of the critical process, and thus a pre-stage of super-ego development. For individuals who "remain arrested" at this intermediate stage, she thought that "the behavior of the superego towards others is as ruthless as that of the superego towards the patient's own ego in melancholia. Perhaps when the evolution of the superego is thus inhibited, it indicates an abortive beginning of the development of melancholic states" (1936, pp. 119-120). The critical importance of introjection as a defense in depressive states will be explored in a subsequent section.

Fenichel

Like Anna Freud, and in keeping with classical psychoanalytic theory, Fenichel (1945) contended that defense is motivated by a feeling either of fear or of guilt over an undesirable instinct. In his classification he distinguished between successful defenses (e.g., sublimation) and unsuccessful defenses, the latter necessitating the need to resort repeatedly to maneuvers to "prevent the eruption of the warded-off impulses."

Fenichel (1945) was particularly interested in the problem of guilt, which he thought was an expression of the anxiety of the ego towards the id. He distinguished between *guilt feelings proper* ("I have done wrong"), which refer to events in the past and *conscience* ("I should not do this"), which serves as a kind of warning function similar to signal anxiety to protect the individual in the future. In conscience, which evolved with the development of the super-ego, fear becomes internalized and danger is felt to threaten from within.

Fenichel also thought that premature loss of narcissistic supplies (the basis for self-esteem) plays a key motivating role in defense, as well as depression (1945). Although, initially, the care and affection shown by a caretaker is the source of the infant's narcissistic supplies, they are later obtained from the super-ego, with the internalization of parental ideals and prohibitions. Once established as part of the personality, the superego largely controls which discharges are permitted or negated (Fenichel, 1945).

Cramer (1990) has argued that Fenichel frames guilt feelings within an object relations perspective in which the ego's dread of losing narcissistic supplies becomes a warning signal to mobilize defense. This view, she asserts, runs counter to a. Freud's supposition that the primary motive for defense is protection against id demands:

> *Fenichel's modification of Anna Freud's view provided a second basis for enlisting defense mechanisms -- namely the need to protect the self from humiliation or annihilation* (p.7).

Although Fenichel, who maintains that "neurotic conflict takes place between the id and the ego," might object to Cramer's assertion that he abandoned instinct theory

in formulating the defensive role of guilt, it is clear that his defense equation, with the introduction of the super-ego, becomes more complex. He depicts the ego as siding either with or against the super-ego. For example, when guilt feelings motivate defense, the ego sides with the super-ego *against* the id. But, in certain conditions, such as depression, Fenichel believes that the ego attempts to ward off guilt feelings, and the conflict that ensues pits the ego against both super-ego *and* id. As we shall see, Fenichel's emphasis on loss of narcissistic supplies, and the punitive role of the superego in coping with that loss, has important implications for how he conceptualized the role of defense in depression.

Subsequent ego psychologists have sought to explain defense in the original libido form of reference (Brenner, 1982), or in the larger context of ego adaptation (Hartmann, 1939, Rapaport, 1959). In a conceptualization broader than Anna Freud's notion of ego as an agency of defense, 1973), Hartmann proposed that basic autonomous ego structures exist from birth, operating independently of the drives (Meissner, 1997) in a conflict-free domain. Although he viewed all defenses, at least initially, as adaptive ego operations, helping to maintain a reciprocal relationship between organism and environment, they were only one of many ego activities devoted to organizing and synthesizing functions, such as the acquisition of language, memory, and judgement.

Interpersonal psychiatry: Sullivan

With the advent of object relations theory (Klein, 1940, 1946,1948; Fairbairn, 1952; Winnicott, 1965), and interpersonal theory (Sullivan, 1953) the emphasis in personality development shifted from drive discharge and gratification to the basic

need for human (object) relatedness. Defense became understood in the context of social interactions and interpersonal conflict. Sullivan's work stressed human relations as they played out in the objective (external) world in contrast to object theorists who speculated on manifestations of defense mechanisms in early fantasy and internal self and object representations. In Sullivan's work, desire to protect that relatedness -- "interpersonal security" --became a primary motivation for defense.

Sullivan (1953) thought that the innate striving for social relatedness both guides and influences how human beings view themselves. He was particularly interested in the impact of real life interpersonal interactions because the self-concept, he maintained, is derived from "reflected appraisals." That is to say, individuals come to know themselves by how others perceive and experience them. Offering an alternative to Freud's tripartite mental structure, he conceived of the personality as a self-system. He argued that the parts of us most appreciated and valued by others become personified by the self, and identified as "good me." Experiences, or parts of the self, associated with anxiety and distress become viewed negatively as "bad me." Those attributes or experiences associated with severely disturbed interpersonal relations that are too anxiety-provoking to be fully cognitively processed are not integrated into the self-system; these are termed "not me."

Security operations help to manage anxiety arising from problematic, anxiety-provoking relationships (Sullivan, 1953). Akin to defense mechanisms, they are also different -- Sullivan conceives of such operations as more actively involved in re-establishing relatedness, or interpersonal security. Although anxiety is central in Sullivan's thinking, he does not couch his notion of defense in ego-id/ impulse-

defense terms; instead he speaks about the cognitive operation of selective inattention, and how this defensive maneuver of avoiding or denying discongruent or upsetting information is embedded in a dyadic notion of psychological functioning, in problematic interpersonal relationships.

Sullivan's work has influenced cognitive theories of depression (e.g., Beck), as well as contemporary theorists such as Safran & Segal (1990), and Wachtel (1977), who argue that maladaptive interpersonal relationships persist in part because of selective inattention to potentially disconfirming evidence.

Object Relations: Melanie Klein

Klein's contribution to defense theory is based on a conception of the unconscious mental life of the pre-Oedipal child (1948; Segal, 1964). Drawing on Freud's dual instinct theory (1900), Klein claimed that the struggle between the life and death instincts was at the heart of the infant's experience, and recast it as an "interplay of love and hate in relation to objects," thus making object relations, not psychic regulation, the fundamental determinant of personality. (Lerner & Lerner, 1990, p. 141).

Klein believed that the infant has sufficient ego to experience anxiety, use defenses, and form primitive object relations. Preverbal defensive processes -- splitting, projective identification, and idealization -- revolve around what Klein called "internal objects" -- the infant's fantasied relation to parts of his parents' bodies (e.g., breast, penis). Although Klein's concept of internal objects (1946) derives from Freud's discussion of the relation between an introjected parental figure and the development of the super-ego as mental structure (Cooper, 1989), she assigned it

primary status in her metapsychology, and dated its origin to early life.

She distinguished between two major constellations of anxieties and related defenses, the paranoid-schizoid and depressive positions, which exist in dynamic relationship along a continuum of increasing integration. In the paranoid-schizoid position (Klein, 1946; Segal, 1964) primitive anxieties threaten the immature ego and trigger defenses. Klein believed that the individual is threatened by an innate destructiveness, based on the death instinct, which is projected into the object to create the prototype of a hostile object relationship (Steiner, 1994). At the same time, primitive sources of love, based on the life instinct, are projected to create a loving object relationship. Splitting, the main defense in this position, keeps apart these two types of good and bad object relationships, along with a corresponding split in the ego as either good or bad.The infant also experiences both self and objects in terms of body parts (breast, face) not yet integrated into a whole person.

Klein also described a depressive period in the infant's life. The depressive position (Klein, 1945, 1940; Segal, 1964) coincides with the recognition of whole objects. The infant sees that the frustrating breast is also the satisfying breast, with the result that both love and hate for the object (ambivalence) can be felt. This engenders the ego capacity to bring together good and bad (persecutory and idealized) experiences, and promotes an important shift in which concern for survival is supplanted by concern with the fate of the object upon which the individual depends (Steiner, 1994). As a result, loss and guilt can be experienced, ultimately enabling mourning to take place.

An important aspect of Klein's thinking is that her positions are constitutionally derived and developmentally normal. Klein (1946; Segal, 1964) underscored that

normal splitting in infancy is a vehicle for organizing chaotic experience and for allowing the nurturance of a good object relationship to develop free from attack by destructive impulses. Similarly, ambivalence in the depressive position is an expectable response in light of the child's struggle to accept his very real helplessness and dependency. Thus, defenses not only protected the ego from overwhelming feelings and sensations, but serve as "nondefensive organizing principles of infantile mental life" (Lerner & Lerner, 1990).

In the depressive position, the developmental achievement for the child is to learn how to tolerate guilt and anxiety for having harmed the person he loves. The full realization of the child's destructiveness establishes the need for a new defense -- the manic defenses -- to counteract the psychic pain.

> *In essence those defenses are directed against experiencing the psychic reality of the depressive pain, and their main characteristic is a denial of psychic reality. Dependence on the object and ambivalence are denied and the object is omnipotently controlled and treated with triumph and contempt so that the loss of the object shall not give rise to pain or guilt. Alternatively, or simultaneously, there may be a flight to the idealized internal object, denying any feeling of destruction or loss* (Segal, 1964).

Whereas Klein focused on the infant's depressive experience, Winnicott (1965) explored the effect of the depressed mother on the child. In his interpretation of manic defense, Winnicott believed that the liveliness of the child is used by the depressed mother to sustain or replace something missing in herself. As a result the child resorts to compliancy (to meet the mother's need) at the expense of sacrificing his own spontaneity. This compliancy becomes the basis for Winnicott's concept of the defensive personality organization of false self. Winnicott essentially shifts the emphasis from internalization of the object, as the primary organizing experience for

the child, to the capacity of the good-enough maternal environment to protect the child from his destructive id-impulses while simultaneously fostering his ego strength and self-integration.

Contemporary Psychoanalytic Views

Most contemporary theorists have adopted an integrative approach to defense that incorporates elements from instinct-based theory and object relations theory. Following Gedo and Goldberg (1973), Cooper (1989 p. 87) argues that, increasingly, theorists agree that "defenses arise due to "psychic disequilibrium," which can be caused "either by the inability for a drive to be gratified or discharged *or* an unsatisfactory or traumatic environmental situation" ((italic mine).

Two psychoanalysts, representing integrationalist views of defense, are Otto Kernberg, who describes pre-oedipal phenomena in an instinct-based ego psychological theory of defense and Arnold Modell, whose theory of defense accommodates both notions of instinct-defense and defenses against objects (Cooper, 1989) in a formulation that tries to capture the phenomenology of self-experience.

Kernberg (1975, 1983) speculated that both impulses and defenses find expression through affectively-imbued internalized object relations. He conceives of intrapsychic conflict as a form of character defense which takes place between two opposing sets of internalized object relations -- a defensive constellation of self and object representations directed against an opposite, anxiety-producing, repressed self and object representation (Cooper, 1989). His work has focused on borderline personality

organization, a particular type of personality organization characterized by the defense mechanism of splitting, and an inability to integrate positive and negative identifications and introjects.

Lerner & Lerner (1990) suggest that Kernberg's concept of character pathology relates levels of internalized object relations to types of defensive functioning.

> *According to Kernberg, internalized object relations are organized on the basis of specific defensive structures. As part of this model he systematically defines and coordinates the primitive defenses previously reported by Klein and clarifies the relationship between splitting and repression. He suggests that although splitting serves developmentally as a defensive precursor of repression, it continues to function pathologically in those patients who are pre-oedipally fixated, that is, in those individuals incapable of whole object relations or evocative object constancy.* (p. 144).

Thus, he has identified two levels of defensive organization associated with pre-oedipal (splitting) pathology and oedipal (repression) pathology. At the lower level, splitting is the critical defensive operation, in tandem with related defenses of denial, primitive idealization and devaluation, and projective identification. At the higher developmental level, repression supplants splitting and is accompanied by such defenses as intellectualization, undoing, rationalization, and higher forms of projection.

Arnold Modell's (1975, 1984) theoretical views of defense derive from the two-psychology perspective inherent in object relations of the British Middle School, most notably the work of Brierley (1937) and Winnicott (1965, 1971). Much of Modell's understanding of defense is based on Brierley (1937)'s contention that affects function as defenses against object ties:

> *The child is first concerned with objects only in relation to its own feelings and sensations but, as soon as feelings are firmly linked to objects, the process of instinct-defense becomes a process of*

> *defense against objects. The infant then tries to master its feelings by manipulating its object carriers* (Brierley, 1937, p. 51).

This idea, that "affects are the medium through which defenses against objects occur" (Modell, 1984), is related to a new understanding of conflict . "...I view disturbances of the self to be exquisitely conflictual," he writes, "but the conflict occurs between the self and the object; so that the context of defense is not intrapsychic but interpsychic" (p. 6).

Modell discovered the limitations of the intrapsychic concept of defense when working with narcissistic patients. He observed that these patients seem to exist in a "cocoon" of self-sufficiency using noncommunication of affects as a means of maintaining omnipotent control (1975).

> *This state of nonrelatedness is a defense, but it is not an intrapsychic defense: It is rather a defense that is protective of the fragility of the self with its illusion of self-sufficiency* (1984, p.2).

Here, Modell's defensive configuration of nonrelatedness draws upon Winnicott's (1965) notion of false self organization which derives from the caretakers' inability to provide emotional holding in formative years: "The child, attuned to this failure in parental function, prematurely falls back on the self through compensatorily determined, omnipotent fantasies." Although Modell critiques the psychoanalytic concept of internalized objects -- he says they exist as fantasies but cannot supplant or stand for actual object relations -- he does not advocate that the two person psychology replace traditional psychoanalytic views of structure formation and internalization. Instead, he argues for a complementarity to exist between the two schools of thought:

> *The self is both a psychic structure, colored by the process of*

> *internalization, and also an endopsychic perception, exquisitely dependent upon the immediacy of the response of the other* (1984, p. 22).

He maintains that defenses are organized against instinctual conflict as well as against object failure (Cooper, 1989). However, he places new emphasis on the role of the external world in the defensive process by asserting that defenses can be organized directly against a disturbing bit of reality, without reference to internal sources of anxiety or unpleasure.

With these various shifts in theoretical emphasis, the traditional drive-arousal -> defense -> compromise solution model has given way to a view of defense as emerging in and determined by early caregiver-infant interactions, and prompted interest in the mental representations in which these formative interactions are expressed. Defense was no longer seen simply a means of regulating instincts or powerful emotions, but as being intrinsic to the affectively charged distorted self and other representations that result from object relational or interpersonal pathology.

B. Coping: Social Cognitive approaches to Defense:

Psychoanalytic theories of defense mechanisms support the idea that defense is a distorting operation which shields the individual from unpleasant aspects of reality. Implicit in such a view is the idea that reality-testing constitutes a basic criterion of positive mental health (e.g., Haan, 1977; Menninger, 1963; Vaillant, 1977).

A contrary perspective is offered by researchers in social psychology and stress appraisal (Lazarus, 1966, 1983; Taylor, 1983), who have studied cognitive

adaptation to threatening events, and propose interesting theories about the benefits of illusion and self-deception.

Self-enhancing evaluations, for example, are frequently used as coping mechanisms by individuals in adverse situations such as medical crises (Taylor, 1983; Taylor & Brown, 1988). Illusions of control and unrealistic optimism have been associated with psychological adjustment in cancer patients (Wood, Taylor, and Lichtman, 1985). As Taylor (1983) points out, the clearest evidence for the benefits of illusions comes from research on the impact of depressive cognitions. In contrast to normal (non-depressed) subjects who tend to overestimate their control over positive outcomes, depressed people are more realistic in their assessments of self and others, and fail to derive pleasure from a heightened sense of confidence and well-being.

In their work on stress and cognitive appraisal, Lazarus & Folkman (1984) define coping as cognitive and behavioral efforts to manage stressful demands which are appraised as taxing or exceeding an individual's resources. In contrast to defense, which they conceptualize as a static, traitlike construct, coping is a process-oriented phenomenon, which takes stock of the specifics of the situation. Problem-focused coping predominates when environmental conditions seem amenable to change; emotion-focused coping predominates when the situation or event looks hopeless or too threatening (Folkman & Lazarus, 1980).

In a review of the role of denial-like coping processes in medical studies with both good and poor outcomes, Lazarus (1983) has found that denial can be a beneficial response in certain situations but damaging in others. Janis (1958, 1974; cited in

Lazarus, 1983) found that denial of threat (low fear) prior to surgery was related to higher distress during the recovery period, because patients had not anticipated or prepared themselves for post-surgical pain and discomfort. In a study of asthmatics (Staudenmeyer et al., 1979; cited in Lazarus, 1983), patients responded to early symptoms (e.g., difficulty breathing) either with vigilant, fearful responses or calm, denial responses, the latter of which were based on a belief the symptoms would naturally abate. Rehospitalization for asthma attacks over a six month period was far more frequent for the low-fear denying patients because, unlike the vigilant copers who took action quickly, they allowed the symptoms to worsen until they needed serious medical care.

On the other hand, studies of burn victims and paralytic polio patients suggest that denial of the severity of injury and its long-term behavioral consequences may help patients and their families better tolerate and adjust to a slow, difficult recovery and rehabilitation. Partial denial can also be beneficial -- patients with diabetes can deny the seriousness of the situation if they rigorously attend to diet, activity level, and insulin, indicating that they know they must take proactive steps to maintain their health (Lazarus & Folkman, 1984).

Such findings suggest that denial is adaptive when a situation does not warrant vigilant attention or when worrying has no clear benefits. However, when denial impedes direct and necessary action (e.g., delays in seeking medical attention for cardiac events), it can be harmful and lead to greater distress later on. In each case, the situational context is essential to assess the utility of a given coping strategy:

Coping as a concept is typically equated with adaptational success,

> *especially in the ego psychology models, wherein unsuccessful or less successful efforts to deal with stress are called defense. This results in a confounding of coping and its outcome. If progress is to be made in understanding the relationship between coping and outcome, that is, what helps or hurts the person and in what ways, coping must be viewed as efforts to manage stressful demands regardless of outcome. Accordingly , no strategy should be considered inherently better or worse than any other... Denial or denial-like behaviors, for example, may be adaptive in some sense in certain situations and/or at certain stages of an encounter* (Lazarus & Folkman, 1984, p.140).

Lazarus et al. (1984) view depression in a situational context, and challenge the unilateral formulation of learned helplessness in which depression is synonymous with "the failure to cope" (Abramson et al., 1978). Based on a drive-reinforcement learning paradigm, Abramson et al. argued that helpless passivity, which results from recognition that one's outcomes are not contingent upon one's behavior, generalizes eventually even to controllable or predictable situations. Lazarus et al. (1984) argue it is simplistic to assume that lack of contingency between effort and outcome, by itself, produces the belief in one's helplessness, since many individuals with negative experiences remain optimistic, whereas those with positive experiences can become depressed. More accurate is Abramson et al.'s revised view (1980), consistent with the concept of cognitive appraisal, that individuals construe events in part depending upon the extent to which they feel responsible for their outcomes.

> *...when a negative outcome is thought to be a product of the person's effort (internality), there will be a loss of self-esteem and a greater likelihood of depression than if the outcome is seen as the result of external factors* (Lazarus & Folkman, 1984, p. 202).

Thus, the use of denial in taxing or uncontrollable situations may not be related to depression, nor reflect a cognitive distorting process that is inherently maladaptive.

The tendency for depressed people to deceive themselves is integral to Beck's cognitive theory of depression (Kovacs & Beck, 1978). But others (Alloy et al., 1990; Coyne, 1976) argue that depressed individuals have painfully realistic ideas on how they are viewed -- hence the phrase, "depressive realism" (Mischel, 1979). Coyne & Gotlib (1983) have shown that depressed people accurately assess their negative affect on others, and are objectively aware of their lack of self-esteem. Such findings prompts one to speculate whether depression, rather than being a defensive operation, reflects a failure of defense.

C. Empirical Work on Hierarchical Models of Defense:

A different understanding of defense is reflected in the hierarchical construct. Hierarchical models of defense have been based on criteria such as: primary-secondary process (Wallerstein, 1967); chronological age (Lichtenberg & Slap, 1972, Vaillant, 1977); level of psychopathology (Menninger, 1963); and psychosexual development (Anthony, 1970; Gedo & Goldberg, 1973; Swanson, 1988). In general terms, the hierarchical notion of defense derives from attempts to explain individual differences in one's capacity to adjust to and tolerate unpleasant aspects of reality.

> *Over the years of the development of psychoanalytic clinical theory, a distinction emerged between the more archaic and the more mature defenses, the former characterized by the psychological avoidance or radical distortion of disturbing facts of life, and the latter involving more of an accommodation to reality.* (McWilliams, 1994, p. 27)

In ego psychological theory, what differentiates a lower level defense from a higher one is that the former negotiates the boundary between the self and the external world, whereas the higher level defense manages internal boundaries --between ego

and id, between ego and super ego, or between observing and experiencing parts of the ego (McWilliams, 1996). But a number of empirical investigators (Bond et al., 1983; Haan, 1963; 1977; Semrad et al., 1967, 1973; Vaillant, 1971, 1976) have also speculated that defenses exist along a continuum of cognitive maturity.

Haan: Coping and Defending

Haan (1977) 's model of coping was one of the first empirical attempts to measure defenses. Haan described three ego processes in a tripartite hierarchical arrangement: from coping to defending to fragmentation. In her taxonomy, there are ten generic dimensions, each with a mode of expression: (1) coping allows for choice; (2) defending is rigid and forced, and permits a narrower range of affective and cognitive responses; and (3) fragmenting, the third ego process, indicates serious psychopathology -- it is ritualistic, automatic, and irrationally expressed (Haan, 1977). Broadly speaking, defense and coping are both ego processes, but she equates coping with being a normative (adaptive, reality-oriented) mechanism, whereas defenses are inherently distorting and maladaptive.

In longitudinal research on a normative sample, the Oakland Growth Study, Haan (1963, 1977) found relationships between ego processes and intelligence, gender, and socioeconomic status. Although she rejected "the notion of strict developmental stages of defense, she maintained there are developmental phases "when special patterns of ego processes are more evolved or heavily used." She thought that the individual must attain a level of cognitive functioning before certain coping mechanisms can be used. For example, the coping process of objectivity requires a

capacity for abstract thinking. But she also pointed out that contextual and environmental factors (social, moral, affective) can impede a person from using an ego process consistent with his or her level of cognitive functioning.

Vaillant: a Defense Hierarchy (immature-mature)

Vaillant (1971) was an early empirical researcher who recognized the value of clarifying the diagnostic and prognostic implications of defense choice. He assesses defenses along the lines of maturity and psychopathology in an ego psychological framework that bears the influence of Anna Freud (1936) and Bibring et al. (1961). By operationalizing *defensive behavior*, as per Wallerstein (1985), Vaillant brought a new methodological rigor to the study of defense mechanisms. Defense mechanisms "cannot be directly visualized, but...they are appreciated by their systematic distortions of those events that we cannot see" (1971, p. 108). By cataloguing these different defensive styles, which he considered the external manifestations of defense mechanisms, Vaillant achieved consensually validated definitions of defenses.

Vaillant described 18 individual defenses, or defensive styles, in terms of four levels of maturity, ranging from primitive (immature) to mature. His hierarchy includes immature defenses (e.g., projection, acting out) which are most common before the age of five but appear in adult fantasy and dreams, as well as people with mental illness; intermediate defenses (e.g., repression, displacement, reaction-formation) which he has observed in both normal and neurotic adults; and mature defenses (humor, altruism) which he associates with healthy functioning adults (Snarey & Vaillant, 1985; Vaillant, 1976, 1977).

Vaillant first investigated his theoretical defense hierarchy in a 40-year prospective "Grant Study" of college sophomore "healthy" men, who completed elaborate questionnaires and psychological tests. Life narratives were also obtained from extensive interviews of these study subjects on how they handled significant life events (e.g., crises and conflicts) over this period of time. He found that depression and anxiety arise when sudden change or conflict creates a discrepancy between two of the following psychological domains: needs, external reality, conscience, and significant others on whom the subject in some way depends (1976). Effective use of unconscious defense mechanisms helps to mediate among these domains and minimize anxiety and depression.

In a replication of the Grant findings, Snarey and Vaillant (1985) explored defense use in economically disadvantaged urban boys, who were also followed over a 40-year period. Their findings support the hypothesis that defense styles evolve with maturity, and are correlated with successful life adjustment, and that, contrary to expectations, socioeconomic status did not predict adjustment. In general, studies show defense maturity relates positively to marital success, career choice, physical health, and psychopathology (Vaillant, 1971, 1976, 1977, 1986, 1991; Vaillant & Drake, 1985).

Vaillant (1986) concludes that defensive style is "an enduring fact of personality". His work demonstrates that conceptualizing psychopathology in terms of a cluster of defenses rather than a unitary diagnosis provides a better assessment of the degree of illness and potential for recovery in mental disorder. He argues that the clinical diagnosis of a patient is more often based on an identified defense and its adaptive

or maladaptive facets rather than on global deficit states. Vaillant's proposed hierarchy does not define the individual in terms of absolute health or sickness but rather allows a way of showing how recovery, including spontaneous remission, may be a consequence of a shift in adaptive style.

> *Nobody is absolutely healthy or sick, but how individuals maintain the dynamic balance amongst the conflicting elements of their personality will determine whether they are perceived as "sick" or "well." a hierarchical model of defense mechanisms renders this process comprehensible* (1976, p. 545).

Empirical support for Vaillant's hierarchical model comes from a number of investigators (Batttista, 1982; Bond et al., 1983, 1986; Andrews et al., 1993), who have also demonstrated that people who utilize mature (coping) mechanisms are happier, healthier, and enjoy more gratifying relationships than individuals who use immature (defending) mechanisms.

II. DEPRESSION AND DEFENSE

Depression is conceptualized here as an affect state, encompassing both normal and pathological responses, from transitory grief reactions to persistent mourning associated with a debilitating clinical disorder (Blatt, 1974; Blatt et al., 1990). The prevailing view among personality theorists is that depressed individuals possess a negative view of self characterized by feelings of profound inadequacy and pessimistic expectations, often self-fulfilling, of interpersonal failure and rejection

(Gotlib and Hammen, 1992). Depressive experiences are thought to be determined by negative life events in tandem with individual variables (e.g., low self-esteem; impaired object constancy; cognitive vulnerability), which affect one's response to significant events and situations.

Are depression and personality separate and distinct conditions (independence)? Do they share an aetiology (common cause)? Researchers have shown that there is a high incidence of Axis II disorders in chronically depressed samples (Koenigsberg et al., 1985; Kocsis et al., 1986; Markowitz et al., 1992), and that chronically depressed patients are at greater risk for character pathology than acutely depressed patients. Klein et al. (1988) found that early-onset dysthymics had higher levels of perceived stress, poorer global functioning, more negative traits and personality disorders than nonchronic major depressed patients, with the predominant axis II comorbidities in the anxious Cluster C category. Various studies report that, when compared with other axis I disorders, dysthymia is related to a higher rate of personality disorders, particularly borderline and avoidant disorders (Klein & Kelly, 1985). Finally, Klein et al. (1988) found an increased rate of personality disorders in relatives of dysthymic patients, which would challenge the prevailing view that their axis II problems are simply a consequence of having an early-onset depressive disorder. Clearly, all of these findings suggest the need to study in greater depth the role of personality factors in the pathophysiology, course, and treatment of depression.

The theoretical relationship between personality and depression is, of course, a longstanding one, beginning with early descriptions of the German phenomenologists, but has been obscured, in recent years, with the diagnostic emphasis on

dysthymia. As a construct, the depressive personality, though included in the standard international nosologic system (ICD-9), has never been endorsed by the American Diagnostic and Statistical Manual of Psychiatric Disorders (DSM). But the definitional narrowness of dysthymia and the need to account for depressed patients with characterological problems has led some to call for diagnostic inclusion of a depressive personality in the DSM.

> *It has seemed to many clinicians that there is a longstanding personality variant of depressive disorders that can characterize a person's attitudes, relationships, functioning, and self-image. As such, this disorder of personality (depressive personality disorder), which may be linked to axis I mood disorders, should be considered an affective spectrum disorder* (Gunderson et al., 1994, p. 1300).

A number of researchers have focused on possible interactions between depression and personality. Widiger (1993) identifies four interactional models:

- Personality can contribute to the development of depression (vulnerability)
- Personality can be altered by the occurrence of depression in the sense of postdepressive (postmorbid) personality traits (complication or scar)
- Personality and depression are not causally related but the presence of one can modify the presentation, course, or outcome of the other (pathoplasty)
- Personality and depression can represent overlapping manifestations of a common, underlying aetiology (spectrum).

Psychodynamic and psychological theorists have adopted a diathesis-stress (vulnerability) model, in which a specified condition, such as a personality variable, is seen as a risk factor for the development of depression. Cognitive models, for example, propose that negative beliefs or attributional styles serve as predisposing factors for depression. Psychiatric and biologically-oriented researchers, on the other hand, would include such personality features in the fourth (spectrum)

category, regarding them to be prodromal, subclinical, or attenuated manifestations of a common pathological process (in this case, an affective syndrome).

A. DSM Nosology: The emergence of Dysthymic Disorder

A lack of conceptual clarity concerning the role of personality in depression is evident in ongoing revisions of DSM nomenclature. Until the introduction of Dysthymic Disorder in 1980, a view of depression as a character pathology, consistent with psychoanalytic formulations, prevailed. In the DSM-I (1952), depressive reaction was characterized as one of the psychoneuroses. In the DSM-II (1968), depressive neurosis was subsumed under the general category of Neuroses.

The decision to classify depressive neurosis (now termed Dysthymic Disorder) as an Axis I affective disorder in DSM-III had important ramifications both for the conceptualization and the treatment of depression. It gave credence to the idea that all affective disorders have a biological basis (Philips et al., 1990), which fueled increased interest in pharmacological trials.

> *The changes in name and in category of assignment were in the spirit of DSM III's tendency to broaden the inclusiveness of the affective disorders section and reflected the notion that dysthymic disorder represents a mild, chronic form of depression on a spectrum with the more florid and acute manifestations of affective disorders. The creation of the category of dysthymic disorder was based on very little empirical evidence (as was the choice of its specific diagnostic criteria), but the new system had the virtue of attempting to distinguish chronic minor from acute major depression, and has stimulated research to determine the descriptive characteristics and treatment response of chronic depression* (Kocsis & Frances, 1987, p. 1534).

Although the authors of DSM-III retained, in parentheses, the term "depressive neurosis," and added to the manual a statement that affective features of dysthymia

can be "viewed as secondary to an underlying personality disorder" (cited in Phillips et al., 1990), these compromises did not mollify critics of the classification change, who claimed that dysthymic disorder suffered from "over-inclusiveness" and "extreme heterogeneity," problems only slightly diminished by new nosological refinements -- early v. late onset; primary v. secondary type -- to the DSM-III-R definition (APA, 1987).

B. The Depressive Personality: Early & Psychoanalytic Views

The notion of a depressive personality begins with the early German psychiatrists who linked mood disturbance to hereditary factors. Emil Kraepelin (1921) described a gloomy, guilt-ridden, joyless patient with a constitutionally-based "depressive temperament," which he considered a "rudiment" of manic-depressive insanity. This "peculiar form of psychic personality" was a mood disorder that could persist for periods of time, "shade into" melancholia, or, more seriously, lead to a florid manic-depressive episode, even psychotic depression.

Kraepelin's depressive temperament resembles what we now call a subclinical affective disorder (Askiskal, 1983), with the dysphoric personality characteristics (trait) reflecting a mild expression of a major affective disorder (state). This trait-state continuum view of mental illness was also supported by Kretschmer (1928) who thought that a hereditary depressive personality type, linked to body humors, represented a pre-psychotic state.

In contrast, Schneider's (1959) "depressive psychopathy" represents the first psychological characterization of depression in the psychiatric literature. Schneider emphasized the aetiological importance of neonatal and environmental influences on

depressive personality (Kocsis & Frances, 1987), but rejected a genetic link between depressive personality and major depression, maintaining that the gloomy, self-devaluing characteristics of depressed individuals were linked to normal personality traits and types rather than major affective disorders.

Psychoanalytic formulations of depressive character subscribe to a developmental view, with the emphasis on predisposing --oral (passive-aggressive) or anal (obsessive) -- personality traits. Abraham (1911/1985) introduced a new phase of libidinal development, oral-sadism, to account for the aggression and ambivalence observed in depressives. Depression has also been linked to masochism and self-defeating behaviors. Kernberg (1988) describes a depressive-masochistic personality, characterized by traits of superego pathology, overdependency, and retroflexed hostility.

More recently, empirical researchers from psychodynamic and cognitive-behavioral perspectives have identified two types of life experiences thought to contribute to people becoming depressed -- disrupted interpersonal relationships, which evoke fears of separation and loss, and threats to self-integrity, which elicit critical feelings of self-blame (Arieti & Bemporad, 1978; Beck, 1983; Bowlby, 1969, 1977, 1980; Blatt, Quinlan et al., 1992, Blatt & Zuroff, 1992). Drawing on this work, Andrews (1989) proposes there is a depressive personality prototype --a "self-effacing personality style" which comprises self-blaming and dependent subtypes. Within psychiatric circles, diagnostic inclusion of depressive personality continues to be a matter of debate (Phillips et al., 1990; Gunderson et al., 1994). As we shall see, within psychiatric circles, the construct of depressive personality holds considerable appeal (Gunderson et al., 1994; Phillips et al., 1990).

C. Dysthymia -- Axis I or Axis I

Dysthymia is classified as a mood disorder in the DSM-IV. But, to some extent, the controversy concerning the DSM-III introduction of dysthymic disorder persists. Early critics argued that dysthymia, though clearly a depressive condition, shared more key characteristics -- early onset and a pernicious, often lifelong course -- with a traitlike personality disorder than a mood disturbance. Today, the Axis I/II issue still provokes questions: (1) Is dysthymia distinct from major depression, or does it represent a phase of a single process? (2) Should dysthymia be classified as a personality disorder? (3) Is a depressive personality construct necessary or valid?

Dysthymia and Major Depression

The recent DSM-IV field trial on mood disorders found that 79% of subjects (n = 191) meeting criteria for DSM-III-R dysthymia had a lifetime history of major depression. High comorbidity rates have also been found in studies of dysthymic and major depressed inpatients, outpatients, children, adolescents, and adults (see Klein & Kelly, 1993 for a review). Studies on familial transmission report high rates of mood disorders in the first degree relatives of dysthymic patients equal to or higher than in the relatives of patients with major depression (Klein et al., 1988). And biological markers for major depression, such as shortened rapid eye movement latencies, have been observed in some dysthymic groups (Akiskal, 1983). Finally, Horwath et al. (1992) found that dysthymic patients with no prior history of major depression had a 5.5 greater chance of experiencing an acute episode during a one-year study period. These findings have led researchers to conclude that dysthymia and major depression are part of a single process, with the primary difference being

only qualitative -- in mode (abruptness) of onset and severity -- and, therefore, that ample justification exists to retain dysthymia as an axis I mood disorder.

Dysthymia as Axis II?

The high comobidity between personality disorders and dysthymia lends support to the view that chronic mild depression is equivalent to a personality disorder. Both are enduring conditions with an early onset and debilitating effects on psychosocial functioning that suggest a stable, traitlike underlying construct. The presence of shared characteristics (e.g., dependent traits) as well as poor medication response in some dysthymic subtypes (Akiskal, 1983) and personality disorders (Zuckerman et al., 1980; Charney et al., 1981; Pfohl et al.,1984; Markowitz, 1996), is also evidence for their overlap.

Empirical support for a possible role of personality factors in the expression of chronic mild depression comes from Akiskal's researches in the late 1970s and early 1980s.

> *The basic premise of Akiskal's model is that personality characteristics in certain subgroups represent milder or alternative expressions of a basic and biogenetically determined affective illness process* (Klein et al., 1993, p. 13).

In a series of papers, Akiskal identified two depressive subtypes, "subaffective disorder" and "character-spectrum disorder" on the basis of the responses of patients initially diagnosed with depressive neurosis (as per DSM II) to open trials of antidepressants.

Akiskal (1983) maintained that the subaffective patients were characterized by Schneiderian depressive personality traits -- gloominess, pessimism, passivity -- yet

responded well to antidepressants. In addition they showed a family history of mood disorders and shortened REM latency. He distinguished this subtype from character-spectrum disordered patients, who showed a preponderance of unstable traits associated with Cluster B disorders and sociopathic personality traits, early object loss, and normal REM latency, as well as poor medication response. Akiskal argued that their dysphoria was secondary to chronic characterological problems derived from unstable developmental histories (e.g., parents with sociopathic traits or nonaffective personality disorders).

Akiskal initially proposed that his subaffective dysthymia was the true axis I dysthymic disorder, but later amended this view (1989), arguing that it constitutes a form of depressive personality, an earlier-onset counterpart of dysthymia, which belongs on axis II. He proposed that the definition of axis I dysthymia be narrowed to denote a more symptomatic and later-onset disorder (Phillips et al., 1990).

Those who subscribe to dysthymia as a mood disorder argue that the axis II comorbidity (particularly avoidant symptoms) reflect the effects of mood on personality, and that, at any rate, the overlap between groups of dysthymic and depressive personality patients is lower than expected -- only 30% (Klein & Kelly, 1993). Moreover, significant differences between groups have been reported (e.g., higher percentage of males, milder depressive symptoms, less nonbipolar disorder in relatives for the depressive personality subjects).

Depressive personality

Phillips et al. (1990) describe depressive personality as an enduring type of character or temperament associated with early onset, subjective distress, and stable

cross-situational traits lasting for long periods of time regardless of symptomatic state. As empirical support for depressive personality, they cite Akiskal's work on an affective, non-drug-responsive depressive personality on axis II.

One reason for the need for a depressive personality as a diagnostic category is the failure of the dysthymia diagnosis to encompass patients with clear depressive character traits, including those who lack sufficient symptoms to meet criteria for a clinical disorder. The DSM-III-R diagnosis was heavily weighted towards the somatic and neuro-vegetative symptoms, at the expense of affective symptoms (Kocsis & Frances, 1987), a weakness the DSM-IV tried to address by adding a new criterion that depressive symptoms must "cause clinically significant distress" or impairment in social and other areas of functioning" (APA 1994). But there are larger conceptual and nosological questions as well that bear on how we define personality disorders, and how they are separate from axis I syndromes. As Phillips et al. (1990) suggest, the concept of depressive personality -- both the psychoanalytic view of a developmentally determined depressive character and the German concept of an inherited depressive temperament (an attenuated form of major depression) -- is compatible with our view of personality disorders, "as multidetermined conditions with biological, psychological, and social determinants." The depressive personality may in fact be a distinct subtype whose symptoms are chronically associated with temperamentally determined dysfunctional personality traits (Klein & Kelly, 1993).

> *A common misperception is that axis I disorders are exclusively biogenetic and axis II disorders psychodevelopmental in origin. A more realistic model that may apply to the depressive personality is that of "spectrum" disorders...It may be that [an] affective spectrum exists between major depression and dysthymia on axis I and an*

> *early-onset, trait-like axis II counterpart* (Phillips et al., 1990, p. 835).

Phillips et al. (1990) also argue that dysthymia and depressive personality can and should be differentiated in a clinically meaningful way:

> *The depressive personality should ...be, by definition, more trait-like than state-like--i.e. more stable, durable, and resistant to change across situations and time than the symptoms arising from a state such as dysthymia.*

The implications for treatment outcome are consequently significant:

> *It would follow that any medication-induced change in the depressive personality should not be rapid or dramatic, as this would be a more state-dependent psychopathology than is appropriate for categorization as a personality type. Similarly, such a change should not dramatically affect all domains of the disorder--i.e., behaviors, relationships, cognitions, and self-concept--as this would imply a single-factor etiology, which is unlikely to pertain to a personality disorder* (pp. 835-6).

By this argument, the patients recruited for this study -- all diagnosed with DSM-III-R dysthymia -- should show rapid response to medication, but substantially less progress or substantially slower progress on measures that assess for significant personality change, such as defense mechanism use.

An aim of this study is to ask, then, whether dysthymia and depressive personality are such indistinct conditions, and whether positive changes on multiple levels of functioning, including self-concept and defense mechanism use can be demonstrated in this population over a relatively short (16 weeks) treatment. At the same time, I expect that positive changes will be most evident in patients receiving both medication and a form of therapeutic intervention. Patients treated only with medication are not expected to show higher rates of change than their combined medication/therapy treated counterparts.

One might also argue that significant change or good outcome on multiple measures -- symptomatology, self-concept, as well as defense functioning -- in the medication-only dysthymia patients would be consistent with the kinds of changes to be expected only with a stable, traitlike construct such as depressive personality, and therefore casts doubt on the distinctiveness of these two Axis I and II forms of depression.

Such questions have led me to conclude that research on defense functioning in dysthymic patients, as well as the strong theoretical and empirical tradition linking personality factors and chronic depression, is an important and underinvestigated area for study.

D. Defensive processes in Depression

When Freud proposed in 1917 that the loss of an ambivalently-loved object (individual), followed by a defensive response of turning anger inward, led to melancholia, he captured the essence of depressive despair (1917/1968):

> *The distinguishing mental features of melancholia are a profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterances in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment* (p. 51).

Freud's original understanding of depression, embedded in his theory of neurotic conflict as repressed libido, with its emphasis on oral fixation and incorporation fantasies, has been subsequently modified. But introjection -- as an explanatory internalization mechanism for how aggression turned round on the self becomes experienced as despair -- still retains heuristic appeal.

1. Introjection

The theme of introjection as a defense against loss, including loss of self-esteem, has had a long precedent in psychoanalytic writings on depression (Abraham, 1911; Arieti & Bemporad, 1978; Bibring, 1953; Fenichel, 1945; Freud, 1917; Gaylin, 1968; Jacobson, 1971; Rado, 1928). Knight (1940) described introjection as the "unconscious inclusion of an object or part of an object into the ego of the subject." Fenichel (1945) viewed it as "an attempt to make parts of the external world flow into the ego. " Introjection is a defense because it protects against separation anxiety. But Freud also viewed it as an identificatory process which, during the course of development, facilitates the capacity to be autonomous. It is the introjection of parental standards that fosters ego formation and becomes the basis for conscience mechanisms (super-ego) in the developing personality (Freud, 1917/1968). What is taken into the self-representation is not always saluatory, of course; introjection also allows into the self "the sense of badness that comes from painful experiences with the object" (McWilliams, 1994, p. 233). In depression, this frequently entails the unconscious internalization of the lost object's most hateful qualities.

Freud (1917/1968) thought that self-devaluation, associated with loss of a loved object, sets depression apart from ordinary mourning. Although the normal grieving person is free to withdraw his emotional attachment (libidinal cathexis) from the object, the melancholic, immersed in the act of castigating himself while brooding over his loss, is unable to do so. His self-attacks, however, are directed not at the

self but at the lost object, with whom the melancholic individual has become narcissistically identified:

> *If one listens patiently to the many and varied self-accusations of the melancholic, one cannot in the end avoid the impression that often the most violent of these are hardly at all applicable to the patient himself but that with insignificant modifications they do fit someone else, some person whom the patient loves or ought to love...so we get the key to the clinical picture. We perceive that the self-reproaches are reproaches against a loved object which have been shifted away from it onto the person's own ego..*

Freud (1917/1968) viewed narcissistic identification as an early (oral) developmental phase -- a very primitive mode of relating (between autoeroticism and object love) to which the melancholic person regresses during a depressive episode. Such identification "has the trappings of self-love" (Gaylin, 1968), but the cathexes (libidinal energy) are actually invested in the introjected object, which, once taken within, becomes confused with the self.

