

2014

Primitive Defenses and Unilateral Termination of Psychotherapy: Are the Lerner Defense Scales Useful in Predicting Premature Termination in Psychotherapy?

Teal Fitzpatrick

Follow this and additional works at: <https://dsc.duq.edu/etd>

Recommended Citation

Fitzpatrick, T. (2014). Primitive Defenses and Unilateral Termination of Psychotherapy: Are the Lerner Defense Scales Useful in Predicting Premature Termination in Psychotherapy? (Doctoral dissertation, Duquesne University). Retrieved from <https://dsc.duq.edu/etd/543>

This Immediate Access is brought to you for free and open access by Duquesne Scholarship Collection. It has been accepted for inclusion in Electronic Theses and Dissertations by an authorized administrator of Duquesne Scholarship Collection. For more information, please contact phillips@duq.edu.

PRIMITIVE DEFENSES AND UNILATERAL TERMINATION OF
PSYCHOTHERAPY: ARE THE LERNER DEFENSE SCALES USEFUL IN
PREDICTING PREMATURE TERMINATION IN PSYCHOTHERAPY?

A Dissertation

Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Teal Fitzpatrick, M.A.

December 2014

Copyright

Teal L. Fitzpatrick

2014

PRIMITIVE DEFENSES AND UNILATERAL TERMINATION OF
PSYCHOTHERAPY: ARE THE LERNER DEFENSE SCALES USEFUL IN
PREDICTING PREMATURE TERMINATION IN PSYCHOTHERAPY?

By

Teal L. Fitzpatrick

Approved November 7th, 2014

Roger Brooke, Ph.D., ABPP
Professor of Psychology
(Committee Chair)

Jessie Goicoechea, Ph.D.
Professor of Psychology
(Committee Member)

Alex Kranjec, Ph.D.
Professor of Psychology
(Committee Member)

James C. Swindal, Ph.D.
Dean, McAnulty Graduate School of
Liberal Arts, Duquesne University
Professor of Philosophy

Russell Walsh, Ph.D.
(Acting Chair) Clinical Psychology
Professor of Psychology

ABSTRACT

PRIMITIVE DEFENSES AND UNILATERAL TERMINATION OF PSYCHOTHERAPY: ARE THE LERNER DEFENSE SCALES USEFUL IN PREDICTING PREMATURE TERMINATION IN PSYCHOTHERAPY?

By

Teal L. Fitzpatrick

December, 2014

Dissertation supervised by Roger Brooke, Ph.D., ABPP

This study explored whether a predictive relationship exists between primitive defense scores on the Lerner Defense Scales and premature termination from psychotherapy. A review of literature that described the history and development of the construct of primitive defense, as well as the purpose and formation of the Lerner Defense Scales was conducted in order to provide a context for the relevance of this study. Using achieved patient files from the Duquesne University Psychology Clinic, subjects were chosen for this project based on properly archived Rorschach Protocols (which are used to score the Lerner Defense Scales) and descriptive Final Summaries that described the conditions of termination. The Lerner Defense Scales were scored for the presence and frequency of primitive defense use, and subjects were determined to fall

into either a Premature Termination Group or a Non-Premature Termination Group. Statistical analysis were run in order to determine 1) whether there was a predictive relationship between any Lerner Defense Scales and the termination group status and 2) whether there were statistically significant descriptive differences between these two groups. Results of these analyses showed that there was predictive value between combined scores measuring splitting, projective identification, and denial. Descriptively, the use of splitting was found to be significant between groups, with all individuals who used this defense terminating prematurely. These findings are discussed in more detail, and potential future directions for expanding this research are also addressed.

ACKNOWLEDGMENTS

Many individuals and organizations supported this dissertation, and I would like to acknowledge and thank those who helped realize this study. The anonymous participants, previous patients at the Duquesne University Psychology Clinic, signed waivers that allowed their data to be used in research projects, and I am grateful for their willingness to contribute to psychological research.

The Society for Personality Assessment generously supported my work through one of the organization's dissertation grants, which helped me fund this research.

My dissertation committee, Drs. Roger Brooke, Jessie Goicoechea, and Alex Kranjec, deserve many thanks and gratitude for their involvement in, support of, and considerate feedback on my work. Their diverse knowledge and kind attention to this project cannot be overstated.

I would also like to thank Dr. Martin Packer, who was an original committee member, for his honest, rigorous, and invaluable contributions to the design of this project as I worked on my dissertation proposal. Though I sometimes wondered how deeply I might be in over my head, his critiques made this a stronger project.

Will Hasek volunteered his time to learn the Lerner Defense Scales and was the inter-rater scorer for this project. I am grateful for his generous participation.

Dr. Gavin Elder deserves his own chapter of thanks, as he helped guide and teach me through a quantitative research project as my statistics advisor and friend. He took frantic phone calls, taught and retaught me with saintly patience, and shared his good

humor at the most needed times. I will always remember him telling me: “Trust me, the more you know about statistics, the sillier statistics prove to be.”

Finally, I would like to thank my family and many friends who have been pillars of support throughout this dissertation, and throughout the (sometimes seemingly endless!) course of my Ph.D. program. My parents have never waived in their confidence in my work, academically and as a clinician and a person. Their trust in both my brain and my heart has helped me through many times when I doubted both. My brother Ethan, not a psychologist, is one of the most psychologically-minded, smart, and sensitive people that I know, and I am lucky to have him as a friend, advisee, and reality-checker.

There are too many friends to mention individually, but I am lucky to have a social support network that keeps academia an important, but not all-consuming aspect of my life. Being able to laugh, revel, adventure and fall back on all of these amazing people has, as I have said so many times during the program, “truly kept me sane.” Special thanks to Bob, Sherri, Madison, Huy, Patrick, Chris, Sue, Gary, Jon and all the Pittsburgh musicians who I’ve played with over the years. And a very special acknowledgement to Travis Hall, my friend and cohort-member, who has both inspired me to be the best clinician and student that I can be, and has offered unconditional friendship over the past six years.

TABLE OF CONTENTS

	Page
Abstract.....	iv
Acknowledgment.....	vi
List of Tables.....	vi
Chapter One: Introduction and Conceptual Framework.....	1
Chapter Two: Defense Mechanisms.....	18
A Theoretical History of Defense Mechanisms.....	21
Contemporary Ideas about Defense Mechanisms and Clinical Practice.....	42
Chapter Three: Assessment and the Lerner Defense Scales.....	49
The Assessment Situation.....	49
The Lerner Defense Scales.....	54
Chapter Four: Method.....	61
Data Collection Procedures.....	61
Scoring the Lerner Defense Scales.....	62
Scoring the Termination Status.....	64
Analytic Approach.....	66
Chapter Five: Results.....	68
Describing and differentiating the premature termination (PTG) and not- premature termination (NPTG) groups.....	68
Predictive Results.....	70
Chapter Six: Discussion.....	72
Splitting as a significant descriptive factor.....	72

Prediction of Premature Termination.....	73
Recommendations.....	75
Limitations.....	80
Areas of suggested further inquiry.....	82
Conclusions.....	85
References.....	86
Appendix A: The Lerner Defense Scale scoring criteria.....	94
Appendix B: Participant Defense Score Scatterplots.....	101

LIST OF TABLES

	Page
Table A1. <i>Means, standard deviations (SD), and termination group differences</i> <i>in defense use</i>	68
Table B1. Splitting Scores.....	100
Table B2. Devaluation Scores.....	101
Table B3. Idealization Scores.....	102
Table B4. Denial Scores.....	103
Table B5. Projective Identification Scores.....	104

Chapter One

Introduction and Conceptual Framework

“Ms. Smith¹ attended the intake and assessment sessions but she did not show up for her first session. Upon the receipt of my call, she scheduled a session that she cancelled on the day of the meeting. I attempted to call her a couple of times and sent her a letter thereafter, but she did not return any further communications.” (From a final treatment summary, Duquesne University Psychology Clinic)

This project explores whether the presence of primitive defense mechanisms may correlate with early termination from psychotherapy. The experience of meeting with a new patient, only too quickly followed by missed appointments, unreturned phone calls, or departure from therapy just when it seems that progress begins, is a familiar scenario for most therapists. Determining just what “premature termination” means, however, is a far more complex task. In a 2012 meta-analysis of studies related to premature termination, Swift and Greenberg aim to define the term:

Premature discontinuation in therapy can be defined as occurring when a client starts an intervention but discontinues prior to recovering from the problem (symptoms, functional impairment, distress, etc.) that led him or her to seek treatment. Implicit in this definition is the idea that the client has stopped the intervention without meeting the therapeutic goals or without gaining the full benefits that would have been available if the client had continued to attend and been fully invested in the sessions. (p. 547).

Other factors used to determine premature termination in research studies include: therapist judgment, length of treatment, number of sessions attended, or assessment of

¹ Pseudonym

patient functioning at the time of termination. Swift and Greenberg attend to the ways in which these criteria have been used, and provide critiques of various methods. “Therapist judgment has historically been considered the preferable classification [for defining premature discontinuation of therapy], but this method depends on clinical judgment that can be biased and flawed” (Swift & Greenberg, 2012, 548). Other studies have used length of treatment and conditions of dropout as the basis for determining premature termination:

After pointing out the existence of many different operationalizations for the construct [premature termination], Garfield (1994) suggested that a dropout can be defined as a client who starts therapy (has at least one session) and then discontinues on his or her own without mutual agreement with the therapist. (Swift and Greenberg, 2012, p. 548)

A common construct found in psychological literature is that of “therapeutic alliance”, or a strong relationship between the patient and therapist.

In another recent meta-analysis that included 11 studies from the psychotherapy dropout literature, Sharif, Primavera and Diener (2010) found a significant relationship between the strength of the therapeutic alliance and premature discontinuation; weaker alliance was associated with an increased likelihood of dropping out. (Swift & Greenberg, 2012, 549)

Because therapeutic alliance reflects a complex network of interpersonal relational factors this construct is more difficult to operationalize, and therefore this term has various definitions between studies. Even though operationalizing the term is inconsistent, “several studies have shown that, rather than categorical diagnosis, it is the

preexisting quality of the patient's relationships that most significantly affects the quality of the therapeutic alliance" (Bender, 2005, p. 74).

How common is premature termination? According to Swift and Greenberg's meta-analysis, including 669 studies representing 83,834 clients, "...the average weighted dropout rate was 19.7%" (Swift and Greenberg, p. 555). This suggests that fewer patients are dropping out of treatment now (one in five) than in 1993, when the last meta-analysis was conducted; that study showed that 47% of patients were leaving therapy prematurely (Wierzbicki & Pekarik, 1993). Looking more closely at various groups identified within these studies, Swift and Greenberg determined that:

Dropout rates were also higher for younger clients, those seen in a university based clinic, those with a personality or an eating disorder diagnosis, those who received a treatment that was not time-limited or manualized, and those who were seen by a provider in training. (Swift & Greenberg, 2012, p. 555)

The authors also looked at dropout rates between various patient groups. They cited one study looking at patients diagnosed with personality disorders, and found that dropout rates for this population were higher than the average national rate. "McMurrin, Huband and Overton (2010) recently conducted a systematic review of non-completion in personality disorder treatments. Across 25 empirical studies, they found a median non-completion rate of 37% (Swift & Greenberg, 2012, p. 549). The authors go on to comment:

The fact that clients with personality disorder and eating disorder diagnoses had higher rates of dropout fits with McMurrin et al.'s (2010) recent findings of a 37% non-completion rate among personality disordered clients. Given the rigid

nature of these disorders and the slow progress that is often observed in their treatment, it is perhaps not surprising that this result was found. (Swift & Greenberg, 2012, p. 556)

Analyses looking at the various criteria used to determine dropout rate (therapist judgment, length of treatment, number of sessions, patient opinion) found that “dropout rates were highest when determined by therapist judgment (37.6%)” (Swift & Greenberg, 2012, p. 555).

As the mental health field adjusts to an ever-growing number of people seeking mental health treatment, patient dropout is of critical concern. “Clients who prematurely terminate have been found to exhibit poorer treatment outcomes and to be generally more dissatisfied with treatment” (Swift & Greenberg, 2012, p. 547). Furthermore, “therapy dropouts can also have a larger impact on agencies by limiting the number of people that can be served in an agency and by being more likely to start and stop treatment on multiple occasions as various site” (Swift & Greenberg, 2012, p. 547) and Ingenhoven, Duivenvoorden, & Passchier state: “In mental health clinics, length of stay and appropriate termination are highly related to successful treatment outcome, while premature termination, especially early dropout, is associated with low (cost)-effectiveness” (2012, p. 172).

For individuals who are critically in need of treatment but for various reasons have difficulty utilizing therapeutic resources, multiple unsuccessful treatment attempts or chronic difficulties related to mental health create strain on providers and prolong suffering for the patient.

Even though there have been hundreds of studies investigating premature termination, “little is known about predictors of treatment duration and premature termination of psychotherapy” (Ingenhovern et al., 2012, p. 172). Ingenhovern, et al. (2012) explored the relationship between “adaptive and maladaptive psychodynamic variables, as assessed by the Developmental Profile (DP)” and “premature termination in an inpatient psychotherapeutic treatment program for young adults with personality disorders” (p, 173). This study differs from most premature termination studies because it uses psychodynamic constructs as independent variables rather than a diagnostic category or demographic category. The authors defined premature termination as “the absence of regular discharge” (p. 175). The DP measures 10 psychodynamic variables, and the authors “computed aggregate variables” (p. 175) based on “primitive developmental level” variables (PRIM) and “neurotic developmental level” variables (NEURO). Their findings showed that “psychodynamic personality variables significantly predicted treatment duration and premature discharge. These findings support the relevance of psychodynamic assessments in clinical practice” (Ingenhovern et al., 2012, p. 172).

The issue of premature termination is complex and, despite the many studies that attempt to elucidate reasons patients leave treatment, researchers have yet to agree on why this phenomenon is so widespread. Early-career therapists and seasoned clinicians alike report the bewildering, frustrating, and deflating experience of feeling that a therapy was beginning well when a patient suddenly disappears from treatment and cannot be reached. Patients have been described as “resistant”, “un-invested”, and “not ready for treatment”. Some of these patients fit criteria for diagnostic categories, particularly personality disorders, which are often considered “difficult to treat” by nature. Other

clinicians, less focused on diagnostic differentiation, would consider “poor fit” in the therapist/patient relationship (Elkin et al., 2010), or would suggest that confounding factors including substance abuse, cognitive deficits, or trauma may problematize engagement with treatment (Walitzer, Dermen, Connors, 1999). Particular explanations notwithstanding, the desire to make sense of patient termination is part and parcel of the therapist’s experience.

There is no question that early termination has significant consequences for institutions, clinicians and especially, patients themselves. Better understanding the reasons that some individuals might leave treatment and considering ways to increase these patients investment in treatment are important areas of investigation. Swift and Greenberg remind us that: “...one in five clients still discontinue therapy prematurely. It is important to increase efforts to help these clients stay in therapy for the full duration” (2012, p. 557). This study examines factors that may help clinicians predict premature termination with the hope that these findings may make a practical difference in efforts to minimize unnecessary patient dropout.

This dissertation was originally conceived as an intersection of several areas of psychological interest: (a) the clinical problem of patient dropout; (b) an interest in the intersection of psychodynamic theory and quantitative research; (c) the value of projective testing; and (d) the value of assessment in case formulation and treatment planning.

This project assumes that use of psychological defenses may affect willing participation in psychotherapies of all sorts, and that understanding the relationship between defenses and the reaction to therapy itself may help clinicians better understand,

prepare for, and work collaboratively with the patients to maximize successful courses of treatment.

As a clinician in training, I have experienced firsthand patients leaving treatment unexpectedly or abruptly, often early in the therapeutic process. For some of these individuals there were clear indications that therapy was not appropriate, or there were obvious circumstances that led to early departure. With other patients, however, there was a clinical sense that something *greater than external circumstance or poorness of fit* was indicated in a decision to leave. The act of leaving treatment seemed to be somehow relevant to the psychopathology or situation that brought these people to treatment in the first place. I became intrigued by the idea that clinicians may have tools at their disposal to identify patients that may benefit from treatment but are made anxious or frightened by treatment processes early on. It seemed that part of the clinical puzzle might be identifying individuals for whom the act of staying in treatment itself may be the first step in recovery.

Following these ideas, I assumed that the act of leaving therapy did not necessarily mean that therapy was a poor treatment option for that person. Rather, it suggested that flexible and creative treatment planning and therapeutic intervention are important in order to best set up the conditions of successful treatment adherence and therefore increase beneficial treatment outcomes for patients. This focus on clinician responsibility and expertise is rooted in the understanding that therapy can benefit many patients regardless of their psychological or diagnostic profile. Nancy McWilliams writes that: “Experienced diagnosticians generally know by the end of the initial interview whether they are dealing with a person whose character presses for flight”

(2011, p. 16). While this comment certainly testifies to the attunement of careful interviewing and the great knowledge attained through clinical experience, there are often elements of psychological organization that are not readily apparent. Especially when considering unconscious processes, including defense structures, many clinicians discover that prominent or even foundational elements of psychological functioning are only evident later on in treatment or, in the case of early termination, may be inferred after a premature exit from treatment.

This project assumes that individuals' psychic functioning is heavily influenced by the use of defenses, or psychological behaviors that serve to avoid or manage "some powerful, threatening feeling" and "the maintenance of self-esteem" (McWilliams, 2011, p. 101). One way to explore the relationship between patient's personality structure and how these structures may contribute to premature termination of treatment is to look more closely at the ways that defense mechanisms impact reactions to therapy itself. Because psychotherapy provides a venue that challenges and explores ways that individuals manage anxiety and other unpleasant emotions, one might expect that individuals who rely heavily on certain types of defense will feel frightened by and threatened by traditional psychotherapies; in short, the "treatment" excites and activates the patient's compelling desire to flee the treatment environment. Melanie Klein describes this phenomenon beautifully:

For the patient is bound to deal with conflicts and anxieties re-experienced toward the analyst by the same methods he used in the past. That is to say, he turns away from the analyst as he attempted to turn away from his primal objects; he tries to split the relation to him, keeping him either as a good or as a bad figure; he

deflects some of the feelings and attitudes experienced towards the analyst on to other people in his current life, and this is part of ‘acting out.’ (Klein, 1986, p. 209)

Understanding the behavior of a client who responds to anxiety with defenses like splitting or devaluation as a way to protect the self from the unpleasant feelings provoked in therapy can make the desire to leave treatment more intelligible. Furthermore, the ability to empathize with the patient’s attempt to manage seemingly unmanageable feelings may allow the therapist to understand the transference position he or she may inhabit for the skittish patient. “The patient may at times try to escape from the present into the past rather than realize that his emotions, anxieties and phantasies are at the time operative in full strength and focused on the analyst” (Klein, 1986, p. 240). In this way, the patient’s pathology or suffering is manifest in the treatment room, in the relationship between the patient and therapist.

