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Lack of Affect Defenses, Affect Isolation of an Inclusive Kind or Affect Inhibition Were Uncommon in the Defense Mechanism Technique modified (DMTm) when Psychodynamic Therapy was Recommended by the Clinical Staff

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A group of 200 psychiatric patients, 129 women and 71 men, were given recommendations by a four-person staff of their receiving psychodynamic therapy (PDT; 47 women, 17 men), cognitive psychotherapy (CPT; 19 women, 5 men) or cognitive behavioral therapy (CBT; 34 women, 20 men), or of their having no psychotherapy (NPT; 29 women, 29 men). The staff knew the ICD-10 diagnoses but made its judgments primarily on the basis of information obtained from a clinical interview performed with each of the patients by some one of the members of the staff. All of the patients were given the Defense Mechanism Technique modified (DMTm), a percept-genetic technique, although the results of it had not yet been scored and were thus not used by the staff in making their recommendations. The question of the characteristics that could be expected to appear in the DMTm less frequently when PDT is recommended than when CPT, CBT or NPT is recommended was considered. The following three DMTm characteristics were predicted to appear less frequently in the PDT patients than in the other three groups: a lack of affect defenses, the presence of affect isolation of an inclusive kind and affect inhibition. This was found to hold, both for the male and for the female patients. The occurrence of inclusive affect isolation was found to be the most decisive characteristic.

Keywords: Defense Mechanism Technique modified (DMTm), cognitive behavioral therapy (CBT), cognitive psychotherapy (CPT), percept-genesis, psychodynamic therapy (PDT)

In the now classic Menninger Psychotherapy Research Project (Wallerstein, 1986), the results of being given psychoanalysis five times a week were compared with those of being given supportive or expressive psychotherapy two to three times a week. The patients were not

randomized to these two forms of psychotherapy but were provided the treatment which the clinical staff considered would be most effective with them. This appears to be a usual strategy in clinical praxis when two or more forms of psychotherapy are available for patients. In the present study, of similar design, the following psychotherapies were offered: psychodynamic therapy (PDT), cognitive psychotherapy (CPT) and cognitive behavioral therapy (CBT). Those patients were also identified for whom none of these psychotherapies appeared suitable (the group NPT, or no psychotherapy).

Each patient met with and was diagnosed according to the ICD-10 Classification of Mental and Behavioural Disorders (World Health Organization, 1990) by some one of the psychiatrists at the clinic, who also made the remittance to psychotherapy, the decision of the type involved and of whether psychotherapy appeared advisable being made by a four-person staff: two psychologists, both authorized for PDT, and a psychologist and a psychiatrist who were both authorized for CBT. The diagnosis, together with a clinical interview performed by some one of the staff members, was the information the staff used in deciding whether the patient was to obtain therapy and of what kind. A percept-genetic technique, the Defense Mechanism Techniqe modified (DMTm; Andersson & Bengtsson, 1985), was also administered to most of the patients by two of us (MW or LTO, both psychologists belonging to the four-person staff). DMTm, which was intended to be used later in an attempt to evaluate the outcome of the therapies, was thus not scored at this point, its accordingly playing no role in the decision by the staff regarding the type of therapy if any was to be offered and of whether therapy should be given a particular patient at all. This made it possible to pose the following question: What characteristics should appear in the DMTm less often when PDT is recommended by the staff than when CPT, CBT or NPT is recommended?

Signs of anxiety and defense against anxiety found in DMTm are interpreted in terms of the Andersson (1991) developmental and psychodynamic model of the mind. Since handling intrapsychic conflict by means of a process of working through is important both within psychoanalysis (Freud, 1914) and within PDT, our interest here was primarily in defenses individuals may use for handling such conflicts. In the Andersson model these defenses are referred to as affect defenses, to be distinguished from denial and identity defenses, the latter also being referred to as denial through reversal. To us it seemed obvious that for persons without the capacity to handle intrapsychic conflicts by means of affect defenses, PDT is not the best choice. In DMTm, a lack of affect defenses is signalled by the failure of repression, projected introaggression, affect inhibition, introaggression, barrier isolation or affect isolation to be scored.

We also believed that the appearance of certain affect defenses in the DMTm could indicate PDT to be a doubtful option. Affect isolation, particularly of the inclusive kind that involves a total loss at some point of the content just specified in the preceding exposure within a given DMTm series (scored according to the DMTm manual as isolation 4, to be distinguished from partial affect isolation, which only involves ”whitening” of the threatening person and is referred to as isolation 3), was our first choice in this respect. The specified motive in the case of affect isolation in the Andersson model corresponds to what Melanie Klein (1935, 1940, 1946) in her affect positions model refers to as the manic-obsessional position. In a very literal sense, inclusive affect isolation represents a total annulment of the subjective, affective world (and is often referred to, therefore, as a ”zero phase” of the DMTm genesis). We felt that in therapy this could show the patient to be inclined to refuse to give symbolic form to that world, something which is necessary for PDT to have the desired effect.