> *Thus the shadow of the object fell upon the ego, and the latter could henceforth be judged by a special agency, as though it were an object, the forsaken object. In this way an object-loss could be formed into an ego-loss and the conflict between the ego and the loved person into a cleavage between the critical activity of the ego and the ego as altered by identification* (Freud, 1917/1968, p. 58).

The introjected object --now "the ego as altered by identification" -- is attacked by the critical part of the ego (forerunner of the super-ego). It is this subsequent split in the ego (into sadistic attacker and a receptive part identified with the object) which is experienced as "a conflict between one part of the ego and its self-criticizing faculty" (Freud, 1917/1968), and which results in a sense of diminished self-esteem.

In Freud's account, melancholia is a pathological compromise formation resulting from (real or fantasied) loss. With the introduction of the tripartite personality theory

(1923), the notion of introjection in depression evolved from the simple idea of incorporating an external object (or its image) to encompassing more complex relations between the personality substructures, ego and super-ego (Freud, 1926).

> *In melancholia it seems as if the main emphasis of the personality has been shifted from the ego to the superego. The patient's conscience represents his total personality; the ego altered by the introjection is the mere object of this conscience and is entirely subdued by it* (Fenichel (1945).

Whereas previously the self-punishing behavior of the depressed patient serves to punish the abandoning love figure, now there is an "internal instrument for self-punishment" in the form of an incorporated, critical parent in the structure of the superego (Gaylin, 1968). As Fenichel (1945/1968) puts it, "the superego treats the ego in the same way that the patient unconsciously had wished to treat the object that was lost" (p. 126), and, consequently, becomes its surrogate.

Since Freud first wrote about the "disturbance in self-regard" in melancholia (1917/1968), the construct of self-esteem, and its role in superego pathology, became increasingly central in psychoanalytic theories of depression (see Andrews, 1989). Rado (1928), Fenichel (1945), Bibring (1953), and Jacobson (1971) have all argued that what is lost in depression is not necessarily a loved person but a sense of narcissistic integrity.

Fenichel (1945/1968), countering Freud's belief that lowered self-esteem was the *product* of depression (triggered by object loss), asserted that depression *is* the loss of self-esteem, and, further, that self-esteem regulation is contingent upon the ego's relation to the super-ego.

> *In the phenomenology of depression, a greater or lesser loss of self-*

> *esteem is in the foreground. The subjective formula is: 'I have lost everything; now the world is empty,' if the loss is mainly due to a loss of external supplies, or 'I have lost everything because I do not deserve anything,' if it is mainly due to a loss of internal supplies from the superego* (p. 115).

Fenichel described the depressed patient as a "love addict" who exists in "perpetual greediness," and is fixated on the need for narcissistic supplies from others to bolster his self-esteem. Initially, the gratification of the young child's oral needs (hunger, etc), is achieved through nourishment provided by the mother, and it is this gratification that serves as the "first regulator" of the child's self-esteem.

Subsequently, the child derives self-esteem from "narcissistic supplies" in the form of love and affection: *The small child loses self-esteem when he loses love, and attains it when he regains love* (Fenichel, 1945).

Later still, the superego functions as the primary source and regulator of narcissistic supplies, such that "every feeling of guilt lowers self-esteem,"while "every fulfilment of ideal raises it." Guilt derives mainly from forcing the love object into providing needed narcissistic supplies. But Fenichel locates the root of depression more in the loss of superego support than in punishment. And, further, he maintains that it is not simply the loss of a loved one that produces depression, but the loss of a person in whom one has invested feelings of worth and value (Gaylin, 1968):

> *What we are mourning is our lost self-esteem, the love object being merely symbolic of it (p. 17).*

With diminished self-esteem in depression assuming more prominence in aetiological considerations, subsequent theorists reformulated the role of defensive processes. Bibring (1953) and Jacobson (1954, 1971), in particular, abandoned the

traditional view of defense as a mechanism for coping with object loss for a view of defense as helping to regulate perceived discrepancies between actual and desired selves.

Working within an ego psychological framework, Bibring (1953/1968) made self-esteem the *cause* of depression, but rejected the idea that its regulation is contingent upon the ego-superego relationship. He maintained that depression is purely an ego phenomenon -- a basic human response to one's helplessness that is aggravated by a profound disappointment in being unable to live up to important ideals.

> *...depression is primarily not determined by a conflict between the ego on the one hand and the id, or the superego, or the environment on the other hand, but stems primarily from a tension within the ego itself, from an inner-systemic 'conflict.' Thus depression can be defined as the emotional correlate of a partial or complete collapse of the self-esteem of the ego, since it feels unable to live up to its aspirations* (Bibring, 1953/1968).

In conceptualizing depression as a basic, non-reducible affective state, Bibring equated it with anxiety. But whereas anxiety is a response to expected danger (survival mechanism), depression denotes an ego paralysis, the failure to meet and contend with danger, and respond effectively to frustrations beyond the ego's control.

Previous psychoanalytic theorists attributed the helplessness observed in depression to an oral fixation characterized by elevated dependency needs. But Bibring argued that there are other forms of helplessness which correspond to different developmental stages (Blatt et al., 1990). Depression can derive from helplessness related to the failure to achieve "anal" aspirations or goals (such as the mastery over one's body or one's impulses, which leads to feeling dirty and

unworthy) as well as "phallic" ones (such as competitive strivings and desire for success, leading to feeling defeated or punished), and does not simply encompass the fear of not being loved.

> *... everything that lowers or paralyzes the ego's self-esteem without changing the narcissistically important aims represents a condition of depression...the subsequent results will be the same: the individual will regressively react with the feeling of powerlessness and helplessness with regard to his loneliness, isolation, weakness, inferiority, evilness or guilt.* (Bibring, 1953/1968, pp. 177-8).

Conceptualizing the traumatic impact of loss in the context of superego pathology led early psychoanalysts to speculate that depression was intrinsically reparative. The whole depressive process is "an attempt at reparation, intended to restore the self-esteem that has been damaged" (Fenichel, 1945/1968). Similarly, Rado (1928) saw depression as a form of expiation for guilt at manipulating affections from a coveted love object. He interpreted the self-abusive behavior of depressed individuals as the result of super-ego punishing ego, with the punishment serving as atonement (Gaylin, 1968).

In Bibring's ego psychological formulation, depressive symptoms are not reparative. Rather the depressed person's "attempts at reparation" represent a natural emotional reaction to depression, or loss of self-esteem, in the context of profound life disappointments.

> *[I]f depression is a simple, basic experiential state like anxiety, it is to be expected that individuals may form certain defenses against it or even that it may serve a useful purpose (again, like anxiety) when experienced in mild forms. Therefore the symptoms of depression itself are not reparative (as postulated by Rado and others), but other symptoms in reaction to depression may well be so* (Arieti & Bemporad, 1978, p. 32).

In this view, defense against the depressive affect is only mobilized when the ego's

"recovery mechanisms" fail, and tends to find expression in the form of apathy or hypomania (Bibring, 1953/1968). Apathy is the consequence of "a blocking of the depressive emotion," and can lead to mechanisms of depersonalization in chronically depressed individuals. Hypomania, on the other hand, constitutes a reaction formation to depression, usually combined with a denial of the causes of depression (Bibring, 1953/1968).

Edith Jacobson (1954, 1964, 1971) also underscored depression as a pathology of self-esteem, but her approach, which attempts to integrate drive formulations with object relations theories, contrasts sharply with Bibring's intrasystemic perspective.

Depression, in her view, emerges in the context of an aggressive cathexis of the self-representation; a primitive, poorly differentiated super-ego; and object representations still fused with childhood parental ideals (Arieti & Bemporad, 1973). Specifically, loss of self-esteem in depression arises from a rupture between the self-representation (internalized self-image) and the wished-for self, which is characterized by exceedingly high expectations and ideals.

Jacobson's developmental model draws on Hartmann's distinction between ego (an abstraction referring to a personality substructure) and self (which represents the total person). She equates self-representation with the individual's internal self-image, and speculated that both self- and object relationships are cathected by libidinal or aggressive energy. Positive self-esteem thus denoted a libidinally cathected self representation; low self-esteem an aggressively cathected self-representation (1971).

According to Jacobson (1954, 1964), our self-image is initially unstable. Derived

from sensations barely distinguishable in infancy from perceptions of the gratifying part-object (breast), it is experienced as fused (and confused) with object-images (Mendelson, 1974). Under normal supportive circumstances, the infant develops a stable self-image and clearly differentiated boundaries between self and others. But overgratification postpones boundary establishment and intense frustration and disappointment result in a devaluement of parental objects which yields an aggressive cathexis of object and self-images generating feelings of inferiority and self-disparagement (Mendelson, 1974). Depression of this type is not the product of abandonment or deprivation but, rather, hostile or ambivalent parent-child relationships, which engender subjective feelings of doubt, guilt, hypervigilance, and self-criticism.

It is this discrepancy between the devalued self (now fused with the image of a hostile parental object) and the idealized (e.g., perfect) self that results in depressive symptomatology and diminished self-esteem.

> *For Jacobson the basic conflict in all affective disorders is as follows: When frustration is encountered, rage is aroused and leads to hostile attempts to gain the desired gratification. However, if the ego is unable (for external or internal reasons) to achieve this goal, aggression is turned to the self image. The depressed individual may then defensively try to fuse with an omnipotent object (mania) or turn to a new object to replenish libidinal supplies in order to raise self-esteem* (Arieti & Bemporad, 1978, p. 30)

Whereas Jacobson (1971) characterized depression as a symptom resulting from defensive operations (Milrod, 1988), in which parental devaluement leads to turning against the self, Gaylin (1968) has argued

that it is the breakdown of the function of symptom formation that aggravates depression.

> *Symptoms are the attempts of the individual to compromise his way out of a conflict situation. They are the reparative maneuvers and manipulations of the threatened ego. In depression, however, the distinguishing feature is the paucity of such maneuvers. The "symptoms" are the non-symptoms of passivity, inactivity, resignation, and despair. Here the reparative mechanisms are at a minimum.*

Unlike the phobic who finds solace through the defense mechanisms of avoidance and displacement, the depressed patient has no illusion. Paradoxically, his one recourse is to use dependency (a non-defense) as a survival mechanism in such a way that "the very stripping of one's defenses becomes a form of defensive maneuver" (Gaylin, 1968).

Contemporary views of depression posit that defenses do not cause depressive symptoms, although the effectiveness or adaptability of defensive responses may influence the course of symptoms (Perry, 1994). In this view, similar to Bibring's (1953), defenses constitute important variables that mediate the relationship between life stressors and episodes of affective disorders.

2. Theories of Mental Representation -- Schema, Internal Working Models, Self-Representation

Loss -- loss of meaning, loss of something of value to one's self-concept -- is also a central idea in cognitive-interpersonal formulations of depression (Gotlib &

Hammen, 1992):

> *[T]he key psychological ingredient determining whether someone will experience depression following a negative event is the appraisal of the meaning of the event as signaling loss of self-worth, a belief that something essential for one's experience of being valued has been lost with no means of replacing it (p. 149).*

As with later psychoanalytic formulations (Bibring, 1953; Jacobson, 1971), it is not the actual event of loss per se that is so distressing but its mental representation -- what it means in terms of one's conception of self.

Increasingly, theorists from diverse orientations, rely on psychological meaning structures as a means of understanding cognitive-affective processes in personality development and psychopathology (see Westen, 1991 for a review). These hypothetical structures -- schemas (Beck, 1983; Sandler & Rosenblatt, 1962), self-representations (Jacobson, 1954); person schemas (Horowitz, 1972, 1988a), object representations (Blatt & Lerner, 1983; Kernberg); internal working models (Bowlby, 1977,1980) -- function as organizers of thoughts and feelings about self and others, and, as such, provide a framework for finding links between defense and depression. Horowitz (1988) argues that defense is an unconscious aspect of information organization at the schematic level, and thus critical to understanding conscious regulation of feeling and thought. Westen (1991) demonstrates how conflictual representations in working memory (e.g., self as "alcoholic" vs. self as "good mother") can lead to defensive distortion (and compromise schemas) to minimize disturbing discrepancies in an individual's self-concept.

A defense mechanism is a form of thought, a mental operation which protects against unacceptable (ego-dystonic) ideas. It organizes reality to make it more congruent with one's view of self, other, and the world. Similarly, a schema

(Bartlett, 1932; Piaget, 1926) is an organizing construct, a stored body of knowledge that influences the way we take in, understand, and use new information.

Self-schema, a term first used by psychoanalysts Sandler and Rosenblatt (1962) in their study of the representational world, is the central construct in Beck's (1983) cognitive theory of depression. Blatt and colleagues (Blatt, 1990; Blatt & Ford, 1994) describe mental representations as "cognitive-affective schemas," by which he means "the conscious and unconscious mental schema...that evolve out of significant interpersonal encounters." (p.6). It is the internalization of caring experiences that results in the construction of self and other representations, and for which impairments reflect critical disruptions in the caregiver-child relationship (Blatt, 1990).

Empirical support for the enduring influence of representational structures on interpersonal functioning also comes from the attachment investigators (Bowlby, 1980; Bretherton, 1995; Main et al., 1985), and more recently, developmental psychopathologists (Sroufe, 1988; Cicchetti & Schneider-Rosen, 1988; Cicchetti & Toth, 1995), who assert that inadequate "internal working models" resulting from insecure attachments can lead to psychopathological conditions, including depressive disorders.

E. Empirical approaches to Depression and Defense

As we shall see in the work of four empirical investigators, constructs of introjection and schema processing enter into studies of depression and defense. Beck relies predominantly on a cognitive understanding of the schema construct;

Blatt formulates introjection in part as a representational process that results in the formation of cognitive-affective schemas; Horowitz uses the schema construct to elucidate interpersonal role conflict and the formation of maladaptive mental states; and Bowlby identifies a biologically-wired representational operation called the internal working model, which is also rooted in theories of schematic processing.

A) Beck's Depressogenic Schemata

Beck (1967, 1983)'s cognitive theory of depression asserts that a pervasively nihilistic view of self, the world, and the future, which he termed the "negative cognitive triad," is the most salient psychological symptom of depressed patients. The "altered thinking" observed in depressed individuals (Kovacs & Beck, 1978) is also expressed in cognitive distortions (idiosyncratic meaning) and systematic errors in logic (arbitrary inference; magnification; overgeneralizing). In particular, depressed patients view failure experiences in a self-referential negatively-biased manner (Kovacs & Beck, 1978).

Beck maintained that self-evaluations are generated by underlying knowledge structures -- self-schemas. Early negative circumstances in childhood (e.g., loss, deprivation, death of an important person) lead to the formation of an organized collection of maladaptive thoughts about the self -- depressogenic schemas -- which in later life may be triggered, consciously or unconsciously, by experiences analogous to the earlier events. It is the negative content of the individual's self-view -- the persistent belief that he or she cannot control events -- that determines the individual's vulnerability to depression in the face of social adversity (Segal & Muran, 1993).

Rooted in theories of cognitive psychology and information-processing (Bartlett, 1932; Piaget, 1954; Neisser, 1967; Shank & Abelson, 1977), Beck's schema model emphasizes how control over attention and the information that manages to filter through, constitutes a defensive operation. He draws on the work of Neisser (1967), for example, who defines schemata as representations of prior experience that facilitate recall and focus attention. Much of this selective control, it is thought, pertains to the processing of self-related information contained in social experience (Markus, 1977 see also Segal & Muran, 1993). Markus & Nurius (1986), working in social cognition, have introduced the notion of self-schemas representing "possible selves" -- what an individual thinks he or she might become, might like to become, or fears becoming. "Possible selves," as guiding constructs which generate self-enhancing behaviors, bear resemblance to Jacobson's (1971) idealized self-images, and their protective role in regulating self-esteem. It suggests that motivational factors, intrinsic to psychodynamic formulations of super-ego formation and self-esteem regulation, are receiving more prominence in cognitive approaches.

Cognitive theorists view depressogenic schemas as stable, traitlike cognitive structures. Reviewing experimental support for an underlying self-structure in Beck's theory, Segal (1988) argues that a construct accessibility or availability theory may explain the persistence of pathological schemas. The more a schema is activated, the more easily it is made available, or accessed.

> *Since, by definition, depressed individuals are in a chronic state of negative mood activation, negative self constructs will come to mind more easily than will positive or neutral alternatives, even when they may be available in memory. More frequent activation of these negative constructs makes it easier for them to be activated*

> *in future instances and thus to continue their potential domination over fresh or disconfirming information in the person's mind* (Segal & Muran, 1993, p. 139).

Depressed people do recall more negative than positive information, and show longer latencies in recalling pleasant memories. But these recall biases tend to normalize following recovery from a depressive episode (Gotlib & Hammen, 1992). An ongoing challenge for cognitive depression researchers is to tap underlying schemas not confounded by dysphoric mood, especially in light of the limited utility of assessing depressogenic schemas using self-report methodologies (see Introduction to this thesis; also, Segal, 1988).

More recently, priming has been introduced as a way of eliciting latent schemas. Depressive self-schemas are understood in the context of a vulnerability model in which an environmental trigger activates the cognitive structure in order to guide information processing. Priming is thought to "unlock" or "unfreeze" elements of a self-representation which, in the absence of an adverse precipitating event, has remained unaccessed (Segal & Muran, 1993).

Priming may also be a more viable means of tapping the complex layering of self-schemas. In a variant on the personality self-system (Sullivan, 1953), Markus (1990) proposed that self-schemas encompass multiple self representations (e.g., good me, bad me, not me, actual me), a formulation that emphasizes affective and interpersonal processes in the formation of self-concept, and is not dissimilar to Horowitz's more dynamic notion of self-schemas. The willingness to explore affect in depression, in particular, is important given the tendency for cognitive theorists to dismiss mood as a confounding variable in schema assessment (Blatt & Bers, 1993).

Moreover, recognition of affective dimensions of the self-schema, and its relation to interpersonal action, is necessary to tap contents less available to consciousness due to defensive operations.

In an effort to capture more complex, ecologically valid self-representations, Muran et al. (1991) has proposed a narrative-based measure of self-description to activate latent depressogenic self-schemas. Self-scenarios are idiographically constructed vignettes of optimal and distressing events in the depressed patients lives. Their content establishes a highly self-referent context -- "best case" and "worst case" scenarios -- which are thought to prime the patient's recognition of habitual optimal and bad modes of responding (Segal & Muran, 1993). As a means of activating bad (depressogenic) self-representations, it is an extension of the theoretical framework that links actual-ideal self discrepancies to loss of self-esteem and depressive affect (Bibring, 1953; Jacobson, 1971).

The clinical utility of this narrative procedure (self-scenarios), though still being tested empirically, is based in part on the assumption that stable cognitions operating automatically (out of awareness) are less influenced by mood. Unlike inventory-based and adjective-based methodologies, they allow the patient to participate more actively in generating the assessment stimuli and thus present a broader picture of schematic activity (Segal & Muran, 1993).

Self-scenarios tap cognitive and affective dimensions of depressive experience, and are among the new cognitive methodologies that attempt to illuminate problems in intimacy and relatedness that previous cognitive studies of self-representation have been unable to investigate. As a priming procedure, self-scenarios are akin to "projective" test methods (e.g., the Thematic Apperception Test) which also use

stimulus situations to activate schemas (Bers & Blatt, 1993), and represent another convergence in psychodynamic and cognitive approaches to depression assessment.

In recent years, the traditional cognitive therapy approach to depression has been modified in response to the prevalence of refractory (difficult-to-treat) patients. The emphasis on everyday negative cognitions has yielded to greater focus on core maladaptive assumptions originating in early experience. Increasingly, cognitive therapists acknowledge the utility of illuminating the psychological impact of attachment pathology and problems in separation-individuation on the formation of self (Gotlib & Hammen, 1992).

Beck's model has been faulted for overemphasizing the cognitive dimensions of depression at the expense of unconscious motivational and affective processes. Safran & Segal (1990) have tried to redress this deficiency by introducing the concept of the cognitive-interpersonal schema. Such schemas, which stress affective, motoric as well as cognitive dimensions, provide a framework for understanding cycles of maladaptive social interaction, and their perpetuation by systematic cognitive errors and distortions in thinking. Interpersonal schemas are similar to internal working models (IWM; Bowlby, 1969; 1976;1980) in that both derive from generalized cognitive representations of self-other relationships, but their pervasiveness is attributed to the influence of negative life events and does not encompass the developmental or motivational perspectives of psychodynamic and attachment formulations.

B) Horowitz: Pathological mourning, person schemas and defensive controls

Mardi Horowitz's (1988, 1994) psychotherapy research integrates cognitive theories of schema formation and information processing with psychodynamic theories of defense. Although his focus is not on clinical depression per se, he has studied a state of mind, which he refers to as "pathological mourning," that bears phenomenological resemblance to a depressive condition, but a primary interest appears to be in coping strategies ("control processes") following traumatic stress (Horowitz, 1986).

Defense, in Horowitz's view, is accomplished through the activation of self and person schemas (Horowitz, 1988; Paulhus et al., 1997). He describes the self-schema as "a view of the self whose conscious representation is not necessarily available but persists unconsciously to organize inner mental processes" (p. 29). Horowitz draws on multiple schema forms (motivational, relational, body, superordinate, partial) to understand the cognitive and dynamic aspects of the patient's object representations, and how they factor in various mental states.

> *...individuals have multiple images of self and others, as well as multiple images of typical interactions, termed 'role relationship models.' One method of defense is to change the image or schema that is currently active, which in turn controls those specific aspects of self and other that are currently perceived (Paulhus et al., 1997, p. 555).*

His work emphasizes two types of phenomena associated with unconscious conflict -- "intrusions" and "omissions." Both are disruptions to the flow of ordinary conscious awareness -- either "*intrusions* of the unexpected" or "*omissions* of the representations expected from conscious awareness" (1988, p.7) -- which attempt to mediate between prohibited wishes and defensive aims. More recently, he and colleagues have started to examine these unconscious control processes in study of

single subjects in therapeutic settings (Paulhus et al., 1997).

C) Bowlby: Internal Working Model (IWM)

Bowlby's (1969, 1978, 1980) seminal contribution to attachment theory was to explain the catastrophic consequences of premature separation and maternal deprivation in young children. Mourning and depression are the child's response to loss of the loved parent, through actual separation or emotional neglect.

Bowlby's work postulated that human infants possess an innate, biologically-determined propensity to maintain close proximity to their principal caregiver. A sensitive, reliable caregiver provides a "secure base" enabling the child to freely explore the world while feeling confident she is valued and loved. In a repudiation of Freud's energic, pleasure-seeking model, Bowlby argued that humans are motivated to seek attachment (in the form of an emotional bond) rather than pleasure, and that healthy psychological adjustment is the product of a dynamic balance between attachment and self-exploration (Bretherton,1995).

Repeated transactions with attachment figures lead the infant to develop reasonable expectations about future interactions and relationships with significant others (Bowlby,1980). These patterns of interactions become represented in stable mental structures, or internal working models (IWM). In particular, patterns of insecure attachment, such as anxious-avoidant (preoccupied) attachment styles, lead to depression (Bowlby, 1980; Sroufe, 1988).

Ideally, IWM are thought to be flexible, adaptive structures which "accommodate" to change in the Piagetian sense. Failure to revise one's view of the world after a

significant life event or change puts an individual at risk for pathology (Bowlby, 1980; Bretherton, 1995). Defensive exclusion is his term for someone who fails to revise an IWM by blocking anxiety-provoking or guilt-arousing information from awareness. As Bretherton (1995) notes, cognitive research shows that information processing is always selective, undergoing multiple stages of analysis and synthesis prior to reaching awareness (see Erdelyi, 1974):

> *Building on these findings, Bowlby (1980) argues that defensive exclusion of perpetual stimuli and remembered information from awareness should be viewed as a special case of selective exclusion, though with a different aim. Whereas the aim of selective processing is to extract/retrain the most relevant/salient aspects of incoming and remembered information, the aim of defensive processing is to protect an individual from experiencing unbearable mental pain, confusion, or conflict by altering the inner world rather than coping with the exigencies of the external world* (Bretherton, 1995, pp 237-8).

It is this altering of the inner world -- to avoid mental pain and to maintain an affective bond -- that distinguishes IWM from the cognitive schema that Beck describes. Although IWM are evolving structures which predict future attachment relationships, they lack the rich, detailed complexity of analytic constructs because they are based on generalized expectations (prototypes) of caretaker interactions (Diamond & Blatt, 1994), and fail to incorporate an understanding of developmental sequence of enactive, imagistic, and symbolic modes of representation (Horowitz, 199 ; Diamond & Blatt, 1994).

Bowlby does not deny defense mechanisms exist but he does avoid labeling defensive behavior. He seems to suggest that phenomena attributed to psychoanalytic defense mechanisms (e.g., projection), and traditionally thought to be pathogenic responses, could alternatively be viewed as comprehensible

misattributions due to a patient's attempts to make sense of the world as he or she has experienced it or has been told to experience it.

D) Blatt: Introjective and Anaclitic Depression (Depressive subtypes)

Blatt's developmental model conceptualizes depression as impairments in object relations (1974) which hinder the capacity to sustain stable emotional contact with important objects. Influenced by Piaget's work on cognitive development and particularly the concept of object permanence, Blatt (1974, 1990) has introduced an understanding of cognitive-affective schemas that correspond to different levels of object relatedness and personality organization. Piaget's cognitive schemata begin as sensorimotor preoperations in infancy and gradually evolve over successive developmental stages into complex mental activities, such as symbol formation and abstract reasoning. In the early sensorimotor stages, the child lacks any representational capacity, and can only use a primitive form of signification. Blatt (1995) places Piaget's formulations into interpersonal terms:

- *Boundary constancy* (2-3 months - smiling behavior, initiating engagement)
- *Recognition (libidinal) constancy* (6-8 months - stranger anxiety)
- *Evocative constancy* (16-18 months - sense of object not immediately present in perceptual field)
- *Self and object constancy* (30-36 months - stable concepts of self and others, as expressed in use of "me," "I," and "mine.")

At approximately age 5 or 6 the child develops new cognitive capacities:

- *Concrete operational thought*- (age 5 - triadic configurations;"we" concept)
- *Formal operational thought* (ages 11-12 - personal and cultural relativism)

- *Self identity* (late adolescence - capacity to be intimate without losing one's individuality; fuller sense of "we" or "self-in-relation")
- *Integrity* (mature adulthood - continued development of above).

In Blatt's (1974;1990) developmental scheme of depression, the impairment in achieving self or object constancy reflects problems with the capacity to differentiate self from others.

> *Once basic boundary differentiation has been established between self and nonself, and inside and outside, then the developmental task is to establish object and self representations, which become increasingly articulated, diverse, integrated, symbolic, and constant... It is these later stages of object representations which are relevant to an understanding of depression* (1974, p. 108).

At this critical juncture in the child's life, two developmental lines emerge --self-definition and interpersonal relatedness. Although broadly portrayed as personality configurations, Blatt links problems of interpersonal relatedness and self-definition to "anaclitic" and "introjective" depression, or subtypes of depressive personalities, respectively.

> *Anaclitic depression is characterized by fears of abandonment and desperate struggles to maintain physical contact with the need-gratifying object. Introjective depression, in contrast, is characterized by feelings of worthlessness, guilt, and a sense of having failed to live up to expectations and standards. There are fears of a loss of approval, recognition, and love for the object* (Blatt, 1974).

In theoretical support of his subtypes, Blatt draws on Grinker (1961) who identified two independent factors of depression --one based on feelings of guilt, the other

based on deprivation -- in a descriptive study of clinically depressed patients, and Schmale's (1971) distinction between helplessness and hopelessness as two types of depressive affect. All impairments in object representations, regardless of depressive subtype, entail an effort by the individual to maintain contact with the object, either directly or through an intensification of introjection (Blatt, 1974). The capacity to fully experience loss of the object (mourning) is contingent upon the establishment of adequate levels of representation through the process of internalization in which the Oedipus complex is resolved and infantile object choices, such as a nurturing mother figure, are ultimately relinquished (Blatt, 1974).

As an empirical measure of his theory of depressive subtypes, Blatt et al. (1976) developed the Depressive Experiences Questionnaire (DEQ) which measures qualities of self-criticalness, dependency, and efficacy in depressed patients. He found a significant correlation between conceptual level of object representation and developmental level of depression, as measured by the DEQ, supporting his distinction between a dependent, immature anaclitic depression and a more developmentally mature introjective depression.

Anaclitic and introjective personality configurations have been associated with the use of different defense mechanisms (Blatt & Shichman, 1983; Cramer et al., 1988). Anaclitic defenses are avoidance maneuvers (denial, repression, displacement), designed to maintain interpersonal relations, while neglecting the development of the self. Introjective defenses (projection, externalization) are designed to protect and guard the self at the expense of maintaining satisfying interpersonal relationships. Anaclitic depression is comparable to anxious-ambivalent patterns of attachment whereas introjective depression is comparable to avoidant patterns of attachment

(Diamond & Blatt, 1994).

Finally, the two types of depressive personality are characterized by different modes of representation, ranging from sensorimotor, perceptual, iconic, and conceptual (Piaget) or enactive, imagistic and lexical (Horowitz, 1972). Blatt, Wain et al. (1979) found that parental descriptions characterized by sensorimotor operations are found in anaclitic depressives, whereas external iconic modes are associated with introjective depressives.

Blatt's developmental theory argues that loss, or perceptions of loss, can be experienced without the risk of acute or prolonged depression once the individual attains stable, integrated, symbolic self and object representations. In cognitive theory, however, the depressed individual remains vulnerable to adverse life situations if the negatively biased cognitions triggering the depressive affect have not been eradicated (Kovacs & Beck, 1978). To the extent that defenses distort an individual's perception of reality or capacity to sustain a consolidated self-concept, he or she will remain vulnerable to depressive recurrence.

In a contribution to depression research, Blatt and colleagues' have claimed that some treatment effects are linked more to patient variables than the treatment process itself. They have proposed that patient characteristics -- specifically anaclitic and introjective personality configurations -- can be significant outcome predictors in clinical treatment.

In studies of seriously disturbed patients undergoing long-term, intensive, psychodynamically oriented inpatient treatment, Blatt (Blatt & Ford, 1994; Blatt et al.,

1988) has found that introjective patients change more readily along cognitive dimensions (decline in thought disorder on the Rorschach; elevated intelligence test scores) and measures of symptom improvement, whereas change for anaclitic patients is more gradual and is reflected in the quality of interpersonal relationships (based on clinical reports, representations of the human figure on the Rorschach). Overall improvement of introjective patients on various psychological and behavioral assessments was significantly greater than that of anaclitic patients (Blatt & Ford, 1994; Blatt et al., 1988).

Blatt has also studied the impact of these personality distinctions in a re-analysis of The National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP; Elkin et al., 1989), a large, multisite study of brief treatments of major depression. The NIMH TDCRP found no difference in treatment efficacy for three different forms of active treatment compared over 16 weeks: Interpersonal therapy (IPT), cognitive behavioral therapy (CBT) and imipramine plus clinical management (IMI-CM), in addition to placebo with clinical management (PLA-CM). No one psychotherapy was found to be more effective than the other, nor less effective when compared to the medication plus management modality (Elkin et al., 1989).

Drawing on the work of Sotsky et al., whose (1991) reanalysis of the NIMH TDCRP data found that (1) better social functioning at intake on a subscale of the Social Adjustment Scale (SAS; Weissman & Paykel, 1974) predicted a favorable outcome particularly in IPT, whereas (2) total lower score on the Dysfunctional Attitude Scale (DAS; Weissman & Beck, 1978) predicted favorable outcome especially in CBT and IMI-CM), Blatt et al. (1995) used the DAS, an inventory which

taps typical depressogenic attitudes, to determine whether introjective and anaclitic patient characteristics predict response to therapeutic interventions.

Blatt et al. (1995) found that the DAS factors, Perfectionism, a personality dimension highly congruent with the introjective (Self-Critical) depressive subtype of the DEQ (Blatt et al, 1976), but not Need for Approval, the dimension associated with the anaclitic (Dependent) depressive subtype, significantly predicted negative outcome in all treatment conditions.

Introjective patients are concerned with problems of self-definition and self-worth. They tend to be more emotionally and socially isolated than anaclitic patients, for whom maintaining the relationship bond is paramount. This isolation, in tandem with a predilection for counteractive defenses, makes it difficult for the introjective patient to establish an affective therapeutic alliance, which can lead to good therapeutic outcome (Blatt et al., 1993).

Although Blatt has concluded introjective patients do poorly in brief forms of treatment, they appear to respond well to long-term intensive, and psychoanalytically oriented inpatient treatment (Blatt et al., 1988; Blatt, 1992). Given enough time to form an alliance with the therapist, these patients apparently have the resources to effectively utilize it. Subsequent research will be conducted to see whether a high prevalence of personality disorders in this perfectionistic patient subset contributed to the negative outcome of introjective patients in brief therapy.

It is important to point out that Blatt uses the introjective and anaclitic personality configurations to subsume a wide range of diagnostic categories. The 15 month treatment studies in which introjective patients fared so well (Blatt et al., 1988) involved schizophrenic and borderline young adult patients, and has not been replicated with major depressives. Nor, to my knowledge, has Blatt or his colleagues examined the response of dysthymic patients (anaclitic or introjective) to long-term or brief courses of therapy treatment.

III. DEFENSE AND THE TAT

Early investigators studying defense mechanisms sought to establish an empirical framework for identifying defense mechanisms. Since that time, the emphasis has turned to refinement of specific methodologies.

Projective tests have always provided a rich data source for studying defense mechanisms, as well as an important means of operationalizing psychoanalytic concepts. Much of this research was devoted to developing Rorschach measures of defense (Blatt et al., 1976; Lerner and Lerner, 1982; Schafer, 1954). But a number of theorists have specifically discussed defense use in the Thematic Apperception Test (Rapaport, 1959; Gill, and Schafer, 1946; Henry, 1956; Bellak, 1975), and various investigators have tried to establish explicit criteria for measuring defenses on projective stories including the TAT (see: Dias, 1976; Holzman, 1966; Shapiro & Rosenwald, 1975; Bush, Hatcher, and Mayman, 1969). In recent work not focused

specifically on defense mechanisms, Westen (1989) has applied an object relations measure on the TAT to successfully differentiate major depressives from borderline patients.

As a storytelling task, the TAT is well-suited for eliciting defensive functioning because it uses emotionally evocative social stimuli to activate unconscious schemata and requires the production of a spontaneous narrative, which can be anxiety-provoking and self-revealing.

> *Because defense mechanisms are rather complex mental processes, they are more likely to be revealed in relatively extended samples of thought, as compared to questionnaires that allow only a yes-no, or true-false response. The open-ended nature of the TAT story affords the opportunity for content to be expressed in a variety of forms, without restrictions on style and length. This unhampered verbal production gives us a window into discovering the thought processes of the individual, including the working of defense mechanisms* (Cramer, 1996, p.87).

A. Methods of assessing Defense: Self-report, Clinical judgment, and Projective tests

The main methodological approaches to defense rely on three data sources: Clinical judgement; the patient's self-report; and projective testing. A review of all the different available instruments is beyond the scope of this study (see Cramer 1991 and Paulhus et al., 1997 for two comprehensive compilations). Only the more widely used defense measures --particularly those instruments used in empirical studies of depressed patients -- will be described here.

Of the self-report instruments, the Defense Mechanisms Inventory (DMI, Gleser & Ihilevich, 1969; Ihilevich & Gleser, 1986) is the most thoroughly investigated

(Cramer, 1991). The DMI is a fixed-choice paper and pencil instrument which elicits the subject's responses to 10 conflict situations scenarios. Subjects are asked to select their least and most likely responses to these threatening situations in terms of how they would characterize their actual behavior, affect, thought, and fantasy behavior. The DMI contains five defense clusters (1) Turning Against the Self [TAS]; (2) Turning Against the Object [TAO]; (3) Projection [PRO]; (4) Reversal [REV], which includes denial, and (5) Principalization [PRN] which includes rationalization, isolation, and intellectualization.

Findings from a number of studies (see Cramer, 1991) indicate that the Reversal is the only scale to show a consistent relationship to its criterion measures (e.g., denial, avoidance). Men tend to score higher on TAO (Turning against the Object, whereas women are more likely to score higher on TAS (Turning Against the Subject). In a number of samples, men also scored higher on PRO (Projection) than women. In a study of male alcoholics (O'Leary et al., 1977), high pre-therapy scores on REV was positively associated with the patients' ability to complete a year of treatment; whereas high TAO scores were related to rehospitalization. A similar study of alcoholics conducted by Hague et al. (1976) found no relationship between DMI and therapy outcome after a 2-month treatment period. A positive relationship between TAS and depression has been found in two large samples (Gleser & Ihilevich, 1969); it has also been found to be a sex-linked defense, occurring more frequently in women, and especially women and men with a feminine orientation, as assessed by the BEM Sex Role Inventory (Evans, 1982; see Gleser & Ihilevich, 1969). Problems with the instrument are considerable item overlap among the scales, which suggests either that the items have poor content validity or that defense clusters interrelate,

and perhaps represent a single defense continuum (Cramer, 1991).

Defense Style Questionnaire (DSQ, Bond et al. 1983).

The DSQ, a self-administered 81-item questionnaire of self-perception of defensive style, was devised as a means of measuring defense mechanisms through self-appraisals of conscious derivatives (Bond et al., 1983). Although this instrument does not tap unconscious defense mechanisms, Bond contended that individuals can be aware of their protective thoughts, feelings, and actions, and that the groups of defensive or coping operations, which the DSQ measures, reveal an individual's characteristic manner of dealing with conflict. As a self-rated method, the DSQ avoids the common problem of having to establish inter-rater reliability because it does not rely on an outside rater's subjective judgment.

The original DSQ consisted of 4 factors (24 defense scales) which represented different levels of maturity of a developmental continuum, ranging from immature, image-distorting, self-sacrificing. More mature defenses in the DSQ were related to increasing ego strength and higher levels of ego development (Cramer, 1991). Bond's (1983)'s original DSQ has been modified by Andrews et al. (1989) into a 72-item questionnaire corresponding to the defense mechanisms included in the DSM-III-R. Andrews et. al (1989), from a study of 142 psychiatric outpatients , 67 patients consulting their physician, and 204 normal controls, found 3 Factors -- Immature coping (Factor 1, a combination of Bond's Factors 1 and 2); Neurotic coping (Factor 2); and Mature coping (Factor 3).

Self-report instruments have the advantage of potentially enhanced reliability since

they do not rely on observer judgement. But they have the disadvantage of accessing only conscious derivatives of defenses (Skodol & Perry, 1993).

Clinical judgement

Early investigators such as Haan, Bellak and Vaillant used psychiatric interviews and autobiographical reports to assess defense mechanisms. Vaillant combined questionnaire and interview data in longitudinal research of 268 male college undergraduates.

Semrad et al.'s (1973) 45-item Ego Profile Scale measures nine types of ego defense functioning. The scales, based on clinical interviews of psychiatric patients, consists of 8 factors: Factor 1 is a combination of hypochondriasis and somatization scales; the others are projection, denial, dissociation, neurasthenia, compulsion, anxiety alert, and dissociation. In a 13-week study of a young schizophrenic girl, Semrad et al 1973) found that a decrease in the patient's reliance on primitive defenses such as projection and distortion, and an increase in more mature defenses, such as hypochondriasis and dissociation, coincided with her shift from an acute psychotic episode to a state of recovery.

The Defense Mechanism Rating Scale (DMRS, Perry & Cooper, 1989)

A number of empirical studies have used the DMRS (Perry & Cooper, 1989; Bloch et al., 1993), a clinician-rated scale assessing patient use of 30 defenses in videotaped clinical interviews. THE DMRS groups defense mechanisms into levels of maturity or adaptability which correspond to *immature* (minor denial, projection, hypochondriasis, passive-aggression, acting-out, and schizoid fantasy); *image-*

distorting (splitting, denial, projective identification, idealization, omnipotence, and devaluation); *neurotic* (repression, dissociation, displacement, reaction formation, isolation, intellectualization, rationalization, and undoing), and *mature* (affiliation, anticipation, suppression, self-observation, self-assertion, humor, altruism, sublimation) defenses. The investigators also defined summary defense scales, on the basis of conceptual relatedness, which consist of, in descending order of maturity, *obsessional* (isolation, intellectualization, and undoing), *narcissistic* (omnipotence, idealization, devaluation), *disavowal* (projection, denial, rationalization), *borderline* (splitting and projective identification), and *action* (acting-out, passive aggression, and hypochondriasis).

Pilot work using the DMRS, as shall be reported later, has focused on defenses of subjects with borderline personality disorder, antisocial personality disorder, and Bipolar II disorder (Perry & Cooper, 1989; Perry, 1994), as well as DSM-III-R dysthymic patients (Bloch et al., 1993).

The advantage of using unstructured or semi-structured interview format is that patients provide rich, spontaneous samples of thought processes. But Cramer (1991) suggests there are limitations to post-hoc judgements made by clinician-raters, who must decide when a defense, and which one, was used. Additionally, a potential confound with the interviewing method of assessing defense structure is the inability to control for an interviewer's particular style. For example, the style endorsed for the DMRS is explicitly confrontational in order to elicit as many defense mechanisms as possible (Bloch et al., 1993).

B. Cramer's Defense Mechanisms Manual (DMM)

Cramer's impetus for examining defense mechanisms in adult and clinical populations stems from her interest in children's use of defenses as part of normal development. She conceptualizes Denial, Projection, and Identification as representing different ego capacities for more differentiated, integrated, and increasingly complex thinking.

Denial protects through the withdrawal of attention (perceptual denial), physical avoidance of aversive stimuli, or through the use of fantasy (A. Freud, 1936). In its simplest terms, denial is described as "not seeing" -- by avoiding, distorting, or refusing to accept some unwanted aspect of self. Denial evolved out of a physiological withdrawal system (the state of sleep) and retains roots in perceptual processes (literally not seeing), initially expressed in behaviors such as blinking and averting one's head. Denial appears in more complex behaviors, such as playacting and daydreams, and constitutes a necessary and normal stage in early childhood development (A. Freud, 1936).

Projection entails putting unacceptable parts of self into others. It represents a form of seeing what is not there. It is considered to be more mature than denial because it requires the capacity to differentiate between internal and external stimuli, together with the capacity to make judgments about what is acceptable or unacceptable.

Identification is the adaptation of other to self, or self to other, either in defensive ways, such as taking in the positive attributes of another into one's self-concept or

ego ideal. Successful identification is the most mature defense because it involves the capacity to use new information leading to a modification within the ego (Cramer, 1991), a mechanism related to Piaget's notion of accommodation in schema formation.

For all defense mechanisms there are both adaptive and maladaptive components. Denial involves avoidance and selectivity. Projection involves elimination and empathy -- dual operations that involve joining with and separating from the other. In Cramer's model, identification can be defensive (avoidance of anxiety or loss of self-esteem) or developmental (leading to ego growth, self-differentiation, and development of conscience).

Cramer (1991)'s developmental hypothesis regarding defense mechanisms draws support from Piaget's (1929, 1954) theory of cognitive development which proposes that children go through predictable stages in intellectual growth, from an early form of sensori-motor intelligence that evolves into abstract and symbolic reasoning.

Research on children's comprehension of different defense mechanisms documents that they undergo a chronological progression in their capacity to use defense mechanisms, (Whiteman, 1967; Chandler et al., 1978; Dollinger & McGuire, 1981), with denial used more in early childhood, projection in later childhood and preadolescence, and identification use beginning in childhood but intensifying in adolescence.