Psychoanalytic and psychodynamic theory understands psychological functioning as rooted in early childhood experiences and continually evolving in relationship to a person’s environment, relationships, and understanding of self. In this model, particular diagnoses can then be seen in a wide variety of personality structures and therefore will look different depending on the overall psychological organization of each individual. For example, depression in a psychotically organized person will look and function quite differently than depression in a neurotically organized individual. As Jonathan Shedler (2013) aptly states: “depression may be better understood as a nonspecific symptom—the psychic equivalent of fever—of a wide range of underlying difficulties, for example, in attachment, or interpersonal functioning, or in reconciling inner contradictions” (para.

5). With this understanding we see psychiatric diagnoses not as discrete pathologies, but as particular constellations of symptoms that may originate from different foundational struggles. Understanding symptoms as the expression of relationships between personality organization and external circumstances is at the heart of psychodynamic understanding of suffering.

Since a depressed individual, in this view, may be exhibiting symptoms of depression for a variety of reasons, the clinician will want to know much more about each patient and his or her personality structure in order to best plan for treatment. This project assumes that one element of sensitive diagnosis is identifying defense patterns as well as manifest symptoms, and using this data to plan the best way to provide service for the “skittish patient” who may be responding or fleeing from treatment based on defensive style. George E. Vaillant unequivocally states: “No mental status or clinical formulation should be considered complete without an effort to identify the patient’s dominant defense mechanism” (1992, p. 3), and Michael Bond cautions that: “linking defenses with specific illnesses can create confusion. The term *defense* should refer to a style of dealing with conflict or stress, whereas the term *diagnosis* should refer to a constellation of symptoms or signs” (Bond, in Vaillant, 1992, p. 130).

Ultimately, the goal of treatment is to support the patient in developing a stronger sense of psychological well-being and increase his or her satisfaction and self-awareness. This process occurs over time, and while some patients report improvement after only a few weeks and others remain in treatment for many years, it is an obvious fact of treatment that, for the work to begin, the patient must show up. McWilliams points to the clinician’s attunement and diagnostic skill as essential to establishing the necessary

rapport to begin a therapy relationship: “An issue related to conveying empathy involves keeping the skittish patient in treatment” (2011, p. 16).

Of course, all premature termination cannot be ascribed to defensive reactions. There are countless reasons that individuals choose to leave treatment, which is one of the reasons that this phenomenon is so difficult to study. Factors external to the treatment, including relocation, financial circumstances, or the end of a school semester are all common reasons for ending therapy. A lack of concurrent therapy goals between therapist and patient, improvement in symptoms, a lack of improvement in symptoms, and therapist errors are all valid reasons for terminating treatment as well, and have nothing to do with the activation of defenses. However, for those patients whose anxiety is triggered by the intimacy and intensity of therapy itself, early identification of defensive flight is exceptionally important.

Foundational to the development of this research question is the construct of defense. “The term ‘defense,’” writes McWilliams (2011) “in psychoanalytic theory is in many ways unfortunate. What we end up calling defenses in mature adults begin as more global, inevitable, healthy, adaptive ways of experiencing the world” (p. 100). In other words, defense processes can be considered natural, healthy and adaptive. The psychological processes that create what we later call defenses are developed early on, and are considered important components of an individual’s psychological functioning. By looking at ways that patients’ employ defenses, and how defensive operations have served the patient in the past, we may have greater empathy in understanding the role played by these individuals’ personality structures in organizing interactions with the world. Though diagnoses can communicate a great deal of information about symptoms,

functioning, and levels of psychological pathology, defenses tell us about the patient's style of *experiencing* the world and relationships, allowing insight into individual styles of coping. As Bond observes: "defense styles might identify aspects of a person's stage of development and render other information about ego functioning independent of diagnosis" (Bond, in Vaillant, 1992, p. 130).

One such use of identifying defense styles might be to establish whether the person employs defense mechanisms in a primarily adaptive or pathological manner. Are the defense patterns operating in the support of ego development and health, or are they hindering an individual's functioning and quality of life? Are the prominent defense processes developmentally appropriate (e.g. does an adult rely primarily on more mature defense patterns) or do these processes support a more pathological presentation?

Well-trained clinicians are aware of and capable of responding to primitive defense manifestations during the course of therapy. The ability to work with transference and countertransference, provide a safe holding environment, and avoid becoming overwhelmed by intense emotional material are all hallmarks of good therapy with highly defensive patients. Many of these skills, however, are employed during the course of an ongoing therapy in which rapport has already developed, both the patient and therapist have developed an understanding of the therapeutic space, and there is investment by both parties in the process. Grotstein writes:

Abnormal splitting and projective identification [primitive defense] emerge from infantile mental catastrophe, disappointment, dissolution, and despair. Thus, the therapist who wishes to acknowledge the importance of splitting and projective

identification must allow himself to become “pregnant” with his patient’s material. (2005, p. 461)

Here, Grotstein refers to the therapist’s attunement to the patient’s primitive material, and his or her ability to allow feelings to be felt subliminally and grow, until they are ready to be born into an interpretation within language. Sensitivity to the deeply emotional, often preverbal sources of these defenses is crucial. With the appropriate development of the therapeutic relationship, the therapist holds emotionally charged and labile events in the session room, and uses this material in the service of therapeutic progress. This becomes more challenging, however, when these defenses rise without a foundation in place, for example as the therapy first begins. It can be difficult, technically and emotionally, to identify and manage strong defensive strategies (such as splitting) during the early stages of therapy, as early as intake session. For many patients, intake and early sessions are a critical period as they determine, consciously or unconsciously, whether to remain in treatment. It is a reasonable hypothesis that the very practice of beginning a therapy may raise anxiety, suggest power imbalances, and highlight the patient’s role as “in need.” These circumstances then set the conditions for primitive defenses to come into play quickly for the patient who relies heavily on these strategies. “We see from case histories,” Grotstein writes, “that these patients invariably had to resort to the use of defensive spitting and projective identification because of their feelings of enfeeblement and helplessness” (Grotstein, 2005, p. 461).

For these individuals, therapy may be a short-lived experience. Once splitting or projective identification defenses are activated, the therapist or therapy may be understood as threatening or dangerous, and the patient may flee treatment. In this

hypothetical situation a defense pattern leads to a termination of therapy, which is the focus of this study. If a significant correlation between defense profiles and early terminations can be found, therapists may be able to identify these patients before the dropout occurs and work with that person to encourage continuation of treatment. Additionally, therapists may have more material to guide assessment and treatment planning practices, encouraging the best possible therapeutic outcomes for patients that may traditionally “fall through the cracks.”

Research studies have looked at correlations between diagnostic groups and early termination, looking for categorical differences in treatment adherence between populations with shared diagnoses (Ingenhoven, Duivenvoorden, Passchier, & Van den Brink, 2012; McMurrin, Huband, & Overton, 2010). However, there is a dearth of research that addresses the presence of primitive defense and the question of premature termination related to this presentation. Theoretical literature is rich with clinical descriptions of primitively defended patients, and there is no shortage of material on links between defense, diagnoses, personality structure, and therapeutic work focusing on defense patterns (Bender, 2005; Samstag, Batchelder, Muran, Safran & Winston, 1998). In psychological research, there is ample work that focuses on early termination, the therapeutic alliance, diagnoses and therapeutic success, and appropriate therapy modalities for varying presenting problems. However, the scarcity of research that addresses termination as a potential result of personality *structure* rather than personality *profile* (e.g. symptoms or demographics) is indicative of a common tendency to avoid dynamic constructs in research projects. There are some valuable exceptions to this rule.

In a study using the Rorschach test, Horner and Diamond found that clients with a predominance of *narcissistic themes* were more likely to drop out of treatment, whereas clients who continued treatment showed a predominance of *rapprochement themes*. Hilsenroth and Handler found that Rorschach variable of *interpersonal relatedness* significantly predicted premature termination, with more dependent patients staying in psychotherapy longer. Finally, in a study by Perry et al., the number of sessions in long-term dynamic psychotherapy was directly predicted by a higher adaptive defensive style. (Ingenhoven, Duivenvoorden, Passchier, & Van Den Brink, 2012, p. 173).

This project was designed as a contribution to this small but important body of research linking premature termination and defensive patterns. As Ingenhoven et al. (2012) asserts, there is still ample room for additional knowledge in this area.

Clarkin and Glock stressed the importance of characterological aspects in the prediction of treatment duration and treatment outcome. Yet little is known about the role of psychodynamic personality characteristics in the prediction of length of stay or dropping out of psychotherapy. (p. 173)

The present research project asks whether a statistically significant relationship may be found between demonstration of primitive defense use and unilateral termination of treatment. It was conceived as an attempt to fill a gap in research regarding dropout rates in therapy, a need suggested by Swift & Greenberg in a 2012 meta-analysis of psychotherapy drop out trends:

Future reviews are needed to study dropout in the areas not covered by this review, including examining the influences of process variables on dropout, studying dropout in substance abuse treatments, reviewing dropout for children and/or family therapy, and so on. (Swift & Greenberg, 2012, p. 558)

This research focuses on the ways that therapy-related dynamics, based on patient defense organization, may contribute to drop out rate, thus adding to the existing research on patient termination. Purposefully, defense was identified as the independent variable over diagnosis, as this construct is considered particularly relevant to anxiety management. While appropriate diagnosis can offer a good description of a patient's presenting symptoms and difficult experiences, defenses demonstrate where and how a patient experiences anxiety, and anxiety is assumed to be one reason that patients flee the treatment situation. McWilliams notes that therapy elicits different responses for different patients depending on his or her history, and some of these responses may increase risk for flight from treatment: "Those with hypomanic personalities, for example, because early experiences of depending on others came out disastrously, tend to bolt from relationships as soon as the therapist's warmth stimulates their dependent longings" (2011, p. 16). Here, it is not a matter of the diagnosis in and of itself driving flight, but the *anxiety provoked by the relationship with the therapist* that leads to the unilateral termination.

Separating the examination of defenses from the issue of diagnosis would allow the concept of defense to be used more precisely during investigations of fluctuations in a person's style of dealing with a particular stress at a particular time and under particular circumstances. (Vaillant, 1992, p. 130)

In order to identify the presence of defense, the Lerner Defense Scales, scored from the Rorschach Inkblot Test, were chosen as the assessment method, and termination status (premature or not) was gleaned from discharge summaries in patient files.

My hypothesis at the beginning of this study was that *there would be an evident link between some primitive defenses and unilateral patient termination of treatment.*

The research aimed to answer two main questions: 1) did the presence of primitive defense in a profile predict premature termination, and 2) was there a significant difference found between groups (premature and not premature termination) and the presence or amount of primitive defenses used?

Fundamentally, this project is looking at measurable relationships. However, it tried to simultaneously maintain a focus on contextualizing these findings and considering potential findings' clinical utility. Quantitative findings are valuable in demonstrating relationships between variables, but are not fully utilized until they have been applied to the human subjects they aim to describe. Always, this work was guided by a strong belief in the practical utility of research findings, so eloquently stated by Applebaum: "As a guide to action, the test report should answer the question, 'What practical difference do test findings make?' 'So What?'" (1970, p. 354).

Chapter Two

Defense Mechanisms

This review summarizes major theoretical contributions concerning defense mechanisms and beliefs over time regarding hierarchies or developmental models of defense. Since Freud's introduction of the term defense, defining defense mechanisms, much less "primitive" vs. "secondary" defenses has been an ongoing, often halting process. George Vaillant notes that:

In terms of recognizing a continuum of defenses from pathological to less pathological, many early contributors to ego psychology... recognized the likelihood of such a hierarchy. But none provided specific hierarchical outlines or empirical evidence for such a hierarchy. (Vaillant, 1992, p. 90)

Though a hierarchy of pathology may not be widely developed or accepted, differentiating defenses into categories that differentiate between lower order and higher order (primitive and secondary) groups is commonly assumed in contemporary psychoanalytic theory.

Broadly speaking, primitive or primary defenses are seen as natural expressions of pre-verbal psychological development, and are only considered "problematic" when adults use these defenses in lieu or in the absence of more mature (secondary) defense operations. Psychodynamic theory considers defense use important to proper case formulation, and views defense constellations as part of a developmental trajectory.

McWilliams (2011) describes the two major categories of defense profiles as follows:

In general, the defenses that are referred to as primary or immature or primitive or “lower order” (Laughlin, 1970) are those that involve the boundary between the self and the outer world” (p. 98) while “Those [defenses] that are conceived as secondary or more mature or advanced or ‘higher order’ deal with internal boundaries such as those between the ego or superego and the id, or between the observing and experiencing parts of the ego (p. 98).

Although primitive defenses are the first natural order of defenses, expected in children and, in moments, with adults, relying on primarily primitive defenses into adulthood is seen as a developmentally problematic way of managing internal conflict and interpersonal relationships.

In the most primitive state, which may be retained in illness, and to which regression may occur, the object behaves according to magical laws, i.e., it exists when desired, it approaches when approached, it hurts when hurt.

Lastly, it vanishes when not wanted. (Winnicott, 2005, p. 184)

Here, Winnicott vividly describes the patient who has maintained or regressed to an emotional understanding that mirrors preverbal thinking. Though this individual may present with appropriate reality testing to the casual observer, his or her emotional state reflect deep anxiety related to the fear of annihilation that goes beyond language. For example, a man questioned about his fear of being left by his wife may not be able to articulate more than basic tropes about feeling nervous about being lonely, feeling like a failure, or other cognitively unremarkable responses. However, the emotional core of his fear, the feelings that arise and take over when he considers this possibility, may feel so overwhelming that he cannot tolerate the experience. He is experiencing this emotional

state much as he may have experienced the world as a much younger person. Similarly, the individual who feels compelled to count the number of cracks in a sidewalk for fear that her mother may fall ill, can express a cognitive understanding that this is not a logical behavior, and that most people would not believe that there could be a correlation between this ritualized act and another person's health. However, if she is so overtaken by anxiety if she cannot complete this task that she experiences panic attacks, Winnicott would surely argue that she, psychologically and emotionally speaking, responds to her situation from this place of magical thinking, driven by preverbal ways of experiencing the world.

Primitive defenses (used interchangeably in the literature with "primary" defenses) must "show evidence of two qualities associated with the preverbal phase of development: a lack of attainment of the reality principle and a lack of appreciation of the separateness and constancy of those outside the self" (McWilliams, 2011, p. 102). Primitive defenses include: (a) primitive withdrawal, (b) denial, (c) omnipotent control, (d) primitive idealization (and devaluation), (e) projection, introjection, and projective identification, (f) splitting, and (g) dissociation. Based on the nature of psychotherapy as a venue in which both issues of reality and issues of self-knowledge are explored, one might expect that individuals who rely heavily on primitive defenses will feel frightened by and threatened by traditional psychotherapies; the "treatment" excites and activates the patient's compelling desire to flee the treatment environment. A patient who relies heavily on splitting, for example, as a means of avoiding deep fears of abandonment and annihilation, might perceive the possibility of intimacy (and therefore potential rejection) in the therapeutic relationship as dangerous, and thus leave treatment. We will return to

this idea when discussing the assessment situation and the function of defense mechanisms.

This chapter presents a historical overview of psychoanalytic theories of defense, and provides a brief summary of ways that two contemporary practitioners (Vaillant and McWilliams) incorporate psychoanalytic theory on defense and practical guidance for clinical work. Because this study aimed not only to explore potential correlation between defense and termination, but to also suggest clinical implications of these findings (including suggestions for therapists in using this information in practice), both theory and application of this theory were integral to this literature review.

A Theoretical History of Defense Mechanisms

Sigmund Freud

Sigmund Freud (1856-1939) introduced the term “defense mechanism” in 1894 in his paper “The Neuro-psychoses of Defence.” For Freud, defense mechanisms are the psychological response to anxiety. “Anxiety is a reaction to a situation of danger. It is obviated by the ego’s doing something to avoid that situation or to withdraw from it” (Freud, 1959, pp. 54-55). Freud believed that the human psyche is self protective in the same way that the human body seeks to avoid pain or suffering and that signs of danger, whether or not these dangers have a basis in reality, set a series of defensive processes in motion. “The defensive process is analogous to the flight by means of which the ego removes itself from a danger that threatens it from outside. The defense process is an attempt at flight from instinctual danger” (Freud, 1959, p. 71).

Between the introduction of the defense mechanisms in 1894 and the publication of *Inhibitions, Symptoms, and Anxiety* in 1926, Freud continued to refer to defense and

repression rather interchangeably. It is commonly written that, during those years, Freud abandoned the terms defense and defense mechanisms completely, and subsumed these ideas under the larger construct of “repression.”

Freud had first cleanly differentiated among various defense mechanisms and then confounded the issue by making one of his favorite psychoanalytic concepts, repression, stand both for the mental technique of denying certain ideas access to consciousness and for all other ways of parrying unpleasurable excitations. He was now ready to correct this imprecision by returning to ‘the old concept of ‘defense’ as a ‘general designation for all the techniques’ the ego employs in the conflicts that may lead to neurosis, ‘while ‘repression’ remains the name of one certain method of defense.’ (Gay, 1988, p. 488)

However, Freud did continue to write about defenses, though much more sparingly, during this period although he did in fact prefer the term repression. It is unclear whether he meant to use defense as the action taken by the psyche, and repression as the function itself, which may explain his continued use of the word “defense.” In the addendum to *Inhibitions, Symptoms, and Anxiety*, Freud clarified his thoughts on defenses vs. anxiety, stating:

In the course of discussing the problem of anxiety I have revived a concept... of which I made exclusive use thirty years ago... but which I later abandoned. I refer to the term ‘defensive process.’ I afterward replaced it by the word ‘repression,’ but the relation between the two remained uncertain. It will be an undoubted advantage, I think to revert to the old concept of ‘defence,’ provided we employ it explicitly as a general designation for all the techniques which he ego makes use

of in conflicts which may lead to a neurosis, while we retain the word ‘repression’ for the special method of defence. (1959, p. 89)

Perhaps one of the reasons that Freud saw a need to clarify multiple types of defensive functions was his growing understanding of the way that defense fit into a developmental trajectory.

It may well be that before its sharp cleavage into an ego and an id, and before the formation of a super-ego, the mental apparatus makes use of different methods of defence from those which it employs after it has reached these stages of organization. (Freud, 1959, p. 90)

Freud spent some time in *Inhibitions, Symptoms, and Anxiety* hypothesizing about the ways that children and adults are alike and different in their need for and use of particular modes of defense. He does not, however, go so far as to delineate developmental qualities of each defense, nor does he bring the term “primitive defense” into parlance.

For Freud, the use of defense, whether couched in terms of defense mechanisms, inhibitions, or repression, is one of the hallmarks of human psychological functioning, and has implications for neurosis and psychopathology. It was his daughter Anna Freud, however, who expanded the study of defense mechanisms into a particularly robust subfield within psychoanalysis. Her father had reintroduced the importance of acknowledging specific defense mechanisms (as opposed to linking all defenses under the umbrella of “repression”) when he was 70 years old. He was aware of Anna Freud’s careful attention to this area of investigation and, in essence, passed the torch when he stated: “there are an extraordinarily large number of methods (or mechanisms, as we say) used by our ego in the discharge of its defensive functions... my daughter, the child

analyst, is writing a book upon them” (Freud, 1936, p. 245). Anna Freud’s most important work, *The Ego and the Mechanisms of Defense*, was her 80th birthday gift to her father (Vaillant, 1992).