Finally, PDT could be thought to be less useful for patients who in the DMTm employ the defense referred to as affect inhibition. The specified motive for affect inhibition in the Andersson model is derived from the Kleinian depressive position, its also being the specified motive for the affect defense of introaggression. These two defenses are very different from one another, however, introaggression having been found, for example, to be strongly related to creativity and affect inhibition (like affect isolation) to be strongly related to non-creativity (Ryhammar, 1996; Andersson & Ryhammar, 1998; cf. Andersson, Dahlström & Ekvall, 2003). We reasoned, therefore, that the defense of affect inhibition could be a hindrance to the openness to the affective world that is required of the patient for PDT to be successful.

METHOD

Participants

During the period of March 1996 to October 1999, a total of 257 patients were remitted by psychiatrists at a psychiatric clinic in a hospital in the central part of Sweden to the staff of four persons who were to judge in each case whether psychotherapy was an appropriate form of treatment for them, and if so, which type was best. Thirty-two patients abstained from being judged in this manner and 149 of the 225 that remained were regarded as suitable for psychotherapy, although 7 of these were not tested with DMTm. The 142 patients that were left, who all had taken DMTm, were assigned to the different types of psychotherapy as follows: 64 PDT (47 women, median age 33, age range 20-59 years; 17 men, median age 35, age range 20-58 years), 24 CPT (19 women, median age 36, age range 19-52 years; 5 men, median age 32, age range 22-42 years) and 54 CBT (34 women, median age 34, age range 20-

57 years; 20 men, median age 33, age range 22-55 years). Of the 76 remaining patients for whom psychotherapy was not recommended, 58 were tested with DMTm. This NPT group included 29 women (median age 34, age range 19-59 years) and 29 men (median age 35, age range 21-59 years). There were thus 200 DMTm protocols altogether, for 129 women and 71 men, available for scoring.

All patients were diagnosed according to ICD-10. Sixty-two (31 %) of them had more than one diagnosis. The following diagnoses were found in only very few patients: psychosis (two patients, one not recommended for psychotherapy and the other recommended for PDT), somatoform disorders (2 NPT), other neurotic disorders (1 CBT, 3 NPT), eating disorders (3 PDT, 1 CPT, 1 CBT, 4 NPT) and unspecified behavioral disorders (1 CPT). Reactions to severe stress as well as adjustment disorders were overrepresented in the PDT group (11 PDT, 0 CPT, 1 CBT, 1 NPT; $p = .0003$, Fisher Exact Probability Test, two-tailed), mood disorders in the PDT and CPT groups (38 PDT, 13 CPT, 14 CBT, 19 NPT; $p = .00009$), phobic anxiety disorders (4 PDT, 5 CPT, 19 CBT, 6 NPT; $p = .00009$) and obsessive-compulsive disorder (3 PDT, 2 CPT, 12 CBT, 2 NPT; $p = .0006$) in the CBT group and, finally, other anxiety disorders in the NPT group (14 PDT, 3 CPT, 10 CBT, 21 NPT; $p = .02$). There was no statistically significant difference between the groups in terms of their frequencies of personality disorders (21 PDT, 6 CPT, 10 CBT, 18 NPT).

Defense Mechanism Technique modified

In DMTm, like in its forerunner the Defense Mechanism Test (Kragh, 1960), two picture motifs are shown tachistoscopically, in both the exposure times increasing successively in a series of 20 exposures from 5 to 1150 milliseconds. Both pictures include a threatening peripherally-situated person (referred to as Pp) who in the first picture is of female gender (“the threatening mother”) and in the second of male gender (”the threatening father”). In each picture there is a centrally-placed child or young person (hero/heroine or H) of the same gender as the subject tested, and also a disguised sexual attribute (referred to as A) located in front of H.

The DMTm pictures are aimed at arousing various forms of anxiety that can find expression either directly in the subject’s reports or indirectly as various forms of defense against anxiety. The scoring, which is based on the subject’s drawings and verbal reports pertaining to each of the 40 exposures (20 from each series) also provides some ”additional signs” not referred to as expressions of anxiety and defense, yet important in diagnostic terms. The scoring, conducted in accordance with the latest DMTm manual (Andersson, 2004) and

performed before the predictions of the present study were specified, was carried out independently by each of the three of us. Thereafter, two of us (MW and LTO) agreed on a scoring to be compared with the scoring made by the one of us (ALA) who had not been involved in the testing or in the therapeutic decisions made (for a recent assessment of the interrater agreement between MW and ALA in connection with another sample, see Wilhelmsson & Andersson, 2005). The few discrepancies found were settled in joint discussion prior to analysis of data.

Inclusive affect isolation was found for 54 of the patients. In accordance with the DMTm manual, the total loss of content indicative of this sign usually appears in a single exposure, but must nevertheless appear in no more than two consecutive exposures in order to be scored. The defense of affect inhibition, found here for 6 of the patients, is scored when (1) Pp is seen on at least five consecutive exposures as a petrified, inanimate or disguised being that is neither threatening nor unpleasant, or as a specified object (repression occurring at the place where Pp is located is not scored here), or when (2) Pp is seen on at least five consecutive exposures as an object distinguished by its contour, or as a framed, empty surface or a white or shining object or surface (barrier isolation or partial affect isolation are not scored here).