In a study examining children's comprehension of social causality in children, and their capacity to comprehend types of parental defense, Chandler et al. (1978)

explored the connection between level of cognitive-operational competence and ability to interpret defensive transformations (defined as operations that alter an affectively-charged interpersonal interaction):

> *... all interchanges involve...[a]n author of subject (s) [who] initiates an impulse or affect (a) toward a particular target or object (o). Under circumstances of defense, this subject-affect-object complex is experienced as personally unacceptable and is subjected to some transformation which serves to negate the complex in whole or part* (Chandler et al., 1978).

Chandler et al. (1978) found support for the Piagetian idea that reversibility of thought (evident in negation) is a defining feature of operational thought. Preoperational children in their study lacked the skills to interpret any kind of defensive transformation.

Chandler et al. (1978) also found that children competent in concrete operations understood defenses involving simple inverse operations (e.g., denial - "I'm not angry") or reciprocal operations (e.g., turning against the self, "You are mad at me"). But formal operational children could decipher complex defenses involving 2nd order transformations such as projection ("I am angry at you because you are angry at me"), supporting Piaget's idea that children at the level of concrete operations could not yet comprehend propositional logic. The investigators also found that the capacity to look beyond immediate circumstances for explanations in remote (distal) events is a developmental phenomenon observed in children who have achieved concrete and formal levels of operational thinking.

Developmental changes in cognitive competence and self-awareness may facilitate our understanding of depression in children, especially how they experience and express emotion and utilize defensive operations. Theories of crossgenerational

transfer of psychopathology, from genetic and learning theory accounts, suggest that children imitate and recreate the dysfunctional actions and behaviors of their parents (Chandler et al., 1978). But the child's response to, or ability to use, types of parental defense depend on whether the complexity of defensive operation exceeds his or her ability to comprehend it.

C. Studies of DMM and the TAT

The DMM is a diagnostic assessment tool designed to measure the developmental level of defense. Research studies using the DMM have been conducted in children (Cramer, 1983, 1988, 1990), adolescents and their mothers (Brody & Layton, unpublished manuscript), college students (Cramer, in press), as well as psychiatric patients (Cramer et al., 1988, Cramer & Blatt, 1990).

Scores on the DMM relate to assessments of level of ego development, autonomy, object relationships, and self-reported fears (see Cramer, 1991). Decline in overall defense use is associated with reduction in psychiatric symptoms (Cramer, Blatt, 1990).

Testing the theory that defense functions help maintain self-esteem, Cramer studied the use of defense mechanisms in elementary school-age children in a marble rollway game, a test of sensorimotor coordination. One group of children were told their efforts had been successful and were rewarded; another group was informed they had failed. TAT stories were collected before and following the experiment.

As expected, the children who were told they had failed were more likely to use defenses associated with their age (Denial and Projection). The successful children showed an increase in the use of Identification, a mature defense mechanism for

school-age children (Cramer, 1996).

In another study, to assess whether defense use is associated with decreased psychological distress, adolescent males exposed to a traumatic event (a lightning strike which resulted in a fatality of one boy) were administered modified TAT cards depicting lightning scenes. The boys whose stories scored highest for total number of defenses, as well as the highest scores for age-appropriate projection, showed the least disturbance.

Cramer (1983, 1987) has found gender differences in use of defense mechanisms, with Denial used more frequently by women and Projection used more frequently by men that showed an expected adherence to sex-role stereotypes in which women use withdrawal as a response to upsetting events, whereas men use more externalizing forms of behavior to cope with the disturbance or stress.

The DMM has also been investigated in psychiatric populations. Cramer et al. (1988) investigated the use of defense mechanism in 90 hospitalized psychiatric young adult patients previously judged to have primarily an anaclitic or introjective personality organization. All patients (45 women, 45 men) were evaluated 6 weeks after hospital admission for changes in the use of denial, projection, and identification, along with psychiatric symptoms and other measures of interpersonal behavior. The authors expected that the anaclitic patients would show a greater use of denial whereas the introjective patients would be more likely to use projection, and some components of identification.

Drawing on Vaillant's (1971) developmental hierarchy of defenses, they hypothesized that the patients using the more primitive defense mechanism (denial)

would also show greater degrees of pathology, whereas the least pathologically disturbed patients in the sample would mainly rely on the mature defense of identification. In administering the TAT, the investigators selected three TAT cards (Cards 1, 14, and 13MF), and summed the defense scores for each patient across the three stories.

Contrary to expectations, there were no significant differences between the anaclitic and introjective groups in terms of defense use, although in each group patients functioning at the lowest level tended to use the lower-level defenses. Within the anaclitic patient group (n = 42), impaired functioning was positively related to the use of denial and negatively related to the use of identification. In particular, high scores on denial was positively related to psychological immaturity, poor interpersonal relationships, and a Rorschach measure of thought disorder. But the anaclitic patients also showed a surprisingly high score on identification.

The introjective patients, on the other hand, showed greater use of denial and lower use of identification than expected, with no significant correlations between defense scores and measures of interpersonal relations. Cramer et al. (1988) speculated that, in light of the severity of disturbance in this population, a more primitive form of identification (incorporation) was possibly being tapped in the anaclitic patients. Similarly, the high use of denial in the introjective group suggests these patients are on the lower end of the introjective personality spectrum and thus more apt to rely on avoidant defenses such as denial or reversal, which is a component of denial (Blatt & Schichman, 1983). Cramer et al. (1988) concluded that the developmental model of defense use may not directly apply in acutely disturbed patients. If disturbed patients do use more primitive types of identification (e.g.

incorporation), presumably a decline in the use of this defense mechanism would result from a successful course of therapy, and be associated with independent assessments of improved psychological functioning (Cramer et al., 1988). However, one limitation in the DMM model is its inability to capture through scoring the use of developmentally lower or higher level components within a given defense mechanism.

Cramer and Blatt (1990) reexamined this patient population after they had received 15 months of intensive individual psychodynamic psychotherapy, and found a significant decline in the overall use of defense mechanisms, especially in the introjective patients, which was positively related to a significant decline in psychiatric symptoms. In addition, they found that patients with "sex-incongruent" personality configurations (e.g., anaclitic men) used defenses (e.g., denial) more associated with the opposite sex (Cramer, 1983).

In general, patients with a sex-incongruent diagnosis (anaclitic men; introjective women) had higher defense scores. The prevalence of denial in anaclitic men or projection in introjective women reported by Cramer et al., 1988 is not surprising, since one would expect that someone with a predominantly dependent personality would prefer an avoidant response to a challenging one. A more interesting result was found with the use of identification.

For sex-incongruent patients who underwent the 15 months of treatment, a *decrease* in identification (a mature defense mechanism) was associated with improved interpersonal relationships. Whereas the opposite phenomenon (increased use of identification was positively related to interpersonal improvement) held true for the sex-congruent patients. Again, this finding raises an important question as to

whether a high use of identification with more disturbed patients taps a mature defensive phenomenon or a more primitive identificatory process (Cramer, 1991). The intention underlying the identificatory process is significant. Cramer et al.'s (1988) study does not examine whether the identifications of sex-incongruent patients supported or countered their sex incongruency. One could ask, did the TAT narratives of sex-incongruent individuals (e.g., anaclitic men) show a desire to emulate supportive, nurturant male figures, or men more self-directed in their actions? Although a relationship between men and introjective personalities and projective defenses has been found, as has a relationship between women with anaclitic personalities and avoidant tendencies, the precise nature of the role of identification with disturbed individuals who deviate from standard sex-linked personality configurations or defense profiles remains difficult to interpret when no empirical studies have demonstrated precisely how *non-disturbed* sex incongruent individuals use identification, either adaptively or defensively. It will be interesting to see if Cramer et al's (1988) pattern of identification manifests in sex-incongruent chronically depressed patients.

Validation of Cramer's DMM has been provided by Hibbard et al. (1994), who compared responses of young patients on an acute psychiatric ward of a VA hospital with college undergraduate controls and found that the psychiatric patients used more primitive type defenses (denial and projection), as well as less identification.

Denial, Projection, and Identification in the context of Depression

In this study, the role of the defense mechanisms of denial, projection, and identification in depression can be conceptualized in several ways. First, denial,

projection and identification can represent aspects of selective or distorting cognitive processes (e.g., schema, defensive exclusion, omission) that perpetuate biased assumptions about the self.

Secondly, denial, projection and identification can be seen as operations that help to maintain different states or levels of object relatedness. Avoidant defenses (e.g., denial) may support an anaclitic attachment, whereas counteractive defenses (e.g., projection) maintain a sense of self-containment and autonomy associated with introjective depressive organization.

Thirdly, one can view denial, projection and identification as attempts to maintain a balance or equilibrium between actual and desired (ideal) selves (Jacobson, 1971). One can argue that one cannot achieve a balance with the use of either denial or projection -- denial because it negates the presence of an actual negative or unwanted self, and projection because it attributes the unwanted elements to an external other. Only identification, through the different component mechanisms of taking on attributes or finding affiliation through sharing, encompasses the awareness that what is actual and what is ideal may be separate. As Cramer (1991) notes:

> *The process of identification contains a certain paradox. This process, in which attributes of the mother are taken over and become part of the child's own ego, not only result in the differentiation of the self from the (m)other, but at the same time preserves the (m)other, both emotionally and cognitively, within the self. Thus, identification allows the child to give up the mother and move towards autonomy while serving as an ego defense against anxiety associated with the loss of mother or other dangers to the ego* (p. 98).

IV. THERAPEUTIC TREATMENT OF CHRONIC DEPRESSION

Surprising little empirical research exists on defense use in chronically depressed patients. This may be due to the paucity of systematic, controlled research on psychotherapy for chronic depression, which in turn, is a result of an increasing recognition of the efficacy of antidepressant medication for dysthymic patients.

A. Overview of Therapeutic Approaches

Clinical research on psychotherapy of depression has focused on individual treatments of *acute* (unipolar) depression. Controlled psychotherapy studies of chronic depression are relatively rare, even though dysthymia is a more insidious, refractory illness than major depression, with a possibly poorer response to both medication and psychotherapy (Markowitz, 1994).

As with major depression, the primary treatment goal in most individual therapy of chronic depression is symptom reduction (alleviation of depressed mood), achieved either by addressing faulty information processing or problematic social interactions. Below is a brief description of the main psychotherapy treatments for depression: cognitive therapy and interpersonal therapy, followed by descriptions of group therapy and combined treatment approaches for chronic depression.

Cognitive therapy (CT):

CT is the best studied psychological intervention for depression, and efficacy in treating major depression has been demonstrated in clinical trials (e.g., Elkin, 1989). CT theorists contend that depression results from and is maintained by erroneous beliefs and maladaptive belief systems (or schemas) and distorted information-

processing (Beck, 1967). CT alleviates depressive symptomatology by helping patients systematically evaluate the accuracy and usefulness of their thoughts and perceptions. Reports of mostly brief individual cognitive behavioral therapies of dysthymia (Harpin et al., 1982; Stravynski et al., 1991; McCullough, 1991), using cognitive reframing, psychoeducation, or social competence training, suggest patients respond to this approach, evidenced by reduced symptomatology on depression with response roughly equivalent to response for controlled antidepressant trials (Markowitz, 1994).

Interpersonal therapy (IPT):

An effective short-term individual interpersonal therapy has been developed for acutely depressed outpatients (Klerman et al., 1984; Elkin et al., 1989). In IPT, patients learn links between mood disorder and interpersonal functioning. Depression is explained as a medical illness, with patients adopting "the sick role" while dealing with role transition, grief, and loss. Markowitz (1994) documents evidence in a case series for the efficacy of time-limited IPT in the treatment of a small number dysthymic patients previously nonresponsive to an antidepressant trial, and two HIV-seropositive patients with lifelong depression who experienced symptom reduction despite the stress of HIV infection.

Group therapy of chronic depression:

The efficacy of group therapy for chronically depressed patients is poorly documented, with the few published research studies using a cognitive approach. Several decades ago, psychoanalytic writers advocated group therapy for neurotically depressed patients, particularly depressions characterized by personality disturbance

(Foulkes, 1965; Stein, 1975). It was generally thought that chronically depressed patients had a much poorer response than patients with acute depressive reactions to tricyclic antidepressants, the medication commonly used at that time (Stein, 1975). Although a number of psychodynamic clinical case reports have been published (e.g., Arieti & Bemporad, 1978) on treating dysthymic patients in individual treatment, and Astigueta (1983) has discussed integrating pharmacology with contemporary psychoanalytic group psychotherapy, the efficacy of psychodynamic treatments for depression, individual or group, has never been empirically tested.

In a review of group cognitive therapies, Blaney (1981) found no definitive clinical evidence for effectiveness. Rush & Watkins (1991) found that individual cognitive therapy was superior to group cognitive therapy, but Shapiro et al. (1982) concluded that group cognitive therapy was more effective for treating depression than individual forms of therapy. Wierzbicki et al. (1987) found that subjects in individual cognitive treatment showed more symptom improvement than group treatment subjects or subjects in a delayed treatment condition, but that group therapy patients showed more improvement than controls.

Reasons for the mixed findings in cognitive group therapy are unclear, and the lack of detail on therapeutic technique in this literature does not help. Cognitive deficits may be more effectively addressed in the individual therapy setting. Most reported cognitive group studies focus on symptom amelioration. But they don't take advantage of the intrinsically interactional nature of the therapy group to address interpersonal dysfunction or promote in vivo practice of social skills -- and it may be precisely these factors that are more predictive of good outcome in the group therapy setting.

An important finding with regard to depression treatment is that dysthymic patients tend to do poorly in nonspecific therapies -- that is to say, therapies which fail to directly address symptom alleviation and the attendant social and interpersonal complications of chronic depression. Data from BIMC Brief Psychotherapy Research Project (see Winston et al., 1994) was analyzed to determine the effect of DSM-III-R dysthymia upon treatment retention and outcome in a variety of forms of individual brief psychotherapy.

A total of 85 patients treated in 30-session protocols without concurrent antidepressant medication were studied. Forty patients met criteria for dysthymia, whereas a comparison group of 45 subjects met criteria for Axis I disorders other than dysthymia (depression [n = 17], anxiety disorders [n = 17]; and adjustment disorder or V-codes [11]).

Although there was no significant difference between the groups on Axis II disorders, which fell mostly among Cluster C categories, the overall outcome was significantly poorer for patients in the dysthymic group. A comparison of drop-out rates demonstrated that significantly more patients in the dysthymia group (53%) than in the comparison group (27%) did not complete the 30-session protocol, and for those who did complete it, significantly more in the comparison group (64%) v. the dysthymia group (18%) improved on measures of symptom and interpersonal functioning.

One reason for the poorer outcome among dysthymic patients in nonspecific therapy is the failure to address specific depressive symptomatology. Another reason could be the failure to address the tenacity of their defenses, which can perpetuate the kind of ingrained negative self-beliefs and self-defeating ways of relating

associated with this refractory condition. It suggests that a treatment approach targeting chronic, habitual cognitive-affective-behavioral patterns associated with depression might be more effective.

Combined medication and psychotherapy of depression

I will not review here the extensive literature comparing different (medication v. psychotherapy) treatments for depression, culminating in the aforementioned NIMH TDRCP study. The recent interest in combined medication-therapy treatments reflects a growing awareness that treatment effects can be additive and that different modalities can target stages of the illness at different times.

Again, studies of most combined treatments for mood disorders have adopted a symptom-based approach, which focuses on remission or recurrence in the acutely depressed and which tends to overlook a broad range of outcome variables of psychological dysfunction (isolation, dependence) associated with chronic dysthymic illness.

Recent research on combined treatments for major depression has produced equivocal results. In an analysis of six large randomized clinical trials for major depression, Thase et al. (1997) suggest that combined treatment may be most effective for patients with more severe and recurrent depressions, with less benefit for milder depressions ("dysthymics" were not included in these studies). But Paykel (1994) has critiqued the failure of combined treatment studies to differentiate clearly between symptoms and social functioning, and notes that most combined treatments have not examined effects in dysthymic patients separately.

Smaller combined studies include Blackburn et al.'s 1981 study, in which CT (as an individual modality) combined with tricyclic antidepressant treatment proved superior to pharmacotherapy alone, but not CT alone, in a general practice setting of major depressive patients. In Hollon et al. (1992), combined treatment appeared to be more effective than either psychotherapy or medication alone, but these findings were nonsignificant. Fava et al. (1994) studied the benefits of CBT when added to antidepressant medication in major depression, and found an alleviation of residual symptoms. After medication discontinuation, CBT led to a lower rate of relapse at 2 year follow-up (15%) as compared to clinical management alone (35%), though these differences were not significant.

To date, there has been no empirical investigation on the clinical efficacy of combining antidepressant medication with group psychotherapy in the treatment of dysthymia.

In this brief overview of psychological treatments of depression, several points are salient:

- Psychological treatments are generally brief, educational, with goals aimed at symptom reduction and improved functioning.
- The few reported individual therapy studies of dysthymia are limited by small study groups and different outcome measures.
- Group psychotherapy treatments of chronic depression are rare and predominantly cognitive in orientation; although they do show some clinical utility, they have not consistently addressed the depressed individual's underlying interpersonal problems.
- Combined approaches to depression treatment seem promising but need more research.
- Despite no published reports of controlled studied for group therapy of medication-treated dysthymic patients, combining these treatments may provide an advantage. Since medication and group therapy may exert

differential effects, their combined use could result in additive benefits for most dysthymics, or possibly certain subgroups of dysthymic patients.

B. Empirical Studies of Defense in Depression

Although a number of studies have examined the use of defense mechanisms in different forms of psychopathology (Gleser & Ihilevich, 1969; Haan, 1977; Kelly, 1986; Lerner & Lerner, 1982), relatively few researchers have focused on their role in the depressive disorders (Akkerman et al., 1992 Bloch et al., 1993; Perry and Cooper, 1986).

Bond et al. (1986) investigated frequency and type of defense style in a sample of 209 psychiatric patients (n = 111) and controls (n = 98). Factor analysis revealed four cluster of defenses, correlated with independent measures of ego adaption and maturity (Loevinger, 1976), on the basis of which Bond inferred 4 styles: Defense Style 1 (consisting of derivatives of immature defense functions --withdrawal, regression, acting out, inhibition, passive aggression, and projection); Defense Style 2 (derivatives of omnipotence, splitting, and primitive idealization); Defense Style 3 (derivatives of reaction formation and pseudo-altruism); and Defense Style 4, the most "adaptive" style (derivatives of suppression, humor, sublimation).

In a follow-up study using a smaller patient sample (n = 69), Bond et al. (1986) assessed the relationship between diagnosis and defensive style in three diagnostic (DSM-III) categories: psychotic disorders (n = 22); affective disorders (n = 22); and personality disorders type B (n = 20). Bond et al. found that the depressed patients responded most often with a description of "no defense style." But they also used the "adaptive" defense style more often than any other style.

Although Bond et al.'s study had limitations (small sample size; the collapsing of

bipolar and unipolar patients into one diagnostic category), the finding of a greater use of mature defense styles and no defense styles among the affectively disordered patients is notable. Either depressed patients use more adaptive defenses than other psychiatric groups or else they respond in ways not measured by the DSQ. Depressed patients may also differ from the other groups in ways other than defense style (such as their psychodynamic conflict), or their pathology may reflect a biochemical factor rather than a defense style (Bond et al., 1986). Particularly in cases where no distinct style was endorsed, depressed individuals may be using defense or coping mechanisms not included in the questionnaire.

Using a different methodology (clinical judgment), Perry and colleagues (Perry & Cooper, 1986, 1989) found a higher degree of defense use in their sample of depressed subjects. They rated defenses using the DMRS on videotaped initial psychiatric interviews of 73 patients with borderline personality disorder, antisocial personality disorder, and bipolar II disorder. Although they did not assess the subjects for DSM-III-R dysthymia, they found, on post hoc analysis, significant associations between chronic depression and the defenses of devaluation, passive aggression, and hypochondrias.

The preponderance of affective and anxiety disorders, along with Axis II disorders, in this sample, prompted the investigators to study relationships among stress, defense and symptomatic episodes using both cross-sectional and longitudinal follow-up data over a 3 year period (Perry, 1994).

Following Vaillant's (1971) hierarchical theory of defense mechanisms, Perry & Cooper found a significant relationship between the maladaptiveness of a defense

and aspects of anxiety and affective disorders -- prevalence, recurrence rates, and overall time spent in symptomatic episodes over follow-up.

Defenses most strongly linked to affective symptoms and pathology were, in order, the action, borderline, and disavowal defenses (Perry, 1994). In particular, the action defense scale was associated with higher median levels of symptoms for the Hamilton Depression Rating Scale (HDRS; Hamilton, 1960), and had a more protracted course for depressed patients over several years of follow up. This led Perry (1994) to conclude that a lack of awareness of internal conflicts, which is associated with an action type of defense, served no protective function for depressed patients. Obsessional defenses, on the other hand, were associated with the absence of affective disturbance.

Perry's findings of a strong association between lower level defenses and depression contradicts Bond's (1986) results. However, the high degree of personality disorders in this latter sample and the failure to rate mature defenses at intake, may have contributed to a lower than expected incidence of mature defenses on follow-up (Perry, 1994).

Bloch et al. (1993) sought to extend Perry & Cooper's (1986) work by establishing a defense mechanism profile for subjects with DSM-III-R primary type, early onset dysthymia. These investigators rated videotaped clinical interviews with the DMRS to examine differences in defense mechanism use in dysthymic patients ($n = 22$) and panic disordered patients ($n = 22$). Three subjects had both diagnoses: two with primary panic disorder and secondary dysthymia; one with primary dysthymia also had panic disorder. The authors did not specify whether their

subjects, who were recruited from an outpatient Dysthymia and Anxiety Disorders clinic, were receiving antidepressant medication at the time of their interviews.

As expected, both dysthymic and panic subjects endorsed lower-maturity defense mechanisms, but dysthymic patients scored significantly higher on narcissistic, disavowal, and action defense levels. Consistent with Perry & Cooper's (1986) earlier findings with depressed patients, dysthymic subjects were more likely to use defense mechanisms associated with poor management of anger and self-esteem -- devaluation, passive aggression, projection, and hypochondrias, as well as acting out.

When compared to panic disordered subjects, dysthymic patients externalized the source of conflict (projection) rather than directly confront internal or external stressors. They tended to experience themselves as powerless (passive aggression and hypochondriasis), prevailed upon others to intervene on their behalf, and when frustrated turned their frustrations on themselves as well as others, at a severe cost to their self-esteem and belief in the efficacy of others.

Panic disordered subjects, on the other hand, had different means of dealing with conflicts involving guilt over self-assertion or anger expression. They resorted to reaction formation, by which they turned negative affects into positive ones, and undoing, which allowed them to dilute their negative actions or experiences (Bloch et al., 1993).

Bloch et al.'s (1993) study provided empirical support for Abraham's (1911) understanding of projection as a prominent defense mechanism in depression, which relates to the DMRS view of projection as falsely attributing one's unacknowledged feelings, impulses, or thoughts to others to avoid vulnerability. In addition, Freud's

theory of melancholia as turning anger felt for others inward relates to the DMRS construct of passive aggression, in which anger outwardly expressed ultimately backfires by inviting retaliation against the self (Bloch et al., 1993).

Although this study did not examine the effects of treatment on defense use, the authors noted that establishing an individual's particular pattern of defense could aid in treatment design.

> *If dysthymic patients demonstrate a predictable set of defenses, therapists could anticipate defensive styles and adopt appropriate treatment strategies. Dysthymic patients who respond to medication often need to learn new interpersonal skills to deal with day-to-day living. Psycho- therapies that identify and alter maladaptive defensive styles may be critical to sustained recovery* (Bloch et al., 1993, p. 1198).

C Empirical Studies of Defense Change in Psychiatric and Depressed Patients

Unfortunately, empirical studies of defense change in psychotherapy treatment of acutely depressed or chronically depressed patients, are rare. Although, as Bloch et al. (1993) suggest, establishing a defense profile for dysthymia could facilitate effective treatment design, it is still an empirical question whether characterological change -- such as improvements in defense functioning -- can occur in relatively brief depression treatment. As previously noted, Blatt et al. (1995) observed that perfectionism, a characteristic of introjective patients, had a devastating impact on the effectiveness of brief treatment for acute depression in the TDCRP sample, whereas a sample of introjective psychiatric inpatients (with schizophrenic and borderline disorders) improved significantly over a course of 15 months of

psychotherapy.

In an early study (Ablon et al., 1974), clinicians rated observations of defensive functioning in 36 unipolar and bipolar patients on the Ego Profile Scale (Semrad et al., 1973) during a psychiatric hospitalization of an average 16 week duration. Five of these patients switched both from depression to mania, and from mania to depression during their stay. Of the 29 patients who were not manic during hospitalization, 15 were unipolar (with no prior history of mania or hypomania), and 14 had a past history of bipolar illness. The treatment consisted of medication, 2 hours of weekly psychotherapy, group therapy, and active therapeutic milieu.

Three triads of ego defenses patterns, ranging from primitive to relatively healthy, were assessed: the narcissistic triad (denial, projection, and distortion), described as primitive attempts to maintain ego integrity despite acute stress; the affective triad (obsessive-compulsive, hypochondriacal, neurasthenic patterns) described as attempts to elicit help and support; and the neurotic triad (dissociation, somatization, anxiety), described as means of obtaining mutual gratification from others, at the expense of self-sacrifice (Ablon et al., 1974). The patients' therapists filled out the ego profile questionnaire twice a week. Consensus global ratings of depression and mania were collected twice daily by a nursing team.

Almost 90% of the patient sample showed a decline in the (narcissistic) defenses of denial, distortion, and projection less frequently as they improved clinically, and 12 patients (66%) showed a rise in the anxiety alert subscale (neurotic triad) during recovery from an affective episode. Patients (n = 14) whose affective disturbance deteriorated during hospitalization (i.e. a relapse from relative euthymia into a manic or depressed state) also showed a corresponding increase in use of primitive

defenses. Ablon et al. (1974) could not distinguish unipolar from bipolar affective illness on the basis of overall scores of defensive patterns but did find that a majority of unipolar depressed patients under stress used hypochondriasis and somatization more frequently than bipolar patients. When experiencing distress (reflected in higher depression ratings), they had a more flexible repertoire, and did not need to resort to more primitive defenses. In bipolar patients, greater use of these same defenses was associated with a switch of affective state, particularly a shift out of a manic episode.

The finding of increased anxiety during periods of clinical improvement suggests that greater anxiety tolerance signals more emotional resiliency. It also supports the view that depression acts as a defense against anxiety, so that the lifting of the affective disturbance allows the anxiety to be experienced.

Akkerman et al. (1992) examined ego defenses in acutely depressed patients (21 hospitalized patients; 16 clinical patients) using Bond's (1983) self-rated DSQ over a relatively short course (7-9 weeks) of treatment. Ratings were collected at two intervals, pretreatment and posttreatment.

Akkerman et al. (1992) hypothesized that mature defense styles provide the most effective psychological protection (Bond, 1986; Vaillant et al., 1986). However, no significant changes were found in the self-rated use of neurotic or mature defenses. Instead, Akkerman and his colleagues found that subjects reported a decline in the use of immature defenses with symptomatic recovery from their depressive episode. They concluded that improvement in defense style, defined post-hoc as a significant decrease in the use of immature defenses, was the result of successful treatment.

Building on Akkerman et al.'s (1992) findings, Kneepkens et al. (1996) investigated the improvement of defense in acutely depressed adults (n = 31) over a brief 1 week (7.1 $\pm$ 2.8 days) hospital stay that consisted of standardized inpatient treatment (counseling; therapeutic milieu) and antidepressant medication. At the time of admission, 27 patients were taking medication, and that number increased by two patients by the time of discharge.

Subjects completed the DSQ and the 20-item Center for Epidemiological Studies-Depression Scale within 48 hours of admission and within 24 hours before or after discharge. Discharge ratings on the DSQ showed substantially higher mature defense ratings, significantly lower immature ratings, and stable neurotic ratings. This study concluded that relatively rapid improvement in defense style, including mature defenses, can occur for some medicated depressed individuals undergoing inpatient treatment.

Several theorists (Davanloo, 1980; Kernberg, 1976; Malan, 1979; and Reich, 1949) have singled out the patient's use of defense (which leads to therapeutic resistance) as an important technical focus, but few empirical studies have demonstrated that addressing or challenging defenses in psychotherapy is intrinsically therapeutic. Foreman & Marmar (1985) and Truax & Wittner (1973) suggest that confronting defensive behavior can produce a positive therapeutic effect in short-term group and individual treatment, but Crits-Cristoph et al. (1988) found that interpreting the wishes and expectations of patients in psychotherapy--but not their defenses -- predicts positive outcome. Others (Hadley & Strupp, 1976; Yalom & Lieberman, 1971) suggest that challenging defenses can produce a negative

effect, or no effect at all.

One study that focuses explicitly on changes in defense behavior of psychiatric patients over the course of psychotherapy treatment was conducted at Beth Israel Medical Center (BIMC). Winston et al. (1994) studied the frequency and level of defensive behavior in 28 outpatients (mean age = 39.3; SD = 8.7) in the context of two manualized psychodynamic treatment approaches: (1) short-term dynamic psychotherapy (STDP; Laikin & Winston, 1988), based on principles developed by Davanloo (1980), and (2) brief adaptive psychotherapy (BAP; Pollack et al., 1988), which was developed at BIMC.

In Winston's heterogeneous sample, a small percentage of patients were given primary diagnoses for acute or chronic depression (21.4% received a primary diagnosis of dysthymia and 7.1% of major depression). Additionally, patients showed a high incidence of personality disorders in this population (39.3% received an Axis II [DSM-III-R] diagnosis of cluster C personality disorders; 28.6%, a diagnosis of mixed personality disorder with primarily cluster C features; 14.3%, a diagnosis of mixed personality disorder with clusters B and C, and 7.1%, a diagnosis of histrionic personality disorder.

Although both treatments were psychodynamic, in STDP, the therapist directly confronts and challenges defense, anxiety, and impulse, and in BAP, the therapist identifies and elucidates the patient's primary maladaptive interpersonal pattern in light of the patient's past, present, and therapeutic relationship.

Winston et al. (1994) examined the relationship between the manner (e.g., questions, confrontations, clarifications, empathic statements, and interpretations) and frequency with which therapists directly address defense (TAD) and the three

levels of defense shown by the patient (immature [projection, acting out]; intermediate [intellectualization, displacement]; and mature [altruism, humor, suppression]). Four videotaped sessions from four quartiles (the 1st ten, 2nd ten, 3rd ten, and last ten visits) of the 40-session protocol were coded for both therapist (TADs) and levels of defense. Outcome measures included the Social Adjustment Scale -SR (Weissman & Bothwell, 1976) and the Symptom Checklist (SCL-90-R; Derogatis et al., 1973).

A significant decrease in the frequency of *intermediate* defensive behavior was evident across the four quartiles of therapy, which was not related to patient outcome. However, the investigators found a positive relationship between the frequency of immature defenses in the first 10 sessions (quartile) of treatment and outcome at termination.

The extent to which the therapist addressed the patient's defensive behavior proved to be important: The frequency of TAD was significantly related to patient outcome, with a positive relationship between the therapist addressing defensive behaviors early in treatment and a subsequent decrease in immature and intermediate defenses.

That the only significant decline in defensive behavior was associated with the intermediate defenses may have been an artifact of the treatments studied. Mature defenses were too small in number to be included in the analyses, and may not have been detected since dynamic therapy focuses on conflictual interpersonal interactions rather than more adaptive levels of functioning (Winston et al., 1994). Yet one would expect use of immature defenses to change significantly over dynamic treatment. Their failure to do so prompted investigators to speculate that immature

defenses require a longer course of therapy to show real improvement. But it may be that the specific technique of confronting a patient's defenses is more effective with neurotic (intermediate) defensive behavior than with more primitive defenses. This might explain why, despite a positive relationship between TAD and a drop in use of both immature and intermediate defenses, only use of the latter declined significantly.

Although the investigators divided patients into good and poor outcome groups, they failed to find differences with respect to total patient defenses, nor with respect to the way the intermediate or immature defenses shifted over time. It remains an open question whether patients who mostly use neurotic (intermediate) defenses might be more amenable to, or have greater capacity to make use of, a confrontative therapeutic approach. It is also possible that TAD evokes greater defensiveness in patients who predominantly use immature defenses.

It is difficult to draw conclusions from this study concerning the clinical utility of addressing defense in the treatment of depression, since we do not know what percentage of patients diagnosed with chronic or acute depression showed significant defense change. The treatments investigated here also represent the type of nonspecific treatments (cited in the BIMC data analysis) associated with poorer outcome for dysthymic patients. Nevertheless, the positive relationship between TAD and lower defense use, as well as the significant decline in the use of intermediate defenses across the quartiles of therapy, suggests more research is warranted.

D. Rationale for a Combined Treatment Approach to Dysthymia

An important premise guiding this dissertation is that significant change in the treatment of chronic depression is more likely to result from a combined therapeutic modality than an individual approach (either psychotherapy or psychopharmacology).

Contemporary practitioners in the health disciplines support a biopsychosocial model of illness in which biological, psychological, and environmental factors are mutually interactive. This biopsychosocial perspective has influenced mood disorders researchers (Akiskal et al., 1988; Schuchter et al., 1996, Klerman et al., 1984), as well as clinicians investigating psychological aspects of depression, including reciprocal relationships between depression and personality (Klein et al., 1993; Gotlib & Hammen, 1992). The prevailing "disease model" of depression as a pure endogenous state has yielded to an understanding of depression as a clinically complex, heterogeneous condition in which the individual's perceptions, thoughts, feelings, and coping mechanisms interact with biological variables (e.g., temperament) and contextual factors (e.g. attachment history) to determine vulnerability and recovery.

Evidence for the biological foundations of depression is based on research that shows depression vulnerability can result from problems in neuroendocrine functioning (e.g., hypercortisolism). But early adverse life circumstances and genetic factors may also contribute to biological vulnerability: It has been speculated that depressive experiences themselves may alter neuroendocrine functioning (Gotlib & Hammen, 1992), and there is increasing evidence of the short- and long-term physiological and behavioral effects (increased heart rate, altered brain enzyme levels, changed hormone levels) of object loss (Hofer, 1984). In light of these interactions, augmenting a successful medication trial with psychotherapy would

seem to have special clinical merit. At a basic level, medication, by alleviating symptomatic distress, helps to make depressed patients more accessible to therapy. Psychotherapy, in turn, reinforces medication compliance, and addresses longstanding, intractable personality issues. But the beneficial synergy of the combined approach may also derive from common (yet to be discovered) neurobehavioral pathways through which somatic treatments and psychotherapies exert their effects.

This study proposes that group psychotherapy is a potentially powerful modality in the treatment of chronic depression. The therapy group is an optimal forum to address the persistent psychological problems of dysthymic patients. Most of the more refractory depressive symptoms -- self-criticism, impairment in social relationships, poor communication skills, poor self-concept, self-defeating ways of relating, and a sense of personal failure -- are well suited for group treatment, a structured form of therapeutic social interaction which can provide insight, experiential and affective learning, as well as education and support.

Group therapy in combination with antidepressant medication may be an especially effective intervention for patients in the post-dysthymic phase of treatment. Patients successfully treated with antidepressants often experience confidence, enhanced self-esteem, greater clarity and focus as a result of the alleviation of symptomatic distress, yet are unable to capitalize on these gains due to the effects of chronic social deficits and functional impairments. Such patients may lack the "skills to survive euthymia" (Markowitz, 1993). Psychotherapy augments the powerful effects of medication by providing the newly recovered patient a conceptual framework for

evaluating thoughts and perceptions unclouded by depressed mood, and for placing them into a personally meaningful context so they can be integrated into the patient's self-system.

For dysthymic patients who have a poorer response to monotherapy (both psychopharmacology [Harrison and Stewart, 1993; Howland, 1991] and psychotherapy [Markowitz, 1994; Thase et al., 1994]) when compared to acutely depressed patients, combined medication-group psychotherapy may be the treatment of choice.

III. STATEMENT OF THE PROBLEM AND RESEARCH HYPOTHESES

This dissertation will investigate the use of defense mechanisms in patients with Dysthymic Disorder prior to and following psychotherapy and pharmacological treatment. It will explore whether the type and the degree of defense use changes as a result of specific clinical interventions, and whether these changes reflect improvements in other domains of psychological functioning.

As noted earlier, the lack of empirical research on defense use in chronically depressed patients stems both from a paucity of controlled psychotherapy trials and growing clinician confidence in medication efficacy as a first-order treatment. But a substantial portion of patients diagnosed with dysthymia either do not respond to antidepressant medication or, for a variety of reasons, refuse medication or cannot tolerate it (Markowitz, 1996). Moreover, studies have shown that dysthymic medication responders, even upon attaining a euthymic state, do not attain community levels of social and vocational functioning (Kocsis, 1991; Leader & Klein, 1996). And in some studies documenting pharmacological successes, a number of patients report that symptoms related to psychological functioning persist even if they receive some symptom (e.g., neurovegetative) relief (Hellerstein et al., 1993).

Medication, though it may radically improve mood and thus bolster an individual's self-confidence and sociability, cannot redress ingrained patterns of self-defeating behaviors and poor interpersonal skills for individuals who have been chronically withdrawn and isolated for many years. It is argued that a systematic analysis of defense functioning in dysthymic patients undergoing treatment may help illuminate why some patients improve more than others, and why some seem not to improve substantially at all.

This thesis is based on a developmental model of defense (Cramer, 1991; Vaillant, 1971, 1986) which argues that defense mechanisms represent different levels of ego functioning, cognitive complexity, and potential for interpersonal relatedness. It is hypothesized that the patients who will show greatest changes in defense functioning (such as a substantial drop in primitive defense use) will have received a course of treatment that therapeutically addresses their refractory (interpersonal) symptoms. Thus, a combined medication-psychotherapy treatment should be more effective in alleviating symptoms and improving interpersonal functioning than a treatment consisting of medication alone. Such a view is in line with DSM-I and DSM-II formulations which characterize depression as the product of maladaptive defense mechanisms.

If, however, improvements in depressive symptomatology and defense functioning are more robust in medication-alone patients over a short period of treatment, it would compel a re-examination of antidepressant use as a potentially viable psychological treatment effecting characterological change. Such a view supports the conceptualization of dysthymia as a mood disturbance for which defense is a secondary or compensatory reaction (Bloch et al., 1993). The possibility of significant personality or interpersonal change in patients only receiving medication treatment raises the spectre of the Axis I/II controversy which has yet to resolve whether a characterological form of depression exists. It will be useful, then, to determine if significant improvement on personality measures in medicated-alone patients is due to greater Axis II pathology, as their improvement may reflect a beneficial shift in their interpersonal functioning rather than their mood alleviation. Significant improvement on personality measures in a group of medicated only

patients may simply reflect the powerful effects of antidepressant medication. Yet the very fact that personality change could be demonstrated in such patients also suggests that dysthymia, as a nosological and conceptual construct, cannot be easily separated from depressive personality, and that depression as a pure form of affective disorder that is wholly independent of and uninfluenced by personality variables is rare indeed.

It is also possible that the primary developmental level of the patient's defense mechanisms at intake will dictate subsequent treatment response, regardless of treatment (Combined or Medication-alone) assignment. For example, a patient with more lower level defenses (e.g., denial) or intermediate defenses (e.g, projection) at the outset might show greater change over the course of treatment because she has further room for improvement.

Conversely, a patient who starts treatment with more Identification defenses may achieve a better clinical outcome than a person who shows more immature defenses at intake presumably because the former patient is psychologically healthier to begin with, and has more adaptive mechanisms at his disposal.

Conceivably, the type of treatment is a less important factor in clinical outcome than the initial developmental level of defense, or the degree of change the defense use undergoes. If this is true, one can argue that defenses are primary, either in the sense that they can protect against dysphoric mood or other symptomatology, or in the sense that both depression and defense are closely related to another independent phenomenon, such as vulnerability to interpersonal loss or impaired self-esteem.

The aims of this investigation are threefold:

1. To study the defense mechanisms in dysthymic patients treated with combined medication-therapy and medication alone.
2. To assess whether changes in depressed patients' defensive functioning are related to improvements in depressive symptomatology and interpersonal functioning.
3. To determine whether treatment response (as measured on both symptom-based and interpersonal assessments) is related to level of defense functioning at intake.

Hypotheses:

(1) Depressed patients treated with combined medication-group therapy will show greater change on immature defenses (e.g., Denial) and intermediate defenses (e.g., Projection) than patients treated with medication only.

(2) Depressed patients treated with combined medication-group therapy will show greater change on mature defenses (e.g., Identification) than patients treated with medication only.

(3) Mature defenses (e.g., Identification) will be positively associated with clinical outcome (depressive symptoms, interpersonal functioning); conversely, primitive defenses (e.g., Denial) will be negatively associated with clinical outcome.

(4) Improved interpersonal functioning and a decrease in primitive defenses (e.g., Denial) at termination will be positively associated with relief from depressive symptoms.

Research Questions:

a) Is there a subset of dysthymic patients who improve symptomatically but do not show changes in defense use and functioning?

b) Is there a subset of patients who show changes in defense use but who do not improve symptomatically?

c) Are different types of defense mechanisms (e.g., Denial) associated with different interpersonal problems (e.g. socially avoidant)?

d) Are different types of defense mechanisms (e.g., Denial) associated with different depressive subtypes (e.g. anaclitic)?

This proposed study has both a practical and theoretical significance. At a practical level, the study can demonstrate the clinical utility of using defense mechanisms in assessing therapeutic outcome. A systematic study of defense mechanism use in depressed patients is seen as a means to develop better assessment and treatment strategies for this population.

At a theoretical level, the study can help illuminate the psychological mechanisms through which therapeutic change takes place, as well as the treatment conditions (e.g., combined or single-treatment modalities) most conducive to such change. Finally, it can provide a basis for refining the ways in which the treatment of chronic depression can be optimally designed and implemented.

METHOD

This is a study on the use of defense mechanisms and their relationship to symptom change and interpersonal functioning in outpatients treated with antidepressant medication (fluoxetine) and time-limited group psychotherapy for DSM-III-R Dysthymic Disorder.

A. Subjects

All subjects in this thesis were participants in a larger randomized, prospective open-label study (n = 40) on the efficacy of using fluoxetine-alone *vs.* fluoxetine plus time-limited group therapy at Beth Israel Medical Center (BIMC), a large urban tertiary care teaching hospital. The purpose of the trial was to assess the benefits of adding group therapy to medication treatment for dysthymic outpatients. Patients were recruited from press releases and advertisements placed in the *New York Times* and the *Village Voice* and pre-screened in telephone interviews prior to the initial intake interview.

In order to qualify for participation in this study, subjects had to meet criteria for DSM-III-R Dysthymia Disorder (early onset, primary type) and had to have discontinued any psychotropic medication 6 weeks prior to entry into study. In addition, they had to receive a score of greater than or equal to 14 on the Hamilton Depression Scale (21 items) at baseline.