Anna Freud

In 1936, Anna Freud (1895-1982) published “The Ego and the Mechanisms of Defense,” the first publication dedicated solely to the exploration and understanding of defense mechanisms. In this book, Anna Freud reiterated and condensed much of Sigmund Freud’s work on the subject but expanded these concepts enormously, naming and describing multiple defensive processes that are still referred to in psychoanalytic theory today. Anna Freud embraced her father’s theory that defense mechanisms provided the ego with necessary relief from neurotic anxiety:

The institution which sets up the defense and the invading force which is warded off are always the same; the variable factors are the motives which impel the ego to resort to defensive measures. Ultimately all such measures are designed to secure the ego and to save it from experiencing unpleasure. (1966, pp. 69-70)

However, her work clearly inferred a developmental context, referring to the “infantile ego” as opposed to the ego of the latency period, adolescent period, or adult period. Sigmund Freud hinted at a differentiation between primitive and secondary defense mechanisms in *Inhibitions, Symptoms, and Anxiety*, but did not draw a clear distinction between the two. Anna Freud also evades categorically describing defenses in this way, and clearly states that the project of determining hierarchical levels of defense is premature.

The chronology of psychic processes is still one of the most obscure fields of analytic theory... so a classification of the defense mechanisms according to position in time inevitably partakes of all the doubt and uncertainty which even today attach to chronological pronouncements in analysis. It will probably be best to abandon the attempt so to classify them and, instead to study in detail the situations which call for the defensive reactions. (Freud, 1966, p. 53)

She goes on to predict, however, further developments in this classification process.

As our knowledge of the unconscious activity of the ego advances, a much more precise classification will probably become possible. There is still considerable obscurity about the historical connection between typical experiences in individual development and the production of particular modes of defense. (1966, p. 173)

Though she points out difficulties with the task of classifying types of defense, Anna Freud makes ample use of terms that assume developmental qualities associated with defense use, suggesting that lower-level defenses rely on phantasy and make-believe while higher-order defenses operate in the realm of reality. Anna Freud identifies *fantasy* itself as an early defense, common and “a normal phase in the development of the infantile ego” (1966, p.80) but notes that: “if it recurs in later life, it indicates an advanced stage of mental disease” (1966, p. 80). These observations foreshadow the later work of theorists such as Otto Kernberg, who identify developmentally inappropriate use of primitive defense mechanisms as the hallmark of borderline personality organization.

Making good on her purported goal of “study in detail the situations which call or the defensive reactions” (1966, p. 53), Anna Freud attends to the particular projects of the

ego at various stages of development, and how defense assists in maintaining ego functioning. For the infant, not yet fully differentiated from his or her environment, maintaining and developing the ego is a monumental task. “The infantile ego experiences the onslaught of instinctual and external stimuli at the same time; if it wishes to preserve its existence it must defend itself on both sides simultaneously” (Freud, 1966, p.174). This preservation of existence calls for all-or-nothing manifestations of psychological functioning, and defense mechanisms including repression, denial and what Melanie Klein later refers to as “splitting” allow the infant to contain and isolate unpleasant sensations. “For some years the infantile ego is free to get rid of unwelcome facts by denying them, while retaining its faculty of reality testing unimpaired” (1966, p. 83). Anna Freud is quick to point out that at these early stages of development these types of psychological behaviors are not aberrant and are, in fact, developmentally appropriate.

The mechanism of avoidance is so primitive and natural and, moreover, so inseparably associated with the normal development of the ego that it is not easy, for purposes of theoretical discussion, to detach it from its usual context and view it in isolation. (1966, p. 94)

In other words, the infant that manages anxiety by falling asleep is not circumventing a more appropriate way of handling this situation, but is using the available resources at his or her disposal to maintain functioning.

Anna Freud also begins to construct a framework that explains why particular defensive processes may be recycled throughout a lifetime. There are times of extreme stress, she suggests, that call on the ego to muster all available resources in the service of managing anxiety. “Any additional pressure of instinctual demands stiffens the resistance

of the ego to the instinct in question and intensifies the symptoms, inhibitions, etc., based upon that resistance” (1966, p. 151).² Not all “redoubled defense activities” are regressive, and Anna Freud relies on metaphors of force and power to describe the changing demands placed on the ego by the id. Describing the “human ego’s great capacity for transformation,” set against the “immutability of the id” defense patterns in different stages of life become more intelligible.

Let us take as an example the ego in early childhood and the ego at puberty. At the one period and at the other it differs in compass, in content, in its knowledge and capacities, in its subordinate relationships and anxieties. Consequently, in its conflicts with the instincts it makes use of different defense mechanisms in the different periods. We may expect that a more detailed examination of these differences between early infancy and puberty will throw light onto the formation of the ego... (1966, p. 141)

Here, Anna Freud provides us with a lovely example of the flexibility of the psyche to respond to perceived threats in a variety of ways, and that the response to threat depends on the perceived danger of the threat. This idea will be especially relevant when we later discuss rigid and overcompensating ways of responding to anxiety.

Notwithstanding the appropriateness of the defense response, Anna Freud emphasized that the goal of defensive behavior is always the same.

The ego is victorious when the defensive measures effect their purpose, i.e., when they enable it to restrict the development of anxiety and unpleasure and so to

² Apparently, stigmatization of hormonal changes associated with menstruation (exemplified by the inclusion of Premenstrual dysphoric disorder in the DSM 5) has changed little over time; here, Anna Freud links premenstrual symptoms and pathology in the same breath: “We know from the study of neurotic symptoms and premenstrual states that, whenever the demands of instinct become more urgent, the ego is impelled to redouble its defensive activities” (1966, p. 150).

transform the instincts that, even in difficult circumstances, some measure of gratification is secured.” (1966, p. 176)

Although she maintained her position that each defense mechanism is specifically employed to address a particular manifestation of anxiety or fear, Anna Freud consistently alluded to the importance of developmental processes: “Possibly each defense mechanism is first evolved in order to master some specific instinctual urge and so it associated with a particular phase of infantile development” (Freud, 1966, p. 51). Melanie Klein’s work describing the schizoid and depressive positions takes this idea as its foundation.

Heinz Hartmann

Often referred to as the father of ego psychology, Heinz Hartmann (1894-1970) was interested not only in the identification and understanding of psychopathology, but in a broader conceptualization of psychological development. At the time he was developing his theories Hartmann was unique among psychologists and psychoanalysts in that he strove to both preserve and incorporate the foundational elements of Freudian drive theory, and to expand the field of psychology as a greater intellectual discipline. For Hartmann, this greater discipline approached psychological processes as not only associated with intrapsychic conflict but rather as adaptive strategies that allowed humans to appropriately respond to and interact with their surroundings. This theoretical position applied to mechanisms of defense as it did to other psychological processes. “Defense processes may *simultaneously* serve both the control of the instinctual drive and adaptation to the external world” (Hartmann, 1958, p. 51). In this statement, Hartmann both validates Freudian drive theory, acknowledging that defenses may arise to manage

individuals' instinctual conflicts, and asserts that defense mechanisms have a positive role in healthy psychological development as an adaptive capacity. Furthermore, Hartmann stressed a developmental quality to defense organization, and noted that the adaptive function of a defense was dependent on when and how it was used during the lifespan. "What developed as a result of defense against an instinctual drive may grow into a more or less independent and more or less structured function. It may come to serve different functions, like adjustment, organization, and so on" (Hartmann, 1964, p. 123).

One of the important ways that Hartmann expanded psychological understanding of defense was to reconsider the way that defense mechanisms were discussed in within the psychoanalytic community, which used language that described an intrapsychic, closed system.

Many of us would agree today that in speaking of 'successful defense,' we refer to the fact that the function of the defense mechanisms has been performed, its aim has been reached- and not to the possible long-range outcome of health or disease. (Hartmann, 1964, p. 225)

For Hartmann, it was important to consider how the defense mechanisms came into use for a person, what purposes it served (both adaptive and pathological), and how this broader understanding might help clinicians perform helpful interventions. This multifaceted approach to identifying and understanding patterns of defense suggested the importance of considering both the developmental origin of defense, as well as the current presentation of defensive strategies. Not only did Hartmann call into question the inherent pathology of

defense operations, he also suggested that individuals might use the same defense in both healthy and pathological ways depending on the situation and his or her psychological state:

To touch on at least one of the genetic problems involved, we can assume that many defense mechanisms are traceable to primitive defense actions against the outside world, which in part probably belong to the ego's primary autonomy, and that only later, in situations of psychic conflicts, do they develop into what we specially call mechanisms of defense. Also, we can say of many of them that after having been established as such, they become in a secondary way invested with other functions (intellectualization, for example). This makes for a complicated overlapping of their role as resistances with various other functions they represent. It is because of this, that if we want to analyze defenses in a rational way, we have to consider their structural, their intersystemic and intrasystemic ramifications, beyond the aspect of resistance they offer to analysis. (Hartmann, 1964, pp. 151-2)

In other words, an individual may develop a defense mechanism, such as isolation of affect, in an adaptive way as a child in order to help manage strong emotions that feel unbearable without a developmentally mature level of ego functioning. This defense serves to support the child's emotional state until his ego strength is such that he can tolerate strong emotions in a more productive way, and the defense becomes less pronounced. This same individual may revert back to prominent use of this defense in a period of stress, perhaps while serving in the

military in a combat zone. The ability to distance emotion from cognition in this situation, which demands the control of reactivity and focused concentration, may allow him to survive a life-threatening situation. Thus far, all the functions of isolation of affect could be considered adaptive and productive. If this individual, however, returns from combat and the defense does not abate, Hartmann might consider this a shift toward a pathological presentation. This individual, if unable to appropriately manage and express emotion in his relationships, or feels dehumanized by the disconnection between his thinking and feeling, has entered into a stage when the defense is not serving an adaptive function, but has become disabling.

Once a defense was identified as maladaptive, Hartmann approached therapeutic work similarly to Freud and other drive theorists, suggesting that it was possible to interpret defense failure in a way that led to greater psychological integration.

Defenses (typically) not only keep thoughts, images and instinctual drives out of consciousness, but also prevent their assimilation by means of thinking. When defensive processes break down, the mental elements defended against and certain connections of these elements become amenable to recollection and reconstruction. (Hartmann, 1958, p. 63)

For clinicians, and important in the conceptualization of this research, Hartmann's turn toward recognizing both healthy and pathological modes of psychological functioning has major implications for the practice of psychotherapy and the treatment of individual patients. The understanding that even highly maladaptive defense patterns may have originated from an adaptive period of psychological

growth suggests the enormous possibility of human change. Though many patients come to therapy because previously adaptive strategies are no longer viable, Hartmann's work also alerted clinicians to the possibility of not simply eradicating or replacing problematic patterns, but to move back toward a healthier manifestation of a foundational defensive style.

Melanie Klein

Melanie Klein (1882-1960) emphasized intrapsychic development beginning as early as infancy, one of her major areas of divergence from Sigmund Freud, who analyzed children but did not speak about ego development prior to age five or six. This move toward an object-relations perspective is evident in her writings about the foundations of anxiety.

The analysis of very young children has taught me that there is no instinctual urge, no anxiety situation, no mental process which does not involve objects, external or internal; in other words, object relations are at the *centre* of emotional life. (Klein, 1986, p. 206)

Melanie Klein further advanced Freud's theoretical ideas related to defenses with particular attention to defense organization as it relates to developmental stages. Perhaps her greatest contribution to the field of psychoanalysis was her identification of two major developmental processes during infancy: she couched these processes in stage theory, and introduced the concepts of the paranoid-schizoid and the depressive positions. Klein had a keen eye for developmental changes in ego development based on her years of analytic work with children and these developmental issues are the core of her understanding of these two positions. During infancy, Klein posited that the child exists

in “two polarized states, dramatically contrasting in both conceptual organization and tone” (Mitchell & Black, 1994, p. 92). This division between states of existence is present long before the ability to reality-test, and allows the infant to compartmentalize loving and destructive feelings so that the latter does not annihilate the former.

Every external or internal stimulus (e.g. every real frustration) is fraught with the utmost danger: not only the bad objects but also the good ones are thus menaced by the id, for every access of hate or anxiety may temporarily abolish the differentiation and thus result in a ‘loss of the loved object’. (Klein, 1986, p. 120)

The separation of affective states and perception of objects as “good” or “bad” characterizes the paranoid-schizoid position. Here, “schizoid refers to the central defense: *splitting*, the vigilant separation of the loving and loved good breast from the hating and hated bad breast” (Mitchell & Back, 1994, p. 93). Klein describes the infant’s experience of the world in this way:

The comfort and care given after birth, particularly the first feeding experiences, are felt to come from good forces. In speaking of ‘forces’ I am using a rather adult word for what the young infant dimly conceives of as objects, either good or bad. The infant directs his feelings of gratification and love toward the ‘good’ breast, and his destructive impulses and feelings of persecution toward what he feels to be frustrating, i.e. the ‘bad’ breast. At this stage splitting processes are at their height, and love and hate as well as the good and bad aspects of the breast are largely kept apart from one another. (Klein, 1986, p. 202)

As the infant develops and begins to acquire greater capacity for cognition and reality testing, Klein understood the central psychological process to be integration of the

good and bad elements of the world, including the good and bad elements within one object. The movement toward the depressive position is facilitated by this integration. The depressive position moves beyond a general sense of persecution and into an economy of guilt: the child is aware of the damage he or she can do to loved objects. The child becomes aware of his or her own power. At this time, the child's "belief in her own capacity for reparation is crucial to the ability to sustain the depressive position" (Mitchell & Black, 1994, p. 95). In other words, the child has to navigate the complex interpersonal waters of "give and take" and "to believe that her love is stronger than her hate" (Mitchell & Black, 1994, p. 95). The differences between these two positions are important to a review of defense mechanisms because in each position different strategies (defenses) to manage very different states of anxiety are called into action.

Melanie Klein describes the infant experience of managing loving and aggressive impulses, and posits that primitive defenses are the result of human beings' earliest attempts to manage these conflicting emotional states. "The baby's impulses and feelings are accompanied by a kind of mental activity which I take to be the most primitive one: that is phantasy-building, or more colloquially, imaginative thinking" (Klein, 1975, p. 60). Her comments here support Anna Freud's assertion that fantasy is integral to childhood development, and that imaginative thinking is the first way by which a child makes sense of the world.

Klein writes prolifically on the defensive use of splitting and her work in this area is particularly relevant to this project.

I have, for many years, attributed great importance to one particular process of splitting, the division of the breast into a good and bad object. I took this to be an

expression of the innate conflict between love and hate and the ensuing anxieties.

(Klein, 1986, p. 216)

For Klein, like Freud, individuals use whatever resources at his or her disposal to manage seemingly unmanageable feelings of anxiety, and Klein clearly identifies splitting as one of the earliest forms of defense.

Splitting, omnipotence, denial, and control of internal and external objects are dominant at that [the first three or four months] stage. These first methods of defense are of an extreme nature, in keeping with the intensity of early emotions and the limited capacity of the ego to bear acute anxiety. (Klein, 1975, p. 70)

The act of “splitting,” in this way, is seen as a natural developmental process, albeit one that must be outgrown as maturation occurs. “Splitting normally succeeds only temporarily or partially. When it fails, the infant’s persecutory anxiety is intense” (Klein, 1975, p. 241). Because splitting is not a sustainable way of managing anxiety as the infant develops, reality based defenses must emerge as primary strategies. Klein suggests the pathology that may follow if splitting continues as a primary force:

If the split between the two aspects of the object is too deep, the all-important processes of ego integration and object synthesis, as well as of mitigation of hatred by love, are impaired and the depressive position cannot be worked through. A very deep and sharp division between loved and hated objects indicates that destructive impulses, envy and persecutory anxiety are very strong and serve as a defense against these emotions. (Klein, 1986, p. 217)

Here, splitting becomes a barrier to adaptive human development, and an expected maturational process is frustrated.

Even in healthy development, Klein asserts that no defense is fully left behind. Assuming that a person adequately moves through the schizoid and depressive positions and accumulates a varied set of primitive and secondary defense strategies, previous methods are not eradicated. “For the ego, when it becomes fully identified with the object, does not abandon its earlier defense mechanisms” (Klein, 1986, p. 119). From a developmental standpoint, mature defenses will occupy a preferential position, but under periods of extreme stress or duress an individual will regress and revert to more primitive ways of managing anxiety.

Although Klein’s writes clearly and eloquently on the subject of splitting she also has been criticized for using the term too broadly, in much the same way Freud used the term “repression.” Otto Kernberg was one such critic, and noted that:

Klein’s failure to consider structural factors in her theories and her lack of precision in the use of her own terminology, specifically in regard to splitting which she appears to use for all kinds of dissociated or repressed material creates very serious difficulties for her formulations. (Kernberg, 1984, p. 26)

Kernberg’s own work attempted to clarify the role that splitting plays in personality development in a more nuanced and precise manner, and became the foundation of his theory of borderline pathology, which will be explored in more detail.

W.R.D. Fairbairn

W.R.D. Fairbairn was profoundly influenced by Melanie Klein and her followers although he placed significantly more importance on the infant’s early investment in relationships than Klein, whose writings were categorically more focused on the

intrapsychic experience of the individual. Like Klein, Fairbairn was fascinated with the schizoid position, noting that:

The most characteristic feature of the state of infantile dependence is *primary identification with the object*. Indeed, it would not be going too far to say that, psychologically speaking, identification with the object and infantile dependence are but two aspects of the same phenomenon.

(Fairbairn, 2005, p.53)

Fairbairn agreed that the principal project of the infant is to move from this primary identification state of the schizoid position to the depressive state, in which *mature dependence*, characterized by “a relationship between two independent individuals, who are completely *differentiated* from one another as mutual objects,” (Fairbairn, 2005, p. 53), is achieved. Although Fairbairn did not describe particular defense mechanisms in the same detail as Anna Freud or Klein, he was clear that there were two distinct purposes in the use and deployment of defenses:

Where a schizoid tendency is present, the defensive techniques represent methods designed to avert the ultimate psychopathological disaster which follows from loss of the ego, and where a depressive tendency is present, they represent methods designed to avert the ultimate psychopathological disaster which follows from loss of the object. (Fairbairn, 2005, p. 63)

During the transition from the schizoid to depressive position, Fairbairn posited that the infant created his or her internal experience by the process of internalizing experiences with the external world. In this way, Fairbairn sees introjection as more relevant than projection during this developmental period,

and this differentiation is fundamental to his theoretical divergence from Klein's work. While Klein and Fairbairn both emphasized the role of splitting in the schizoid position, Klein focused on "the infant's role in projecting and splitting of the *object*. She thought the infant mainly tried to get unpleasant experience and affect outside the self by locating it in the mother" (Scharff, 2005, p. 7). Fairbairn, on the other hand, believed that the splitting occurred internally – an ego split – and was "accompanied by repression, that is, disposing of unpleasant internalized relationships by splitting them off from the main core of the self and burying them" (Scharff, 2005, p. 7). This description of the self as a repository of "parts" of self, some available to consciousness and some repressed, sets up Fairbairn's philosophy of psychoanalytic treatment, of which he says "the chief aim... is to promote a maximum 'synthesis' of structures into which the ego has been split" (Fairbairn, 2005, p. 102).

