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**Enhanced Denial or the Emergence of Affect Isolation of an Inclusive Kind Were
Uncommon in the Defense Mechanism Technique modified (DMTm) after
Successful Psychodynamic Therapy**

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A group of 74 psychiatric patients who had undergone psychodynamic therapy (PDT; 24 women, 10 men), cognitive psychotherapy (CPT; 9 women, 2 men) or cognitive behavioral therapy (CBT; 17 women, 12 men) were given the Defense Mechanism Technique modified (DMTm), a percept-genetic technique, both prior to therapy and four months after completing it, at which time they evaluated by questionnaire the therapeutic outcome in terms of their degree of satisfaction, change in personality, symptoms, and handling of problems and the therapy's usefulness. As hypothesized, either an increase in denial or the emergence of inclusive affect isolation following therapy in DMTm occurred less frequently in PDT patients who rated their therapy as successful than in the remaining PDT patients and in both of the other two patient groups (CPT and CBT), irrespective in the latter case of how the therapeutic outcome was rated. The findings were interpreted in terms of the Andersson developmental and psychodynamic model of the mind.

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

In two case reports exploring use of the Defense Mechanism Test (DMT) before and after psychotherapeutic treatment with classic psychoanalysis in the one case and the Wolpe type of behavior modification in the other, Kragh (1983) suggested that the DMT (Kragh, 1960) and kindred percept-genetic techniques could be useful for the assessment of personality change due to therapy. In the present study, the Defense Mechanism Technique modified (DMTm; Andersson & Bengtsson, 1985) was employed with such an aim, the effects of three types of therapy being compared: psychodynamic therapy (PDT), cognitive psychotherapy

(CPT) and cognitive behavioral therapy (CBT). The participants were a subsample of patients we had studied (Andersson, Wilhelmsson & Tollin Olsson, 2007) by means of DMTm administered directly prior to their having begun the therapy in question, the type of therapy patients received being based on recommendations a four-person staff provided. This earlier study also included patients who were not recommended to take any of the just mentioned types of therapy (a group referred to as NPT or “no psychotherapy”).

The staff knew the diagnoses given the patients according to the ICD-10 Classification of Mental and Behavioural Disorders (World Health Organization, 1990), but made its recommendations primarily on the basis of information from a clinical interview conducted in each case by some one of the staff members (two of them authorized for giving PDT and two for giving CBT). When the staff made its recommendations regarding therapy, the DMTm results had not yet been scored, the staff’s recommendations thus not being affected by them. Our interest was primarily in whatever defenses the patients might use in the therapeutic process of working through, a process of central importance not only in psychoanalysis (Freud, 1914) but also in PDT. Such defenses concerned with the handling of intrapsychic conflicts, are referred to in the DMTm as affect defenses. They include repression, projected introaggression, affect inhibition, introaggression, barrier isolation and affect isolation, and are to be distinguished from relational defenses such as denial and identity defenses, defenses of the latter type also being referred to as denial through reversal.

A hypothesis considered in the Andersson et al. (2007) study was that the following three characteristics should appear less frequently in the DMTm protocols of patients for whom PDT had been recommended than in those of patients for whom CPT, CBT or NPT had been recommended, the characteristics of showing no affect defenses at all, of showing the defense of inclusive affect isolation (referred to in the DMTm manual as isolation 4, appearing in the percept-genesis as a “zero phase” and to be clearly distinguished from partial affect isolation, also referred to as isolation 3), and of showing the defense of affect inhibition. This was the case for both the male and the female patients, the occurrence of inclusive affect isolation being the most decisive characteristic. As in the earlier study, our interest in possible changes in DMTm results following therapy concerned what differences there might be in this respect between PDT patients on the one hand, and CPT and CBT patients on the other. We also took into account the question of whether the therapy, if completed, could be considered successful, a matter that we decided to let the patients themselves be the judges of.

Since the DMTm defense of inclusive affect isolation had been considered in the previous study to be of central importance, we found it reasonable to assume that after completion of

therapy this defense should not appear in DMTm protocols (the testing done at this point being referred to as DMTm-II, as distinguished from DMTm-I, the testing done prior to therapy) as often in patients reporting the PDT to have been successful as in the other patients, i.e., in the other patients who were given PDT, as well as in the patients who were given CPT or CBT, irrespective of for the latter two groups of how they assessed the therapeutic outcome. The specified motive for affect isolation, according to the Andersson (1991) developmental and psychodynamic model of the mind, is to be found in what Melanie Klein (1935, 1940, 1946) refers to in her affect positions model (which has been incorporated into the Andersson model) as the manic-obsessional position (cf. Andersson & Ryhammar, 1998). Inclusive affect isolation indicates there to in effect be a total annulment of the subjective, affective world, a state that we thought might readily appear in cases in which the PDT had not had its desired effects, and also following therapies in which the process of the working through of intrapsychic conflict was not of primary concern, as it is in the case of CPT and CBT.