Candidates excluded from this study were pregnant or nursing women; individuals meeting DSM-III-R criteria for Major Depression; Bipolar Disorder, Schizophrenia, Severe Borderline Personality Disorder; or with a principal diagnosis within the past 6 months of Panic Disorders, Severe GAD, OCD, PTSD; individuals meeting DSM-III-R

criteria within past 6 months for abuse of or dependence on any drug, including alcohol; any individual who posed a serious risk of suicide during course of study; or had a life-threatening medical illness or an illness assessed as probable cause of dysthymia.

The present study sample consisted of thirty subjects (male = 14;female = 16). The main patient characteristics are shown in Table 1. The mean age was 44.93 (SD = 9.55). The majority of patients were Caucasian (90%) with a significantly lower percentage of African American subjects (3.3%) and Asian subjects (6.7%). The three main religious affiliations were Jewish (33%), Catholic (30%) or no affiliation (23%). A high proportion of patients described themselves as single (46.7%), with the remainder married (26.&%), separated or divorced (16.6%), living with a partner (6.7%) or living without a partner (3.3%). Four patients identified themselves as gay/lesbian (13.3%), and one subject did not select a sexual orientation. Subjects in this sample tended to be predominantly middle-class professionals in fields ranging from law, film production, art design, finance, journalism: Close to 90% had obtained a baccalaureate degree, and of that percentage a substantial proportion (46.7%) had completed a master's or post-master's level education. Most subjects were employed in full-time or part-time capacities or were self-employed (90%). Ten percent were unemployed.

Concerning the psychiatric history of the subjects, the age of onset of dysthymia occurred mostly in childhood (n = 8) or adolescence (n = 15). Past major depression (PMD) was endorsed by 13 subjects (43.3%), and 9 patients had taken fluoxetine previously. Most had previously undergone at least one course of standard psychotherapy (individual therapy = 83.3%; couples therapy = 0%). Nine patients

reported a past diagnosis of anxiety disorder (30%) and three patients (10%) reported anxiety existing concurrently at the outset of the study. On the SCID-II, 6 patients met criteria for more than one personality disorder (20%), and a slightly smaller percentage (13.3%) were classified with Personality Disorder NOS, signifying that they possessed features of 1 ± personality disorder, but did not meet full criteria for any singe one disorder. The 6 patients with a diagnosis for multiple (1 ±) personality disorders showed a predominance of Cluster C symptoms: Patient 1- avoidant, obsessive-compulsive; patient 2 - avoidant, self-defeating; patient 3- avoidant, dependent, obsessive-compulsive; patient 4: avoidant, obsessive-compulsive; patient 5 -passive-aggressive, self-defeating, paranoid, histrionic; and patient 6 - avoidant, dependent, obsessive-compulsive, and passive-aggressive.

Of the remaining axis II disorders, the most common diagnosis was obsessive compulsive (16.7%), followed by passive-aggressive (3.3%), avoidant (3.3%), and histrionic (3.3%). Only 11 patients (36.7%) received no axis II diagnoses.

A number of subjects reported a history of sexual abuse (16.7%), physical abuse (10%), and combined sexual and physical (6.7%). Four subjects (13.3%) reported a past eating disorder. Three subjects (10%) reported attempting suicide at one point in their lives, and the same percentage had also been hospitalized for psychiatric reasons.

Only thirty subjects of the original sample were used. The ten patients not included in the present study had either prematurely dropped out of the study or else had failed to complete pertinent personality-based measures.

TABLE 1

PATIENT CHARACTERISTICS

	Frequency	Percent
Gender:		
Male	14	53.3
Female	16	46.7
Ethnic background		
Caucasian	27	90.0
African-American	1	3.3
Asian	2	6.7
Education		
High School	4	13.3
Bachelors	12	40.0
Masters/Post-masters	14	46.7
Employment		
Unemployed	3	10.0
Part-time	7	23.3
Full-time	20	66.7
Marital Status		
Married	8	26.7
Divorced/Separated	5	16.6
Single	14	46.7
Living w/Partner	2	6.7
Living w/out Partner	1	3.3
Sexual Orientation		
Heterosexual	25	83.3
Gay/Lesbian	4	13.3
Unspecified	1	3.3
Diagnostic Information		
Onset: Childhood	8	26.7
Onset: Teens	15	50.0
Onset: Young Adulthood	4	13.3
Past MDE	13	43.3
Past Fluoxetine use	9	30.0
Other antidepressants	13	43.3
Past Psychotherapy	25	83.3

B. Procedure

After the initial assessement, all participants in this study were given an 8-week fluoxetine trial. They met biweekly with their prescribing psychiatrists for the first 4 weeks, and then monthly thereafter. Patients received open-label fluoxetine beginning at 10mg/day, increased to 20mg/day within 7-10 days, and thereafter were adjusted clinically, according to symptomatology and side effects, to a miximal dose of 80 mg/day. Patients who demonstrated a partial medication response (or greater) by week 8 (defined as $\geq$ 40% decrease in Hamilton Depression Rating Scale (HDRS; Hamilton, 1960) and a score of 1 (very much improved) or 2 (much improved) on the Clinical Global Impression scale (CGI) were then randomized to one of two treatment conditions: (1) Group psychotherapy and antidepressant medication or (2) Antidepressant medication alone. In the larger study sample, major assessments were performed at Intake (Week 0), Midphase (Week 8, prior to randomization) and at Termination (Week 24), but only assessments administered at intake and termination were used for this study.

Initial assessment included: (1) Telephone Screening; (2) Structured Clinical Interview for DSM-III-R (Spitzer), a semi-structured interview used to determined diagnosis on Axis I and Axis II on DSM-III-R.

In the present study, all patients are administered two symptom-based inventories, Beck Depression Inventory (Beck, 1961) and the Hamilton Depression Rating Scale (Hamilton, 1960), two personality/interpersonal inventories, The Depressive Experiences Scale (Blatt, 1976) and the Inventory of Interpersonal Problems (Alden,

1990).

The Thematic Apperception Test (TAT: Morgan and Murray, 1935; Murray, 1943) was also administered by clinical psychology graduate students at Weeks 0 and 24. The TAT was administered with the following instructions as per the original TAT manual (Murray, 1943):

> This is a test of imagination, one form of intelligence. I am going to show you some pictures, one at a time; and your task will be to make up as dramatic a story as you can for each. Tell what has led up to the event shown in the picture, describe what is happening at the moment, what the characters are feeling and thinking; and then give the outcome. Speak your thoughts as they come to your mind.

The testers administering the TAT were told to prompt subjects if they forgot their instructions, to control for variability in the length of protocols.

C. The Group Therapy Treatment:

The group therapy treatment was designed to help patients manage their chronic depressive condition by learning how cognitions, affects, and behaviors become interlocked in self-defeating patterns characterized by the use of defenses and other avoidant operations. The therapists used the treatment components of psychoeducation, mindfulness training, and interpersonal learning to facilitate this process.

1. Format:

Modality:	Accelerated, problem-focused, cognitive-interpersonal-experiential group psychotherapy
Time & Duration:	Sixteen sessions of group therapy held on consecutive weeks for a duration of 1 hour and 20 minutes per week.
Participants:	Adult men and women diagnosed with DSM-III-R Dysthymia per

group (approximately ten per group).

Therapy leaders: Two doctoral students in clinical psychology.

2. Pre-Group Therapy Interview

The therapy leaders met separately with the group participants in an initial interview. The objectives of the pre-group interview were: (1) to establish an early working alliance; (2) to identify individual treatment targets and focal problem areas for the group; (3) to impart a therapeutic rationale for time-limited combined-group treatment of dysthymia. Targets were based on each patients' greatest area(s) of interpersonal difficulty (as identified by their ratings on an interpersonal inventory at intake) as well as focal themes that emerge in the interview. Common focal areas include: social withdrawal or acting helpless during depressive episodes; misconstruing neutral events as confirmation of personal failure, etc.

3. Treatment Components

a) *Psychoeducation of chronic depression: Promoting Patient Self-Efficacy*

Patients who acquire knowledge about depressive illness, biological vulnerability, and symptoms and stressors associated with depressive episodes become more active participants in their treatment and recovery. Patients learn to identify, anticipate, and modify the psychosocial factors that precipitate or exacerbate depression in order to engender a sense of personal efficacy in managing their condition. Our model departs from Klerman et al.'s (1984) medical disease model

(IPT), which inducts patients into the "sick role" to liberate them from psychological burden and social pressure, but may also compromise their sense of competence. Patients are explicitly asked to take a proactive, informed stance with regard to psychoeducation, illness management and rehabilitation, and ultimately recovery. The goal is to help engender in patients a sense of personal control and efficacy over depressogenic thoughts and behaviors without a feeling of self-blame.

Benefits of Psychoeducation:

- Builds self-esteem
- Promotes understanding
- Fosters more active stance towards recovery.

b) *Mindfulness/Attentional control training*

Mindfulness is based on a meditation model (Kabat-Zinn et al., 1985) and techniques for voluntary attentional control (Teasdale et al., 1995). Mindfulness (an intentional regulation of moment to moment attention) enables patients to become detached observers of their own mental activity, including problematic habits and distortions (Kutz et al., 1985). The focus of mindfulness training is on breathing to facilitate the experiential monitoring of one's body/state to reduce stress. Attentional control training (ACT; Teasdale et al., 1995) targets the production of negative schemas about the self and others and provides techniques for redeploying attention to neutral (non-depressogenic) cognitions. Preliminary evidence suggests this approach is helpful for patients recently recovered from major depression. These

techniques, when practiced in tandem in a therapy group setting, enhance awareness of self and other in nondefensive ways, thus facilitating interpersonal growth and change (see Kutz et al., 1985).

Benefits of Mindfulness Training & Attention Redeployment:

- Stress reduction and increased relaxation
- Enhanced awareness of physical sensations (i.e. shallow or constricted breathing) associated with anxiety or depression
- The capacity to shift focus from "hot" negative thought patterns to "cool" neutral, more adaptive cognitions
- Greater capacity to regulate emotional state, and understand links between somatic experience, cognitions, and emotional response

c) *Cognitive and interpersonal learning*

Cognitive-interpersonal learning identifies and alters defensive behaviors linked to maladaptive social interactions and poor self-concept associated with chronic depression. Three problematic areas are emphasized:

(1) Persistence of negative views of self

Depressed people tend to ignore or discredit self-discrepant information and selectively channel experience in negatively reinforcing ways (Andrews, 1989). The failure to take in potentially disconfirming positive information acts as a defensive maneuver to retain a self-confirming but self-defeating view of self.

(2) Emotional blocking and conflict avoidance:

Defending against strong affects (sadness, anger), placating others through submission, etc. perpetuates the depressed person's passive role and dependency on others at the expense of self-reliance and

autonomy.

(3) Defense against emotional connection and intimacy:

Fear of rejection or loss associated with depression can be expressed in maladaptive interpersonal styles (hypersensitivity to criticism, emotional detachment). These styles often emerge in group encounters where they can be explored, challenged, and therapeutically modified. Various techniques and exercises --group "go-rounds," cognitive restructuring, modeling interpersonal feelings, positive reappraisal, and peer monitoring -- are also used to facilitate interpersonal learning and challenge maladaptive styles of relating.

Benefits of cognitive-interpersonal learning:

- Challenges negative depressogenic self-beliefs
- Identifies possible depressive precipitants and triggers
- Targets defensive styles and behaviors
- Provides opportunities for peer feedback
- Facilitates group cohesiveness

The goal in combined-group therapy treatment is not merely to reduce symptomatology but to address the psychosocial sequelae associated with depression. Once patients are stabilized on medication, we sought to maintain their therapeutic gains and reduce recurrence risk by focusing our interventions on their self-devaluing identity and the self-confirming styles that sustain it. A patient can be liberated from the constraints of rigid self-views and painful cycles of negative interactions only if he or she can generate more adaptive responses which expose the futility of old modes of relating. The role of the group is key in facilitating the exposure and resolution of defensive and dysfunctional enactments.

Outline of Stages of Treatment:

I. Defining Depression

- Establish a working definition of Dysthymia
- Identify Symptoms, Stressors & Consequences of Chronic Depression
- Introduce Mindfulness Exercise

II. Establishing Treatment Goals

- Articulate Individual Treatment Goals
- Establish Focal Themes for the group

III. Promoting Mindfulness

- Using the Mindfulness Exercise to promote self-awareness - helping patient distinguish between euthymic/dysthymic bodily states

- Highlighting the role of emotional avoidance and defensive processes in depression

- Each member begins to articulate defensive cognitive-interpersonal depressive patterns of behavior

IV. Developing Coping Strategies

- Members learn to identify and challenge and work through each others' habitual patterns of relating and communicating in the group - how these habitual ways of behaving preclude clear communication and emotionally satisfying interactions

- Members explore how their behavior emotionally affects others in the group

- Members practice giving one another feedback, peer monitoring, and positive reappraisal

V. Termination

- Each member evaluates his/her success in meeting individual treatment goals

- Each member evaluates/critiques the success of the group as a whole in addressing important focal themes

- Members anticipate problematic scenarios that lie ahead and might jeopardize remission
- Members practice in-session coping strategies and skills to protect them during periods of emotional vulnerability and help offset potential symptom relapse.

D. Instruments

1) Depressive Symptomatology

Clinician-rated:

Hamilton Depression Rating Scale (HDRS: Hamilton, 1960) is a 24-item clinician-rated instrument of the presence and severity of depressive symptomatology. Ten items are rated on a three-point scale, and the remaining items are rated on a five-point scale. All items are rated with respect to degree of severity with the anchors varying. Adequate psychometric properties have been established.

Patient-rated:

Beck Depression Inventory (BDI: Beck et al, 1961) is a 13-item patient self-report scale of cognitive, affective, behavioral, vegetative, and motivational symptomatology associated with depression. Each item is rated on a four-point Guttman-like scale. Adequate psychometric properties have been reported (see also Beck et al., 1988). Criteria for improvement for individual measures in the symptomatology domain are (a) scores within normal range of two measures of depression (HDRS ≤ 7, BDI ≤ 10) and (b) no longer receiving a diagnosis of Dysthymia on the SCID interview for DSM-III-R).

2) Personality Measures

Defense Mechanisms

Defense Mechanism Manual (DMM: Cramer,1987).

The use of the defense mechanisms of denial, projection, and identification will be assessed from the patients' responses to 10 TAT cards. (All subjects were administered Cards 1, 2, 4, 5, and 10. In keeping with Murray's (1943) original protocol, male subjects were administered Cards 3BM, 6BM, 7BM, and 8BM, and female subjects were administered Cards 3GF, 6BGF, 7GF, 8GF, and 9GF).

Each TAT narrative is scored for the occurrence of three defenses. For each defense there are seven different categories to be scored, each representing a different component of the defense. The seven components for each defense are as follows:

Denial:

(1) Omission of major characters or objects; (2) Misperception; (3) Reversal; (4) Statements of negation; (5) Denial of reality; (6) Overly maximizing the positive, or minimizing the negative; (7) Unexpected goodness, optimism, positiveness, gentleness.

Projection:

(1) Attribution of aggressive or hostile feelings, emotions, or intentions to a character or other feelings, emotions, or intentions that are normatively unusual; (2) Additions of ominous people, ghosts, animals, objects, or qualities; (3) Magical or circumstantial thinking; (4) Concern for protection from external threat; (5) Apprehensiveness of death, injury, or assault; (6)

Themes of pursuit, entrapment, and escape; (7) Bizarre or very unusual story or theme.

Identification:

(1) Emulation of skills; (2) Emulation of characteristics; (3) Regulation of motives or behavior; (4) Self-esteem through affiliation; (5) Work: delay of gratification; (6) Role differentiation; (7) Moralism.

The frequency of use of each component occurring in each TAT story determines the three defense scores for that story. The scores are then summed across the three stories to determine an overall score for each defense. Although Cramer (1991) conceptualizes the 7 components within each defense category along a developmental continuum, she has not devised a means of scoring them.

Interpersonal behavior/style

Inventory of Interpersonal Problems (IIP: Horowitz et al., 1988) is a 127-item self-report inventory. The items include the type of interpersonal problems that people often encounter and the level of distress associated with them. They are organized into two sections corresponding to the most common way that patients express complaints during an intake interview: (a) 78 concern behaviors that are hard to do and (b) 49 concern behaviors done too much. Each item is rated on a five-point Likert scale in terms of degree of distress. Eight 8-item subscales have been identified through factor analysis as representing the different octants within a two-dimensional interpersonal circumplex model. The dimensions of the model include Control (i.e.,

dominance-submission) and Affiliation (i.e., hostility-friendliness). The subscales include Domineering, Vindictive, Overly-Cold, Socially Avoidant, Nonassertive, Exploitable, Overly-Nurturant, and Intrusive. Adequate psychometric properties have been established. Criteria for improvement on interpersonal measures are significant residual change scores on the IIP, both in the overall mean score and in the subscale scored the highest at intake.

Depressive Experiences Questionnaire (DEQ: Blatt et al., 1976)

The DEQ is a 66-item self-report inventory of general feelings about self and interpersonal relations. It consists of three scales: Dependency, Self-Criticism, and Efficacy. Each item is rated on a seven-point Likert-type scale from "Strongly disagree" to "Strongly agree." Adequate psychometric properties have been reported (see also Viglione et al., 1990).

TAT story length

Individual differences in length of TAT narrative may appear between subjects in this study. TAT length (number of words used in a given story) can also *vary within* individuals from Time 1 (intake) to Time 2 (termination), with the longer narratives producing potentially inflated defense scores. An abbreviated protocol may reflect depressed mood, but it could also be a sign of patient noncompliance.

Preliminary analyses will thus be conducted to determine whether depression and story length have a significant relationship. The correlation between depression level at intake and TAT story length at intake, will be assessed, and if significant correlations exist, TAT story length will be co-variated out in subsequent analyses.

Correspondingly, correlations between defense and story length at intake and at termination will also be assessed for significance.

A Note about the Sample Size

Thirty subjects will be used in this study. According to Kraemer (1981), a sample size of 20 subjects in clinical psychiatric research is acceptable as the basis for a peer-reviewed publishable research study. With fewer than 10 subjects per treatment group, one or two outliers can control and skew the results. By increasing subjects from 10 to 20, one gains 27% in estimated power -- 41% power, based on a two-sample t-test, using a 5% 1-tailed test, with an effect size of 1 (Kraemer, 1981). The next increase of 10 subjects (from 20 to 30) gains 16% (68% power), with the following increase of 10 (from 30 to 40 subjects) gaining only 8% additional power (76%). Thus, the cost-power ratio return (matching accelerating costs of patient recruitment against comparable gains in power) begins to diminish significantly after 30 subjects.

RESULTS

The following results are based on a sample of thirty chronically depressed outpatients who were drawn from a larger research study designed to test the efficacy of a combined modality for the treatment of DSM-III-R Dysthymic Disorder. This section is divided into two parts: (1) preliminary analyses and (2) analyses conducted to test the major study hypotheses and research questions.

A. Preliminary Analyses

Inter-Rater Reliability

Interrater reliability in the present study was established by the following method: Three advanced level clinical psychology graduate student raters were initially trained on Cramer's standard scoring manual, and a set of TAT protocols from a college student sample, Cards 1 and 17BM, used by Cramer in her own reliability studies. The coders were then trained in interrater agreement established on "practice" TAT protocols obtained from two sources: (1) TAT protocols of patients who had participated in past studies conducted in the Brief Psychotherapy Research Program at Beth Israel Medical Center, as well as (2) the protocols of dysthymic patients who had been initially screened and accepted for treatment in the Mood Disorders Research Unit Dysthymia Project but had terminated prematurely. All raters were blind to treatment group and the hypotheses of the study.

Reliability was established by informal consensus based on a 6-8 week training period, using 5 "practice" TAT protocols. When the coders appeared to be readily

reaching agreement, a more formal test was conducted on seven additional practice TAT protocols of dysthymic patients over a training period of 5-6 months. The mean reliability scores for each defense mechanism on these 7 sessions were .62 (SD = .41) for Denial; .86 (SD = 8.19) for Projection; and .80 (SD = .15) for Identification. Coders were thus trained to this level. Fifteen protocols were randomly selected to establish overall reliability. Based on the three coders' ratings on these 15 protocols, the mean intra-class correlation coefficients were as follows: For Denial, M = .66 (SD = .30), for Projection, M = .85 (SD = 7.70), and for Identification, M = .85 (SD = .13).

The minimum criterion requirement for reliability for this study was set at .6, which is satisfactory according to Kraemer (1981). The power of a given test depends upon the sample size but also the reliability coefficient. In clinical psychiatry research, a coefficient of 80% and above in clinical psychiatry research is almost perfect; a coefficient of 60%-80% is satisfactory, 40%-60% is acceptable but possibly improvable, 20% -40% demands improvement, and 20% or below is totally unacceptable (Kraemer, 1981). Following this classification scheme, it was determined that for any defense ratings that dipped below the .6 criterion, the coders would reanalyze the protocols as a team until they reached consensus ratings.

Group Differences on Pre-Treatment Variables

Preliminary analyses were first conducted to assess whether there were significant differences at intake between the two treatment groups (Combined Medication + Psychotherapy; Medication alone) on the major study variables, including age, mean number of major depressive episodes, depressive symptomatology, interpersonal

functioning (Table 2), as well as Axis II comorbidity.

It was first important to determine that the initial severity of mood disturbance did not differ for the two treatment groups, and thus represent a confounding variable when evaluating performance on the other study variables.

To assess whether depression at intake differed according to the two treatment groups (Combined *v.* Medication), *t*-tests were conducted on the Beck Depression Inventory (BDI) and on the Hamilton Depression Rating Score (HDRS) for independent samples of groups. There were no significant differences at intake between treatment groups on either depression inventory, the BDI or the HDRS. Given this non-significant relationship between initial depression level and treatment group, a covariate for depression was not used in subsequent analyses.

Analyses (*t*-tests) were also conducted to assess for group differences on patient characteristics such as age, mean number of major depressive episodes, and a measure of problematic interpersonal functioning. Again, no significant differences were found (Table 2).

TABLE 2

Group Differences on Intake Variables

	Treatment Type				
	Combined* N=16		Medication** N=14		
Variable	M	SD	M	SD	r-value+
Age	46.11	8.11	45.71	11.30	.02
MDE	2.44	4.49	2.50	3.44	.01
BDI	13.38	6.39	13.93	5.37	.05
HDRS	16.56	7.21	17.93	7.12	.10
IIP (mean)	1.71	.45	1.63	.56	.08

* Combined (Medication + Psychotherapy) ** Medication (Medication only).
+ Effect size of correlation coefficient
Major Depressive Episode; Beck Depression Inventory; Hamilton Depression Rating Scale; Inventory of Interpersonal Problems.

Axis II Pathology by Treatment Group

Another set of analyses was conducted to assess whether Axis II pathology differed between groups. The presence of personality disorders in this sample of depressed patients is consistent with other studies on depression (Akiskal, 1983; Keller, 1988; Klein et al., 1993). The actual Axis II incidence in this sample was relatively high (63.3%), with the distribution of personality disorders heavily weighted towards Cluster C symptoms both for those patients diagnosed with only one Axis II disorder (n = 9) and those patients diagnosed with more than one Axis II disorder (n = 6).

To assess group differences on DSM-II-R personality disorder diagnoses, a chi-square was computed between the Combined (Medication + Psychotherapy) group and the Medication only group to determine whether the presence of "no" Axis II disorders and "any" Axis II disorders at intake differed for treatment group. The result,

$X^2(1) = 1.42$, was non-significant. The data was also organized into 5 different cells: (1) Multiple number of personality disorders (e.g., > 1 personality disorders); (2) N.O.S. (e.g., 1 ± subthreshold diagnoses); (3) Clusters A & B; (4) Cluster C; and (5) No diagnosis of personality disorder. Since both Clusters A & B represent primitive types of characterological impairment, and only one patient met criteria for a Cluster A disorder, they were included in one cell [A/B]. Again, no significant difference was found between groups,

$X^2(1) = 2.70$, but the effect size of the correlation coefficient was moderate, r = .29.

TABLE 3

Frequency Distribution of Axis II Pathology by Treatment Group

Type of Diagnosis	Combined Treatment	Medication only
Multiple Axis II	4	2
Personality N.O.S.	3	1
Cluster A & B	1*	1**
Cluster C	4+	3++
No Axis II	4	7

* = histrionic; ** = paranoid; + = obsessive-compulsive (n = 3); passive-aggressive; + + = obsessive-compulsive (n = 2); avoidant.

Upon examination of the distribution of Axis II disorders, the Combined Treatment patients showed a higher incidence of disorders (n = 12) than the Medication alone group did (n = 7). With a larger sample size, these differences between groups might have reached significance.

B. Analyses conducted to test the major hypotheses and research questions

The principal aim of this study was to investigate changes in the type of defenses used in patients undergoing treatment for chronic depression. Defense scores for each patient in this study were summed across the ten Thematic Apperception Test (TAT) stories (Cards 1, 2, 3GF/BM, 4, 5, 6GF/BM, 7GF/BM, 8GF/BM, 9GF/BM, and 10).

The mean values and standard deviations for the three defense subscales used in this study, Denial, Projection, and Identification, assessed at intake, are shown below in Table 4.

As this table indicates, patients began treatment with a relatively high mean number of Identification scores (9.22), which suggests that some patients, despite their distress prior to beginning treatment, had the capacity to use a mature defense mechanism.

TABLE 4

Raw Means & Standard Deviations of Defenses at Intake (Whole Sample)

	Intake	
Defense	M	SD
Denial	6.66	5.16
Projection	10.70	3.51
Identification	9.22	4.49

N = 30

TAT Story Length as Co-variate

A significant association was found between story length (total number of words per protocol) and two defenses, Denial and Identification. A higher total word number per TAT protocol was positively related to greater use of each of these two defense mechanisms. Correlations between story length and Denial ($r = .53 < .003$) and between story length and Identification ($r = .57$, $p < .001$) were both significant. But no significant correlation was found between story length and Projection

(r = .21). ANCOVAs using story length as the covariate were used in subsequent analyses when assessing residualized change scores in Denial and Identification, but not when assessing residualized change scores in Projection.

Associations between TAT story length and measures of depression were not found to be significant. The correlation between story length and the Hamilton Depression Rating Scale [HDRS] was .09. The correlation between story length and the Beck Depression Inventory [BDI] was also non-significant (r = .35), but had a moderate effect size (Cohen et al., 1988).

Gender and Defense Use at Intake

Since evidence (Cramer, 1983; Cramer & Blatt, 1990) exists for gender differences on defense use, t-tests for independent samples were conducted to examine whether men and women differed on defense use at intake. The results were non-significant. For Denial, means scores for men were 6.69 (SD = 6.71); for women: M = 6.71, SD = 5.62, r value (converted from t-score) = .01. Of note was a moderate effect size for Projection: Men: M = 8.88, SD = 5.06; Women: M = 12.29, SD = 6.33, r-value = .29. A slightly smaller effect size was found for Identification: Men: M = 10.26, SD = 5.32; Women: M = 8.31, SD = 3.54, r-value = .22. With a larger sample size, significance between the sexes on defense use at intake might have been obtained.

Differences between Treatment Groups on Defenses at Intake

Finally, t-tests conducted to assess whether the treatment groups differed on defense use (Table 5) were non-significant.

TABLE 5

Differences between Treatment Groups on Defenses at Intake

Variable	Combined*		Medication**		Group Difference			
	M	SD	M	SD	t	df	p	r-value +
Denial	7.71	5.58	5.45	4.52	1.21	28	.24	.22
	M	SD	M	SD	t	df	p	r-value +
Projection	11.71	6.77	9.54	4.79	1.00	28	.33	.18
	M	SD	M	SD	t	df	p	r-value +
Identification	9.85	5.27	8.50	3.45	.82	28	.42	.15
	M	SD	M	SD	t	df	p	r-value +
Total Defenses	29.27	11.36	23.49	8.22	1.58	28	.13	.29

*N = 16; **N = 14

\+ Effect size by correlation coefficient

Change in Defense Scores Over Time (All Subjects and by Treatment Group)

It was hypothesized (Hypothesis 1) that dysthymic patients assigned to the Combined (Medication + Psychotherapy) group would show greater change on immature defenses (e.g., Denial and/or Projection) than patients who only received medication. It was also hypothesized (Hypothesis 2) that dysthymic patients assigned to the Combined treatment would show greater change on mature defenses (e.g., Identification) than patients treated only with medication.

First, *t*-tests were first conducted to determine whether there was a significant change in overall level of defense scores for the entire sample, independent of treatment group. Denial decreased significantly in overall level (mean number) for all patients ($t(29) = 2.40$, $p < 023$; Combined, $M = 6.66$, $SD = 5.16$; Medication, $M = 4.80$, $SD = 3.51$). No other significant changes on defenses from intake to termination were found (Table 6).

TABLE 6

Changes in Total and Individual Defenses (Raw Scores) from Intake to Termination Independent of Group

	M	SD	Paired Differences t-value	df	p	r-value
Denial						
at Intake	6.66	5.16	2.40	29	.023*	.41
at Termination	4.80	3.51				
	M	SD	Paired Differences t-value	df	p	r-value
Projection						
at Intake	10.70	5.93	1.60	29	.80	.28
at Termination	8.92	4.40				
	M	SD	Paired Differences t-value	df	p	r-value
Identification						
at Intake	9.22	4.50	-.86	29	.40	.16
at Termination	10.16	4.71				
	M	SD	Paired Differences t-value	df	p	r-value
Total Defenses						
at Intake	26.57	10.28	1.48	29	.15	.26
at Termination	23.89	6.60				

N = 30 for all pairs

*Probabilities at two-tailed level of significance.

I-tests were also conducted to assess for differences between the Combined and Medication groups on changes in total mean number of defenses (Denial, Projection, and Identification). A significant group difference was found for Denial, with patients assigned to the Medication-alone group showing greater decline (see Table 7).

However, the usefulness of examining overall level (total number) of defense use at termination as an indication of change is limited since it does not take into account the patient's initial level of defense functioning.

For this reason, residualized change (gain) scores (Luborsky et al., 1988), computed on the basis of the mean gain for all patients functioning on the same level at intake, was thought to be a more reliable and useful measure of assessing change over time. The actual gain score is first computed by subtracting the patient's raw pretherapy (intake) score from the post-therapy (termination) score. The predicted gain (based on the mean gain of all patients on the same initial level) is then subtracted from the actual gain to derive the residual gain score.

Table 7 shows the means, standard deviations for defenses at intake, termination as well as residualized change scores for all three defense mechanisms, by treatment group.

TABLE 7

Means and Standard Deviations and Residualized Change Scores of Defenses at Intake and Termination by Treatment Group

	Intake		Termination						Residualized Change	
Denial	M	SD	M	SD	t-value	df	p	r-value*	M	SD
					3.11	22	.005	.55		
Combined	7.71	5.58	6.39	3.88					1.17	2.86
Medication	5.45	4.52	3.00	1.88					-1.33	1.97
Projection	M	SD	M	SD	t-value	df	p	r-value*	M	SD
					-.01	28	.995	.001		
Combined	11.71	6.77	8.91	3.72					-.26	3.13
Medication	9.54	4.79	8.92	5.22					.29	5.18
Identification	M	SD	M	SD	t-value	df	p	r-value*	M	SD
					.21	25	.84	.04		
Combined	9.85	5.27	10.33	5.68					.61	5.23
Medication	8.49	3.45	9.97	3.48					-.70	3.41

*effect size of correlation coefficient

To assess differences between the treatment groups on change in defense use over time, defense scores were analyzed with a 2 (treatment group) by 3 (defense) analysis of covariance, using story length as the covariate (see Table 8).

In analyzing residualized change on Denial, a significant main effect was found for treatment group, with the Combined (Medication + Psychotherapy) group showing greater improvement than the Medication group, which did more poorly. Patients did not, however, show significant residualized change on either Projection or Identification, when assessed by treatment group.

Additional analyses were conducted to ascertain whether change scores on the different defense mechanisms were influenced by gender or by the presence or absence of Axis II pathology. No significant effect was found for gender on residualized defense change (Table 9).

TABLE 8

Residualized Change in Defenses by Treatment Group

	Combined*		Medication**				
Defense	M	SD	M	SD	E value	df	p
Denial	1.17	2.86	-1.33	1.97	6.57	1,29	.02
Projection	-.26	3.13	.29	5.18	.13	1,29	.72
Identification	.61	5.23	-.70	3.41	1.23	1,29	.28

*N = 16; **N = 14.

TABLE 9

Residualized Change in Defense by Gender

	Men		Women		Group Difference			
Defense	M	SD	M	SD	t	df	p	r-value
Denial	.62	2.87	-.54	2.83	-1.11	28	.28	.21
Projection	-.02	4.14	.01	4.28	.02	28	.99	.004
Identification	1.03	5.42	-.90	3.32	-1.19	28	.24	.22

*Effect size by correlation coefficient

To assess the effect of Axis II personality disorders at intake ("none" *v.* "any") on defense change by treatment group, residualized defense scores were analyzed with MANOVAs. No significant differences between treatment groups were found. For Denial: F (1,28) = 2.43, p = .13. For Projection: F(1,28) = .04, p = .84. However, a main effect for Axis II pathology on residualized change on Identification approached significance for the whole sample, but not for treatment group, with patients diagnosed as having "no" Axis II disorders showing improvement on the use of Identification than patients diagnosed with "any" Axis II disorders who showed a decline (Table 10).

TABLE 10

Residualized Change on Identification by Axis II Pathology Independent of Treatment Group

No Axis II*		Axis II**				
M	SD	M	SD	F-value	df	p
.04	3.77	-.14	4.95	3.69	1,28	.067

* N = 10 ; N = 19

Additional analyses were conducted to determine whether the four subtypes of Axis II pathology (e.g., no Axis II; > 1 Axis II diagnosis; Personality Disorder N.O.S.; Cluster A/B; and Cluster C) and patients with no Axis II would show differences in residualized change on defense mechanisms. One-way Anovas comparing Axis II groups on residualized change for Identification (Table 11) showed that patients with Cluster C disorders improved significantly more than patients with multiple personality disorders or Personality Disorder N.O.S. No significant

differences were found for patients with no Axis II (M = .24, SD = 3.64) and Cluster A/B disorders (M = 2.78, SD = 2.12) between patients with Cluster C disorders or the other two groups, although both were in the direction of greater improvement. ANOVAs comparing Axis II groups on Denial and Projection were non-significant.

Table 11
Residualized Change on Identification by Axis II Subgroup

Axis II subgroup	M	SD	F-value	df	p
Cluster C*	3.26	5.46	3.01	4,29	.04
Multiple **	-3.10	3.11			
NOS***	-3.10	2.81			

* N = 7; ** N = 4; *** N = 6.

Relationships between Defense Mechanisms and Depressive Symptoms and Interpersonal functioning

It was hypothesized (Hypothesis 3) that mature defenses (e.g., Identification) at intake would be positively associated with clinical outcome (less depressive symptomatology, improved interpersonal functioning), and that, conversely, primitive defenses (e.g, Denial) would be negatively associated with clinical outcome. This hypothesis was designed to assess whether initial level of type of defense at intake would predict clinically significant improvement on two depression measures, the Beck Depression Inventory and the Hamilton Depression Rating Scale, and on the Inventory of Interpersonal Problems. Results showed partial support for this hypothesis.

a) Defense and Depressive Symptoms

First, controlling for story length, partial correlation coefficients were computed between the defense subscales and depressive symptoms at intake. A significant negative relationship was found between Identification and the BDI (r = -.49, p<.007), indicating that patients using this defense mechanism prior to beginning treatment had lower levels of depressive symptomatology than patients who were using it less frequently.

Correlations between primitive defense mechanisms at intake, Denial and Projection, and scores on depressive symptoms were non-significant. In addition, initial level of defense functioning of patients at intake did not predict how patients performed on residualized change scores on any of the outcome measures. A correlation matrix of defenses at intake and depressive symptoms at intake and residualized change scores on depression is shown in Table 12.

TABLE 12

Correlations between Defense Scores at Intake and Depressive Symptoms at Intake and Over Time

			Residualized Change	
	BDI	HDRS	BDI	HDRS
Denial	-.03	.16	.25	.21
Projection	.14	.18	-.01	-.07
Identification	- .49*	-.18	.06	-.07

N = 30

*Probability is less than .01 at the two-tailed level of significance.

Correlations between residualized change scores on defenses and residualized change on depressive symptoms (using story length as a covariate) were non-significant, both when assessed independently of treatment group (Table 13) and when assessed for possible differences between the treatment groups. Correlations between residualized defense scores and depressive symptoms by treatment group, again using story length as a covariate, are shown in Table 14.

TABLE 13

Correlations between Residualized Change on Defense Scores and On Depressive Symptoms Independent of Group

	BDI	HDRS
Denial	.06	.01
Projection	-.11	-.11
Identification	-.04	-.18

N = 30

TABLE 14

Correlations between Residualized Change on Defenses and on Depressive Symptoms by Treatment Group

	Combined		Medication	
	BDI	HDRS	BDI	HDRS
Denial	.15	.33	-.02	-.06
Projection	-.04	-.29	-.15	-.09
Identification	.07	-.04	-.26	-.18

N = 30

b) Defense and Interpersonal functioning

Interpersonal behavior was assessed by a 127-item self-report measure, the Inventory for Interpersonal Problems (IIP), discussed earlier. A high total mean score on the IIP indicates the presence of problems in various domains of interpersonal functioning, under the general rubric of "Control" (Dominant-Submissive) and "Affiliation" (Hostile-Friendly) Patients rate the number of problems they encounter in everyday social interactions as well as the psychological distress associated with these problems.

Partial correlation coefficients, controlling for story length, computed between the three defenses and residualized change on the IIP were non-significant: For Denial and residualized change on IIP, $r = -.01$; for Projection and residualized change on IIP, $r = .01$; for Identification and residualized change on IIP, $r = .16$.

Change on Interpersonal Functioning, Defenses, and Clinical Outcome

It was also hypothesized (Hypothesis 4) that change (improvement) in interpersonal functioning and positive change (decline) on primitive defenses would be associated with clinical outcome (relief from depressive symptoms). To assess these relationships, partial correlation coefficients, controlling for story length, were computed between the IIP, Denial, and measures of depressive symptomatology.

a) IIP and Depressive Symptoms

Correlation coefficients between the IIP and changes scores on the BDI and HDRS are shown in Table 15. Regardless of treatment group, change on both depressive symptom measures and on overall mean score for the IIP were significantly correlated. Residualized change on the IIP score was significantly correlated with residualized change on the BDI ($r = .65$, $p < .001$) and somewhat less robustly on the HDRS ($r = .48$, $p < .05$). Of note is that the largest effect size was obtained for the correlation between the two self-report measures (IIP and BDI).

Correlations between residualized change scores on the BDI and on the IIP remained significant for each treatment group. However, significant relationships between the HDRS and the IIP only held up for those patients receiving antidepressants.

This last finding is interesting as it shows a discrepancy between how clinicians in this study rated patient improvement on symptomatology by patient group. That is to say, the clinicians rated the patients who received medication only as showing a significantly greater alleviation of depressive symptomatology than those patients

assigned to the combined treatment modality, even though the Combined patients reported higher levels of relief on the Beck Depression Inventory than their medication only counterparts.

TABLE 15

Correlations between Residualized Change on Interpersonal Functioning and on Depressive Symptoms

	All Patients	Combined	Medication only
	IIP	IIP	IIP
BDI	.65*	.68**	.63***
HDRS	.48***	.38	.68**

* probability less than .001 at the two-tailed level
** probability less than .01 at the two-tailed level
*** probability less than .05 at the two-tailed level

b) IIP and Defenses

I had hypothesized that residualized change on immature defense mechanisms, in tandem with an improvement in interpersonal functioning, would be related to good clinical outcome. However, as already reported, no significant relationships between residualized change on defense and on the depression measures were found. Post-hoc analyses conducted to determine correlations between residualized change on the IIP and on defense mechanisms also were non-significant.

Research Questions

Only one research question of the four initially posed -- whether different depressive subtypes, as assessed by the Depressive Experiences Questionnaire -- are associated with different defense mechanisms, provided clinically significant and useful findings. These results will be discussed at the end of this section.

One question asked whether some patients showed improvements on depressive symptomatology but not changes on defense use, or conversely, whether some patients showed change on defense use without the benefit of symptom relief. My rationale for asking this question was to identify specific subsets of depressed patients for whom defenses were more or less effective with regard to depressive symptomatology. For example, one could speculate that a subset of patients who showed significant symptom *relief without* the benefit of significant change on defense, possessed more of an endogenous depression, along the lines of Akiskal's (1983) sub-affective dysthymia, than a characterological disorder, for whom personality variables play an important role.

On the other hand, a subset of patients who showed changes on defense use but not on symptom-based measures would also provide support for the argument that defenses and depressive symptoms are unrelated, and, additionally, that defense mechanisms, for some individual, may be related to an independent phenomenon, such as poor self-concept (see Bloch et al., 1993).

In fact, the majority patients in this study showed symptom improvement (defined by a score of 7≤on the HDRS and a score of 10≤on the BDI by the end of treatment. Only five patients did not recover (e.g., retained a diagnosis of Dysthymia). Although no clear pattern of defense use differentiated these non-remitting patients, four of the five belonged to the Medication alone group.

Another research question asked whether different defense mechanisms are associated with different interpersonal problems, as assessed by the Inventory of Interpersonal Problems. However, the overall mean of the IIP, although a useful measure of overall interpersonal functioning, does not permit investigation into the

different octants, and the ipsatized scale of the IIP were discarded as a less reliable measure than the overall mean.

Relationship between Defense and Depressive Subtypes

A good deal of empirical research has been devoted to studying the depressive personality. Blatt et al., 1978 has found evidence for two depressive personality types -- Dependent (Anaclitic) depression and Self-critical (Introjective) depression, which correspond to two distinct subfactors on the Depressive Experiences Questionnaire (DEQ). As discussed previously, the Self-Critical subtype, in terms of level of object relations and defensive operations, has been conceptualized as a developmentally higher personality configuration, than the Dependency subtype. The DEQ was included in this study as a predictive variable to assess whether different types of depressive experience are related to improvements or changes in defense use. All results are shown in Table 16.

A significant positive relationship was found between Dependency (Anaclitic depression) and Projection at intake, which suggests that greater use of Projection as a defense was associated with greater vulnerability to experiences involving interpersonal loss or separation. This finding had a moderate to large effect size.

There was also a significant negative association between Identification and Self-criticism (Introjective depression), indicating that individuals who judge themselves harshly and feel distress over of feelings of worthlessness, guilt, and failure are less likely to make use of this more mature defense mechanism. There was a non-significant negative correlation between Identification and Dependency, with a moderate effect size. A similar non-significant positive relationship was found

between Projection and Self-Criticism, again with a moderate effect size.

Finally, to determine if changes in defense scores differed according to depressive type, pairwise partial correlation co-efficients were computed, controlling for story length of the TAT. A strong negative relationship was found between Self-critical depression and residualized change on Identification.. This suggests that the extent to which a patient is self-critical does predict how much change he or she will show on the defense mechanism of Identification over time. Although Denial and Self-critical depression were not correlated at intake, an almost significant negative relationship between Self-critical depression and residualized change on Denial was obtained, with a moderate effect size. Similarly, an almost significant negative relationship between Dependent Depression and residualized change on Identification was found.

