Techniques in Psychodynamic Therapy:

A Clinical and Empirical Investigation of Defense Interpretations

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ABSTRACT

In psychodynamic theory, defense interpretations are considered a fundamental component of effective psychodynamic therapy (Summers & Barber, 2010; Shedler, 2010; Weiner & Bornstein, 2009). Despite their significance, the research to date examining the interpretations of defenses in-session has been limited. Studies have been scarce or conducted with small samples and methodological limitations (e.g., Despland et al., 2001; Junod, et al., 2005; Petraglia, Janzen, Perry & Olson, 2009).

This dissertation aimed to provide a clearer understanding of how psychotherapists interpret defenses in-session and the impact this process has on patient defensive functioning, therapeutic alliance and patient outcome. The manuscripts in this dissertation are separated into two parts. Part I explores practicing psychodynamic therapists' attitudes towards the importance of defense mechanisms, and specific guidelines on how to address patient defenses in their own clinical practice (Petraglia, Bhatia, & Drapeau, 2013). Part II outlines two empirical manuscripts that explore the relationship between therapist use of interpretations, defenses, and the therapeutic alliance in-session.

RÉSUMÉ

En théorie psychodynamique, l'interprétation de la défense est considérée comme un élément fondamental de la thérapie psychodynamique efficace (Summers & Barber, 2010; Shedler, 2010; Weiner & Bornstein, 2009). Malgré son importance, la recherche sur les interprétations de défenses demeure limitée. Les études sont donc rares ou ont été réalisées avec de petits échantillons ou encore présentent des limites méthodologiques importantes (par exemple, Despland et al, 2001; Junod, et al, 2005; Petraglia, Janzen, Perry, & Olson, 2009).

Cette thèse vise à fournir une meilleure compréhension de la façon dont les psychothérapeutes interprètent les défenses et l'impact de ce processus sur le fonctionnement défensif des patients, l'alliance thérapeutique et le pronostic des patients. La thèse est divisée en deux parties. La première partie explore les attitudes des thérapeutes psychodynamiques vis-à-vis l'importance des mécanismes de défense et des directives précises sur la façon d'aborder les défenses du patient en clinique (Petraglia, Bhatia, & Drapeau, 2013). La deuxième partie décrit deux études empiriques qui explorent la relation entre les interprétations du thérapeute, les défenses du patient, et l'alliance thérapeutique en cours de séances de psychothérapie psychodynamique brève.

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PREFACE

Contributions of Manuscript Co-Authors

All four manuscripts in this dissertation represent the original writing of doctoral candidate (Maneet Bhatia) except wherever appropriate referencing was indicated. M. Bhatia was responsible for the development and writing of all components of this dissertation. He was the primary author on all four manuscripts and responsible for integrating the feedback his supervisor, doctoral thesis committee and co-authors provided.

Dr. Martin Drapeau supervised the dissertation and provided intellectual, statistical, methodological, analytical and editorial contributions at all stages of this dissertation until its completion. He played a substantial role in the successful completion of the candidate's comprehensive examination.

Drs. Yves de Roten and Elisabeth Banon served as members of the doctoral thesis committee and provided intellectual, methodological, and statistical contributions and were involved in reviewing all written material presented in this dissertation. Dr. Jean-Nicolas Despland provided the data set that was used for data analysis for the third (Chapter 5) and fourth (Chapter 6) manuscripts. Fellow doctoral candidate and colleague in the McGill Psychotherapy Process Research Group (MPPRG) Jonathan Petraglia, played an important role in data collection, data transcription, and data coding that was instrumental for the third and fourth manuscripts, and provided editorial contributions for all manuscripts.

Statement of Originality

I (Maneet Bhatia) confirm that this dissertation represents an original work and contribution to the advancement of knowledge. All scholarly works of other authors have been referenced fully according to the standard referencing format provided by the

American Psychological Association. I attest, to the best of my knowledge, that the dissertation does not infringe upon another's copyright except where noted, nor violates any proprietary rights. The dissertation has been approved by my doctoral thesis committee and has not been submitted for another educational degree or certificate at any other institution.

CHAPTER 1:

INTRODUCTION-

LITERATURE REVIEW & OVERALL RESEARCH AIMS OF DISSERTATION

Change Mechanisms in Psychodynamic Psychotherapy

Psychodynamic psychotherapy, along with cognitive and humanistic therapies, is the most commonly practiced therapy among clinicians (Norcross, 2005). Meta-analyses have demonstrated the efficacy and effectiveness of psychodynamic psychotherapy (de Maat, et al., 2008; Leichsenring & Rabung, 2004, 2008; Shedler, 2010) in general, while other studies have demonstrated the efficacy of psychodynamic therapy and short-term psychodynamic therapy for specific disorders such as depression (Driessen et al., 2010; Leichsenring, 2001), anxiety and panic (Mildrod et al., 2007), somatoform disorders (Abbass, Kisely & Kroenke, 2009), depression and comorbid personality disorders (Abbass, Town & Driessen, 2011), posttraumatic stress disorder, eating disorders, substance-related disorders, and personality disorders (Leichsenring & Leibing, 2003; Town, Abbass, & Hardy, 2011).

A growing focus in psychotherapy research has shifted towards understanding change mechanisms within specific theoretical orientations, and in general across all treatment modalities. Along with transference interpretations, the identification, exploration and understanding of defenses, and the interpretation of these constructs, is considered the heart of psychodynamic psychotherapy (Shedler, 2010; Weiner & Bornstein, 2009).

Defense Mechanisms

Sigmund Freud, through his clinical observations from 1893 to 1895, noticed that his patients would attempt to avoid “psychic pain” by forgetting troubled memories. Over time, with continued observation, Freud recognized that his patients employed the defense of repression as a way to protect themselves from pain associated with conflicting thoughts, wishes, ideas, and emotions. This was problematic because using defenses such as

repression played a critical role in patients' resistance to therapy. Since the success of psychoanalysis lied in the analysts' ability to uncover these unconscious painful processes, defense mechanisms posed a serious roadblock to successful treatment. At first, Freud only considered repression as a defence mechanism but as his thinking evolved and with continued clinical examples, he recognized that patients employ more defenses beyond the use of repression.

It was not until his daughter, Anna Freud (1937), began studying defense mechanisms and elaborated upon the connections between defense and resistance, that it became apparent that ego mechanisms of defense could be clinically observed through patients' resistances. As such, she began cataloguing defenses and suggested that defenses change throughout the course of one's life and that defenses used early in one's development may not be appropriate in later adulthood. Through this 40-year period of conceptualizing defense mechanisms, Sigmund and Anna Freud outlined five important properties of defense mechanisms as outlined by Vaillant (1994): 1) Individuals use defenses as a means for managing conflict and affect; 2) defenses are relatively unconscious; 3) defenses are different from one another; 4) defenses are reversible, and 5) defenses can be both used in an adaptive or pathological way depending on situation.

Studying defense mechanisms empirically has been a challenge since the days of Anna Freud. Though Freud (1937) catalogued and defined most of the defenses used today, debates still ensue in regards to the definitions of individual defenses (Cramer, 2006,1998; Vaillant, 1998). For starters, since defenses are largely unconscious, it is hard to truly capture the essence of defenses without there being an overlap amongst them. As well, given

that they are unconscious in nature, it is challenging to delineate and to create clear boundaries between different types of defenses.

Other scholars have tried to distinguish between coping and defenses and found that defenses differ from coping because they are unconscious, whereas coping behaviours are, for the most part, conscious actions taken by individuals in times of distress (Cramer, 2001). However, depending on the situation and the type of defense, its use can be conscious or unconscious, and this makes the categorization of defenses quite challenging (Erdelyi, 2001). Taking this into consideration, it is difficult to create instruments to effectively study, measure, and categorize defense mechanisms, leading some theorists to conclude that defense mechanisms as a construct will always be clinically valid but not necessarily reliable (Vaillant, 2003).

Empirical Research on Defense Mechanisms

While the definition of defenses may vary, a general and overarching definition characterizes a defense as an "automatic psychological process that protects the individual against anxiety and from the awareness of internal or external stressors" (DSM-IV, American Psychiatric Association, 2000, p. 751). As such, defenses are considered a central construct within psychodynamic theory, research, and practice.

There is some evidence to suggest that defenses are related to psychopathology as studies have demonstrated the relationship between defensive functioning and Axis I and Axis II disorders (Bond, 2004; Bond & Perry, 2004; Bloch, Shear, Markowitz, Leon, & Perry, 1993; Vaillant, 1993; Akkerman, Karr, & Lewin, 1992). Research also indicates that change in defensive functioning is related to treatment outcome. For example, Roy and colleagues (2009) found a large effect (d = .76) for change in defense use after successful

psychoanalysis. Specifically, the authors found that patients decreased their use of maladaptive defenses while simultaneously increasing their employment of adaptive or mature defenses.

Additionally, Winston and colleagues (1993) examined two forms of short-term dynamic approaches and found that mid-level defenses changed after 40-sessions of therapy. Another study by Hersoug, Bogwald, and Hoglend (2005) also found that maladaptive and mid-level (neurotic) defenses decreased during psychotherapy and this decrease was associated with the use of interpretive techniques.

A study by Perry (2001) found evidence for increases in overall defensive functioning of patients with personality disorders even several years after treatment had terminated. Additionally, Perry and colleagues (2009) in a longitudinal analysis of four patients found that improvement in defensive functioning was linked with improvement in symptoms. Another interesting finding in this study was the potential existence of differences in the levels of change experienced for patients who were either in short-term or long-term psychodynamic treatment.

Though some of these studies were limited by small sample sizes (e.g., Perry et al., 2001; Perry et al., 2009), they provide some support for the importance of defensive functioning as a key change variable in psychodynamic psychotherapy. It is evident that the use of adaptive defenses and an increase in overall defensive functioning is related to a decrease in psychopathology and positively related to outcome in psychodynamic psychotherapy (for a comprehensive review see: Hentschel, Draguns, Ehlers, & Smith, 2004).

Interpretations

Freud (1900a) began using the term “interpretation” in the context of understanding dreams with the goal of helping the patient become aware of some aspect of his mind (e.g., feelings, wishes, drives, impulses, inhibition). Later, other theorists (Fenichel, 1941; Loewenstein, 1951; Shapiro, 1970) refined the concept of “interpretation” by adding significant components that consider the timing, quality, presentation, and content of each interpretation (for a review see Akhtar, 2009). As Langs (1973) puts it, “interpretations are at the heart of the psychotherapeutic intervention” (p. 455). Interpretations can be defined as verbal interventions through which the therapist brings to the patient's awareness and consciousness, ideas, thoughts, behaviours, wishes or any material that was previously unconscious in a meaningful and affective way (Langs, 1973).

Interpretation of both transference and patient defense mechanisms are the hallmarks of all psychodynamic therapy models, irrespective of treatment length (Weiner & Bornstein, 2009). It is these two techniques that differentiate psychodynamic therapy from all other therapies (Akhtar, 2009; Shedler, 2010; Weiner & Bornstein, 2009). The ultimate goal of these techniques is to bring unconscious material into conscious awareness and help patients gain insight into how these processes work to keep patients feeling emotionally and psychologically distressed. Therefore, insight is a critical component of bringing about meaningful change according to dynamic theory. Despite the importance of these constructs, there are few studies examining therapist interpretation and its impact on psychotherapy process and outcome and the findings of these studies are mixed.

Transference interpretations

The research on transference interpretations has produced varied results and has typically focused on interpersonal patterns, object relations, and core conflictual themes. For example, Malan (1976) reported that greater proportions of transference interpretations related to parental or sibling relationships predicted positive treatment outcomes. Malan's (1976) finding has influenced the theoretical conceptualizations of many short-term and experientially-focused dynamic therapies (e.g., Davanloo, 2000; McCullough et al. 2003).

Hoglend (1993) and Piper, Azim, Joyce, and McCallum (1991) both found that patients who had a high quality of object relations and who received high proportions of transference interpretations tended to have poorer treatment outcomes. In contrast, Connolly, Crits-Christoph, Shappell, Barber, Luborsky, and Shaffer (1999) examined the relationship between transference interpretations to outcome in early sessions of supportive-expressive therapy and they found that patients with a low quality of interpersonal relationships who received a high amount of transference interpretations within sessions tended to have poorer outcomes. Similar to Connolly and colleagues (1999), Piper, Joyce, McCallum, and Azim (1993) found that patients with a low quality of object relations who received a greater number of transference interpretations had poorer outcomes at 6-month follow-ups. However, unlike the Hoglend (1993) and the Piper, Azim, Joyce, and McCallum (1991) studies mentioned above, these authors found that patients with a greater quality of object relationships had better outcomes with higher frequency of interpretations.

Barber, Crits-Christoph and Luborksy (1996) also examined the impact of interpretations that facilitated patients' self-understanding into their core conflictual relationship themes. The authors found that when expressive interventions (including

interpretations) were delivered competently, they predicted treatment outcome more effectively than supportive interventions, therapeutic alliance, and earlier symptom improvements. For example, a patient with low levels of object relations may not be able to handle emotionally challenging and "deep" interpretations especially in the early phases of treatment. Additionally, in their review of therapist techniques that negatively impact the therapeutic alliance, Ackerman and Hilsenroth (2001), found that when therapists used excessive amounts of transference interpretations, it negatively influenced the therapeutic alliance. They also noted that therapists' need to monitor the amount and intensity of interpretations they utilize in treatment.

In contrast, Hoglend and colleagues (2008) conducted an experimental dismantling study with follow-up evaluations one year and three years after treatment termination of 100 outpatients suffering from depression, anxiety, personality disorders, and interpersonal problems. Patients were randomly assigned to receive weekly sessions of dynamic therapy for 1 year with or without transference interpretations. The results of this study indicated that patients with lower quality of object relationships differed in terms of improvement, and this depended on the number of transference interpretations they received. The key being that those who received a moderate amount demonstrated healthier outcomes. Also, those in the transference group were less likely to seek out a mental health professional relative to the comparison group.

In another study, Hoglend, Dahl, Hersoug, Lorentzen, and Perry (2011) conducted a dismantling randomized clinical trial to examine the long-term effects of transference interpretations on 46 patients suffering primarily from cluster C personality disorders. Patients were randomly assigned to one year of dynamic therapy with or without

transference interpretations. The findings indicated that PD patients in both groups improved; however patients who received transference interpretations had better outcomes in the areas of core psychopathology and interpersonal functioning, their drop-out rates were reduced to zero, and their use of health services was reduced by 50%.

These findings together indicate that too many interpretations are problematic and not helpful for treatment outcome. However, if conducted in moderation, transference interpretations can have a positive impact on outcome and can facilitate the therapeutic alliance. The high number of contradictory findings highlights the methodological limitations that continue to haunt these studies, including the use of a naturalistic study design (Hoglend et al., 2008). Specifically, these varying findings may indicate the need to better understand characteristics of the interpretation (e.g., timing, depth, accuracy, length, and therapist verbosity), therapeutic process (e.g., quality of therapeutic alliance) and the phase of therapy during which these interpretations occur (e.g., early, middle, late sessions).

Defense Interpretations

Unlike the research on transference interpretations, there are a smaller number of studies that have explored defense interpretations, and there is less controversy in their findings. Studies have found that interpreting defenses leads to improvements in patient functioning (i.e., defensive functioning, symptoms, etc.) and in the therapeutic relationship (i.e., therapeutic alliance).

For example, Foreman and Marmar (1985) found that when therapists interpreted patients' defensive feelings toward the therapist, their alliance improved over the course of treatment. Moreover, those patients who improved were in a treatment that addressed patient defenses. A study by Winston, Samstag, Winston, and Muran (1993) examined short-term

dynamic psychotherapy and found that continuous interpretations led to a change in patient defense mechanisms. Supporting this was the findings of Hersoug, Bogwald, and Hoglend (2005) that found that patients' use of maladaptive defenses decreasing was related to an increased number of interpretations by therapists.

Banon, Evan-Grenier, and Bond (2001) examined the early sessions of psychodynamic treatment for seven male patients suffering from borderline personality disorder and found that early transference interpretations -whether positive or negative- had a detrimental impact on the therapeutic alliance. The authors indicated that the ways in which the therapist handled the negative reaction (i.e., patient defensive behaviour) following the transference interpretation was crucial to alliance management. For example, defense interpretations that followed accurate transference interpretations helped keep the alliance intact. This study was not without limitations as it was an exploratory, discovery-oriented study that only had seven participants and focused on a particular diagnosis. However, the study did illustrate the complex relationship between patient functioning, therapist interpretations, and the phase of therapy on the therapeutic alliance.

A body of research has focused on therapist accuracy and techniques used to address patient defenses. Despland and colleagues (2001) developed an adjustment ratio that placed therapist interventions on a continuum from supportive to interpretive and compared it to patient defensive functioning. The authors found that in order to be most effective it was best for therapists to interpret patients' mature defenses and to use supportive techniques when addressing immature defenses. Subsequent research has supported the concept of therapist adjustment.

For example, Junod and colleagues (2005) examined therapist adjustment in the context of the therapeutic alliance and found when therapists interpreted patients' mature defenses it positively influenced the therapeutic alliance. As well, the authors found that therapist accuracy was positively related with the strength of alliance between therapist and patient. Taken together however, these studies provide support for the importance of accuracy and adjustment of interpretations to effectively work with defense mechanisms.

Limitations and Gaps

Therapist Technique

In the area of therapeutic technique, there is a lack of research examining the relationship between technique and other therapeutic variables such as: a) patient characteristics (e.g., motivation for change, psychological mindedness, severity of symptoms, etc.); b) therapist characteristics or behaviour (e.g., warmth, flexibility, language used, timing and accuracy of intervention); and c) the therapist-patient relationship (e.g., therapeutic alliance). This limited perspective causes problems from both a research and clinical perspective as it undervalues the role of key therapist and patient variables in the implementation of technique, and ultimately, provides a false sense of how technique actually plays out in context of the therapeutic relationship.

Interpretation of Defenses In-Session

Despite the central emphasis placed on defense mechanisms in psychodynamic theory (Etchegoyen, 2005), and the impact of adaptive defensive functioning on psychological well-being, personality changes, in-session and outcome improvements (e.g., Hersoug, Sexton, & Hoglend, 2002; Perry, 2001; Perry & Bond, 2005; Roy, Perry, Luborsky & Banon, 2009; Vaillant, 1994), relatively few studies have examined therapist technique

aimed at addressing defensive functioning. As outlined above, most studies of therapist interpretive activity have focused on transference interpretation. Future research needs to explore how to effectively conduct interpretation of defenses in-session with a greater emphasis on therapist adjustment to patient defensive functioning.

For example, further studies are needed with larger sample sizes exploring the therapist-patient dyads and their impact on therapist technique, therapy process, and therapy outcome such as the ones conducted by Banon, Evan-Grenier, and Bond (2001), Despland and colleagues (2001), and Junod, de Roten, Martinez, Drapeau, and Despland (2005). Research thus far has focused more on how defenses change as a result of treatment progress or other treatment variables (e.g., therapeutic alliance) but a systematic analysis of how therapists need to address defenses in-session is surprisingly missing from the literature. The majority of studies examining interpretations have not examined the quality, timing, and context of the interpretations nor the impact of these considerations on patient in-session functioning and outcome.

Therefore, studying defenses in-session will provide us with a greater understanding of the intricate and dynamic process by which therapist and patient engage in the therapeutic encounter with the goal of bringing together the key ingredients that make psychotherapy work: patient functioning, therapist technique, and the therapeutic alliance; the goal being to provide a clinically relevant understanding of patient defenses and the interpretation of defenses in-session.

Rationale for Dissertation

Ten Guidelines on Interpreting Defenses

Research has clearly demonstrated that defense mechanisms are an important indicator of effective process and outcome in psychodynamic psychotherapy (Hentschel, Draguns, Ehlers, & Smith, 2004). As described above, studying patient defenses in-session will help inform our understanding of numerous components of the therapeutic encounter, including the interpretation of patient defenses by therapists' in-session. Consequently, an important question that follows from this point is: *How should therapists address defense mechanisms in psychodynamic psychotherapy?* Petraglia, Bhatia, and Drapeau (2013) set out to investigate this question by examining the psychodynamic literature on defenses and the interpretation of defenses. The authors analyzed scientific articles and books that focused on defense mechanisms and therapeutic techniques (Petraglia, Bhatia, & Drapeau, 2013). The objective was to analyze and consolidate the literature with the focus on uncovering existing theory, research, and practice guidelines on how therapists should address patient defenses in-session. In the end, the authors derived ten clinical principles based on their analysis. They are described in detail below.

The first principle suggests that therapists need to *consider 'depth' of an interpretation* (Petraglia, Bhatia, & Drapeau, 2013). This principle is based on the idea that when therapists are interpreting patient material they are working to make the unconscious conscious (Freud, 1913). Defenses aim to protect patients from deeper, more troubling feelings, thoughts, and anxieties and therapists leave the interpretation of deeper material to later on in therapy and begin by focusing on that patient material which is readily accessible

("surface to depth" rule) (e.g., Fenichel, 1945; Greenson, 1967; Langs, 1973; Wolberg, 1977).

The second principle asks therapists to *intervene with the patient's most prominent defenses* (Petraglia and colleagues, 2013). This principle suggests that therapists should address the patient's most prominent defenses, as they are almost certainly to involve repressed material. Scholars view most prominent as being patients' most characterological defenses and those that are "out of character" (e.g., Greenson, 1967; Langs, 1973).

Principle three suggests *therapist interpretations should begin with defenses used as resistance* (Petraglia, Bhatia, & Drapeau, 2013). This principle forms the basis of psychodynamic theory suggesting that that any action the patient exhibits that impedes the therapeutic process should be attended to before specific patient material is addressed (e.g., Gill & Hoffman, 1982).

Principle four refers to the idea that therapists *attend to defenses used both inside and outside of the therapeutic hour* (Petraglia, Bhatia, & Drapeau, 2013). This principle indicates that therapists need to focus on external stressors occurring in the patient's life outside therapy (including defensive behaviours) in-session, as they will impact the course of therapy (Vaillant, 1993). Other scholars (e.g., Gray, 1994) contend that the defensive behaviour occurring within the therapeutic relationship are the only defenses that therapists should focus their interpretive activity on (Petraglia, Bhatia, & Drapeau, 2013). Despite having differing positions on the concept of defenses used inside and outside the therapeutic hour, these theorists acknowledge the significance of therapists focusing on these different types of defenses.

Principle five suggests that therapists *consider the timing of interventions* when working with defenses (Petraglia, Bhatia, & Drapeau, 2013). This principle is based on the idea that therapists need to always be mindful of when to intervene with patient defenses (Langs, 1973; Reid, 1980) during the course of the therapy session (e.g., timing of intervention during the therapeutic hour) and in treatment overall (e.g., phase of therapy).

Reid (1980), for example, suggested that the middle phase of long-term therapy was the most appropriate time for therapists to attend to patient defenses because this allowed for the development of therapeutic alliance between the therapist and patient where it would be less cumbersome for patients to handle difficult and painful clinical material. Additionally, Langs (1973) believed that when therapists interpret defenses early in treatment this could lead to a rupture in the therapeutic relationship. Additionally, addressing defenses in the later phases of therapy was not recommended because leaving it until the end would not provide an appropriate amount of time to work through the material, and ultimately have a negative impact on the patient.

The sixth principle asks therapists to *consider the affect associated with the defense when appropriate* (Petraglia, Bhatia, & Drapeau, 2013). This principle rests on the idea that the function of all defense mechanisms is to keep painful affects out of awareness. Therefore, when working with defenses, therapists are continually working to uncover the underlying affect patients are defending against (Chessick, 1974). Therapist naming and communicating these affects to patients is a central component of psychodynamic therapy. In his conceptualization of psychodynamic conflict, Malan (1979) created a triangle of conflict where patient defenses and anxieties work to block the experiencing and expression of his or her true, visceral feelings. When certain avoided feelings are activated, this leads to

the patient feeling anxiety and utilizing numerous defenses to quell both the anxiety and avoided feeling.

Principle seven suggests that therapists should *consider the degree of emotional 'activation' associated with the defense* (Petraglia, Bhatia, & Drapeau, 2013) when making defense interpretations. This principle suggests that in some cases, patients will present defenses in an emotionally charged or "hot" manner. Some scholars argue that in these moments interpretations are ineffective due to the amount of emotionality the patient is experiencing (McWilliams, 1994). On the other hand, if defenses are exhibited in an emotionally detached or "cold" manner, interpretations will also be ineffective because patients lack enough anxiety for the interpretations to be useful for change (Lowenstein, 1951).

Therapists should *avoid using technical language in interpretations* is the eight principle outlined by Petraglia, Bhatia, and Drapeau (2013). This principle suggests that therapists should not use excessively technical language and psychological jargon when articulating defense interpretations to their patients as it can have an adverse impact on therapeutic process and outcome (Langs, 1973).

The ninth principle suggests therapists' *balance between supportive and interpretive interventions* (Petraglia et al., 2013). This principle reminds therapists that interpreting defenses is not the only important technique therapists should use during treatment and that therapists need to provide supportive techniques that interpret feelings and situations especially when patients suffer greater psychological distress (McWilliams, 1994).

There is a growing body of research that indicates when therapists adjust their interventions between expressive and supportive that it is related to both therapeutic process

(e.g., therapeutic alliance) and patient defensive functioning (Petraglia, Bhatia, & Drapeau, 2013).

Principle ten indicates therapists should *accurately identify defense mechanisms used by patients* (Petraglia, Bhatia, & Drapeau, 2013). Accurate interpretations are those where therapists correctly identify the defense a patient is displaying (e.g., identifying rationalization when in fact the patient is rationalizing) and then being able to understand the purpose of this defense and inevitably communicating this to the patient (Junod, de Roten, Martinez, Drapeau, & Despland, 2005; Petraglia, Perry, Janzen, & Olsen, 2009).

This study by Petraglia and colleagues (2013) should serve as a guide for researchers who examine if and how therapists interpret patient defenses as it provides specific guidelines that focus on the numerous elements of interpretation of defenses outlined by psychodynamic theorists.

Importance of Defense Interpretations in Practice

The clinical and theoretical principles outlined by Petraglia, Bhatia, and Drapeau (2013) and the empirical investigations described earlier are encouraging signs that research is increasing on the interpretation of defenses. However, there exists very little research on understanding the views and actions of practicing therapists within the psychodynamic community, and whether practicing psychodynamic therapists take into account theoretical/clinical/empirical guidelines on addressing patient defenses in their own clinical practice. Data on the clinical application of psychodynamic theory are scarce with only a few studies exploring the attitudes of practicing psychodynamic therapists when it comes to the utilization of psychodynamic techniques (e.g., Wogan & Norcross, 1985). This is troubling because a better relationship between the science and practice of psychotherapy

extends to the consideration of what psychodynamic therapists actually do in their own clinical practice with respect to psychodynamic theory. In this dissertation, the focus will be on clinically relevant research aimed at overcoming the limitations and gaps outlined above as well as understanding the clinical and practical perspectives of practicing psychodynamic therapists about patient defenses and interpretation of defenses.

Overall Research Objectives

Given the limitations and gaps outlined above, the goals of this dissertation are:

1) To provide information about the attitudes and beliefs of practicing psychodynamic therapists of different theoretical orientations on the importance of working with defense mechanisms in their clinical practice;
2) To understand the importance practicing psychodynamic therapists give to the theoretical and clinical guidelines on how to address patient defenses outlined by Petraglia, Bhatia, and Drapeau (2013); and
3) To empirically examine two principles outlined by Petraglia, Bhatia, and Drapeau (2013) on how therapists should address defenses in-session to better understand the relationship between therapist technique of interpreting defenses, patient defensive functioning, therapeutic alliance, and therapeutic outcome.