Otto Kernberg

Otto Kernberg, in his seminal works on borderline personality organization, masterfully linked defensive functions to psychopathology and neurotic presentations. The term "borderline" came to exist in the 1950's when therapists began to notice a particular group of patients that, while primarily diagnostically rooted in the neurotic range, lacked capacity for certain types of introspection, presented with severe mood-swings and transference regression, and manifested some psychotic symptoms when experiencing significant stress. Because these "types" of patients did not seem to share overall similarities in the particulars of their presentations, "the term borderline was a

very broad one, somewhat synonymous with ‘the difficult patient’” (Kernberg, 1989, p. 3).

Kernberg posited a developmental model of the mind based on psychoanalytic theory, using complementary elements of Freudian, Jacobsonian and Kleinian theory. His ideas about necessary developmental processes are in line with many of Klein’s formulations. In order to understand the etymology of the term “borderline” it is important to understand the particular way that Kernberg used this descriptor. For Kernberg, “borderline” referred to a developmental tier of psychological development, operating in between the more profoundly disturbed psychotic individual and the more psychologically healthy neurotic individual. Kernberg understood a person with borderline personality organization as generally experiencing appropriate differentiation between self and other, but lacking the ability to integrate ambiguous feelings (e.g. love and hate) toward others.

For Kernberg, like Klein, the infant’s first psychological task is to create psychological autonomy, and to appropriately differentiate between self and other. Failure to accomplish this task is, in Kernberg’s view, the foundation of all psychotic states. Without reliable differentiation between what is self and what is other, a clear distinction between internal and external, between reality and fantasy, is impossible.

Even after an adequate individuation of self has been attained, Kernberg understood the psyche to maintain *affective segregation* between good and bad parts of the self and others. Like Klein, Kernberg understood the ego-development of the infant as still inchoate, and therefore the task of simultaneously holding loving and aggressive impulses is still impossible. Slowly integrating these affective states, or learning that

objects may be perceived as *both* good and bad simultaneously (echoing Klein's understanding of movement into the depressive position), is the psychological project of the individuated infant. A failure to overcome this state of splitting, according to Kernberg, results in borderline personality organization.

Patients in this "borderline" category have historically been seen as a particularly challenging population in treatment settings. Many individuals with borderline personality organization are quite functional, but experience significant interpersonal problems and complex relationships with his or her own identity. Patients with borderline personality structure are often associated with high levels of primitive defense, but are not as frequently identified or hospitalized as psychotically organized individuals (Davison, 2000). McWilliams asserts that:

One of the most striking features of people with borderline personality organization is their use of primitive defense. Because they rely on such archaic and global operations as denial, projective identification, and splitting, when they are regressed they can be hard to distinguish from psychotic patients. (McWilliams, 2011, p. 63)

As discussed above, Kernberg's "borderline" personality organization refers to a developmental psychological structure, and is *not the same* as the contemporary diagnosis of borderline personality disorder. However, this diagnosis shares some important characteristics with individuals identified as organizationally borderline, and there is evidence that the structural elements identified by Kernberg are likely to inform behaviors that are identified as symptoms of borderline personality disorder in the DSM 5.

Diagnostic criteria for borderline personality disorder do not include particular patterns of defense use. However, because the use of primitive defenses can manifest as behaviors or symptoms associated with Borderline Personality Disorder (for example, one of the DSM 5 criteria for Borderline Personality Disorder: “a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation” aptly describes the residual consequences of splitting), literature about this diagnostic group is helpful in grounding our overview. Borderline or “difficult” patients are often deemed more difficult to work with in long-term psychotherapy, quite often because of irregular treatment adherence and early termination. Bender (2005) neatly summarizes this in her paper on therapeutic alliance in the treatment of personality disorders (which includes discussion of borderline personality disorders as well as other Cluster B (DSM-IV-TR) disorders):

Patients with narcissistic, borderline and paranoid personality traits are likely to have troubled interpersonal attitudes and behaviors that will complicate the patient’s engagement with the therapist. While a strong positive therapeutic alliance is predictive of more successful treatment outcomes, strains and ruptures in the alliance may lead to premature treatment of termination. (2005, p. 73)

This description nicely depicts the way that *traits* of individuals typically diagnosed with a personality disorder influence interpersonal relationships in a way that is relevant to psychotherapy and behavioral interventions. Specifically, she highlights the point that:

These categories [DSM diagnostic groups] do not adequately capture the complexity of character pathology and that clinicians also need to consider which

aspects of a patient's personality pathology are dominant at the moment in considering salient elements of the therapeutic alliance. (Bender, 2005, p. 73)

This observation supports to Kernberg's clinical observation that:

Borderline patients oscillate between narcissistic expectations—that little will be required of them and much will be given to them—and profound feelings of distrust—with the belief that they will be treated malevolently and must protect themselves from the therapist. (Kernberg, 1989, p. 35)

Acknowledging the ways that defensive structures serve to “protect” individuals from anxiety, deregulation, and even, as Kernberg posits, “the therapist,” speaks to the positive intention of defensive behaviors. Kernberg, like Hartmann before him, stresses the protective function of these actions, and not just the maladaptive consequences.

Contemporary Ideas about Defense Mechanisms and Clinical Practice

Because this research is interested in the clinical value of identifying a relationship between primitive defense mechanisms and premature termination from therapy, this section summarizes the influences of George E. Vaillant and Nancy McWilliams, both of whom have made great contributions to the literature on clinical applications of defense theory.

George E. Vaillant

George E. Vaillant has devoted much of his professional career seeking ways to categorize, operationalize, and empirically study defense mechanisms. His research has led to clearly articulated suggestions for clinicians working with patients with various presentations of defense style, differentiating appropriate interventions, for example, between patients who use borderline and neurotic styles of defense. Vaillant endorses a

hierarchy of defense mechanisms, and organizes them into four major categories: mature defenses, psychotic defenses, neurotic defenses, and immature defenses. For Vaillant, mature defenses are those employed by individuals with healthy psychological functioning, and help maintain ego stability in a productive way. “Mature defenses require no response from the clinician- other than verbal admiration” (1992, p. 60). Psychotic defenses are primary in individuals who qualify for psychotic diagnoses, and Vaillant sees these patients as unavailable for traditional psychoanalytic interpretative strategies. “In the case of psychotic distortion, delusional projection, and denial of external reality, the brain is not working well enough for psychotherapeutic intervention” (1992, p. 60). Vaillant described only the neurotic and immature defenses as amenable to interpretation in psychotherapy, and specified that each must be approached in a distinct way.

For neurotic patients, interpretation is the meat of therapeutic work, as it allows the patients to identify, reflect upon, and work with the defensive operations that contribute to his or her unhappiness.

Neurotic individuals suffer from their defenses (e.g., repression, isolation, reaction formation and displacement) and thus welcome insight and view interpretation of their defenses as helpful. In contrast, the defenses of patients with personality disorders often only make others suffer; the owners view interpretations of their defenses as an unwarranted attack. (1992, p. 61)

For personality-disordered patients, comparable to Kernberg’s “borderline” patients, defenses “have become part of the warp and woof of their life histories and of their personal identities” (1992, p. 61). Vaillant cautions that the same strategies of

interpretation that bring relief to neurotic individuals can deregulate individuals relying heavily on immature defense. “By carelessly threatening an immature defense, a clinician can evoke enormous anxiety and depression in the patient and rupture the therapist-patient relationship” (1992, p. 62).

Vaillant describes three components he believes are necessary for the task of “enabling patients to replace immature defenses with more mature defenses: stabilizing the external environment, altering the internal environment, and controlling countertransference” (1992, p. 63). In essence, Vaillant prescribes slow and careful decisions about destabilizing immature defenses until a patient has taken the opportunity to develop an arsenal of neurotic or mature defenses with which to replace previous maladaptive strategies. Similar to Kernberg, Vaillant emphasized that therapeutic interventions are heavily dependent on personality organization and that an approach that is ideal for one patient may be counterproductive or even disastrous for another. For this reason, identifying the modes of defense utilized by each patient is imperative. Relevant to this study is the idea that early identification of defense patterns may allow the clinician to consider the first treatment intervention the actual process of encouraging treatment adherence, and tailoring the early sessions accordingly.

Nancy McWilliams

Nancy McWilliams provides a lovely description of various defense mechanisms (both primitive and secondary) in her book, *Psychoanalytic Diagnosis, 2nd Edition*. Although this book is not intended as a guidebook for the practice of psychotherapy, McWilliams aims to provide clinicians with helpful summaries of diagnostic principles that assist in appropriate diagnosis and treatment of individuals with a variety of

personality structures. Essential to her formulations are the identification of personality organization (neurotic, borderline, and psychotic) as well as the particular defense patterns and relational patterns that emerge when treating different patients. Like the ego psychologists, McWilliams asserts that defense mechanisms are not inherently pathological, and that significant psychological problems may be seen in patients who are psychologically *under-defended* as well as in patients that use defense to extremes.

“Analytically influenced therapists have sometimes understood certain problems, notably psychotic and close-to-psychotic “decompensations,” as evidence of insufficient defenses” (McWilliams, 2011, p. 101). Diagnosis, for McWilliams, operates on both vertical and horizontal levels: one can identify the overall character structure of a patient (e.g. psychopathic, masochistic, depressive, narcissistic, etc.) and then further determine the level of personality organization of that same individual (e.g. psychotic, borderline, or neurotic). Expectedly, individuals within these groups can be expected to present differently, and to use different mechanisms of defense. That being said, McWilliams identified particular defense mechanisms that are highly associated with different character structures, and notes that more primitive uses of these defenses are associated with the particular level of personality organization. For example, a neurotically organized paranoid character may use projection, but in a way that still preserves an “observing ego” part of the self. This ability to *recognize* that one is projecting suggests an ability to self-reflect that is available to the neurotic patient but not the psychotic patient, who may use projective identification in a completely ego-dystonic way (McWilliams, 2011).

For these reasons, according to McWilliams, patients who use primitive defense can be found within all character organization, and primitive defense use is not only associated with specific mental health diagnoses. Individuals experiencing high levels of distress, regardless of mental health diagnosis, are more vulnerable to primitive defense styles that may manifest in many areas of functioning. “Primitive defenses operate in a global, undifferentiated way in a person’s total sensorium, fusing cognitive, affective, and behavioral dimensions, whereas more advanced ones make specific transformations of thought, feeling, sensation, or behavior, or some combination of these” (McWilliams, 2011, p.102)

McWilliams invites clinicians to be sensitive to the ways that the clinician’s own personality structure can favor particular modes of intervention, and how this approach may derail the therapy. “If a person with this psychology [referring to a depressive character] and its corresponding therapeutic ideology were to treat a patient whose psychological economy worked in an opposite way... the results could be disastrous” (McWilliams, 1999, p. 112). Hypothetically, we might consider a therapist conveying warmth and empathy to a patient who has come for treatment for the first time. With many patients, this position is considered inviting and supportive. For some patients, however, this invitation for closeness may activate a need to defend against intimacy, which feels invasive and overwhelming. This is not to suggest that therapists should be able to accurately identify an individual’s needs and personality structure immediately upon meeting, but rather to recognize that even the most intuitive therapeutic skills or choices may have very different effects on patients with more disorganized personality structures.

Another clinically useful approach to assessing defense requires the clinician to assess whether defensive reactions represent characterological or situational responses to the environment. McWilliams notes that a person manifesting a characterological defense pattern will use that defense “in almost any circumstance” (1999, p. 90), whereas a situational response may be elicited only by a particularly provocative condition. One reason that using projective assessment can help in determining whether defense styles are characterological or situational is that this task introduces another “circumstance” into the therapy situation; if, for example, a person’s Rorschach responses show high levels of devaluation, the person demonstrates devaluing attitudes about others in her description of friends and family, and the therapist feels rejected and minimized by the patient, there are three different reference points that indicate this as a central defense.

Regardless of the identified defense, attempting to understand the purpose of the defensive act is crucial. “For clinical purposes, it is more important to know the meaning of a person’s behavior than to describe that behavior accurately the way an external observer would” (McWilliams, 1999, p. 87). The patient who comes to one session and then does not return for the next scheduled session can be accurately described as “leaving treatment.” However, it is important to understand the meaning of that behavior if one aims to accurately interpret the function of the behavior. Did the patient have a strong reaction to the therapist, who reminded him of his abusive grandmother? Did the patient suddenly take a new job and was too busy and distracted to call to cancel his session? The meaning of the behavior drastically changes the understanding of the motivation and the psychological importance that one ascribes to it, and curiosity about one possible meaning of premature termination was the impetus for this research project.

Clinically speaking, the finding of this research aim to help clinicians understand some patients' behaviors in a way that will allow an appropriate approach to treatment. As McWilliams aptly states: "in order to help a person, we need to appreciate the particular way in which he or she is using thoughts, feelings, and actions to relieve upsetting internal states" (1999, p. 87).

Chapter Three

Assessment and the Lerner Defense Scales

The Assessment Situation

Assessment is a clinical and therapeutic resource, used for the purpose of guiding and facilitating interventions that identify psychological needs and respond to these in the way that best serves the patient's mental health. Particularly when employing therapeutic, relational, and collaborative assessment (Fischer, 1994), testing gives clinicians an opportunity to explore how individuals take up relational processes and to identify therapeutic goals, techniques, and challenges very early in the intervention process.

Psychodynamic assessment takes a "patient-first" perspective, insisting that testing tools are most useful when data is interpreted in relation to the overall clinical profile of each patient. "A psychoanalytic approach has a clinical orientation. Here, one is assessing, not measuring; the patient, rather than the test, is regarded as the centerpiece; and the assessment is conducted in a manner and style consistent with clinical purposes" (Lerner, 1998, p. 4). Lerner goes on to assert that diagnosis is not necessarily the end-goal of assessment practices.

From a clinical perspective, the ultimate purpose of an assessment is not the achieving of a diagnosis and the assigning of a diagnostic label. Instead, one attempts to understand the testee in his or her totality, complexity, and uniqueness, and then use that understanding as a basis for making decisions and suggesting interventions that will be beneficial to that individual. (Lerner, 1998, p. 4)

In the pursuit of understanding personality structures, defense organization, and relational patterns it is this attention to the complexity of the individual that generates useful clinical material.

Assessment procedures allow access not only to important information about the patient, but insight into relational dynamics between patient and therapist, and patient and the process of therapy itself. “The testing situation has many dynamic implications which actively contribute to the response process for all but the healthiest individuals” (Cooper, Perry & Arnow, 1988, p. 189). This information includes insight into ways that the patient relates to others, to the unusual and intimate experience of therapeutic interaction, and to the self in high-stress situations. Individuals who are particularly sensitive to interpersonal dynamics, have developed strong defenses in the service of avoiding conflict, or experience confrontation as a threat to self or identity may be particularly prone to experiencing therapy in negative ways. Early assessment may illuminate a patient’s tendencies to run from, undo, or avoid certain difficult elements of the therapeutic process.

The assessment situation, approached dynamically, is a way to understand a patient’s experience of the world in general by carefully examining response to the testing itself. “A core assumption to psychological testing is that every behavior segment bears the imprint of the organization of the behaving personality” (Lerner, 1998, p.9). For many patients, assessment and therapy are fraught with anxiety. An individual typically comes into treatment because of concerns (this or her own or the concerns of others) about mental health or adaptation and the examiner or clinician is thus in a position of power. Freud and Klein’s attention to anxiety as the root cause of neurotic responses

helps us frame the ways that early therapy or assessment situations can set the conditions to quickly access a patient's defensive strategies.

If anxiety is the sentinel on the tower sounding the alarm, the defenses are the troops mobilized to check the invader. Defensive maneuvers may be far harder to track down than anxiety, for they work almost entirely under the protective, scarcely penetrable cover of the unconscious. But like anxiety, the defenses are ledged in the ego; like anxiety, they are indispensable, all too human and all too fallible ways of managing. In fact, one of the most momentous things to be said about the defenses is that, from having been the assiduous servants of adaptation, they may turn into intransigent obstacles to it. (Gay, 1988, p. 488)

In an anxiety-provoking situation, defenses are likely to manifest quickly. The inherent tension of the assessment process is at once destabilizing and demanding, and watching the ways that an individual manages these requests and challenges gives important information about his or her strategies of self-regulation under pressure.

[Schafer] notes that under such challenges [intimate communication and violation of privacy without trust; the relinquishment of control of the relationship; exposure to the dangers of confrontation and premature self-awareness; regressive temptations and the dangers of freedom] and anxiety arousing conditions it is inevitable that defensive and transference reactions will be stimulated or exacerbated. Such reactions, he suggests, are not to be avoided, minimized, or ignored, but rather are to be scrutinized as one would any clinical experience, for they provide an important basis for understanding the patient. (Lerner, 1998, p. 96)

Before formalized assessment practices were developed, the therapy room was the space where these responses to stress and anxiety were more closely observed and studied.

Anna Freud describes the analytic session as the ideal setting to observe defense mechanisms in action:

The analyst has an opportunity of witnessing, then and there, the putting into operation by the latter [the patient] one of those defensive measures against the id which I have already described and which are so obscure, and it now behooves him to make it the object of his investigation. (1966, p. 14)

Freud understood the analyst as a catalyst for the introduction of defense when the process of therapy disturbs the typical psychological regulation of the patient.

Insofar as the ego institutions have endeavored to restrain the id impulses by methods of their own, the analyst comes on the scene as a disturber of the peace... except insofar as the patient's insight into his illness determines matter otherwise, the ego institutions regard the analyst's purpose as a menace. (Freud, 1966, 29)

As a "menace" to the ego institutions, the analyst or therapist is perceived as a danger, which increases anxiety and raises the defenses in order to neutralize the situation. The informed clinician, curious about and sensitive to the various manifestations of defense processes, can use this situation to develop formulations about the ways a patient employs defense and how this contributes to the response to treatment.

The assessor holds a similar, perhaps exaggerated, position of "menace" to the ego. Assessment situations are typically less conversational than therapy sessions, and because the patient is aware of being "examined" or "evaluated," the potential for anxious response is increased. Furthermore, because of standardized test administration

procedures, assessors are often less able to respond to or empathize with the patient in typical ways.

Since the testing situation is not usually experienced by patients as optimally empathetic it becomes an excellent opportunity to study how a patient responds to less than optimal empathy. This understanding can sharpen the therapist's awareness of a patient's response to the inevitable empathetic failures of the therapist. (Arnow and Cooper, 1998, p. 54)

In situations that allow a single clinician to function as both the assessor and the therapist, assessment can provide particular value at the outset of an individual's treatment.