TABLE 16

Correlations between Depressive Types and Defense Scores

	Anaclitic (Dependent) Type	Introjective (Self-Critical) Type
Denial		
Intake	.01	-.10
Residualized	-.08	-.33+
Projection		
Intake	.45*	.32
Residualized	-.25	-.08
Identification		
Intake	-.33 +	-.41**
Residualized	-.35 +	-.42**

* probability less than .01 at the two-tailed level
** probability less than .05 at the two-tailed level
\+ probability less than .09 at the two-tailed level

DISCUSSION

This dissertation examines relationships among defenses, depressive symptomatology, and interpersonal functioning in adult patients receiving medication and psychotherapy for DSM-III-R Dysthymic Disorder in an ambulatory care psychiatric setting.

The purpose of this study was to determine whether relatively brief group treatment could effect a significant change in three defense mechanisms -- Denial, Projection, and Identification -- and whether such change would be related to significant improvements in other domains of functioning. It was also hypothesized that initial level of defense (immature *v.* mature) would predict clinical improvement in patients, regardless of treatment assignment. Defenses are primary psychological mechanisms which manage conflict, regulate affect, and protect self-esteem. The type and developmental level of a given defense mechanism contributes both to our understanding of specific psychopathologies as well as personality development overall.

The summary of the major findings are as follows: That change on Denial (but not Projection or Identification) does occur in brief group psychotherapy; that Identification is negatively related to depressive distress; that improved interpersonal functioning is related to a decline in depressive symptoms; that types of depressive experiences (Blatt, 1974) are related to specific defenses, and introjective (Self-Critical) depression, in particular, predicts how much change a patient will show on Identification.

The relationship between depression and defense originates in early analytic theory, with Freud's (1917) characterization of introjection as the means by which melancholic individuals resolve conflict over object loss. Although distress related to perceived or actual loss continues to play an aetiological role in psychological formulations, contemporary theorists from cognitive and psychodynamic perspectives depict depression more broadly as a pathology of self-esteem. It has been proposed that depression represents an ego reaction to one's basic helplessness and unfulfilled aspirations (Bibring, 1953), a predisposition to negatively biased self-schemata (Beck, 1967,1983), an injury to infantile narcissism (Fenichel, 1945), and a sense of personal inadequacy in the face of repeated failure (Bleichman, 1996). Freud even speculated on "whether a loss in the ego irrespectively of the object -- a purely narcissistic blow to the ego -- may not suffice to produce the picture of melancholia" (1917/1968).

More recently, Blatt (1974; Blatt & Schichman, 1983; Blatt et al., 1990), integrating cognitive theory and the psychoanalytic literature on depression, introduced a developmental model which encompasses both experiences of loss, linked to oral, pre-oedipal fixations, and threats to self-esteem, traced to super-ego conflicts concerning desires for approval and success. In all these various psychological conceptions, defenses serve largely a protective role, from avoidance of separation anxiety, deflection of hostility, to efforts to recover self-esteem.

This study takes as a starting point the theory that defenses begin in childhood as psychologically normative operations (A. Freud, 1936; Vaillant, 1971, 1976). The view of defenses having pathological and non-pathological functions emerges in

Anna Freud's portrayal of denial in play-acting, and has been extended by Vaillant's researches on what spurs healthy functioning across the lifespan, which led him to conceptualize ego defenses as the mental equivalent of the body's immune system (1993).

Empirical research has shown that defenses arise in different developmental periods commensurate with the level of cognitive understanding and ego maturity the child has achieved. Used in adulthood, primitive defense mechanisms may signal disturbances in cognitive capacity, self-concept, and interpersonal relatedness which ultimately disrupt one's functional ability. But defense mechanisms, particularly those defined as mature, can reflect an ability to accommodate, in the Piagetian sense, to the natural stresses of life, and to predict healthy, positive functioning.

This study views defense as a potential mediating variable between personality vulnerabilities, biological dysregulation (e.g., serotonin deficit), and precipitating life stressors. Defenses operate in tandem with psychological structures (schemas, internal working models, etc.) which encompass "templates" of self in interaction with other (Diamond & Blatt, 1994), and are the vehicles through which relationships are organized and mediated. How an event or experience is perceived, interpreted, and integrated into the individual's self-representation determines in part the severity of a depressive reaction, and the need to mobilize defenses against it.

As this study demonstrates, the role of defenses in mediating certain kinds of subjective depressive distress enriches our present understanding of chronic depression on the Axis I/II continuum, and points to avenues for further research that may inform more appropriate and effective treatment strategies for this clinical population.

A. Discussion of Demographic Characteristics of Patients

As reported, no group differences were found on demographic characteristics. In addition, sex of the patient had no impact on changes in defense mechanisms. As previously noted, Cramer (1983, 1987) found in normal samples that defenses are gender-related, with women showing more frequent use of denial, and men more frequent use of projection, which is consistent with stereotypic notions of sex role behavior. But, in a psychiatric inpatient population, Cramer (Cramer et al., 1988; Cramer & Blatt, 1990) found opposite patterns of expected defense use with sex-incongruent (e.g., projection with anaclitic men) inpatients.

This study did not corroborate these findings. The results obtained here support Vaillant (1992)'s conclusion, based on a comprehensive review of longitudinal data, that gender does not significantly affect defensive style. Vaillant's sample and the present group of dysthymic patients were older and higher functioning than the borderline and schizophrenic inpatients in Cramer et al.'s studies. Cramer et al.'s sex-incongruent findings on defense may reflect the interpersonal dysfunction of their younger, more disturbed psychiatric patients, who, conceivably, had a less fixed adherence to socially sanctioned sex roles, which can help consolidate and reinforce gender identity. However, the adaptiveness of stereotypic gender-defense relationships needs more empirical study.

The psychiatric history of the overall patient sample was notable for a high incidence of personality disorders (63.3%), consistent with Klein et al.'s (1988) finding of increased rates of personality disorders in early onset dysthymic patients.

On closer examination, patients diagnosed with single Axis II disorders presented mainly with Cluster C features (particularly obsessive-compulsive disorder), also consistent with Klein et al.'s (1988) research. In addition, the six patients in our study with more than one personality disorder showed a preponderance of obsessive-compulsive personality disorder. This diagnosis is associated with a neurotic personality organization and higher level defenses (Kernberg, 1975, 1976), and lacks the high degree of affective lability characteristic of Cluster A and B disorders, as well as borderline types of depression, which reflect personality disorganization, including the inability to maintain a consistent sense of self.

The greater ratio of Cluster C to Cluster B diagnoses in our depressed sample may explain how many of them, despite their Axis II comorbidity, managed to maintain professional jobs and to function at a reasonably high level. Although no difference between the treatment groups pertaining to Axis II was found, the higher proportion of personality disorders diagnosed amongst the Combined patients (37% v. 23% for the medication alone group) suggests that, with a larger sample size, significant group differences might have been obtained.

Post-hoc analyses revealed the impact of Axis II disorders when comparing patients diagnosed with and without personality disorders. Patients without personality disorders showed greater improvement on Identification than patients with some personality disorders, a finding not surprising given the developmental maturity this particular defense mechanism represents. In Cramer's (1990) scoring system, Identification represents a mutual relatedness that presupposes self-other differentiation; it does not measure the symbiotic, merger identifications more

characteristic of patients with primitive object relations.

Further post-hoc analyses revealed that patients with predominantly Cluster C type disorders improved more on Identification than patients diagnosed with Personality Disorder N.O.S., or personality disorders high on Cluster A/B features. This finding supports Cramer's (1991) thesis that maturity of defense mechanisms corresponds to level of psychopathology. It also reinforces the need to identify Axis II in depressed samples to better understand the mediatory role of defense.

B. Change in Defenses over Time

The first hypothesis tested whether patients assigned to the combined treatment (medication + therapy) would show a greater change (e.g., decline) on immature defenses (Denial, Projection) over the course of treatment. Based on previous research, which links increased use of immature defense mechanisms with higher levels of pathology (Cramer et al., 1988), and their decline with good psychological outcome (Vaillant, 1976), depressed patients who used a high degree of primitive defense mechanisms were hypothesized to respond more rapidly to a treatment regimen of medication plus psychotherapy than medication alone. To test this hypothesis, Denial and Projection were examined through an analysis of covariance (treatment group) by (defense), controlling for story length.

The use of Denial (but not Projection) decreased for all patients over the 24 weeks of treatment. Furthermore, as predicted, a significant group difference on Denial was found, with patients assigned to the Combined treatment (medication + therapy) showing greater improvement than patients assigned to the medication only

treatment. (Despite evidence that decline of immature defense mechanisms is associated with good psychological outcome [Vaillant, 1976], Denial did not correlate significantly with any of the outcome measures, either at intake or over the course of treatment. This finding will be explored in a subsequent section).

Denial, as it is used here, refers to defense against painful aspects of external reality. It is considered a primitive, rather simplistic mechanism which develops early in life, and reflects the immature ego of the child for whom the boundaries between reality testing and denial in fantasy are still permeable (A. Freud, 1936). A salient feature of this defense mechanism is the use of cognitive or perceptual distortion to avoid experiencing loss or separation (Blatt, 1974). Modell (1984) has characterized denial of separateness as the illusion that the object, being part of the self, cannot be lost. This conceptualization echoes the analytic view of introjection, seen as preserving the object within the ego to maintain some semblance of emotional tie. A diffuse self-other boundary is a distinguishing aspect of all immature defense mechanisms (Cramer, 1991), but the presence of elevated dependency needs is particularly associated with Denial (Blatt, 1974).

What accounts for the significantly greater decline on Denial in the Combined treatment patients? One explanation is that greater decline is to be expected in patients undergoing psychotherapy treatment than patients only receiving medication. Several factors support this explanation:

First, immature defenses appear to change readily with brief therapy treatment. A number of empirical studies on changes in the use of immature defenses (including Denial) during relatively short-term psychiatric treatments for depressed inpatients

and outpatients patients has been documented (Ablon et al., 1974; Akkerman et al., 1992; Kneepkens, 1996).

Secondly, the specific group therapy intervention may have contributed to greater decline in denial. One aim of our group treatment was to help patients recognize the maladaptive consequences of their own avoidance behaviors. Coyne (1976) has documented how depressed individuals induce negative responses in others in ways that perpetuate their depressed state. Though outwardly distressed, some members tended to disavow angry or sad affects as a way to distance themselves. Group interventions focused on emotional blocking, angry use of silence, and topic switching to avoid engagement; mindfulness techniques which facilitated emotional awareness; and cognitive structuring tasks which linked negative thoughts with self-defeating behaviors to encourage disconfirmation of global negative predictions about self and others.

A group modality may be particularly suited for patients who use primitive denial to cope with conflict. Supportive peer confrontation appears to be a more effective treatment strategy for patients with immature defenses, who show little benefit from traditional interventions, such as interpretations, or from psychopharmacological treatment (Vaillant, 1993).

The intrinsically social nature of the group, which encourages frank exchange, may be especially valuable for depressed individuals who suffer from isolation and self-estrangement. Several group patients acknowledged longstanding difficulties discussing their depression with family members. Self-disclosure has been identified as an important therapeutic factor in group treatments (Yalom, 1995) linked to group cohesion and positive outcome (Bloch & Crouch, 1985). Thus, the decrease in Denial

in the Combined patients could reflect a willingness to let down their guard. This may not have translated into measurable symptom change, but might have eased a need to resort to old withdrawal patterns when navigating interpersonal relationships.

No change was demonstrated with Projection, for the sample as a whole or for the individual treatment groups. The tendency to externalize one's own hostile intentions or feelings by attributing them to another did not abate for the patients. This result is surprising given Cramer et al. (1988)'s finding that Denial and Projection were positively correlated, Pearson $r(88) = .33$, $p < .01$, consistent with the hypothesis that these immature defense mechanisms lie adjacent on a developmental continuum. However, in our sample, a non-significant negative relationship between Denial and Projection ($r(30) = -.14$) was found, suggesting little conceptual overlap. Projection may be a more entrenched defense than Denial, and change on externalizing defenses in therapy may require a direct challenge. Projection, for example, showed significant change in the Winston et al., 1994 study when directly confronted by therapists.

The second hypothesis, that patients assigned to the Combined treatment would show change on mature defenses (Identification) over the course of treatment, was also examined with an analysis of covariance (treatment group) by (defense), controlling for story length. This hypothesis presupposed that patients possessing adaptive defense mechanisms would have sufficient resources to utilize psychotherapeutic treatment to address problematic relational issues. The results obtained did not support this hypothesis, either for the sample as a whole or for the

two treatment groups.

It is not altogether surprising that a complex defense mechanism such as Identification failed to show change. Identification is also a life-long developmental process, involving a modification within the ego (Cramer, 1991), which differentiates it from its more primitive counterparts. Identificatory potential spurs personality development and serves as the "emotional basis of psychological growth" (McWilliams, 1994).

> *This capacity evolves in a natural developmental line from the earliest infantile forms of introjection, which have the quality of swallowing the other person whole, to more subtle, discriminating, and subjectively voluntary processes of selectively taking on another person's characteristics* (p. 135).

Psychoanalytic theory maintains that healthy character formation is contingent upon the establishing of positive identifications within the ego and super-ego. Prior to developing a conscience, children rely on the external world -- initially the parental objects -- to control their wishes and impulses. Once the superego becomes part of the mental apparatus, they perform for themselves the function of restraint (Modell, 1984). In Freud's (1923) terms, a child takes into his internal world the contents of his parents' super-ego, as well as the attitudes of society, through the process of identification. He learns to master impulses, operate independently of parental figures, and control his environment -- all important ego functions (Rycroft, 1968) that emerge through imitating, emulating, and ultimately internalizing the attributes of another. It is largely the lack of healthy identifications that leads to aggressive cathexis of the self-image which characterizes the depressed individual (Jacobson, 1954).

How might such a complex process as Identification develop over the course of psychotherapy treatment? Traditionally, in individual therapy, transference is the vehicle through which positive identifications are formed. It is this "capacity of human beings to identify with new love objects," in the context of the therapeutic relationship, that permits recovery from emotional suffering and allows psychotherapy to effect change (McWilliams, 1994, p. 137).

Identification is the culmination of the internalization process, beginning with oral incorporation, and evolves into the capacity to take in ("metabolize") the other without relinquishing the integrity of the self. Internalization, and accordingly Identification, is thought to be established in cyclical experiences of separation and relatedness (Diamond & Blatt, 1994; Mahler et al., 1975). A gratifying involvement with the object is an essential precondition for internalization, but only disruption with that involvement catalyzes internalization (Blatt & Bass, 1990).

One can observe how this dialectic plays out in therapy. Indeed, the very multifariousness of the transference relationship (idealized, unobjectional positive, obstructing, etc.) illustrates diverse ways patients learn to utilize, often with great ingenuity, elements of connection and difference, to maximize its reparative potential.

Working in a cognitive-interpersonal perspective, Safran and Muran (1995) have proposed that exploring in-session ruptures both strengthens the therapeutic alliance and achieves significant interpersonal change. Here the change mechanism is contingent upon the validation of new (disconfirming) emotional experience that liberates the patient from having to re-enact depressogenic interpersonal schemas.

Although we tried to establish a positive working alliance in our group, it may have

lacked a certain emotional valency. Time constraints and the focused nature of the treatment limited our ability to create the intimate connection between patient and therapist that is established in the resolution of difference. In retrospect, the cohesiveness of our therapeutic group, which manifested first amongst group members, may have resisted forming alliances with the therapists.

The failure to show change on Identification further supports the argument that a such complex psychological process requires a longer, more intensive form of therapeutic intervention. This is consistent with Blatt's findings that introjective (Self-critical) patients do particularly poorly in brief treatments (Blatt et al., 1995), but improve significantly in intensive, long-term psychodynamic therapy (Blatt, 1992). His (1995) re-analysis of the NIMH depression study (Elkin et al., 1989) showed that perfectionism, associated with introjective depression, predicted negative outcome in all treatment groups.

It should be noted that the relatively high level of Identification amongst patients at intake may provide a further explanation as to why this defense mechanism did not show significant change. More than half the sample (53%) scored equal to or above the mean overall number of Identification defenses ($\geq$ 9.2), which represents a sizeable portion (34.7%) of all defenses assessed at intake. This finding suggests that most patients managed to retain the capacity to use mature defense mechanisms, both at a time when they were experiencing acute distress and did not have the benefits of treatment, and thus would be unlikely to show a significant rate improvement over a relatively short course of therapy.

C. Defenses, Depressive Symptomatology and Interpersonal Functioning

The first two hypotheses addressed whether treatment modality (medication alone or medication + psychotherapy) affected changes in the type of defenses used. The third hypothesis addressed a different issue -- whether maturity or immaturity of defense predicted patients' overall improvement. If defense mechanisms are truly protective, patients would be expected to show less distress and less problematic interpersonal functioning by the end of treatment.

It was specifically hypothesized that mature defenses (e.g., Identification) would be related to good outcome, whereas immature defenses (e.g., Denial) would be related to poor outcome, as measured by change on depressive inventories as well as interpersonal functioning. Correlations were computed between these defense mechanisms and two measures of depressive symptomatology, the Beck Depression Inventory, rated by patients, and the Hamilton Depression Rating Scale, rated by the prescribing psychiatrists. Post-hoc analyses were also conducted to determine relationships between defense mechanisms and a measure of interpersonal functioning, the Inventory of Interpersonal Problems.

Defenses and Depressive Symptomatology

As expected, a strong negative association was found between Identification and the BDI, but not for the HDRS. This relationship was significant at intake but non-significant for change in depressed mood over time. Thus, patients beginning treatment in a serious depressed state do not appear to use the defense mechanism of Identification, and conversely, patients who do use this defense show significantly less depression. However, any relief that these patients ultimately gained was not

related to initial level of Identification. No association was found between Denial and either depressive measure (BDI or HDRS).

a) Denial and Depression

The failure to find a relationship between Denial and depressive symptoms raises questions about the therapeutic benefits of this particular defense mechanism in a sample of chronically depressed patients. Two opposing perspectives -- Cognitive theory (Beck et al., 1967, 1983) and Depressive Realism (Mischel, 1979; Alloy et al., 1988) -- examine the role of cognitive distortion in depression.

Ostensibly, a low degree of Denial use in patients should be beneficial since it shows less of a reliance on compromised forms of cognition, which are thought to impede objective assessment of one's life and relationships. That is the premise of Beck's (1967) cognitive theory: Negative thought processes about the self engender depression. It was also a central tenet of the group treatment, which drew connections between cognitive biases and self-defeating behaviors. By this argument, less use of Denial, as well as a decline on Denial over the course of treatment, should result in clinically significant reduced levels of depressive symptomatology, as patients begin to identify problems in information processing (selective abstraction, arbitrary inference, personalization) that result in emotional avoidance and negative self-views. However, this result was not obtained in this study.

Other theorists (Alloy et al., 1988) argue that the real problem for depressed individuals is not negative cognitive bias but the impoverishment of the kind of positive illusions that seem to protect non-depressed patients. Studies involving

social comparison and competitive performance found depressed individuals to be coldly realistic when predicting how well they would do, compared to nondepressives who viewed their assets with unjustified optimism (Alloy et al., 1988). Moreover, depressed individuals, although accurate about themselves, harbor overly positive judgments about others which serve only to accentuate their negative self-perceptions.

> *...depressed individuals may be suffering from the absence or breakdown of normal, optimistic biases and distortions. Maladaptive features of depression such as low self-esteem, negative affect, decreased persistence, poor coping with stress, and hopelessness may be consequences, in part, of the absence of healthy personal illusions* (Alloy et al., 1988).

This sense of fatalism, or Depressive Realism, brings to mind Bibring's (1953) notion of ego paralysis which renders depressed individuals ill-equipped to cope with frustrations and setbacks. Research on the adaptiveness of Denial in medical patients also suggests depressed patients might benefit from a little more illusion. Diabetic patients, for example, who derived relief when minimizing the gravity of their diagnosis, even while still adhering to important medical regimens, provide an illustration of the benefits of this defense mechanism (see Lazarus & Folkman, 1984).

One factor governing when denial might be beneficial in depression is personal appraisal, the process by which individuals assess to what extent they have control over a probably negative outcome. Accountability appears to be key in determining how certain individuals become depressed. Abramson (1980) has argued that depression often results when the individual feels personally responsible (internal locus of control) for a negative event. To the extent that he feels a negative outcome

was due to internal factors, he is more likely to become depressed and suffer loss of self-esteem following that event (Lazarus & Folkman, 1984). Thus, determining whether a patient possesses an internal or external locus of control, in the context of personally controllable outcomes, may help assess the potential value of Denial. Internally-oriented patients may get more upset at the prospect of succumbing to depressed mood or at failing to take adequate prophylactic steps against possible recurrence. Some medication responders in our study who experienced "dips" in affect often felt anticipatory dread that relapse is imminent. For some, this triggered a chain of distressing negative associations that began to activate a latent depressogenic schema (Segal & Muran, 1993). For such patients, denial of responsibility (manifested by a strong adherence to a medical model of illness) may have provided a buffering function associated with less depression.

Clearly, psychotherapy can be illuminating, and with illumination comes some discomfort and pain. For a person with a lifelong history of depression, it may not be easy to challenge long-cherished, but self-deceiving, "truths." Thus, a failure to use Denial may have be a possible source of distress -- especially for patients in the combined treatment group. Decreased denial may have made them more realistic but feel less protected --"wiser but sadder" (Alloy et al., 1988). Hence their failure to show improvements on measures of clinical outcome, such as depressed mood.

b) Identification and Depression

What accounts for the significant negative relationship between depressive symptoms and Identification at intake? The quality of one's emotional bond with others determines an individual's risk for depression. Psychoanalytic theory (Freud,

1917, attachment theory (Bowlby, 1977, 1980; Main et al., 1985), as well as integrated cognitive and interpersonal perspectives (Gotlib and Hammen, 1992), all endorse the idea that adverse parent-infant interactions disrupt the child's capacity to form stable, cohesive self-representations which, in turn, are needed to achieve positive interpersonal and object relations.

> *[T]he quality of the identification with the object is determined by the actual object relation...psychic development requires a specific form of identification that depends upon the actual experience of 'good enough' parental care (Modell, 1984, p.56).*

To identify implies the ability to gain emotional sustenance through mature modes of relating to and interact with others, such as emulation, association, or becoming "like" another in positive ways. More importantly, for depression, Identification is one means by which we come to internalize feelings of self-worth (Fenichel, 1945). The failure to sustain supportive relations with others suggests that something in the internal world of the chronically depressed patient may be fundamentally flawed.

Freud (1921) thought Identification was the means by which the first emotional tie (relatedness) is established. But when describing narcissistic identification in melancholia (1917), he refers to an introjective process, a precursor of mature identification. Most theorists now maintain identifications are formed earlier, in the pre-oedipal period of life. As Milrod (1984) notes, "Now we would define Identification as a complex process by which the individual becomes more like the object in reality terms...The self representation is...altered so that we can say identification is a process that builds structure."

Jacobson (1954, 1964) differed from Freud in shifting the emphasis from loss to

early hostile parent-child interactions which become a source of later self-disparagement. She conceptualized the development of ego identifications in three stages: (1) first through the fusion of the child's self image with the mother's image; (2) through the child's imitation of love objects, and (3) in mature identification, through real modification of the child's self to become "like" the parents. Early childhood disappointments, as well as excessive gratification, leads to a premature devaluation of the love-object. Given the tendency for self and object images to coalesce in infancy, the self-image takes on some of the aggressive cathexis of the devalued object, which ultimately produces a loss of self-esteem.

In normal adolescence, the ego ideal, which derives from idealized self and object images, gradually supplants the super-ego. "The longing to become like the ego ideal stimulates ego development so that in counteracting self devaluation it is next in importance to parental love" (Mendelson, 1974, p. 79.) Whereas healthy identifications reflect a positive, intact ego ideal, unhealthy identifications are dominated by super-ego guilt.

Building on these earlier theories, Blatt (1974) has proposed that depression results from impairments in object constancy which impede one from holding a consistent, comforting image of another in mind. He has found that insecure attachment is related to depression in different ways: Depressed patients with anxious-ambivalent attachment style experience strong dependency needs and longings for connection; patients with an avoidant attachment style are more concerned with self-identity issues, and become vulnerable when they fail to meet standards or obtain the acceptance and approval of others.

An insecurely attached child acquires negative representations of self (similar to

negative schemata) as a result of inconsistent or rejecting caregiving, and experiences parental loss (whether through separation or emotional unavailability) as more devastating than a child whose secure base and secure internal working models of attachment are well-established. Both attachment and psychoanalytic conceptualize problems in the individual's representational world as the result of early adverse experiences which lead to difficulties relating to others as well as sustaining a stable, integrated sense of self.

Cognitive-interpersonal perspectives (see Gotlib & Hammen, 1992), less wedded to the recapitualizing power of the past, stress how the self is continually confirmed through social interaction, yet, increasingly, acknowledge that a negative cognitive representation of self (schemata), established in early parent-child encounters, increases risk of depression recurrence.

The strong negative relationship between Identification and depression present at intake did not hold over time. If persons experiencing acute depressive distress have such low levels of Identification, why aren't improvements in symptom relief related to parallel gains in the use of this defense mechanism?

Again, the short-term nature of our group intervention may have been a limiting factor. But there is also the difficulty of comparing change in clinical symptoms with change on defense mechanisms since these two phenomena (depression as syndrome v. depression as personality dysfunction) represent different dimensions and levels of inference. Whereas symptom reduction can occur rapidly in a treatment study, the acquisition of developmentally mature defenses require more time. Such distinct phenomena can never be equivalent, not only because they progress at different rates, but because they do not measure the same things.

Defenses and Interpersonal Functioning

The failure to find significant relationships between defense mechanisms and interpersonal functioning, as assessed by the Inventory of Interpersonal Problems, is surprising. Rooted in the interpersonal tradition (Leary, 1957; Sullivan, 1953), the IIP, which postulates that individuals involved in social interaction reciprocally influence one another's behavior, measures interpersonal dysfunction and sources of interpersonal distress along the dimensions of power and control (dominant-submissive) and affiliation and nurturance (hostile-friendly). Thus, hostile dominant behavior elicits hostile submissive behavior. Tensions develop in the context of non-complementary behaviors -- when partners strive for dominance, for example -- which may become fixed maladaptive patterns over time.

> *Although maladaptive relationship patterns are often experienced as painful, the defensive efforts to avoid anxiety and to protect the self-image lead an individual to repeat those patterns* (Horowitz et al., 1993 p. 549).

How can the failure to find relationships between defense mechanisms and this measure be explained? As will be discussed in a later section, significant relationships in this study were found between defense and types of depressive experiences (Blatt, 1974) that reflect pathologies in internalized representations. Previous research (Blatt et al., 1988; Cramer et al., 1988; Cramer and Blatt, 1990) has found significant correlations between defense mechanisms and interpersonal functioning in psychiatric patients diagnosed with anaclitic and introjective personality configurations.

Cramer et al. (1988), for example, found that, for anaclitic patients, high scores on

Denial and Projection were correlated with psychological immaturity and poor interpersonal relationships, respectively. However, no significant relationships were found between defense scores and these interpersonal measures for introjective patients.

Although defenses have been conceptualized as mechanisms which theoretically protect individuals in both their internal and interpersonal worlds, it may be that specific depressive type (anaclitic v. introjective) influences the relationship between defense and interpersonal functioning in ways that this study has not accounted for. Perhaps, correspondences between defense mechanisms, as intrapsychic constructs, and depressive personality types, which reflect developmentally determined, internalized kinds of pathology, will be more robust than relationships between defense mechanisms and interpersonal style in a sample of chronically depressed patients with high Axis II comorbidity.

D. Improved Interpersonal Functioning and Clinical Outcome

The last (fourth) hypothesis examined the problem of maladaptive interpersonal styles in depressed patients, and asked whether improvements in this domain, in tandem with a decline on Denial, was linked to good clinical outcome. The results obtained provided partial support for this hypothesis.

The failure to find significant relationships between decline on Denial and abatement of depression was not unexpected since, as discussed previously, there was no significant relationship between these variables at intake. The reduction in denial might have exacerbated the Depressive Realism in such patients, precluding any alleviation of psychological disturbance.

Although defense use had no impact on relief of depressive symptomatology or

interpersonal functioning over time, there was significant evidence that problematic interpersonal functioning (as assessed by the IIP) is connected with increased symptom distress for both treatment groups.

Depressed people are less socially skillful and have more interpersonal conflict than non-depressed people in part because they engage in complementary behaviors (dominant-submissive dyads) that perpetuate or confirm negative views of self (Andrews, 1990; Coyne, 1976) while inducing rejecting responses in others.

> *[D]epressive operations include a variety of behaviors that maneuver others towards the fulfillment or confirmation of an underlying self-other representation. [A]n expression of helplessness may exert a strong pull for help from another, and implicit to such an operation may be the representation of the self as weaker and others as stronger... These patterns persist because they are based on interpersonal schemas that are consistently confirmed by the interpersonal consequences of the individual's behavior* (Muran, 1993)

Interpersonal theorists do not conceptualize depression independently of interpersonal functioning: "A change in depression requires a concomitant change in the patient's interpersonal functioning" (Horowitz et al., 1993). Moreover, in a sample of outpatients undergoing brief dynamic psychotherapy, they found that problems of hostile dominance, which improved much less readily than problems of friendly submissiveness, may require a longer course of treatment.

When analyzed according to treatment group, correlations between interpersonal functioning and the clinician-rated depressive symptom measures differed markedly. Although patients in both treatment groups showed significant correlations between the IIP (overall mean score) and the BDI, these relationships were not sustained on the clinician-based inventory, the HDRS. Significant associations were found

between the IIP and the HDRS for the medication-alone patients but not for patients in the combined treatment.

Other studies on depression treatment have reported patient-clinician discrepancies when assessing functioning. But, typically, clinicians report higher rates of improvement. In Hellerstein et al.'s (1993) study comparing fluoxetine and placebo in dysthymic outpatients, clinicians using the HDRS rated patients on fluoxetine as significantly more clinically improved at week 8 than placebo patients, whereas patients, using a self-report measure, the Hopkins Symptom Checklist-58 (HCL-58), reported no greater improvement on fluoxetine versus placebo. Hellerstein et al. (1993) argued that the HCL-58, as a general measure of symptom level, is not refined enough to discriminate between depressive symptoms and transient medication effects, such as anxiety, restlessness and nausea. However, an enduring negative bias of chronically depressed patients in this study may also have accounted for their failure to report symptom improvement, or to confuse those effects with signs of subjective discomfort.

What is striking about our study is that the patients, not clinicians, reported *greater* relief on symptom-based inventories. Each of the three psychiatrists who rated the HDRS managed the medication of a subset of patients (from both treatment modalities). No one was blinded to treatment assignment. Each met with patients biweekly for the first 4 weeks, then monthly thereafter. Treatment at these visits, 15-20 minutes in length, was limited to discussion of symptoms, medication, and side-effects. Psychiatrists were instructed not to engage in psychotherapy, counseling, or the form of "clinical management" as defined in the NIMH Treatment of Depression Collaborative Research Program (Elkin et al., 1989, p. 973). Although

clinical transactions were supposed to be brief and "business-like," the realities of working with patients over 6 months suggest some clinician-patient alliances formed, leading to variability in patient treatment.

This finding raises intriguing issues and questions about possible differential treatment of patients by physicians. It is possible, for example, that the psychiatrists in this study responded differently to some of the Medication-alone patients, who, because of significantly fewer physician contacts, demanded more attention or demonstrated more need. Perhaps they were more attentive to, or solicitous of, such patients because they lacked the "benefits" of the group therapy intervention. Other possibilities, yet to be empirically confirmed, are that psychiatrists have lower standards for people just receiving medication, or, conversely, higher standards for patients receiving both antidepressants and psychotherapy (e.g., they should show more improvement). Psychotherapy research has long recognized the impact of the clinician-patient relationship on outcome. But the few controlled studies evaluating the efficacy of Combined (medication + psychotherapy) studies in which multiple providers may manage treatment have largely ignored this important therapeutic factor.

E. Defense and Depressive Personality

This study assessed symptom improvement in depressed patients as a measure of outcome. But growing recognition of the characterological and psychological dimensions of depression, which runs counter to the psychiatric model of illness (Klein et al., 1993; Blatt), indicate a need to assess the utility of different interventions or therapies with individuals with different types of depression. An

important finding in this study is the predictive value of depressive personality type on defense use.

As noted previously, basic disruptions in early object representations engender vulnerability to two kinds of depressive experiences -- introjective (Self-Critical) depression and anaclitic (Dependent) depression (Blatt, 1974). Such experiences represent disturbances in two fundamental lines of personality development which fall under the rubric of self-definition (establishing a positive identity) and relatedness (maintaining mutually satisfying relationships). In ordinary development, the individual becomes increasingly able to integrate these two experiences of self identity and interpersonal relatedness. But inordinant preoccupation with one or the other dimension in tandem with adverse life events triggers a depressive reaction (Blatt & Zuroff, 1993). Depressive recurrence is seen as the product of an interaction between predisposing vulnerabilities and stressful life events related to an early painful or traumatic experience.

A strong positive relationship was found between Projection and the Dependency subfactor of the DEQ. This finding is at odds with previous research (Blatt et al., 1978), which has shown that anaclitic patients use avoidant (denial) responses when confronted with the possibility of separation or abandonment.

The most frequently coded projective defenses on the TAT protocols in our study revealed a concern with the malevolent intentions of another, as well as threats to body integrity. Such responses contradict Blatt's premise that anaclitic patients have difficulty expressing anger and hostility because they are vulnerable to abandonment.

The unexpected finding between the Dependency subfactor and Projection may reflect an inherent methodological weakness in this particular subscale for dysthymic

patients. In addition, coders could have recorded an inflated number of responses on Projection (the mean level of this defense mechanism was consistently higher than the mean levels of the other defenses, at Intake and termination), but the high reliability coefficient for Projection (.85, SD = 7.70) across 15 protocols suggests the coders were generally in agreement.

Barring any methodological explanation, the question remains: What motive would impel a person with dependency longings to attribute to others aggressive feelings? Abraham (1911) maintained that unconscious hostility differentiated grief from melancholia: One passes from mourning to depression when the response of the lost object is charged with anger mixed with love (Gaylin, 1968). Abraham saw connections between depressed and obsessively neurotic individuals in their ambivalence to object ties. He speculated that the hostility of depressed patients, predicated on a wish to destroy the object, reflected impairments at an early anal stage of development, whereas the neurotics, developmentally more mature and less ambivalent, showed a tendency to conserve the object.

Seen in this light, projection may serve as a defense against dependency. Fearful of re-experiencing past relationship disappointments, the patient externalizes hostile thoughts to create emotional distance, a behavior more consistent with the avoidant attachment style, than the anxious attachment pattern associated with anaclitic patients. Recent investigations into the nature and developmental level of self and object representations associated with attachment styles (Levy & Blatt, 1997) have indicated that both anxious-ambivalent and anxious-avoidant styles are associated with more malevolent, negative representations than a secure attachment status, for which benign representations abound.

Most clinicians do not encounter patients with a pure depressive subtype in treatment. Blatt (1982) has reported significant intercorrelations between the Dependency and Self-criticism factors in male and female inpatient samples. Although the validity of a mixed (anaclitic-introjective) depressive type has yet to be firmly empirically established, our findings suggest that some anaclitic patients may possess introjective features which makes them prone to using a higher level, externalizing, and counter-dependent, form of defense mechanism such as projection. For such individuals, a sense of failure and guilt could coexist with unresolved dependency needs (Viglione et al., 1990). More empirical research is needed to better establish internally consistent and distinct factors corresponding to different types of depressive experiences in clinical samples.

Although the relationship between Projection and anaclitic depression is not supported by prior research, the strong negative relationship between introjective depression and Identification at intake is consistent with theory. Self-denigrating patients begin treatment with lower levels of Identification defenses. Moreover, the intensity of their self-criticism predicts how much change patients show on this defense over time. The Self-Critical DEQ factor, compared to the Dependency factor, has been shown to correlate more highly with independent measures of depression, such as the BDI (Blatt et al., 1982).

The self-critical function is part of the process of the consolidation of the superego, whereby the child learns to internalize, through identification, his parents' opinions, attitudes, values, and rules as his own (A. Freud, 1936).

A positive link between secure attachment and the capacity for self-reflection has been empirically established (Cicchetti & Toth, 1995). Healthy self-reflection entails being able to tolerate, and ultimately integrate, good and bad images into whole representations of self and others. In contrast, introjective depression reflects a preoccupation with bad, rejecting, or disapproving aspects of self to the exclusion of those that are good or benevolent, and leads to perfectionistic tendencies to compensate for feelings of low self-worth.

A defensive precursor to successful internalization is identification with the aggressor (A. Freud, 1936). As part of the normal developmental process, children introject the harsh, punitive attributes of the parent to transform themselves from being the ones threatened to the ones making the threat. But the toxic nature of persecutory internal objects preclude full and successful identification (Jacobson, 1954), and perpetuate a harsh super-ego which devalues the self.

Self-criticism in depression reflects a disruption in the identificatory capacity, a thwarted attempt to achieve ego differentiation which, at the same time, engenders an excessive reliance on others to feel valuable. Introjective patients do have attachment strivings but they get transmuted into perfectionistic concerns with success and achievement, and a pernicious form of self-criticism that is linked to hostile, demanding, internal objects, and hinders their capacity to develop a healthy ego ideal.

The negative impact of introjective depression has important clinical implications. As noted previously, in the re-analysis of the NIMH Depression study (Blatt et al., 1995), Perfectionism (as measured by the Dysfunctional Attitudes Scale; Weissman & Beck, 1978) had a consistently negative effect on outcome in brief treatment. In

contrast, several studies (Blatt & Ford, 1994; Blatt et al., 1988), including a re-analysis of the Menninger Psychotherapy Research Project (Blatt, 1992) have shown that self-critical or perfectionist patients prospered in long-term psychoanalysis or analytically-oriented inpatient treatment, and, moreover, did significantly better in this form of treatment than in supportive-expressive psychotherapy.

Given that perfectionism is a feature of obsessive-compulsiveness, it is likely our patients, who showed a high Axis II comorbidity with disorders of the Custer C variant, most notably obsessive-compulsive personality disorder, as well as self-critical tendencies, might show greater gains in a longer, or more intensive, treatment.

Limitations of the Study

The preliminary nature of this study raise a number of caveats for the interpretation of the obtained results. First, this study was based on a small homogenous sample, and caution should be exercised when generalizing from these results to younger and/or more acutely ill depressed patients. Given the dearth of empirical studies on dysthymia treatment, this study does provides a useful starting point from which to build future studies with other clinically depressed populations.

Secondly, the psychotherapeutic portion of the Combined treatment modality was relatively brief (only 16 weeks) -- a period, it can be argued, insufficiently long enough to document significant personality change. Moreover, although the treatment focused on recurring maladaptive interpersonal behaviors of depressed patients, it did not specifically address defense mechanisms. Greater change on defense might have resulted if the defense mechanisms under investigation in this

study had been directly confronted and challenged by the group co-leaders.

The study would also have benefited from the inclusion of an untreated control group (placebo) to better assess the possible pure effect of the antidepressant on clinical outcome or change. Similarly, the addition of a psychotherapy-alone group (without medication) would have provided a better means of determining the benefits of a therapeutic modality, especially in light of the lack of controlled studies on the efficacy of this treatment modality (with and without medication) for dysthymic patients. Further, the use of blinded clinicians to rate changes in patients' symptom levels would have added greater rigor to the research design.

In addition to these limitations, a decision to pair patients with clinical interviewers midway during the study may have created unforseen methodological problems. Most of the first 15 recruited subjects had different interviewers at intake and at termination. In an attempt to control for interviewer variability, the remaining patients were assigned the same interviewer throughout their treatment. It is possible that a familiarity ensued in the matched pairs, which may have affected the interviewer's objectivity when administering the various psychological instruments, including the TAT.

Future Directions

Several questions are raised by this study. First, how should we conceptualize clinically meaningful change in depression treatment? Symptom reduction has been the goal of most controlled psychotherapy studies of depression, achieved by either addressing faulty information processing or problematic social interactions. But change can be reflected in interpersonal behavior, as well as subtle shifts in object

relations. The high rates of symptom recurrence and relapse in the depressive disorders (Marlatt & Gordon, 1985; Keller, 1988), suggests that underlying psychological problems, not merely symptom distress, makes this condition so intractable.

Mood disorders researchers, now studying the impact of antidepressants on interpersonal change, maintain that rapid social amelioration can result from brief psychopharmacological interventions. Markowitz et al. (1996) documented significant improvements in dysthymic subjects on Inventory of Interpersonal Problem (IIP) subscales following 10 weeks of desipramine treatment. But for a subset of medication responders assigned to a 16 week continuation phase, non-significant improvements on the IIP were reported. It has yet to be empirically established that rapid gains achieved through medication will hold up over time. The need to identify underlying psychological mechanisms which contribute to, or offset, risk for depression remains paramount, because only interventions that promote functional improvements on multiple levels successfully address the problem of chronicity and relapse.

One such potential mechanism is affect dysregulation, which derives from both insecure attachment and neurotransmitter aberrations, and provokes speculation as to whether insecure internal representations affect brain organization, neurophysical functioning, and information processing (Cicchetti & Toth, 1995).

Given the centrality of affective lability in the depressive disorders, researchers might profitably examine relationships between defense use and positive and negative affect in dysthymic patients. An unpublished study of normal adolescents and their mothers (Brody & Layton, 1989) found that adolescents who had difficulty

expressing negative affect when interacting with their mothers used Denial more often, whereas adolescents with difficulty expressing positive affect used Projection. One might ask to what extent does an intolerance or incapacity for negative feelings put an individual at greater risk for depression? Findings from research on expressed emotion suggest that high levels of criticism and negative affect in spouses of unipolar depressed partners significantly contributed to higher rates of depressive relapse (Hooley, 1986).

Thompson (1986) has proposed a measure of affect maturity which rates an individual's capacity to express and cope with feelings, on a continuum, from descriptions of global, undifferentiated, event-like emotions to the ability to endow another with subtle and specific forms of emotional responsiveness. Thompson suggests that emotions have their own trajectory -- consistent with Anna Freud's (1963) developmental lines -- which reveal an increasing capacity for reflectiveness and intentionality.

Ego psychology, and correspondingly defense mechanisms, have at times been critiqued for underplaying the affective dimension in psychopathology (Hauser et al., 1995), including depression, by focusing primarily on the impact of cognitive dysfunction (e.g., on perception, judgment, memory). But primitive defenses, in tandem with labile affects, might create specific propensities for depression occurrence. Research should be directed at establishing how defenses facilitate or impede expression of affective states. In Ablon et al.'s (1974) study, alleviation of depressive symptoms was positively correlated with a decline in primitive defenses but also an increase in anxiety, suggesting that, for these patients, anxiety tolerance during periods of clinical improvement signifies greater emotional resiliency. If high

levels of affect maturity are associated with mature defenses, how do such defenses promote increased tolerance of intense affect states?

Attachment studies have shown that parental depression can have a devastating impact on the young child's ability to regulate and communicate emotion that may also generate impairments in neurophysiological functioning. Babies with depressed mothers had greater difficulty with self-quieting than babies of psychiatrically impaired parents (Sameroff et al., 1982). Hyper-attunement to negative parental affective expression leads a child to suppress anger and to placate the parent with mollifying behaviors -- premature "caregiver responses" -- which, if encouraged, leads to entrenched styles of relating later on. Moreover, suppression of negative affect in children is related to higher levels of defensiveness (see Cicchetti & Toth, 1995).