Organization of Dissertation

Chapter 1 outlines the rationale for the dissertation with respect to patient defenses and therapist interpretation of defenses in psychodynamic therapy based on current trends in theory, research, and practice. Chapter 1 also reviews the study by Petraglia, Bhatia, and Drapeau (2013) that outlines ten guidelines on how therapists should address patient

defenses in-session as this study forms the context and guiding framework for the entire dissertation.

The remaining chapters in this dissertation are aimed at bridging the gap between theory and practice in psychodynamic therapy by empirically testing the principles outlined by Petraglia, Bhatia, and Drapeau (2013). The chapters are divided into two parts. Part I (research objective 1) includes two manuscripts (Chapters 2 and 3) that provide information on the clinical utility of defense mechanisms across different theoretical orientations within the psychodynamic community (Chapter 2) and the importance of the clinical principles on how to interpret defenses in-session outlined by Petraglia and colleagues (2013) (Chapter 3) and Part II includes two manuscripts (Chapter 5 and 6) that empirically investigate two guidelines on how to address patient defenses (research objective 2).

Chapter 2 outlines the first manuscript, titled "*Do Therapists Practicing Psychoanalysis, Psychodynamic Therapy, and Short-term Dynamic Therapy Address Patient Defenses Differently in their own Clinical Practice?"* This manuscript was a pilot study that aimed to provide preliminary information on whether psychodynamic therapists view defense mechanisms as an important theoretical construct in psychodynamic therapy, and in their own clinical practice. The manuscript focused on providing a snapshot of therapist perceptions about important theoretical guidelines and whether differences emerged between therapists who practice different types of psychodynamic psychotherapy (e.g., psychodynamic, short-term psychodynamic therapy, and psychoanalysis).

Chapter 3 outlines the second manuscript, titled "*Psychodynamic Therapists' Rating of the Most Important Technical Guidelines to Follow When Interpreting Defenses In-Session."* This manuscript aimed to address the limitations and directions for future research

outlined in the first manuscript by using a larger sample, different methodology and statistical analyses to understand the importance of defense mechanisms and how therapists should interpret defenses in-session. In order to accomplish this, the second manuscript asked participants to rank the importance of the specific guidelines on how to address defenses outlined by Petraglia, Bhatia, and Drapeau (2013) in their own clinical practice.

Chapter 4 outlines the transition from Part I to Part II of the dissertation. The focus of the dissertation will shift from the first research objective that explores the clinical and practical utility of defense mechanisms for practicing psychodynamic therapists, and the guidelines on how to address patient defenses as outlined by Petraglia, Bhatia, and Drapeau (2013) to the second research objective that outlines the empirical examination of two of these specific guidelines.

Chapter 5 describes the third manuscript, titled "*Is There a Relationship between Therapist Language Use, Patient Defensive Functioning and the Therapeutic Alliance?"* This manuscript empirically examined the defense principle that therapists should "avoid using technical language in interpretations" and aimed to: 1) operationalize therapists' verbosity in interpretation of defenses (TVID), and 2) examine the relationship between different components of TVID and overall patient defensive functioning, symptomatic functioning, and the therapeutic alliance.

Chapter 6 investigates the guideline outlined by Petraglia, Bhatia, and Drapeau (2013) that therapists should "intervene with clients' most prominent defenses" in the fourth and final manuscript, titled "*What Defense Mechanisms do Therapists Interpret In-Session?"* This manuscript aimed to determine: 1) what are patients' most prominent (i.e.,

characterological) and least prominent (i.e., “out of character”) defenses, and 2) whether therapists interpret patients’ most prominent or least prominent defenses in-sessions.

Chapter 7 concludes the dissertation by providing implications for psychology including general conclusions, implications for practice, limitations, and future directions for research. All supporting documents for the dissertation can be found in the appendices.

CHAPTER 2:

SURVEY OF PSYCHODYNAMIC THERAPISTS ON HOW TO INTERVENE WITH PATIENT DEFENSES

Running Head: SURVEY OF PSYCHODYNAMIC THERAPISTS

Do Therapists Practicing Psychoanalysis, Psychodynamic Therapy, and Short-term Dynamic Therapy Address Patient Defenses Differently in their own Clinical Practice?

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Abstract

Defense mechanisms are a central component of psychodynamic theory (Shedler, 2010; Weiner & Bornstein, 2009) and the interpretation of defenses is key to psychodynamic practice. Over the years, varying perspectives on dealing with a patient's defense mechanisms have been outlined (e.g., Petraglia et al., 2013). However, little research has been conducted to examine how psychodynamic therapists deal with patient defenses in practice. This study asked psychodynamic therapists (N=114) of different theoretical models (e.g., psychoanalysis, short-term psychodynamic psychotherapy, and psychodynamic therapy) to complete an online survey. Respondents (N = 114) indicated that defense mechanisms are a very important component of practice for psychodynamic psychotherapy. Significant differences between short-term psychodynamic therapy (STDP) and psychodynamic therapists on how they address defenses in their clinical practice were found. Clinical implications of these results, and directions for future research are discussed.

Keywords: defenses, defense mechanisms, interpretation, therapist technique, psychodynamic therapists, psychodynamic psychotherapy

Do therapists practicing Psychoanalysis, Psychodynamic therapy, and Short-term dynamic therapy work differently with patient defenses in their own clinical practice?

Defense mechanisms have been a central feature of psychodynamic theory since Freud (1894) observed that his patients would "repress" painful memories in order to protect themselves from psychic pain and anxiety. Later, Anna Freud (1965) began to systematically outline different defense mechanisms that patients would use to deal with conflict. Since then there has been a proliferation of perspectives on how to understand defenses (e.g., Bond, 1986; Cramer, 1987, 2006; Perry, 1990; Vaillant, 1993). It is clear that the understanding and interpretation of defenses is considered an important aspect of psychodynamic psychotherapy (Shedler, 2010; Weiner & Bornstein, 2009), both in long term (e.g., Greenson, 1967) and short-term modalities (e.g., Davanloo, 2000; McCullough et al., 2003).

Despite the importance of defenses both theoretically and clinically, very little attention has been placed on understanding just how psychodynamic therapists are using psychodynamic theory and techniques with their patients in clinical practice. Most surveys of psychodynamic therapists have examined: the popularity and frequency of psychodynamic therapy use in clinical practice (e.g., Tamtam, 2006); their use of homework assignments in therapy (e.g., Fehm & Kazantzis, 2004); ethical beliefs and behaviours in practice (e.g., Pope et al., 1988); and actions to take when there is treatment failure (Kendall, Kipnis, & Otto-Salaj, 1992; Stewart & Chambliss, 2008).

However, a few studies have examined the types of therapeutic techniques therapists use in their private practices (Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010; Northey, 2002; Wogan & Norcross, 1985). For example, Wogan and Norcross (1985) surveyed over

300 psychotherapists from all theoretical orientations (humanistic, cognitive, and psychodynamic) on their use of 99 therapeutic techniques and skills. In terms of findings specific to psychodynamic theory, the authors found that psychodynamic therapists reported frequently analysing transference and interpreting patients' pasts more often than other therapists from different theoretical orientations. These findings support the idea that psychodynamic psychotherapists follow the theoretical underpinnings of psychodynamic psychotherapy in practice.

Despite the importance of these studies and their attempts to continually increase our understanding of therapist activity in practice and bridge the gap between theory and practice, there still remains a lack of studies reporting on psychodynamic clinicians activities in-session with respect to psychodynamic principles. As well, the Wogan and Norcross (1985) study did not examine defenses or the interpretation of defenses when surveying dynamic therapists. This is surprising as there is a growing body of research demonstrating the importance of adaptive patient defense use and its relationship to positive therapy process and outcome (e.g., Perry et al, 2009; Roy et al., 2009). As well, there is a body of research that demonstrates positive relationship between the interpretation of defenses and outcome (e.g., Orlinksy, Ronnestad, & Willutzki, 2004).

Different Psychodynamic Models of Therapy

Psychodynamic therapy is not a single entity. Over the years, psychoanalytic thought on human behaviour, and personality development has evolved with three major schools emerging: ego psychology, object relations and self-psychology (Summers & Barbers, 2010). It is beyond the scope of this paper to provide a comprehensive analysis of the numerous schools of psychodynamic therapy but it is important to note that psychodynamic

therapy is filled with a multitude of theoretical orientations that share similarities and differences in terms of length of treatment, role of therapist, and the frequency and intensity of therapeutic technique (see Mitchell & Black, 1995, and Summers & Barbers, 2010, for a comprehensive review of these models).

Research examining similarities and differences of how therapists of varying theoretical orientations incorporate therapeutic technique in their practice is virtually non-existent. Given the importance of defenses and the interpretation of defenses to psychodynamic theory and practice (e.g., Shedler, 2010), and the limited research exploring clinician self-reports on the importance of defenses in their own practice, this study focused on exploring the attitudes of therapists who self-identified as practicing different variations of psychodynamic therapy regarding the importance of defense mechanisms in their practice.

Methods

Recruitment

Recruitment involved asking psychotherapists to respond to an online survey. Solicitation of potential participants was conducted over the Internet via e-mails sent to the following institutions and groups, requesting them to forward the survey invitation to their respective listservs: the Society for Psychotherapy Research, the International Psychoanalytic Association, Division 39 of the American Psychological Association, the American Psychoanalytic Association, and the Canadian Psychological Association section on Psychoanalytic and Psychodynamic Psychology. The survey invitation informed potential participants of the purpose and duration of the study (approximately 10–15 minutes) and that ethical approval had been obtained for the study. No compensation was

offered and there were no inclusion criteria beyond being a practicing psychodynamic psychotherapist. Participants were explicitly asked to provide informed consent by clicking on a link that directed them to the online survey. As third parties sent out the invitations, it is not possible to determine how many individuals were contacted or what proportion of them responded to the invitation to participate.

Participants

In total, one hundred and thirty nine ($N = 139$) individuals consented to participate in this study. One hundred and fourteen ($N = 114$) practicing psychodynamic psychotherapists completed questions 1 to 6; 112 ($N = 112$) participants completed questions 1 to 13; and 107 ($N = 107$) participants completed the entire survey from questions 1-19. 53.5 % of the total participants were male ($N = 61$) and 46.5% were female ($N = 53$). Data regarding the participants' theoretical orientation, profession, highest degree obtained, and years of experience as a clinician, can be found in Table 1.

Theoretical Orientation

As part of the survey, participants were asked to self-report what type of psychodynamic therapy they practice. Subsequently, the theoretical orientations that participants reported as using predominantly in their clinical practice were divided into three broad categories: short-term psychodynamic psychotherapy (STDP), psychodynamic psychotherapy, and psychoanalysis. Participants who identified as practicing "short-term psychodynamic", "intensive short-term psychodynamic, "accelerated experiential psychodynamic", "experiential dynamic psychotherapy" or any other variation of "short-term" were categorized as practicing STDP. Participants who identified as practicing "psychoanalysis" were classified as psychoanalysis. The psychodynamic category consisted

of participants who practiced “psychodynamic psychotherapy”, “psychoanalytic psychotherapy”, “object relations”, or “relational psychotherapy.”

Overall, 49 participants (41.5%) were assigned to the “psychodynamic psychotherapy”, 44 participants (37.3%) were assigned to the “STDP” group, and 21 participants (17.8%) identified as practicing “Psychoanalysis.” Four additional participants completed the survey but because they did not practice psychodynamic therapy (i.e., one identified as CBT, another as “integrative constructivism”, a third as practicing “interpersonal therapy” and another did not identify their theoretical orientation) they were removed from all analyses. The majority of participants held a Ph.D. (43%), were licensed psychologists (61%), and had been practicing between 5-10 years (20.2%; see Table 1).

The Survey

The survey was designed to document the opinions of clinicians about the importance of various psychodynamic techniques for working with patients’ defense mechanisms in clinical practice. The first three authors created the items of the survey by examining the existing literature on defense interpretations. The survey was then piloted to 5 practicing clinicians for feedback that was integrated to aid in the creation of the final version. The survey included two parts. Part I asked participants demographic questions (see Table 1). Part II of the survey asked respondents to rate 19 questions on a Likert scale ranging from 1 (Not Important) to 5 (Very Important) to determine the importance of the defense principles in their own practice. Mean scores were tabulated for responses to the survey questions based on theoretical orientations (see Table 2).

Data Analysis

Data analysis consisted of conducting descriptive statistics (means and standard deviations) and a MANOVA for the theoretical orientation categories (STDP, Psychodynamic, and Psychoanalysis) of participants' ratings of the 19 questions on a Likert scale from "strongly disagree" to "strongly agree."

Results

The MANOVA showed an overall significant difference between STDP, Psychodynamic, and Psychoanalytic therapists, with F (2, 38) = 3.25, $p < .001$. Post hoc pairwise comparisons were conducted between different theoretical orientation groups with the exception of participants in the Psychoanalysis group because of the small size of that sample. Results showed significant differences between the groups on four questions.

Significant differences were found between STDP clinicians (M = 4.5, SD = 1.1) and psychodynamic clinicians (M = 3.85, SD = 1.15), F (2, 100) = 3.166, p = .04 on question 8 (Rate the importance of accurately identifying and addressing the defenses used by patients in-session [e.g., interpreting the defense Isolation when the patient is in fact using that defense].) On question 11 (Is it important in psychotherapy to use increasingly "deeper" interpretation with patients as therapy progresses [the so-called "surface-to-depth" rule]?), STDP clinicians (M = 3.00, SD = 1.18) differed significantly from psychodynamic clinicians (M = 3.72, SD = 0.96), F (2, 100) = 5.792, $p < .001$. On question 16 (On average, how long do you believe it takes for therapeutic techniques aimed at addressing defensive behaviour to promote more adaptive defense use by patients?), significant differences were found between STDP (M = 2.70, SD = 0.61) and psychodynamic clinicians (M = 3.75, SD = 0.97), F (2,100) = 21.389, $p < .001$. Finally, on question 17 (How important do you believe it is to

support the use of adaptive/mature defenses by patients?) significant differences were found between STDP clinicians ($M = 3.89$, $SD = 1.09$) and psychodynamic clinicians ($M = 4.43$, $SD = 0.89$), $F\ (2,100) = 4.989$, $p < .001$.

Discussion

Despite the general agreement among the overwhelming majority of individuals surveyed regarding the importance of defense mechanisms as both a theoretical construct and clinical consideration (see Table 2), this study found significant differences among participants who identified as STDP and psychodynamic therapists on key clinical questions.

One of those questions asked clinicians to *Rate the importance of accurately identifying and addressing the defenses used by patients in session (e.g., Interpreting the defense Isolation when the patient is in fact using that defense)*; STDP clinicians rated this to be more important than psychodynamic therapists. Perhaps these differences emerge from the specific emphasis placed by STDP clinicians on addressing defenses as they arise within the session. As Malan (1979) formulated psychodynamic conflict into three distinct poles (defenses, anxiety, and feelings), STDP clinicians view defenses as a barrier to important feelings that need to be experienced and expressed and perhaps more than other psychodynamic therapists, focus intently and systematically on specific technical interventions aimed at defenses.

Additionally, significant differences were found between STDP therapists and psychodynamic therapists on the item that asked participants: *"Is it important in psychotherapy to use increasingly 'deeper' interpretations with patients as therapy progresses (the so-called 'surface to depth' rule)?"* This item tapped into the principle of

moving from "surface to depth" (Fenichel, 1945) as an important guideline when interpreting patient defenses. Therapists should not interpret deeper, unconscious material at the onset; rather they focus on conscious, easily accessible patient material.

STDP therapists rated this as being less important than psychodynamic therapists. These differences may be due in part to the short-term nature of STDP and its active, experiential focus early in therapy (e.g., Davanloo, 2000; McCullough et al., 2003). Additionally, "traditional" psychodynamic models may hold onto the conceptualization that in order to make deeper interpretations, the transference must be well established, and that this process takes time to crystallize. In STDP, especially in intensive models (e.g., Davanloo, 2000), therapeutic intervention aimed at tackling the transference can begin immediately. Davanloo identified the "pressure and challenge" system of attacking defenses patients use and this culminates in the "head-on collision" technique, where the therapist challenges patients to face warded-off feelings as quickly as possible. In general terms, this leads to a rise in transference feelings towards the therapist, which are then systematically processed.

Another difference may lie in how STDP therapists and psychodynamic therapists conceptualize an "interpretation." A number of STDP participants in this study left comments at the end of the survey reflecting their view of what it means to "interpret" a defense. For example, one participant indicated that:

> "I have difficulty with your use of the word 'interpret'. In short-term dynamic work the process is not one of traditional interpretation but rather pointing out defenses, getting the patient to notice the defenses, addressing all the consequences of the defense and in that process getting the patient to a point of an

> emotional response to the way they have been defeating themselves by using that defense – e.g., sadness, self-compassion, etc. After that work is done, then motivating the will of the patient to change the defensive pattern. Finally, then, exploring with the patient alternative responses to using the defenses. I have answered the questions of this survey using this understanding of interpretation."

As well, significant differences emerged between STDP and psychodynamic therapists on an item that asked participants: *"On average how long do you believe it takes for therapeutic techniques aimed at addressing defensive behavior to promote more adaptive defense use by patients?"* STDP therapists reported that it would take less time for patients to use more adaptive defenses in comparison to psychodynamic therapists, who reported it would take longer. This difference is consistent with the tenets of STDP, as STDP is an active, shorter, and accelerated treatment, which emphasizes the view that character change can occur "quicker" than it can in longer-term treatments.

Another item asked participants: "*How important do you believe it is to support the use of adaptive/mature defenses by patients?"* and STDP therapists rated this is as being less important than psychodynamic therapists. One possible explanation is in the conceptualization of defense mechanisms by both STDP and psychodynamic therapists. It may be the case that psychodynamic therapists in this study followed the model of defensive functioning outlined by Vaillant (1993), which conceptualizes patient defenses being organized in a hierarchy from immature to mature defenses. The goal then is to move patients towards increasingly mature levels of defense. An important distinction in the STDP literature is the emphasis placed on reducing the patient's use of tactical defenses (e.g., non-verbal body language actions such as avoiding eye contact, inappropriate laughter,

etc.), so that they can experience and express underlying feelings (Davanloo, 2000; McCullough et al., 2003). Again, this does not imply that STDP therapists do not see defenses as part of an individual's character or that psychodynamic therapists do not appreciate the significance of working with tactical defenses. Rather, the discrepancy may be that of differences in focus of the therapeutic work.

This study had some limitations that need to be considered when interpreting the results. First, there may be a discrepancy between what therapists say is important to their practice, and what they actually do in-session, as research suggests that often therapists who claim to be practicing a particular therapy are in actuality practicing something quite different (Shedler, 2010). Additionally, the sample size could have been larger, which may have increased differences among groups and provided the ability to compare both the STDP and psychodynamic groups with the psychoanalysis group.

The study was limited by a small sample size. As well, using third party invitations did not allow us to determine the actual number of individuals who were contacted and therefore, we could not determine the response rate to the survey. In addition, it was not possible to predict which association or region in the world participants' who completed survey came from. These factors limit the generalizability and representativeness of the study.

Using a Likert Scale and asking psychodynamic clinicians to self-report on the importance of defense mechanisms created the likely conditions for a positive response bias. That is, most clinicians thought that these principles were "important" to "very important" in their own practices. Variability among responses was not high and confirms what we already intuitively know: psychodynamic practitioners believe that working with defenses is

important. Despite this, significant differences and a lack of uniform agreement on the definition and applications of these principles emerged between groups.

Many participants commented on the survey's inability to capture the different perspectives and understanding they had about defenses and interpretations. For example, there were varying views on the definition of defenses (e.g., tactical or characterological), and what it means to "interpret" a defense rather than "intervening" with defenses. These disagreements shed light on an important issue in that the psychodynamic community is a diverse group and that defense mechanisms are understood from many perspectives both theoretically (e.g., Vaillant, 1993; Cramer, 2006) and clinically (e.g., Davanloo, 2000). The results of this study definitely support that position and help us understand that just because psychodynamic therapists agree with the importance of defense mechanisms, this does not clearly translate to how, why, and when they chose to address defenses in-session.

Conclusion

Overall, this study of practicing psychodynamic therapists found that the overwhelming majority of psychodynamic practitioners surveyed believe that defenses are both an important construct in psychodynamic therapy, and that in their own clinical practice, it is important to interpret patient defenses. Despite global agreement, in general, on the value of working with defenses in session, differences emerged in a few areas between STDP therapists and psychodynamic psychotherapists. More research is needed to better understand the importance of defenses in clinical practice among the rich, diverse, and unique theoretical branches on the tree of psychodynamic theory and practice.

References

Akhtar, S. (2009). *Comprehensive dictionary of psychoanalysis.* London: Karnac Books.

Bond, M. (1986). Defense Style Questionnaire. In G. E. Vaillant (Ed.), *Empirical studies of ego mechanisms of defense* (pp. 146-152). Washington, DC: American Psychiatric Press.

Cook, J. M., Biyanova, T., Elhai, J., Schnurr, P. P., & Coyne, J. C. (2010). What do psychotherapists really do in practice? An internet study of over 2,000 practitioners. *Psychotherapy: Theory, Research, Practice, Training, 47*(2), 260-267.

Davanloo, H. (2000). *Intensive Short-term Dynamic Psychotherapy*. Chichester: Wiley.

Etchegoyen, R. H. (2005). *Fundamentals of psychoanalytic technique.* London: Karnac.

Fenichel, O. (1945). *The psychoanalytic theory of neurosis.* New York: Norton & Co.

Fehm, L., & Kazantzis, N. (2004). Attitudes and use of homework assignments in therapy: a survey of German psychotherapists. *Clinical Psychology and Psychotherapy, 11*(5), 332-343.

Freud, S. (1894). The neuro-psychoses of defence. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud,* (Vol. 2, pp. 45-61). London: Hogarth Press.

Freud, A. (1965). *The ego and the mechanisms of defense.* New York: International Universities Press.

Greenson, R.R. (1967). *The technique and practice of psycho-analysis.* New York: International Universities Press.

Hersoug, A.G., Sexton, H., & Hoglend, P. (2002). Contribution of defensive functioning to the quality of working alliance and psychotherapy outcome. *American Journal of Psychotherapy, 56,* 539-554.

Kendall, P. C., Kipnis, D., & Otto-Salaj, L. (1992). When clients don't progress: Influences on and explanations for lack of therapeutic progress. *Cognitive Therapy and Research, 16*(3), 269-281.

Malan, D. (1979). *Individual psychotherapy and the science of psychodynamics*. London, Butterworth.

McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C.L. (2003). *Treating affect phobia: A manual for short-term dynamic psychotherapy.* New York: Guilford Press.

Perry, J.C. (1990). *The Defense Mechanism Rating Scales, fifth edition*. Cambridge, MA: auteur.

Perry, J.C., Beck, S.M., Constantinides, P., & Foley, J.E. (2009). Studying change in defensive functioning in psychotherapy using the Defense Mechanism Rating Scale: Four hypotheses, four cases.

Mitchell, S.A., & Black, M.J. (1995). Freud and beyond: A history of modern psychoanalytic thought. New York: Basic Books.

Northey, W. F. (2002). Characteristics and clinical practices of marriage and family therapists: A national survey. *Journal of Marital and Family Therapy, 28*, 487-494.

Petraglia, J., Bhatia, M., & Drapeau, M. (2013). Ten principles to guide psychodynamic technique with defense mechanisms: An examination of theory, research, and clinical implications. *Manuscript submitted for publication.*

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1988). Good and poor practices in psychotherapy: National survey of beliefs of psychologists. *Professional Psychology: Research and Practice, 19*(5), 547-552.

Orlinksy, D.E., Ronnestad, M.H, & Willutzki, U. (2004). Fifty years of psychotherapy process outcome research: Continuity and change. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th edition) (pp. 307-389). New York: John Wiley and Sons, Inc.

Reid, W.H. (1980). *Basic intensive psychotherapy.* New York: Brunner Mazel.

Roy, C.A., Perry, J.C., Luborsky, L., & Banon, E. (2009). Changes in defensive functioning in completed psychoanalysis: The Penn psychoanalytic treatment collection. *Journal of the American Psychoanalytic Association, 57,* 399-415.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65,* 98-109.

Stewart, R. E., & Chambless, D. L. (2008). Treatment failures in private practice: How do psychologists proceed. *Professional Psychology: Research and Practice, 39*(2), 176-181. doi: 10.1037/0735-7028.39.2.176

Summers, R.F. & Barber, J.P. (2010). *Psychodynamic therapy: A guide to evidence-based practice.* New York, NY: Guilford Press.

Tamtam, D. (2006). Psychotherapy in the UK: Results of a survey of registrants of the United Kingdom council for psychotherapy. *European Journal of Psychotherapy and Counselling, 8*, 321-342.

Vaillant, G. E. (1993). *The wisdom of the ego.* Cambridge: Harvard University Press.

Vaillant, G.E., Bond, M., & Vaillant, C.O. (1986). An empirically validated hierarchy of defense mechanisms. *Archives of General Psychiatry, 43,* 786-794.

Weiner, I.B. & Bornstein, R.F. (2009). *Principles of psychotherapy: Promoting evidence-based psychodynamic practice* (3rd ed.). NJ: Wiley.

Winston, B., Winston, A., Samstag, L.W., & Muran, J.C. (1993). Patient defense/therapist interventions. *Psychotherapy, 31,* 478-491.

Wogan, M., & Norcross, J. C. (1985). Dimensions of therapeutic skills and techniques: Empirical identification, therapist correlates, and predictive utility. *Psychotherapy: Theory, Research, Practice, Training, 22*(1), 63-74.

