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ORIGINAL ARTICLE

The relationship between defense mechanisms and the quality of therapeutic alliance in analytic psychotherapy*

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ABSTRACT

INTRODUCTION: The quality of a therapeutic alliance is essential in psychoanalytic psychotherapy and influences the therapeutic process. This study evaluated the relationship between the level of defense mechanisms and the quality of therapeutic alliance established during psychotherapy. **METHOD:** Patients in psychotherapy and their respective therapists completed the Helping Alliance Questionnaire (patient version and therapist version, respectively). The level of defenses was inferred by the Defensive Functioning Scale proposed in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision. **RESULTS:** There was no association between the quality of therapeutic alliance and the patient's level of defense mechanisms in this sample. On the other hand, there was a difference when the therapist version was compared to the patient version: patients established a stronger therapeutic alliance in relation to their therapists. **CONCLUSION:** The lack of influence of defense level in the quality of therapeutic alliance suggests that the therapist's training and personal characteristics may lead to the ability of connecting with the patient, despite impairment in their psychic functioning.

Keywords: Psychotherapy, psychoanalysis, defense mechanisms, therapeutic alliance.

INTRODUCTION

Psychoanalytic psychotherapy (PP) is a modality of psychological treatment based on psychoanalysis theory and technique that uses the concept of unconscious proposed by Freud,[1] using free association and interpretation of dreams, mood and faulty actions to understand and provide meaning to unconscious conflicts. However, although PP considers the transference/countertransference pattern to understand the patient and build up interpretations, differently from psychoanalysis, which is characterized by use of couch, higher frequency of sessions (three to five weekly sessions) and by frequent use of transference interpretation, it mainly uses extratransference interpretations and a lower frequency of sessions (once or twice a week), and it does not use a couch.

Throughout the years, several studies have tried to define the factors associated with better outcomes in PP, with the aim of improving indication of this type of treatment and enhancing the technique.[2-6] Among the aspects that have been stressed as good indicators of prognosis, therapeutic alliance (TA), firstly described by Freud7 in 1912 as positive transference, seems to play a major role.[2,8]

TA is defined as a positive and stable relationship between therapist and patient, which allows for the conduction of a psychoanalytic psychotherapy. According to Melanie Klein,[9] such alliance is based on the early object relationships, and it requires at least one experience in which it was possible to have a healthy interaction with another person, such as, for example, an affective and "continent" relationship between an infant and its caregiver (commonly referred to as mother-infant relationship). Marcolino[10] found that a better TA quality was associated with better results and with a higher reduction in symptoms in patients undergoing a brief psychotherapy program. Kaplan[11] suggests that no analysis can proceed without the establishment of a good TA, which requires the existence, in the patient's mind, of a part able to remain free from conflicts and being rational. This instance should detach itself to recognize the irrational nature of other parts in his mind that unconsciously repeats psychic conflicts.

One of the aspects frequently mentioned as determinant of TA quality is the patient's personality, which, among other aspects, is manifested through his defense mechanism pattern. Fadiman[12] argues that defense mechanisms are a set of operations aiming to reduce or suppress stressful stimuli that cause displeasure, therefore trying to maintain the psychic apparatus' homeostasis. The use of defense mechanisms is present in all individuals and is crucial for psychic functioning. What defines a better or worse adaptive capacity is the nature, intensity and frequency of using more or less mature defense mechanisms.

George Vaillant,[13] in his book *Adaptation to life*, chapter 5, "Ego adaptive mechanisms, a hierarchy," reports to the studies of Freud and Anna Freud to classify 18 defense mechanisms into four levels. psychotic mechanisms (common in psychoses, dreams and in small children), immature mechanisms (common in severe depressions, personality disorders and adolescence), neurotic mechanisms (common in all individuals), and mature mechanisms (common in healthy adults), according to the evolution of the adaptive process, its maturity and pathological importance. He also suggests that maturity in human life is followed by evolution of these adaptive processes and that the hierarchy described not only reflects a continuum from child to adult, but also from illness to health. In this same sense, Kipper,[14] in a recent study, showed that patients with panic used more maladaptive defense mechanisms compared with normal controls, and there were differences after psychopharmacological treatment.