An earlier study by Hallborg and Andersson (2002), in which the DMTm was given to patients both when they were in a state of depression and when they had recovered from it, made us aware of the fact that during a state of depression a defense such as denial could hinder patients from using their affect defenses adequately, particularly barrier isolation and affect inhibition, both of which are related to the depressive position in the Kleinian and Andersson model. Feelings of abandonment, which according to the Andersson model are the specified motive for the defense of denial, were thought to be the reason for this, such feelings being assumed to be more pronounced during an acute depressive state than after recovery from it. Since the termination of therapy can be thought to readily arouse feelings of abandonment, we reasoned that such feelings tend to be dealt with rather adequately by patients given PDT, at least if they experienced their therapy as successful. We were in doubt, however, concerning the question of whether feelings of abandonment are dealt with as readily by CPT or CBT as by PDT. We felt that, if our reasoning was correct, there would tend to less frequently be an increase in the frequency scored denial found in DMTm-II as compared with DMTm-I for PDT patients who judged their therapy to have been successful than there would be for the other patients.

In the earlier Andersson et al. (2007) study, a greater number of patients had taken DMTm-I than was the case in the present study, in which in addition to DMTm-I the patients had also taken DMTm-II. Accordingly, it was regarded as important to check on the extent to which the present, reduced group was representative of the original group, i.e., to what extent

the DMTm-I characteristics used in Andersson et al. (2007) as the basis for the hypotheses considered were distributed in a similar way across the different therapy groups.

METHOD

Participants

A group of 257 patients were remitted during March 1996 until October 1999 by psychiatrists at a psychiatric clinic in a hospital in the central part of Sweden to the four-person staff here for judgment of whether PDT, CPT, CBT or NPT would be most suitable for them. Thirty-two of these patients abstained from being judged and 7 were not tested with DMTm-I, which resulted in a total of 142 patients who were offered therapy, being together with 58 out of 76 NPT patients studied in Andersson et al. (2007). In the group of 142 patients, there were 5 who abstained from therapy, 14 who broke off their therapy before it was ended, 8 who were still in therapy at the deadline for the evaluation in October 2001, 14 who did not turn up at the evaluation, and 9 who by mistake were not called to the evaluation. There was thus 92 patients who took part in the evaluation, 44 of whom received 10-88 hours (median 40 hours) of PDT, 13 of whom received 13-100 hours (median 35 hours) of CPT and 35 who received 7-62 hours (median 28 hours) of CBT.

Evaluation of the changes in DMTm results which had occurred was conducted 4 months after the therapy was ended, there being 74 patients who completed DMTm-II on that occasion. These patients distributed as follows: 34 PDT (24 women and 10 men with an age range of 21-59 years and a median age of 36), 11 CPT (9 women and 2 men with an age range of 19-40 years and a median age of 34) and 29 CBT (17 women and 12 men with an age range of 20-55 years and a median age of 35). The distributions on ICD-10 diagnoses were much the same as in the original group of 200 DMTm-I patients reported on in Andersson et al. (2007). Thus, mood disorders were overrepresented in the PDT and CPT groups (20 PDT, 7 CPT, 5 CBT; $p = .0003$, Fisher Exact Probability Test, two-tailed), there being an overrepresentation of phobic anxiety disorders (2 PDT, 1 CPT, 12 CBT; $p = .0006$) and obsessive-compulsive disorder (2 PDT, 1 CPT, 7 CBT; $p = .04$) in the CBT group and of reactions to severe stress and adjustment disorders in the PDT group (5 PDT, 0 CPT, 1 CBT; $p = .09$). There were no statistically significant differences between the groups in their frequencies of other anxiety disorders (8 PDT, 1 CPT, 6 CBT), eating disorders (3 PDT, 1 CPT, 1 CBT) and personality disorders (11 PDT, 3 CPT, 6 CBT).