Table 1. Demographic Information

Variable	N	%
Gender		
Male	61	53.5
Female	53	46.5
Age		
<30	6	5.3
30-35	10	8.8
36-40	17	14.9
41-45	9	7.9
46-50	17	14.9
51-55	18	15.8
56-60	11	9.6
61+	25	21.9
License		
Counsellor	7	6.1
Psychiatrist	20	17.5
Psychologist	72	63.1
Family Physician (G.P.)	1	0.9
Social Worker	6	5.2
Non-licensed	7	6.1
Did Not Respond	1	0.9
Highest Degree		
Ed.D.	1	0.9
D.Ps/Psy.D.	8	7
Masters	35	30.7
M.D.	21	18.4
Ph.D.	49	43
Years Practicing		
<5	9	7.9
5-10	23	20.2
11-15	21	18.4
16-20	16	14
21-25	13	11.4
26-30	13	11.4
31+	19	16.7
Number of Sessions		
<10	4	3.5
10-20	15	13.2
21-40	30	26.3
41-60	21	18.4
61+	43	37.7
None of the above	1	0.9

Table 2. Means and Standard Deviation across Theoretical Orientations

Question	STDP		Psychodynamic		Psychoanalysis	
	Mean	SD	Mean	SD	Mean	SD
1. In your opinion, are defense mechanisms an important construct in psychodynamic psychotherapy?	4.75	0.61	4.61	0.79	4.67	0.48
2. Rate the importance of interpreting patient defenses	4.30	0.95	4.20	0.88	4.33	0.66
3. Rate the importance of interpreting the patient's most common defense.	4.36	0.92	4.24	0.88	4.52	0.51
4. Rate the importance of interpreting the patient's out of character defenses (e.g., Healthy Neurotic patient who infrequently acts out).	3.95	0.94	3.67	0.88	4.48	0.75
5. Rate the extent to which a therapist's choice of defense to interpret in-session should be based on psychodynamic theory.	3.86	1.07	3.86	1.04	3.95	1.32
6. Rate the importance (as a therapist) of adjusting one's therapeutic technique to patients' defensive maturity level.	4.36	0.69	4.53	0.81	4.33	1.2
7. Rate the importance of correctly timing an intervention that aims to address some aspects of defensive functioning.	4.53	0.63	4.43	0.78	4.42	0.93
8. Rate the importance of accurately identifying and addressing the defenses used by patients in-session (e.g., interpreting the defense Isolation when the patient is in fact using that defense).*	4.50	1.1	3.85	1.15	4.14	1.15
9. Rate the importance of making "deep" interpretations in psychodynamic psychotherapy (that include motives, wishes, repressed or latent content).	3.40	1.28	3.93	0.95	3.76	1.14
10. How important is it to address the defense used by the patient as opposed to what is defended against (unconscious motive, wish, impulse or drive)?	3.70	1.12	3.67	1.01	4.00	1.23
11.Is it important in psychotherapy to use increasingly "deeper" interpretation with patients as therapy progresses (the so-called "surface-to-depth" rule)?**	3.00	1.18	3.72	0.96	3.57	1.21
12. Rate the importance of naming the affect associated with each defense mechanism when making interpretations in psychotherapy.	4.14	1.01	4.07	0.90	4.55	0.61
13. Rate the importance of interpreting a defense when it is emotionally charged (meaning that the emotional content associated with the defense is readily observable to the therapist).	4.16	1.11	4.15	0.82	4.33	0.66
14. Rate the importance of interpreting a defense when it is emotionally detached or "cold" (meaning that the emotional content associated with the defense is not readily observable to the therapist).	3.60	1.28	2.98	1.35	3.00	1.18
15. How helpful do you believe it is to use interpretive techniques with "Immature" defense such as Splitting, Projection, & Acting Out?	3.38	1.19	3.51	1.28	3.95	1.02
16. On average, how long do you believe it takes for therapeutic techniques aimed at addressing defensive behavior to promote more adaptive defense use by patients?***	2.70	0.61	3.77	0.97	3.90	0.89
17. How important do you believe it is to support the use of adaptive/mature defenses by patients?****	3.80	1.09	4.42	0.91	3.81	0.87
18. How often do you interpret defenses used by patients in their lives outside of therapy as opposed to defenses used within the session?	3.53	0.99	3.60	0.90	3.52	1.08
19. How important do you believe it is to avoid the use of technical language when expressing the interpretation of defenses to patients?	4.43	0.87	4.23	1.09	4.38	0.87

*Significant mean difference between STDP and Psychodynamic group, $p = .04$

CHAPTER 3:

RANKING PRINCIPLES ON HOW TO ADDRESS PATIENT DEFENSES IN-SESSION

Running Head: THERAPISTS and DEFENSES

Psychodynamic Therapists' Rating of the Most Important Technical Guidelines to Follow When Interpreting Defenses In-Session

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Abstract

Interpretation of defenses is considered a fundamental technique in psychodynamic psychotherapy based on the theoretical, clinical, and empirical literature (Shedler, 2010; Weiner & Bornstein, 2009). In order to overcome gaps in research that examine the clinical practice of the interpretations of defenses, Petraglia, Bhatia, and Drapeau (2013) reviewed the existing literature and created a list of ten guiding principles on how therapists should interpret defenses in-session. This study attempted to gain a systematic understanding of the attitudes of practicing psychodynamic therapists on the importance of clinical principles on how to interpret defenses in-session. This study asked practicing psychodynamic psychotherapists ($N = 140$) to complete an online survey to determine their: 1) level of agreement and 2) ranking from most important to least important on the clinical importance of clinical principles on how to address patient defenses. Results of the survey indicated that therapists strongly agreed with the importance of the clinical principles. When examining therapists ranking of the principles from most important to least important three groups emerged (high, middle, and low). Clinical implications of these findings and directions for future research are explored.

Keywords: defenses, defense mechanisms, interpretation, therapist technique, psychodynamic therapists, psychodynamic psychotherapy

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Defense mechanisms are considered a prominent theoretical and clinical construct within psychodynamic psychotherapy (Etchegoyen, 2005). Along with transference interpretations, the interpretation of defenses is the key therapeutic intervention that distinguishes psychodynamic therapy from other therapies (Shedler, 2010). Despite the theoretical and empirical importance of this construct, little research has been conducted on: 1) technical guidelines on how to therapists should interpret defenses, and 2) therapists' attitudes on how to interpret patient defenses in-session in their clinical practice.

In an attempt to better understand interpretations of defenses, Petraglia, Bhatia, and Drapeau (2013) set out to synthesize the clinical and theoretical literature outlining technical guidelines for how therapists should address patient defenses in-session. Petraglia and colleagues (2013) reviewed 29 textbooks, 49 empirical studies, and 19 theoretical articles in order to identify suggestions on how therapists should address patient defenses in-session. When the process was complete, the authors created a list of ten clinical principles on how therapists should address defenses in-session based on all the available clinical and theoretical literature (Table 1 provides a chart of the ten principles). The overall aim of Petraglia and colleagues (2013) was to provide a set of guidelines that could inform future research studies and clinical practice.

Surveying Clinical Attitudes

A key limitation and gap within psychotherapy research is the lack of research directed at understanding the link between theoretical constructs and clinical practice. Within the psychodynamic community, there are very few studies that have examined

clinicians' attitudes, views, and perspectives on practice guidelines (for exceptions, see Wogan & Norcross, 1985; Langs, 1973). Additionally, psychodynamic therapy has in the past lagged behind other theoretical models in regards to empirical investigation of the veracity of its theories and practices (Shedler, 2010). This attitude may also contribute to the lack of research involving practicing psychodynamic therapists and their own clinical work.

A recent study conducted by Bhatia, Petraglia, de Roten, and Drapeau (2013) focused on the practical application of theoretical principles in psychodynamic therapy. The authors set out to examine practicing psychodynamic therapists attitudes of the importance of defense mechanisms to their clinical practice and their level of agreement with the clinical principles in the literature on how therapists should address patient defenses in-session. In their study, Bhatia and colleagues (2013) solicited the participation of practicing psychodynamic therapists (N=114) of different theoretical models (e.g., psychoanalysis, short-term psychodynamic psychotherapy, and psychodynamic therapy) to complete an online survey that asked them to rate 19 statements examining their level of agreement on the importance of defense mechanisms and theoretical considerations on how to address patient defenses in-session. The authors found that the majority of therapists within each group rated the construct of defense mechanism as being "important" to "very important" to their clinical practice and that interpreting defenses was "important" to "very important" in their own clinical practice. Despite the high levels of agreement among participants across the questions, the study showed significant differences between the STDP and psychodynamic group on a number of questions.

For example, STDP and psychodynamic therapists differed on the following questions: "*How important do you believe it is to support the use of adaptive/mature*

defenses by patients?"; "On average how long do you believe it takes for therapeutic techniques aimed at addressing defensive behaviour to promote more adaptive defense use by patients?"; "Is it important in psychotherapy to use increasingly 'deeper' interpretation with patients as therapy progresses (the so-called 'surface to depth' rule)?" These differences demonstrated that within the psychodynamic community, therapists adhere to theoretical models that shape their attitudes about defenses, technique, and process of therapy in ways that differ. Defense mechanisms, and interpretation of defenses are important to their work; but the specifics vary.

The Bhatia and colleagues (2013) study had a few limitations. First, there tended to be a positive response bias towards the statements as most participants agreed or strongly agreed with the clinical statements. Furthermore, the Bhatia and colleagues (2013) study was conducted prior to the Petraglia and colleagues (2013) study that formally outlined clinical principles on how therapists should interpret defenses in-session. As a result, the study excluded important theoretical guidelines on how therapists should interpret defenses in-session as outlined in the literature (e.g., therapists interpreting both inside and outside defenses).

While Bhatia and colleagues (2013) provided important information on therapists' level of agreement regarding the importance of defenses, and principles on working with defenses, the study did not provide information on which of these principles are more important than others nor did the analysis allow for a categorization of therapist ratings of these clinical principles into specific therapist interpretation dimensions.

Current Study

This study aimed to overcome limitations from previous surveys examining psychodynamic technique (e.g., Bhatia et al., 2013) and add to a scarce area of investigation by determining practicing psychodynamic therapists' attitudes about the clinical utility of the guidelines on how therapists should interpret defenses in-session as outlined by Petraglia, Bhatia, and Drapeau (2013). The goal of this study was to: 1) determine therapists rating of the clinical principles in terms of degree of agreement and 2) determine therapists ranking of the clinical principles from most important to least important in order to decrease the potential for positive response bias.

Method

Recruitment

Recruitment involved asking psychotherapists to respond to an online survey. Solicitation of potential participants was conducted over the Internet via e-mails sent to the following institutions and groups, requesting them to forward the survey invitation to their respective listservs: the Society for Psychotherapy Research, the International Psychoanalytic Association, Division 39 of the American Psychological Association, the American Psychoanalytic Association, and the Canadian Psychological Association section on Psychoanalytic and Psychodynamic Psychology. Social media was used to solicit participation as well. For example, an invitation to the survey was posted on two Facebook pages: Affect Phobia Therapy and the Dynamic Experiential Therapy. As well, the Contemporary Psychodynamic group on LinkedIn posted an email invitation to the survey. The survey invitation informed potential participants of the purpose and duration of the study (approximately 10–15 minutes) and that ethical approval had been obtained for the

study. No compensation was offered and there were no inclusion criteria beyond being a practicing psychodynamic psychotherapist. Participants were then explicitly asked to provide informed consent by clicking on a link that directed them to the online survey.

Participants

In total, one hundred and sixty two (*N*=162) individuals consented to participate in this study. However, 22 participants were removed from the study because of incomplete data. Therefore, one hundred and forty (*N*=140) participated in this study and completed Part I and Part II of the survey and one hundred and twelve (*N*=112) completed the entire survey. 53.6 % of the total participants were male (*N*=75) and 45.0% were female (*N*=63) while two participants did not specify their gender. Data regarding the participants' type of practicing license, highest degree obtained, and years of experience as a clinician, can be found in Table 2.

The Survey

The survey was designed to ask participants to report the degree to which they agreed or disagreed with the principles outlined in Table 1. The second and last author reviewed the survey, and they provided input on the items, and revised items for clarity and consistency with the clinical principles. Additionally, the survey was piloted with a sample of 10 practicing psychodynamic therapists and their feedback was solicited with an open-ended section for comments. The comments provided by participants in the Bhatia and colleagues (2013) study were also taken into consideration when creating this survey.

Some of the ten principles outlined by Petraglia and colleagues (2013) contained multiple elements and were subdivided into several statements to capture these different elements. For example, principle four indicates that therapists should *attend to defenses used*

*both inside and outside of the therapeutic hour***.** In the survey, this principle was divided into two statements: therapists should interpret defenses used inside the therapeutic hour and therapists should interpret defenses used outside the therapeutic hour (see Table 1 for a full breakdown of the principles and how they were utilized in this study).

The survey was comprised of three parts. Part I asked participants demographic questions (see Table 2). Part II of the survey asked respondents to rate 16 statements on a Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree) to determine their level of agreement with clinical principles. Part III asked participants to rank each statement from 1 (most important) to 16 (least important).

Data Analysis

Descriptive statistics (means and modes) for both the Likert scale ratings of the principles from "strongly disagree" to "strongly agree" and the rankings of the principles from most important to least important were examined.

Results

Degree of Agreement and Disagreement with Clinical Principles

The survey asked participants to rate 16 statements using a Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). Detailed results can be found in Table 3. The data indicated that *therapists should avoid using technical language in defense interpretations* ($M = 4.5$, $SD = 0.8$) had the highest mean rating and *therapists should not interpret a defense when a patient uses it in an emotionally "cold" manner* had the lowest mean rating ($M = 2.7$, $SD = 0.9$).

Importance Ranking of Clinical Principles

The survey also asked participants to rank the 16 statements from most important to least important. Descriptive data are summarized in Table 3. The statements were ordered from most important to least important based on their mean rank ratings. Table 3 also reports the mode ranking for each item. The modes suggest that the principles could tentatively be divided into three groups: principles ranked high (i.e., principles 1-7), principles ranked in the middle (i.e., principles 8-12) and principles with the lowest rank (i.e., principles 13-16).

Seven principles were ranked high with the highest ranked (mean rank) principle statement being *therapists should systematically move form "surface to depth" interpretations when working with patient defenses* (see Table 3 for details). Five principles were ranked in the middle including the principle that *therapists should accurately identify the defenses a patient uses in-session.* Four principle statements were ranked as least important, including: *therapists should interpret a defense when the patient uses it in an emotionally charged or "hot" manner*; *therapists should interpret a defense when a patient uses it in an emotionally "cold" manner*; *therapists should not interpret a defense when a patient uses it in an emotionally charged and/or "hot" manner*; and *therapists should not interpret a defense when a patient uses it in an emotionally "cold" manner.*

Discussion

Degree of Agreement and Disagreement with Clinical Principles

The results of this study indicate that in terms of participants' degree of agreement with the clinical principles, on average there was high level of agreement and a lack of disagreement (e.g., no mean ratings of 1 or 2) amongst psychodynamic therapists regarding

the clinical principles. A possible explanation for the high level of agreement could be positive response bias as a function of using a Likert scale. Alternatively, the high level of agreement between therapists and the lack of variability provides support for the theoretical and clinical utility of principles outlined by Petraglia, Bhatia, and Drapeau (2013) to clinical practice.

Importance Ranking of Clinical Principles

In order to overcome the potential lack of variation and the positive skewedness of the responses with respect to level of agreement, rankings of the principles from most important to least important were collected. Examining the mode rankings of the principles led to organizing the therapist rankings of the principles into three groups: (high, middle, and low) and they provided important research and clinical ramifications.

The highest ranked principle was *therapists should systematically move from "surface to depth" interpretations when working with patient defenses*. This principle-which is known as the "surface-to-depth" rule (Fenichel, 1945)-is based on the position originally postulated by Freud (1913) that therapist interpretations are aimed at making the unconscious conscious. Therefore, patient material needs to be addressed with this goal but in such a manner that more readily conscious and "surface" material is explored before moving towards more difficult, unconscious and deeper patient material as therapy progresses (Fenichel, 1945; Greenson, 1967; Langs, 1973; Wolberg, 1977). In terms of therapist technique, this is a well-established technical guideline that is promoted by psychodynamic theorists and therapists (Wachtel, 2011). As such, there is a clear connection between the theoretical and clinical importance of this principle based on therapist rankings in our study.

Furthermore, when examining the seven high ranked principles, it is clear that they do not differentiate themselves much from one another. This is important clinically, as each of these principles is a necessary component of what constitutes a "good" or "sound" defense interpretation. Clinically, working from the perspective that any one principle alone is sufficient for a sound defense interpretation is not recommended. As a result, clinicians recognize that all of these principles are needed together in order to effectively communicate sound interpretations to their patients and their rankings reflect this.

An area of research on therapist interpretation of defenses that has garnered considerable attention is therapist accuracy (e.g., Crits-Christoph, Cooper, & Luborsky, 1988; Junod, de Roten, Martinez, Drapeau, & Despland, 2005; Petraglia, Perry, Janzen, & Olsen, 2009; Silberschatz, Fretter, & Curtis, 1986). Many researchers and clinicians assume that an important component of an effective interpretation is for the interpretation to be accurate. Therefore, if a patient is using the defense of *repression*, the therapist should be able to accurately identify the *repression*, be able to understand the purpose and function of the *repression* and relay this information to the patient. Yet in our study, this principle was not one of the highest ranked principles in the descriptive analyses (see Table 3).

One possible explanation for this seeming disconnect between the research on therapist accuracy and clinicians' importance rankings in our study is that clinicians may hold the viewpoint that therapist accuracy must be considered within the context of other clinical principles in order to be effective. This is consistent with the gaps in the current literature on the concept of therapist accuracy, as some researchers have argued that therapist accuracy alone is not a sufficient criterion when addressing patient defenses (e.g., Despland et al., 2001; Junod et al., 2009; Petraglia et al., 2009), and that therapist accuracy

needs to be measured along with other elements of therapist interpretation including timing, language, and depth (Petraglia, Bhatia, & Drapeau, 2013); the first seven principles ranked most important by the clinicians in our study.

It is important to note that when examining the groupings for the rankings of the clinical principles, there is little variation between the middle (i.e., 8-12) and low (i.e., 13-16) groups, particularly when examining the mode rankings. However, the differentiation between the middle and low groups was created based on the fact that the lowest four statements represented components of a single principle outlined by Petraglia and colleagues (2013) (see principle seven in Table 1).

Specifically, this principle suggests that *therapists should consider the degree of emotional "activation" associated with the defense* when making an interpretation. Our study attempted to break this principle into its different components and determine what practicing therapists considered most or least important about this principle (e.g., interpreting “hot” or “cold” defense use). This principle is based on the notion that therapists need to pay attention to, and explore the emotional intensity associated with patient defense use. Different psychodynamic theorists have argued that the emotional activation or lack thereof that the patient exhibits can influence the therapeutic impact of an interpretation.

For example, McWilliams (1994) indicated when patients exhibit defenses when they are emotionally charged or “hot” they are less likely to integrate interpretations made by therapists, consequently, therapists should wait until the patient is less emotional. McWilliams’ (1994) believed that in those emotionally charged moments, the situation could escalate and this could have a destructive impact on patient functioning and therapeutic process.

Similarly, Lowenstein (1951) indicated that interpreting defenses when they are too emotionally activated would not provide a therapeutic effect because patients would not be responsive to interpretations in those moments. As well, Lowenstein (1951) indicated when patients express defenses in an emotionally disconnected or "cold" manner that patients would dismiss therapist interpretations due to a lack of emotionality and anxiety.

One of the reasons why components of this clinical principle were ranked as less important may be that not all therapist technique in psychodynamic therapy is interpretive. Research indicates that the range of therapist interpretive technique can vary from 4% to 40% (Connolly Gibbons, Crits-Christoph, Barber, & Schamberger, 2007). Therefore, it may be the case that therapist in our study, value the importance of emotional activation but do not believe that interpretation in these situations is the optimal way to handle emotions. For insistence, McWilliams (1994) recommended that therapists be mindful of a patient's level of emotional distress when deciding on techniques to use, and to be mindful of the importance of balancing between supportive and interpretive techniques when working with patient defenses. Specifically, when the patient suffers strong psychological distress it is better in those moments to use supportive techniques and interpret the patient's feelings rather than directly interpreting defenses. In our study, the clinical principle that therapists should balance between supportive and interpretive techniques was ranked in the high group and third overall in terms of importance.

A fundamental element of psychodynamic therapy is addressing patient resistance to therapy. Theorists and clinicians have long held the view that patient resistance must be handled prior to any specific patient material otherwise the therapeutic process will be compromised (e.g., Weiner & Bornstein, 2009).

Another high ranked statement was that "therapists should interpret defenses patients use inside the therapeutic hour." This statement was a component of the principle that therapist should *attend to defenses used both inside and outside therapy* as outlined by Gray (1994) and Vaillant (1993). In our study, therapists ranked interpreting defenses used inside therapy as more important than those outside therapy.

Gray (1994) asserted that therapists should only attend to patient material exhibited within the context of the therapist-patient relationship, and that patient material outside of therapy was not a priority for a therapist. Conversely, the statement "therapist should interpret defenses used outside the therapeutic hour" was ranked as less important (middle group) which suggests that clinicians in our study were less supportive of Vaillant's (1993) view that external stressors patients are facing outside therapy before tackling stressors that take place within therapy, as they can negatively impact on patient functioning and therapeutic process. Again, the rankings do not suggest that therapists in our study only focus on defenses inside therapy (e.g., Gray, 1994) or that they do not value those defenses used outside therapy (Vaillant, 1993) but rather therapists deemed it more important to focus on patient defenses used inside the therapeutic hour.

In terms of therapeutic focus, Greenson (1967) and Langs (1973) indicated that when working with defenses, therapists' need to *intervene with patients' most prominent defenses*. This principle was separated into two statements that captured the positions of Greenson (1967) and Langs (1973) that therapists need to intervene with patients' "characterlogical" and "typical" defenses as well as those defenses that are "atypical" and "out of character." In our study, therapists ranked focusing on patients' most "typical" and characterological defenses as more important (second highest mean ranking) than those

defenses that are “atypical” and “out of character” (ranked in the middle and tenth in mean ranking). It would be important to empirically examine what constitutes patients most “typical” and “atypical” defenses, and to gather a clearer understanding of which of these types of defenses therapists are tackling in-session.

This study did have limitations. The study would have benefitted from a larger sample size. Given the nature of the survey (online and third party invitations), we were unable to ascertain how many practicing psychodynamic therapists actually received the e-mail invitation to complete the survey (i.e., response rate). As well, we were unable to determine from which professional organization/community and part of the world participants completing the survey originated from.

Our study did not compare responses of participants who identified themselves as practicing specific theoretical models more than others (e.g., a short-term psychodynamic therapist versus a psychoanalyst). The purpose of this study was to determine the level of agreement with, and clinicians ranking from most important to least important, of the clinical principles outlined by Petraglia, Bhatia, and Drapeau (2013) before moving towards examining clinical importance rankings across varying theoretical orientations.

. However, future research could examine the similarities and differences between varying theoretical orientations (e.g., short-term dynamic therapy, psychoanalysis, psychodynamic). In addition, it is possible that therapist factors including theoretical orientation, therapeutic style, personality, and patient populations they treat may have also contributed to the variability in the results. Future studies examining therapists’ attitudes should explore these specific factors as a variable of comparison.

Conclusion

Overall, psychodynamic therapists in this study provided strong levels of agreement and support for the clinical importance of the principles on how to interpret defenses in-session as outlined by Petraglia and colleagues (2013). The descriptive analyses found that seven principles were highly ranked by clinicians (e.g., the "surface-to-depth" principle; therapist avoiding technical language when interpreting defenses) while elements of one principle outlined by Petraglia, Bhatia, and Drapeau (2013) made up the lowest ranked principles (e.g., emotional activation). Future research on the importance of these principles to therapeutic process and outcome are needed.

References

Bhatia, M., Petraglia, J., de Roten, Y., & Drapeau, M. (2013). Do therapists practicing psychoanalysis, psychodynamic therapy, and short-term dynamic therapy address patient defenses differently in their own clinical practice? *Manuscript submitted for publication.*

Chessick. R. D. (1974). *The technique and practice of intensive psychotherapy.* New York: Aronson.

Connolly Gibbons, M. B., Crits-Christoph, P., Barber, J. P., & Schamberger, M. (2007). Insight in psychotherapy: A review of empirical literature. In L. Castonguay & C. Hill (Eds.), *Insight in psychotherapy* (pp. 143–165). Washington, DC: APA Press.

Crits-Christoph, P., Cooper, A., & Luborsky, L. (1988). The accuracy of therapists' interpretations and the outcome of dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 56(*4*),* 490-495.

Davanloo, H. (2000). *Intensive Short-term Dynamic Psychotherapy*. Chichester: Wiley.

Etchegoyen, R. H. (2005). *Fundamentals of psychoanalytic technique.* London: Karnac.

Fenichel, O. (1945). *The psychoanalytic theory of neurosis.* New York: Norton & Co.

Freud, A. (1937/1965). *The ego and the mechanisms of defense.* New York: International Universities Press.

Gill, M.M. & Hoffman, I.Z. (1982). Analysis of transference: II Studies of nine audio-recorded psychoanalytic sessions. *Psychological Issues, 54,* 1-236.

Gray, P. (1994). *The ego and the analysis of defense.* New Jersey: Jason Aronson.

Greenson, R.R. (1967). *The technique and practice of psycho-analysis.* New York: International Universities Press.

Junod, O., de Roten, Y., Martinez, E., Drapeau, M. & Despland, J.N. (2005). How to address patients' defenses: A pilot study of the accuracy of defence interpretation and alliance. *Psychology and Psychotherapy: Theory, Research, and Practice, 78,* 419-430.

Kaechele, H. & Thomă, H. (1994). *Psychoanalytic practice.* New Jersey: Aronson.

Langs, R. (1973). *The technique of psychoanalytic psychotherapy: Vol.1.* New York: Aronson.

Loewenstein, R. M. (1951). The problem of interpretation. *The Psychoanalytic Quarterly, 20,* 1-14.

McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C.L. (2003). *Treating affect phobia: A manual for short-term dynamic psychotherapy.* New York: Guilford Press.

McWilliams, N. (1994). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process.* New York: Guilford Press.

Petraglia, J., Bhatia, M., & Drapeau, M. (2013) Ten principles to guide psychodynamic technique with defense mechanisms: An examination of theory, research, and clinical implications. *Manuscript submitted for publication.*

Petraglia, J., Janzen, J. I., Perry, J. C., & Olson, T. R. (2009). The relationship between therapist interpretation accuracy and in-session change in patients' defensive functioning. Paper presented at the Canadian chapter of the Society for Psychotherapy Research (SPR), Montreal, Canada.

Reid, W. H. (1980). *Basic intensive psychotherapy.* New York: Brunner Mazel.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65,* 98-109.

Silberschatz, G., Fretter, P.B., & Curtis, J.T. (1986). How do interpretations influence the process of psychotherapy? *Journal of Consulting and Clinical Psychology, 5,* 646-652.

Vaillant, G. E. (1993). *The wisdom of the ego.* Cambridge: Harvard University Press.

Wachtel, P.L. (2011). *Therapeutic Communication: Knowing What to Say When.* New York: The Guilford Press.

Weiner, I.B. & Bornstein, R.F. (2009). *Principles of psychotherapy: Promoting evidence-based psychodynamic practice* (3rd ed.). NJ: Wiley.

Westen, D. (2007). Discovering what works in the community: Towards a genuine partnership of clinicians and researchers. In S.G. Hofmann & J. Weinberger (Eds.), *The art and science of psychotherapy* (pp. 3-29). New York, NY: Routledge.

Wogan, M., & Norcross, J. C. (1985). Dimensions of therapeutic skills and techniques: Empirical identification, therapist correlates, and predictive utility. *Psychotherapy: Theory, Research, Practice, Training, 22*(1), 63-74.

Wolberg, L.R. (1977). *The technique of psychotherapy* (3rd ed.). New York: Grune & Stratton.