Consistent with theories of intergenerational transmission of attachment style, children appear to adopt their parents' defense patterns (Chandler et al., 1978), further impinging upon their ability to effectively manage and communicate feelings. Future studies documenting developmental changes in affect regulation, cognitive competence, and defense use, in the context of secure or insecure attachment relationships, will contribute to a better understanding of depression in children.

It may be that affective homeostasis may help foster the resiliency that some individuals show in times of stress. Not all people who have suffered a devastating loss, endured a series of setbacks, or survived a painful attachment history become depressed. Much of the current psychiatric interest in defense (Perry & Cooper, 1986, 1989) derives from the work of Vaillant whose longitudinal study of adaptation in non-clinical adult males (1976) has shown that defenses are remarkably

protective mechanisms in times of adversity, and that, with maturation, are linked to a host of positive outcomes, including good health, creativity, and general life satisfaction. But we need to better understand how individual differences influence the evolution of ego defenses in chronically depressed people, and to what extent variations in physical, cognitive, or psychosexual development pose challenges to daily or long-term adaptation. How, for example, do individual ego strengths and defenses foster adaptation in these circumstances, and what defenses are connected with unfavorable outcomes or specific vulnerabilities (Hauser et al., 1995). Blatt's research on developmental depressive subtypes indicates that depression may be linked to risk factors at different points in the life cycle for certain individuals. As we gain a better understanding of these pivotal junctures, we can begin to understand when -- and which -- defense mechanisms will be most useful, and how such information can be better integrated into treatment planning.

The high comorbidity of Axis II in chronically depressed patients, which also relates to the problem of affective dysregulation, provides further support for the utility of addressing defenses in this population. Our study suggests that neurotic personality organization (obsessive-compulsive disorder), compared to disorders with Cluster A & B features, predicts greater improvement on mature defenses over time. Patients with more primitive personality disorganization may require more intensive therapeutic interventions to alleviate the interpersonal consequences of more chaotic defense patterns.

A schism between proponents of depression as psychological impairment and of depression as biological deficit seems to dominate much of contemporary depression

research. But this distinction, in a therapeutic sense, is a brittle one. After all, the core of depressive experience -- subjective unhappiness -- derives from both somatic (low energy) and psychological features (hopelessness), usually experienced in an undifferentiated manner.

New inroads into the psychobiology of depression suggests that optimal treatment strategies must recognize that depression is a heterogenous condition characterized by both biological dysregulation and personality variables (present life experiences and attachment history).

Cloninger (1976) has proposed a biological model of personality, which consists of three heritable dimensions of temperament and character -- novelty-seeking, harm avoidance, and reward dependence -- each of which is linked to different systems of neurotransmitter activity. Chien & Dunner (1996) found that these dimensions function as stable traits in normals, but possess both state and trait properties in dysthymic patients. They reported elevated rates of harm avoidance in dysthymic patients which improve along with parallel gains in symptom reduction. Other studies have shown that aberrant serotonin activity corresponds with altered neural information processing, and destabilization of affect, cognition, and behavior (Spoont, 1992). Although pharmacological interventions cannot "cure character," they may modify its biological basis by helping to regulate the inherent neurochemical instability in individuals with personality (and affective) disorders (Soloff, 1990).

In his work on the psychobiology of bereavement, Hofer (1992) examines object relations in the context of biological systems:

> *Human relationships are conducted at the mental or symbolic as*

> *well as at sensorimotor levels. Our lives are lived as much within the internal world of mental representations as among the actual people themselves. This enables us to endure temporary separations without full-scale bereavement responses.*

In prematurely weaned rat pups, Hofer has found physiologic and behavioral effects (increased heart rate, altered brain enzyme levels, changed hormone levels) associated with object loss. But bonding experiences with the mother serve an important regulatory function: The accumulating effects of soothing maternal behaviors and attributes alters the pup's brain structure in such a way that fosters increasing self-regulation (Mohl, 1987). Speculating on the links between these stabilizing physiological maternal effects and potentially protective role of internal representations in humans, Hofer asks:

> *Could these elements of our inner life come to serve as biological regulators, much the way the actual sensorimotor interactions with the mother function for the infant animal?*

It is an intriguing way to think about the adaptive properties of our internal world, and to imagine a psychobiological function of defense. It brings to mind Freud's (1923) concept of the stimulus barrier which shields the immature infant from the onslaught of external stimuli, and Cramer's (1990) contention that all mental defenses have physiological prototypes. It also invokes Blatt's (1974) belief that evocative object constancy, for which memory serves as the stabilizing function, helps buffer against depression.

Summary and Conclusion

The major findings of this study have established that immature defenses (Denial) decrease over time as a result of a group psychotherapy intervention; that depressive

distress is at its most acute in the absence of mature defense mechanisms, such as Identification; that depressive personality types are linked to specific defense mechanisms, and introjective (Self-Critical) depression, in particular, impinges on one's capacity to use Identification over time. Finally, the type of defense used, and particularly the capacity to use more mature defenses such as Identification, is affected by the presence of Axis II pathology, with neurotically-organized patients more likely to improve on Identification than patients who are seriously disturbed.

The concept of defense is integral to the evaluation of personality structure and functioning. It has evolved from the management of intrapsychic conflict to include adaptation to the demands of external reality (Skodol & Perry, 1993). Defenses are not static constructs but vital processes with both risks and benefits to psychological well-being. As a variant of successful coping, it has become a concept that bridges psychodynamic, cognitive, and social perspectives. Empirical validations of a developmental hierarchy of defenses further reinforce their potential utility in psychological assessment and treatment planning.

This study assessed symptom and interpersonal improvement in depressed patients as a measure of outcome but documents, as well, the need to investigate how individuals with specific types of depression respond to different interventions. Patients come into treatment with diverse expectancies, needs, resources, and goals. They do not experience biological vulnerabilities or psychological dysfunction in the same way. Moreover, treatment modalities have different and varying rates of effectiveness for different people (Hauser and Sayfer, 1995).

Our findings suggest that the type of depression (introjective or anaclitic) an

individual experiences, as well as defense maturity, can help dictate the best kinds of therapeutic interventions. For patients prone to using primitive defense mechanisms, relatively brief treatment may be adequate to show some improvement in defense functioning. But longer-term psychotherapy, or a therapy group which taps core disturbances related to negative attachment experiences, may be more appropriate for patients for whom elaborate, complex defense mechanisms predominate. To document significant personality change -- by transmuting malignant introjects (or depressogenic schemata) into more benign variants -- an intensive psychotherapy treatment is recommended, one which utilizes the therapeutic relationship as the primary catalyst.

By finding more robust relationships between defense mechanisms and depressive personality types than with depressive symptoms, this study supports the notion of depression as a clinically heterogenous disorder which spans an Axis I-Axis II continuum. To establish an empirical relationship between defense and subjective depressive distress is to provide support for a stable, trait-like depressive personality which endures despite fluctuations in symptomatic expression, and counters the prevailing psychiatric view of depression as a purely state-dependent, biogenetic illness. It urges reexamination of the kinds of psychotherapeutic interventions needed to offset symptom recurrence and prevent relapse. But, as this study has shown, the utility of a given intervention is contingent upon its ability to encompass and address differences in the specific ways individuals experience their depression, as well as the defense mechanisms they might use to alleviate it.

Patient name:_____ **Visit date:** _____ **Visit week:**_____

BDI

On this questionnaire are groups of statements. Please pick out the one statement in each group which best describes how you have been feeling recently. If several statements apply equally well, circle all that are true of you. **Be sure to read every statement in each group before making your choice.**

1. a. I do not feel sad.
   b. I feel sad.
   c. I am sad all the time and I can't snap out of it.
   d. I am so sad or unhappy that I can't stand it.

2. a. I am not particularly discouraged about the future.
   b. I feel discouraged about the future.
   c. I feel I have nothing to look forward to.
   d. I feel that the future is hopeless and that things cannot improve.

3. a. I do not feel like a failure.
   b. I feel I have failed more than the average person.
   c. As I look back on my life, all I can see is a lot of failure.
   d. I feel I am a complete failure as a person.

4. a. I get as much satisfaction out of things as I used to.
   b. I don't enjoy things the way I used to.
   c. I don't get real satisfaction out of anything anymore.
   d. I am dissatisfied or bored with everything.

5. a. I don't feel particularly guilty.
   b. I feel guilty a good part of the time.
   c. I feel quite guilty most of the time.
   d. I feel as though I am very bad or worthless.

6. a. I don't feel disappointed in myself.
   b. I am disappointed in myself.
   c. I am disgusted with myself.
   d. I hate myself.

7. a. I don't have any thoughts of killing myself.
   b. I have thoughts of killing myself, but I would not carry them out.
   c. I would like to kill myself.
   d. I would kill myself if I had the chance.

8. a. I have not lost interest in other people.
   b. I am less interested in other people than I used to be.
   c. I have lost most of my interest in other people and have little feeling for them.
   d. I have lost all of my interest in other people and don't care about them at all.

9. a. I make decisions about as well as I ever could.
   b. I put off making decisions more than I used to.
   c. I have greater difficulty in making decisions than before.
   d. I can't make decisions at all anymore.

10. a. I don't feel I look any worse than I used to.
    b. I am worried that I am looking old or unattractive.
    c. I feel that there are permanent changes in my appearance that make me look unattractive.
    d. I believe that I look ugly.

11. a. I can work about as well as before.
    b. It takes an extra effort to get started at doing something.
    c. I have to push myself very hard to do anything.
    d. I can't do any work at all.

12. a. I don't get more tired than usual.
    b. I get tired more easily than I used to.
    c. I get tired from doing almost anything.
    d. I'm too tired to do anything.

13. a. My appetite is no worse than usual.
    b. My appetite is not as good as it used to be.
    c. My appetite is much worse now.
    d. I have no appetite at all anymore.

Patient name: _____ **Date:** _____ **Visit week:** _____

HAM-D-24

Circle the number of the one "cue" which best characterizes the patient at the time of rating.

1. **Depressed Mood** (sadness, hopeless, helpless, worthless)	0	Absent
	1	These feeling states indicated only on questioning
	2	These feeling states spontaneously reported verbally
	3	Communicates feeling states non-verbally
	4	Patient reports virtually only these feeling states in his spontaneous verbal and non-verbal communication
2. **Feelings of Guilt**	0	Absent
	1	Self-reproach, feels he/she has let people down
	2	Ideas of guilt or rumination over past errors or sinful deeds
	3	Present illness is a punishment. Delusions of guilt.
	4	Hears accusatory or denunciatory voices and/or experiences
	5	threatening visual hallucinations
3. **Suicide**	0	Absent
	1	Feels life is not worth living
	2	Wishes he were dead or any thoughts of possible death to self
	3	Suicide ideas or gesture
	4	Attempts at suicide
4. **Insomnia (Early)**	0	No difficulty falling asleep
	1	Complains of occasional difficulty falling asleep (>1/2 hr)
	2	Complains of nightly difficulty falling asleep
5. **Insomnia (Middle)**	0	No difficulty
	1	Patient complains of being restless & disturbed during night
	2	Waking during the night; any getting out of bed (except to void)
6. **Insomnia (Late)**	0	No difficulty
	1	Waking in early hours of morning but goes back to sleep
	2	Unable to fall asleep again if gets out of bed
7. **Work and Activities**	0	No difficulty
	1	Thoughts and feelings of incapacity, fatigue or weakness related to activities, work or hobbies
	2	Loss of interest in activity: hobbies or work--either directly reported by patient, or indirect--in listlessness, indecision, vacillation (feels he has to push self to work or join activities
	3	Decrease in actual time spent in activities or decrease in productivity
	4	Stopped working because of present illness.

8. **Retardation (slowness of thought & speech, impaired ability to concentrate, decreased motor activity)**	0	Normal speech and thought
	1	Slight retardation at interview
	2	Obvious retardation at interview
	3	Interview difficult
	4	Complete stupor
9. **Agitation**	0	None
	1	Fidgetiness
	2	"Playing" with hands, hair, etc.
	3	Moving about, can't sit still
	4	Hand-wringing, nail-biting, hair-pulling, biting of lips
10. **Anxiety-Psychic**	0	No difficulty
	1	Subjective tension and irritability
	2	Worrying about minor matters
	3	Apprehensive attitude apparent in face or speech
	4	Fears expressed without questioning
11. **Anxiety- Somatic**	0	Absent (Physiological concomitants of anxiety:
	1	Mild gastro-intestinal-dry mouth, wind, indiges-
	2	Moderate tion, diarrhea, cramps, hyper-ventilation,
	3	Severe sighing, urinary frequency, sweating)
	4	Incapacitating
12. **Somatic Symptoms--Gastro -intestinal**	0	None
	1	Loss of appetite but eating. Heavy feelings in abdomen.
	2	Difficulty eating without urging. Requests or requires laxatives or medications for bowels or medications for G.I. symptoms.
13. **Somatic Symptoms-General**	0	None
	1	Heaviness in limbs, back, or head. Backaches, headache, muscle aches. Loss of energy and fatigability.
	2	Any clearcut symptom
14. **Genital Symptoms**	0	Absent (Symptoms such as loss of libido, menstrual disturbance)
	1	Mild
	2	Severe
15. **Hypochondriasis**	0	Not present
	1	Self-absorption (bodily)
	2	Preoccupation with health
	3	Frequent complaints, requests for help, etc.
	4	Hypochondriacal delusions

16. **Loss of Weight**	Actual weight change (since last visit)	
	0	No weight loss or weight loss NOT caused by present illness
	1	Weight loss probably caused by present illness
	2	Definite weight loss caused by present illness
17. **Insight**	0	Acknowledges being depressed and ill or acknowledges state of remission
	1	Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
	2	Denies being ill at all
18. **Diurnal Variation - if present circle severity and check whether symptoms are worse in AM or PM**		
	0	Absent
	1	Mild Worse in morning □ Worse in evening □
	2	Severe
19. **Depersonalization & Derealization**	0	Absent
	1	Mild (Feelings of unreality, nihilistic ideas)
	2	Moderate
	3	Severe
	4	Incapacitating
20. **Paranoid Symptoms**	0	None
	1	Suspicious
	2	Ideas of reference
	3	Delusions of reference and persecution
21. **Obsessive & Compulsive Symptoms**	0	Absent
	1	Mild
	2	Severe
22. **Helplessness**	0	Not present
	1	Subjective feelings which are elicited only by inquiry
	2	Patient volunteers helpless feelings
	3	REQUIRES urging, guidance, reassurance to accomplish chores, hygiene
	4	Requires physical assistance for dressing, grooming, eating, personal hygiene
23. **Hopelessness**	0	Not present
	1	Intermittently doubts that "things will improve" but can be reassured
	2	Consistently feels "hopeless" but accepts reassurances
	3	Expresses feelings of discouragement, despair, pessimism about future, which cannot be dispelled
	4	Spontaneously and inappropriately perseverates, "I'll never get well" or its equivalent

24. **Worthlessness - Ranges from mild loss of esteem, feelings of inferiority, self-depreciation to delusional notions of worthlessness**

0	Not present
1	Indicates feelings of worthlessness (loss of self-esteem) only on questioning
2	Spontaneously indicate feelings of worthlessness (loss of self-esteem)
3	Different from 2 by degree: Patient volunteers that he/she is "no good," "inferior," etc.
4	Delusional notion of worthlessness -- i.e. "I am a heap of garbage" or equivalent

TOTAL SCORE =

DEPRESSIVE EXPERIENCES QUESTIONNAIRE©

Listed below are a number of statements concerning personal characteristics and traits. Read each item and decide whether you agree or disagree and to what extent. If you strongly agree, circle 7; if you strongly disagree, circle 1; if you feel somewhere in between, circle any one of the numbers between 1 and 7. The midpoint, if you are neutral or undecided, is 4.

		Strongly Disagree						Strongly Agree
1.	I set my personal goals and standards as high as possible.	1	2	3	4	5	6	7
2.	Without support from others who are close to me, I would be helpless.	1	2	3	4	5	6	7
3.	I tend to be satisfied with my current plans and goals, rather than striving for higher goals.	1	2	3	4	5	6	7
4.	Sometimes I feel very big, and other times I feel very small	1	2	3	4	5	6	7
5.	When I am closely involved with someone, I never feel jealous.	1	2	3	4	5	6	7
6.	I urgently need things that only other people can provide.	1	2	3	4	5	6	7
7.	I often find that I don't live up to my own standards or ideals.	1	2	3	4	5	6	7
8.	I feel I am always making full use of my potential abilities.	1	2	3	4	5	6	7
9.	The lack of permanence in human relationships doesn't bother me.	1	2	3	4	5	6	7
10.	If I fail to live up to expectations, I feel unworthy.	1	2	3	4	5	6	7
11.	Many times I feel helpless.	1	2	3	4	5	6	7
12.	I seldom worry about being criticized for things I have said or done.	1	2	3	4	5	6	7
13.	There is a considerable difference between how I am now and how I would like to be.	1	2	3	4	5	6	7
14.	I enjoy sharp competition with others.	1	2	3	4	5	6	7
15.	I feel I have many responsibilities that I must meet.	1	2	3	4	5	6	7

		Strongly Disagree						Strongly Agree
36.	The way I feel about myself frequently varies: there are times when I feel extremely good about myself and other times when I see only the bad in me and feel like a total failure.	1	2	3	4	5	6	7
37.	Often, I feel threatened by change.	1	2	3	4	5	6	7
38.	Even if the person who is closest to me were to leave, I could still "go it alone."	1	2	3	4	5	6	7
39.	One must continually work to gain love from another person: that is, love has to be earned.	1	2	3	4	5	6	7
40.	I am very sensitive to the effects my words or actions have on the feelings of other people.	1	2	3	4	5	6	7
41.	I often blame myself for things I have done or said to someone.	1	2	3	4	5	6	7
42.	I am a very independent person.	1	2	3	4	5	6	7
43.	I often feel guilty.	1	2	3	4	5	6	7
44.	I think of myself as a very complex person, one who has "many sides."	1	2	3	4	5	6	7
45.	I worry a lot about offending or hurting someone who is close to me.	1	2	3	4	5	6	7
46.	Anger frightens me.	1	2	3	4	5	6	7
47.	It is not "who you are," but "what you have accomplished" that counts.	1	2	3	4	5	6	7
48.	I feel good about myself whether I succeed or fail.	1	2	3	4	5	6	7
49.	I can easily put my own feelings and problems aside, and devote my complete attention to the feelings and problems of someone else.	1	2	3	4	5	6	7
50.	If someone I cared about became angry with me, I would feel threatened that he (she) might leave me.	1	2	3	4	5	6	7
51.	I feel uncomfortable when I am given important responsibilities.	1	2	3	4	5	6	7
52.	After a fight with a friend, I must make amends as soon as possible.	1	2	3	4	5	6	7
53.	I have a difficult time accepting weaknesses in myself.	1	2	3	4	5	6	7

Inventory of Interpersonal Problems

Here is a list of problems that people report in relating to other people. Please read the list below, and for each item, consider whether that problem is a problem for you with respect to people in your life. Then select the number that describes how distressing that problem is and circle that number.

EXAMPLE

How much have you been distressed by this problem?

It is hard for me to:	Not at all	A little bit	Moderately	Quite a bit	Extremely
00. get along with my relatives.	0	1	2	(3)	4

Part I. The following are things you find hard to do with other people.

It is hard for me to:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. trust other people.	0	1	2	3	4
2. say "no" to other people.	0	1	2	3	4
3. join in on groups.	0	1	2	3	4
4. keep things private from other people.	0	1	2	3	4
5. let other people know what I want.	0	1	2	3	4
6. tell a person to stop bothering me.	0	1	2	3	4
7. introduce myself to new people.	0	1	2	3	4
8. confront people with problems that come up.	0	1	2	3	4
9. be assertive with another person.	0	1	2	3	4
10. make friends.	0	1	2	3	4
11. express my admiration for another person.	0	1	2	3	4
12. have someone dependent on me.	0	1	2	3	4

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It is hard for me to:	Not at all	A little bit	Moderately	Quite a bit	Extremely
13. disagree with other people.	0	1	2	3	4
14. let other people know when I am angry.	0	1	2	3	4
15. make a long-term commitment to another person.	0	1	2	3	4
16. stick to my own point of view and not be swayed by other people.	0	1	2	3	4
17. be another person's boss.	0	1	2	3	4
18. do what another person wants me to do.	0	1	2	3	4
19. get along with people who have authority over me.	0	1	2	3	4
20. be aggressive toward other people when the situation calls for it.	0	1	2	3	4
21. compete against other people.	0	1	2	3	4
22. make reasonable demands of other people.	0	1	2	3	4
23. socialize with other people.	0	1	2	3	4
24. get out of a relationship that I don't want to be in.	0	1	2	3	4
25. take charge of my own affairs without help from other people.	0	1	2	3	4
26. show affection to people.	0	1	2	3	4
27. feel comfortable around other people.	0	1	2	3	4
28. get along with people.	0	1	2	3	4
29. understand another person's point of view.	0	1	2	3	4
30. tell personal things to other people.	0	1	2	3	4
31. believe that I am loveable to other people.	0	1	2	3	4
32. express my feelings to other people directly.	0	1	2	3	4
33. be firm when I need to be.	0	1	2	3	4

It is hard for me to:	Not at all	A little bit	Moderately	Quite a bit	Extremely
34. experience a feeling of love for another person.	0	1	2	3	4
35. be competitive when the situation calls for it.	0	1	2	3	4
36. set limits on other people.	0	1	2	3	4
37. be honest with other people.	0	1	2	3	4
38. be supportive of another person's goals in life.	0	1	2	3	4
39. feel close to other people.	0	1	2	3	4
40. really care about other people's problems.	0	1	2	3	4
41. argue with another person.	0	1	2	3	4
42. relax and enjoy myself when I go out with other people.	0	1	2	3	4
43. feel superior to another person.	0	1	2	3	4
44. become sexually aroused toward the person I really care about.	0	1	2	3	4
45. feel that I deserve another person's affection.	0	1	2	3	4
46. keep up my side of a friendship.	0	1	2	3	4
47. spend time alone.	0	1	2	3	4
48. give a gift to another person.	0	1	2	3	4
49. have loving and angry feelings towards the same person.	0	1	2	3	4
50. maintain a working relationship with someone I don't like.	0	1	2	3	4
51. set goals for myself without other people's advice.	0	1	2	3	4
52. accept another person's authority over me.	0	1	2	3	4
53. feel good about winning.	0	1	2	3	4

It is hard for me to:	Not at all	A little bit	Moderately	Quite a bit	Extremely
54. ignore criticism from other people.	0	1	2	3	4
55. feel like a separate person when I am in a relationship.	0	1	2	3	4
56. allow myself to be more successful than other people.	0	1	2	3	4
57. feel or act competent in my role as parent.	0	1	2	3	4
58. let myself feel angry at somebody I like.	0	1	2	3	4
59. respond sexually to another person.	0	1	2	3	4
60. accept praise from another person.	0	1	2	3	4
61. put somebody else's needs before my own.	0	1	2	3	4
62. give credit to another person for doing something well.	0	1	2	3	4
63. stay out of other people's business.	0	1	2	3	4
64. take instructions from people who have authority over me.	0	1	2	3	4
65. feel good about another person's happiness.	0	1	2	3	4
66. get over the feeling of loss after a relationship has ended.	0	1	2	3	4
67. ask other people to get together socially with me.	0	1	2	3	4
68. feel angry at other people.	0	1	2	3	4
69. give constructive criticism to another person.	0	1	2	3	4
70. experience sexual satisfaction.	0	1	2	3	4
71. open up and tell my feelings to another person.	0	1	2	3	4
72. forgive another person after I've been angry.	0	1	2	3	4
73. attend to my own welfare when somebody else is needy.	0	1	2	3	4

It is hard for me to:	Not at all	A little bit	Moderately	Quite a bit	Extremely
74. be assertive without worrying about hurting the other person's feelings.	0	1	2	3	4
75. be involved with another person without feeling trapped.	0	1	2	3	4
76. do work for my own sake instead of for someone else's approval.	0	1	2	3	4
77. be close to somebody without feeling that I'm betraying somebody else.	0	1	2	3	4
78. be self-confident when I am with other people.	0	1	2	3	4

Part II. The following are things that you do too much.

79. I fight with other people too much.	0	1	2	3	4
80. I am too sensitive to criticism.	0	1	2	3	4
81. I feel too responsible for solving other people's problems.	0	1	2	3	4
82. I get irritated or annoyed too easily.	0	1	2	3	4
83. I am too easily persuaded by other people.	0	1	2	3	4
84. I want people to admire me too much.	0	1	2	3	4
85. I act like a child too much.	0	1	2	3	4
86. I am too dependent on other people.	0	1	2	3	4
87. I am too sensitive to rejection.	0	1	2	3	4
88. I open up to people too much.	0	1	2	3	4
89. I am too independent.	0	1	2	3	4
90. I am too aggressive toward other people.	0	1	2	3	4

The following are things that you do too much.	Not at all	A little bit	Moderately	Quite a bit	Extremely
91. I try to please other people too much.	0	1	2	3	4
92. I feel attacked by other people too much.	0	1	2	3	4
93. I feel too guilty for what I have done.	0	1	2	3	4
94. I clown around too much.	0	1	2	3	4
95. I want to be noticed too much.	0	1	2	3	4
96. I criticize other people too much.	0	1	2	3	4
97. I trust other people too much.	0	1	2	3	4
98. I try to control other people too much.	0	1	2	3	4
99. I avoid other people too much.	0	1	2	3	4
100. I am affected by another person's moods too much.	0	1	2	3	4
101. I put other people's needs before my own too much.	0	1	2	3	4
102. I try to change other people too much.	0	1	2	3	4
103. I am too gullible.	0	1	2	3	4
104. I am overly generous to other people.	0	1	2	3	4
105. I am too afraid of other people.	0	1	2	3	4
106. I worry too much about other people's reactions to me.	0	1	2	3	4
107. I am too suspicious of other people.	0	1	2	3	4
108. I am influenced too much by another person's thoughts and feelings.	0	1	2	3	4
109. I compliment other people too much.	0	1	2	3	4
110. I worry too much about disappointing other people.	0	1	2	3	4

The following are things that you do too much.	Not at all	A little bit	Moderately	Quite a bit	Extremely
111. I manipulate other people too much to get what I want.	0	1	2	3	4
112. I lose my temper too easily.	0	1	2	3	4
113. I tell personal things to other people too much.	0	1	2	3	4
114. I blame myself too much for causing other people's problems.	0	1	2	3	4
115. I am too easily bothered by other people making demands of me.	0	1	2	3	4
116. I argue with other people too much.	0	1	2	3	4
117. I am too envious and jealous of other people.	0	1	2	3	4
118. I keep other people at a distance too much.	0	1	2	3	4
119. I worry too much about my family's reactions to me.	0	1	2	3	4
120. I let other people take advantage of me too much.	0	1	2	3	4
121. I too easily lose a sense of myself when I am around a strong-minded person.	0	1	2	3	4
122. I feel too guilty for what I have failed to do.	0	1	2	3	4
123. I feel competitive even when the situation does not call for it.	0	1	2	3	4
124. I feel embarrassed in front of other people too much.	0	1	2	3	4
125. I feel too anxious when I am involved with another person.	0	1	2	3	4
126. I am affected by another person's misery too much.	0	1	2	3	4
127. I want to get revenge against people too much.	0	1	2	3	4

Appendix: Manual for Scoring Defenses

This manual was developed to assess the use of three defenses—denial, projection, and identification—as revealed in stories told for standard TAT and CAT cards. Specific criteria have been developed for CAT Cards 3, 5, and 10, and for TAT Cards 1, 3, 3GF, 5, 6BM, 6GF, 7BM, 7GF, 8BM, 8GF, 10, 12MF, 13MF, 14, 17BM, and 18GF.

The scoring for each defense is based on seven categories, each designed to reflect a different aspect of the defense. Each category may be scored as often as necessary, with the exception of a direct repetition in the story; in cases of repetition, the category is scored only once.

Although examples are provided to aid in deciding whether or not a category should be scored, questions inevitably arise. A thorough knowledge of the nature of the defense mechanisms will help in answering these questions. Beyond this, the general rule to be followed is, "When in doubt, leave it out." That is, if there is a serious question about whether or not the story segment is an example of the defense, do not score it.

Denial: Summary of Scoring Categories

1. Omission
2. Misperception
3. Reversal
4. Statements of negation
5. Denial of reality
6. Overly maximizing positive, minimizing negative
7. Unexpected goodness, optimism, positiveness, gentleness

Primitive Denial

In the categories of primitive Denial, the storyteller assumes that the stimulus card *is* something, and the defense is seen in the avoidance or changing the nature of that thing.

1. Omission of Major Characters of Objects

This category refers to the failure to perceive salient stimuli that are perceived by nearly all one's peers. This applies only to the major or obvious objects. Omission of any of these objects from the story is scored, according to the following plan.

CAT 3:	pipe plus cane = 1
	mouse = 1
	lion = 1
CAT 5:	2 out of 3; bed, forms in bed, crib = 1
	teddy bears = 1
CAT 10:	bathroom = 1
	adult dog = 1
	baby dog = 1
TAT 1:	boy = 1
	violin = 1
TAT 3:	person = 1
	gun or knife = 1
TAT 3GF:	person = 1
TAT 5:	woman = 1
	room = 1
TAT 6BM:	young man = 1
	older woman = 1
TAT 6GF:	man = 1
	woman = 1
TAT 7BM:	older man = 1
	younger man = 1
TAT 7GF:	young girl = 1
	woman = 1
	baby or doll = 1
TAT 8BM:	gun = 1
	knife = 1
	standing young man = 1
	prone man = 1
TAT 8GF:	woman = 1
TAT 10:	man = 1
	woman = 1
TAT 12MF:	standing man = 1
	prone man = 1
TAT 13MF:	standing man = 1
	prone woman = 1
TAT 14:	standing man = 1
	window = 1
TAT 17BM:	man = 1
	rope = 1
TAT 18GF:	woman above = 1
	woman below = 1

Do not score if reference to the function of a critical object is made. For example, the *knife* in TAT 8BM may be implied by the mention of an operation; the *cane* in CAT 3 may be implied by reference to lameness. On TAT 1, reference to the object, even if not named, is sufficient. (However, if it is named incorrectly, score under Denial (2).)

2. Misperception

This may come about because the perceptual process itself is distorted by pathology or because, in the case of a child or inexperienced person, the name of the object is not known and the individual defensively calls it something it is not, rather than referring to it as a "thing" or an "object," in which case no score is given. In this latter case, the point is whether, in a situation in which the individual does not have all the information needed, he is able to cope adaptively, or whether he must distort the situation to fit his inadequate knowledge.

Examples of adaptive coping are seen in the following two stories for TAT 1; in both cases, the child is uncertain about how to identify the violin:

This person is thinking what to do, with something that is in front of him. He might use it for something, or something might happen. The thing that might happen is that he might think of something to do with the thing. (What happens?) He's going to do something with it. He's thinking that he will use it for what it is supposed to be used for; on some kind of material, which is called paper.

That's a little boy. He's down on his work bench and he's looking this over and he's wondering what it is. And he's wondering if he'll ever find out. He can't wait till his father comes home so he can ask his father. And he's kind of sitting there wondering when his father will come home.

(a) *Any unusual or distorted perception of a figure, object, or action in the picture*, which is without sufficient support for the observation, *if and only if* the projected image is NOT of ominous quality, in which case it would be scored under Projection.

"(TAT8BM) The man is tickling the man lying down;"
"(CAT3) He's in a wheelchair;"
"(TAT1) That's a cross-bow;"
"TAT17BM) That's a statue climbing down a rope";
"(TAT1) He's eating;"
"(TAT1) He's playing checkers;"
"(TAT17BM) Is that a picture of me?" (*S* is 5 years old)

(b) *Perception of a figure as being of the opposite sex from that usually perceived.*

"(TAT12M) The girl on the couch;"

Note: If the storyteller misperceives an object, and then corrects the misperception, score Denial (2). If, after the correction, he continues to

use the misperception as the basis for the story, score also under Denial (5).

Do not score on TAT 1 if children call the violin a guitar, harp, or instrument. Do not score if violin is called a "thing," "object," or "that." Only score when violin is turned into something other than a musical instrument. Do not score if violin is referred to as "homework or a "project" unless it is clear that this means something *other than* a violin—e.g., a book, a boat, etc.

3. Reversal

The reversal may be either in terms of the usual perception of the card or in the story itself, especially when the reversal is normatively unusual.

(a) *Transformations* such as weakness into strength, fear into courage, passivity into activity, and vice versa.

"He had been king of the jungle, but now he was very old;"
"The mouse used to be afraid; then he grew up and fought the lion;"
"He used to be an excellent surgeon, but then he killed a man by mistake;"

Note: If the transformation involves a drastic change for the good, score under Denial (7).

(b) *Score any figure who takes on qualities previously stated conversely* in the story, including change of sex of figure.

"(TAT12M) The boy is in a coma and the man is hexing him. The boy will get the man in his power;"
"He's dead, and he'll come back to life."
"(TAT17BM) *I* am in a big cave and *I*'m caught . . . And he's half way up to the top" (Here the *S* has changed the threatened "I" into "he;"
"He is an actress" (*S* is 9 years old).

Reversal differs from Denial (4) and Denial (6) in that it involves both ends of a continuum (e.g., weak–strong) rather than just one end that is negated (e.g., weak–not weak: Denial 4) or overly stressed (Denial 6). Reversal may be scored where one end of the continuum is implied but not explicitly stated (strength–weakness, implied by growing old).

Do not score "growing old" by itself.

Do not score if a character doesn't know how to do something and then learns how.

Do not score if character was strong, became weak through tiredness, but in the end won, or was strong again; or if sad, but through doing something, becomes happy.

4. Statements of Negation

Simply stating something in the negative (e.g., "He didn't do it") is not sufficient to be scored in this category. Whether or not a negative statement should be scored depends on whether the negation is defensive. Sometimes this can be determined by the fact that the negative statement is unusual or unexpected (e.g., "He didn't stuff peanuts up his nose")—that is, that no one would have expected this event to happen anyway, so why point out that it didn't happen? At other times the defensive nature of the negation is more straightforward (e.g., "He didn't get hurt"). Often, only the context makes it clear if the statement is defensive or not.

(a) *Score if a character "does not . . ." any action, wish, or intention*, which, if acknowledged, would cause displeasure, pain, or humiliation.

"He caught the mouse but did not kill him;"
"He never fell down from ropes."

(b) *Also score statements in which the storyteller negates or denies a fact or feeling.*

"He is going to go hunting and catch something. I don't know what, though;"
"I don't know what that is (referring to whole card or part of card);"
"At first I thought he was dead, but he isn't;"
"No one is in that bed" (CAT 5, referring to large bed);"
"I don't know where he is going."

(c) *References to doubt as to what the picture is or represents.*

"What is it? I don't understand the picture" should be scored here, and should be distinguished from references to difficulty in formulating a story ("I can't think of what to say"), which is an example of repression. The difference lies in the fact that denial generally operates on a more concrete level, whereas repression is seen in the person's inability to *think* of something.

Do not score if "I don't know" is used as a way to end a story, or is in response to a question by the examiner.

Do not score if a character wants to or tries to do something, but can't or isn't able to, or doesn't know how to.

Do not score if a character doesn't like something, or doesn't want to do something that is neutral or pleasant in nature (e.g. do not score "He doesn't want to practice the violin").

Do not score "He doesn't want to get hurt," but *do* score "He doesn't get hurt."

Do not score "He does not reveal it" (a secret, a clue, etc.) here; score under Projection 4).

Do not score, on TAT 17BM, "He's got no clothes on."

Do not score if subject asks, at the end of the story, if the story was "right" or "correct."

5. Denial of Reality

This is an overlapping category with Denial (4).

(a) *The storyteller denies the reality of the story or situation* by the use of phrases such as

"It was just a dream;"
"It didn't really happen;"
"It was all make-believe;"
"(TAT 8BM) That's really a dummy; when they cut it, it was all red cotton;"
"They're going to play (pretend) a fight."
or describing the picture as part of a movie.

Do not score TAT 8BM if it is described as a dream, because of the nebulous atmosphere of the picture.

(b) *Sleeping, daydreaming, or fainting as a way of avoiding something unpleasant.*

(c) *References to avoiding looking at something* that would be unpleasant to see, or hearing something that would be unpleasant to hear, or thinking something that would be unpleasant to think.

"He's walking away because he doesn't want to see the operation."

(d) *Any perception, attribution, or implication which is blatantly false with regard to reality* as generally defined or by reality as defined by the picture.

"(CAT 10) The two dogs are playing checkers;"
"(CAT 10, referring to crib) Nothing is in here;"
"(CAT 10) He's going to have puppies;"
"That dog climbs up the rope;"
"(TAT17BM) A statue climbing a rope" (score also under Denial (2) for misperception of figure in the picture.) The score under Denial (5) is for a statue doing something statues cannot do in reality.

Note: If the perception is not false so much as unusual or distorted, including seeing the picture as being of the opposite sex from the usual perception, score under Denial (2).

Do not score running away from or avoiding "society" here; score under Identification (3).

Pollyannish Denial

Pollyannish denial belongs to a later period of development than primitive denial, and may involve a rather saccharine, "life is beautiful" attitude. It is often characterized by a note of unfounded optimism.

6. *Overly Maximizing the Positive or Minimizing the Negative*

Any gross exaggeration or underestimation of a *character's* qualities, potency, size, power, beauty, or possessions.

"(CAT3) A small lion;"
"An old lion (weakness implied);"
"The most beautiful . . . in the world;"
"The biggest . . . in the world;"
"The eagle picks up the lion."

Note: If the exaggerated quality involves a reversal of the character's usual nature, score under Denial (3).

Do not score exaggeration of physical objects (e.g., "the highest mountain;" "he fell thousands of feet").

7. *Unexpected Goodness, Optimism, Positiveness, Gentleness*

(a) *Unexpected goodness*. This is a difficult category to score and should be scored only when beyond doubt. It is often seen in instances of revenge, when the revenge is built up to, but never consumated when the opportunity arises. Building up to a theme of harm and then concluding without justification that all is well is scored here. Also when a character "takes his lumps" or punishment or bad luck completely in stride when all previous indications were of an avenging "righteous indignation" attitude.

"The lion chases the mouse for many hours; he finally catches him, but then he lets him go;"
"He has always failed, but he knows that he will be successful in the end."

(b) *Any sort of drastic change of heart for the good.*

"He is a murderer who goes around killing people. But then he decides to become a doctor and saves many lives."

(c) *Also scored here are references to natural beauty, wonder, awesomeness.*

"He realized the beauty and magnificence of the forest;"
"She contemplated the wonder of the universe;"
"(TAT1) He found peace with his violin;"
"(TAT14) He finds enlightenment."

(d) *Nonchalance in the face of danger.*

(e) *Acceptance of one's (negative) fate or loss*, with the justification of not really wanting it any way; a "sour grapes" attitude.

"He learns to make the best out of what he's got."

Do not score "they lived happily ever after" or similar clichés if used at the end of a story.

Note: If the change for the good involves a moralistic turn, score under Identification (7).

Projection: Summary of Scoring Categories

1. Attribution of aggressive or hostile feelings, emotions, or intentions to a character, or other feelings, emotions, or intentions that are normatively unusual
2. Additions of ominous people, ghosts, animals, objects, or qualities
3. Magical or circumstantial thinking
4. Concern for protection from external threat
5. Apprehensiveness of death, injury, or assault
6. Themes of pursuit, entrapment, and escape
7. Bizarre or very unusual story or theme

Projection

1. Attribution of Aggression or Hostile Feelings, Emotions, or Intentions to a Character, or of Any Other Feelings, Emotions or Intentions that Are Normatively Unusual

This category can be scored either when such emotions are attributed by the storyteller to a character in the story or when one character attributes them to another character, *but only* if such attribution is without sufficient reason.

References to a character's *face* looking a certain way (e.g., anguished, puzzled, etc.) are scored here.

"He killed her because he hated her" (with no explanation of the reason for his hatred) [Score twice, once under Projection (5)];
"(CAT3) This is a mean lion;"
"I think he dislikes me" (unexplained);
"(CAT3) The lion growls too much;"
"(CAT3, mouse speaking) I think that lion is thinking about getting after me;"
"His parents don't care, even if he's sick" (This is a borderline case, but is scored because it is implied that the parents, through neglect, are mean to the child);
"(TAT1) He is looking at it with contempt" (This is also somewhat borderline but is scored here because contempt includes hostility toward the object of contempt);
"(TAT17BM) He had to find his girl friend or they would kill her" (unexplained);
"(TAT17BM) Maybe he's angry" (unexplained);
"(TAT17BM) Probably that look on his face is a signal of some kind;"
"(TAT17BM) His features become distorted and take on the look of an animal as it hides from a hunter;"
"(TAT17BM) His look is that of frustration and great emotion" (scored once);
"(TAT17BM) He has a mean personality; he is a murderer" (scored twice);
"(TAT17BM) He was in the shower . . . a fire . . . he feels *embarrassed* [due to nakedness];"

"(TAT1) He's looking at it in a mad way" (unexplained);
"He's contemplating suicide."

Note: Score aggressive or hostile *actions* under Projection (5).

Do not score TAT 17BM for simple mention of fright, tenseness, or tiredness.

Do not score depression or thought of suicide on TAT 13MF; if suicide is actually carried out on card other than TAT 13MF, score Projection (5).

Do not score TAT 3MB for simple mention of sadness or depression, or crying, if reason is given.

Do not score TAT 6GF for mention of woman looking surprised, startled.

2. Addition of Ominous People, Ghosts, Animals, Objects, or Qualities

(a) *This category is scored only if the details added to the situation are of an ominous or potentially threatening nature.*

"(CAT3) He got an *axe* and killed him;"
"(CAT3) They said if he wasn't good they'd put him in front of *alligators*;"
"(CAT5) He was afraid to go to sleep because he heard scary *noises* . . . then a *robber* came" (score both for noises and for robber, score fear of sleep under Projection 5);
"(CAT5) There are *bees* outside the window;"
"(TAT1) That's a dangerous toy;"
"(TAT17BM) There are warriors coming;"
"(TAT17BM) The guards are trying to get him" (This is a borderline case; do not score for mention of guards alone; score only if the guards are clearly threatening; if guards are pursuing, score under Projection (6) only);
"(TAT17BM) The soliders throw spears" (score only once for the spears; the soliders alone are not necessarily ominous);
"Fire."

Do not score TAT 17BM for mention of prison, dungeon, cave, guards alone, prisoner, or pursuers (the latter is scored under Projection (6).

(b) *Score especially the addition of blood, mention of serious and uncommon illnesses, including mental illness, comas, and nightmares.*

"(TAT8BM) This guy got badly hit by malaria;"
"(TAT12M) He finds out that the boy is in a coma;"
"(TAT8BM) He has these horrible nightmares."

(c) *Also, score here references to people, animals, or objects being decrepit, falling apart, or deteriorating.*

"(CAT5) This crib looks like it's going to fall over;"
"(CAT5) It must have been an old crib that they sent away to a place to get fixed up;"
"(CAT5) The lamp looks like it's all cracked;"

"(TAT1) He's sad because one of his strings are broke;"
"He foud his violin all over the floor all broken."

Note: In TAT 1, score for violin being broken only if the implication is that someone not in the picture (unknown or disliked) breaks it, or if it was broken before the story begins (i.e., was "inherently" damaged).