Although there is a theoretical hypothesis a priori that use of more mature defense mechanisms facilitates TA establishment, some studies, such as a multi-center study conducted by Hersoug[15] investigating the association between defense mechanisms used by the patient and TA quality, showed that the defense pattern had no influence on TA quality or on improvement in dynamic brief psychotherapy. Conclusion is that symptoms disappear at the beginning of therapy and that defenses can change throughout the treatment.

This study aims at investigating the relationship between the patient's ability to establish a TA (according to patient's and therapist's own perception) and the level of unconscious defense mechanisms used by the patient at that moment in a sample of patients receiving care at the Psychoanalytic Psychotherapy Program of Hospital de Clínicas de Porto Alegre (HCPA).

METHOD

This is a cross-sectional, convenience sample study: patients undergoing PP at the Psychotherapy Clinic of HCPA during the study period and their therapists were invited to participate. The therapists were comprised of residents in the Psychiatry Service of HCPA and second- and third-year students of the specialization course in Psychiatry at the Department of Psychiatry and Forensic Medicine, Faculdade de Medicina (FAMED), Universidade Federal do Rio Grande do Sul (UFRGS).

The patients were referred to the Psychotherapy Program by other HCPA programs, including the screening program (which receives patients referred by the municipal health network of primary care), when there was a likely indication of PP. Referral was confirmed by the therapist, with the aid of his supervisor, considering the criteria described by Cordioli,[16] such as existence of a work focus, ability to think psychologically, motivation to undergo PP, previous adaptation level, among others. The patients were randomly allocated to each therapist according to order of admittance to the clinic and schedule availability.

The therapists had permanent supervision activities throughout the study, oriented by supervisors with at least 15 years of experience in PP: 1 hour of weekly individual supervision, in addition to a weekly 80-minute group supervision, in which a patient was interviewed by one of the supervisors. The case was then discussed as to diagnosis and therapeutic planning. All therapists were trained to apply the scales. TA and the patient's symptoms were inferred by self-reporting scales, and defense mechanisms by a structured questionnaire proposed in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR).[17]

Except for indication of PP, there were no exclusion criteria. All the patients who participated in the study and their respective therapists signed a consent form approved by the Ethics Committee of HCPA.

To evaluate defense mechanisms, the Scale of Defensive Functioning of DSM IV-TR[17] was used, in which the therapist must choose, using a hierarchic score, the seven defense mechanisms more frequently used out of a total of 25. The patient's defensive mechanism is later classified into one of the following levels: high adaptive level, level of mental inhibitions (formation of commitment), level of mild image distortion, level of denial, level of major image distortion, level of action and level of defensive deregulation. A standardized glossary is used to homogenize conceptualization of each defense mechanism, as well as of each defensive level.[16] These seven levels were later grouped into mature (level 1), intermediate (level 2) and immature or primitive (level 3) defense levels.

The diagnosis registered in the patient's medical record according to DSM-IV-TR criteria was used.[17] The diagnosis was performed by the therapists, supervised by respective preceptors, based on clinical interviews of diagnostic assessment and therapeutic indication, using the last data of each patient's medical record.

TA was evaluated using the instrument Helping Alliance Questionnaire (HAq II),[18] patient and therapist version, developed by Luborsky et al. in 1996. It consists of a self-reporting questionnaire comprised of 19 items evaluating essential dimensions in a patient-therapist relationship in a Likert scale (1 to 6), such as feelings of understanding, trust, interest, common objectives and desire to progress. This scale was translated and back-translated by English/Portuguese teachers with knowledge of the research area, tested and adapted according to the rules of the Graduation and Research Group (GPPG) of HCPA, and its final version adapted to Brazilian Portuguese was approved and authorized by the author of the original instrument.