Table 1. Clinical Principles on How to Address Patient Defenses In-Session

Defense Principles (Petraglia, Bhatia, and Drapeau, 2013)	Description of Petraglia, Bhatia, and Drapeau's (2013) Defense Principles	Bhatia and colleagues (2013) Principles for Interpreting Defenses
1. Considering the "Depth" of an Interpretation.	This principle is based on the idea that when therapists are interpreting patient material they are working to make the unconscious conscious (Freud, 1913). Defenses aim to protect patients from deeper, more troubling feelings, thoughts, and anxieties and therapists leave the interpretation of deeper material to later on in therapy and begin by focusing on that patient material which is readily accessible (Fenichel, 1945; Greenson, 1967; Langs, 1973; Wolberg, 1977).	Therapists should systematically move from "surface-to-depth" interpretations.
2. Intervene with Clients' most Prominent Defenses.	This principle suggests that therapists should address the patient's most prominent defenses, as they are most likely to involve repressed material. Scholars view most prominent as being patients' most characterological defenses and those that are "out of character" (Greenson, 1967; Langs, 1973).	Therapists should interpret the patients' most "typical" defenses and characterological defenses. Therapists should interpret the patients' most "atypical" and "out of character" defenses.
3. Interpretations should begin with Defenses used as Resistance.	This principle forms the basis of psychodynamic theory suggesting that that any action the patient exhibits that impedes the therapeutic process should be addressed before specific patient material is addressed (Gill & Hoffman, 1982; Gray, 1994; Greenson, 1967; Kaechele &Thomă, 1994; Langs, 1973; Reid, 1980; Weiner & Bornstein, 2009; Wolberg 1977).	Therapists should first interpret defenses used as resistance by the patient.
4. Attend to Defenses used both Inside and Outside of the Therapeutic Hour.	This principles indicates that therapists need to focus on external stressors occurring in the patient's life outside therapy (including defensive behaviours) in-session as they will impact the course of therapy (Vaillant, 1993) Other scholars (e.g., Gray, 1994) contend that the defensive behaviour occurring within the therapeutic relationship are the only defenses that therapists should focus their interpretive activity on.	Therapists should interpret defenses used inside the therapeutic hour. Therapists should interpret defenses used outside the therapeutic hour.
5. Consider the Timing of Interventions.	This principle is based on the idea that therapists need to always be mindful of when during the course of the therapy session (e.g., timing of intervention during the therapeutic hour) and in treatment overall (e.g., phase of therapy) to intervene with patient defenses (Langs, 1973; Reid, 1980).	Therapists should keep defense interpretations for the middle phase of therapy (not the beginning or end). Therapists should interpret defenses during the beginning of the therapeutic hour.
6. Consider the Affect Associated with the Defense when Appropriate.	This principle rests on the idea that the function of all defense mechanisms is to keep painful affects out of awareness. Therefore, when working with defenses, therapists are continually working to uncover the underlying affect patients are defending against (Chessick, 1974).	Therapists should understand the affect associated with the defense when making defense interpretations.
7. Consider the Degree of Emotional "Activation" Associated with the Defense.	This principle suggests that in some cases, patients will present defenses in an emotionally charged or "hot" manner. Some scholars argue that in these moments interpretations are ineffective due to the amount of emotionality the patient is experiencing (McWilliams, 1994). On the other hand, if defenses are exhibited in an emotionally detached or "cold" manner, interpretations will also be ineffective because patients lack enough anxiety for the interpretations to be useful for change (Lowenstein, 1951).	Therapists should interpret a defense when the patient uses it in an emotionally charged or "hot" manner. Therapists should *not* interpret a defense when a patient uses it in an emotionally charged and/or "hot" manner. Therapists should interpret a defense when a patient uses it in an emotionally "cold" manner. Therapists should *not* interpret a defense when a patient uses it in an emotionally "cold" manner.
8. Avoid using Technical Language in Interpretations.	This principle suggests that therapists should not use excessively technical language and psychological jargon when articulating defense interpretations to their patients as it can have an adverse impact on therapeutic process and outcome (Langs, 1973).	Therapists should avoid using technical language in defense interpretations.
9. Balance between Supportive and Interpretive Interventions.	This principle reminds therapists that interpreting defenses is not the only important technique therapists should use during treatment and that therapists need to provide supportive techniques that interpret feelings and situations especially when patients suffer greater psychological distress (McWilliams, 1994).	Therapists should balance between supportive and interpretive techniques when working with defenses.
10. Accurately Identify Defense Mechanisms used by Clients.	This principle indicates that therapists need to be accurate when interpreting patient defenses. Accurate interpretations are defined as therapists being able to correctly name the defense the patient is using (e.g., identifying rationalization when in fact, the patient is rationalizing), understand the purpose of the defense use and communicate this to the patient (Junod, de Roten, Martinez, Drapeau, & Despland, 2005; Petraglia, Perry, Janzen, & Olsen, 2009).	Therapists should accurately identify the defenses a patient uses in-session.

Table 2. Demographic Information

Variable	N	%
Gender		
Male	75	53.6
Female	63	45.0
Age		
<30	10	7.1
30-35	16	11.4
36-40	9	6.4
41-45	16	11.4
46-50	14	10.0
51-55	15	10.7
56-60	21	15.0
61-65	12	8.6
65+	27	19.3
License		
Counsellor	20	14.3
Psychiatrist	11	7.9
Psychologist	79	56.4
Social Worker	8	5.7
Non-licensed	9	6.4
Other	13	9.3
Highest Degree		
Ed.D.	4	2.9
D.Ps/Psy.D.	17	12.1
Masters	44	31.4
M.D.	10	7.1
Ph.D.	62	44.3
Did Not Report	3	2.1
Years Practicing		
<5	15	10.7
5-10	29	20.7
11-15	19	13.6
16-20	18	12.9
21-25	15	10.7
26-30	12	8.6
31+	31	22.1
Did Not Report	1	0.7

Table 3. Descriptive Statistics for Rating and Ranking of Clinical Principles

Principles for Interpreting Defenses	Mean Rating (SD)	Mean Rank (SD)	Mode Rank	Mode Rating
1. Therapists should systematically move from "surface-to-depth" interpretations when working with patient defenses.	4.1 (0.9)	4.1 (3.4)	1	4
2. Therapist should interpret the patients' most "typical" defenses and characterological defenses.	4.1 (0.8)	4.8 (2.9)	3	4
3. Therapists should first interpret defenses used as resistance by the patient.	3.8 (1.1)	5.0 (3.0)	4	4
4. Therapists should interpret defenses used inside the therapeutic hour.	4.3 (0.7)	5.0 (2.7)	4	5
5. Therapists should understand the affect associated with the defense when making defense interpretations.	4.0 (0.9)	5.7 (3.3)	2	4
6. Therapists should balance between supportive and interpretive techniques when working with defenses.	4.4 (0.7)	6.2 (4.0)	1	5
7. Therapists should avoid using technical language in defense interpretations.	4.5 (0.8)	6.3 (3.8)	1	5
8. Therapists should accurately identify the defenses a patient uses in-session.	4.0 (0.8)	6.9 (3.6)	12	4
9. Therapists should interpret defenses used outside the therapeutic hour.	3.9 (0.6)	8.4 (2.7)	9	4
10. Therapists should interpret the patients' most "atypical" and "out of character" defenses.	3.1 (0.9)	9.7 (3.9)	10	3
11. Therapists should keep defense interpretations for the middle phase of therapy (not the beginning or end).	2.7 (1.2)	10.8 (3.6)	11	2
12.Therapists should interpret defenses during the beginning of the therapeutic hour.	3.0 (1.0)	10.8 (3.4)	12	3
13. Therapists should interpret a defense when the patient uses it in an emotionally charged or "hot" manner.	3.2 (0.9)	11.6 (3.0)	13	3
14. Therapist should interpret a defense when a patient uses it in an emotionally "cold" manner.	2.9 (1.0)	12.4 (2.2)	13	3
15. Therapists should *not* interpret a defense when a patient uses it in an emotionally charged and/or "hot" manner.	3.3 (0.9)	13.7 (2.4)	15	3

CHAPTER 4:

TRANSITION TO PART II OF DISSERTATION- AN EMPIRICAL INVESTIGATION OF CLINICAL PRINCIPLES ON HOW TO INTERPRET DEFENSES

Part I of this dissertation focused on exploring practicing psychodynamic therapists' attitudes towards the importance of defense mechanisms in their clinical practice. Both survey manuscripts suggested that practicing psychodynamic therapists: 1) strongly agree with the importance of working with defenses in their own practice, and 2) agree with the clinical principles as outlined by Petraglia, Bhatia, and Drapeau (2013).

Chapter 2 provided initial evidence for discrepancies in attitudes between different theoretical models within psychodynamic theory. For example, significant differences emerged between therapists self-identifying as STDP and psychodynamic therapists on a number of items, including the importance of: therapists accurately identifying patient defenses; therapists supporting patients' adaptive/mature defense use; therapists adhering to the "surface-to-depth" principle; and the amount of time it takes for therapist techniques aimed at adaptive defense use to take effect. In chapter 2, possible explanations for these specific differences are discussed. Ultimately, these differences attest to the rich and varied theoretical models that exist within the psychodynamic perspective.

In Chapter 3, the second survey manuscript focused exclusively on the clinical principles as outlined by Petraglia, Bhatia, and Drapeau (2013) and found that therapists agree with the importance of these principles and that tentatively these principles can be categorized into three groups in terms of importance (high, middle, and low).

Together, these manuscripts provide support for the clinical utility of these principles; however, it is yet to be seen if these clinical and theoretical principles hold much weight empirically. Part II of the dissertation attempted to fill in the gaps in the literature that has examined techniques without the appropriate consideration of patient, therapist, and outcome variables (e.g., Beutler et al., 2004) by empirically investigating the relationship

between therapist defense interpretations of patient defenses in-session, patient defensive functioning, and the therapeutic alliance.

Specifically, Part II of the dissertation empirically examines two guidelines outlined by Petraglia, Bhatia, and Drapeau (2013) on how therapists should interpret defenses in-session. Chapter 5 outlines the third manuscript, *Is There a Relationship between Therapist Language Use, Patient Defensive Functioning and the Therapeutic Alliance?* This manuscript investigates the clinical principle that *therapists should avoid using technical language in interpretations* and aims to examine components of therapist verbosity in interpreting defenses (TVID) and its relationship with the therapeutic alliance, patient defensive functioning and symptomatic functioning.

Chapter 6 investigates the principle that *therapists should intervene with clients' most prominent defenses* in the fourth and final manuscript, titled *What Defense Mechanisms do Therapists Interpret In-Session?* This manuscript aimed to determine what patients' most prominent (i.e., characterological) and least prominent (i.e., "out of character") defenses are and whether therapists interpret patients most prominent or least prominent defense levels in-sessions.

These two principles were chosen for empirical investigation for numerous reasons. First, these manuscripts are part of a larger psychodynamic therapy process research program that plans to operationalize and empirically examine all the clinical principles outlined by Petraglia and colleagues (2013). Secondly, these two principles were chosen because they were appropriate to operationalize based on the sample that was utilized for the studies outlined in Part II of the dissertation. Finally, among clinicians surveyed in the second manuscript (Chapter 3), components of these two principles were ranked highly. The

principle that *therapists should avoid using technical language in interpretations* had the highest mean rating by participants who were asked to report their level of agreement with this principle (See Table 3 in Chapter 3). In their ranking of the most importance principles, this principle was ranked third highest by therapists.

Furthermore, the statement "therapist should interpret the patients' most "typical" defenses and characterological defenses" is a component of the clinical principle that *therapists should intervene with the patient's most prominent defense* (see Table 1 in Chapter 3) and this statement had the second highest mean rank in therapists rankings of the most important clinical principles (See Table 3 in Chapter 3) while the statement "therapists should interpret the patients' most "atypical" and "out of character" defenses". Empirical investigation of this discrepancy is warranted to determine if what therapists report as being important is actually what happens within the course of therapy. Overall, it is important to determine if these clinical principles are empirically relevant and related to key therapeutic processes and outcome.

CHAPTER 5:

AVOID USING TECHNICAL LANGUAGE IN INTERPRETATIONS

Running Head: THERAPIST VERBOSITY

Is There A Relationship between Therapist Language Use, Patient Defensive Functioning and the Therapeutic Alliance?

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Abstract

Interpretations are a key technique that separates psychodynamic therapy from many other treatment modalities (Etchegoyen 2005; Shedler, 2010). Research has explored elements of interpretations (e.g., accuracy, timing, depth) and their impact on various variables such as patient defensive functioning, the therapeutic alliance and treatment outcome. However, while there is universal agreement among psychodynamic scholars and clinicians (e.g., Chessick, 1974; Langs, 1973; Wolberg, 1977) that therapists should refrain from using psychological jargon and overly technical language when making interpretations, this question had not yet been investigated empirically. This study examined 32 psychotherapy sessions (15 high alliance and 17 low alliance) of 17 students in therapy at a university counselling center and aimed to examine the relationship between the therapists' verbosity when interpreting defenses, patient defensive functioning and the therapeutic alliance. Three components of therapist verbosity in interpretation of defenses (TVID) were explored: average length of interpretation, average word length per interpretation, and the total number of technical words in interpretations to determine their relationship to the therapeutic alliance and patient defensive functioning. Results indicated no significant differences between the different components of TVID and therapeutic alliance. However, average word length of therapist interpretation had a significant negative relationship with overall patient defensive functioning. Clinical implications of these results, and directions for future research are discussed.

Keywords: defense mechanisms, interpretation, therapist language, therapist technique, psychodynamic therapy, therapeutic alliance

Is There A Relationship between Therapist Language Use, Patient Defensive Functioning and the Therapeutic Alliance?

In order to be effective clinicians, therapists must understand what their patients are suffering from, and effectively communicate that understanding to their patients. This requires therapists to be able to listen, and express that understanding through verbal interactions; not only must the therapist understand the patient; the patient has to understand the therapist. This means that interventions must be phrased, formulated, and uttered in ways digestible for the patient and his or her level of capacity.

Perhaps no other therapy endeavour focuses on the therapist's verbal ability more than psychodynamic psychotherapy, given the central focus, and unique place that interpretations have within psychodynamic psychotherapy (Etchegoyen, 2005). In a survey of psychoanalysts' practices, Glover (1955) found "almost complete agreement" (p. 291) for avoiding the use of technical language when constructing interpretations. Chessick (1974) recommended that "interpretations should be realistic and in the clear, simple, and everyday language of the patient" (p. 209). Langs (1973) hypothesised that patients may become increasingly defensive if therapists use excessively technical language in their interpretations, as the conversation becomes increasingly heavy with "psychological jargon." Therefore, therapists need to be mindful to not collude with patients' defensive structure.

More recently, a systematic review of the psychodynamic literature examining recommendations on how therapists should effectively work with defenses, Petraglia, Bhatia and Drapeau (2013) found that an overarching guideline outlined by numerous scholars was that therapists should refrain from using excessively technical and/or excessively long interpretations when addressing patient defense mechanisms (Langs, 1973; Wolberg, 1977). These suggestions are in line with the research conducted by Sasche (1993) within a client-

centered model of psychotherapy that highlights the importance of the ways in which therapists verbally deliver their interventions in general, and within psychodynamic psychotherapy, the delivery of defense interpretations. Working within a client-centered psychotherapy framework, Sachse (1993) examined the phrasing of therapist interventions and its impact on the therapeutic process. He outlined many aspects of therapist language use that can have an impact on a patient's ability to process and integrate it. He discussed the *size of text* (the more words in an intervention, the more the patient has to process), *implicitness* (it becomes harder to process information if it is provided in an increasingly vague manner), *complexity as to contents* (the more complex the intervention, the harder it is to process), and *unclarity* (incomprehensible, too technical, or sharing content that is irrelevant). Sachse (1993) discovered that the way in which therapists formulate a verbal statement had an impact on the therapeutic process. Specifically, when therapists used brief, clear, and not overly complex words, there was a higher chance that patients would be able to process, comprehend, and integrate the words in a meaningful way.

Interpretations, Patient Defensive Functioning, and the Therapeutic Alliance

Research has shown that a key indicator of successful psychodynamic psychotherapy is when patients are using more adaptive defenses and less maladaptive defenses by the end of treatment (e.g., Ambresin, de Roten, Drapeau, & Despland, 2007; Bond & Perry, 2004; Drapeau, de Roten, Perry, & Despland, 2003; Hersoug, Sexton, & Hoglend, 2002; Roy, Perry, Luborsky, & Banon, 2009). As well, research indicates that improvement in patient defensive functioning is related to improved patient mental health years after treatment, reduced dropout rates, and successful outcome (e.g., Perry, 2001). For example, Perry and Bond (2012) found that changes in patients' overall defensive functioning (ODF) over the

first two and a half years of long-term psychoanalysis as measured by the Defense Mechanism Rating Scale (DMRS) predicted improvement in quality of life and symptoms in five year follow-ups.

Subsequently, an aim of effective psychodynamic therapy is to address patient defenses. Research has demonstrated that in psychodynamic therapy, therapist verbal interventions including interpretations, designed to focus on patient defenses are positively related to numerous therapeutic processes and patient outcome (e.g., Banon, Evan-Grenier, & Bond, 2001; Despland, Despars, de Roten, Stigler, & Perry, 2001; Hersoug, Bogwald, & Hoglend, 2005; Perry, 2001, Perry et al., 2008; Perry & Bond, 2012; Roy et al., 2009; Winston et al., 1993).

For example, Winston, Winston, Samstag, and Muran (1993) found that the use of therapist techniques, including interpretations, aimed at addressing patient defenses was correlated with less maladaptive defense use by the patient and improved treatment outcome.

Other research has demonstrated that addressing patient defenses can impact the therapeutic alliance as Foreman and Marmar (1985) found that therapeutic alliances improved in those therapeutic dyads were therapists frequently interpreted the patient's defensive feelings towards the therapist. Conversely, Banon, Evan-Grenier and Bond (2001) found that early transference interpretations had a negative impact on the therapeutic alliance. However, therapists who were able to effectively handle negative reactions following those interpretations (i.e., through the use of defense interpretations following transference interpretations) were able to salvage the alliance. This study had a small sample

and focused primarily on transference interpretations, yet it demonstrated that therapist interpretations and patient defensive functioning can impact the therapeutic alliance.

Additionally, Siefert and colleagues (2006) examined the relationship between the use of therapist defense interpretations, the therapeutic alliance, and defensive functioning in short-term psychodynamic psychotherapy. The authors found that therapist's use of both psychodynamic and cognitive interventions was influenced by the patient's level of defensive functioning and those patients who exhibited less adaptive defenses, received more psychodynamic interventions.

Current Study

As outlined above, numerous studies have examined the different components of therapist interpretations (e.g., frequency, accuracy) and their relationship to process variables in psychotherapy. Though the results of these studies are mixed, the studies provide support for the relationship between the therapeutic alliance, patient defensive functioning, and therapist interpretative activity.

Yet in spite of the fact that many authors agree on the importance of therapist interpretation of defenses, and therapist verbosity when making defense interpretations (Langs, 1973; Reid, 1980; Wolberg, 1977), to the best of our knowledge, there have been no empirical examinations of therapists' verbosity in interpretations of defenses (TVID) during psychodynamic psychotherapy, and its relationship to the therapeutic alliance, overall patient defensive functioning, and patient symptomatic functioning.

Therefore, this study focused on the identification of three components of TVID including: 1) the average word length of interpretations; 2) the average length of words in an interpretation; and 3) the number of "psychological-sounding" words which are "technically

complicated" found in therapist interpretations during the entire session. These three components of TVID were compared across different alliance sessions (e.g., high or low) for each therapist/patient dyad, and patient overall defensive functioning, to determine the relationship between the varying types of interpretations and the process of psychodynamic psychotherapy.

Method

Participants

The sample for this study was collected at the University of Lausanne, Switzerland (UNIL-EPFL) as part of a psychotherapy process study in psychodynamic psychotherapy that included 17 students between the ages of 18 and 30 years (M = 24.63, SD = 3.63), who received one to two sessions per week of manualised (Gilliéron, 1997) Short-Term Dynamic Psychotherapy (STDP), ranging from 8 to 40 sessions (M = 30.6 sessions, SD = 10.40).

Every participant was an outpatient in need of psychotherapy services and in order to participate in this study, patients needed to be at least 18 years of age and meet DSM-IV-TR criteria for a depressive, anxiety, or personality disorder. All therapy sessions (and subsequent ratings) were conducted in French.

Psychotherapists. Nine (6 male and 3 female) STDP clinicians with over ten years of experience in this theoretical model provided treatment to an average of two patients each. These psychotherapists also supervised trainees at the center for psychoanalytic psychotherapy (CEPP) at the UNIL-EPFL.

Measures. The measures for this study focused on key therapeutic variables: therapeutic alliance, patient defensive functioning, and therapist technique and therapist language.

Alliance. In order to rate alliance strength for individual therapy sessions, the Helping Alliance Questionnaire (HAq-I: Alexander & Luborsky, 1986) was utilized. The HA-q has shown acceptable levels of reliability and validity in comparison to other measures of alliance in psychotherapy research (Luborksy, 2000).

In our study, for each subject, high therapeutic alliance and low therapeutic alliance session were determined based on the individual subject's alliance score. If an individual HA-q score was one and half standard deviations above the mean alliance score for that individual patient then that was delineated as a high alliance session. Conversely, if an individual HA-q score was one and half standard deviations below the mean alliance score for that individual patient then that was marked as low alliance session.

Defense mechanisms. Defense mechanisms were assessed using the observer-rated Defense Mechanism Rating Scales (DMRS: Perry, 1990). The DMRS requires trained raters to rate 30 defenses based on a seven-level hierarchy. Numerous studies have provided evidence for the reliability and validity of the DMRS (e.g., Perry & Henry, 2004; Perry, Beck, Constantinides, & Foley, 2008; Perry & Hoglend, 1998; Perry & Kardos, 1995). There are three levels of scoring on the DMRS: a patient's *overall defensive functioning* (ODF), a patient's *defense level*, and a patient's *individual defense score*. For the purpose of this study, only the ODF scores were used for analysis. A patient's ODF is calculated by taking the weighted mean of each defense mechanism scored by level. The interrater reliability for the DMRS for the current study was based on a larger sample used by Kramer, Despland, Michel, Drapeau, and de Roten (2010) who examined roughly 20% of all transcripts [Intra-class correlation (ICC 2, 1)] and reported reliability on the ODF varied between .81 and .95 (M = .88; SD = .03).

Therapist interventions. In-session therapeutic interventions used by therapists were categorized using the Psychodynamic Intervention Rating Scale (PIRS: Cooper, Bond, Audet, Boss, & Csank, 2002) The PIRS consists of ten types of interventions along a continuum that can be clustered into two broad categories: interpretive interventions (defense interpretations, transference interpretations), and supportive interventions (clarifications, reflections, associations, support strategies, questions, contractual arrangements, work-enhancing strategies, acknowledgments). Defense and transference interpretations can additionally be organized into "levels" or depths of interpretation from one to five.

Raters are trained to examine written transcripts of psychotherapy sessions and categorize the verbal interventions therapists used according to the interventions listed above. Specifically with interpretive interventions, in addition to scoring them, raters also must specify the depth level of the interpretation. Interrater reliability is conducted on 20% of the sample and disagreements are resolved by means of a consensus meeting.

The PIRS was used in this study because it is a reliable measure of therapist interventions in psychodynamic psychotherapy (e.g., Drapeau et al., 2008; Milbrath et al., 1999) that has been utilized in numerous psychotherapy process studies (e.g., Junod et al., 2005; Drapeau et al., 2008; Hersoug, Bogwald, & Hoglend, 2003, 2005). In this study, only interpretive interventions (i.e., defense interpretations) were considered for analysis. For this sample, the mean intra-class correlation coefficients (ICC 2, 1) for all PIRS categories were .77 (range = .65-.94; also see Banon, Perry, Bond, Semeniuk, de Roten, Hersoug, & Despland, 2013).

Therapist verbosity in interpreting defenses. TVID was divided into three components: “average length of interpretation”, “average word length per interpretation”, and “number of technical words”.

First, the “average length of interpretation” was calculated by adding up the total number of words per therapist interpretation in the session and dividing this number by the total number of interpretations per session. “Average length of interpretation” was computed to explore whether longer or shorter interpretations had a relationship with patient defensive functioning in sessions with low and high alliance scores.

Second, adding the number of letters per word in an interpretation and dividing it by the total number of words in that interpretation calculated the “average word length” per interpretation. Then each average word length per interpretation was added up and the sum was divided by the total number of interpretations in the session. “Average word length” was calculated to explore whether patient defensive functioning was related to therapists’ use of smaller or larger words when making their interpretations in sessions with low and high alliance scores.

Finally, a “technically complicated” word was defined as any word that could be construed as a psychological construct (e.g., defense, cognition, affect, interpersonal conflict, unconscious), which can be found in a standard psychology dictionary. A trained research assistant and a graduate student reviewed all the transcripts and highlighted these words in the interpretations and searched them in Corsini’s (2002) *Dictionary of Psychology* to determine if the word was considered a psychology term. Interrater reliability was conducted on 10% of the sample and led to high level of agreement with a mean Kappa = 0.94.

In total, 32 transcribed transcripts rated for the PIRS, DMRS, and the HA-q were included for analysis. Of those 32 sessions, a total of 15 were identified as low alliance sessions, and 17 were identified as high alliance sessions. Two sessions were not included because the transcripts were not available for transcription and data analysis. Paired *t*-tests and Pearson correlations were used to examine the data.

Results

TVID and Alliance

Average Length of Interpretation

Paired *t*-tests were used to compare the average length of interpretations in sessions between low and high alliance scores. No significant differences were found when comparing the average length of interpretations for sessions with low alliance ($M = 53.6$, $SD = 31.19$) and high alliance ($M = 42.91$, $SD = 15.49$) scores, $t\ (14) = 1.31$, $p = .21$.

Average Length of Words

Paired *t*-tests were used to compare the average word length per interpretation per session in high and low alliance groups. No significant differences were found when comparing the average word length per interpretation for sessions with low alliance scores ($M = 4.3$, $SD = 0.27$) and sessions with high alliance scores ($M = 4.39$, $SD = 0.22$) conditions; $t\ (14) = 1.11$, $p = .28$.

Use of Technically Complicated Language

Paired *t*-tests were conducted to compare the number of technically complicated words per session with high and low alliance groups. No significant differences were found when comparing the total number of technical words used in interpretations for sessions

with low alliance (M = 5.5, SD = 6.43) and high alliance (M = 5.5, SD = 4.03) scores; t (14) = 0.38, p = .71.

TVID and Patient Overall Defensive Functioning (ODF)

Average Length of Interpretation

Pearson correlation coefficients showed no significant correlation between average length of interpretation and overall defensive functioning, in sessions with low alliance scores, r = 0.15, p = .59 and sessions with high alliance scores, r = -0.23, p = .33.

Average Length of Words in Interpretation

Pearson correlation coefficients showed a significant negative correlation between the average length of words per interpretation and ODF in sessions with low alliance scores, r = -0.41, p = .02 but no significant correlation between average word length per interpretation and ODF, r = -0.68, p = .08 in sessions with high alliance scores.

Use of Technically Complicated Language in Interpretation

Pearson correlations also showed no significant correlation between the total number of technical words and ODF in sessions with low alliance scores, r = -0.99, p = .73 and in sessions with high alliance scores, r = -0.31, p = .22.

Discussion

This study explored the relationship between therapist verbosity in the interpretation of defenses (TVID) and its relationship with the therapeutic alliance, and overall patient defensive functioning. The results showed that there were no differences in all three components of TVID in sessions with low and high alliance scores. As well, there existed no relationship between two components of TVID (i.e., average length of interpretation and number of technical words) and overall patient defensive functioning in sessions with low

and high alliance scores. However, there was a significant negative relationship between one component of TVID-therapists' use of longer words in their interpretations and patient ODF scores in sessions with low alliance scores.

This preliminary finding is important given the research that has found a relationship between overall defensive functioning, therapy process, and successful treatment outcome (e.g., Hersoug, Bogwald, & Hoglend, 2005; Perry, 2001; Perry et al., 2008; Perry & Bond, 2012; Roy et al., 2009; Winston et al., 1993). As well, within treatment, patient ODF has been shown to predict treatment dropout as Perry (2001) found that patients utilizing more adaptive defenses remained in treatment over the course of one year versus those patients who used more maladaptive defenses.

Though the results of this study are too preliminary to indicate such a relationship exists here, it is conceivable that future research may determine that TVID is a contributing variable- among other therapist and patient variables- in whether patients remain or drop out of treatment. Additionally, TVID may play a role in facilitating the shift from patients using less adaptive to more adaptive defense in-session, which in turn is related to treatment outcome. As such, it may be the case that TVID needs to be considered as a variable in the implementation of effective treatment both from a process level, and from an outcome level.

This study partially supports Chessick's (1974) assertion that interpretations need to be stated in concise and layperson language. As well, Sachse (1993) suggests that for therapists to have a positive impact on the therapeutic process, and to connect with their patients, interventions need to be short so that patients are able to process them more easily as this requires less cognitive capacity. He found that therapist statements which are brief and clear, and that contain words of "medium complexity" are those that are easily

processed by patients. This might help explain in our study why the use of longer words by therapists in their defense interpretations was negatively related to patient defensive functioning. Perhaps longer words are more challenging to process for patients, and in turn this can negatively influence their functioning in-session.

The ability for patients to process challenging words raises an important consideration about the level of education of the patients. Despite being university students and having a high level of education, therapists' use of longer words in their defense interpretations negatively affected their in-session functioning. Replicating this study with a population that varies with respect to level of education (e.g., patients with lower levels of education) and symptomatic functioning (e.g., more severe psychopathology) with a larger sample size (sample size for this study was small with only 17 therapist/patient dyads and 32 sessions being investigated) would allow for a greater generalizability of results.