“Because of the similarities between the assessment and treatment frames, the examiner who explicitly sets the assessment frame and then observes the patient responses to it is in a unique position to predict patient reactions to the treatment frame” (Lerner, 1998, p. 68).

Many assessment tools are useful in exploring interpersonal dynamics and personality structure. Connie Fischer (1994) pioneered collaborative approaches to assessment processes that allow for almost any test to be interpreted according to both standardized and individualized measures. The Rorschach Inkblot Test (The Rorschach) is a particularly useful tool in assessing ways the patient approaches ambiguous situations and solves novel problems. The Rorschach is defined as a “projective test” because of the unstructured nature of test stimulus and the subjective nature of response patterns. The Rorschach stands out among the projective tests because of the body of empirical research validating its sensitivity and efficacy at identifying important elements of psychological functioning (Lerner, 2008; Meyer, Hsiao, Viglione, Mihura, & Abraham,

2013, Atkinson, L. & Quarrington, B., Alp, I.E., & Cyr, J.J., 2011). “As a result [of rigorous scientific investigation], what at one time was considered Rorschach lore is now a sound body of knowledge, which furnishes a sturdy basis for Rorschach interpretation” (Lerner, 1998, p. 7).

The Rorschach is an ideal assessment tool for exploring relational dynamics. “Of particular importance in discussing the test situation is the consideration that Rorschach assessment takes place in an interpersonal context” (Lerner, 1998, p. 67). This interpersonal context was one of several reasons Lerner and Lerner chose to use the Rorschach as the foundational assessment tool for the Lerner Defense Scales.

The Lerner Defense Scales

The Lerner Defense Scales (LDS) were constructed to specifically and “systemically assess and score the primitive defenses of the borderline patient” (Lerner, 1980, p. 257). Paul Lerner and Howard Lerner believed that the primitive ego defenses identified by Kernberg (splitting, projective identification, denial, devaluation, and idealization) “become manifest in the patient’s object relations” (Lerner, 1980, p. 257), and that these approaches to object relations could be measured with projective tests.

Historically, there have been few psychological tests that have specifically identified particular types of defenses within individual patients. In 1980, P. Lerner and H. Lerner, based on the theoretical and clinical work of Kernberg, Mayman, Holt, and Peebles, “devised a Rorschach scoring manual designed to evaluate the specific defensive operations presumed to characterize the developmentally lower level of defensive functioning” (Lerner, 1998, p. 271). This “Rorschach scoring manual” later became

known as the Lerner Defense Scales. These scales, scored from Rorschach responses that describe Human Movement, identify primitive defenses, specifically splitting, devaluation and idealization, projective identification and denial. The construction of the Lerner Defense Scales was based on Kernberg's theoretical assertion that this constellation of "lower-level primitive defenses distinguishes borderline and psychotic patients, on the one hand, from neurotic patients, on the other" (Lerner, 1998, p. 279). In order to evaluate the construct validity of the scales, "initial validating studies involved comparing the Rorschach records of borderline patients with the protocols of other clinical groups" (Lerner, 1998, p. 279). The results of these studies showed that certain primitive defenses (splitting and projective identification) were "observed exclusively in the borderline groups" (Lerner, 1998, p. 280), whereas high-level scores on idealization and devaluation were found more predominantly in the neurotic groups. Studies that examined the primitive defense constellations in borderline and schizophrenic patients found different patterns of defense manifestation based on diagnostic categories, suggesting that particular primitive defenses are more often employed in patients with different manifest symptoms (i.e. schizophrenic patients were more likely to use projective identification) (Stuart et al, 1990; Blais, Hilsenroth, & Fowler, 1998; Greene, 1988; Bond, 2004; Leichsenring, 1999; Hilsenroth, Hibbard, Nash, & Handler, 1993). The results of these studies "not only support theoretical propositions, they coincide with clinical experience as well" (Lerner, 1998, p. 280). Numerous other studies have demonstrated the validity of the Lerner Defense Scales in identifying primitive defense use (Lerner, Sugarman, and Barbour, 1985; Van der Keshet, 1988; Collins, 1983; Farris, 1998; Piran et al., 1988).

The Lerner Defense Scales have also demonstrated good reliability. In Lerner's initial investigation, inter-rater scoring reliability between two independently trained raters ranged from 83-100% perfect agreement. In subsequent tests, inter-rater reliability showed similar levels of agreement: In Van-Der Keshet's 1988 study, "Anorexic Patients and Ballet Students: A Rorschach Analysis," inter-rater reliability was 80-100% perfect agreement, and in Gacano's 1988 dissertation, "A Rorschach Analysis of Object Relations and Defensive Structure and their Relationship to Narcissism and Psychopathy in a Group of Antisocial Offenders," he reported inter-rater reliability percentages between 88-100%. Lerner (1998) writes: "results from various studies indicate that the reliability of the scoring system for the Lerner Defense Scale, as judged by level of inter-rater agreement, is particularly high for an inkblot measure" (p. 279).

Scoring the Lerner Defense Scales requires specific training but is not a difficult task. Lerner and Lerner (1980) clearly describe the scoring process, which is summarized here.

Only Human Movement responses are examined. Some protocols may have many and others, including ones used in this research, have none.

These responses may contain any combination of the five primitive defenses, each of which are coded according to particular criteria. Each protocol is scored for each of these defenses, resulting in a numerical value representing the presence of each within the responses. Most defenses are scored on a scale (devaluation is scored 1-5, idealization 1-5, and denial 1-3)³; splitting and projective

³ For the scaled defenses, responses that devalue or destroy the humanness of the percept receive a higher score; for example, a high devaluation score would involve a de-humanized figure (an alien) who is also described in negative terms (ex: an alien with a missing leg; some sort of creature whose head has been cut off)

identification are not scored on a scale, and the presence of either in a response is scored as 1 point per response.

Following the lead of Lerner and Lerner as well as other investigators (Hilsenroth et al.), each response is individually scored and then all of the scores for that particular defense are summed to generate the overall score for the protocol. For example, a protocol with three devaluation scores (at levels 3, 4, and 1) would receive a *total* devaluation score of 8. This summed score is divided by the total number of human responses in order to generate the mean score for each protocol. For example, a devaluation score of 8, in a protocol containing 8 Human responses, will generate an overall mean devaluation score of 1.0 for the protocol. This mean is considered the final score for that defense. The Lerner Defense Scales have not been normed.

The following, a description of responses scored for splitting, is sourced from Lerner's scoring guidelines, published in 1980.

“Splitting refers to what a person does with his inner and outer objects. More specifically, it involves a division of internal and external into (1) parts, as distinct from wholes, and (2) good and bad part-objects... Score splitting in the following cases.

A human percept described in terms of a specific, nonambivalent, nonambiguous affective dimension is immediately followed by another human response in which the affective description is opposite. Ex: *'looks like an ugly criminal with a gun'* immediately followed by *'couples sitting together cheek to cheek'*

In the description of one total human figure a clear distinction of parts is made, so that one part of the figure is seen as opposite another part” Ex: *‘A giant. His lower part here conveys danger, but his top half looks benign’*

Included in one response are two clearly distinguished figures, and these figures are described in opposite ways”. Ex: *‘Two figures, a man and a woman. He is mean and shouting at her. Being rather angelic, she is standing there and taking it’*

An implicitly idealized figure is tarnished or spoiled by the addition of one or more features, or an implicitly devalued figure is enhanced by the addition of more or more features. Ex: *‘a headless angel’.*” (Lerner, 1998, pp. 272-3)

Each of the other defenses measured have similar scoring guidelines.

For Lerner and Lerner, each defense is linked to “relational potentials,” or ways that the defense can be seen in interpersonal manifestations. These types of exchanges, particularly those that appear to be patterns in a patient’s relational style, can be expected in a therapeutic relationship, as they can in all other relationships. For example:

Projective identification is an inevitable aspect of the externalization of an internal object relation. Further, in the treatment relationship there is always a component in the therapist’s countertransference that represents an induced identification with a part of the patient’s ego that is enmeshed in a particular unconscious internal object relation. (Lerner, 1998, pp. 84-5).

Here, Lerner begins to illuminate the reasons that defense employment has a significant effect on the early therapist/patient relationship. Throughout his writing, Lerner reinforces the interpersonal aspects of primitive defense, drawing on object-relations

theory to make this point. “Splitting, projective identification, denial, primitive devaluation, idealization- are represented object relationally, serve a primitive organizing function, and simultaneously reflect the relatively undifferentiated, incompletely internalized or metabolized quality of the representation” (Lerner, 1998, p. 289).

Lerner acknowledges the Psychoanalytic Experiential Model of understanding the Rorschach Inkblot Test in the development of the Lerner Defense Scales. Influenced primarily by Schachter and Mayman and later developed further by Paul Lerner, this approach links Rorschach test responses “more directly to the patient’s actual experiences, thus offering a more experience-near understanding of the Rorschach task” (Lerner, 1998, p. 16). Mayman was a strong proponent of understanding human movement responses as “representative samples of the testee’s inner object world... as a direct expression of the individual’s interpersonal experience” (Lerner, 1998, p. 16). Schachtel (1966) nicely describes the process of describing percepts as experience-near, and therefore a valuable window into the patient’s inner life when he writes:

When one disregards specific attitudes and pays attention only to the general process of enlivening the percept by looking at it, not detachedly, but by putting oneself inside of it in imagination, by feeling from inside how it moves and lives, then one is concerned with those general qualities of the movement response which make them representative of what Rorschach called the capacity for inner creation and what I believe to be a factor in man’s capacity for creative experience [pp. 230-231]. (Lerner, 1998, p. 109)

Taking this one step further, Lerner emphasizes that Schachtel's observations not only suggest this insight into patient experience, but also point the clinician to the patient's available psychological resources.

According to Schachtel, those attitudes that are available to the individual to use creatively in the act of experiencing are reflected in the kinesthetic aspect of the movement response. For example, a person whose repertoire of kinesthesias, as reflected in Rorschach imagery, is limited to more passive activities... will either selectively empathize with this aspect of others or will ascribe it to them. (Lerner, 1998, p. 110)

This conceptualization of human movement responses, the basis for the Lerner Defense Scales, suggests that human movement responses can give the assessor valuable information about psychologically relevant relational elements of the patient, therefore implying direct possibilities related to the therapeutic relationship.

Most studies using the Lerner Defense Scales look at how scores manifest in particular populations identified by diagnosis. "Because of the conceptual roots of the Lerner Defense Scale, initial studies using the scale were designed to evaluate the scoring system's efficacy in distinguishing groups of borderline patients from groups of other diagnostic entities" (Lerner, 1998, p. 290). Subsequent studies looked at specific populations (anorexics, antisocial personalities, schizophrenic patients⁴) and how these groups' primitive defense scores compared to other diagnostic or control populations. There is no research that specifically explored the relationship between Lerner Defense Scale scores and termination patterns.

⁴ See Van-Der Keshet, 1988 and Gacano, 1988

Chapter Four

Method

Data Collection Procedures

Data for this project was drawn from closed and archived files of patients at the Duquesne University Psychology Clinic, a community mental health clinic located in downtown Pittsburgh. This clinic serves a diverse population of individuals presenting with a variety of diagnoses. This project was reviewed and approved by the Internal Review Board (IRB) at Duquesne University. The IRB approved the review and use of the following items from the patients' files: Rorschach protocols, including the verbatim responses given by the patient and the final summary of treatment, written by the treating clinician.

During a pre-project exploration of the archives, 54 patient files were identified as containing Rorschach protocols. Upon closer examination, many of these files were determined unusable for two main reasons: (a) The file included a Rorschach protocol, but the patient's original responses were not included in the file and (b) The patient's verbatim responses were handwritten by the clinician and were illegible to the point that full responses could not be translated. If the final summary was missing, those records were also excluded. After identifying records that included all the necessary information, 35 files were included in this study. Pairs of Rorschach protocols and final summaries were matched and coded, and the documents were de-identified.

Archived files were sourced for Rorschach protocols and treatment summaries. In order to create the data set, two types of data were extracted: (a) Rorschach protocols that archived transcripts using the patients' verbatim language were used to create Lerner

Defense Scale scores and (b) final summary reports written by the treating clinician and containing clinical observations, number of sessions attended, and progress achieved during work together, were used to determine the patients' termination status.

Of the 35 files used as the sample for this project, 18 patients were men (51%) and 17 were women (49%). Most patients (32) were between 18-55 years of age, and the majority of patients for whom racial identification was provided were Caucasian (92%). This is not representative of the general population served in mental health settings. However, because participants were selected based on the availability of both Rorschach protocols and final summaries in their medical records, demographic information was not considered in this selection process.

Scoring the Lerner Defense Scales (LDS)

Each Rorschach protocol was scored according to the instructions laid out by Lerner and Lerner. The protocols were blindly scored without scorer knowledge of the termination group. Additional literature and previous studies were referenced when making scoring choices. Because there is no codified guidebook, the scoring was informed by extensive literature review in order to best represent the intentions of the LDS authors. Each Human Movement response (or part-response that met criteria for projective identification) was individually scored for all defenses identified by the Lerner Defense Scales (splitting, devaluation, idealization, denial, and projective identification). Following the lead of Lerner and Lerner, the total score for each defense was calculated by dividing the raw score by the total number of Human Movement responses. The Lerner Defense Scales have not been normed on any populations, so normed comparisons to other groups were not possible.

McWilliams' observed that: "many defensive processes have more primitive and more mature forms" (2011, p. 103). Two of the defenses measured by the Lerner Defense Scales, idealization and devaluation, appear to measure *both* primitive and more mature forms of the defense manifestation. As McWilliams points out: "idealization can denote an unquestioning, worshipful conviction that another person is perfect, or it can refer to a subtle subdued sense that someone is special or admirable despite some visible limitations." The idealization scale on the Lerner Defense Scales scores a 5 (most severe) when "the humanness dimension is lost" and the response describes a figure with supernatural powers of great power (Lerner, 1991, p. 184), whereas a score of 1 (least severe) is given for a description of a figure that "is described in a positive, but not excessively flattering way: for example, 'two nice people looking over a fence.'" (Lerner, 1991, p. 184). It is dubious whether a response that scores a 1 would qualify as a primitive defense. The devaluation scale on the Lerner Defense Scales is scored in the same manner as the idealization scale. For this reason, devaluation and idealization were grouped to form a "higher level primitive defense" group and splitting, denial and projective identification were grouped to form a "lower level primitive defense" group.

To provide a descriptive characterization that allows for comparison of relative differences among scales, Z-score distribution transformations were used ($M=0$, $SD=1$) for logistic regression analysis. This was necessary to allow for comparisons between the defense scores, which are calculated differently. For example, splitting is scored on an interval scale between 1 and 0 (0 if the response does not meet criteria for splitting and 1 if the response demonstrates splitting) and devaluation is scored on an interval scale, according to severity, between 1 and 5 points).

This author scored all 35 protocols. Another scorer, trained by this author and also familiar with the literature by Lerner and Lerner, examined half (n=17) of the protocols and independently scored each item. For those items with disparate scores, the scorers met and discussed the rationale behind the scoring decision and re-consulted the literature. In cases where one score clearly had stronger support, that score was adopted. In cases where neither the literature nor the discussion led to a clear consensus, the average of the two scores was calculated and used for the final data. Inter-rater reliability was found to be 83%. This value is comparable to inter-rater reliability scores demonstrated in other studies (Lerner, 1991).

Scoring the Termination Status

Operationalizing the term “premature termination” for this study was a challenging task. Parameters used to differentiate the Premature Termination Group from the Not Premature Termination Group were based on precedents used in previous research, as well as the type of information available in the patients’ final summary documents. Special consideration was given to ways to differentiate “premature termination” from “rejecting therapy,” as discussed by Swift and Greenberg: “Premature termination occurs unilaterally by the client, rather than through a mutual agreement between the therapist and client to end treatment. Dropping out of therapy can be contrasted to both completing and rejecting therapy” (2012, p. 547). Since clinicians and patients acknowledge that there are a multitude of reasons individuals leave therapy (limited financial resources, work schedules, or resolution of circumstantial stressors), it was important to try, even though the methods were imperfect, to differentiate between

premature termination that may have been based on dynamics related to therapy and termination related to issues unrelated to the therapy processes.

The method for determining the “premature” and “not premature” groups changed during the course of the study. The process was adapted in response to particular challenges encountered during the coding process as well as common practices in previously published research. Originally, after reviewing relevant literature related to premature termination, the use of “clinician judgment” was the planned method of assessing premature termination. However, because not all final treatment summaries included the therapist’s opinion on the matter, this turned out to be too imprecise and a more formalized method of assessing elements of premature termination was required.

There were several important factors to consider when determining assignment into the “premature termination” group. Based on prior research, the available data within the final summary, and observations made when reviewing these documents, a cluster of variables was identified for use in coding termination status. These variables were: (a) number of sessions (for example “intake and assessment only”, 1-4 sessions, 4-8 sessions, etc.), (b) clinician judgment, (c) evidence of external interfering circumstances (for example moving, the end of the semester, etc.), and (d) indications of patient ambivalence (scheduling and then missing multiple sessions, verbalized ambivalence). A termination score, based on the presence or absence of certain factors including clinician judgment, evidence of external interfering circumstances and patient ambiguity and the length of treatment (scored between 0 and 5, with 5 representing the shortest treatment) was calculated and patients who met a threshold score (6 points) were assigned to the “premature termination group” (PTG). Individuals with scores that did not meet this

threshold were considered the “not premature termination group” (NPTG). 9 individuals (26%) were assigned to the Premature Termination Group and 26 individuals (74%) were assigned to the Not Premature Termination Group. The percentage of patients who fell into each group was commensurate with the numbers of overall premature terminators presented by Swift and Greenberg in their 2012 meta-analysis of patient dropout rates.

Analytic Approach

This study was concerned with (a) determining whether use of primitive defense predicted early termination from treatment and (b) describing differences in the use of defense types between individuals who terminated therapy prematurely versus individuals who did not.

Given that the assessment situation preceded treatment, this project was able to evaluate whether defense use assessed during the Rorschach predicted early termination once individuals began treatment. To assess this aim – the predictive utility of amount of defense usage – binary logistic regression was performed with each defense type predicting membership in the termination group. The results of logistic regression provide estimates of the increased likelihood of terminating treatment early for each increase in one unit of measurement (in this case, one standard deviation unit). This is referred to as the odds ratio. Given theoretical presuppositions regarding similarities among lower-order (i.e., splitting, denial, projective identification) and higher-order (i.e., idealization, devaluation) defense types, scores of these scales were averaged to create overall indexes of Lower Order LDS versus Higher Order LDS defense types. Given that the scaling was different among each defense, defense, scores were transformed to a common metric (as described above) using a Z score distribution with a mean of one and

a standard deviation of zero. This transformation allowed for the varying metrics among each scale to be included on a common, universal metric, without losing the qualities of each scale's distribution (i.e., someone with a score placing them at the 35th percentile would continue to be at the 35th percentile). The influence of overall defense was also considered by creating an averaged score across all defense types (Total Defense Score).