In examining the characteristics – evident in the DMTm protocols – other than those related to our research questions, we found no statistically significant differences between the four groups studied (as checked by means of the $\chi 2$ test) for any of the following 26 signs appearing in more than 5 % of the participants: affect anxiety, identity anxiety, separation anxiety, traumatic anxiety, H-repression, Pp-repression, A-repression, projected introaggression, introaggression, barrier isolation, isolation 3-4, marked denial 1 (denial 1 in four or more consecutive exposures), denial 2-3, denial through reversal I, denial through reversal II 1-2, denial through reversal II 3, denial through reversal III, denial through reversal IV, splitting, disappearance of H/partial disappearance of H/loss of meaning of H/only Pp, negation, disappearance of threat, H being seen as positive, H afraid, H sad, or wrong gender of Pp.

RESULTS

The findings, both for the men (Table 1) and for the women (Table 2), and thus for the group as a whole (Table 3), were in line with our expectations.

Regarding the men, none of them were scored for affect inhibition without being scored for inclusive affect isolation as well, and there were very few of them who lacked affect defenses. Inclusive affect isolation was obviously the decisive sign differentiating for the male

participants between the PDT group and the other three groups combined (the contrasts for the appearance versus nonappearance of this sign being 1/16 and 22/32, respectively, giving p = .007). For the women, the three DMTm characteristics of inclusive affect isolation, affect inhibition and lack of affect defenses, had to be considered as a whole in order for statistical support for the hypothesized difference between the PDT group and the three other patient groups to be obtained.

Table 1. *Distribution of the male patients (n = 71) across the four comparison groups, regarding certain of the characteristics obtained in DMTm.*

Men	PDT	CPT	CBT	NPT
(a) No affect defenses	1		4	3
(b) Inclusive affect isolation but no affect inhibition	1	2	8	11
(c) Affect inhibition but no inclusive affect isolation				
(d) Both inclusive affect isolation and affect inhibition				1
(e) Other affect defenses than inclusive affect isolation and affect inhibition	15	3	8	14

Men	PDT	CPT, CBT and NPT
(a), (b), (c) and (d)	2	29
(e)	15	25

p = .002, Fisher Exact Probability Test, two-tailed (also Tables 2 and 3)

Table 2. *Distribution of the female patients (n = 129) across the four comparison groups, regarding certain of the characteristics obtained in DMTm.*

Women	PDT	CPT	CBT	NPT
(a) No affect defenses	5	4	4	6
(b) Inclusive affect isolation but no affect inhibition	8	5	11	6
(c) Affect inhibition but no inclusive affect isolation		1	2	1
(d) Both inclusive affect isolation and affect inhibition	1			
(e) Other affect defenses than inclusive affect isolation and affect inhibition	33	9	17	16

Women	PDT	CPT, CBT and NPT
(a), (b), (c) and (d)	14	40
(e)	33	42

p = .04

In the total group, just as in the male group, inclusive affect isolation, taken alone, appeared less often in the PDT group than in the CPT, CPT and NPT groups combined (the contrasts being 10/54 and 44/92, respectively, giving p = .02). It is also of interest to note that when the PDT group was compared with the CPT and CBT groups combined (the contrasts for the men being 2/15 and 14/11, giving p = .004, those for the women being 14/33 and 27/26, giving p = .04, and those for the men and women combined being 16/48 and 41/37,

giving p = .001), the findings being in principle the same when the patients in the NPT group were added to those in the CPT and CBT groups combined.

Table 3. *Distribution of the patients as a whole (n = 200) across the four comparison groups, regarding certain of the characteristics obtained in DMTm.*

All patients	PDT	CPT	CBT	NPT
(a) No affect defenses	6	4	8	9
(b) Inclusive affect isolation but no affect inhibition	9	7	19	17
(c) Affect inhibition but no inclusive affect isolation		1	2	1
(d) Both inclusive affect isolation and affect inhibition	1			1
(e) Other affect defenses than inclusive affect isolation and affect inhibition	48	12	25	30

All patients	PDT	CPT, CBT and NPT
(a), (b), (c) and (d)	16	69
(e)	48	67

p = .0007

DISCUSSION

The patients studied here were not randomized to the three forms of psychotherapy provided. Instead, the four-person staff decided which of any of the three therapies available appeared best for a given patient. It appears, on the basis of our results, that the staff was rather consistent in these decisions since the predicted DMTm findings were true for both gender groups.

What can be seen as the critical finding in the present investigation is that the recommendations of the four-person staff of for whom PDT would be more appropriate than CPT, CBT or NPT were found to be consonant with how the patients handled their affect anxiety in the DMTm. The finding that the occurrence or absence of the defense of inclusive affect isolation was of decisive relevance here should not be seen as surprising from a psychodynamic point of view. The specified motive for this defense according to the Andersson model is to be found in the Kleinian manic-obsessional position, a position usually considered as opposed to the demanding efforts required for working through an intrapsychic conflict. Particularly notable here is the apparent apprehension of this by the members of the four-person staff in making their recommendations without use of information obtained in the DMTm.

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