Additionally, Langs (1973) hypothesized that patients would become increasingly defensive if therapists used overly technical language in their interpretations. He believed that the more verbose interpretations therapists made would lead to a greater use of intellectual defenses by patients. This may have been the case in our study. However, our study did not specifically examine the different defense levels and defenses patients used as we focused primarily on overall defensive functioning to gather a global view on defensive change. As well, the use of correlational analysis prevented us from determining the causality of this relationship. It is possible that patients with certain ODF levels or other patient characteristics (e.g., quality of object relations, different defense clusters, symptom severity) react differently to therapist interpretations of varying word length. Therefore, it

would be important to also examine the relationship between TVID and other variables including patient characteristics.

Our findings indicate that longer words- but not longer interpretations and number of technical words- in TVID were negatively correlated with patient ODF in sessions with low alliance scores. These findings raise important questions about what it means to be overly technical or verbose. A better understanding of what psychodynamic theorists mean when they recommend against the use of "verbose" interpretations is needed. It may mean that longer words are more verbose than shorter ones or that verbosity means using more words or both using more and longer words.

Our study found no relationship between the number of technical words in TVID and both patient ODF and the therapeutic alliance. This may have been the case for two reasons. First, in this study, any word that could be found in *The Dictionary of Psychology* (Corsini, 2002) was categorized as a "technically complicated" word. This may have been too general of a categorization as certain words (e.g., stress, anxiety) are words that are psychological but are often used in everyday language. The consequence then is we may have been too liberal in our definition of technical language, which may have potentially influenced the clinical significance of technical language and its relationship with patient functioning. In future studies, a more stringent definition of technical language might yield discernable differences in a clinically relevant manner.

Secondly, there was an assumption that being overly technical is related to, or impacted by, the overuse of psychological words that are "technically complicated". The findings in our study indicate that a therapist can be overly technical and communicate jargon-laden interpretations without using psychological words that are "technically

complicated". Therapists can also use psychological words without being overly technical. Future research should look to examine the conditions that make therapist interpretations too technical, if the use of psychological words by therapists plays a role, and if these conditions are related to patient defensive functioning and the therapeutic alliance.

A key component of therapist technique is the idea that what is important may not be *what* the therapist says but rather *how* the therapist says it. This study did not analyze the tone of voice the therapists used or their voice inflection as well as non-verbal communication when they verbalized their interpretations. For example, it could have been the case that some therapists were warm, attentive, and engaging, while others may have provided their interpretations in a detached, cold, and unempathetic manner. These variables may play a crucial role in how patients perceive the therapist's interventions more than perhaps the words themselves (Wachtel, 2011) and warrant investigation when assessing TVID in subsequent studies.

As well, given that therapists in our sample saw multiple patients, it is possible that our results were in part influenced by individual therapists' linguistic style, therefore future research would benefit from examining therapist variables and its relationship to TVID. The study had individual therapists treating multiple patients, and given the data available to us we were not able to assess for therapist effects and their relationship to the results of the analyses. In addition, given the nature of the sample (i.e., small and university sample) removing these therapists would have severely limited our ability to carry out exploratory analyses. This is a limitation that would need to be addressed both from a methodological and clinical perspective in future research.

Moreover, other clinical principles outlined by Petraglia, Bhatia, and Drapeau (2013) such as the timing, accuracy, and depth of the interpretation could be examined in conjunction with TVID. Research on therapist timing and accuracy of defense interpretations has been linked to patient defensive functioning, therapy process, and outcome (e.g., Despland, de Roten, Despars, Stigler, & Perry, 2001). Examining TVID within the context of these other elements may provide a more detailed understanding of the relationship between therapist verbosity in interpretations and therapist technical activity in-session. As well, research could look to determine if specific technical guidelines are more important than others (e.g., accuracy is more important than TVID or vice versa) when it comes to their relationship with patient functioning, therapy process, and outcome.

Conclusion

Overall, this study found initial evidence for the relationship between a specific component of therapist verbosity in interpreting defenses (TVID) and patient defensive functioning in sessions with low alliance scores. This finding, though preliminary, provides partial support for the widely-held view in psychodynamic therapy that therapists should avoid technical language when making defense interpretations (Chessick, 1974; Glover, 1955; Langs, 1973). Further research is needed to corroborate these findings, and more research efforts are needed to understand the role of therapist verbosity in interpreting defenses and its relationship to both therapy process and outcome so that it can inform better practices for clinicians.

References

Alexander, L.B., & Luborsky, L. (1986). The Pen helping alliance scales. In L.S. Greenberg &W.M. Pinsof. (Eds.), *The psychotherapeutic process: A research handbook* (pp. 325-366). New York: Guilford Press.

Ambresin, G., de Roten, Y., Drapeau, M., & Despland, J.N. (2007). Early change in maladaptive defense style and development of the therapeutic alliance. *Clinical Psychology and Psychotherapy, 14,* 89-95.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders,* (4th ed.). Washington: American Psychiatric Association.

Banon E., Perry J.C., Bond M., Semeniuk T., de Roten Y., Hersoug A.G., & Despland J.N. (2013). Therapist interventions using the Psychodynamic Interventions Rating Scale (PIRS) in dynamic therapy, psychoanalysis and CBT. *Psychotherapy Research*, 1-16.

Banon, E., Evan-Grenier, M., & Bond, M. (2001). Early transference interventions with male patients in psychotherapy. *Journal of Psychotherapy Practice & Research, 10,* 79-92.

Bond, M., & Perry, J.C. (2004). Long-term changes in defense styles with psychodynamic psychotherapy for depressive, anxiety, and personality disorders. *American Journal of Psychiatry, 161,* 1665-1671.

Chessick. R. D. (1974). *The technique and practice of intensive psychotherapy.* New York: Aronson.

Cooper, S., Bond, M., Audet, C., Boss, K., & Csank, P. (2002). *The Psychodynamic Intervention Rating Scale – 4th edition*. Manual: McGill University.

Corsini, R. (2002). The Dictionary of Psychology. New York: Brunner-Routledge.

Derogatis, L.R. (1994). *Symptom Checklist-90-Revised: Administration scoring and procedures manual (3rd ed.)*. Minneapolis, MN: National Computers Systems.

Despland, J.N., de Roten, Y., Despars, J., Stigler, M., & Perry, J.C. (2001). Contribution of patient defense mechanisms and therapist interventions to the development of early therapeutic alliance in a brief psychodynamic investigation. *The Journal of Psychotherapy Practice and Research, 10,* 155-164.

Drapeau, M.de Roten, Y., Beretta, V., Blake E., Koerner, A., & Despland, J.N. (2008). Therapist technique and patient defensive functioning in ultra-brief psychodynamic psychotherapy: A LAG sequential analysis. *Clinical Psychology and Psychotherapy, 15,* 247-255.

Drapeau, M., de Roten, Y., Perry, J.C., & Despland, J.N. (2003). A study of stability and change in defense mechanisms during a brief psychodynamic investigation. *The Journal of Nervous and Mental Disease, 191,* 496-502.

Etchegoyen, R. H. (2005). *Fundamentals of psychoanalytic technique.* London: Karnac.

Fenichel, O. (1941). *Problems of psychoanalytic technique.* New York: Psychoanalytic Quarterly Inc.

Fenichel, O. (1946). *The psychoanalytic theory of neurosis.* London: Taylor-Francis.

Foreman, S.A. & Marmar, C.R. (1985). Therapist actions that address initially poor therapeutic alliances in psychotherapy. *American Journal of Psychiatry, 142,* 922-926.

Gilliéron, E. (1997). *Manuel de psychothérapies brèves*. Paris: Dunod.

Glover, E. (1955). *The technique of psycho-analysis.* New York: International

Universities Press.

Hersoug, A.G., Bogwald, K.P., & Hoglend, P. (2003). Are patient and therapist characteristics associated with the use of defense interpretations in brief dynamic psychotherapy? *Clinical Psychology and Psychotherapy, 10,* 209-219.

Hersoug, A.G., Bogwald, K.P., & Hoglend, P. (2005). Changes of defensive functioning: Does interpretation predict change? *Clinical Psychology and Psychotherapy, 12,* 288-296.

Hersoug, A.G., Sexton, H., & Hoglend, P. (2002). Contribution of defensive functioning to the quality of working alliance and psychotherapy outcome. *American Journal of Psychotherapy, 56,* 539-554.

Hoglend, P. & Perry, J.C. (1998). Defensive functioning predicts improvement in major depressive episodes. *Journal of Nervous and Mental Disease, 186,* 238-243.

Junod, O., de Roten, Y., Martinez, E., Drapeau, M. & Despland, J.N. (2005). How to address patients' defenses: A pilot study of the accuracy of defence interpretation and alliance. *Psychology and Psychotherapy: Theory, Research, and Practice, 78,* 419-430.

Kramer U., Despland J.-N., Michel L., Drapeau M., & de Roten Y. (2010). Change in Defense Mechanisms and Coping over the Course of Short-Term Dynamic Psychotherapy for Adjustment Disorder. *Journal of Clinical Psychology, 66,* 1232-1241.

Langs, R. (1973). *The technique of psychoanalytic psychotherapy: Vol.1.* New York: Aronson.

Luborsky, L. (2000) .A pattern-setting therapeutic alliance study revisited. *Psychotherapy Research: Theory, Research and Practice, 10,* 17–29.

Milbrath, C., Bond, M., Cooper, S., Znoj, H.J., Horowitz, M., & Perry, J.C. (1999). Sequential consequences of therapist's interventions. *Journal of Psychotherapy Practice and Research, 8,* 40-53.

Perry, J.C. (2001). A pilot study of defenses in adults with personality disorders. *Journal of Nervous and Mental Disease, 10*, 651-660.

Perry, J.C., Beck, S.M., Constantinides, P., & Foley J.E. (2008). Studying change in defensive functioning in psychotherapy using the Defense Mechanism Rating Scales: Four hypotheses, four cases. In R.A. Levy, & J.S. Ablon (Eds.), *Handbook of evidence-based psychodynamic psychotherapy* (pp.121-153). New York: Human Press.

Perry, J.C. (1990). *The Defense Mechanism Rating Scales,* (5th ed.). Cambridge, MA: auteur.

Perry, J.C. & Henry, M. (2004). Studying defense mechanisms in psychotherapy using the Defense Mechanism Rating Scales. In U. Hentschel, G. Smith, J.G. Draguns, & W. Ehlers. (Eds.), *Advances in psychology, 136: Defense mechanisms: Theoretical, research and clinical perspectives* (pp.165-192). New York: Elsevier.

Petraglia, J., Bhatia, M., & Drapeau, M. (2013) Ten principles to guide psychodynamic technique with defense mechanisms: An examination of theory, research, and clinical implications. *Manuscript submitted for publication.*

Reid, W.H. (1980). *Basic intensive psychotherapy.* New York: Brunner Mazel.

Roy, C.A., Perry, J.C., Luborsky, L., & Banon, E. (2009). Changes in defensive

functioning in completed psychoanalysis: The Penn psychoanalytic treatment collection. *Journal of the American Psychoanalytic Association, 57,* 399-415.

Sachse, R. (1993). The effects of intervention phrasing on therapist-client communication. *Psychotherapy Research, 3*(4), 260-277.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65,* 98-109.

Siefert, C.J., Hilsenroth, M.J., Weinberger, J., Blagys, M.D. & Akerman, S.J. (2006). The relationship of patient functioning and alliance with therapist technique during short-term psychodynamic psychotherapy. *Clinical Psychology and Psychotherapy, 13,* 20-33.

Vaillant, G. E. (1993). *The wisdom of the ego.* Cambridge: Harvard University Press.

Vaillant, G.E., Bond, M., & Vaillant, C.O. (1986). An empirically validated hierarchy of defense mechanisms. *Archives of General Psychiatry, 43,* 786-794.

Wachtel, P.L. (2011). *Therapeutic Communication: Knowing What to Say When.* New York: The Guilford Press.

Winston, B., Winston, A., Samstag, L.W., & Muran, J.C. (1993). Patient defense/therapist interventions. *Psychotherapy, 31,* 478-491.

Wolberg, L.R. (1977). *The technique of psychotherapy* (3rd ed.). New York: Grune & Stratton.

Table 1. Means and Standard Deviation for Therapist Verbosity in Interpreting Defenses (TVID)

Category	Mean	Standard Deviation
Average length of interpretation		
Overall (N=32)	49.98	26.59
Low Alliance (N=15)	53.60	31.19
High Alliance (N=17)	47.40	23.48
Average length of word per interpretation		
Overall (N=32)	4.32	0.24
Low Alliance (N=15)	4.30	0.27
High Alliance (N=17)	4.34	0.22
Total number of technical words		
Overall (N=32)	5.17	5.03
Low Alliance (N=15)	5.50	6.43
High Alliance (N=17)	4.94	3.97

CHAPTER 6:

CHALLENGING PATIENTS' MOST PROMINENT DEFENSES

Running Head: INTERPRETING DEFENSES

What Defense Mechanisms do Therapists Interpret In-Session?

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Abstract

One of the key technical guidelines outlined by psychodynamic theorists and clinicians is for therapists to interpret a patient's most prominent defenses (Greenson, 1967; Langs, 1973). However, a debate exists about what constitutes a patient's most prominent defense and which defenses therapists choose to interpret in-session. This study aimed to shed light on this debate by examining 35 psychotherapy sessions (18 high alliance and 17 low alliance) of individuals in therapy at a university counselling center. The analysis focused on comparing the patients' most prominent defenses and the range of defenses they utilized, and the therapists' most prominent interpretation level as well as the range of interpretation level. Paired sample *t*-tests showed no significant mean difference between sessions with low and high alliance scores in patient defense levels (e.g., frequency and range) and therapist interpretation levels (e.g., frequency and range). Significant differences were found between the range of patient defense levels and the range of therapist interpretation levels. Correlational analyses showed no significant relationship between patient defense levels and therapist interpretation levels on both the frequency and range levels. Clinical implications of these results, and directions for future research are discussed.

Keywords: defense mechanisms, interpretation, therapist language, therapist technique, psychodynamic therapy

What Defense Mechanisms do Therapists Interpret In-Session?

Interpreting defenses is a hallmark of all psychodynamic therapeutic models (Etchegoyen, 2005). Interpretations can be defined as verbal interventions through which the therapist brings to the patient's awareness and consciousness, ideas, thoughts, behaviours, wishes or any material that was previously unconscious in a meaningful and affective way (Langs, 1973). It is assumed by clinicians and researchers that an effective interpretation is one that accurately addresses patient conflicts. Research has supported this intuitive truism. For example, Silberschatz, Fretter and Curtis (1986) examined the agreement between three patient and therapist dyads in regards to treatment planning and they discovered that transference interpretations that were in line with the patients' case formulations led to the best outcomes. Similarly, Crits-Christoph, Cooper and Luborsky (1988) examined the relationship between accuracy of interpreting a patient's wish and response to others of 43 patients in dynamically oriented therapy and found that the accuracy of these interpretations was significantly related to therapy outcome.

Within the context of interpretation of defenses, therapist accuracy can be defined as the ability of therapists to correctly address the defenses used by patients (Junod, de Roten, Martinez, Drapeau, & Despland, 2005). Research exploring therapist accuracy in interpreting defenses has been limited in part due to the challenge in effectively operationalizing and measuring the concept of therapist accuracy. In addition, while therapist accuracy of patient defenses is a crucial component of therapy, scholars have argued that there is more to therapists addressing defenses than accuracy.

For example, some researchers have proposed that not only do therapists need to be accurate in their interpretations, they also need to be able to optimally adjust their

interpretation to the patient's level of defensive functioning (Despland, de Roten, Despars, Stigler, & Perry, 2001). Defensive functioning is predicated on the notion that patient defenses can be categorized on a hierarchy. Specifically, Vaillant (1976, 1983) hypothesized that defense mechanisms exist on a hierarchy in which lower or immature defenses are qualitatively different from higher order, mature or adaptive defenses. In order to test his hypotheses, Vaillant (1976, 1983) followed a group of inner-city men who were either of middle or lower class from college into late adulthood to determine if and how, their use of defense mechanisms changed, as they grew older. Vaillant (1976, 1983) discovered that as men grew older they began to use less immature defenses, and utilize more mature defenses when faced with stressful situations. Furthermore, Vaillant (1976, 1993) found that the continued use of immature defenses led to men facing more emotional, interpersonal, and behavioural difficulties. Based on this research, a hierarchy of defenses (Vaillant, Bond, & Vaillant, 1986) was created which placed defense mechanisms on a continuum based on three unique groups: immature, neurotic or mid-level, and adaptive or mature.

Others (Andrews, Pollack, & Stewart, 1989; Bond et al., 1983; Perry & Cooper, 1989; Soldz & Vaillant, 1998; Vaillant, 1993; Vaillant et al., 1986) have provided research support for Vaillant's conceptualization of a hierarchy of defenses due to an individual's level of maturity. Additionally, research has demonstrated that when patients move from using maladaptive (immature) to adaptive (mature) defenses this is related to positive therapy process, patient outcome, and long-term personality and psychological change (e.g., Roy et al., 2009).

In order to examine whether therapists adjust their interpretations to patients defense levels, Despland and colleagues (2001) tabulated 'therapist adjustment' by first using the

Defense Mechanisms Rating Scale (DMRS: Perry, 1990) and calculating the patient overall defensive functioning (ODF) from one to seven (the DMRS is based on a hierarchy of defense maturity from one to seven). Second, they assessed therapist interventions using the Psychodynamic Intervention Rating Scale (Cooper & Bond, 1992), rank-ordering interventions on an Expressive Supportive Intervention Level (ESIL) continuum from one to seven (see Gabbard, 2000). An adjustment ratio was calculated by dividing ESIL by ODF. Therefore, an adjustment score of 1 meant that the therapist accurately adjusted his intervention to the patient's ODF. The authors found that: 1) therapists did adjust their interventions between supportive and interpretive depending on patient defensive functioning, with interpretive techniques being used for mature defenses and supportive techniques being used for immature defenses, and 2) higher adjustment was related to positively to therapeutic alliance.

However, research efforts based on Despland and colleagues' (2001) conceptualization of adjustment have led to mixed results. For example, Siefert, Hilsenroth, Weinberger, Blagys, and Ackerman (2006) provided support for the notion that patient defensive functioning influenced the type of intervention therapists would utilize in treatment (i.e., adjusting between supportive and interpretive). Yet contrary to Despland and colleagues (2001), research by Hersoug, Hoglend, and Bogwald (2004) found that in some insistences low adjustment ratios were correlated with a stronger alliance score as patients who exhibited more mature defenses were provided support strategies resulting in better alliances.

Alternatively, when examining the concept of therapist adjustment within the context of the therapeutic alliance, Junod and colleagues (2005) found that accuracy was related

negatively with alliance, in that, low alliance dyad sessions were filled poor accuracy scores and high alliance dyad sessions had stronger accuracy scores.

Additionally, Petraglia, Perry, Janzen, and Olsen (2009) used a different methodology to tackle therapist adjustment. Using the DMRS, Petraglia and colleagues (2009) rated the three defenses prior to an interpretation (rated with the Psychodynamic Intervention Rating Scale: Cooper, Bond, Audet, Boss, & Csank, 2002) and the three defenses post interpretation. The authors found that therapists interpreting mature defenses resulted in an increase in patients' defensive maturity following the therapist interpretation.

Despite all of these studies, there still does not exist a clear understanding of the characteristics of the actual interpretations (e.g., depth, timing, content), and there is a lack of exploration of what patient defensive material therapists actually target in-session. Specifically, there is a dearth of research examining how therapists choose to intervene with their patients' defenses during psychotherapy sessions and what exactly constitutes the "most prominent defenses" of a patient. Based on theory, it is thus not clear if prominent refers to the most frequent or common defenses patients' use (characterological defenses), or whether the most prominent defenses are those that are "out of character" (i.e., atypically immature or mature) and infrequently used (Greenson, 1967; Langs, 1973). Characterological defenses are those defenses that patients use regularly and that fit into their typical defensive profile. For example, patients who use defenses in the neurotic level will typically display defenses such as Intellectualization, Isolation of Affect or Undoing. These defenses are ingrained as part of their personality and character. It would be less likely for these patients to use action defenses such as Acting Out or Passive-Aggression

regularly. In the event patients use these defenses, they would be deemed "out of character" and not consistent with their usual neurotic defensive functioning.

Greenson (1967) and Langs (1973) both suggest that therapists should focus their efforts to confronting defenses that appear to be most related to the patient's current distress, presenting problems, and/or any impairments to overall psychological functioning. This involves therapists addressing both characterological and out of character defenses.

In order to provide preliminary empirical information on the concept of characterological and out of character defenses, patient defenses and therapist interpretation of defenses were analysed to determine a) the most frequent, most atypically immature and mature defense levels patients exhibited; b) which of these levels therapists were interpreting most; and c) if this interaction was different in sessions with low and high alliance scores.

Method

Participants

This study consisted of 19 students (12 male, 7 female) attending a large university in Switzerland. The sample was 63% female and 37% male. Students ranged in age from 18 to 30 years (M = 24.63, SD = 3.46) and received between eight and forty sessions (M = 30.6 SD = 10.40) of short- term dynamic therapy (STDP: Gilliéron, 1997). All therapy sessions were conducted in French.

Psychotherapists

Psychotherapists in our sample consisted of nine (6 male and 3 female) clinicians with more than ten years of experience working within the STDP model. Psychotherapists in this study provided treatment to an average of two patients each.

Measures

The measures for this study focused on key therapeutic variables: the therapeutic alliance, patient defensive functioning, and therapist interpretation of defenses.

Alliance. The Helping Alliance Questionnaire (HAq-I: Alexander & Luborsky, 1986) was used to rate alliance strength for individual therapy sessions. The HA-q has shown adequate levels of convergent validity with other self-rated measures of alliance in psychotherapy research (Luborsky, 2000).

In this study, sessions with high alliance scores and sessions with low alliance scores were determined based on the individual patient's alliance score. High alliance sessions were defined as a HA-q score one and half standard deviations above the mean alliance score for that individual, while a low alliance session was defined as a HA-q score one and a half standard deviations below the subject's mean alliance.

Defense mechanisms. The Defense Mechanism Rating Scale (DMRS; Perry, 1990) was utilized to measure defenses in our study. The observer- rated DMRS requires trained raters to rate 30 defenses based on a seven-level hierarchy that ranges from adaptive/mature to maladaptive/immature. Scoring on the DMRS occurs on three different levels: a patient's ODF, a patient's *defense level*, and a patient's *individual defense score*. This study focused only on the patient's defense level (Table 1 provides a visual representation of patient defense levels as operationalized in the DMRS).

The DMRS has strong reliability (Perry & Henry, 2004; Perry & Hoglend, 1998; Perry & Kardos, 1995), clinical validity (Perry, Beck, Constantinides, & Foley, 2008) and predictive validity (e.g., Hoglend & Perry, 1998). Interrater reliability of the DMRS for the current study was conducted on approximately 20% of all transcripts used in a larger study

by Kramer, Despland, Michel, Drapeau and de Roten (2010) [intra-class correlations (ICC 2, 1)] with reliability for the defense levels varying between .76 and .98 (M = .90; SD = .08).

Therapist interventions. The Psychodynamic Intervention Rating Scale (PIRS: Cooper, Bond, Audet, Boss, & Csank, 2002) is a categorical rating scale that groups the in-session activities and techniques of therapists (e.g., questions, interpretations, etc.) into two broad categories: interpretive interventions (which include defense interpretations and transference interpretations), and supportive interventions (which include clarifications, reflections, associations, support strategies, questions, contractual arrangements, work-enhancing strategies, acknowledgments). Interpretive interventions (transference and defense) can be further categorized from one to five depending on the depth of the interpretation.

The PIRS has been used in widely in the psychotherapy research and studies have demonstrated that the PIRS is a reliable (Drapeau et al., 2008; Milbrath et al., 1999) and valid (Hersoug, Bogwald, & Hoglend, 2005) measure of therapist interventions. As a result, the PIRS serves as an acceptable measure of psychodynamic technique for this study. For this sample, the mean intra-class correlation coefficient (ICC 2, 1) for all PIRS categories was .77 (range = .65-.94) (for details see Banon et al., 2013).

Operationalization of Prominent Defenses and Therapist Interpretation

Using the procedures outlined in Junod and colleagues (2005), patients' defense levels and therapists' interpretation levels were operationalized. As outlined above, the PIRS was used to rate the type of interventions (e.g., supportive or interpretive) therapists were using. Then, the DMRS was used to rate each defense interpretation to determine which defenses the therapist interpreted in order to determine the corresponding defense level (as

outlined in Table 1). Intra-class correlation (2,1) was used to assess for inter-rater reliability in defining therapist interpretation levels with the ICC being 0.78. In total, patient defense levels and therapist interpretation levels were separated into four categories: the most frequent, the most atypical mature, the most atypical immature and the range. The most frequent level was used as a proxy for patients' "characterological" defenses and the most atypical mature and most atypical immature defense level represented patients' "out of character" defenses. An atypical immature defense is a defense a patient uses infrequently and is assumed to be problematic and maladaptive (i.e., if a patient begins to act out or becomes passive-aggressive). An atypical mature defense is a defense that is also used infrequently but represents adaptive defensive functioning. For example, a patient may start to use the defense *suppression* to deal with anger rather than the defense of *acting out*. Subsequently, both defenses cover the extreme of infrequent defense use by patients (maladaptive and adaptive) and the range of defense level captures this.

Patient Most Frequent Defense Level. Each defense level of the specific defenses patients used in-session was recorded and the mode level was labeled "most frequent" defense level. For example, if a patient exhibited a total of 40 defenses in a session, of which 25 were Level 5 defenses, then Level 5 would constitute that patient's "most frequent" defense level (see Table 1).

It is important to note that patients' most frequent defense level was explored rather than patients' ODF because ODF provides a mean score of patients' total defense usage over an entire session. As a result, this score is limited in terms of its clinical usefulness. For example, if a patient has an ODF of 3.5 but the defenses the patient used are all Level 1's and Level 5's, the ODF does not capture the actual defensive levels the patient is functioning

at. In this particular case, the patient is not using disavowal (Level 3) defenses, as the ODF score would suggest this. Examining the patient's most frequent defense level provides a potentially more accurate indicator of the actual defense level the patient is functioning at.

Patient Most Atypical Mature Defense Level. For each patient, the highest (most mature) defense level they expressed which had the lowest number of defenses was labeled as the patient's "most mature" defense level. For example, if a patient had one Level 7 defense, then the Level 7 would constitute the patient's "most atypical mature" defense level. If there was an equal number of defenses between two defense levels (i.e., one Level 6 and one Level 7 defense) then the higher defense level (Level 7) was considered the patient's "most atypical mature" defense level.

Patient Most Atypical Immature Defense Level. For each patient, the lowest (most immature) defense level which occurred least frequently was labeled as the patient's "most atypical immature" defense level. For example, if a patient used one Level 1 defense, three Level 2 defenses, and two Level 3 defenses then Level 1 would be the patient's "most atypical immature" defense level.

Range of Patient Defense Level. Subtracting the "most mature" defense level from the "most immature" defense level provided the range of defenses that patients used during a psychotherapy session (see Table 1). For example, if the "most immature" defense the patient exhibited was a Level 2 defense (e.g., Acting Out) and the "most mature" defense the patient exhibited was a Level 7 defense (e.g., Humor), the theoretical range of defenses the patient exhibited would be 5 (7-2 = 5). This provides a sense of the range within which the patient is operating defensively.

Therapist Interpretation Level. For therapist activity, each therapist defense interpretation rated using the PIRS was then assessed to determine which specific defense it intended to address and the corresponding defense level. For example, if the therapist interpreted the patient's intellectualization (i.e., Level 6 defense), then the therapist interpretation level would be classified as a Level 6. If in total, the therapist made 9 interpretations in the session, and 5 of those interpretations were addressing Level 6 defenses, then the "most frequent" interpretation level in that session would be Level 6. Additionally, the highest defense level the therapist interpreted was classified as the "most mature" interpretation level (e.g., Level 7 defense interpretation), and the lowest defense level the therapist interpreted was classified as the "most immature" interpretation level (e.g., Level 1 defense interpretation).