To examine the difference between groups, t-tests were used to determine whether the groups differed in average scores for each defense type. Given that the Lerner Defense Scales were developed primarily to assess for presence and absence of defenses, use of defense types was also considered in this way and frequency distributions were compared between groups using Chi Squared (X^2). The X^2 test assesses whether the distribution of frequencies of defense use is the same between the two groups (i.e., the null hypothesis would be that there was an proportionate number of defense users in each group, so the expected distribution would be equally present in each of the termination groups).

Chapter Five

Results

Describing and differentiating the premature termination (PTG) and not-premature termination (NPTG) groups

The primary goal of this study was to determine whether primitive defense use predicted premature termination from therapy. The null hypothesis was that primitive defense use would not predict premature termination.

Before determining whether defense use predicted early termination, it was important to determine whether the Premature Termination Group (PTG) was differentiated from the Non Premature Termination Group (NPTG) by defense characteristics. Table 1 displays the descriptive statistics of each defense type for the total sample as well as for each termination group.

Table A1.

Means, standard deviations (SD), and termination group differences in defense use.

<i>Defense Type</i>	Total (n=35) M (SD)		Termination Group					
			Premature (PTG) (n=9) M (SD)		Not Premature (NPTG) (n=26) M (SD)			
Splitting	0.04	(0.12)	0.14	(0.21)	^A	0.00	(0.00)	^B
Denial	0.02	(0.04)	0.01	(0.02)		0.02	(0.04)	
Projective Identification	0.01	(0.03)	0.02	(0.07)	[†]	0.00	(0.00)	[†]
Idealization	0.14	(0.20)	0.14	(0.32)		0.13	(0.15)	
Devaluation	0.30	(0.27)	0.28	(0.31)		0.31	(0.27)	

Note: Superscript letters indicate significant differences between groups ($p < .05$). [†] indicates a group difference that approached, but did not attain statistical significance.

T-Tests were run for each defense in order to assess whether the means of the premature termination and non-premature termination groups differed significantly in terms of the *amount* of each defense used. Because the defenses were scored on scales that reflected different levels of severity (two scales score between one and two, one scale scores between one and three, and two scales score between one and five), *amount* is relative to each scale, and reflects both the frequency and severity of the scores for each defense. T-tests are used to compare *difference in average values between groups* (for example, the average splitting score between the PTG and the NPTG). T-tests ask whether a difference between two groups' averages is unlikely to have occurred due to chance. For splitting, a significant difference was found between groups such that the early termination group had higher average levels of splitting, $t(33) = 3.43, p < .01$. Analysis showed that variance was not significant, and so pooled variance was used as the measure for this test. The Premature Termination Group had higher levels of projective identification use; however, this effect approached but did not attain statistical significance, $t(33) = 1.75, p = .09$. There were no significant difference in mean levels of defense use for any other defenses measured (denial, devaluation, and idealization), all $ps > .30$.

In order to assess whether the overall *presence or absence* of defense use differed between the groups, Chi-Square Tests (X^2) were used. Because this tests looks at whether the defense was used (rather than the frequency or severity of use), the data used for this test simply reflected whether the protocol contained any scored responses that used the measured defense (i.e. if the defense was present, it was scored 1, and if it was not, it was scored 0). Results confirmed that the two groups differed in expected frequencies (i.e. the

proportion of splitting used by the premature termination group was greater than that expected by chance) for use of splitting, $\chi^2(1) = 9.48, p < .01$, and 100 percent of individuals who used splitting terminated prematurely.

To summarize, *statistically significant differences in the use of splitting were found between the Premature Termination Group and the Not Premature Groups, both in the presence or absence of this defense, as well as in the mean scores for this defense.*

Predictive results: do defense scores predict premature termination?

In order to assess whether defense use had a *predictive relationship* to termination status, data was analyzed using logistic regression. Logistic regression is used to evaluate how one or more independent variables determine a dichotomous outcome. In this case, logistic regression asked whether the defense scales offered predictive value in determining termination status. Because the data set was highly positively skewed (i.e. there were many values of 0, indicating that the defense was not used), the data did not conform to a normal distribution and therefore violates one of the assumptions for regression. Consistent with recommended practices, square root and log transformations were applied. These transformations apply the consistent mathematical formula to each data point that results in a change (transformation) to the scaling of the distributions to approximate a normal distribution. Log transformations resulted in closer approximation of normal distribution; however, this transformation did not change the results of logistic regressions, all $ps > .16$. Given the null findings and the difficulties associated with interpreting results that include transformed variables, results are presented in raw score. Results of logistic regression analyses showed that *none of the five defenses individually predicted early termination, all $ps > .31$.*

Logistic regression for *groups* of defenses indicated some predictive value. Given the scaling variations between Lerner Defense Scales, Z-distribution transformations (M=0, SD=1) were applied so that all defense scores could be combined using a common metric. Analysis of the distributional qualities of these combined scores indicated that there was no significant violation of the normal distribution assumption, (skewness and kurtosis < 3).

For Total Defense Scores (the sum of Z-scores for all five defenses), the association between score and termination status approached but did not attain statistical significance, $r(1) = 2.07$, Standard Error (SE) = 1.16, Odds Ratio (OR) = 7.91, $p = .08$. For logistic regression analyses, the odds ratio is considered the best approximation of relative risk. This suggests that, *for each 1 SD increase in Total Defense Score, there is a 7.9 times greater likelihood that an individual will terminate prematurely*. Because the criterion was not met for statistical significance ($p < .05$), this relationship should be considered tentative.

Logistic regression for the *lower order primitive defenses scale* (summed Z-scores for splitting, denial, and projective identification) showed predictive value, $r(1) = 0.56$, (SE = 0.26), OR = 1.75, $p = .03$. In other words, *for each standard deviation increase in total score for lower order primitive defenses, there is a 1.75 greater likelihood that an individual will terminate therapy prematurely*. Logistic regression did not indicate any predictive relationship between the higher order primitive defenses (idealization and devaluation) and premature termination from treatment, $p > .88$.

Chapter Six

Discussion

This study explored the relationship between the presence of primitive defense mechanisms and premature termination from psychotherapy. Specifically, it tested the hypotheses that 1) primitive defense scores will predict premature termination and 2) that there will be measurable differences between groups of patients that terminated prematurely and those that did not. This was evaluated using both parametric and nonparametric analysis of the data as well as looking for correlations between particular defenses and early termination. In addition, this study looked at differences between non-premature termination and premature termination groups. This chapter provides interpretation of the results, conclusions based on the findings, recommendations for clinicians and assessors, limitations of the present study and implications for future research.

Splitting as a significant descriptive factor

Chi-Squared analysis indicated that the presence of splitting in a patient protocol was significant for the group that left treatment early. In fact, all individuals who employed splitting as a defense left treatment prematurely. Independent T-tests for each primitive defense also identified splitting as the defense variable that showed significance for difference between groups.

Splitting was the only primitive defense that was significantly associated with difference between groups. This was found on both parametric and nonparametric measures. This suggests that the presence of splitting was *clinically significant in and of itself*, regardless of the “amount” or “frequency” with which the patient employed this

defense. Even though the base rate of individuals who used splitting was low, the fact that all individuals who were scored for splitting terminated prematurely is noteworthy.

Prediction of Premature Termination

Logistic regression analysis showed that the three defenses identified as “lower level primitive defenses” (splitting, denial and projective identification) were predictive of premature termination from therapy. In other words, for each standard deviation increase in the score for lower level primitive defenses, a patient is 1.75 times more likely to leave therapy prematurely. The “total defense score” (the sum of all defense scores for a protocol) approached significance but was not statistically significant ($p = .08$). This means that there was a strong indication that a total defense score could predict early termination, though another study with a larger sample would be necessary to test this hypothesis.

One important question is why, given that splitting was identified as the significant indicator of difference between groups, this variable did not have predictive value (e.g. was not found statistically significant when analyzed using logistic regression) in determining termination outcomes. One potential reason is that the sample size was too small and the variance too small. Because this is the first study to assess the Lerner Defense Scales’ relationship to premature termination there is no established effect size. Effect size is necessary to determine power analysis and therefore an appropriate sample size. Rough estimates based on similar study designs suggest that a sample size of 100 may be appropriate for future research.

T-tests are less affected by power than logistic regression, so the finding of significance for splitting in t-test analysis is promising. Furthermore, the combination of

variables (for example total defense score and lower level defense score groups) did show predictive values, suggesting that increasing the number of data points strengthens the relationship between defense score and premature termination. Using multiple-item measures, assuming they all are features of a particular construct, allows for greater precision in identifying the effect of that construct.

A second theoretical argument for multiple-item measures is that a multiple-item measure captures more information than can be provided by a single-item measure. This argument comes in two forms. One argument for a multiple item measure capturing more information than a single-item measure is that a multiple-item measure “is more likely to tap all facets of the construct of interest.”

(Baumgartner and Homburg 1996, p. 143)

Given the likelihood that this study was statistically underpowered to resolve effects (Type-II Error), the ability of single-item measures (i.e. each individual defense) may have further influenced the ability to detect effects. That said, differences between groups were observed with more descriptive (non-predictive) tests, suggesting that these groups do indeed differ.

The finding that there is predictive power based on primitive defense use is an exciting outcome. This suggests that early identification of defense structure has applicable clinical utility in approaching treatment planning and patient collaboration. Psychoanalytic literature has addressed the importance of defense use in personality structure and psychopathology as a foundational component of diagnosis and treatment approach. In this study, quantitative data supports the importance of understanding and

responding to defensive operations in order to improve treatment adherence and improve therapy outcomes.

Recommendations

The findings of this study suggest several intervention strategies that may be helpful for clinicians interested in incorporating defense assessment into clinical practice in order minimize premature termination for primitively defended patients.

Including assessment as part of the intake process

Incorporating formal assessment as part of early therapeutic processes of developing a case conceptualization, building rapport with the patient, and acquiring informed consent for treatment is strongly encouraged. Particularly for clinicians familiar with psychodynamic theory and projective testing, using projective tests has particular utility in “seeing beyond” a guarded presentation and inviting the patient to express patterns beyond symptoms.

This project asserts that assessment is a powerful tool, not only in developing diagnostic decisions, but also as a task that provides valuable information about a patient’s reactions to treatment and intervention. Assessment tools serve to gather information: for example, symptom profiles, evidence for particular emotional states, and suggestion of patient attitude toward the assessment process. These tools also can serve as a catalyst for a particular type of interpersonal interaction that can provide clues about a person’s relational style and also “set the scene” for potential interactions between patient and therapist moving forward. Levine (1988) emphasizes that psychological assessment may “provide a framework in which to understand and unravel the complex interactional patterns occurring in the therapeutic process” (p. 97).

Assessment also provides information that can be quickly interpreted and shared with the patient in order to build a solid therapeutic base. Providing the patient with information that reflects his or her experience and informs treatment planning can be a great comfort to an individual who is feeling anxious, lost, or uncertain about what lies ahead in a therapy relationship. “When done well, assessment can have a therapeutic effect. It assists individuals in understanding and gaining perspective on the nature of their difficulties and deciding what to do about them” (Lerner, 1998, p. 71).

Findings from this study suggest that early identification of defense patterns may help clinicians recognize individuals who are likely to abandon treatment. Since early termination is by definition a time-sensitive issue, using assessment practices to recognize early indications of termination can help therapists decide upon the types of intervention strategies and timing of these interventions to support treatment adherence.

Using the Lerner Defense Scales as part of early assessment practice

For clinicians familiar with the Lerner Defense Scale, noting and identifying the presence of primitive defenses can be done as the test is administered. No post-test scoring is required for the *initial identification* of these defense processes. A clinician who chooses to administer a Rorschach during the first 1-3 intake sessions can assess for the presence of splitting and other lower level primitive defenses, as well as select an appropriate way to discuss this information with the client in a manner that will benefit treatment moving forward. Some patients may be appropriate candidates for a collaborative assessment discussion. Clinicians may share with the patient that other individuals who have provided similar responses are more likely to become triggered by high stress interpersonal situations and, in a therapy setting, may be more likely to leave

treatment when things feel particularly intense or the patients perceive conflict between self and therapist. This may provide space for a meaningful conversation about times the patient has experienced similar events, and lead to a collaborative discussion about ways that this might be handled differently in a treatment context. For other patients, for whom a collaborative conversation may be less productive in this early session, the clinician may choose to emphasize the treatment frame with the patient who has provided splitting or lower level defense responses. Making a purposeful decision to more firmly discuss the cancellation or attendance policies, or to vocalize the process for reaching out if there are missed appointments, may help to solidify the parameters of therapy in a way that gives this patient a secure sense of limits and boundaries. It also gives the therapist ground for approaching subsequent limit testing or early termination signals in a direct and therapeutically relevant manner.

Role and Responsibility of the Therapist

In the earliest stages of therapy, therapists should be alert to indications that the patient may be reacting to the anxiety of the therapy experience by considering termination. This is not to say that the therapist should assume all patients who do not take on therapy enthusiastically should be considered primitively defended, anxious, or enacting interpersonal patterns through this behavior. Rather, clinical acumen, careful consideration of the circumstances of departure, and analysis of the clinical material and assessment tools employed up to the time of termination should be thoughtfully examined for evidence of primitive response, as opposed to rejection of therapy, or other common reasons for patient-driven termination. Clinical attunement to primitive defense patterns can serve two positive functions: (a) allowing the clinician to make intervention decisions

that are helpful to this group of patients and (b) allowing the clinician to empathize with the patient who may elicit less warmth and sympathy based on these behaviors. Ways in which clinicians might use this information to minimize flight, including a strong focus on the clinical frame and collaborative discussion with the patient about assessment results, have already been mentioned.

The ability to recognize the effects that primitive defense manifestations may have on the therapeutic relationship is equally important. The clinician who is attuned to the ways that defense can affect the interpersonal relationship between self and patient is in a better position to empathize with the patient's behaviors that may present as challenging. Understanding the patient's defensive patterns as a means to protect a fragile sense of self is a far more sympathetic position than interpreting defenses as simply "resistant" or "oppositional." Kohut describes this therapeutic stance beautifully when he writes:

Defense motivation in analysis will be understood in terms of activities undertaken to save at least that sector of his nuclear self, however small and precariously established it may be, that he has been able to construct and maintain despite serious insufficiencies in the development-enhancing matrix of the selfobjects of childhood. (Kohut, 1984, p. 115)

When the "small and precariously established" part of self that may be anxiously activated by the therapy process is recognized, attended to, and made to feel more safe, therapy may become a more realistic option for the skittish patient.

Vaillant acknowledges the ways that the therapist may respond in a negatively countertransference way to the primitively defended patient, stating: "Immature defenses

are contagious.” (1992, p. 66). The therapist may easily respond to primitive defense with a similarly defensive pattern, which may contribute to the “poor rapport” credited for many failed therapeutic relationships. Being confronted with splitting, especially when one is taking on the “bad object” projections of the patient, can be a deflating or discouraging experience for the clinician. When a therapist finds him or her self reacting to a patient with contempt, irritation, or frustration, it is useful to reflect upon the ways a patient’s behavior may elicit a counter-behavior or attitude that is relevant to the presenting problem or the patient’s pathology or suffering.

We have to again and again analyze the splitting processes, which I now think is the most difficult part of the analytic procedure... It is of the greatest importance to observe every detail in the transference situation which throws light on the earliest difficulties. (Klein, 1986, p. 226)

A benefit of early identification of primitive defense is that potentially negative countertransference reactions can be recognized and managed early on, and the clinician can focus on developing appropriate treatment plans. For the primitively defended patient, perhaps no sessions are more important than the first several, when basic assumptions about therapy and the therapeutic relationship are established.

In a psychotherapy setting, to dismiss the patient’s split positive and negative affects as ‘just transference’ is to miss the point. The therapist must work to create an atmosphere that is conducive to letting the patient experience simultaneously negative and positive aspects of important relationships, including his or her relationship with the therapist. Unconditional positive regard, safety, and firmness are all necessary- all within the same session. (Vaillant, 1992, p. 72)

As Vaillant suggests, recognizing defense is not enough; the responsible therapist then relies on clinical acumen and case formulation to cultivate an environment that is safe and structured so that the therapy can begin to take place.

Limitations

The limitations of the present study include: 1) a small sample size; 2) the files used were all sourced from one mental health clinic, and therefore are limited to a population that is geographically, and to a degree, demographically, homogenous; 3) all of the tests and summaries were recorded by training therapists; and 4) there were challenges in operationalizing the terms “premature termination” and “not premature termination” and assigning patients into these groups.

The most notable limitation is the sample size used for this study. A sample size of 35 is small, particularly when running more complex analyses, including logistic regression. During exploratory research, 54 patients were identified as potential subjects for this study because their files contained Rorschach protocols. However, many of these patients were excluded due to the fact that some of the Rorschach protocols were inadequately archived (for example, did not include patient’s verbatim responses to the card prompts) or the final summaries were not complete.

This research is considered an initial exploratory study, as it is the first to examine the relationship between the Lerner Defense Scales and premature termination. For this reason, effect size and power analyses were not known. The fact that this small data set still allowed for positive predictive findings is exciting, and it is expected that replicating this study with a larger sample population may produce more compelling evidence for a

relationship between primitive defense and premature termination. As previously discussed, a sample size of at least 100 would be appropriate for a follow-up study.

Another limitation to this study is that the findings represent a generally homogenous population. Though full demographic information was not available, the subjects were almost all Caucasian adults from the greater Pittsburgh area. Studies that aim to replicate these findings should attempt to capture a study population that is more representative of the general population seeking psychotherapy.

Furthermore, all of the patient files used for this study were drawn from one training clinic. Rorschach tests were administered and documented by therapists in training; the same therapists typically wrote the final summaries. While this did not affect the scoring of the Lerner Defense Scales (which were scored separately for this project based on the written responses to the Rorschach test), there may have been problems with the transcription of patient responses or the detail captured by the clinicians. In other words, there is no way to verify the accuracy of the verbatim responses to the Rorschach test. Similarly, clinicians had different approaches to writing the final summaries and some files had more detailed summaries than others. Future studies may benefit from using videotaped administrations of the Rorschach test in order to ensure accuracy in capturing patients' responses. Other ways of ensuring good data may be to use protocols from known administrators who have been trained in the same administration practices, and using structured final summary templates that ask for particular information.

Finally, the methods for defining premature termination and then dividing patients into groups were developed during the course of this study. Other studies have used a variety of criteria for determining "premature termination" and there is not "standard

practice” in the existing research. Clinician judgment has been a commonly used qualifier and was the proposed method for this project. However, the information available in final summaries was inadequate to allow this factor to be the sole determinant. As described in the methods chapter, several factors, including number of sessions, clinician judgment, patient ambiguity and external events were all considered, scored, and summed to create a total score related to termination factors. Subjects were assigned into groups based on their total scores. Although this method worked well for this study, and the percentages of individuals who terminated prematurely were commensurate with percentages reported in other studies, future studies may use different approaches to determining termination status and evaluate whether the findings presented here are replicated.