Self ratings of therapeutic outcome

In evaluating the outcome of their therapy, the patients rated it in terms of degrees of satisfaction, usefulness, personality change, symptom change and problem handling. The questions employed, adapted from Carlsson (1993), were as follows: On the whole, how satisfied are you with the result of the psychotherapy (1 very satisfied, 2 rather satisfied, 3 somewhat satisfied, 4 somewhat unsatisfied, 5 rather unsatisfied, 6 very unsatisfied)? How much use have you had from the psychotherapy (1 very much, 2 rather much, 3 some, 4 very little, 5 nothing at all)? How much in your opinion have you changed as a person as a result of the psychotherapy (1 very much, 2 rather much, 3 somewhat, 4 very little, 5 not at all)? To what degree have the problems or symptoms changed that led to your seeking psychotherapy (1 wholly disappeared, 2 decreased very much, 3 decreased rather much, 4 decreased somewhat, 5 not changed, 6 become worse)? How well do you think you can handle problems now (1 very well, 2 rather well, 3 neither well nor poorly, 4 rather poorly, 5 very poorly)?

The summed ratings obtained from each patient were used as a variable. Complete ratings were obtained for 88 patients, their ranging from 7 to 25. The values 7-9 determined the lower quartile ($n = 22$), used here to define successful psychotherapy, values from 16 to 25 ($n = 22$) the upper one, used to define unsuccessful psychotherapy. Of the 74 DMTm-II patients examined in the study, 19 were found in each of the two extreme quartiles, the 36 remaining constituting the intermediate group.

Defense Mechanism Technique modified

DMTm, administered to the patients (by either MW or LTO) both before and after therapy, is a sequel to the DMT developed by Kragh (1960). In it, two picture motifs are shown tachistoscopically, the exposure times increasing successively in a series of 20 exposures from 5 to 1150 milliseconds in both cases. These pictures include a threatening, peripherally-situated person (referred to as Pp), of female gender in the first picture ("the threatening mother") and of male gender in the second ("the threatening father"). In both pictures, there is also a centrally-placed child or young person (hero/heroine or H) of the same gender as the subject being tested. Located in front of this person is a disguised sexual attribute (referred to as A).

After each of the 40 exposures (20 in each series), the subject is to report verbally what he/she has seen and to make a simple drawing of it. The DMTm pictures are aimed at arousing various forms of anxiety which can find expression both directly in the subject's reports and indirectly as various forms of defense against anxiety. There are also some

”additional signs” not referred to as expressions of anxiety or defense and yet being of important diagnostic value. The scoring, done independently by each of the three of us before the hypotheses of the present study were specified, was conducted in accordance with the latest DMTm manual (Andersson, 2004). Two of us (MW and LTO, both clinical psychologists who together with a psychiatrist and another psychologist formed the four-person staff) agreed on our scorings prior to their being compared with those of the one of us (ALA), who had not been involved in the testing and who was not familiar with the therapeutic decisions made. The few discrepancies that appeared were settled in joint discussion prior to analysis of the data (for a recent assessment of interrater agreement between MW and ALA on another sample, see Wilhelmsson & Andersson, 2005).

Only the scoring of those two DMTm defenses of particular interest in the present study will be presented here (for a complete account of the DMTm scoring scheme, see Andersson, 2004). The defense of inclusive affect isolation is scored when the person tested in a DMTm series reports a total loss of the specified content in the exposure preceding the loss. Usually this loss appears on only one exposure, and for inclusive affect isolation to be scored the loss is to appear on not more than two consecutive exposures.

Table 1. Distribution of patients (n = 74) across the three therapy groups and in terms of certain characteristics found in DMTm prior to therapy (cf. Andersson et al., 2007).

Group	PDT	CPT	CBT
(a) No affect defenses	2	1	4
(b) Inclusive affect isolation but no affect inhibition	6	4	12
(c) Affect inhibition but no inclusive affect isolation			1
(d) Both inclusive affect isolation and affect inhibition	1		
(e) Other affect defenses than inclusive affect isolation and affect inhibition	25	6	12

Group	PDT	CPT and CBT
(a), (b), (c) and (d)	9	22
(e)	25	18

p = .02, Fisher Exact Probability Test, two-tailed (also Table 2)

The defense of denial is scored when (1) in a DMTm series Pp is missing or is uninterpreted on at least seven consecutive exposures, starting with the first exposure (the number of scorings running from one in exposure seven to a maximum of fourteen in the entire series of twenty exposures), or (2) Pp is lacking or is uninterpreted on at least two consecutive exposures after having been specified as something other than a person or a face (the number of scorings continuing from the exposure in which these characteristics are found

to the exposure in which they cease), or (3) when Pp is specified as being a person or a face, Pp is lacking on at least two consecutive exposures (the number of scorings likewise running from the exposure in which these characteristics are found until the exposure in which they cease).