Range of Therapist Interpretation Level. The "range" of therapist interpretation level was calculated using the same method as the range of patient defenses above. The "most immature" interpretation level was subtracted from the "most mature" interpretation level to provide the range of therapist interpretation level. For example, if the highest defense a therapist interpreted was a Level 7 (i.e., most mature) and the lowest defense a therapist interpreted was a Level 3 (i.e., most immature) then the therapist interpretation range level would be 4. The range of therapist interpretation level was examined to provide an understanding of whether therapists are more likely to interpret defense levels across the hierarchy (immature to mature level) or whether they focus on a particular defense level a patient exhibits.

Procedures

In total, 35 sessions (18 high alliance and 17 low alliance) were transcribed and rated for the study (19 therapist-patient dyads) in French. Two of the therapist-patient dyads did not contain both high and low alliance sessions. Of the 35 sessions, 8 sessions were not rateable for the therapist interpretations because in those sessions, therapist interpretations could not be attributed to a specific defense listed in the DMRS. As a result, for therapist interpretations, data analysis was conducted on a total of 27 sessions.

Data analysis consisted of paired sample *t*-tests and Pearson correlation coefficients to examine patients' most frequent defense level and range of defense level, and therapists' most frequent interpretation defense level and range of therapist interpretation level in sessions with low and high alliance scores. Because this study is exploratory in nature, no a priori hypotheses were created.

Results

General Descriptives

Patients in this study exhibited 27.51 (*SD* = 8.44) defenses on average per session. Examining the PIRS ratings, 17.3% of therapist intervention activity in-session was dedicated to either defense or transference interpretations with therapists interpreting 9.17 (*SD* = 5.3) defenses on average per session.

Patients' most frequent defense level and therapists' most frequent interpretation level

Paired sample *t*-tests showed no significant mean differences between the most frequent patient defense level (*M* = 4.25, *SD* = 1.53) and the most frequent therapist interpretation level (*M* = 3.81, *SD* = 0.87) in sessions with low alliance, t (15) = 0.87, p = .45 and no significant mean difference between most frequent patient defense level (*M* = 4.25,

SD = 1.7) and most frequent therapist interpretation level (*M* = 3.22, *SD* = 1.17) in sessions with high alliance scores, *t* (17) = 0.98, *p* = .33.

Because there were no significant mean differences among therapist interpretation levels and the patients' most frequent defense levels in sessions with low and high alliance scores, subsequent analysis examined the total sample independent of the therapeutic alliance. In order to determine whether there was a relationship between therapist interpretive activity (i.e., which defenses they interpreted most frequently) and patients' defensive functioning (i.e., most frequent, most atypical immature, or most atypical mature defense level) Pearson correlations were conducted. Pearson correlations showed no significant relationship between the most frequent patient defense level and the most frequent therapist interpretation level, *r* = -0.32, *p* = .11. However, results showed a negative trend between the most frequent therapist interpretation level and the patient range of defense level, *r* = -0.37, *p* = .06.

Patients' most atypical mature defense level and therapists' most atypical mature interpretation level

Paired sample *t*-tests showed significant mean differences between the most atypical mature patient defense level (*M* = 6.50, *SD* = 0.52) and the most atypical mature therapist interpretation level (*M* = 4.33, *SD* = 0.99) in sessions with low alliance scores, *t* (11) = 5.92, *p* < .001 and significant mean differences between the most atypical mature patient defense level (*M* = 6.67, *SD* = 4.27) and the most atypical mature therapist interpretation level (*M* = 4.27, *SD* = 1.59) in sessions with high alliance scores, *t*(14) = 5.82, *p* < .001.

Patients' most atypical immature defense level and therapists' most atypical immature interpretation level

Paired sample *t*-tests indicated significant mean differences between the most atypical immature patient defense level ($M = 1.50$, $SD = 0.80$) and the most atypical immature therapist interpretation level ($M = 3.00$, $SD = 1.12$) in sessions with low alliance scores, $t(11) = 3.59$, $p < .001$ and significant mean differences between the most atypical immature patient defense level ($M = 1.93$, $SD = 1.1$) and the most atypical immature therapist interpretation level ($M = 2.53$, $SD = 1.12$) in sessions with high alliance scores, $t(14) = 2.2$, $p = .04$.

Range of Patient defense levels and range of therapist interpretation level

Paired sample *t*-tests showed significant mean differences between the range of patients' defense levels ($M = 5.11$, $SD = 0.99$) and the range of therapist interpretation levels ($M = 0.94$, $SD = 1.34$) in sessions with low alliance, $t(15) = 8.71$, $p < .001$ and significant mean differences between the range of patients' defense levels ($M = 4.78$, $SD = 0.94$) and the range of therapist interpretation levels ($M = 1.44$, $SD = 1.59$) in sessions with high alliance, $t(17) = 8.99$, $p < .001$.

In order to determine if a relationship existed between patients' use of "out of character" defenses and therapists interpreting these defenses (i.e., range of therapist interpretation levels) Pearson correlations were conducted. Pearson correlations showed no significant relationship between the range of patient defense levels and the range of therapist interpretation level in sessions with low alliance scores, $r = -0.29$, $p = .25$ and high alliance scores, $r = 0.23$, $p = .36$.

Discussion

One of the ten principles describing how to address patient defenses in-session outlined by Petraglia, Bhatia, and Drapeau (2013) indicated that therapists should *intervene with the patients' most prominent defenses.* This study aimed to examine this concept empirically by better understanding what defenses therapists deem as the most prominent defenses a patient uses based on their interpretive activity. Our findings suggest that therapists were focusing their interpretive activity on the most frequent defense level of the patient, shedding light on the concept of prominence outlined by Greenson (1967) whereby most prominent defenses patients use are considered as those defenses most closely related to the patient's psychopathology. Given that there was no significant mean difference between therapists most frequent interpretation levels and patients' most frequent defense levels suggests that therapists focused their interpretative activity towards addressing the patients' most frequent defense levels and "characterological" defenses.

The mean differences between therapist interpretation level and patient defense levels in the most atypically mature and atypically immature categories suggest that therapists were adjusting their interpretation level based on patient's defense functioning in-session. Specifically, therapists were interpreting at one to two defense levels above the patients' most atypically immature defense levels and interpreting one to two levels below the patients' most atypically mature defense levels.

For example, in-session a patient may use the defense of splitting (Level 2), rationalization (Level 3), and repression (Level 5) when describing his feelings about a conflicted object in his life. The therapist would then respond by focusing his or her interpretation to the patient's rationalization (Level 3). In this case, the disavowal defense

level (Level 3) would be the patient's most prominent defense level, and therapist interpretive activity would focus on that defensive level and would not attend to the atypically immature defense (in this case the splitting). This finding supports other research that has found therapists over-adjust their interpretations to patient defenses (e.g., Despland et al., 2001; Petraglia et al., 2009); however, direct comparisons are difficult to make since these other studies utilized a different methodology.

This study shows that the reverse was also true. When patients exhibited atypically mature defenses, therapists maintained their interpretative activity at the patients' most frequent defense level, and in a sense, "pulled" patients to lower defense levels. For example, a patient may have used an atypically mature defense of intellectualization (Level 6) along with the cluster of defenses described above, and therapists would interpret the patient's rationalization (Level 3) defense, again returning focus of therapist interpretation activity to the patient's most frequent defense level.

The significant mean difference between the range of patient defense level and the range of therapist interpretation level suggests a focus of therapist interpretation level. Within a session, patient defensive functioning tended to be more fluid as patients moved from adaptive to less adaptive defense levels (i.e., use Level 6 defense and then use a Level 3), whereas therapists' interpretative level activity continued to remain focused primarily on patients' most frequent defense level (i.e., Level 3 and 4).

This was further collaborated by the relationship between the therapists' most frequent interpretation level and the range of patient defense level. Though this relationship was not significant, there was a negative trend as the greater the variability in patient defense levels there was within a session, the more therapists' interpreted defenses within patients'

most frequent defense level. This may suggest that therapists were working towards focusing patients back to their typical cluster of defenses and trying to work through them and that therapists chose to not interpret patients' "out of character" defenses. Again, this result was only a trend, and with a larger sample size, results might vary, but it does point to the focus of therapists' interpretive activity. It also suggests that, on average, therapists were not interpreting defenses in the atypically mature and immature levels but rather focused on interpreting at the most frequent level in these cases. Put differently, therapists seemed less interested in interpreting the extremes of the range of defense levels within a session.

The finding that therapists were interpreting patients' most frequent defense levels and not their atypically mature or immature defenses (i.e., "out of character" defense levels) supports the findings of the Bhatia, Petraglia, de Roten, and Drapeau (2013) study examining practicing psychodynamic therapists rankings of the importance of the clinical principles (Petraglia, Bhatia & Drapeau, 2013) that found therapists ranked interpreting patients' most "typical" and "characterological" defenses as more important than interpreting patients' most "atypical" and "out of character" defenses which was ranked as less important. Consolidating the clinical perspectives of practicing psychodynamic therapists (e.g., Bhatia and colleagues, 2013) and the interpretive activities of therapists in this empirical study indicates that in general, therapists deem patient prominent defenses as those patients' most "typical" and "characterological" defenses.

Although mean differences in this study suggested that on average, therapists in this study did not interpret patients' "out of character" defense levels, irrespective of whether they are mature or immature, this does not necessarily mean that therapists were not acknowledging or intervening with the patients' defenses out of their typical range (i.e.,

Level 1 or 2 and/or Level 6 or 7), but rather they were not interpreting them. Because the study focused primarily on defense interpretations, other therapist techniques used to address patient defenses were not considered.

Therapist activity encapsulates much more than interpretation. For example, Connolly Gibbons, Crits-Christoph, Barber, and Schamberger (2007) reviewed the literature on frequency of therapist interpretations and found that there was variation amongst the dynamic therapies with respect to percentage of therapist interventions that could be considered interpretations ranging from 4% to 40%. Therefore it is possible then that therapists were using supportive techniques, as outlined by the PIRS, including support strategies, associations, and acknowledgements, to intervene with patient defenses that fell outside their most frequent range. Research has demonstrated that supportive techniques can enhance the therapeutic alliance when they are used with patients with higher defensive functioning (e.g., Hersoug, Hoglend, & Bogwald, 2004). It may have been the case in our study that therapists used supportive techniques to address patient defenses that were more mature. Again, this study did not examine specific defenses patients used or their overall defensive functioning, nor did it examine non-interpretive techniques therapists used, therefore this interpretation needs to be taken with caution and addressed in future research.

This study had a small base rate of PIRS ratings of defense interpretations that were coded for analysis. In some cases, a therapist would have nine defense interpretations but only three or four of them were specifically related to a particular defense. It was often the case that therapists were making general, non-specific defense interpretations in response to patients' defensive material, therefore, the interpretation could not be assigned to a specific defense level. This could be a methodological limitation, however, clinically, it is not

uncommon. For example, in intensive short-term psychodynamic therapy (ISTDP; Davanloo, 2000) there is an emphasis placed on interpreting "tactical" defenses which are defenses patients use that are non-specific (e.g., laughing when they are sad; avoiding eye contact).

Additionally, our study analyzed two sessions per therapist-patient dyad in order to determine what constitutes a patient's most prominent defense (i.e., "characterological" and "out of character" defenses). It can be argued that these sessions may have not have reflected a typical session (i.e., an outlier session) or the overall defensive profile of the patient (i.e., functioning across entire treatment). Research indicates that through the course of treatment patients shift from immature to mature defenses as part of progress in treatment (Perry, Petraglia, Olson, Presniak, & Metzger, 2012); therefore future research should analyze a larger number of sessions to ensure an accurate representation of the changes that occur in patient defensive functioning as therapy progresses.

Conclusion

Overall, based on the recommendations of Petraglia and colleagues (2013), this study operationalized the concept of prominence to determine if patients' most prominent defenses were their characterological defenses (i.e., most frequent defense level) or "out of character" defenses (i.e., most atypical mature defense level and most atypical immature defense level) and which defenses therapists focus on when making interpretations. This preliminary study found that: therapists focused their interpretative activities to patients' most frequent defense level; therapists over-adjusted and under-adjusted their interpretation levels when interpreting patients most atypically mature and atypically immature "out of character"

defenses; and when patients exhibited a larger range of defense levels, therapists adjusted their interpretations to focus back on patients' most frequent defense level.

References

Alexander, L.B., & Luborsky, L. (1986). The Pen helping alliance scales. In L.S. Greenberg & W.M. Pinsof. (Eds.), *The psychotherapeutic process: A research handbook* (pp. 325-366). New York: Guilford Press.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders,* (4th ed.). Washington: American Psychiatric Association.

Banon E., Perry J.C., Bond M., Semeniuk T., de Roten Y., Hersoug A.G., & Despland J.N. (2013). Therapist interventions using the Psychodynamic Interventions Rating Scale (PIRS) in dynamic therapy, psychoanalysis and CBT. *Psychotherapy Research*, 1-16.

Bhatia, M., Gil Rodriguez, M., Fowler, D.M., Godin, J.E.G., Drapeau, M., & McCullough, L. (2009). Desensitization of conflicted feelings: Using the ATOS to measure early change in a single-case affect phobia therapy treatment. *Archives of Psychiatry and Psychotherapy, 1,* 31-38.

Bhatia, M., Petraglia, J., de Roten, Y., & Drapeau, M. (2013). Do therapists practicing psychoanalysis, psychodynamic therapy, and short-term dynamic therapy address patient defenses differently in their own clinical practice? *Manuscript submitted for publication.*

Connolly Gibbons, M. B., Crits-Christoph, P., Barber, J. P., & Schamberger, M. (2007). Insight in psychotherapy: A review of empirical literature. In L. Castonguay & C. Hill (Eds.), *Insight in psychotherapy* (pp. 143–165). Washington, DC: APA Press.

Cooper, S., Bond, M., Audet, C., Boss, K., & Csank, P. (2002). *The Psychodynamic Intervention Rating Scale* (4th ed.). Manual: McGill University.

Davanloo, H. (2000). *Intensive Short-term Dynamic Psychotherapy*. Chichester: Wiley.

Despland, J.N., de Roten, Y., Despars, J., Stgler, M., & Perry, J.C. (2001). Contribution of patient defense mechanisms and therapist interventions to the development of early therapeutic alliance in a brief psychodynamic investigation. *The Journal of Psychotherapy Practice and Research, 10,* 155-164.

Etchegoyen, R. H. (2005). *Fundamentals of psychoanalytic technique.* London: Karnac.

Fenichel, O. (1945). *The psychoanalytic theory of neurosis.* New York: Norton & Co.

Foreman, S.A. & Marmor, C.R. (1985).Therapist actions that address initially poor therapeutic alliances in psychotherapy. *American Journal of Psychiatry, 142,* 922-926.

Gilliéron, E. (1997). *Manuel de psychothérapies brèves*. Paris: Dunod.

Gray, P. (1994). *The ego and the analysis of defense.* New Jersey: Jason Aronson.

Greenson, R.R. (1967). *The technique and practice of psycho-analysis.* New York: International Universities Press.

Hersoug, A.G., Hoglend, P. & Bogwald, K.P. (2004). Is there an optimal adjustment of interpretation to the patients' level of defensive functioning. *American Journal of Psychotherapy, 58,* 349-361.

Hersoug, A.G., Sexton, H., & Hoglend, P. (2002). Contribution of defensive functioning to the quality of working alliance and psychotherapy outcome. *American Journal of Psychotherapy, 56,* 539-554.

Hersoug, A.G., Bogwald, K.P., & Hoglend, P. (2003). Are patient and therapist characteristics associated with the use of defense interpretations in brief dynamic psychotherapy? *Clinical Psychology and Psychotherapy, 10,* 209-219.

Hersoug, A.G., Bogwald, K.P., & Hoglend, P. (2005). Changes of defensive functioning: Does interpretation predict change? *Clinical Psychology and Psychotherapy, 12,* 288-296.

Hill, C.E., Helms, J.E., Tichenor, V., & Spiegel, S.B. (1988). Effects of the therapist response modes in brief psychotherapy. *Journal of Counseling Psychology, 35,* 222-233.

Junod, O., de Roten, Y., Martinez, E., Drapeau, M. & Despland, J.N. (2005). How to address patients' defenses: A pilot study of the accuracy of defence interpretation and alliance. *Psychology and Psychotherapy: Theory, Research, and Practice, 78,* 419-430.

Kramer U., Despland J.-N., Michel L., Drapeau M., & de Roten Y. (2010). Change in defense mechanisms and coping over the course of short-term dynamic psychotherapy for adjustment disorder. *Journal of Clinical Psychology, 66,* 1232-1241.

Langs, R. (1973). *The technique of psychoanalytic psychotherapy: Vol.1.* New York: Aronson.

Luborsky, L. (2000). A pattern-setting therapeutic alliance study revisited. *Psychotherapy Research: Theory, Research and Practice, 10,* 17–29.

Malan, D. (1979). *Individual psychotherapy and the science of psychodynamics.* London, Butterworth.

Perry, J.C. & Bond, M. (2012). Change in defense mechanisms during long-term

dynamic psychotherapy and five-year outcome. *American Journal of Psychiatry, 169,* 916–925.

Perry, J.C. (1990). *The Defense Mechanism Rating Scales, fifth edition*. Cambridge, MA: auteur.

Perry, J.C., Beck, S.M., Constantinides, P., & Foley J.E. (2008). Studying change in defensive functioning in psychotherapy using the Defense Mechanism Rating Scales: Four hypotheses, four cases. In R.A. Levy, & J.S. Ablon (Eds.), *Handbook of evidence-based psychodynamic psychotherapy* (pp. 121-153). New York: Human Press.

Perry, J.C., Petraglia, J., Olson, T.R., Presniak, M.D., & Metzger, J.A. (2012). Accuracy of defense Interpretation in three character types. In R.A. Levy (Eds.), *Psychodynamic psychotherapy research: Evidence-based practice and practice-based evidence* (pp. 417-447).

Petraglia, J., Janzen, J. I., Perry, J. C., & Olson, T. R. (2009). The relationship between therapist interpretation accuracy and in-session change in patients' defensive functioning. Paper presented at the Canadian chapter of the Society for Psychotherapy Research (SPR), Montreal, Canada.

Petraglia, J., Bhatia, M., & Drapeau, M. (2013) Ten principles to guide psychodynamic technique with defense mechanisms: An examination of theory, research, and clinical implications. *Manuscript submitted for publication.*

Roy, C.A., Perry, J.C., Luborsky, L., & Banon, E. (2009). Changes in defensive functioning in completed psychoanalysis: The Penn psychoanalytic treatment collection. *Journal of the American Psychoanalytic Association, 57,* 399-415.

Schanche, E., Stiles, T. C., McCullough, L., Svartberg, M., & Nielsen, G. H. (2011). The

relationship between activating affects, inhibitory affects, and self-compassion in patients with cluster C personality disorders. *Psychotherapy: Theory, Research, Practice, Training, 48,* 293-303.

Sifenos, P. E. (1987). *Short-term dynamic psychotherapy*. New York: Plenum.

Siefert, C.J., Hilsenroth, M.J., Weinberger, J., Blagys, M.D. & Akerman, S.J. (2006). The relationship of patient functioning and alliance with therapist technique during short-term psychodynamic psychotherapy. *Clinical Psychology and Psychotherapy, 13,* 20-33.

Stiles, W.B., Shapiro, D.A., & Firth-Cozens, J.A. (1988). Verbal response mode use in contrasting psychotherapies: A within-subject comparison. *Journal of Consulting and Clinical Psychology, 54,* 646-652.

Vaillant, G. E. (1993). *The wisdom of the ego.* Cambridge: Harvard University Press.

Vaillant, G.E., Bond, M. & Vaillant, C.O. (1986). An empirically validated hierarchy of defense mechanisms. *Archives of General Psychiatry, 43,* 786-794.

Winston, B., Winston, A., Samstag, L.W., & Muran, J.C. (1993). Patient defense/therapist interventions. *Psychotherapy, 31,* 478-491.

Wolberg, L.R. (1977). *The technique of psychotherapy* (3rd ed.). New York: Grune & Stratton.

Table 1. Hierarchy of Defenses and Defense Levels (Perry, 1990)

Defense Level	**Examples of Individual Defenses**
High Adaptive	
Level 7- Mature	Humor, Sublimation, Altruism, Self-Observation
Neurotic Level	
Level 6- Obsessional	Intellectualization, Isolation of Affect, Undoing
Level 5-Hysterical, Other neurotic	a) Repression, Dissociation, b) Reaction formation
Immature Levels	
Level 4- Minor image distorting (Narcissistic):	Devaluation, Idealization, Omnipotence
Level 3-Disavowal	Denial, Projection, Rationalization
Level 2-Major image distorting level (Borderline):	Splitting, Projective Identification
Level 1-Action	Acting-out, Hypochondriasis, Passive-aggression

Table 2. Means and Standard Deviations

Category	Mean	Standard Deviation
Patient Most Frequent Defense Level		
Overall (N=35)	4.22	1.57
Low Alliance (N=17)	4.18	1.50
High Alliance (N=18)	4.28	1.67
Patient Most Atypically Mature Defense Level		
Overall (N=27)	6.59	0.50
Low Alliance (N=12)	6.50	0.52
High Alliance (N=15)	6.67	0.49
Patient Most Atypically Immature Defense Level		
Overall (N=27)	1.74	0.98
Low Alliance (N=12)	1.50	0.79
High Alliance (N=15)	1.93	1.10
Range of Patient Defense Level		
Overall (N=35)	4.95	0.97
Low Alliance (N=17)	5.11	0.99
High Alliance (N=18)	4.77	0.94
Therapist Most Frequent Interpretation Level		
Overall (N=27)	3.61	1.00
Low Alliance (N=12)	3.83	0.83
High Alliance (N=15)	3.43	1.11
Therapist Most Atypically Mature Interpretation Level		
Overall (N=27)	4.30	1.33
Low Alliance (N=12)	4.33	0.99
High Alliance (N=15)	4.27	1.58
Therapist Most Atypically Immature Interpretation Level		
Overall (N=27)	2.74	1.13
Low Alliance (N=12)	3.00	1.13
High Alliance (N=15)	2.53	1.13
Range of Therapist Interpretation Level		
Overall (N=35)	1.2	1.47
Low Alliance (N=17)	0.94	1.33
High Alliance (N=18)	1.44	1.58

CHAPTER 7:

GENERAL DISCUSSION- IMPLICATIONS FOR PSYCHOTHERAPY RESEARCH AND PRACTICE

IMPLICATIONS FOR PSYCHOTHERAPY RESEARCH AND PRACTICE

The final chapter in this dissertation begins with a summary of the findings from the studies presented in the previous chapters. Implications for research and psychotherapy based on the findings in all the manuscripts followed by a general conclusion complete the dissertation.

Summary of Dissertation Findings

Psychodynamic therapy is a commonly practiced (Norcross, 2005), evidence-based treatment (de Maat, et al., 2008; Leichsenring & Rabung, 2004, 2008; Shedler, 2010) for a multitude of psychological disorders (e.g., Abbass, Kisely, & Kroenke, 2009; Abbass, Town, & Driessen, 2011; Driessen et al., 2010; Leichsenring, 2001; Leichsenring, & Leibing, 2003; Mildrod et al., 2007; Town, Abbass & Hardy, 2011). Given that the efficacy and effectiveness of psychodynamic therapy has been established, the focus of research has moved from understanding *if* psychotherapy is effective to *what* factors make psychotherapy effective. Psychotherapy research efforts have centered on exploring specific factors within theoretical models (e.g., cognitions in CBT) and factors that are common to all approaches (e.g., therapeutic alliance) and the interaction between them. In terms of specific factors related to treatment outcome, defense mechanisms and the interpretation of defenses are considered pillars of psychodynamic theory and practice (e.g., Etchegoyen, 2005; Shedler, 2010; Weiner & Bornstein, 2009; Wachtel, 2011). Along with transference and the interpretation of transference, these two components are the most active features of psychodynamic therapy (Shedler, 2010). Psychotherapy process research in psychodynamic therapy has focused primarily on transference interpretations rather than defense interpretations. This dissertation aimed to expand on recommendations of Beutler and

colleagues (2004) and to fill in the gaps in literature. In their review of therapist variables and their impact on psychotherapy outcome, Beutler and colleagues (2004) concluded, "…the need to integrate patient, therapist, procedural, and relationship factors is the major priority for future research" (p. 292). This priority provided the foundation for this entire dissertation. As described in previous chapters, the manuscripts in this dissertation (Part II) examined specific patient (e.g., overall defensive functioning (ODF)) and therapist (e.g., technical intervention of defense interpretations) factors in relation to therapy process (e.g., therapeutic alliance).

Part I of this dissertation aimed to gather information regarding the attitudes and clinical opinions of practicing psychodynamic psychotherapists. The overarching question that guided this part of the dissertation was: How important are defense mechanisms to practicing psychodynamic therapists and to what extent do they follow theoretical guidelines when making defense interpretations in their own clinical practice?

In Chapter two, the manuscript entitled, *Do therapists practicing psychoanalysis, psychodynamic therapy, and short-term dynamic therapy address patient defenses differently in their own clinical practice?* examined the clinical importance- as rated by practicing psychodynamic psychotherapists- of defense mechanisms and theoretical guidelines on interpreting defenses in their own clinical practice. The manuscript found that the overwhelming majority of practicing psychodynamic therapists considered defenses an important construct both from a theoretical and practical perspective.

In addition, this manuscript revealed that though most therapists tended to agree to strongly agree with the theoretical guidelines, significant differences between psychodynamic and short-term psychodynamic therapists (STDP) emerged, indicating that

though important, different theoretical models within the psychodynamic orientation, view defenses and the interpretation of defenses in specific ways.

Chapter three consisted of the second manuscript entitled, *Psychodynamic Therapists' Rating of the Most Important Technical Guidelines to Follow When Interpreting Defenses In-Session* and it aimed to address the limitations and directions for future research outlined in the first manuscript. Specifically, this manuscript aimed to examine which specific clinical guidelines for addressing defenses outlined by Petraglia and colleagues (2013) are most important and least important to practicing psychodynamic therapists in their own clinical practice. Three clusters of rankings were created (seven principles ranked high; five ranked in the middle; and four ranked low).

Chapter four outlined the transition from Part I to Part II of the dissertation. The focus of the dissertation shifted from examining therapists' attitudes about the clinical principles outlined by Petraglia and colleagues (2013) to empirically examining two of the clinical principles.

Chapter five examined the clinical principle that *Therapists should avoid using technical language in interpretations* (Petraglia, Bhatia, & Drapeau, 2013*)* and outlined the third manuscript titled, *Is There a Relationship between Therapist Language Use, Patient Defensive Functioning and the Therapeutic Alliance?* This manuscript operationalized the different components of therapist verbosity when interpreting defense (TVID) and examined the relationship between different components of TVID and overall patient defensive functioning, symptomatic functioning, and the therapeutic alliance. The manuscript found that one component of TVID was negatively related to patient functioning as therapist interpretation of defenses that consisted of lengthy words was correlated negatively with

patient overall defensive functioning in sessions with low alliance scores. However, all three components of TVID did not differ in sessions with low and high alliance scores and there was no relationship between the average length of interpretation and the number of technical words per interpretation. As a result, the findings from this study are mixed, inconclusive, and require further investigation.

Chapter six set out to investigate the guideline outlined by Petraglia and colleagues (2013) that *therapists should intervene with clients' most prominent defenses* and outlined the final manuscript, titled *What Defense Mechanisms do Therapists Interpret In-Session?* This manuscript aimed to determine: patients' most prominent (i.e., characterological) and least prominent (i.e., "out of character") defenses, and whether therapists interpret patients' most prominent or least prominent defenses in-session.