Do not score if a friend or parent breaks it.

Note: If the same addition is called two different things, score only once (e.g., "a bat or a black widow;" "a thorn, not a hornet").

Do not score the addition of a bullet in TAT 8BM.

Do not score TAT 17BM, rope breaking while climbing, unless prior mention is made of the rope being inadequate to support weight.

Do not score "falling apart" if this is due to some other event specified in the story, such as an explosion, fire, or earthquake, which are themselves scored.

3. *Magical, Autistic, or Circumstantial Thinking*

(a) *Any use of magic or magical powers, including hypnosis or other unusual powers or control of one character over another*; this also includes animals banding together to accomplish some herculean task.

"He was thinking that he had a magic bird that followed him and saved him;"
"The boy died and the parents got a dog, and every night they could hear the boy talking to him;"
"He was putting spells all over the man;"
"This hypnotist turned him into a little green thing."

(b) *Animism*: attribution of human thoughts or emotions to objects other than animals and people (not applicable to the "teddy bears" of CAT 5).

"Canes talking;"
"Rifles feeling sorry;"
"(TAT1) The project has a problem;"
"(TAT1) An idiotic violin;"
"(TAT17BM) The rope tried to overpower him."

(c) *Circumstantial reasoning that has a paranoid flavor; hyperalert search for flaws and misleading cues* (implies a mistrust of others); *efforts to find hidden or obscure meanings; criticism of the way in which the pictures are drawn*. (Implied is that this makes the task more difficult.)

"(TAT17BM) . . . A bobcat jumped at him. Because this is out in the woods and the door was open;"
"(TAT17BM) It must have been a murder the committed, because he isn't carrying any valuables or money;"
"There's probably a trick to this;"
"Is the rope supposed to suggest a hanging?"

4. *Concern for Protection Against External Threat*

(a) *Include here evidence for fear of external threat of physical assault or injury and the need for protection against that threat*, as seen in the erection of walls (real or imaginary), use of masks, disguises, shields, armor, locking of doors or windows, or creation of other protective barriers.

"(CAT3) The mouse is really worried that the lion will bring the cats in and they'll chase the mice" (This overlaps with Projection 6, but is scored here because the emphasis is on the worry);
"The king kicks him out but he puts on a disguise and gets back in again."

(b) *Also included here are references to suspiciousness*, to people or animals hiding or "lying in wait," concern about being "taken by surprise," spying on others, anticipation of kidnap that does not occur, or a feeling that "others are against you" (stated explicitly).

"(CAT5) There's a great big man who is under those covers;"
"(CAT5) The mother and the father are hiding in the bed;"
"(CAT5) There's a crib and no one is there and they wouldn't know if anyone stealed them;"
"(TAT17BM) He has witnessed a crime and is being hunted by the killer."

(c) *References to having seen something one shouldn't have seen*, or that will get one into trouble, and *the necessity for hiding this*; hiding incriminating evidence; protective hiding of oneself or one's property; fear of being seen.

"(TAT17BM) He was captured because he knew too much about something, possibly murder" (score once for captured [Projection 6], and once for knowing);
"(TAT17BM) He's breaking out of prison . . . he's looking around to see if anyone sees him" (score once for escape [Projection 6] and once for fear of being seen).

(d) *Responses indicating a defensive need for self-justification on the part of the storyteller* (i.e., not in response to a question from the examiner).

"(TAT8BM) I say it is a gun because it looks like one we had at home;"
"Although this is just a first reaction, he looks like he is escaping."

5. *Apprehensiveness of Death, Injury, or Assault*

(a) *This is an overlapping category with Projection (4). The difference is that in Projection (5) the death, physical attack, or injury actually occurs or has occurred*, whereas in Projection (4) the emphasis is on the need for *protection* against threat. Unexplained or unjustified punishment is scored here, as is completed suicide.

"(CAT10) The doggie got run over;"
"It looks like his father has just died;"
"(CAT5) Once there was a baby, and he had no mommy. His mommy died."

"He fell off and broke his leg;"
"His son died;"
"He shoots himself;"
"He looks like he just had a fight before;"
"He poisoned all the bloodhounds;"
"He murdered her;"
"He gets eaten by the alligators;"
"He got slapped around."

The following are borderline cases but are scored here because injury is suggested as resulting from the fall. (Do not score a "fall" by itself.)

"The man's going to fall. On his head;"
"The rope is going to fall . . . . It ends with his body down on the floor."

(b) *Score here also fear of going to sleep.*

"At night he was afraid to go to sleep."

Do not score justified punishment by authority or parents. Score under Identification (3).

Do not score if hero aggresses against someone else for justified self-protection or for vindication.

Do not score on CAT 3 if the conflict is between the lion and the mouse.

Do not score on TAT 8BM or 13MF, unless the assault was carried out by a character not present or suggested by the picture; also, *do not score* if the attack against a nonpresent character is in retaliation for some previous physical attack by that character.

Do not score on TAT 12M unless the standing character is about to or has physically attacked the prone character.

Do not score "spanking" on CAT 10.

Do not score "suicide" on TAT 13MF.

6. *Themes of Pursuit, Entrapment, and Escape*

(a) *Included here are themes involving one character pursuing another; also score any mention of one character trapping another, kidnap or unjustified being put jail or prison which actually occurs.*

"(CAT10) The dogs are going to chase the kitty; and the kitty is chasing the mousey";
"(CAT5) The little bears are going to be tooken."
"He's escaping; he's running, the police are chasing him" (score twice);
"He gets trapped in the cave and can't get out."

(b) *Also included are themes of escape.* The escape must be from a physical imprisonment or physical danger, or threat thereof (i.e., not symbolic). "Running away" when there is no pursuer is scored only if it is due to anticipation of pain or punishment, where the anticipation is not justified by the story.

"(TAT17BM) He escaped from the tower and left the country;"
"(TAT17BM) There was a fire and he's escaping out the window" (score twice, once for escape and once for fire [Projection 2].

Note: The category may be scored twice: once for pursuit–entrapment, once for escape.

Note: If "being put in jail" is accompanied by a sense of righteousness or moral justification—that is, if the storyteller is identifying with the authority who puts the character in jail, or if jail is the justified outcome of criminal activity—score under Identification (7). "Being put in jail" is scored under Projection only when the character has not committed a crime, but is put there because of the jealousy, fear, or whim of someone else—that is, only when the encarceration is not (legally) justified. Political or war imprisonment is scored under Projection (6).

Note: If the character is already in jail or prison at the beginning of the story, score under Projection only if it is made clear that this is *not* due to criminal activity. If it *is* due to criminal activity, score under Identification (7). If it is not clear *why* he is in prison, do not score.

Note. Score being chased, trapped, or caught by *police* under Identification (7).

Do not score trapping unless one character traps another (e.g., do not score being trapped in a well, unless one character put another there).

Do not score escape if character is being rescued (by hero), where the emphasis is on the rescue rather than on the escape.

Do not score escape if it is only mentioned at the end of the story, or after the examiner's inquiry, unless the need for escape has been implied throughout.

Do not score escape, when the hero is escaping from "society" or "the world" around him [score this under Identification (3)].

Do not score running away from home; this *may* qualify for scoring under Identification (3).

Do not score on CAT 3 if the conflict is between the lion and the mouse. If the mouse is injured, score under Projection (5).

7. *Bizarre or Very Unusual Story or Theme*

This category depends heavily on the subjective judgment of the scorer, who must determine the limits of bizarreness.

(a) *Negative themes that occur very rarely, especially if they have a peculiar twist.*

"(TAT8BM) He goes outside and get glass in his heel and the doctor pulls and puts pins in . . . ;"
"(CAT3) He's going to eat the whole house because no one's there;"
"(TAT1) This is a saw . . . he sawed his desk in half."

(b) *Also included here are instances of unusual punishment, including unusual self-punishment.*

"(TAT8BM) He's thinking what's going to happen to him when he's really old, and like he's done something bad, and he's going to get zapped" (chuckle);
"(CAT3) He ate a big piece of wood and got all bloated and blew up" (This would also be scored under Projection 7a);
"(TAT17BM) He is tortured."

Do not score as unusual punishment spanking alone, unless it continues for a very long time.

Identification: Summary of Scoring Categories

1. Emulation of skills
2. Emulation of characteristics
3. Regulation of motives or behavior
4. Self-esteem through affiliation
5. Work: delay of gratification
6. Role differentiation
7. Moralism

Identification

1. Emulation of Skills

(a) *References to one character imitating, taking over, or otherwise acquiring a skill or talent of another character, or trying to do so.* This is often seen in a younger character emulating an older one.

"(TAT1) He picked up the violin and thought, 'Maybe if I could be as great as my father;'"
"(TAT1) The little boy is wondering what this is, if he'll ever find out; he wants to ask his father . . . waiting until his father comes home . . . then he finds out" (This is a borderline case, but is scored here because the boy acquires his father's knowledge.);
"(TAT1) He wants to do it because he saw other people do it;"
"(TAT1) He was looking at this violin of his father's, he really did want to play it . . . . he learned how to play it;"
"(TAT1) He wanted to play . . . . The man said he would teach him . . . after a while he got good . . . ;"
"(TAT1) His father taught him how to do it;"
"(TAT1) He wants a teacher to teach him how;"
"(TAT1) He wants to do it like his teacher does."

Do not score "it is his father's violin and he is playing with it" (in the sense of fooling around with the violin).

Do not score if learning occurs only at the adult's insistence; the character must *want* to learn.

2. Emulation of Characteristics

(a) *References to one character imitating, taking over, or otherwise acquiring a characteristic, quality or attitude of another character, or trying to do so.*

Examples of "identification with the aggressor" are scored here.

"(TAT17BM) Jack and the Beanstalk . . . he wanted to be a giant;"
"(TAT17BM) He gave his Tarzan call [gives imitation] and Tarzan came and . . . got the bad guy."

(b) *References to one character being like another, the same as another, or, in an extreme case, merging with another.*

"He hoped he could be like his father" (in a general, nonspecific way, i.e., not in terms of a specific skill);
"(TAT1) He became Wagner;"
"(TAT17BM) He is trying to be Tarzan,"
"(TAT17BM) He gets the giant's muscles and now he's a giant."

Do not score acquisition of another's physical property (e.g., money, jewels).

3. Regulation of Motives or Behavior

Keep in mind here that it is the storyteller who has internalized these regulatory mechanisms and is now attributing them to a character in the story.

(a) *References to demands, control, influence, guidance, or prohibitions of one character over another, or through societal mores; or the active rebelling against these* (not in thought only, and not by passively doing nothing), including running away from the pressures of family or society. Include here being caught doing something one shouldn't be doing.

"(TAT1) His mother didn't hear him practicing so he had to start practicing again,"
"(TAT1) he didn't want to take violin lessons . . . so he threw it away and smashed it [the violin] all up;"
"He is going to ask his mother if he can go out . . . and she is going to say no;"
"His mother made him take violin lessons, but he didn't want to so he played hookey" (score twice, once for mother controlling him and once for rebellion);
"He asks his Dad if he can do it some other day;"
"He was told to play his violin but he doesn't want to . . . but he'll get in trouble;"
"He's a recognized criminal so he won't have it too easy in the world outside" (borderline);

"(TAT1) The people who gave it to him . . . said he had to find out what it was before he could play it;"

(b) *Indication of self-criticism, or self-reflection* on the part of either the storyteller or a character in the story.

"It isn't a very good story;"
"The mouse built a trap, but he thought it wasn't very good;"
"He feels guilty for what he did";
"(TAT1) He's not very good . . . he's flunking it . . . *he's really mad* because he wanted to be a really good one;"
"(TAT17BM) He's feeling he should have concentrated more;"
"(TAT1) He started to play it, but it sounded funny, it didn't work. He's feeling that he is stupid;"
"He decided 'I'm not a very good violin player;'"
"(TAT17BM) He climbed up a vine . . . gets in trouble . . . and thinks 'I shouldn't have climbed up this time. Next time, maybe, not this time;'"
"(TAT17BM) He looks around in fear, but realizes that he . . . does have the strength to continue."

(c) *References to justified punishment by parents or authority*, as a way of controlling or regulating a character's behavior.

"His father sent him to his room because he was bad;"
"His mother gets mad and he gets spanked;"
"He breaks it and his father says 'you're never going to get a new thing again . . . ;'"
"(TAT1) The father is furious . . . the boy is having to buy another string to replace the old one."

Note: Score 3(a) only once, even if two different people (e.g., parent and teacher) are applying the same kind of control or pressure.

Note: Control through hypnotism or magic is scored under Projection (3).

Note: Unjustified punishment is scored under Projection (5).

Do not score escape from physical danger, or if the demands are of an ominous nature, or suggest an ominous outcome; instead, score Projection (6).

Do not score child begging parents for something, or hero requesting help, freedom, and so on.

Do not score justified punishment by authority that occurs as the outcome of the story; score under Identification (7) moralistic outcome.

Do not score "being put in jail" here; if being in jail is justified, score under Identification (7); otherwise, it *may* be scored under Projection (6).

Do not score "spanking" on CAT 10.

4. *Self-Esteem Through Affiliation*

(a) *Success or satisfaction that comes about through association with someone else* (not parents, aunts, uncles, grandparents, police), or *the expressed need for this kind of affiliation*.

Adoption by a foster family, if pleasant, is scored here.

"He was happy that he had a friend;"
"He gave his Tarzan call and Tarzan came and got the bad guy" (age 6);
"He realizes that he and his classmate are in exactly the same situation . . . they become very close and comfort themselves with the situation;"
"He must escape and help save his people. The people are very happy . . . they were very poor and now they are rich" (age 5);
"He's lonely and needs to be with a family;"
"He was caught because a trusted friend turned him in" (implied here is the need for a *good* friend);
"Has he the courage to master it? Interest must be backed;"
"He is adopted and lives with a nice family;"
"His brother was killed . . . he was the only source of pleasure."

(b) *Being part of a special group from which some special pleasure or help derives*.

"(TAT17BM) He is part of the English navy . . . he escapes the French . . . he is picked up by an English ship;"
"(TAT17BM) The slave is going down a rope to a fake well. It's part of the underground railroad to help him escape to Canada;"
"(TAT17BM) The sailor and his crew win the battle in a great defeat;"
"(TAT17BM) The people are citizens of the U.S. . . . they have all had hard lives. Now they are almost at the end of their climbs to greatness;"
"(TAT17BM) This man has every desire to be free. He lives in a community of similar people."

Do not score "friends" giving help, "friends" rescuing, or the need for rescue.

5. *Work; Delay of Gratification*

(a) *References to a character working*, or the implication that a character is about to work or has been working, where this is not clearly suggested by the picture. Working at homework, or references to extensive practicing, or studying very hard, are scored here.

"(TAT1) I have to keep on practicing and I have to do my homework from school. This is just fouling up my time" (score once for practicing, once for homework);
"(TAT1) He has a whole bunch of homework to do, and to practice on the violin" (score twice);
"He has to study really hard;"
"He practiced all his life;"
"He is working;"
"(TAT17BM) His muscles are straining and hurting, but he must go on."

(b) *References to delay* (e.g., waiting, biding one's time, planning ahead) to attain some future gratification. A recognition that success will not be immediate.

"He wants to learn it, but not too fast, not in one day;"
"He's looking at a violin . . . later, about four months later he can play one chord on it . . . then 12 months later he can play 19 chords, no, he can play beginners . . . two years later he can play it very well;"
"(TAT1) He's looking at it . . . after a few years he was able to play one . . . ;"
"(TAT17BM) First he was planning his rhythm [his moves] or what he's going to do when he get's up there . . . ;"
"(TAT1) It's a car track and he's been trying to make this for about two weeks;"
"(TAT1) He didn't know how to play it . . . he waited and waited for someone to come and help him . . . his next door neighbor [finally] came and taught him."

The following two examples of "waiting" are borderline cases:

"He is thinking maybe he can play it. And he cares to do it when he grows up;"
"He is going to try to become a violinist in the next years to come."

Do not score references to exercising (unqualified) or to being tired from athletic endeavors.

Do not score references to a character thinking about the fact that he should do some work, but he doesn't do it.

Do not score "in the future he did it" unless the need for delay and/or work is clearly mentioned.

Do not score being trapped somewhere for a period a time before being freed.

6. *Role Differentiation*

(a) *Mention of characters in specific adult roles, other than* mother or father or other relatives (e.g., husband, wife, teacher, sailor, married couple, farmer, priest, soldier, scientist, rock-and-roll player, "professional," king, princess, gymnast (but not "trapezeman").

Also included here are specific historical characters.

Do not score mention of mythical or comic book roles here (e.g., giant, Tarzan).

Do not score a role indicated only by the addition of ____ man or ____ woman to a noun or adjective (e.g., trapezeman, violinman, strongman) *unless* this is the commonly accepted term to designate that role (e.g., mailman, businessman, fireman).

Do not score references to ominous roles (e g., hypnotist); these should be scored under Projection (2).

Do not score "doctor" or "surgeon" on TAT 8BM.

Do not score violinist, musician, or similar term on TAT 1.

Do not score references to law enforcement officers in action here; score under Identification (7).

Do not score "king" on CAT 1.

Do not score "guards," "keepers," "soldiers," or "police" on TAT 17BM.

Do not score "husband," "wife," "boyfriend," "girlfriend," or "prostitute" on TAT 13MF.

Note: Capitalization may help differentiate, e.g, mountain climber (someone climbing mountains) from Mountain Climber (a profession).

7. *Moralism*

(a) *Stories that include a moralistic outcome*, in which good conquers evil, wrongdoing is punished (by other than parents), goodness begets goodness, justice triumphs, a (moral) lesson is learned, and so on.

"(TAT17BM) Prisoner . . . breaks out . . . starts to run . . . Then he thought sooner or later the police will find him. So he decided it would just be better to go back, so he went back;"
"He escaped from the army . . . he was a prisoner [of war] . . . they chased him . . . . He lived to tell everybody;"
"He's been in prison [but] he's innocent . . . . He finally proves that he didn't do it . . . he captures whoever did it;"
"He was in jail for speeding . . . he's escaping . . . gonna kill himself for escaping;"
"Climbed the rope, saw a lion . . . he was scared. 'I'll never do it again;'"
"(TAT17BM) He is probably going to fall because he is a criminal;"
"He's thinking about this homework, wondering what happen if he doesn't get it done . . . he's just sitting there, when he walks home slowly . . . he doesn't do it. When he gets to school [next day] he won't have it done and then he'll have twice as much to do" (This is a borderline case, but is scored because the implication is that he is worse off for not having done what he was supposed to do).

(b) *Justified punishment administered by teacher*, judge, policeman, or other authority figure (excluding parents or guardians).

Included here are stories in which someone breaks (or has broken) the law, is apprehended, and *put in jail*. Usually, this will occur near the end of the story. If a character is in jail at the beginning of the story, score only if it is explained that he is in jail for having committed a crime.

"(TAT17BM) He robbed a bank . . . the police will get him . . . he will be in jail;"

Note: If being put in jail, prison, etc., is not justified (e.g., due to jealousy, fear, or whim) score under Projection (6).

Note: Score being chased, trapped, or caught by *police* under Identification (7).

Note: Unjustified punishment, or extremely cruel or unusual punishment is scored under Projection (6) or Projection (7).

Do not score if punishment is given by parents or guardian; instead, score Identification (3).

BETH ISRAEL MEDICAL CENTER

FIRST AVENUE AT 16TH STREET NEW YORK NY 10003

CONSENT FOR PARTICIPATION IN SCIENTIFIC INVESTIGATIONS

NAME OF SUBJECT	NAME OF INVESTIGATOR
	David Hellerstein, M.D.

TITLE OF PROJECT	PROJECT NUMBER
Combined Medication and Group Psychotherapy of Dysthymia: A pilot study on the impact of group psychotherapy on medication-treated dysthymic patients.	#38-94 (2)

INSTRUCTIONS

TYPE IN LAY TERMS THE NATURE AND PURPOSES OF THE STUDY. THE DURATION OF THE SUBJECT'S PARTICIPATION. THE BENEFITS, RISKS AND DISCOMFORTS OF THE PROCEDURES/TESTS AND/OR DRUGS/DEVICES TO BE USED. THE REQUIREMENTS (SAMPLE COLLECTIONS, BIOPSIES, QUESTIONNAIRES, ETC.) AND RESTRICTIONS (DIET, ETC.) AND DISCLOSE APPROPRIATE ALTERNATIVE TREATMENT PROVIDE THE NAMES OF PERSONS TO CONTACT FOR QUESTIONS ABOUT THE STUDY AND IN CASE OF RESEARCH-RELATED INJURY

Purpose and Nature of Treatment:
I understand that I am being asked to voluntarily take part in a combined medication and psychotherapy treatment. The drug that I am to receive is fluoxetine (a standard drug that is FDA-approved for the treatment of depression). The therapy consists of a time-limited cognitive-experiential group psychotherapy, which has been designed to address the interpersonal problems that are frequently associated with chronic mild depression. The study will attempt to evaluate the benefits of time-limited group psychotherapy for dysthymic individuals who are being treated with antidepressant medication. There is no cost either for the medication or the group psychotherapy treatment.

Explanation of Procedures to be Followed:
The duration of the entire study is approximately 36 weeks: The active treatment phase consists of 24 weeks, with the remaining 12 weeks constituting a follow-up period. The study proceeds as follows: At the beginning of the study, I will be assessed in an initial intervie to determine if I meet criteria for chronic mild depression. If I am deemed eligible, I will

AUTHORIZATIONS

I _____ HAVE READ THE ABOVE AND HAVE BEEN GIVEN A CLEAR ORAL EXPLANATION OF THE NATURE, REQUIREMENTS AND EFFECTS OF THE STUDY AND SATISFACTORY ANSWERS TO MY INQUIRIES. I ACCEPT THE CONDITIONS OF THE STUDY AND I AUTHORIZE THE ABOVE PROCEDURES/TESTS TO BE PERFORMED AND/OR INVESTIGATIONAL DRUGS/DEVICES TO BE USED. I UNDERSTAND THAT IN THE EVENT OF PHYSICAL INJURY RESULTING FROM THIS STUDY, ONLY IMMEDIATE ESSENTIAL MEDICAL TREATMENT AS DETERMINED BY THE HOSPITAL WILL BE AVAILABLE FOR THE INJURY WITHOUT CHARGE TO ME PERSONALLY. THERE WILL BE NO MONETARY COMPENSATION. I ALSO REALIZE THAT I AM FREE TO WITHDRAW THIS CONSENT AT ANY TIME WITHOUT PREJUDICE TO MY FUTURE TREATMENT.

I UNDERSTAND THAT RECORDS OF THIS INVESTIGATION WILL BE KEPT CONFIDENTIAL BUT ARE SUBJECT TO INSPECTION BY THE U.S. FOOD & DRUG ADMINISTRATION

SIGNATURE OF PATIENT / DATE	SIGNATURE OF PERSON GIVING PERMISSION / DATE RELATIONSHIP TO PATIENT	VALID UNTIL

I _____ HAVE CLEARLY AND FULLY EXPLAINED TO THE ABOVE PATIENT (OR PERSON GIVING CONSENT) THE NATURE, REQUIREMENTS AND FORESEEABLE RISKS OF THE STUDY. IN MY JUDGMENT HE/SHE IS FULLY COMPETENT TO COMPREHEND THE NATURE OF THE STUDY AND THE PROCEDURES INVOLVED.

SIGNATURE OF INVESTIGATOR / DATE	SIGNATURE OF AUDITOR-WITNESS / DATE	(STAMP)

COMMITTEE ON
OCT - 2 1996
SCIENTIFIC ACTIVITI

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meet with the physician who will study my present condition as well as my past medical history. A blood sample will be drawn (the amount will be approximately equal to 45cc, which is about 3 tablespoonsful) for analysis of drug concentration and laboratory values. A urine sample will also be required. Once I am accepted into the study I will be put on fluoxetine medication for approximately 8-10 weeks. If I show a positive clinical response to the medication, I will then be randomized to one of two groups. If I am randomized to the first group, I will continue to receive medication and, in addition, begin a course of 16 weekly group therapy sessions. If I am randomized to the second group I will stay on medication only. All initial assessments and group therapy treatment sessions will be videotaped. In addition, I will be asked by my psychiatrist to fill out inventories and answer questions at my regularly scheduled clinic visits. A clinical interviewer will also administer questionnaires to me at 4 assessment points during the 36-week study.

Discontinuation of Medication Treatment

I understand that I will be discontinued from medication treatment at the end of the 24-week trial. I agree to remain off medication for the next 12 weeks, at which time I will be reassessed. During the 12-week follow-up period I will meet monthly with the psychiatrist assigned to me, who will monitor my condition. I may also contact the psychiatrist at any point during the follow-up period if I experience a recurrence of symptoms that require medical attention. If the psychiatrist determines that I need to be re-started on antidepressant medication during the 12-week follow-up period, I will receive it at Beth Israel Medical Center at no charge.

At the Completion of the 36-week Study - 24-week Active Treatment + 12-week Follow-Up

After I have completed the 36-week study, the psychiatrist assigned to me will study my condition and recommend treatment options. If the psychiatrist concludes that I need to be re-started on medication, or, if I am already receiving medication, that I need to continue medication treatment, he or she will then determine whether I am to receive medication treatment at a low fee at Beth Israel, or be given an appropriate referral. If I wish to receive psychotherapy I may also receive a referral for psychotherapy treatment at this time. I am under no obligation to end medication if either I or my psychiatrist deem it injurious to my health.

1. I UNDERSTAND THAT THE PROCEDURES AND THERAPY TO BE FOLLOWED IN THIS STUDY INVOLVE THE FOLLOWING FORESEEABLE RISKS AND DISCOMFORTS FOR ME:

Side effects which may occur during this study, based on the animal studies and experience of other people who have received fluoxetine are as follows: nausea, diarrhea, headache, tremor, dry mouth, drowsiness, weight loss, delayed ejaculation, insomnia, dizziness, and agitation. Even though these side effects are expected to occur in some patients when they are taking medications of this type, few patients have had to discontinue fluoxetine therapy because of side effects. Although studies have shown no effects of fluoxetine on performance, antidepressants have been shown to impair the mental and physical abilities required for the performance of potentially hazardous tasks such as operating an automobile or machinery. Since they could also occur with fluoxetine, caution is advised. In receiving fluoxetine, it is possible, but unlikely, that there could

be some serious side effects which are still unknown to us. Blood will be drawn for tests at initial assessment and after 24 weeks of treatment; during blood drawing, there may be mild discomfort, and bruising might result.

I understand that problems and side effects not listed above and not expected at this time could occur. I understand that I will be told of any changes in the way that the study will be done and of any risks to which I may be exposed.

2. WOMEN OF CHILD-BEARING POTENTIAL:

I agree to use a contraceptive method judged to be effective by the investigator. I understand that if I am pregnant or become pregnant during the study that I or my unborn child may be exposed to unknown risk. Also I agree to notify the investigator as soon as possible, if I become pregnant, and will withdraw from the study.

3. I UNDERSTAND THAT THE BENEFITS OF THE STUDY ARE AS FOLLOWS:

a. Benefits to me: Participation in this study might benefit me by helping to reduce my symptoms and improve my psychosocial functioning.
b. Benefits to other people: If fluoxetine combined with group therapy is found to be effective, other people with problems such as mine might benefit.

4. I UNDERSTAND THAT IF I DO NOT WANT TO PARTICIPATE IN THIS STUDY, THE FOLLOWING TYPES OF ALTERNATIVE TREATMENT ARE AVAILABLE:

a. Treatment with other available drugs.
b. Standard inpatient or outpatient individual treatment.

5. I UNDERSTAND THAT THE PHYSICIAN IN CHARGE OF THE STUDY CAN REMOVE ME FROM THE STUDY WITHOUT MY CONSENT FOR THE FOLLOWING REASONS:

a. His judgment, in an effort to improve my medical care.
b. My failure to follow the study schedule.
c. Any other specified reason.

6. OFFER TO ANSWER QUESTIONS ABOUT THE STUDY:

If I have any questions during the study, I should contact Dr. David Hellerstein, telephone number 420-2800 or 614-1753. If I have any concerns about the conduct of this study, I should contact Navah Harlow, Director of Ethics in Medicine at Beth Israel Medical Center, telephone number 420-3818.

7. RIGHT TO WITHDRAW FROM THIS STUDY:

I understand that I am free to withdraw my consent and discontinue my participation in this study at any time. If I choose not to participate, other treatment options at Beth Israel will be made available to me, but I am under no obligation to use them. I understand that, if I have no objections, I will be asked to undergo the following special procedures if I decide to withdraw from the study.

I will be asked to schedule an appointment with the investigator to inform him or her of my decision to withdraw from the study and at that time I will be asked to:

a. Return all medications to the investigator with the appropriate container they came in.
b. Undergo final assessments:
-physical examination
-blood pressure/pulse/weight
-labwork
-plasma samples
-various rating scales, including self-rating scales

If for any reason I choose not to complete the full treatment, I understand that I can withdraw without any obligation and without prejudice.

8. CONSENT TO PARTICIPATE IN THIS STUDY:

I have read, or have had read to me in my first language, the above information. The content and meaning of this information have been explained to me. I hereby voluntarily consent and offer to take part in this study. I understand that all records, including questionnaires and videotapes, will be maintained at Beth Israel Medical Center. I understand that the information contained in these records will be kept in strictest confidence. Although it is possible that at some point in the future results of my treatment may be published or presented for scientific purposes, adequate precautions will be taken to maintain complete confidentiality, according to the customary professional ethics of Beth Israel Medical Center. I have received a copy of this informed consent agreement.

BIBLIOGRAPHY

Ablon, S., Carlson, G.A., & Goodwin, F.K. (1974). Ego defense patterns in manic-depressive illness. American Journal of Psychiatry, 131, 803-807.

Abraham, K. (1911/1985). Notes on the psychoanalytic investigation and treatment of manic-depressive insanity and allied conditions. In. J.C. Coyne (Ed.), Essential Papers on depression. New York: New York University Press.

Abramson, L.Y., Seligman, M.E.P., & Teasdale, J. (1978). Learned helplessness in humans: critique and reformulation. Journal of Abnormal Psychology, 87, 49-74.

Abramson, L., Garber, G., & Seligman, M.E.P. (1980). Learned helplessness in humans: An attributional analysis. In J. Garber & M.E.P. Seligman (Eds.), Human helplessness: Theory and applications. New York: Academic Press.

Akkerman, K., Carr, V., Lewin, T. (1992). Changes in ego defenses with recovery from depression. Journal of Nervous & Mental Disease, 180, 634-638.

Akiskal, H.S., Bitat, H.S. Et al. (1980). The nosological status of neurotic depression. Archives of Gen Psychiatry, 35, 756-766.

Akiskal. H.S. (1983). Dysthymic disorder: psychopathology of proposed chronic depressive subtypes. American Journal of Psychiatry, 140, 11-20.

Akiskal, H.S. (1988). Personality as a mediating variable in the pathogenesis of mood disorders: Implications for theory, research, and prevention. In T. Helgason & R.J. Daly (Eds.), Depressive illness: Prediction of course and outcome. Berlin: Springer-Verlag.

Akiskal, H.S. (1989). Validating affective personality types. In: The Validity of Psychiatric Diagnosis . Robins, L. & Barret, J. (Eds.), New York: Raven Press.

Alden, L.E., Wiggins, J.S., & Pincus, A.L. (1990). Construction of circumplex scales for the Inventory of Interpersonal Problems. Journal of Personality Assessment, 55, 521-536.

Alloy, L.B., Albright, J.S., Abramson, L.Y., & Dykman, B.M. (1990). Depressive realism and nondepressive optimistic illusions: The role of the self. In Contemporary Psychological Approaches to Depression. Ingram, R.R. (Ed.), New York: Plenum Press.

American Psychiatric Association (1968). Diagnostic and statistical manual of mental disorders (2nd edition). Washington, DC.

American Psychiatric Association (1980). Diagnostic and statistical manual of mental disorders (3rd edition). Washington, DC.

American Psychiatric Association (1987). Diagnostic and statistical manual of mental disorders (3rd edition, revised). Washington, DC.

American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (4th edition). Washington, DC.

Andrews, G., Singh, M., Bond., M. (1993). The defense style questionnaire. Journal of Nervous & Mental Disease, 181, 246-256.

Andrews, J.D.W. (1989). Psychotherapy of depression: A self-confirmation model. Psychological Review, 96 (4), 576-607.

Anthony, E.J. (1970). The behavior disorders of childhood. In P.H. Mussen (Ed.), Carmichael's handbook of child psychology (vol. 2, pp. 667-764). New York: Wiley.

Arieti, S. & Bemporad, J. (1978). Severe and Mild Depression: The psychotherapeutic approach. New York: Basic Books.

Astigueta, F.D. (1983). Integrating psychopharmacology and contemporary psychoanalytic group therapy. Small group behavior, 14, 261-268.

Bartlett, F.C. (1932). Remembering: A study in experimental and social psychology. Cambridge: Cambridge University Press.

Battista, J.R. (1982). Empirical test of Vaillant's hierarchy of ego functions. American Journal of Psychiatry, 139, 356-357.

Beck, A.T., Ward, C.H., Mendelson, M., Mock, J.E. & Erbaugh, J.K. (1961). An inventory for measuring depression. Archives of General Psychiatry, 4, 561-571.

Beck, A.T. (1967). Depression: Clinical, experimental, and theoretical aspects. New York: Harper & Row.

Beck, A.T. (1983). Cognitive therapy of depression: New perspectives. In P.J. Clayton & J.E. Barrett (Eds.), Treatment of depression: Old controversies and new approaches. New York: Raven Press.

Behrends, S. & Blatt, S.J. (1985). Internalization and psychological development throughout the life span. Psychoanalytic Study of the Child, 40, 11-39.

Bellak, L., Hurvich, M., & Gediman, H.K. (1973). Ego functions in schizophrenics, neurotics, and normals. New York: John Wiley.

Bellak, L. (1975). The Thematic Apperception Test, The Children's Apperception Test and the Senior Apperception Technique in clinical use. 3rd ed. New York: Grune & Stratton.

Bibring, G., Dwyer, T., Huntington, D, & Valenstein, A. (1961). A study of the psychological process in pregnancy and of the earliest mother-child relationship. Psychoanalytic Study of the Child, 16, 25-72.

Bibring, E. (1953/1968). The mechanism of depression. In Gaylin (Ed.) The meaning of despair: Psychoanalytic contributions to the understanding of depression. New York: Science House.

Blackburn, I.M., Bishop, S., Glen, A., Whalley, L.J., & Christie, J.E. (1981). The efficacy of cognitive therapy in depression: A treatment trial using cognitive therapy and pharmacotherapy, each alone and in combination. British Journal of Psychiatry, 139, 181-189.

Blaney, P.H. (1981). The effectiveness of cognitive and behavioral therapies. In L.P. Rehm (Ed.), Behavior therapy for depression. New York: Academic Press.

Blatt, S.J. (1974). Levels of object representation in anaclitic and introjective depression. Psychoanalytic Study of the Child, 29, 107-157.

Blatt, S. J., D'Afflitti, J.P., & Quinlan, D.M. (1976). Experiences of depression in normal young adults. Journal of Abnormal Psychology, 85, 383-389.

Blatt, S.J., Wein, S.J., Chevron, E. & Quinlan, D.M. (1979). Parental

representations and depression in normal young adults. Journal of Abnormal Psychology, 88, 388-397.

Blatt, S.J., Quinlan, D.M., Chevron, E.S., & McDonald, C. (1982). Dependency and self-criticism: Psychological dimensions of depression. Journal of Consulting and Clinical Psychology, 50 (1), 113-124.

Blatt, S.J. & Lerner, H. (1983). Investigations in the psychoanalytic theory of object relations and object representations. In J. Masling (Ed.), Empirical studies of psychoanalytic theories,.(Vol. 1, pp. 189-249). Hillsdale, NJ: Erlbaum.

Blatt, S.J. & Shichman, S. (1983). Two primary configurations of psychopathology. Psychoanalysis and Contemporary Thought, 6, 187-254.

Blatt, S.J., Ford, R.Q., Berman, W., Cook, B., & Meyer, R. (1988). The assessment of change during the intensive treatment of borderline and schizophrenic young adults. Psychoanalytic Psychology, 5 (2), 127-158.

Blatt, S.J. & Bass, R. (1990). Attachment and separateness: A dialectical model of the product and processes of psychological development. The Psychoanalytic Study of the Child, 45, 107-127.

Blatt, S.J., Quinlan, D.M., & Chevron, E. (1990). Empirical investigations of a psychoanalytic theory of depression. In J. Masling (Ed.), Empirical Studies of Psychoanalytic Theories. (Vol. 3). Hillsdale, N.J.: Analytic Press.

Blatt, S.J. & Ber, S. (1991). Commentary. In Z.V. Segal & S.J. Blatt (Eds.), The self in emotional distress: cognitive and psychodynamic perspectives. New York: Guilford Press.

Blatt, S.J. (1992). The differential effect of psychotherapy and psychoanalysis with anaclitic and introjective patinets: The Menninger Psychotherapy Research Project revisited. Journal of the American Psychoanalytic Association, 40 (3), 691-724.

Blatt, S. J. & Zuroff, D. (1992). Interpersonal relatedness and self-definition: Two prototypes for depression. Clinic Psychology Review, 12, 527-562.

Blatt, S.J. & Ford, R. (1994). Therapeutic Change: an object relations perspective. New York: Plenum Press.

Blatt, S.J. (1995). Representational Structures in Psychopathology. In D. Cicchetti & S. Toth (Eds.), Emotion, Cognition, and Representation. NY: University of Rochester Press.

Blatt, S.J., Quinlan, D.M., Pilkonis, P.A., & Shea, M.T. (1995). Impact of perfectionalism and need for approval on the brief treatment of depression: The National Institute of Mental Health treatment of depression Collaborative Resarch Program revisited. Journal of Consulting and Clinical Psychology, 63 (1), 125-132.

Bleichmann, H.B. (1996). Some subtypes of depression and their implications for psychoanalytic treatment. International Journal of Psycho-Analysis, 77, 935-961.

Bloch, S. & Crouch, E. (1985). Therapeutic factors in group psychotherapy. Oxford: Oxford University Press.

Bloch, A.L., Shear, K.M., Markowitz, J.C., Leon, A.C., & Perry, J.C. (1993). An empirical study of defense mechanisms in dysthymia. American Journal of Psychiatry, 150, 8, 1194-1198.

Blum, H.P. (Ed.). (1985). Defense and Resistance. New York: International Universities Press.

Bond, M., Gardner, S.T., Christian, J., & Sigal, J.J. (1983). Empirical study of self-rated defense styles. Archives of General Psychiatry, 40, 333-338.

Bond, M.(1986). An empirical study of defense styles. In G.E. Vaillant (Ed). Empirical Studies of Ego Mechanisms of Defense. Washington, DC: American Psychiatric Press.

Bowlby, J. (1968). Process of mourning. In Gaylin, W. (Ed.), The meaning of despair: Psychoanalytic contributions to the understanding of depression. New York: Science House.

Bowlby, J. (1969). Attachment and Loss. Vol. 1. Attachment. New York: Basic Books

Bowlby, J. (1976). Attachment and Loss. Vol. 2. Separation: Anxiety and Anger. New York: Basic Books

Bowlby, J. (1977). The making and breaking of affectional bonds. British Journal of Psychiatry, 130, 201-210.

Bowlby, J. (1980). Attachment and Loss. Vol. 3. Loss: Sadness and Depression. New York: Basic Books

Bower, G. (1981). Mood and memory. American Psychologist, 36, 129-148.

Bretherton, I. (1995). Attachment theory and developmental psychopathology. In D. Cicchetti & S. Toth (Eds.), Emotion, Cognition, and

Representation. NY: University of Rochester Press.

Breznitz, S. (1983). the seven kinds of denial. In S. Breznitz (Ed.), The denial of stress. New York: International Universities Press.

Brody, L.R. & Layton, L. (1989) Adolescents and their mothers: Denial, projection, identification and affect expression on the TAT, Unpublished manuscript, Boston University.

Brierley, M. (1937). Affects in theory and practice. In Trends in Psychoanalysis. London: Hogarth Press, 1951.

Bush,M. Hatcher, R. & Mayman, M. (1969). Reality attentiveness-inattentiveness and externalization-internalization in defensive style. Journal of Consulting and Clinical Psychology, 33 (3), 343-350.

Chandler, M.J., Paget, K.P., & Kock, D.A. (1978). The child's demystification of psychological defense mechanisms: a structural and developmental analysis. Developmental Psychology, 14 (3), 197-205.

Charney, D.S., Nelson, C.J., & Quinlan, D.M. (1981). Personality traits and disorder in depression. American Journal of Psychiatry, 138, 1601-1604.

Chien, A.J. & Dunner, D.L. (1996). The tridimensional personality questionnaire in depression: state versus trait issues. Journal of Psychiatric Research, 30(1), 21-27.

Cicchetti, D. & Schneider-Rosen, K. (1988). An organizational approach to childhood depression. In M. Rutter, C. Izard & P. Read (Eds). Depression in young people. New York and London: The Guilford Press.

Cicchetti, D. & Toth, S.L. (1995). Developmental psychopathology and disorders of affect. In D.Cicchetti & D. Cohen (Eds.) Developmental Psychopathology, Vol.2, Theory and Methods. New York: Wiley & Sons.

Cloninger, R., Svrakic, D., & Przybeck,T. (1993). A psychobiological model of temperament and character. Archives of General Psychiatry, 50, 975-990.

Cohen, J. (1988). Statistical Power Analysis for the Behavioral Sciences. Hillsdale, NJ: Lawrence Erlbaum.

Conti, D.J. & Burton, W.N. (1994). The economic impact of depression in a workplace. Journal of Occupational Medicine, 36 (9), 983-988.

Cooper, S.H., Perry, J.C., & Arnow, D. (1988). An empirical approach to the study of defense mehcanisms: I. Reliability and preliminary validity of the Rorschach Defense Scales. Journal of Personality Assessment, 52, 187-203.

Cooper, S.H. (1989). Recent contributions to the theory of defense mechanisms: A comparative view. Journal of the American Psychoanalytic Association, 37, 865-891.

Coyne, J.C. (1976). Towards an Interactional Description of Depression. Psychiatry, 39, 28-41.

Coyne, J.C. & Gotlib, I.H. (1983). The role of cognition in depression: A critical appraisal. Psychological Bulletin, 94, 472-505.

Cramer, P., & Carter, T. (1978). The relationship between sexual identification and the use of defense mechanisms. Journal of Personality Assessment, 42, 63-73.

Cramer, P. (1979). Defense mechanisms in adolescence. Developmental Psychology, 15, 467-477.

Cramer, P. (1983). Children's use of defense mechanisms in reaction to displeasure caused by others. Journal of Personality, 51, 78-94.

Cramer, P. (1987). The development of defense mechanisms. Journal of Personality, 55, 597-614.

Cramer, P., Blatt, S.J., & Ford, R.Q. (1988) Defense mechanisms in the anaclitic and introjective personality configuration. Journal of Consulting and Clinical Psychology, 56, 610-616.

Cramer, P. (1991). The development of defense mechanisms: Theory, research, and assessment. New York: Springer-Verlag.

Cramer, P. & Blatt, S.J. (1990). Use of the TAT to measure change in defense mechanisms following intensive psychotherapy. Journal of Personality Assessment, 54 (1 & 2), 236-251.