Areas of suggested further inquiry

As the first study to explore how the Lerner Defense Scales may be used in predicting premature termination, this research provides a foundation for future research. Several particular areas of inquiry are suggested by these results.

Attempts to replicate the findings of this study

Because of the small sample size, replication of this study with a larger population is an important future direction. Justification for this larger subject base has been discussed earlier in the chapter, but several points are worth restating. 1) A larger sample size will provide a more reliable data set from which to retest the findings presented here. 2) A larger sample size is more amenable to logistic regression analysis. Working with data from 100 or more subjects would clarify the utility of Lerner Defense Scale scores for predict termination status and may provide more information about predictive value for single-item measures (each defense) as well. 3) A larger sample size would allow for

greater attention to demographic and other categorical factors that may influence the outcomes. It would be interesting, for example, to see whether individuals from various socioeconomic groups or geographic regions of the country have similar or disparate patterns of defense use and termination.

Studying effects of tailored interventions on termination status

If research on larger populations with more statistical power suggests that splitting or lower level defense use is a predictive variable for premature termination, exploring the efficacy of intervention strategies is appropriate. A study might look at individuals who are identified as using splitting during the intake process who receive one of two descriptions of treatment contract after the initial assessment is complete. One group would receive a “business as usual” discussion of treatment frame, including policies and procedures associated with the treatment setting. Another group would have a more intensive discussion about treatment considerations, including a detailed description of attempts to connect if there is a missed appointment, or perhaps contracting for a set number of appointments as a trial period. Termination patterns between groups may indicate whether tailored consent and treatment contacts have an effect on treatment adherence.

Assuming that there would be value in this type of intervention, a more ethically minded design might implement these increased intervention strategies to an entire sample population, evaluate the dropout rates for this group, and compare these rates to those described in the current literature.

Exploring other assessment measures that identify primitive defense use

The Lerner Defense Scales were specifically designed to identify primitive defense use in borderline patients, and rely on tenants of psychoanalytic theory and assessment practices. The Rorschach Inkblot Test is a valuable but time consuming instrument, and for clinicians who do not have training with this test other means of gathering information through tests might be considered. There are several cards in the Rorschach set that are more likely to elicit human percepts than other cards (i.e. Cards III, IV and VI). Potential studies may explore the utility of a “brief” Rorschach test, specifically designed to elicit responses that incorporate human figures and listening for evidence of primitive defense language in each patient’s description. The Thematic Apperception Test is another projective test that almost exclusively portrays human figures on the stimulus cards. Exploring whether the Lerner Defense Scale scoring criteria might apply to other tests that generate descriptions of human activity is a noteworthy area of inquiry.

Updating the Lerner Defense Scales

The Lerner Defense Scales are not commonly used in contemporary assessment practices. They are, however, respected by those who are familiar with the scales and as this study’s findings suggest, have utility in clinical practice. Studies that more rigorously examine the validity and reliability of these scales in current assessment practices are recommended. In this project, for example, the Idealization and Devaluation scales were scored far more frequently than the “lower level primitive defense” scales; furthermore, they used a 1-5 point scoring system, which meant that they captured a greater range of potential defensive expression than the splitting scale, for which an individual either scored or did not. Evaluating whether the five scales all appear to measure the same

construct, and whether the scoring method could be homogenized between scales are both projects that may render the Lerner Defense Scales more user friendly and diagnostically effective in a contemporary clinical environment.

Conclusions

The relationship between “lower level primitive defenses” (splitting, denial, and projective identification) and premature termination from therapy is a promising finding. Especially given the small sample size for this study, significance between these variables (and near-significance between total defense scores and premature termination) suggests that research on a larger scale is an important next step. Furthermore, the finding that splitting has significance as a descriptive difference between termination groups is encouraging for further exploration of the predictive power of splitting. As discussed in the literature review, splitting and other primitive defense mechanisms have an important place, historically, in case formulation and dynamic diagnostic considerations. The value of identifying tendencies to split early in therapy has tremendous implications for individualizing and monitoring the therapeutic process in order to maximize the benefits for the patient and to encourage appropriate interventions by the therapist.

References

- Alexander, M. P., Stuss, D.T., and Benson, D.F. (1979). Capgras syndrome: a reduplicative phenomenon. *Neurology*, 29, 334-339.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th Ed.)*. Arlington, VA: American Psychiatric Publishing.
- Applebaum, S. (1970). Science and persuasion in the psychological test report. *Journal of Consulting and Clinical Psychology*, 135, 349-355.
- Arnou, D. & Cooper, S.H. (1998). Toward a Rorschach psychology of self. In H. Lerner & P. Lerner (Eds.), *Primitive Mental States and the Rorschach* (53-68). Madison, CT: International Universities Press.
- Atkinson, L., Quarrington, B., Alp, I.E., & Cyr, J.J. (1986). Rorschach validity: an empirical approach to the literature. *Journal of Clinical Psychology*, 42(2), 360-362.
- Bender, D. S. (2005). The therapeutic alliance in the treatment of personality disorders. *The Journal of Psychiatric Practice*, 11(2), 73-87.
- Benitez Comacho, E., Chavez-Leon, E., Ontiveros Uribe, M.P., Jimenez, A.Y., & Lopez, O. (2010). The levels of psychological functioning of personality and the mechanisms of defense. *Salud Mental*, 33, 517-526.
- Blais, M., Hilsenroth, M., Fowler, J.C. (1998). Rorschach correlates of the DSM-IV Histrionic Personality Disorder. *Journal of Personality Assessment*, 70(2), 355-364.
- Bond, M. (2004). Empirical studies of defense style: relationships with psychopathology and change. *Harvard Review of Psychiatry*, Sept/Oct, 263-278.

- Buckley, P. (Ed.). (1986). *Essential Papers on Object Relations*. New York, NY: New York University Press
- Chiesa, M., Drahorad, C. & Longo, S. (2000). Early termination of treatment in personality disorder treated in a psychotherapy hospital: a quantitative and qualitative study. *British Journal of Psychiatry*, 177, 107-111.
- Collins, R. (1983). *Rorschach correlates of borderline personality* (Unpublished doctoral dissertation). Department of Applied Psychology, University of Toronto.
- Cooper, S.H., Perry, J., & Arnow, D. (1988). An empirical approach to the study of defense mechanisms: reliability and preliminary validity of the Rorschach Defense Scales. *Journal of Personality Assessment*, 52(2), 187-203.
- Davison, G.C. (2000). A cognitive-behavioral analysis of patients with borderline personality disorder. *Cognitive and Behavioral Practice*, (4), 497-500.
- Derisley, J., & Reynolds, S. (2000). The transtheoretical stages of change as a predictor of premature termination, attendance, and alliance in psychotherapy. *British Journal of Clinical Psychology*, 39, 371-382.
- Elkin, I., Yamaguchi, J., Arnkoff D., Glass, C., Sotsky, S., & Krupnik, J., (2010). "Patient treatment fit" and early engagement in psychotherapy. *Psychotherapy Research*, 9(4), 437-451.
- Fairbairn, W.R.D. (1962). *An Object Relations Theory of the Personality*. New York, NY: Basic Books
- Fairbairn, W.R.D. (1967). *Psychoanalytic Studies of the Personality*. New York, NY: Basic Books

- Farrand, P., Booth, N., Gilbert, T., Lankshear, G. (2009). Engagement and early treatment of contact with a community-based early intervention service for personality disorder in young adults. *Early Intervention in Psychiatry*, 3(3), 204-212.
- Farris, M. (1998). Differential diagnosis of borderline and narcissistic personality disorders. In H. Lerner & P. Lerner (Eds.), *Primitive Mental States and the Rorschach* (299-338). Madison, CT: International Universities Press.
- Feinberg, T.E. (2013). Neuropathologies of the self and the right hemisphere: a window into productive personal pathologies. *Frontiers in Human Neuroscience*, 7(472), 1-4.
- Fischer, C. (1994). *Individualizing psychological assessment*. Hillsdale, NJ: Lawrence Erlbaum Associates.
- Freud, A. (1966). *The ego and the mechanisms of defense*. London: International Universities Press.
- Freud, S. (1959). *Inhibitions, symptoms, and anxiety*. New York, NY: W.W. Norton.
- Freud, S. (1968). *The standard edition of the complete psychological works of Sigmund Freud, Volume III*. London: The Hogarth Press.
- Freud, S. (1969). *An outline of psychoanalysis*. New York, NY: W.W. Norton.
- Freud, S. (1978). *The question of lay analysis*. New York, NY: W.W. Norton.
- Gacano, P. (1988). *A Rorschach Analysis of Object Relations and Defensive Structure and their Relationship to Narcissism and Psychopathy in a Group of Antisocial Offenders*. (Unpublished doctoral dissertation). United States International University: San Diego.

- Gay, P. (1988). *Freud: A life for our time*. New York, NY: W.W. Norton.
- Greene, L.R. (1993). Primitive defenses and the borderline patient's perceptions of the psychiatric treatment team. *Psychoanalytic Psychology*, *10*(4), 533-549.
- Grotstein, J. (2005). *Splitting and projective identification*. In D.E. Scharff (Ed.). *Object Relations Theory and Practice* (460-464). New York, NY: Rowman & Littlefield.
- Hartmann, H. (1964). *Essays on Ego Psychology*. New York, NY: International Universities Press Inc.
- Hilsenroth, M.J., Hibbard, S.R., Nash, M.R., & Handler, L. (1993). A Rorschach study of narcissism, defense, and aggression in borderline, narcissistic, and cluster C personality disorders. *Journal of Personality Assessment*, *60*(2), 346-361.
- Ingenhoven, T.J.M., Duivenvoorden, H.J., Passchier, J., & Van Den Brink, W. (2012). Treatment duration and premature termination of psychotherapy in personality disorders: predictive performance of psychodynamic personality functioning. *Journal of Psychiatric Practice*, *18*(3), 172-186.
- Kaplan-Solms, K., & Solms, M. (2001). *Clinical studies in neuro-psychoanalysis*. London: Other Press.
- Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. New York, NY: Jason Aronson.
- Kernberg, O. (1984). *Object relations theory and clinical psychoanalysis*. New York, NY: Jason Aronson.
- Kernberg, O., Selzer, M.A., Koenigsberg, H.W., Carr, A., Appelbaum, A. (1989). *Psychodynamic Therapy of Borderline Patients*. New York, NY: Basic Books.
- Klein, M. (1975). *Envy and gratitude and other works*. London: The Hogwarth Press.

- Klein, M. & Riviere, J. (1986). *Love, hate and reparation*. New York, NY: W.W. Norton and Co.
- Kohut, H. (1971). *The analysis of the self*. New York, NY: International Universities Press.
- Kohut, H. (1977). *The restoration of the self*. New York, NY: International Universities Press.
- Kohut, H. (1984). *How does analysis cure?* Chicago, IL: The University of Chicago Press.
- Leichsenring, F. (1999). Splitting: an empirical study. *Bulletin of the Menninger Clinic*, 63(4). 520-537.
- Lerner, H.D. (1980). Reflections on the current state of the borderline concept. In J. Kwawer, H. Lerner, P. Lerner & A. Sugarman (Eds.). *Borderline phenomena and the Rorschach test* (11-38). New York, NY: International Universities Press.
- Lerner, H.D., Sugarman, A., & Barbour, C.G. (1985). Patterns of ego boundary disturbance in neurotic, borderline and schizophrenic patients. *Psychoanalytic Psychology*, 2(1), 47-66.
- Lerner, P. (1991). *Psychoanalytic Theory and the Rorschach*. Hillsdale, NJ: The Analytic Press
- Lerner, P. (1998). *Psychoanalytic perspectives on the Rorschach*. Hillsdale, NJ: The Analytic Press.
- Lyons, E., & Cole, A. (Eds). (2007) *Analyzing qualitative data in psychology*. Los Angeles, CA: Sage Publications.

- Maloy, P., Cimino, C., & Coltheart, M. (2005). "Sleights of mind": delusions, defences and self-deception. *Cognitive Neuropsychiatry*, *10*, 305-336.
- McWilliams, N. (1999). *Psychoanalytic case formulation*. New York, NY: The Guilford Press.
- McWilliams, N. (2011). *Psychoanalytic Diagnosis*. New York, NY: The Guilford Press.
- McMurrin, M., Hubbard, N., & Overton, E. (2010). Non-completion of personality disorder treatments: a systemic review of correlates, consequences, and interventions. *Clinical Psychology Review*, *30*, 277-287.
- Meyer, G.J., Hsiao, W., Viglione, D.J., Mihura, J.L., & Abraham, L.M. (2013). Rorschach scores in applied clinical practice: a survey of perceived validity by experienced clinicians. *Journal of Personality Assessment*, *95*(4), 351-365.
- Mitchell, S.A. & Black, M.J. (1995). *Freud and Beyond*. New York, NY: Basic Books.
- Moberly, E. (1985). *The Psychology of Self and Other*. London: Tavistock Publications.
- Piran, N. (1998). Borderline phenomena in anorexia nervosa and bulimia. In H. Lerner & P. Lerner (Eds.). *Primitive mental states and the Rorschach*. (363-376). Madison, CT: International Universities Press.
- Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: applications to addictive behaviours. *American Psychologist*, *47*, 1102-1114.
- Salas, C.E. & Turnbull, O.H. (2010). In self-defense: disruptions in the sense of self, lateralization and primitive defenses. *Neuropsychanalysis*, *12*, 172-182.
- Samstag, L.W., Batchelder, S.T., Muran, J.C., Safran, J.D., & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: an assessment of

- therapeutic alliance and interpersonal behavior. *Journal of Psychotherapy Practice and Research*. 7(2), 126-143.
- Shedler, J. (2013, October, 3). Is NIMH brilliant, stupid, or both? . *Psychology Today*. Retrieved from <http://www.psychologytoday.com/blog/psychologically-minded/201310/is-nimh-brilliant-stupid-or-both>
- Smith, K.J., Subich, M.L. & Kalodner, C. (1995). The transtheoretical model's stage and processes of change and their relation to premature termination. *Journal of Counseling Psychology*, 42, 34-39.
- Spangenberg, K.B., Wagner, M.T., and Bachman, D.L. (1998). Neuropsychological analysis of a case of abrupt onset mirror sign following a hypotensive crisis in a patient with vascular dementia. *Neurocase*, 4, 149-154.
- Stuart, J., Westen, D., Lohr, N., Benjamin, J., Becker, S. et al. (1990). Object relations in borderlines, depressives, and normals: an examination of human responses on the Rorschach. *Journal of Personality Assessment*, 55(1&2), 296-318.
- Swift, J.K., Greenberg, R.P. (2012). Premature discontinuation in adult psychotherapy: a meta-analysis. *Journal of Consulting and Clinical Psychology*, 80(4), 547-559.
- Vaillant, G.E. (1992). *Ego mechanisms of defense: a guide for clinicians and researchers*. Washington DC: American Psychiatric Press.
- Van der Keshet, J. (1988). *Anorexic patients and ballet students: a Rorschach analysis* (Unpublished doctoral dissertation). Department of Applied Psychology, University of Toronto.
- Walitzer, K.S., Dermen, K.H., & Connors, G.J. (1999). Strategies for preparing clients for treatment. *Behavior Modification*, 23(1), 129-151.

Winnicott, D. (2005). *Primitive Emotional Development*. In D.E. Scharff (Ed.). *Object Relations Theory and Practice* (179-271). New York, NY: Rowman & Littlefield.

Appendix A: Criteria to score the Lerner Defense Scales

From Rorschach Assessment of Defense: 2. Recent Measures. In Lerner, P. (1998). *Psychoanalytic Perspectives on the Rorschach*. New Jersey: The Analytic Press.

Splitting

Score splitting in the following cases.

- (A) In a sequence of responses, a human percept described in terms of a specific, nonambivalent, nonambiguous affective dimension is immediately followed by another human response in which the affective description is opposite that used to describe the preceding responses: for example, “looks like an ugly criminal with a gun” immediately followed by “couples sitting together cheek to cheek.”
- (B) In the description of one total human figure a clear distinction of parts is made, so that one part of the figure is seen as opposite another part: for example, “A giant. His lower part here conveys danger, but his top half looks benign.”
- (C) Included in one response are two clearly distinguished figures, and these figures are described in opposite ways: for example, “Two figures, a man and a woman. He is mean and shouting at her. Being rather angelic, she’s standing there and taking it.”
- (D) An implicitly idealized figure is tarnished by the addition of one or more features: for example, “a headless angel.”

Devaluation

In addition to identifying the defense, devaluation is also rated on a five-point continuum. Underlying the continuum are three dimensions. The first dimension involves the degree to which the humanness of the figure is retained. For examples, such percepts as waiters

or clowns are accorded a higher score than are more distorted forms, such as monsters and mythological objects. A temporal-spatial consideration determines the second dimension. Contemporary human percepts set in a current and close locale are scored higher than are those percepts from either the past or future and set in a distant setting. The final dimension involves the severity of depreciation as conveyed in the affective description. Figures described in more primitive, blatant, socially unacceptable ways are scored lower than are those that are described in negatively tinged but more civilized and socially acceptable ways. To denote devaluation, use the symbol DV. Add to this score the number below that corresponds to the appropriate level of devaluation. For example, “an angry man” is scored DV1.

- (1) The humanness dimension is retained, there is no distancing of the figure in time or space, and the figure is described in negatively tinged but socially acceptable terms: for example, “two people fighting”; “a girl in a funny costume.”
- (2) The humanness dimension is retained, there may or may not be distancing of the figure in time or space, and the figure is described in blatantly negative and socially unacceptable negative terms. This score would also include human figures with parts missing: for example, “a diseased African child”; “a woman defecating”; “a sinister-looking male figure”; “a disjointed figure with the head missing.”
- (3) The humanness dimension is retained but involved in the percept is a distortion of the human form; there may or may not be distancing of the figure in time or space; and if the figure is described negatively, it is in socially acceptable terms. This rating includes such figures as clowns, elves, savages, witches, devils, and

- figures of the occult: for example, “sad looking clowns”; “cannibal standing over a pot”; “the bad witch.”
- (4) The humanness dimension is retained, but implied in the percept is a distortion of the human form. There may or may not be distancing of the figure in time or space, and the figure is described in blatantly negative and socially unacceptable terms. This rating involves the same types of figures as in (3); however, the negative description is more severe: for example, “a couple of evil witches”; “two people from Mars who look very scary”; “a sinister Ku Klux Klansman.”
- (5) The humanness dimension is lost, there may or may not be distancing of the distorted form in time or space, and the figure is described in either neutral or negative terms. This rating includes puppets, mannequins, robots, creatures with some human characteristics, part-human-part-animal responses, and human responses with one or more animal features: for example, “Mannequins with dresses but missing a head”; “two people but half-male and half-animal from outer space”; “a woman with breasts, high-heeled shoes, and a bird’s beak for a mouth.”

Idealization

As in the case of devaluation, idealization is also rated on a five-point continuum.