The results of this exploratory study found that: 1) therapists focused their interpretative activities to patients' most frequent defense level; 2) when interpreting patients' most atypically mature and atypically immature "out of character" defenses, therapists altered their interpretation levels in order to "pull" patients to their most frequent defense level; and 3) when patients exhibited a large range of defense levels (i.e., out of character), therapists adjusted their interpretation level to focus back on patients' most frequent defense level suggesting that therapists deem patients' "characterological" defenses as the most prominent and important to interpret.

Implications for Psychotherapy and Future Directions

Westen (2007) recommended that the future of psychotherapy required a greater collaboration between researchers and clinicians in order to bridge the gap between theory, research, and practice. The manuscripts in this dissertation attempted to follow these

recommendations and provide clinically relevant research that has practical implications for research and practice. These implications are presented below.

The survey manuscripts in part I of this dissertation provided support for the idea that psychodynamic therapists of all theoretical orientations strongly agree with the importance of defense mechanisms as a theoretical and practical construct central to psychodynamic therapy (Chapter 2) and validation for the clinical principles on how therapists should interpret defenses in their own practice outlined by Petraglia, Bhatia, and Drapeau (2013) (Chapter 3).

Yet, psychodynamic therapy is not a homogenous entity. Differences exist at the theoretical, clinical, and research level in our understanding of defenses and their application in clinical practice. As a consequence, parceling out differences, discovering similarities, and operationalizing constructs in a manner that attends to the theory and application of defense interpretations remains at the forefront.

In the first manuscript (Chapter 2), significant differences emerged between therapists who identified as STDP, and those who identified as psychodynamic therapists, regarding certain aspects of working with defenses. However, besides the first manuscript, to the best of our knowledge, these differences have not been examined systematically from either a research or clinical perspective. Continued research is needed to determine if differences in therapists' attitudes regarding defense interpretations are based on differences in theoretical orientation, therapeutic context (e.g., phase of therapy and/or time in session), patient characteristics (e.g., patient level of defensive function, symptomatology) or therapy process (e.g., therapeutic alliance).

In order to uncover which of these variables impacts therapists' decisions on the importance of clinical principles, future survey studies could utilize different methods for assessing importance of the clinical principles. For example, instead of survey questions using Likert scales or factor analysis, therapists of varying theoretical orientations (e.g., STDP, psychodynamic, psychoanalytic) could be presented with case vignettes that outline the use of different principles (or violations of these principles) to determine which principle would be most important to adhere to based on specific clinical situations that outline all of the elements of the therapy described above.

Additionally, future survey studies would benefit from larger sample sizes, as it would allow for a greater number of analyses and examination of different questions. In manuscript one (Chapter 2), the comparison between theoretical orientations would have been strengthened if there had been a larger number of therapists who identified as psychoanalysts. This would have allowed for a richer comparison of the attitudes of psychoanalysts, psychodynamic and STDP therapists regarding the importance of defense mechanisms and principles on how to interpret them.

In the second manuscript, the rankings of clinical principles by therapists provided useful implications for both research and practice. For instance, the principle that, *therapists should avoid technical language when making defense interpretations* was strongly endorsed by therapists in both survey manuscripts (high mean rating, high mean ranking and high mode ranking). Moreover, in the third manuscript, partial support for a component of TVID was found, as average word length in interpretations was negatively related to patient defensive functioning in-session with low alliance scores yet the other two components of TVID were not related to therapeutic process or patient defensive functioning at all.

Continued research investigations are needed to better understand exactly what role TVID plays on the therapeutic process.

Clinically, this may speak to the idea that we need to consider therapist use of language in a holistic rather than compartmentalized approach as done in manuscript three. Perhaps, TVID would be better understood as being one component of what constitutes a "good" interpretation. As Wachtel (2011, p. 125) has indicated, "good interpretations tend to be permission oriented". Being "permission oriented" means that interpretations are not accusatory or critical of the patient, nor are they meant to be delivered as the definitive truth that explains the patient's suffering. Rather, they are stated tentatively, with the therapist acknowledging that what he or she understands may not necessarily be what the patient is experiencing, and that embedded in an interpretation, the therapist acknowledges his or her own fallibility.

Both seasoned clinicians and novice trainees should follow the guidelines espoused by Wachtel (2011) that interpretations should be tentative, collaborative, and permission oriented. Along with the guidelines outlined by Wachtel (2001), the concept of TVID should also be considered. Combining these ideas along with examining therapist tone of voice, voice inflections, and non-verbal communication, would allow for a comprehensive exploration of therapist "style" and operationalize the therapist as a factor of analysis when conducting future process research. This approach would potentially help researchers better understand the specific conditions and impact language has on patient functioning and therapeutic outcome and this could ultimately inform clinical practice.

The fourth manuscript in this dissertation utilized a novel conceptualization of therapist interpretive activity aimed at addressing patient defenses. In this manuscript,

DMRS (Perry, 1990) defense levels were utilized to determine patients' most frequent, atypically immature, and atypically mature defense use and therapists' interpretive activity. Analyses were conducted on defense levels, not on specific individual defenses patients used in-session or on overall defensive functioning (ODF). Unlike the Junod et al. (2005) and Petraglia and colleagues (2009) studies, there was no relationship between therapist interpretation level and the therapeutic alliance. Therapist interpretative activity did not change in session with low or high alliance scores and these sessions did not influence therapist interpretative activity.

Several possibilities exist as to why these differences emerged. First, manuscript four examined a different component of how therapists interpret defenses (i.e., the concept of prominent defenses versus therapist adjustment and therapist accuracy) than previous studies and therefore, the differences may be attributed to the fact that adjustment and prominence are varying concepts. Secondly, manuscript four focused on therapist interpretation of defense levels, rather than specific defenses. Thirdly, all studies examined samples of varying length, and utilized distinct theoretical orientations (e.g., short-term dynamic therapy compared to brief dynamic therapy), therapists and patient populations. As a result, making direct comparisons between these studies would not be plausible or justifiable from both a research and applied sense.

In order to overcome these limitations, research could compare the methodology employed by Despland and colleagues (2001), Junod and colleagues (2005), and Petraglia and colleagues (2009), to the methodology outlined in this manuscript in order to assess if these researchers are examining the same phenomenon from a different vantage point or

whether they are examining distinct concepts with unique theoretical assumptions and consequently, with different implications for theory and practice.

Examining the same therapy case using all four methodologies would provide an innovative approach to account for the methodological limitations presented by the studies, and allow for a direct comparison between conceptualizations, as the study would be able to control for all elements of treatment (e.g., therapist characteristics, patient characteristics, theoretical orientation, length of treatment, process and outcome variables). Removing confounding variables would allow for a comprehensive comparison of therapist accuracy, therapist adjustment, and therapist focus on prominent defenses in-session.

Part II of this dissertation focused on exploring two of the ten clinical principles outlined by Petraglia, Bhatia, and Drapeau (2013). As discussed in Chapter four, future research aims to empirically examine all of the clinical principles in order to determine their clinical utility. In addition to this initiative, it would be important to conduct studies that examine multiple principles together, in order to provide a greater understanding of interaction between clinical principles. Specifically, the "surface-to-depth" principle (Fenichel, 1945), which was ranked as the most important principle in the second manuscript, would add another layer to the understanding of the interpretation of defenses in both empirical manuscripts (i.e., Chapter 5 and Chapter 6).

For example, when examining TVID within the context of the "surface-to-depth" principle, verbally complicated and longer interpretations (TVID components) that were "deeper" in terms of content might "miss the mark" clinically, and lead to negative processes and outcomes in treatment. Petraglia, Bhatia, de Roten, Despland and Drapeau (2013) examined the relationship between depth of interpretation, patient defensive

functioning and the therapeutic alliance, and found a correlation between depth of interpretation and frequency of disavowal defenses (Level 3) in sessions with low alliance. Conversely, it may be the case that concise, deeper defense interpretations, which are free of psychological jargon, are less likely to activate disavowal defenses or relate to poorer alliance outcomes.

In manuscript four, while examining which defense levels therapists were interpreting most frequently, an analysis of the depth of those interpretations would have been useful. It is possible that therapists use deeper interpretations when patients exhibit their most typical and "characterological" defenses as it is these defenses that are most related to patients' personality and current suffering (Greenson, 1967; Langs, 1973). Alternatively, it may be the case that therapists employ supportive techniques when patients exhibit immature and mature defenses.

Future research could also employ experimental dismantling studies similar to the ones conducted by Hoglend and colleagues (2008) and Hoglend and colleagues (2011) that examined the effect of transference interpretation on therapy process and outcome in randomized clinical trials. Dismantling studies could examine the aspects of specific principles on how to interpret defenses examined in this dissertation (e.g., TVID and prominence) or any of the other principles that Petraglia, Bhatia, and Drapeau (2013) outlined in their study.

For example, when examining TVID, therapist interpretation could be divided into two groups, with therapists in one group making interpretations with longer and psychological-sounding words and with therapists in another group making interpretations

using “layperson” language in their interpretations. The different types of interpretations could then be compared to the therapeutic alliance, patient characteristics, and outcome.

From a clinical perspective, the manuscripts presented in this dissertation on how therapists interpret defenses in-session indicate that defenses are important constructs for psychodynamic therapists to address in-session and that working with defenses is a multi-layered process. It is not realistic nor is it likely effective to consider using only one clinical principle to guide your interpretive activity in-session. A good interpretation incorporates elements of many principles and therapists assess therapeutic variables when deciding to make these interpretations. As well, interpretations do not exist in a vacuum. They are parts of a whole set of interventions including supportive strategies that therapists must use in tandem to understand, address, and ultimately overcome patient defenses and suffering. Therefore, empirical research needs to continue to explore the theoretical and clinical guidelines prescribed by psychodynamic theory in order to validate existing ideas, provide specific guidelines and to inform clinical practice in real, practical, and effective ways.

As such, therapists can use the principles outlined in Petraglia, Bhatia, and Drapeau (2013) and the findings of those empirically investigated in this dissertation, as guides that they can utilize in-session with their patients. For example, as therapists are about to make a defense interpretation they can be mindful of their level of verbosity. Additionally, they can consider which defense level is most prominent in-session and whether to interpret defenses being exhibited in this level or to utilize support strategies. These types of questions and references to the guidelines can help anchor therapists into theory driven, empirically based clinical interventions. This process becomes more commonplace as the evidence accumulates that respects both the art and science of psychotherapy.

Conclusion

Interpretations are considered the backbone of therapist activity in psychodynamic therapy (Etchegoyen, 2005). This dissertation aimed to provide a clearer understanding of how therapists interpret defenses in-session in psychodynamic therapy. As this dissertation outlined, practicing psychodynamic therapists espoused the importance of working with defense mechanisms in their own clinical practice with differences emerging among different theoretical orientations (Chapter 2), and the importance of the clinical principles outlined by Petraglia, Bhatia, and Drapeau (2013) on how to interpret defenses in-session (Chapter 3). The empirical investigations of two clinical guidelines outlined by Petraglia and colleagues (2013) provided preliminary evidence for a component of TVID and its relationship to therapeutic alliance and patient defensive functioning (Chapter 5), and a preliminary understanding of therapists focusing their interpretive activity to interpreting patients most prominent defense level in-session (Chapter 6).

Considerable work remains on integrating the various process variables in psychodynamic therapy in general, and therapist technique of defense interpretation, specifically. The empirical findings in this dissertation, along with the examination of clinician ratings and rankings of the guidelines on how to interpret defenses, serve as an impetus for the continued exploration and understanding of the relationship between therapists' interpretation of defenses, and therapy process, in a context that appreciates the delicate balance between theory, research, and practice.

References

Abbass, A., Kisely, S. & Kroenke, K. (2009). Short-term psychodynamic psychotherapy for somatic disorders. *Psychotherapy and Psychosomatics, 78,* 265-274.

Abbass, A., Town, J. & Driessen, E. (2011). The efficacy of short-term psychodynamic psychotherapy for depressive disorders with comorbid personality disorder. *Psychiatry, 74*(1), 58-71.

Ablon J.S. & Jones E.E. (1998). How expert clinicians' prototypes of an ideal treatment correlate with outcome in psychodynamic and cognitive-behavioral therapy. *Psychotherapy Research*, *8*(1), 71-83.

Ackerman, S.J., & Hilsenroth, M.J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training, 38,* 171-185.

Akhtar, S. (2009). *Comprehensive dictionary of psychoanalysis.* London: Karnac Books.

Akkerman, K., Karr, V., & Lewin, T. (1992). Changes in ego defenses with recovery from depression. *The Journal of Nervous and Mental Disease, 180,* 634-639.

Alexander, L.B., & Luborsky, L. (1986). The Pen helping alliance scales. In L.S. Greenberg & W.M. Pinsof. (Eds.), *The psychotherapeutic process: A research handbook* (pp. 325-366). New York: Guilford Press.

Ambresin, G., De Roten, Y., Drapeau, M.M & Despland, J.N (2007). Early change in maladaptive defense style and development of the therapeutic alliance. *Clinical Psychology and Psychotherapy* 14, 89-95.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders,* (4th ed.). Washington: American Psychiatric Association.

Banon E., Perry J.C., Bond M., Semeniuk T., de Roten Y., Hersoug A.G., & Despland

J.N. (2013). Therapist interventions using the Psychodynamic Interventions Rating Scale (PIRS) in dynamic therapy, psychoanalysis and CBT. *Psychotherapy Research*, 1-16.

Banon, E., Evan-Grenier, M., & Bond, M. (2001). Early transference interventions with male patients in psychotherapy. *Journal of Psychotherapy Practice & Research, 10,* 79-92.

Beutler, L.E., Malik, M., Alimohamed, S., Harwood, T.M., Talebi, H., Noble, S. & Wong, E. (2006). Therapist Variables. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behaviour change*. (pp. 227-306). New York, NY: John Wiley & Sons.

Bhatia, M., Petraglia, J., de Roten, Y., & Drapeau, M. (2013). Do therapists practicing psychoanalysis, psychodynamic therapy, and short-term dynamic therapy address patient defenses differently in their own clinical practice? *Manuscript submitted for publication.*

Bhatia, M., Gil Rodriguez, M., Fowler, D.M., Godin, J.E.G., Drapeau, M., & McCullough, L. (2009). Desensitization of conflicted feelings: Using the ATOS to measure early change in a single-case affect phobia therapy treatment. *Archives of Psychiatry and Psychotherapy, 1,* 31-38.

Bloch, A. L., Shear, K., Markowitz, J.C., Leon, A.C., & Perry, J.C. (1993). An empirical study of defense mechanisms in dysthymia. *American Journal of Psychiatry, 150,* 1191-1198.

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. (2004). Empirical studies of defense style: Relationships with psychopathology and change. *Harvard Review of Psychiatry, 12,* 263-278.

Bond, M., & Perry, J.C. (2006). Psychotropic medication use, personality disorders and improvement in long-term dynamic psychotherapy. *The Journal of Nervous and Mental Disease, 194*(1), 21-26.

Bond, M., & Perry, J.C. (2004). Long-term changes in defense styles with psychodynamic psychotherapy for depressive, anxiety, and personality disorders. *American Journal of Psychiatry, 161,* 1665-1671.

Connolly, M.B., Crits-Christoph, P., Shappell, S., Barber, J.P., Luborsky, L., & Shaffer, C. (1999). Relation of transference interpretations to outcome in the early sessions of brief supportive-expressive psychotherapy. *Psychotherapy Research, 9,* 485-495.

Cook, J. M., Biyanova, T., Elhai, J., Schnurr, P. P., & Coyne, J. C. (2010). What do psychotherapists really do in practice? An internet study of over 2,000 practitioners. *Psychotherapy: Theory, Research, Practice, Training, 47*(2), 260-267.

Cooper, S., Bond, M., Audet, C., Boss, K., & Csank, P. (2002). *The Psychodynamic Intervention Rating Scale – 4th edition*. Manual: McGill University.

Corsini, R. (2002). *The dictionary of psychology.* New York: NY. Brunner-Routledge. Crits-Christoph, P., Cooper, A., & Luborsky, L. (1988). The accuracy of therapists' interpretations and the outcome of dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 56(*4*),* 490-495.

Cramer, P. (1991). Anger and the use of defense mechanisms in college students. *Journal of Personality, 59,* 39-55.

Cramer, P. (1987). The development of Defense Mechanisms. *Journal of Personality, 55,*

597-614.

Cramer, P. (2006). *Protecting the self: Defense mechanisms in action*. New York: The Guilford Press.

Davanloo, H. (2000). *Intensive Short-term Dynamic Psychotherapy*. Chichester: Wiley.

Driessen, E., Cuijpers, P., de Maat, S., Abbass, A., de Jonghe, F. & Dekker, J. (2010). The efficacy of short-term psychodynamic psychotherapy for depression: A meta analysis. *Clinical Psychology Review, 30,* 25-36.

de Maat, S., Dekker, J., Schoevers, R., van Aalst, G., Gijsbers-van Wijk, C., Hendriksen, M., Kool, S., Peen, J., Van, R., & de Jonghe, F. (2008). Short-term supportive psychodynamic psychotherapy, antidepressants, and their combination in the treatment of major depression: A mega-analysis based on three randomized clinical trials. *Depression and Anxiety, 25,* 565-574.

Derogatis, L.R. (1994). *Symptom Checklist-90-Revised: Administration scoring and procedures manual (3rd ed.)*. Minneapolis, MN: National Computers Systems.

De Saussure, R. (1954). Mechanisms of defence and their place in psycho-analytic therapy: Discussion. *International Journal of Psychoanalysis, 35,* 199-201.

Despland, J.N., de Roten, Y., Despars, J., Stigler, M., & Perry, J.C. (2001). Contribution of patient defense mechanisms and therapist interventions to the development of early therapeutic alliance in a brief psychodynamic investigation. *The Journal of Psychotherapy Practice and Research, 10,* 155-164.

Drapeau, M., de Roten, Y., Beretta, V., Blake E., Koerner, A., & Despland, J.N. (2008).

Therapist technique and patient defensive functioning in ultra-brief psychodynamic psychotherapy: A LAG sequential analysis. *Clinical Psychology and Psychotherapy, 15,* 247-255.

Erdelyi, M.H. (2001). Defense processes can be conscious or unconscious. *American Psychologist, 55,* 761-762.

Etchegoyen, R. H. (2005). *Fundamentals of psychoanalytic technique.* London: Karnac.

Fehm, L., & Kazantzis, N. (2004). Attitudes and use of homework assignments in therapy: a survey of German psychotherapists. *Clinical Psychology and Psychotherapy, 11*(5), 332-343.

Foreman, S.A. & Marmar, C.R. (1985). Therapist actions that address initially poor therapeutic alliances in psychotherapy. *American Journal of Psychiatry, 142,* 922-926.

Freud, S. (1894). The neuro-psychoses of defence. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud,* (Vol. 2, pp. 45-61). London: Hogarth Press.

Freud, A. (1937/1965). *The ego and the mechanisms of defense.* New York: International Universities Press.

Gaston, L., Marmar, C.R., Thompson, L.W., & Gallagher, D. (1988). Alliance prediction of outcome beyond in- treatment symptomatic change as psychotherapy progresses. *Psychotherapy Research, 1*, 104–112.

Gill, M.M. & Hoffman, I.Z. (1982). Analysis of transference: II Studies of nine audio-recorded psychoanalytic sessions. *Psychological Issues, 54,* 1-236.

Glover, E. (1955). *The technique of psycho-analysis.* New York: International

Universities Press.

Gray, P. (1994). *The ego and the analysis of defense.* New Jersey: Jason Aronson.

Greenson, R.R. (1967). *The technique and practice of psycho-analysis.* New York: International Universities Press.

Hentschel, U., Draguns, J.G., Ehlers, W., & Smith, G., (2004). Defense mechanisms: Current approaches to research and measurement. In U. Hentschel, U., G. Smith, J.G. Draguns, & W. Ehlers (Eds.), *Advances in psychology, 136: Defense mechanisms: Theoretical, research and clinical perspectives* (pp. 165-192). New York: Elsevier.

Hersoug, A.G., Bogwald, K.P., & Hoglend, P. (2003). Are client and therapist characteristics associated with the use of defense interpretations in brief dynamic psychotherapy? *Clinical Psychology and Psychotherapy, 10,* 209-219.

Hersoug, A.G., Bogwald, K.P., & Hoglend, P. (2005). Changes of defensive functioning: Does interpretation predict change? *Clinical Psychology and Psychotherapy, 12,* 288-296.

Hersoug, A.G., Hoglend, P. & Bogwald, K.P. (2004). Is there an optimal adjustment of interpretation to the clients' level of defensive functioning. *American Journal of Psychotherapy, 58,* 349-361.

Hersoug, A.G., Sexton, H., & Hoglend, P. (2002). Contribution of defensive functioning to the quality of working alliance and psychotherapy outcome. *American Journal of Psychotherapy, 56,* 539-554.

Hoffer, W. (1954). Defensive process and defensive organization: Their place in psycho-analytic technique. *International Journal of Psychoanalysis, 35,* 194-198.

Hoglend, P. (1993). Transference interpretations and long-term change after dynamic

psychotherapy of brief to moderate length. *American Journal of Psychotherapy, 47*(4), 494-507.

Hoglend, P., Bogwald, K.P., Amlo, S., Marble, A., Randi, U., Sjaastad, M.C., et al. (2008). Transference interpretations in dynamic psychotherapy: Do they really yield sustained effects? *American Journal of Psychiatry, 165,* 763-771.

Hoglend, P. & Perry, J.C. (1998). Defensive functioning predicts improvement in major depressive episodes. *Journal of Nervous and Mental Disease, 186,* 238-243.

Hoglend, P. & Perry, J.C. (1998). Defensive functioning predicts improvement in major depressive episodes. *Journal of Nervous and Mental Disease, 186,* 238-243.

Hoglend, P., Bogwald, K.P., Amlo, S., Marble, A., Randi, U., Sjaastad, M.C., et al. (2008). Transference interpretations in dynamic psychotherapy: Do they really yield sustained effects? *American Journal of Psychiatry, 165,* 763-771.

Hoglend, P., Dahl, H.S., Hersoug, A.G., Lorentzen, S., & Perry, J.C. (2011). Long-term effects of transference interpretations in dynamic psychotherapy of personality disorders. *European Psychiatry, 26*(7), 419-424.

Junod, O., de Roten, Y., Martinez, E., Drapeau, M. & Despland, J.N. (2005). How to address clients' defenses: A pilot study of the accuracy of defence interpretation and alliance.*Psychology and Psychotherapy: Theory, Research, and Practice, 78,* 419-430.

Kaechele, H. & Thomă, H. (1994). *Psychoanalytic practice.* New Jersey: Aronson.

Kendall, P. C., Kipnis, D., & Otto-Salaj, L. (1992). When clients don't progress: Influences on and explanations for lack of therapeutic progress. *Cognitive Therapy and Research, 16*(3), 269-281.

Kernberg, O. (1976). Object-relations theory and clinical psychoanalysis. New York: Jason Aronson.

Kernberg, O. F. (1985). Object relations theory and character analysis. In H.P. Blum (Ed.), *Defense and resistance: Historical perspective and current concepts* (pp. 247-271). New York: International Universities Press.

Kramer, U., Despland J.N., Michel, L., Drapeau, M., & de Roten Y. (2010). Change in Defense Mechanisms and Coping over the Course of Short-Term Dynamic Psychotherapy for Adjustment Disorder. *Journal of Clinical Psychology, 66,* 1232-1241.

Lambert, M.J., & Olges, B.M. (2004). The efficacy and effectiveness of psychotherapy. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behaviour change* (pp. 139-193). New York, NY: John Wiley & Sons.

Langs, R. (1973). *The technique of psychoanalytic psychotherapy: Vol.1.* New York: Aronson.

Leichsnring, F. & Rabung, S. (2004). The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: a meta-analysis. *Archives of General Psychiatry, 61,* 1208-1216.

Leichsenring, F. & Rabung, S. (2008). Effectiveness of long-term psychodynamic psychotherapy: A meta-analysis. *Journal of the American Medical Association, 300,* 1551-1565.

Leichsenring, F. & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive-behavioral therapy in the treatment of personality disorders: A meta-analysis. *The American Journal of Psychiatry, 160,* 1223-1232.

Leichsenring, F. (2001). Comparative effects of short-term psychodynamic psychotherapy and cognitive-behavioral therapy on depression: A meta-analytic approach. *Clinical Psychology Review, 21,* 401-419.

Luborsky, L., Mintz, J., Auerbach, A., Christop P., Bachrach, H., Todd, T…O'Brien, C.P. (1980). Predicting the outcome of psychotherapy: Findings of the Penn psychotherapy project. *Archives of General Psychiatry, 37,* 471-481.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive– expressive treatment.* New York: Basic Books.

Malan, D. H. (1979). Individual psychotherapy and the science of psychodynamics. London: Butterworths.

McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C.L. (2003). *Treating affect phobia: A manual for short-term dynamic psychotherapy.* New York: Guilford Press.

McWilliams, N. (1994). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process.* New York: Guilford Press.

Norcross, J.C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients.* New York: Oxford University Press.

Northey, W. F. (2002). Characteristics and clinical practices of marriage and family therapists: A national survey. *Journal of Marital and Family Therapy, 28*, 487-494.

Orlinksy, D.E., Ronnestad, M.H, & Willutzki, U. (2004). In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th edition) (pp. 307-389). New York: John Wiley & Sons.

Perry, J.C., & Bond, M. (2005). Defensive functioning. In J.M. Oldham, A. E. Skodol, D.

S. Bender (Eds.), *The American Psychiatric Publishing textbook of personality disorders* (pp. 523-540). Washington, DC: American Psychiatric Press.

Perry, J.C. (2001). A pilot study of defenses in adults with personality disorders. *The Journal of Nervous and Mental Disease, 10*, 651-660.

Perry, J.C. (1990). *The Defense Mechanism Rating Scales, fifth edition*. Cambridge, MA: auteur.

Perry, J.C., Beck, S.M., Constantinides, P., & Foley J.E. (2008). Studying change in defensive functioning in psychotherapy using the Defense Mechanism Rating Scales: Four hypotheses, four cases. In R.A. Levy, & J.S. Ablon (Eds.), *Handbook of evidence-based psychodynamic psychotherapy* (pp. 121-153). New York: Human Press.

Perry, J.C. & Henry, M. (2004). Studying defense mechanisms in psychotherapy using the Defense Mechanism Rating Scales. In U. Hentschel, G. Smith, J.G. Draguns, & W. Ehlers (Eds.), *Advances in psychology, 136: Defense mechanisms: Theoretical, research and clinical perspectives* (pp.165-192). New York: Elsevier.

Perry, J.C. & Hoglend, P. (1998). Convergent and discriminant validity of overall defensive functioning. *The Journal of Nervous and Mental Disease, 186,* 529-535.

Perry, J.C. & Ianni, F. F. (1998). Observer-rated measure of defense mechanisms. *Journal of Personality, 66,* 993-1024.

Perry, J.C. & Kardos, M. (1995). A review of the Defense Mechanism Rating Scales. In H.R. Conte & R. Plutchik (Eds.), *Ego defenses: Theory and measurement* (pp. 283-299). Oxford, England: John Wiley & Sons.

Perry, J.D. & Perry, J.C. (2004). Conflicts, defenses and the stability of narcissistic

personality features. *Psychiatry: Interpersonal and Biological Processes, 67,* 310-330.

Petraglia, J., Janzen, J. I., Perry, J. C., & Olson, T. R. (2009). The relationship between therapist interpretation accuracy and in-session change in patients' defensive functioning. Paper presented at the Canadian chapter of the Society for Psychotherapy Research (SPR), Montreal, Canada.