Statistical analysis was performed using the SPSS 13.0 with the support of GPPG. The groups were compared using Student's *t* test and Fisher's exact test, and correlations were investigated using Pearson's and Spearman's tests.

RESULTS

The sample was comprised of 37 dyads (patients/therapists). Three of the 40 dyads that underwent PP at the Adult Psychiatry Clinic of HCPA during the survey period did not agree to participate in the study.

Characteristics of the patient sample are as follows: most were female (27), mean age was 38 years (standard deviation - SD = 13), and all the participants were literate. As to marital status, 45.9% were married, 35.1% were single, and 18.9% were separated.

Characteristics of the therapist sample are as follows: the therapists that participated in the study were 12 residents (residence in Psychiatry at HCPA) or students (specialization course in Psychiatry of the Department of Psychiatry and Forensic Medicine, FAMED, UFRGS); six were second-year and six were third-year students, resulting in minimal time of psychiatric formation of 1.5 year. Seven therapists were male, and five were female. Since the therapists cared for more than one patient, it can be deduced that each therapist participated in more than one dyad.

Considering the patients' defense level, 11 predominantly used level 1 defenses (group of mature defenses), 15 patients used level 2 defenses (group of intermediate defenses), and 11 patients used level 3 defenses (group of primitive defenses).

The diagnosis, according to the DSM-IV-TR, was performed from the clinical interview and discussed in the supervision. Frequency of diagnoses in axis I (Table 1) and axis II (Table 2) are described.

Table 1 - Axis I diagnoses

Diagnoses	Frequency	Percentage
No diagnosis	9	24.3
Alcohol abuse/withdrawal	1	2.7
Generalized anxiety disorder/depression	1	2.7
Bipolar disorder/anorexia nervosa	1	2.7
Major depressive disorder	10	27.0
Moderate depressive disorder	2	5.4
Dysthymic disorder	1	2.7
Bipolar affective disorder in remission	3	8.1
Anxiety syndrome	1	2.7
Generalized anxiety disorder	1	2.7
Panic disorder and agoraphobia	1	2.7
Bipolar affective disorder 1	1	2.7
Bipolar affective disorder 2	1	2.7
Bipolar affective disorder 3	1	2.7
Obsessive-compulsive disorder	2	5.4
Panic disorder	1	2.7
Total	37	100.0

Table 2 - Axis II diagnoses

Diagnoses	Frequency	Percentage
No diagnosis	15	40.5
Depressive personality disorder	2	5.4
Avoidant/phobic personality disorder	1	2.7
Histrionic personality disorder	5	13.5
Pathological grief	1	2.7
Obsessive personality disorder	2	5.4
Dependent personality disorder	1	2.7
Schizoid personality disorder	1	2.7
Histrionic traits	2	5.4
Narcissistic traits	3	8.1
Histrionic/masochist traits	1	2.7
Histrionic/obsessive traits	1	2.7
Obsessive traits	2	5.4
Total	37	100.0

Most patients (59.5%) had two weekly sessions, whereas 40.5% had one weekly session. There was no significant difference ($p = 0.266$) in the analysis of patients' perception of strong or weak alliance according to number of weekly sessions (one or two). The same occurred to total scores in the therapist version of the scale ($p = 0.897$). Therefore, perception of strong or weak TA quality by patients and therapists was independent of the number of weekly sessions.

As to therapy length, 25 patients (67.5%) were undergoing therapy for more than 6 months. Being under psychotherapy for more than 6 months was associated with greater perception of a strong alliance ($p = 0.016$), indicating that the longer the therapy length, the better TA is considered by patients. In the analysis of therapists' perception, there was a tendency to a similar result ($p = 0.053$).