Underlying the continuum are the same three dimensions. For scoring, denote idealization with the letter I. Add to this score the number below that corresponds with the appropriate level of idealization. Thus, “a person with a big smile” is scored I1.

- (1) The humanness dimension is retained, there is no distancing of the figure in time or space, and the figure is described in a positive but not excessively flattering way: for example, “two nice people looking over a fence”; “a person with a happy smile.”
- (2) The humanness dimension is retained, there may or may not be distancing of the figure in time or space, and the figure is described in blatantly and excessively positive terms: for example, “two handsome, muscular Russians doing that famous dance”; “What an angelic figure; long hair, a flowing gown, and a look of complete serenity.”
- (3) The humanness dimension is retained, but implied in the percept is a distortion of human form. There may or may not be distancing of the figure in time or space, and if the figure is described positively, it is in moderate terms. This rating includes such objects of fame, adoration, or strength as civic leaders, officials, and famous people: for example, “Charles de Gaulle”; “an astronaut, one of those fellows who landed on the moon.”
- (4) The humanness dimension is retained, but implied in the percept is a distortion of human form. There may or may not be distancing of the figure in time or space, and the figure is described in blatantly and excessively positive terms. This rating includes the same types of figures as in (3); however, the positive description is more excessive: for example, “a warrior; not just any warrior but the tallest, strongest, and bravest”; “Attila the Hun, but with the largest genitals I have ever seen.”

(5) The humanness dimension is lost, but implied in the distortion is an enhancement of identity. There may or may not be distancing of the distorted form in time or space, and the figure is described in either neutral or positive terms. This rating includes statues of famous figures, giants, supermen or superwomen, space figures with supernatural powers, angels, and idols. Also included are half-humans in which the nonhuman aspect nonetheless adds to the figure's appearance or power: for example, "a bust of Queen Victoria"; "powerful beings from another planet, ruling over these softer creatures.

Projective Identification

Score projective identification in the following cases.

- (A) Confabulatory responses involving human figures in which the form level is Fw- or F- and the percept is overly embellished with associative elaboration to the point that real properties of the blot are disregarded and replaced by fantasies and affects. More typically, the associative elaboration involves material with aggressive or sexual meaning, as in the following example: "A huge man coming to get me. I can see his huge teeth. He's staring straight at me. His hands are up as if he will strike me."
- (B) Those human or detail responses in which the location is Dr, the determinant is Fc, and the figure is described as either aggressive or having been aggressed against: for example, "an ugly face" (with forehead and features seen in reference to the inner portion of Card IV); "an injured man" (Card VI upper, center area).

Denial

Denial in this system refers to a broad group of defenses arranged on a continuum based on the degree of reality distortion involved in the response. Higher-level forms of denial involve a minimum of reality distortion, whereas middle- and lower-level manifestations of denial include increasingly greater degrees of reality distortion. To score denial, use the symbol DN. Add to this score the number below that corresponds to the level of denial. Thus, the response “I know they are not fighting” would be scored DN1.

- (1) *Higher-level denial*: Denial at this level consists of several subsidiary defenses manifested in responses in which the form level is the percept is F+, Fo or Fw+.
 - (a) *Negation*: Negation involves disavowal of the impulse. The disavowal may be manifested in two ways. In one, the disavowal is smoothly blended into the response itself, whereas in the other the response, or aspects of the response, are couched in negative terms: for example, “virgin”; “angel”; “these figures are not angry.”
 - (b) *Intellectualization*: In this process, the response is stripped of its drive and affective charge by its being presented in an overly technical, scientific, literate, or intellectual way: for example, “two homo sapiens”; “two Kafkaesque figures.”
 - (c) *Minimization*: With minimization, drive-laden material is included in the response, but in a reduced and nonthreatening way. This includes changing a human figure into a caricature or cartoon figure: for example, “a shadow cast by an evil person”; “a child with his hand clenched in a fist”; “a funny man, more like a caricature.”

- (d) *Repudiation*: With repudiation, a response is retracted or the individual denies having even given the response.
- (2) *Middle-level denial*: Denial at this level involves responses in which the form level is F+, Fo, or Fw+, and involved in the response is a basic contradiction. The contradiction may be on affective, logical, or reality grounds: for example, “a sexy Santa Claus”; “two nuns fighting”; “a man reading while asleep.”
- (3) *Lower-level denial*: At this level, reality adherence is abrogated, but in a particular way. Specifically, an acceptable response is rendered unacceptable either by adding something that is not there or by failing to take into account an aspect of the blot that is clearly to be seen. This corresponds to Mayman’s (1970) form spoil (Fs) response. In addition, this level *also* includes responses in which incompatible descriptions are given to the percept: for example, “two people but their top half is the female and bottom half male; each has breasts and a penis”; “a person, but instead of a moth there is a bird’s beak”; “a person sitting on its huge tail.”

Appendix B: Lerner Defense Scale Score Scatterplots

Table B1. Splitting

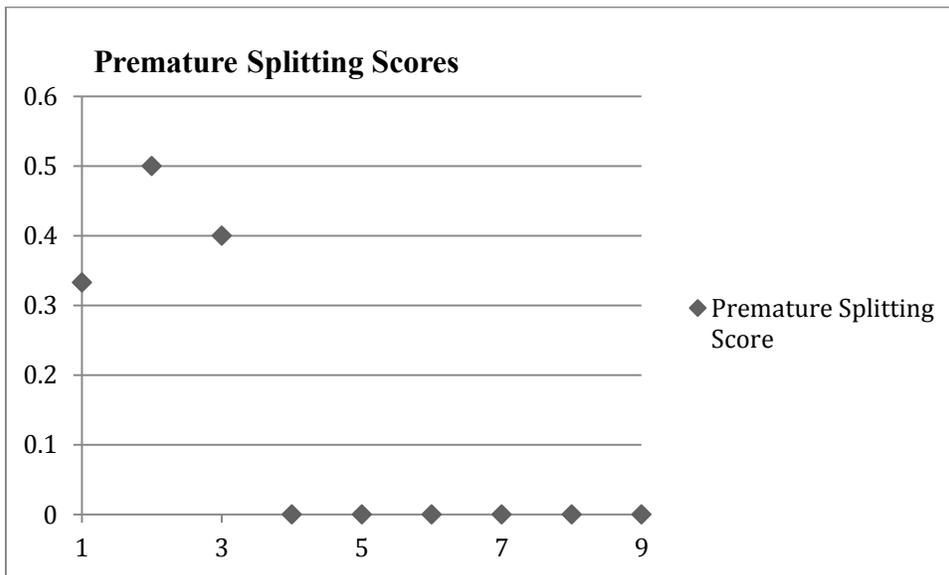
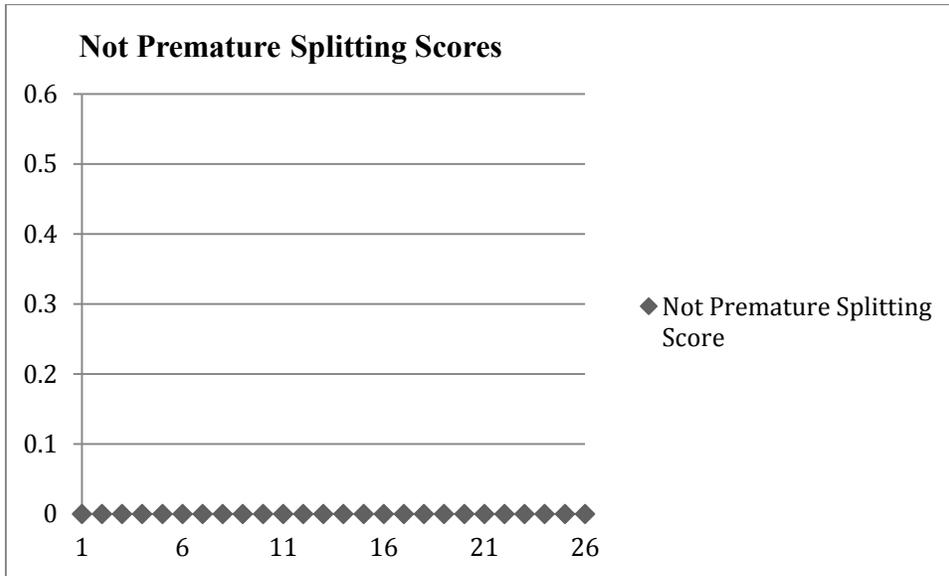


Table B2. Devaluation

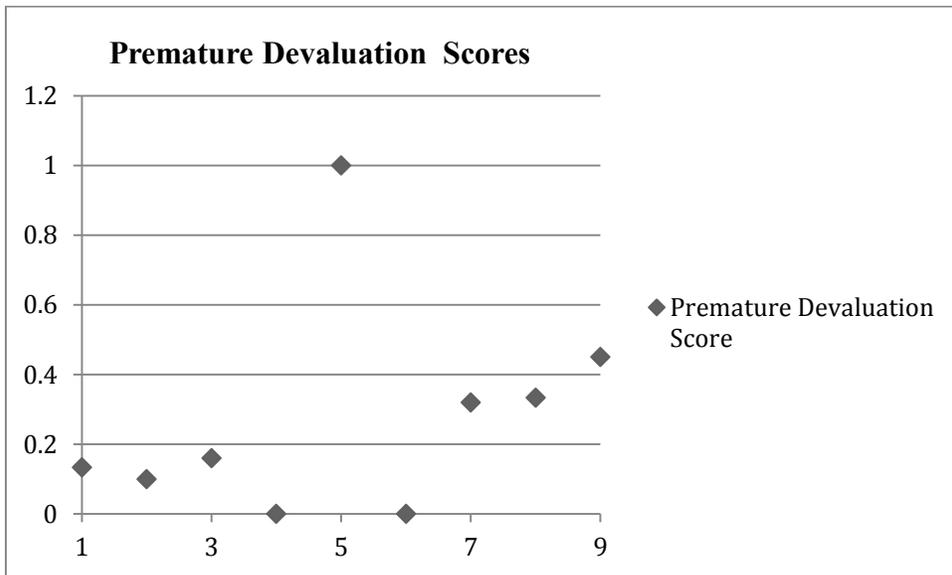
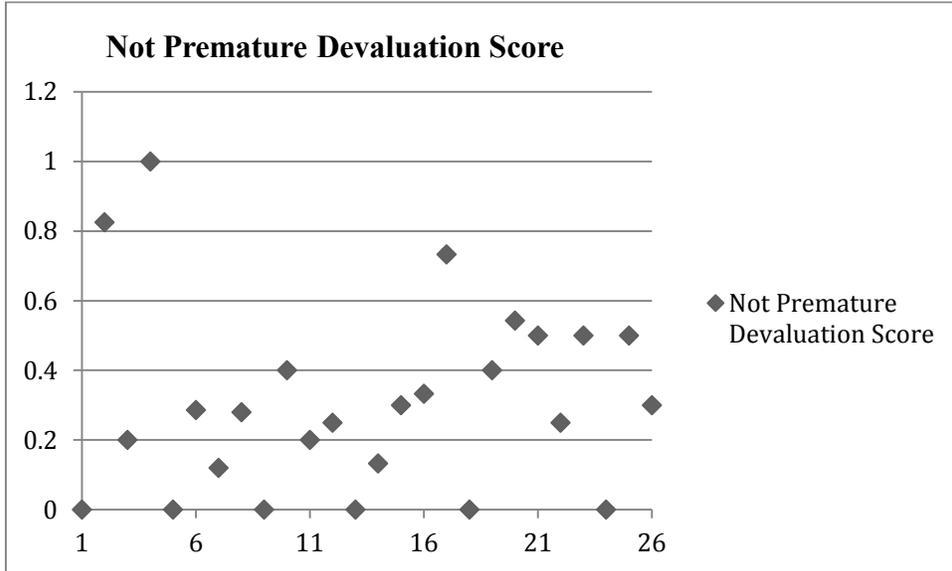


Table B3. Idealization

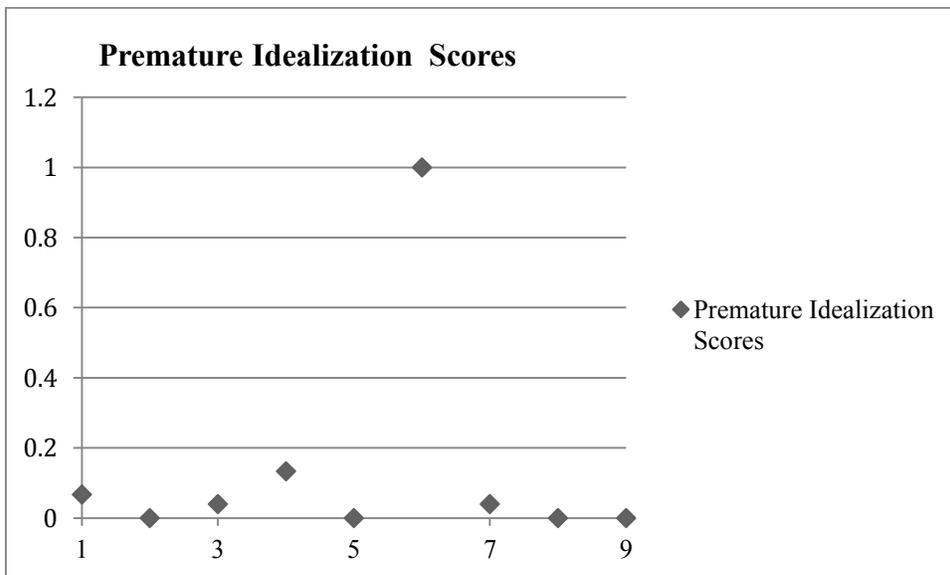
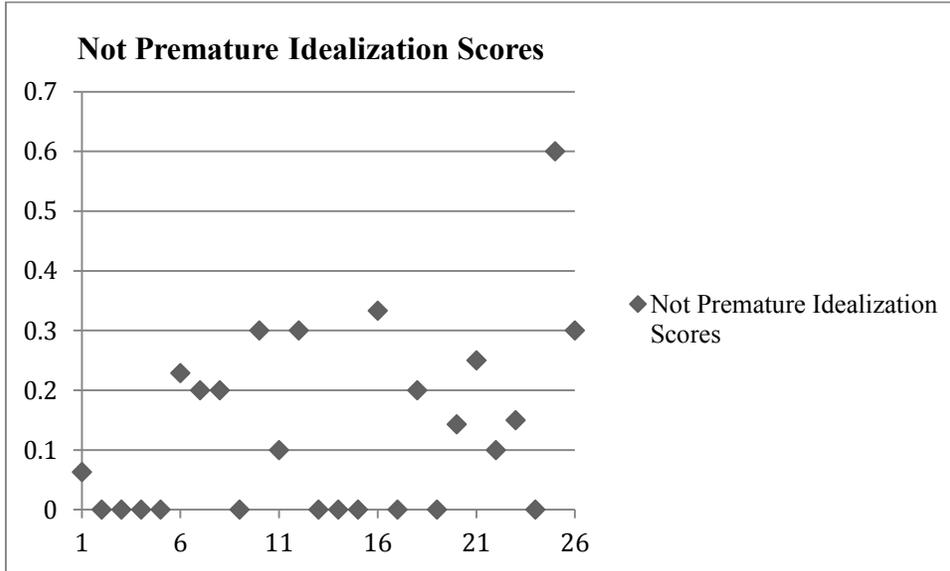


Table B4. Denial

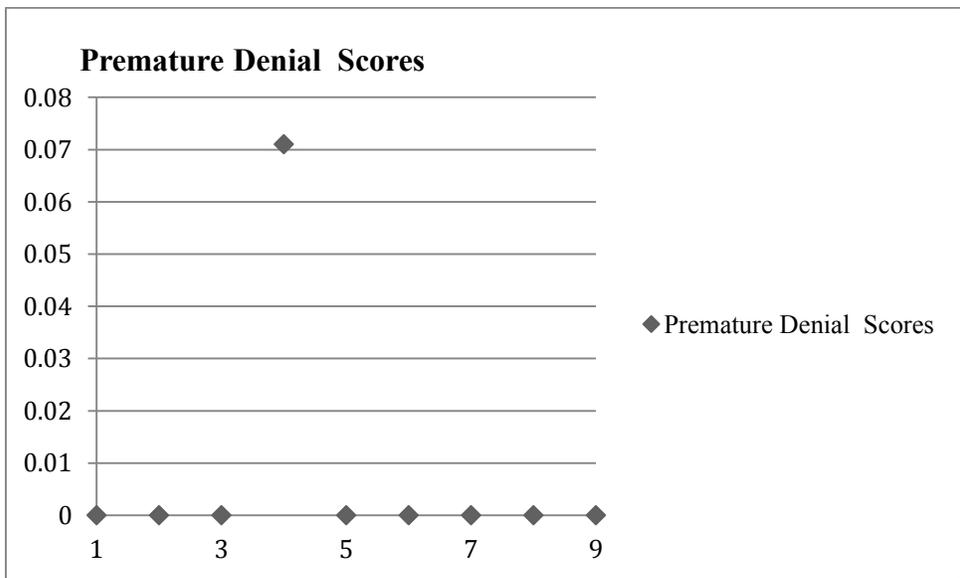
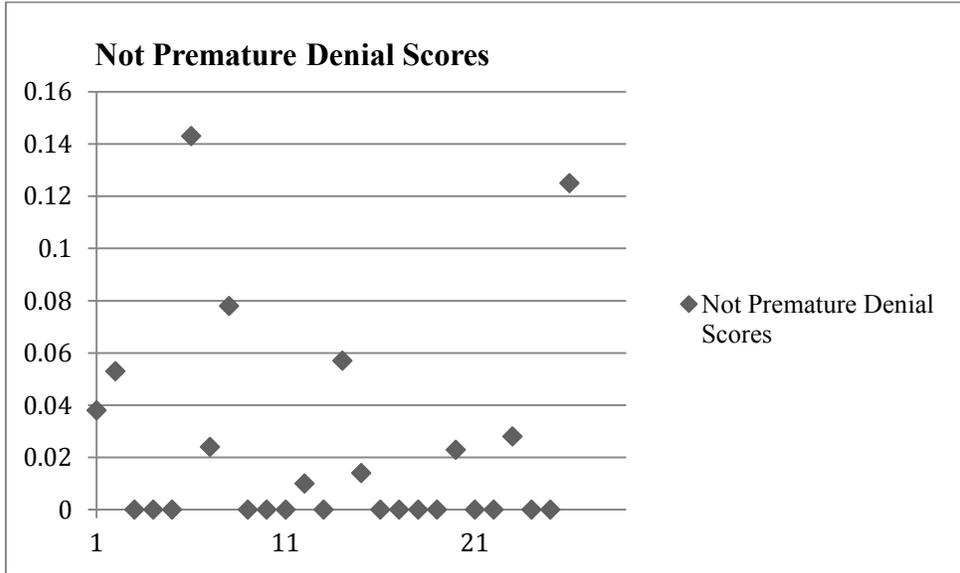


Table B5. Projective Identification