Cramer, P. et al. (1996). Storytelling, Narrative, and the TAT. New York: Guilford Press.

Crits-Cristoph, P., Cooper, A., & Luborsky, L. (1988). The accuracy of therapists' interpretations and the outcome of dynamic psychotherapy. Journal of Consulting and Clinical Psychology, 56, 490-495.

Davanloo, H. (Ed.).(1980). Short-term dynamic psychotherapy. New York: Jason Aronson.

Derogatis, L.R., Lipman, R.S., & Covi, I. (1973). The SCL-90: An outpatient rating scale. Psychopharmacology Bulletin, 9, 13-28.

Diamond, D. & Blatt, S.J. (1994) Internal Working Models and the Representational World in Attachment and Psychoanalytic Theories. In: Sperling, M. & Berman, W.H. (Eds.), Attachment in adults: Clinical and developmental perspectives. New York Guilford Press.

Dollinger, S.J., Staley, A., & McGuire, B. (1981). The child as psychologist: Attributions and evaluations of defense strategies. Child Development, 52, 1084-1086.

Elkin, I., Shea, M.T., Watkins, J.T., Imber, S.D., Sotsky, S.M., Collins, J.F., Glass, D.R., Pilkonis, P.A., Leber, W.R., Dockerty, J.P., Fiester, S.J., & Parloff, M.B. (1989). NIMH Treatment of Depression Collaborative Research Program: General effectiveness of treatments. Archives of General Psychiatry, 46, 971-983.

Elkind, D. (1976). Cognitive development and psychopathology. Observations on egocentrism and ego defense. In E. Schopler & R.J. Reichler (Eds.), Psychopathology and child development. New York: Plenum Press.

Erdelyi, M.H. (1974). A new look at the new look: Perceptual defense and vigilance. Psychological Review, 81, 1-25.

Evans. R.G. (1982). Defense mechanisms in females asa function of self-role orientation. Journal of Clinical Psychology, 38, 816-817.

Fairbairn, R. (1952). Psycho-analytic studies of the personality. London: Routledge.

Fava, G.A., Grandi, S., Zielezny, M., Canestrari, R., Murphy, M.A. (1994). Cognitive and behavioral treatment of residual symptoms in primary major depressive disorder. American Journal of Psychiatry, 151: 1295-1299.

Fenichel, O. (1945). The psychoanalytic theory of neurosis. New York: W.W. Norton & Company.

First, M.B., Spitzer, R.L. et al. Structured Clinical Interview for Axis I DSM-III-R Disorders. Biometric Research Department, New York State Psychiatric Institute.

Foreman, S.A. & Marmar, C.R. (1985). Therapist actions that address initially poor therapeutic alliance in psychotherapy. American Journal of Psychiatry, 142 (8): 922-926.

Folkman, S. & Lazarus, R. (1980). An analysis of coping in a middle-aged community sample. Journal of Health and Social Behavior, 21, 219-239.

Foulkes, S.H. (1965). Therapeutic group analysis. New York: International Universities Press.

Frances, A.J. (1980). The DSM III personality disorder section: a commentary. American Journal of Psychiatry, 137, 1050-1054.

Frances, A. & Cooper, A.M.. (1981). Descriptive and dynamic psychiatry: A perspective on DSM-III. American Journal of Psychiatry, 138, 1198-1202.

Freud, A. (1936/1946). The ego and the mechanisms of defense. New York: International Universities Press.

Freud, A. (1963). The concept of developmental lines. Normality and Psychopathology in childhood: the writings of Anna Freud, Volume 6, New York: International Universities Press, 1965.

Freud, S. (1894). The neuro-psychoses of defense. Standard Edition, 3, 45-61. London: Hogarth Press, 1966.

Freud, S. (1896). Further remarks on the neuro-psychoses of defense. Standard Edition, 3, 161-185. London: Hogarth Press, 1966.

Freud, S. (1911). On narcissism: An introduction. Standard Edition, 14, 67-102. London: Hogarth Press, 1958.

Freud, S. (1917). Mourning and melancholia. In W.Gaylin (Ed.). (1968). The meaning of despair: Psychoanalytic contributions to the understanding of depression. New York: Science House, 1968.

Freud, S. (1921). Group psychology and the analysis of the ego. Standard Edition, 18, 67-143. London: Hogarth Press, 1955.

Freud, S. (1923). The ego and the id. Standard Edition, 19, 1-66. London: Hogarth Press, 1961.

Freud, S. (1926). Inhibitions, symptoms and anxiety. Standard Edition, 20, 77-174. London: Hogarth Press, 1959.

Friedman, R.A. (1993). Social impairment in dysthymia. Psychiatric Annals, 23, 632-637.

Gaylin, W. (Ed.). (1968). The meaning of despair: Psychoanalytic contributions to the understanding of depression. New York: Science House.

Gedo, J. & Goldberg, A. (1973). Models of the mind. Chicago: University of Chicago Press.

Gleser, G.C. & Ihilevich, D. (1969). An objective instrument for measuring defense mechanisms. Journal of Consulting and Clinical Psychology, 33, 51-60.

Goldberger, L. & Breznitz, S. (1982). Handbook of Stress: Theoretical and Clinical Aspects. New York: The Free Press.

Gotlib, I.H. & Asaranow, R.F. (1979). Interpersonal and interpersonal problem-solving skills in mildly and clinically depressed university students. Journal of Consulting and Clinical Psychology, 47, 86-95.

Gotlib, I.H. & Hammen, C. (1992). Psychological Aspects of Depression: Towards a Cognitive-Interpersonal Integration. New York: Wiley & Sons.

Grinker, R.R., Miller, J., Sabshin, M., Nunn, R. & Nunnally, J. (1961). The phenomena of depressions. New York: Huber.

Gunderson, J.G., Phillips, K.A., Triebwasser, J., & Hirschfeld, R.A. (1994) American Journal of Psychiatry, 151, 1300-1304.

Haan, N. (1963). Proposed model of ego functioning: Coping and defense mechanisms in relationship to IQ change. Psychological Monographs, 77(8), 373-378.

Haan, N. (1977). Coping and defending. New York: Academic Press.

Hadley, S.W. & Strupp, H.H. (1976). Contemporary views of negative effects in psychotherapy: An integrated account. Archives of General Psychiatry, 33, 1291-1291.

Hague, W.H., Donovan, D.M., & O'Leary, M.R. (1976). Personality characteristics related to treatment decisions among inpatient alcoholics: A non-relationship. Journal of Clinical Psychology, 32, 476-479.

Hamilton, M. (1960). A rating scale for depression. Journal of Neurological Neurosurgical Psychiatry, 25, 56-62.

Harpin, R., Liberman, R., Marks, I., Stern, R., & Bohannon, W. (1982). Cognitive-behavior therapy for chronically depressed patients: a controlled pilot study. Journal of Nervous & Mental Disease, 170: 295-301.

Harrison, W.M. & Stewart, J.W. (1993). Pharmacotherapy of dysthymia. Psychiatric Annals, 23: 638-648.

Hartmann, H. (1939). Ego psychology and the problem of adaptation. New York: International Universities Press.

Hauser, S.T. & Safyer, A.W. (1995) The contributions of ego psychology to developmental psychopathology. In (Cicchetti, D. & Cohen, D. eds.) Developmental Psychopathology, Vol. I., Theory and Methods. New York: Wiley & Sons.

Hays, R.D., Wells, K.B., Sherbourne, C.D., Rogers, W. & Spritzer, K. (1995). Functioning and well-being outcomes of patients with depression compared with chronic general medical illnesses. Archives of General Psychiatry, 52, 11-19.

Hellerstein, D.J. & Little, S.A.S. (1994). SSRI medications in the treatment

of dysthymia and chronic depression. Journal of Serotonin Research, 1, 181-187.

Hellerstein, D.J. & Little, S.A.S. (1996). Current perspectives on the diagnosis and treatment of double depression. CNS Drugs, 5, 344-357.

Hellerstein, D.J., Samstag, L.W. Cantillon, M., Maurer, M., Rosenthal, J., Yanowitch, P., & Winston, A. (1996). Long-term follow-up of medication-treated dysthymia. Progressin Neuropsychopharmacology and Biological Psychiatry, 18, 139-147.

Hellerstein, D.J., Yanowitch, P., Rosenthal, J., Samstag, L.W., Maurer, M., Kasch, K., Burrows, L., Poster, M., Cantillon, M., & Winston, A. (1993). A randomized double-blind study of fluoxetine versus placebo in treatment of dysthymia, American Journal of Psychiatry, 150, 1169-1175.

Henry, W.E. (1956). The analysis of fantasy. New York: John Wiley.

Hibbard, S., Farmer, L, Wells, C, Difillipo, E., Barry, W., Korman, R., & Sloan, P. (1994). Validation of Cramer's defense mechanism manual for the TAT. Journal of Personality Assessment, 63 (2), 197-210.

Hirschfeld, R.M.A., Klerman, G.L., Clayton, P., & Keller, M. (1983). Personality and depression: Empirical findings. Archives of General Psychiatry, 40, 993-998.

Hofer, M. (1984). Relationships as regulators: A psychobiologic perspective on bereavement. Psychosomatic Medicine, 46, 183-197.

Higgins, E.T. & Bargh, J.A. (1987). Social cognition and social perception. Annual review of Psychology, *38*, 364-426.

Hollon, S.D., DeRubeis, R.J., Evans, M.D., Wiemer, M.J., Garvey, M.J., Grove, W.M., & Tuason, V.B. (1992). Cognitive therapy and pharmacotherapy for depression: Singly and in combination. Archives of General Psychiatry, 49: 774-781.

Holt, R. R. (1977). A method for assessing primary process manifestations and their control in Rorschach responses. In M. Rickers-Ovsiankina (Ed.), Rorschach psychology. Huntington, NY: Krieger.

Holtzman, P.S. (1966, February). Manual for scoring TAT's. Unpublished manuscript.

Hooley, J.M., Orley, J., & Teasdale, J.D. (1986). Levels of expressed emotion and relapse in depressed patients. British Journal of Psychiatry, 148, 642-647.

Horowitz, L.M., Rosenberg, S.E., Baer, B.A., Ureno, G., Villasenor, V.S. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. Journal of Consulting and Clinical Psychology. 56, 885-892.

Horowitz, L.M., Locke, K.D., Morse, M.B., Waikar, S.V., Dryer, D.C.D., Tarnow, E., & Ghannam, J. (1991). Self-derogations and interpersonal theory. Journal of Personality and Social Psychology, 61, 68-79.

Horowitz, M.J. (1972). Modes of representation of thought. Journal of the American Psychoanalytic Association, 20, 793-819.

Horowitz, M.J. (1983). Psychological response to serious life events. In (Breznitz, S. Ed.) The Denial of Stress. New York: International Universities Press.

Horowitz, M.J. (1988a). Introduction to psychodynamics: A new synthesis. New York: Basic Books.

Horowitz, M. J. (1988b). Psychodynamic Phenomena and their Explanation. In Horowitz, M.J. (Ed.), Psychodynamics and Cognition. Chicago and London: The University of Chicago Press.

Horowitz, M. J. (1988c). Unconsciously Determined Defensive Strategies. In Horowitz, M.J. (Ed.), Psychodynamics and Cognition. Chicago & London: The University of Chicago Press.

Horowitz, M.J., Milbraith, C., Jordan, D., Stinson, C., Reddington, D, Ewart, M, Fridhandler, B., Reidbord, S. & Hartley, D. (1994). Expressive and defensive behavior during discourse on unresolved topics. Journal of Personality, 62, 527-563.

Horwath, E., Johnson, J., Klerman, GL, Weismann, M.M. (1992). Depressive symptoms as relative and attributable risk factors for first-onset major depression. Archives of General Psychiatry, 49, 817-823.

Howland, R.H. (1991). Psychopharmacotherapy of dysthymia. Journal of Clinical Psychopharmacology, 11, 83-92.

Howland, R.H. (1993a). Chronic depression. Hospital and Community Psychiatry, 44, 633-639.

Howland, R.H. (1993b). General health, health care utilization, and medical comorbidity in dysthymia. International Journal of Psychiatry in Medicine, 23, 211-238.

Ihilevich, D. & Gleser, G.C. (1986). Defense mechanisms. Their classification, correlates, and measurement with the Defense Mechanisms

Inventory. Owosso, MI: DMI Associates.

Jacobson, E. (1954). The self and the object world. Psychoanalytic study of the Child, 9, 75-127.

Jacobson, E. (1971). Depression: Comparative studies of normal, neurotic, and psychotic conditions. New York: International Universities Press.

Janis, I.L. (1958). Psychological stress: Psychoanalytic and behavioral studies of surgical patients. New York: Wiley.

Janis, I.L. (1974). Vigilance and decision-making in personal crises. In G.V. Coelho, D.A. Hamburg, & J.E. Adams (Eds.), Coping and adaptation. New York: Basic Books.

Jarrett, R. & Kraft,D.(1997). Prophylactic cognitive therapy for major depressive disorder. In-session: Psychotherapy in practice, 3, 65-79.

Kabat-Zinn, J., Lipworth, L.B., Burney, R. (1985). The clinical use of mindfulness meditation for the self-regulation of chronic pain. Journal of Behavioral Medicine, 8, 163-190.

Keller, M.B. (1988). Diagnostic issues and clinical course of unipolar illness. In A.J. Frances & R.E. Hales (Eds.), Review of Psychiatry. Washington, DC: American Psychiatric Press.

Keller, M.B. (1994). Dysthymia in clinical practice: course, outcome and impact on the community. Acta Psychiatrica Scandinavica, 383,Suppl: 23-34.

Kelly, F.D. (1986). Assessment of the borderline adolescent: Psychological

measures of defensive structure and object representation. Journal of Child and Adolescent Psychotherapy, 3: 199-206.

Kernberg, O. (1975). Borderline Conditions and Pathological Narcissism. New York: Jason Aronson.

Kernberg, O. (1976). Object Relations Theory and Clinical Psychoanalysis. New York: Jason Aronson.

Kernberg, O. (1983). Object Relations and Character Analysis. In Blum (Ed.) Defense and Resistance.

Kernberg (1988). Clinical Dimensions of Masochism. Journal of the American Psychoanalytic Association, 36, 1005-10029.

Kernberg, P. (1994). Mechanisms of defense: Development and research perspectives. Bulletin of the Menninger Clinic, 58 (1), 55-87.

Kessler, R.C., McGonagle, K.A., Zhao, S. et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorder in the United States. Archives of General Psychiatry, 51, 8-19.

Klein, D.N., Taylor, E.T., Dickstein, S. & Harding, D. (1988). Primary early-onset dysthymia: Comparison with primary nonbipolar nonchronic major depression on demographic, clinical, familial, personality, and socioenvironmental characteristics and short-term outcome. Journal of Abnormal Psychology, 97, 387-398.

Klein, D. & Kelly, H.S. (1993). Diagnosis and classification of dysthymia. Psychiatric Annals, 23, 609-616.

Klein, M. (1940). Mourning and its relation to manic-depresive states. In: Klein, M., Love, guilt and reparation and other works 1921-1945. New York: The Free Press.

Klein, M. (1946). Notes on some schizoid mechanisms. Klein, M. Envy and gratitude and other works 1946-1963. New York: The Free Press

Klein, M. (1948). Contributions to psycho-analysis: 1921-1948. London: Hogarth Press.

Klein, M.H. (1990). Depressive personality: Reliability, validity and relation to dysthymia. Journal of Abnormal Psychology, 99, 412-421.

Klein, M.H., Kupfer, D.J., & Shea, M.T. (1993). Personality and Depression. New York: Guilford Press.

Klein, M.J., Wonderlich, S. & Shea, M.T. (1993). Models of relationships between personality and depression: Toward a framework for theory and research. In (Klein et al., Eds.). Personality and Depression. New York: Guilford Press.

Klerman, G., Weissman, M., Rounsaville, B. & Chevron, E. (1984). Interpersonal Psychotherapy of Depression. New York: Basic Books.

Kneepkens, R. & Oakley, L. (1996). Rapid improvement in the defense style of depressed women and men. Journal of Nervous & Mental Disease, 184 (6): 358-361.

Knight, R. (1940). Introjection, projection, and identification. Psychoanalytic Quarterly, 9, 334-341.

Kocsis, J. & Frances, A. (1987). A critical discussion of DSM-III dysthymic disorder. American Journal of Psychiatry, 144, 1534-1542.

Kocsis, J., Sutton, B.M., & Frances, A.J. (1991). Long-term follow-up of chronic depression treated with imipramine. Journal of Clinical Psychiatry, 52, 56-59.

Koenigsberg, H.W., Kaplan, R.D., Gilmore, M.M. et al. (1985). The relationship betweeen syndrome and personality disorder in DSM-III experience with 2,462 patients. American Journal of Psychiatry, 142, 207-212.

Kocsis, J. & Frances, A. (1987). A critical discussion of DSM-III dysthymic disorder. American Journal of Psychiatry, 144, 12, 1534-1541.

Kocsis, J.H., Markowitz, J.C., Prien, R.F. (1990). Comorbidity of dysthymic disorder. In J.D. Maser & C.R. Cloninger (Eds.), Comorbidity in Anxiety and Mood Disorders. Washington, D.C.: American Psychiatric Press.

Kocsis, J., Frances, A., Voss, C. et al. (1988). Imipramine and social-vocational adjustment in chronic depression. American Journal of Psychiatry, 145, 997-999.

Kohut, (1977). The Restoration of Self. New York: International Universities Press.

Kovacs, M. & Beck, A. (1978). Maladaptive cognitive structures in depression. American Journal of Psychiatry, 135, 525-533.

Kraemer, H.C. (1981). Coping strategies in clinical psychology research. Journal of Clinical and Consulting Psychology, 49, 309-319.

Kraepelin, E. (1921). Manic depressive insanity and paranoia. Edinburgh: E.&S. Livingstone.

Kretschmer, E. Physique and Character. New York: Harcourt, Brace, 1925.

Kuiper, N.A. & McDonald, M.R. (1983). Schematic processing in depression: The self-based consensus bias. Cognitive Theory and Research, 7, 469-484.

Kutz, I., Borysenko, J., & Benson, H. (1985). Meditation and psychotherapy: A rationale for the integration of dynamic psychotherapy, the relaxation response, and mindfulness meditation. American Journal of Psychiatry, 142, 1-8.

Laikin, M. & Winston, A. (1988). Short-term dynamic psychotherapy manual (STDP). Social and behavior science documents, 18 (2).

Lazarus, R.S. (1986). Psychological stress and the coping process. New York: McGraw-Hill.

Lazarus, R.S. (1983). The costs and benefits of denial. In S.Breznitz (Ed.) The Denial of Stress. New York: International Universities Press.

Lazarus, R.S. & Folkman, S. (1984). Stress, Appraisal and Coping. New York: Springer.

Leader, J.B & Klein, D.N. (1996). Social adjustment in dysthymia, double depression and episodic major depression. Journal of Affective Disorders, 37, 91-101.

Leary, T.F. (1957). Interpersonal diagnosis of personality. New York: Ronald Press.

Lerner, H.D. & Lerner, P.M. (1982). A comparative study of defensive structure in neurotic, borderline and schizophrenic patients. In Psychoanalysis and contemporary thought, Vol. 6. New York: International Universities Press.

Lerner, P.M. & Lerner, H.D. (1990). Rorschach measures of psychoanalytic theories of defense. In Osberg & Schrauger (Eds.) Advances in Personality Assessment, 8, 121-159.

Lichtenberg, J.D. & Slap, J.W. (1972). On the defense mechanism: A survey and synthesis. Journal of the American Psychoanalytic Association, 21, 772-787.

Loewald, H.W. (1973). Ego-Organization and Defense. In: Papers on Psychoanalysis. New Haven: Yale University Press, 1980.

Luborsky, L., Bachrach, H., Graff, H., Pulver, S., & Cristoph, P. (1979). Preconditions and consequences of transference interpretations: A clinical-quantitative investigation. Journal of Nervous & Mental Disease, 167(7), 391-401.

Luborsky, L., Crits-Cristoph, P., Mintz, J., & Auerbach, A. (1988). Who will benefit from psychotherapy: Predicting clinical outcomes. New York: Basic Books.

Mahler, M., Pine, F. & Bergman, A. (1975). The psychological birth of the human infant. New York: Basic Books.

Main, M., Kaplan, N. & Cassidy, J. (1985). Security in infancy, childhood, and
adulthod: A move to the level of representation. In I. Bretherton & E. Waters (Eds.), Growing points of attachment theory and research. Monographs of the Society for Research in Child Development, 50 (1-2, Serial No. 209), 66-104.

Malan, D.H. (1979). Individual psychotherapy and the science of psychodynamics. London: Butterworth.

Markowitz, J.C., Moran, M.E., Kocsis, J.H., & Frances, A.J. (1992). Prevalence and comorbidity of dysthymic disorder among psychiatric outpatients. Journal of Affective Disorders, 24, 63-71.

Markowitz, J.C. (1993). Psychotherapy of the postdysthymic patient. Journal of Psychotherapy Practice and Research, 2 (2), 157-163.

Markowitz, J.C. (1994). Psychotherapy of dysthymia. American Journal of Psychiatry, 151 (8), 114-1121.

Markowitz, J.C. (1996). Psychotherapy for dysthymic disorder. The Psychiatric Clinics of North America,19 (1), 133-149.

Markowitz, J.C., Friedman, R.A., Miller, N., & Spielman, L. (1996). Interpersonal improvement in chronically depressed patients treated with desipramine. Journal of Affective Disorders, 41(1), 59-62.

Markus, H. (1977). Self-schemata and processing information about the self. Journal of Personality and Social Psychology, 35, 63-67.

Markus, H. (1990). Unresolved issues of self-representation. Cognitive

Therapy and Research, 14, 241-253.

Markus, H. & Nurius, P. (1986). Possible selves. American Psychologist, 41, 954-969.

Marlatt, G.A. & Gordon, J.R. (1985). Relapse Prevention. New York: Guilford Press.

McCullough, J. (1991). Psychotherapy for dysthymia: A naturalistic study of ten patients. Journal of Nervous & Mental Disease, 179 (12): 734-740.

McWilliams, N. (1994). Psychoanalytic dialogues: Understanding personality structure in the clinical process. New York: Guilford Press.

Meissner, W.W. (1997). In: Nicholi, A. (Ed.), The new Harvard guide to psychiatry. Cambridge: Harvard University Press.

Mendelson. M. (1974). Psychoanalytic concepts of depression. New York: Spectrum Publications.

Menninger, K., Mayman, M. & Pruyser, P. (1963). The vital balance: The life processes in mental health and illness. New York: Viking Press.

Milrod, D. (1988). A current view of the psychoanalytic theory of depression. The Psychoanalytic Study of the Child, 48, 83-99.

Mischel, W. (1979). On the interface of cognition and personality: Beyond the person-situation debate. American Psychologist, 34, 740-754.

Modell, A. (1975). A narcissistic defense against affects and the illusion of self-sufficiency. International Journal of Psycho-analysis, 56: 275-282.

Modell, A. (1984). Psychoanalysis in a new context. New York: International Universities Press.

Mohl, P. (1987). Should psychotherapy be considered a biological treatment. Psychosomatics, 28 (6), 320-326.

Moos, R.H. & Billings, A.G. (1982). Conceptualizing and Measuring Coping Resources and Processes. In (Goldberger & Breznitz, Eds.) Handbook of Stress: Theoretical and Clinical Aspects. New York: The Free Press.

Morgan, C.D. & Murrray, H. (1935). A method for investigating fantasies: The Thematic Apperception Test. Archives of Neurological Psychiatry, 34, 289-306.

Muran, J.C., Segal, Z.V., & Samstag, L. (1991). The use of self-scenarios as an idiographic measure of self-schemas. Paper presented at the Society for Psychotherapy Research, Lyon, France.

Murray, H.A. (1943). Thematic Apperception Test manual. Cambridge, MA: Harvard University Press.

Neisser, U. (1967). Cognition and reality: Principles and implications of cognitive psychology. San Francisco: Freeman.

O'Leary, M.R., Rohsenow, D.J., Schau, E.J., & Donovan, D.M. (1977). Defensive style and treatment outcome among men alcoholics. Journal of Studies on Alcohol, 38, 1036-1039.

Ouimette, P.C. & Klein, D.N. (1993). Convergence of Psychoanalytic and Cognitive-Behavioral Theories of Depression: An empirical review and new data on Blatt's and Beck's models. In J.M. Mosling & R.F. Bornstein (Eds.), Psychoanalytic Perspectives on Psychopathology. Washington DC: American Psychological Association, 1993.

Paullhus, D.L., Fridhandler, B., & Hayes, S. (1997). Psychological Defense: Contemporary Theory and Research. In R. Hogan, Johnson & Briggs (Eds.) Handbook of Personality Psychology. Academic Press.

Paykel, E. (1994). Psychological therapies. Acta Psychiatrica Scandinavica, 89, (Suppl. 383): 35-41.

Perry, J.C. (1994). Psychological defense mechanisms and the study of affective and anxiety disorders. In Maser, J.D. & Cloninger, C.R., Comorbidity of mood and anxiety disorders. Washington, DC: American Psychiatric Press.

Perry, J.C. & Cooper, S.H. (1986). In G. W. Valliant (Ed.), Empirical Studies of Ego Mechanisms of Defense. Washington, DC: American Psychiatric Press.

Perry, J.C. & Cooper, S.H. (1989). An empirical study of defense mechanisms. Archives of General Psychiatry, 46, 444-452.

Pfohl, B., Stangl, D. & Zimmerman, M. (1984). The implications of DSM-III disorders for patients with major depression. Journal of Affective Disorders, 7, 309-318.

Phillips, K.A., Gunderson, J.G., Hirschfeld, R.M.A. & Smith, L.E. (1990). A review of the depressive personality. American Journal of Psychiatry, 147, 830-837.

Piaget, J. (1926). The language and thought of the Child. New York: Basic Books.

Piaget, J. (1929). The child's conception of the world. New York: Harcourt Brace.

Piaget, J. (1952). The origins in intelligence in children. New York: International Universities Press.

Piaget, J. (1954). The construction of reality in the child. New York: Basic Books.

Pollack, J., Flegenheimer, W., Kaufman, J., Pereira, P., & Sadow, J. (1988). Brief adaptive psychotherapy manual (BAP). Social and Behavioral Science Documents, 18 (2).

Pollack, J., Flegenheimer, W., & Winston, A. (1991). Brief adaptive therapy. In P. Crits-Cristoph & J.P. Barber (Eds.), Handbook of short-term dynamic psychotherapy. New York: Basic Books.

Plutchik, R., Kellerman, H., & Conte, H.R. (1979). A structural theory of ego defenses and emotions. In C.E. Izard (Ed.), Emotions in personality and psychopathology (pp. 229-257). New York: Plenum Press.

Pumpian-Mindlin, E. (1967). Defense organization of the ego and psychoanalytic technique. Panel report. Journal of the American Psychoanalytic Association, 15, 150-165.

Rado, S. (1928). The problem of melancholia. In W.Gaylin (Ed.). (1968). The meaning of despair: Psychoanalytic contributions to the understanding of

depression. New York: Science House, 1968.

Rapaport, D. (1959). An historical survey of psychoanalytic ego psychology. Introduction to Psychological Issues, 1, 5-7.

Rapaport, D., Gill, M.M. & Schafer, R. (1946). Diagnostic psychological testing, Vols. I and II. New York: International Universities Press.

Reich, W. (1949). Character Analysis. New York: Orgone Institute Press.

Rush, A. & Watkins, J. (1981). Group versus individual cognitive therapy: A pilot study. Cognitive Therapy and Research, 5: 95-103.

Rycroft, C. (1968). A critical dictionary of psychoanalysis. London: Penguin Books.

Safran J.D. (1990). Towards a refinement of cognitive therapy in light of interpersonal theory. Clinical Psychology Review, 10: 87-105.

Safran, J.D. & Segal, Z.V. (1990). Interpersonal process in cognitive therapy. New York: Basic Books.

Safran, J.D. & Muran, J.C. (1995). Resolving ruptures in the therapeutic alliance: Diversity and integration. In-Session: Psychotherapy in Practice, 1, 81-92.

Sameroff, A.J., Seifer, R., & Zax, M. (1982). Early development of children at risk for emotional disorder. Monographs of the Society for Research in Child Development, 47: (Serial No. 199).

Sandler, J. & Rosenblatt, B. (1962). The concept of the representational world. The Psychoanalytic Study of the Child, 17, 128-145.

Schafer, R. (1954). Psychoanalytic interpretation in Rorschach testing. New York: Grune and Stratton.

Schneider, K. (1959). Clinical Psychopathology. London: Grune & Stratton, 1959.

Schuchter, S.R., Downs, N., & Zisook, S. (1996). Biologically informed psychotherapy for depression. New York: Guilford Press.

Schmale, A.H. (1972). Depression as affect, character style, and sympton formation. In (R.R. Holt & E. Peterfreund (Eds.), Psychoanalysis and Contemporary Science. New York: Macmillan.

Segal, H. (1964). Introduction to the work of Melanie Klein. New York: Basic Books.

Segal, Z.V. (1988).Appraisal of the self-schema construct in cognitive models of depression. Psychological Bulletin, 103, 147-162.

Segal, Z.V & Muran, J.C (1993). A cognitive perspective on self-representation in depression. In Z.V. Segal & S.J. Blatt (Eds.), The self in emotional distress: cognitive and psychodynamic perspectives. New York: Guilford Press.

Semrad, E. (1967). The organization of ego defenses and object loss. In D.M. Moriarity (Ed.), The loss of loved ones. Springfield, IL: Charles C. Thomas.

Semrad, E.V., Grinspoon, L., & Fienberg, S.E. (1973). Development of an Ego Profile Scale. Archives of General Psychiatry, 28, 42-51.

Shank, R.C. & Abelson, R.P. (1977). Scripts, plans, goals, and understanding. Hillsdale, NJ: Erlbaum.

Shapiro, D. (1965). Neurotic Styles. New York: Basic Books.

Shapiro, D.L. & Rosenwald, G.C. (1975). Free association and repression-sensitization. Journal of Personality Assessment, 39, 25-27.

Shapiro, J., Sank, L., Shaffer, C., & Donovan, D. (1982). Cost effectiveness of individual vs. group cognitive behavior therapy for problems of depression and anxiety in an HMO population. Journal of Clinical Psychology, 38, 674-677.

Shea, M.T., Glass, D.R., Pilkonis, P.A., Watkins, J. & Docherty, J.P. (1987). Frequency and implications of personality disorders in a sample of depressed outpatients. Journal of Personality Disorders, 1, 27-42.

Skodol, A.E. & Perry, J.C. (1993). Should an axis for defense mechanisms be included in the DSM-IV? Comprehensive Psychiatry, 34 (2), 108-119.

Snarey, J.& Vaillant, G.E. (1985). How lower and working class youth become middle class adults: The association between ego mechanisms of defense and upward social mobility. Child Development, 56, 899-910.

Soloff, P. (1990). What's new in personality disorders?: An update on pharmacologic treatment. Journal of Personality Disorders, 4(3), 233-243.

Sotsky, S.M. et al. (1991). Patient predictors of response to psychotherapy

and pharmacotherapy: Findings in the NIMG Treatment of Depression Collaborative Research Program. American Journal of Psychiatry, 148, 997-1008.

Spoont, M. (1992). Modulatory role of serotonin in neural information processsing: Implications for human psychopathogy. Psychological Bulletin, 112, 330-350.

Sroufe, L.A. (1988). The role of infant-caregiver attachment in development. In J. Belsky & T. Nezworski (Eds.), Clinical implications of attachment. Hillsdale, NJ: Erlbaum.

Staudenmeyer, H., Kinsman, R.A., Dirks, J.F., Spector, S.L., & Wangaard, C. (1979). Medical outcome in asthmatic patients: Effects of airways hyperactivity and symptom-focused anxiety. Psychosomatic Medicine, 41, 109-118.

Stein, A. (1975). Group psychotherapy in the treatment of depression. In F.F. Flach & S.C. Draghi (Eds.), The nature and treatment of depression. New York: Wiley & Sons.

Steiner, J. (1994). Psychic retreats.: Pathological organizations in psychotic, neurotic and borderline patients. London & New York: Routledge.

Stewart, J.W., Quitkin, F.M., McGrath, P.J., Rabkin, J.B., Markowitz, J.C., Tricarno, E., Klein, D.F. (1988). Social functioning in chronic depression: effect of 6 weeks of antidepressant treatment. Psychiatric Research, 25, 213-222.

Stravynski, A., Shahar, A., & Verreault, R. (1991). A pilot study of the cognitive treatment of dysthymic disorder. Behavioural Psychotherapy, 4: 369-372.

Sullivan, H.S. (1953). The Interpersonal Theory of Psychiatry. New York: W.W. Norton & Company.

Swallow, S.R. & Kuiper, N.A. (1988). Social comparisons and negative self-evaluation: An application to depression. Clinical Psychology Review, 8, 55-77.

Swanson, G.E. (1988). Ego defenses and the legitimization of behavior. New York: Cambridge University Press.

Taylor,S.E. (1983). Adjustment to threatening events: A theory of cognitive adaptation. American Psychologist, 38,1161-1171.

Taylor,S.E. & Brown,J.D. (1988). Illusion and well-being: A social psychological perspective on mental health. Psychological Bulletin, 103, 193-210.

Teasdale, J.D. & Dent, J. (1987). Cognitive vulnerability to depression: An investigation of two hypotheses. British Journal of Clinical Psychology, 26, 113- 126.

Teasdale, J.D. & Russell, M.L. (1983). Differential effects of induced mood and the recall of positive, negative, and neutral words. British Journal of Clinical Psychology, 22, 162-172.

Teasdale, J.D., Segal, Z.V., & Williams, J.M.G. (1995). How does cognitive-therapy prevent depressive relapse and why should attentional control (mindfulness) help? Behavioral Research and Therapy, 33, 25-39.

Thase, M.E., Greenhouse, J.B., Frank, E., Reynolds, C.F., Pilkonis, P.A.,

Hurley, K., Grochocinski, V., & Kupfer, D.J. (1991). Treatment of major depression with psychotherapy or psychotherapy-pharmacotherapy combinations. Archives of General Psychiatry, 54, 1009-1015.

Thase, M.E., Fava, M., Halbreich, U., Kocsis, J.H., Koran, L., Davidson, J., Rosenbaum, J., Harrison, W. (1996). A placebo-controlled, randomized clinical trial comparing sertraline and imipramine for the treatment of dysthymia. Archives of General Psychiatry, 53, 777-784.

Thompson, A. (1986). An object relational theory of affect maturity: Applications to the thematic appreception test. Madison, CT: International Universities Press.

Truax, C.R. & Wittmer, J. (1973). The degree of the therapist's focus on defense mechanisms and the effect of therapeutic outcome with institutional juvenile delinquents. Journal of Community Psychology, 1, 201-203.

Vaillant, G. (1971). Theoretical hierarchy of adaptive ego mechanisms. Archives of General Psychiatry, 24, 107-118.

Vaillant, G. (1976). Natural history of male psychological health: V. The relation of choic of ego mechanisms of defense to adult adjustment. Archives of General Psychiatry, 33, 535-545.

Vaillant, G. E. (1977). Adaptation to Life. Boston: Little, Brown & Co.

Vaillant, G.E. & Drake, R.E. (1985). Maturity of ego defenses in relation to DSM III axis II personality disorder. Archives of General Psychiatry, 42, 597-601.

Vaillant, G. E. (Ed.). (1986) Empirical studies of ego mechanisms of defense.

Washington, DC: American Psychiatric Press

Vaillant, G. E., Bond, M., & Vaillant, C.O. (1986). An empirically validated hierarchy of defense mechanisms. Archives of General Psychiatry, 43, 786-794.

Vaillant, G.E. (1993). The Wisdom of the Ego. Cambridge, Mass: Harvard University Press.

Van Der Leeuw, P.J. (1971). On the development of the concept of defence. International Journal of Psycho-Analysis, 52, 51-58.

Viglione, D., Clemmey, P., & Camenzuli, L. (1990). The depressive experiences questionnaire: A critical review. Journal of Personality Assessment, 55 (1&2), 52-64.

Wachtel, P. (1977). Psychoanalysis and behavior therapy: towards an integration. New York: Basic Books.

Wallerstein, R.S. (1985). Defenses, defense mechanisms, and the structure of the mind. In H.P. Blum (Ed.)., Defense and resistance. New York: International Universities Press.

Weissman, M.M. & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. Archives of General Psychiatry, 33, 1111-1115.

Weissman, A.N. & Beck, A.T. (1978). Development and validation of the Dysfunctional Attitude Scale: A preliminary investigation. Paper presented at the 86th Annual Convention of the American Psychological Association, Toronto, Ontario, Canada.

Weissman, M.M. & Paykel, E.S. (1974). The depressed women: Study of social relationships. Chicago: University of Chicago Press.

Weissman, M.M., Leaf, P.J., Bruce, M.L. & Florio, L. (1988). The epidemiology of dysthymia in five communities: rates, risks, comorbidity, and treatment. American Journal of Psychiatry, 145, 815-819.

Wells, K.B., Burnam, M.A., Rogers, W. et al. (1992). The course of depression in adult outpatients: results from the medical outcomes study. Archives of General Psychiatry, 49, 788-794.

Weston, D., Lohr, N., Silk, K., Gold, L., & Kerber, K. (1990) Object relations and social cognition in borderlines, major depressives, and normals: A thematic apperception test analysis. Psychological Assessment: A Journal of Consulting and Clinical Psychology, 2 (4), 355-364.

Weston, D. (1991). Social cognition and object relations. Psychological Bulletin, 109 (3), 429-455.

Whiteman, M. (1967). Children's conception of psychological causality. Child Development, 38, 143-156.

Widiger, T.A. (1993). Personality and depression: Assessment issues. In: (Klein et al., Eds.). Personality and Depression. New York: Guilford Press.

Wierzbicki, M. & Bartlett, T. (1987). The efficacy of group and individual cognitive therapy for mild depression. Cognitive Therapy and Research, 11 (3): 337-342.

Winnicott, D.W. (1965). The maturational processes and the facilitating environment.CT: International Universities Press.

Winston, B., Winston, A., Samstag, L.W., & Muran, J.C. (1994). Patient defense/therapist interventions. Psychotherapy, 31(3), 478-491.

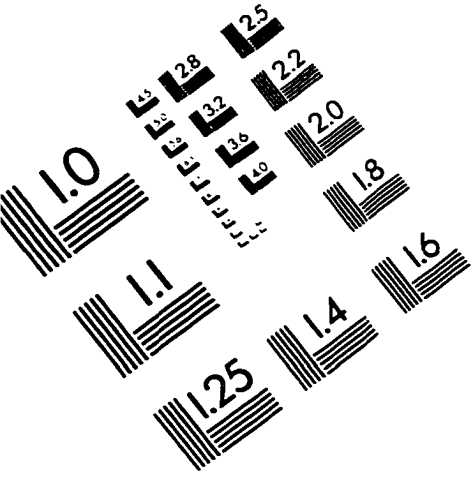
Wood, J.V., Taylor, S.E., & Lichtman, R.R. (1985). Social comparison in adjustment to breast cancer. Journal of Personality and Social Psychology, 49, 1169-1183.

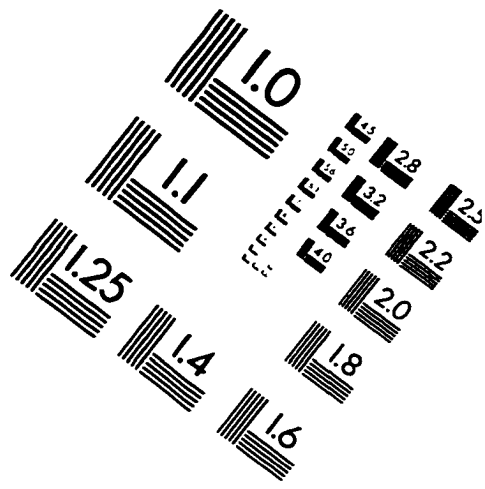
Yalom, I.D. & Lieberman, M.A. (1971). A study of encounter group casualties. Archives of General Psychiatry, 25, 16-30.

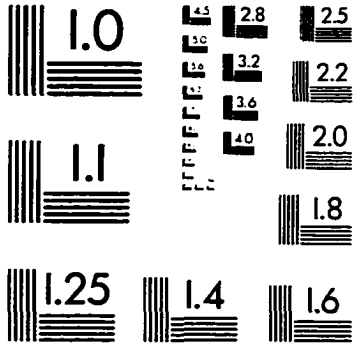
Yalom, I.D. (1995). The theory and practice of group therapy. New York: Basic Books.

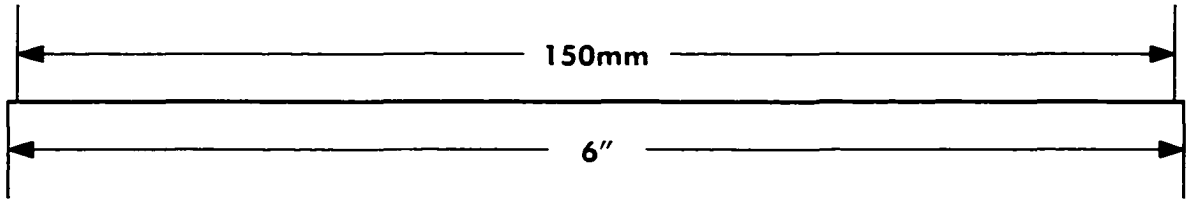
Zuckerman, D.M., Prusoff, B.A., Weissman, M.M. et al. (1980). Personality as a predictor of psychotherapy and pharmacotherapy outcome for depressed patients. Journal of Consulting and Clinical Psychology, 48, 730-735.

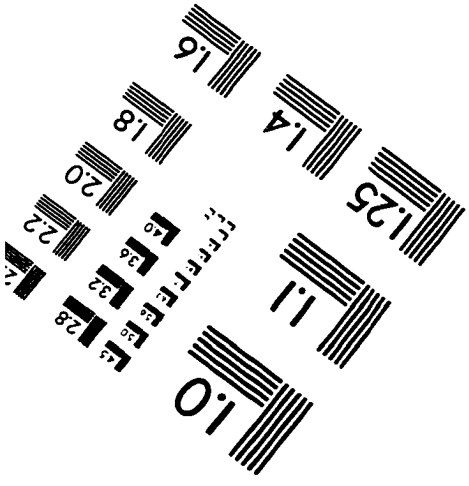
IMAGE EVALUATION
TEST TARGET (QA-3)

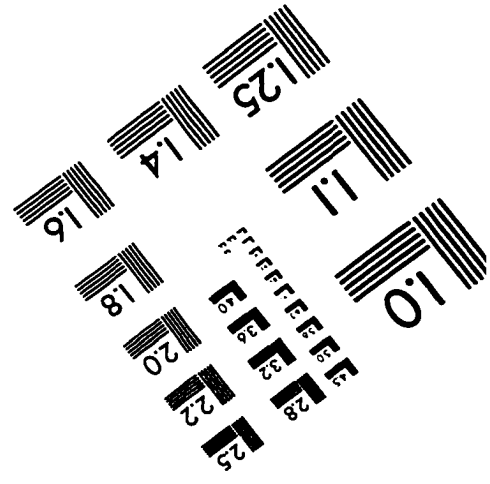












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