Petraglia, J., Bhatia, M., & Drapeau, M. (2013). Ten principles to guide psychodynamic technique with defense mechanisms: An examination of theory, research, and clinical implications. *Manuscript Submitted for Publication.*

Petraglia, J., Bhatia, M., de Roten, Y., Despland, J.N., & Drapeau, M. (2013). An empirical investigation of defense interpretation depth, defensive functioning, and alliance strength in psychodynamic psychotherapy *Manuscript submitted for publication.*

Piper, W.E., Azim, H.F.A., Joyce, A.S., & McCallum, M. (1991). Transference interpretations, therapeutic alliance, and outcome in short-term individual psychotherapy. *Archives of General Psychiatry, 48,* 946-953.

Piper, W.E., Azim, H.F.A., Joyce, A.S., & McCallum, M. (1991). Quality of object relations versus interpersonal functioning as predictors of therapeutic alliance and psychotherapy outcome. *Journal of Nervous and Mental Disease, 179,* 432-438.

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1988). Good and poor practices in psychotherapy: National survey of beliefs of psychologists. *Professional Psychology: Research and Practice, 19*(5), 547-552.

Roy, C.A., Perry, J.C., Luborsky, L., & Banon, E. (2009). Changes in defensive

functioning in completed psychoanalysis: The Penn psychoanalytic treatment collection. *Journal of the American Psychoanalytic Association, 57,* 399-415.

Sacshe, R. (1993). The effects of intervention phrasing on therapist-client communication. *Psychotherapy Research 3*, 260-277.

Scafer, R. (1992). *Retelling a life: Narration and dialogue in psychoanalysis*. USA: Basic Books.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65,* 98-109.

Siefert, C.J., Hilsenroth, M.J., Weinberger, J., Blagys, M.D., & Ackerman, S.A. (2006). The relationship of patient defensive functioning and alliance with therapist technique during short-term psychodynamic psychotherapy. *Clinical Psychology and Psychotherapy, 13*, 20-33.

Silberschatz, G., Fretter, P.B., & Curtis, J.T. (1986). How do interpretations influence the process of psychotherapy? *Journal of Consulting and Clinical Psychology, 5,* 646-652.

Stewart, R. E., & Chambless, D. L. (2008). Treatment failures in private practice: How do psychologists proceed. *Professional Psychology: Research and Practice, 39*(2), 176-181.

Summers, R.F. & Barber, J.P. (2010). *Psychodynamic therapy: A guide to evidence-based practice.* New York, NY: Guilford Press.

Tamtam, D. (2006). Psychotherapy in the UK: Results of a survey of registrants of the United Kingdom council for psychotherapy. *European Journal of Psychotherapy and Counselling, 8*, 321-342.

Town, J., Abbass, A. & Hardy, G. (2011). Short-term psychodynamic psychotherapy for personality disorders: A critical review of randomised controlled trials. *Journal of Personality Disorders, 25,* 723-740.

Vaillant, G. E. (1993). *The wisdom of the ego.* Cambridge: Harvard University Press.

Vaillant, G.E. (1994). Ego mechanisms of defense and personality pathology. *Journal of Abnormal Psychology, 103,* 44-50.

Vaillant, G.E., Bond, M., & Vaillant, C.O. (1986). An empirically validated hierarchy of defense mechanisms. *Archives of General Psychiatry, 43,* 786-794.

Weiner, I.B. & Bornstein, R.F. (2009). *Principles of psychotherapy: Promoting evidence-based psychodynamic practice* (3rd ed.). NJ: Wiley.

Westen, D. (2007). Discovering what works in the community: Towards a genuine partnership of clinicians and researchers. In S.G. Hofmann & J. Weinberger (Eds.), *The art and science of psychotherapy* (pp. 3-29). New York, NY: Routledge.

Winston, B., Winston, A., Samstag, L.W., & Muran, J.C. (1993). Patient defense/therapist interventions. *Psychotherapy, 31,* 478-491.

Wolberg, L.R. (1977). *The technique of psychotherapy* (3rd ed.). New York: Grune & Stratton.

Appendix A: Request Script for Listserv: Manuscript 1 & 2

Dear (name of corresponding individual at listserv)

I am a doctoral student at McGill University working under the supervision of Professor Martin Drapeau. We are currently conducting a study investigating the extent to which psychotherapists practicing psychodynamic psychotherapy focus on the role of defense mechanisms in their therapeutic work. As such, I am contacting your listserv with the request that you could forward members of your listserv an email invitation to the study. The study will take about 15 minutes of your time, during which you will be asked to read and rate a number of short statements. There are no risks involved in participating in this study. I am attaching a copy of the email invitation with the link to the survey below. If you could forward this to the members of your listserv it would be most appreciated. If you have any questions please contact Professor Martin Drapeau at martin.drapeau@mcgill.ca. I thank you in advance for your time and participation in our research study.

Sincerely,

Maneet Bhatia, M.A.
Ph.D. Student
McGill Psychotherapy Process Research Group
McGill University- ECP
Email Address: maneet.bhatia@mail.mcgill.ca

Appendix B: Email Invitation: Manuscript 1 & Manuscript 2

Study 1 Email Invitation

Dear clinician or clinician in training:

I am a doctoral student at McGill University working under the supervision of Professor Martin Drapeau. We are currently conducting a study investigating the extent to which psychotherapists practicing psychodynamic psychotherapy focus on the role of defense mechanisms in their therapeutic work. As such, you are invited to participate in this study. Please be aware that only those currently practicing psychotherapy (or in training) are invited to participate. Please click on the web link located at the bottom of this email. An informed consent form will appear. You will be asked to provide consent by clicking on the "YES" or "NO" options after reading the consent form. Upon consent, a second web page will appear with the research questionnaire. The study will take about 15 minutes of your time, during which you will be asked to read and rate a number of short statements. There are no risks involved in participating in this study.

We thank you in advance for your time and participation in our research study.
For additional information, please contact Professor Martin Drapeau at martin.drapeau@mcgill.ca

Sincerely,

Maneet Bhatia, M.A.
Ph.D. Student
McGill Psychotherapy Process Research Group
McGill University- ECP
Email address: maneet.bhatia@mail.mcgill.ca

PLEASE CLICK BELOW TO PARTICIPATE:
https://www.surveymonkey.com/s/defensemechanisms

Study 2: Email Invitation

Dear Colleague:

I am a doctoral candidate in **Counselling Psychology in the Department of Educational and Counselling Psychology at** McGill University working under the supervision of Professor Martin Drapeau. We are currently conducting a study investigating the extent to which psychotherapists practicing psychodynamic psychotherapy agree with technical guidelines outlined by psychodynamic theorists on how to interpret defenses in their clinical practice. **As such, you are invited to participate in this research study**. Please be aware that only those currently practicing psychotherapy are invited to participate.

Please click on the web link located at the bottom of this email. An informed consent form will appear. You will be asked to provide consent by clicking on the "YES" or "NO" options after reading the consent form. Upon consent, a second web page will appear with the research questionnaire. The study will take no more than 10 minutes of your time, during which you will be asked to read and rate a number of short statements.

There are no risks involved in participating in this study. Your responses will be entirely anonymous and will not be identified with you in any manner. Your anonymous results will be stored under a password protected online account. Upon completion of the study, results will be transferred to a protected data-drive for analysis and storage. Results will be disseminated at national and international scholarly meetings and published in peer-reviewed journals. Given that the **Qualtrics- the online survey software program being used to conduct this survey-maintains data on servers in the United State, there is a possibility that your identifiable data could potentially be accessed under the U.S. Patriot Act.**

Your participation is voluntary and you may choose not to participate or withdraw at any time or refuse to answer any question you do not wish to. **However, you will not be allowed to withdraw your data from the study once submitted.**

For additional information, please contact Professor Martin Drapeau at martin.drapeau@mcgill.ca or myself at maneet.bhatia@mail.mcgill.ca.
If you have any questions or concerns regarding your rights or welfare as a participant in this research study, please contact the McGill Ethics Officer at 514-398-6831 or lynda.mcneil@mcgill.ca

We thank you in advance for your time and participation in our research study. Please print a copy of this consent form for your files.

Sincerely,

Maneet Bhatia, M.A.
Ph.D. Candidate

McGill Psychotherapy Process Research Group
McGill University- ECP
Email address: maneet.bhatia@mail.mcgill.ca

PLEASE CLICK BELOW TO PARTICIPATE:
https://mcgilluecp.qualtrics.com/SE/?SID=SV_77zMymlRkT9JG6x

Appendix C: Copy of Survey Manuscript 1

INFORMED CONSENT, TO APPEAR ON FIRST PAGE OF THE SURVEY

Dear colleague,

This study, entitled "An investigation of the importance of the defense mechanisms construct to psychodynamic psychotherapists" is being conducted at McGill University by Maneet Bhatia, a doctoral student working under the supervision of Professor Martin Drapeau. The purpose of this research is to investigate the extent to which psychotherapists practicing psychodynamic psychotherapy focus on the role of defense mechanisms in their therapeutic work.

Your participation in this study will entail a brief survey, which will last approximately 15 minutes. You will be asked to complete a series of questions assessing the importance of defense mechanisms in psychodynamic psychotherapy.

Your responses will be entirely anonymous and will not be identified with you in any manner. Your anonymous results will be stored under locked conditions for future research. Results will be disseminated at national and international scholarly meetings and published in peer reviewed journals

Your participation is voluntary and you may choose not to participate or withdraw at any time or refuse to answer any question you do not wish to.

You may contact Professor Drapeau at Tel: 514-398-4904 or Maneet Bhatia at maneet.bhatia@mail.mcgill.ca if you have any questions or concerns.

I have read the above information and I agree to participate in this study:

Yes CLICK HERE (LEADS TO NEXT PAGE WITH QUESTIONS)
If not, please close this webpage.

Survey of Defense Technique

Part 1

1. Gender:
Male
Female

2. Age:
Below 30
30-35
40-45
45-50
55-60
65+

3. I am currently licensed as a:
Counsellor
Psychiatrist
Psychologist
Physician (G.P)
Social Worker
Non-licensed
Other (please specify): _____

4. Highest Degree:
Ed.D
D.Ps. / Psy.D.
Master's
M.D.
Ph.D.

5. How many years have you been practicing psychotherapy?
Less than 5
5-10
10-15
15-20
20-25
25-30
30+

6. What approach to psychoanalytic/psychodynamic psychotherapy best describes what you practice (e.g., psychoanalysis, psychodynamic psychotherapy, short-term dynamic therapy, intensive short-term dynamic therapy, experiential dynamic therapy)?

_____

7. On average, how many sessions do you typically see your patients for?

Fewer than 10 sessions

10 to 20 sessions

20 to 40 sessions

40 to 60 sessions

60 +

None of the above

Part II

A. In your opinion, are defense mechanisms an important construct in psychodynamic psychotherapy?

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

In your practice:

B. Rate the importance of interpreting patient defenses.

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

C. Rate the importance of interpreting the patient's <u>most</u> common defense.

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

D. Rate the importance of interpreting the patient's out of character defenses (e.g. Healthy Neurotic patient who infrequently acts out).

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

E. Rate the extent to which a therapist's choice of defense to interpret in-session should be based on psychodynamic theory.

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

F. Rate the importance (as a therapist) of adjusting one's therapeutic technique to patients' defensive maturity level.

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

G. Rate the importance of correctly timing an intervention that aims to address some aspect of defensive functioning.

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

H. Rate the importance of accurately identifying and addressing the defenses used by patients in-session. (e.g., interpreting the defense Isolation when the patient is in fact using that defense).

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

I. Rate the importance of making "deep" interpretations in psychodynamic psychotherapy (that include motives, wishes, repressed or latent content).

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

J. How important is it to address the defense used by the patient as opposed to what is defended against (unconscious motive, wish, impulse or drive)?

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

K. Is it important in psychotherapy to use increasingly "deeper" interpretation with patients as therapy progresses (the so-called "surface to depth" rule)?

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

L. Rate the importance of naming the affect associated with each defense mechanism when making interpretations in psychotherapy.

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

M. Rate the importance of interpreting a defense when it is emotionally charged

(meaning that the emotional content associated with the defense is readily observable to the therapist)

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

N. Rate the importance of interpreting a defense when it is emotionally detached or 'cold' (meaning that the emotional content associated with the defense is not readily observable to the therapist)

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

O. How helpful do you believe it is to use interpretive techniques with "Immature" defense such as Splitting, Projection, & Acting Out?

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

P. On average how long do you believe it takes for therapeutic techniques aimed at addressing defensive behavior to promote more adaptive defense use by patients?

Never	Within 1 session	<25 sessions	25-52 sessions	>52 sessions
1	2	3	4	5

Q. How important do you believe it is to support the use of adaptive/mature defenses by patients?

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

R. How often do you interpret defenses used by patients in their lives outside of therapy as opposed to defenses used within the session?

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

S. How important do you believe it is to avoid the use of technical language when expressing the interpretation of defenses to patients?

Not at all	Slightly	Neutral	Important	Very Important
1	2	3	4	5

Additional Comments:

Thank you for completing the study.

Appendix D: Copy of Survey Manuscript 2

Defense Mechanisms Survey- Informed Consent

Dear colleague,

This study, entitled **"Examining the extent to which psychodynamic therapists agree with the technical guidelines for interpreting defense mechanisms in their clinical practice"** is being conducted at McGill University by Maneet Bhatia, a doctoral candidate working under the supervision of Professor Martin Drapeau. The purpose of this research is to investigate the extent to which psychotherapists practicing psychodynamic psychotherapy agree with technical guidelines outlined by psychodynamic theorists on how to interpret defenses in their clinical practice.

Your participation in this study will entail a brief survey, which will last no more than 10 minutes. You will be asked to complete a series of questions assessing the importance of defense mechanisms in psychodynamic psychotherapy.

Your responses will be entirely anonymous and will not be identified with you in any manner. Your anonymous results will be stored under locked conditions for future research. Results will be disseminated at national and international scholarly meetings and published in peer-reviewed journals.

Your participation is voluntary and you may choose not to participate or withdraw at any time or refuse to answer any question you do not wish to.

You may contact Professor Drapeau at martin.drapeau@mcgill.ca or by telephone at 514-398-4904 or Maneet Bhatia at maneet.bhatia@mail.mcgill.ca if you have any questions or concerns.

Please print a copy of the informed consent for your files.
I have read the above information and I agree to participate in this study. Please print "YES" in the space below:

_____

SURVEY

Part 1 (Circle your choice)

1. Gender:
Male
Female

2. Age:
Below 30
30-35
36-40
41-45
46-50
51-55
56-60
61-65
65+

3. I am currently licensed as a:
Counsellor
Psychiatrist
Psychologist
Physician (G.P)
Social Worker
Non-licensed
Other (please specify): _____

4. Highest Degree:
Ed.D
D.Ps. / Psy.D.
Master's
M.D.
Ph.D.

5. How many years have you been practicing psychotherapy?
Less than 5
5-10
10-15
15-20
20-25
25-30
30+

6. To what extent do you practice each of these models in your clinical practice?

Psychoanalysis

1- Not at all
2- Somewhat
3- Often
4- Very much

Short-term psychodynamic psychotherapy (STDP)

1- Not at all
2- Somewhat
3- Often
4- Very much

Psychodynamic psychotherapy

1- Not at all
2- Somewhat
3- Often
4- Very much

Other (please specify)

1- Not at all
2- Somewhat
3- Often
4- Very much

PART II

A recent review of the psychoanalytic/psychodynamic literature on working with defense mechanisms was conducted and a number of principles explaining how therapists should work with patient defenses were identified. This part of the survey will ask you to examine 16 principles that were identified in this review and rate the extent to which you agree or disagree (1- strongly disagree, 2- disagree, 3- neutral, 4-agree, 5-strongly agree) with each principle in your own clinical practice.

DEFENSE PRINCIPLE:
Therapists should systematically move from "surface to depth" interpretations when working with patient defenses.

DESCRIPTION: Therapists should start by interpreting defensive material that is closer to consciousness rather than that which is unconscious (e.g., motive behind defense, conflict, genetic material, etc.)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapist should interpret the patient's most "typical" defenses and characterological defenses.

DESCRIPTION:
Therapists should interpret those defenses that the patient uses most frequently, or more typically, and that seem to be most closely related to the conflict associated with symptoms, presenting problems, or other difficulties associated with functioning.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapists should interpret the patient's most "atypical" and "out of character" defenses.

DESCRIPTION:
Therapists should interpret defenses that are “out of character” and not part of the “typical set” of defenses used by a patient.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapists should first interpret defenses used as resistance by the patient.

DESCRIPTION:
Therapists should interpret any defense mechanism used by a patient to not engage in the therapeutic process.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapists should interpret defenses used inside the therapeutic hour.

DESCRIPTION:
Therapists should interpret "inside defenses" which are defenses a patient uses in-vivo during the session.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapists should interpret defenses used outside the therapeutic hour.

DESCRIPTION:
Therapists should interpret "outside defenses" which are defenses a patient used or reported using outside the therapy session.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapists should keep defense interpretations for the middle phase of therapy (not the beginning or end).

DESCRIPTION:
Therapists should address defenses in the middle phase of therapy so that the alliance has had sufficient time to develop before uncovering and pointing out the slightly more anxiety provoking aspects of defensive behaviour.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapists should interpret defenses during the beginning of the therapeutic hour.

DESCRIPTION:
Therapists should interpret defenses at the beginning of the therapy session as it allows enough time for patients to assimilate and understand the information throughout the duration of the session.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapists should understand the affect associated with the defense when making defense interpretations.

DESCRIPTION:
In their defense interpretations and whenever possible, therapists should name/identify the affect that is being defended against.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapists should avoid using technical language in defense interpretations.

DESCRIPTION:
Therapists should avoid verbose language or the use of psychological jargon when making defense interpretations.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapists should balance between supportive and interpretive techniques when working with defenses.

DESCRIPTION:
Therapists should intervene by both interpreting defenses that the patient uses, and by using supportive techniques such as clarifications, reflections, associations, questions, acknowledgments, or other support strategies.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapists should accurately identify the defenses a patient uses in-session.

DESCRIPTION:
Therapists should make accurate interpretations, which are those interpretations that correctly identify the type and function of the defense used by the patient in session.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapists should interpret a defense when the patient uses it in an emotionally charged or "hot" manner.

DESCRIPTION:
Therapists should interpret a patient's defense when his/her anxiety and level of emotionality is rising.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapists should NOT interpret a defense when a patient uses it in an emotionally charged and/or "hot" manner.

DESCRIPTION:
Therapists should not interpret defenses that are too emotionally activated because the sheer emotionality of the situation makes it not appropriate to interpret, and harder for the patient to be amenable to interpretation.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapists should interpret a defense when a patient uses it in an emotionally "cold" manner.

DESCRIPTION:
Therapists should interpret when a defense is cold or no longer emotionally active because the patient is more susceptible to interpretation as he/she is less likely to use defenses such as denial or other disavowal defenses to guard against examining the conflicted material.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

DEFENSE PRINCIPLE:
Therapists should NOT interpret a defense when a patient uses it in an emotionally "cold" manner.

DESCRIPTION:
Therapists should not interpret defenses when the emotional level seems "cold" and "detached" because if little anxiety is inculcated by the interpretation it will be forgotten or dismissed by the patient and fall short of its intended target.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

PART III

PART III is the final section of the survey, we promise.

Please rank the following principles in order of significance (from 1= most important to 16= least important) based on your clinical practice.

DEFENSE PRINCIPLE:
Therapists should systematically move from "surface to depth" interpretations when working with patient defenses.

_____

DEFENSE PRINCIPLE:
Therapists should interpret the patients' most "typical" defenses and characterological defenses.

_____

DEFENSE PRINCIPLE:
Therapists should interpret the patients' most "atypical" and "out of character" defenses.

_____

DEFENSE PRINCIPLE:
Therapists should first interpret defenses used as resistance by the patient.

_____

DEFENSE PRINCIPLE:
Therapists should interpret defenses used inside the therapeutic hour.

_____

DEFENSE PRINCIPLE:
Therapists should interpret defenses used outside the therapeutic hour.

_____

DEFENSE PRINCIPLE:
Therapists should keep defense interpretations for the middle phase of therapy (not the beginning or end).

_____

DEFENSE PRINCIPLE:
Therapist should interpret defenses during the beginning of the therapeutic hour.

_____

DEFENSE PRINCIPLE:
Therapists should understand the affect associated with the defense when making defense interpretations.

_____

DEFENSE PRINCIPLE:
Therapists should avoid using technical language in defense interpretations.

_____

DEFENSE PRINCIPLE:
Therapists should balance between supportive and interpretive techniques when working with defenses.

_____

DEFENSE PRINCIPLE:
Therapists should accurately identify the defenses a patient uses in-session.

_____

DEFENSE PRINCIPLE:
Therapists should interpret a defense when a patient uses it in an emotionally "cold" manner.

_____

DEFENSE PRINCIPLE:
Therapists should interpret a defense when the patient uses it in an emotionally charged or "hot" manner.

_____

DEFENSE PRINCIPLE:
Therapists should NOT interpret a defense when a patient uses it in an emotionally charged and/or "hot" manner.

_____

DEFENSE PRINCIPLE:
Therapists should NOT interpret a defense when a patient uses it in an emotionally "cold" manner.

_____

Appendix E: Authorization for Recording of Psychotherapy Session & General Consent

DUPA
DEPARTEMENT UNIVERSITAIRE
DE PSYCHIATRIE ADULTE

HOSPICES CANTONAUX /
ETAT DE VAUD

AUTORISATION D'ENREGISTREMENT

Madame, Monsieur,

Vous avez accepté de participer à une étude sur l'efficience de la psychothérapie psychanalytique brève menée par le Centre d'Etude des Psychothérapies Psychanalytiques.

Par la présente, vous nous donnez votre accord pour que ces séances de psychothérapie individuelle soient enregistrées en audio.

Ces enregistrements sont à l'usage exclusif de la recherche. Certaines séances seront ensuite dactylographiées et rendues anonyme de manière à ce qu'aucune information permettant d'identifier l'un ou l'autre des participants ainsi que toute personne citée au cours des entretiens ne soit maintenue.

Lausanne, le . . . . . Signature :

DUPA
DEPARTEMENT UNIVERSITAIRE
DE PSYCHIATRIE ADULTE

HOSPICES CANTONAUX /
ETAT DE VAUD

CONSENTEMENT ÉCLAIRÉ

Je, soussigné(e), accepte de participer à une recherche concernant l'efficience de la psychothérapie psychodynamique brève menée par le Centre d'Etude des Psychothérapies Psychanalytiques.

J'accepte de remplir les questionnaires qui me seront proposés au début et à la fin de la thérapie ainsi qu'après chaque séance.

J'accepte que les enregistrements des entretiens de psychothérapie que je vais avoir avec le psychothérapeute : . . . . . soient utilisés pour une recherche

J'accepte que ces entretiens soient dactylographiés par un collaborateur du Centre d'Etude des Psychothérapies Psychanalytiques.

J'ai été informé(e) que la recherche se fera sur la base d'un texte dactylographié anonyme et qu'aucune information permettant d'identifier l'un ou l'autre des participants ainsi que toute personne citée au cours de ces entretiens ne sera maintenue.

J'ai été informé(e) que, à ma demande, j'ai la possibilité de consulter le texte dactylographié de ces entretiens.

J'ai eu la possibilité de poser à la personne que j'ai rencontré pour la recherche toutes les questions que je me suis posée sur cette étude et j'ai compris l'information qui m'a été donnée.

J'accepte que les différents résultats de cette étude puissent être divulgués sous la forme de publications scientifiques et de présentations scientifiques, sachant que mon identité ne sera jamais dévoilée et que rien dans le texte de la publication ou de l'exposé ne permettra de me reconnaître, de reconnaître le thérapeute qui m'a traité ou toute personne citée au cours de ces entretiens.

Lausanne, le . . . . . Signature :

DUPA

DEPARTEMENT UNIVERSITAIRE
DE PSYCHIATRIE ADULTE

HOSPICES CANTONAUX /
ETAT DE VAUD

CHEF DE DEPARTEMENT
PROF. PATRICE GUEX

INFORMATIONS GÉNÉRALES

Madame, Mademoiselle, Monsieur,

Vous avez accepté de participer à une recherche menée par Le Centre d'Etude des Psychothérapies Psychanalytiques (CEPP) du Département Universitaire de Psychiatrie Adulte (DUPA) de Lausanne, ce dont nous vous remercions.

La participation à cette recherche implique pour vous deux choses :

1. Accepter que les entretiens soient enregistrés sur cassettes audio.

2. Remplir quelques questionnaires.

Vous trouverez dans cette enveloppe une série de questionnaires. Nous vous conseillons de choisir un moment tranquille dans votre journée pour remplir l'ensemble des questionnaires en une fois. Cela devrait vous prendre entre 50' et 60'.

Vous trouverez ci-joint les questionnaires à remplir suivants :

1. Une liste d'évaluation des symptômes (SCL-90)

Qu'est-ce que c'est? La liste d'évaluation des symptômes, abrégée SCL-90 compte 90 brèves questions concernant des plaintes ou symptômes dont vous pourriez souffrir. Des instructions précises sont notées au début du questionnaire lui-même.

Durée du questionnaire? Environ 15 minutes.

2. Un questionnaire abrégé de Beck

Qu'est-ce que c'est? Ce questionnaire comprend 13 questions qui concernent les symptômes liés à la dépression.

Durée du questionnaire? Environ 10 minutes.

3. Un questionnaire d'auto-évaluation de l'anxiété (STAI)

Qu'est-ce que c'est? Ce questionnaire mesure deux types de symptômes liés à l'anxiété : ce qui correspond à votre état actuel, sur le moment, et ce qui correspond à votre tempérament habituel.

Durée du questionnaire? Environ 10 minutes.

4. Un questionnaire d'adaptation sociale (SAS)

Qu'est-ce que c'est? Le questionnaire d'adaptation sociale, abrégé SAS-SR compte 54 brèves questions concernant 4 domaines de votre existence: le travail, la vie sociale et les loisirs, la famille, les relations avec les enfants si vous en avez. Des instructions précises sont notées au début du questionnaire lui-même.

Durée du questionnaire? Environ 15 minutes.

5. Un questionnaire d'alliance aidante (HAq)

Qu'est-ce que c'est? Il s'agit d'un questionnaire d'alliance thérapeutique qui compte 11 brèves questions concernant votre relation avec le thérapeute que vous avez rencontré à la consultation des étudiants. Le questionnaire cherche à évaluer la qualité de la relation telle que vous la percevez.

Durée du questionnaire? Entre 5 et 10 minutes

6. Un inventaire de problèmes interpersonnels (IIP)

Qu'est-ce que c'est? L'inventaire de problèmes interpersonnels se compose de 127 questions concernant les difficultés que vous pouvez rencontrer dans vos relations avec les autres. Il est composé de deux parties: dans la première, vous devez juger ce qui vous est difficile de faire, dire, être, etc. face aux autres; dans la deuxième, vous devez juger ce que vous avez tendance à exagérer dans vos rapport avec les autres.

Durée du questionnaire? Environ 15 minutes.

7. Une mesure d'actualisation du potentiel (MAP)

Qu'est-ce que c'est? La mesure de l'actualisation du potentiel comprend 27 questions qui cherchent à évaluer votre degré d'autonomie par rapport aux autres et votre capacité d'adaptation.

Durée du questionnaire? Environ 10 minutes.

Une fois remplis, ces questionnaires doivent être envoyés par la poste à l'aide des enveloppes déjà affranchies. Ces questionnaires seront évalués de manière anonyme et votre thérapeute n'aura pas connaissance de vos réponses avant que la totalité de votre traitement soit terminé.

Si vous avez des questions concernant cette recherche, vous aurez l'occasion de les poser à la personne de la recherche que vous rencontrerez. Vous pourrez également lui demander vos résultats aux différents questionnaires.

Merci encore pour votre collaboration qui nous est très précieuse pour évaluer la qualité de nos prestations et améliorer l'efficacité de nos services.

Yves de Roten, Dr psych., PD

Responsable de la recherche