There was a statistically significant difference ($p = 0.001$) regarding quality of TA developed by patients of different genders in relation to their therapists. Male patients perceived a stronger alliance than female patients. However, there was no significant difference when the total score TA perceived by the therapist was considered in relation to the patient's gender ($p = 0.50$).

In agreement with the results found by other researchers,[19] there was no correlation between the patient's defensive style and the TA quality perceived by patients ($p = 0.797$) or therapists ($p = 0.925$). Absence of significance was present even when the dimensions of the HAq II scale were considered individually.

Patients had "stronger" (higher scores) TA perception than therapists, and this finding was significant in 11 out of 19 HAq II questions when analyzed individually.

DISCUSSION

Absence of an association between the patient's defensive style and TA formation might suggest that this variable is in fact more related to so-called "unspecific" factors, reinforcing the importance of factors related to the therapist in relation to the variables that determine prognosis in PP.[19-23]

These findings also have implications for other hypotheses: can the training received by the therapists be considered in the development of a qualified ability to interact with their patients irrespective of diagnosis, symptoms and levels of defense mechanisms?

Despland,[24] in his study on defense mechanisms and therapist's interventions in the development of an early TA, reports that the alliance is quickly developed around the third session, independent of

interventions or patient's defenses. However, adjustment of the therapist's interventions to the patient's level of defense mechanisms could improve TA quality. Adjustment of therapeutic interventions in fact seems to be a promoting factor of TA development.

On the other hand, Ackerman[25] showed, in his study on the influence of the therapist's characteristics and his technique of TA development, that some characteristics of the therapist, such as flexibility, respect, honesty, reliability, confidence, human warmth, interest and tolerance, positively contributed to TA formation. In addition, use of techniques of exploration, reflection, result appreciation, accurate interpretations, facilitation of affection expression, and appreciation of the patient's experience also contributed positively to the alliance.

Another issue to be considered is the fact that patients were examined by therapists with specific characteristics (different age, gender, experience and personal features), which might have compromised internal validity (due to their differences) and external validity, since they are young therapists.

Could the fact of being young therapists, starting their career, cause a higher investment in TA and a greater disposition? Malan,[26] in his pioneering research on dynamic brief psychotherapy, showed that the "enthusiasm" found in young therapists was the most important fact to obtain positive results.

This study has several limitations. Although all cases have been subjectively assessed according to the criteria proposed by Cordioli[16] and discussed with supervisors, it is not possible to ascertain whether all patients actually received indication of PP. Another factor to be stressed, even considering a judicious adaptation process of the HAq II into Brazilian Portuguese, is the absence of validation data in our country to confirm the instrument performance in our population (factor analysis, confirmatory analysis, and reliability test).

As there was no adherence measure based on recorded or videotaped sessions, specificity of the technique used by the therapists should also be considered: were PP techniques used exclusively or was there also use of cognitive or support techniques with an analytic understanding, despite systematic supervision? In this case, the results found could have been influenced by these variables? In addition, the number of dyads involved in this sample can be considered small, even considering the magnitude of results and agreement with other studies, which could lead to a limitation of internal validity due to an increase in chances of beta error.

Non-existence of a PP manual could result in an impairment of procedure uniformity; however, it is worth remembering that Luborski[27,28] stressed that, in PP, use of a manual and very strict parameters might limit psychotherapy planning and that one of the most important agents to achieve effectiveness in psychotherapy is the therapist's personality.

It is possible that the establishment of a better quality TA is not exclusively dependent on the level of defense mechanisms used, but on the type of transference relationship, patient's need and therapist's availability, pointing to the need of studies considering these variables in the investigation of promoting factors of quality TA.

CONCLUSION

The findings in this study showed that there is not a significant correlation between the defense mechanisms used by patients and the ability to establish a good quality TA, confirming the findings of other studies that suggest "unspecific" factors as more important than the patient's characteristics and the technique used.[19-23] Based on this hypothesis, there is the need (and challenge) of developing research instruments and methodologies that promote characterization and investigation of the real impact of such factors.

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