RESULTS

As already indicated, we anticipated to obtain similar results for the present, reduced group of patients as for the larger group of 142 patients in terms of the particular DMTm-I characteristics we found to be related to the type of therapy recommended by the four-person staff. As expected, the PDT patients were less frequently characterized than the CPT and CBT patients by a lack of affect defenses, by inclusive affect isolation and by affect inhibition (Table 1). There was also a tendency for inclusive affect isolation, when examined separately, to be less common in the PDT patients than in the other patients (the contrasts of appearance/nonappearance being 7/27 and 16/24; $p = .08$). No such difference was to be found for inclusive affect isolation scored in DMTm-II, its being found there for 9 PDT, 2 CPT and 10 CBT patients (Table 2).

Denial was a very common sign in the present sample, only 9 patients (3 PDT, 3 CPT and 3 CBT) not being scored for it in DMTm-I, and only 10 (5 PDT, 2 CPT and 3 CBT) in DMTm-II. We considered an increase from DMTm-I to DMTm-II of denial in at least two exposures in any of the two series to be a reliable indication of change. The median for enhanced denial was 5 exposures, the maximum being 12. To these patients, one can add the only case (a CBT patient with intermediate therapy ratings) in whom there was no room for an increase to take place, denial being scored on all the 14 exposures possible in each of the four DMTm series.

As can be seen in Table 2, it was only when PDT had a successful outcome that affect isolation of an inclusive kind or enhanced denial were seldom found in DMTm-II. No such statistically significant difference was obtained for inclusive affect isolation and enhanced denial taken separately. A greater number of patients were scored for inclusive affect isolation after but not prior to therapy ($n = 14$) than both before and after it ($n = 7$).

DISCUSSION

The findings of the study concerned not only the type of therapy the patients had participated in but also how they rated its outcome. It was found that four months after completion of their therapy the patients who in their own view had taken part in a successful PDT were less likely

to have strengthened their denial defense in DMTm or to avail themselves of or maintain the defense of inclusive affect isolation.

Table 2. Distribution of patients (n = 74) across therapy groups, in regard to outcome of therapy as adjudged by the patients themselves and in various DMTm characteristics both before (I) and after (II) therapy.

Group	Enhanced denial	Enhanced denial and inclusive affect isolation in DMTm-II	Enhanced denial and inclusive affect isolation in DMTm-I and DMTm-II	Inclusive affect isolation in DMTm-II	Inclusive affect isolation in DMTm-I and DMTm-II	Neither enhanced denial nor inclusive affect isolation in DMTm-II
PDT						
- successful outcome	2		1			9
- intermediate outcome	3	4		2	1	7
- unsuccessful outcome	3			1		1
CPT						
- successful outcome		1				1
- intermediate outcome	4			1		1
- unsuccessful outcome	1					2
CBT						
- successful outcome	2			2		1
- intermediate outcome	5	1	2			5
- unsuccessful outcome	4	2	1		2	2
<hr/>						
Group	Enhanced denial and/or inclusive affect isolation in DMTm-II			Neither enhanced denial nor inclusive affect isolation in DMTm-II		
PDT with successful outcome	3			9		
The rest	42			20		

p = .009

Another way of expressing these findings is to say that considering a PDT one was given to not have been successful, as indicated by an intermediate or unsuccessful outcome, results in basically the same changes in DMTm as produced by CPT and CBT in any case. Formulated in this way, emphasis is placed on the fact that psychotherapy, irrespective of whether it is PDT, CPT or CBT, appears according to DMTm to often strengthen such a relational defense as denial or to lead to the affect defense of inclusive affect isolation being either preserved or brought into use. According to the Andersson model, denial tends to be used to keep the self intact, especially when the individual is threatened with separation and feelings of abandonment. Denial may thus be a useful defensive strategy, at least in a short-term perspective. Also the use of inclusive affect isolation can be thought of to produce a relief of mental pain, particularly when the demanding efforts of working through an intrapsychic conflict could not be satisfied or are not of primary therapeutic concern.

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