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THE EFFECT OF THE THERAPIST'S DEGREE OF FOCUS ON DEFENSE MECHANISMS AND HIS LEVEL OF ACCURATE EMPATHY ON THERAPEUTIC OUTCOME[1]

The clinical literature abounds with varied techniques utilized by therapists to reduce the level of their client's anxiety. Also, the role played by anxiety in the establishment of a client's defense mechanisms predominates much of the therapeutic literature. Psychoanalysts indicate that these mechanisms of defense become overlearned habits routinized to the point of performance without client awareness. Thus, since they are unconscious and not available to the client's level of awareness, the psychoanalytic therapist utilizes the technique of directly confronting the client by bringing his own defense mechanisms to his conscious awareness (Menninger, 1958). That is, the analyst invokes the notion to his client that he should be aware of these defenses which he utilizes against exposure to ego threatening material. Also, Freud (1920) never capitulated to the client's neurosis and felt obligated to confront the client's self-denial of his defense mechanisms. This was especially true in Freud's technique of overcoming the client's resistance directly following or during free association.

Contemporary learning theorists also believe that the client's utilization of defense mechanisms brings only a momentary reduction in anxiety and in time will do more harm than good. Therefore, it may be useful for the therapists to assist the client in learning new types of behavior by pointing out his utilization of defense mechanisms. That is, learning theory therapists feel it is their obligation to teach the client new and healthier patterns of overcoming fears of anxiety (Dollard & Miller, 1950; Mowrer, 1960; & Wolpe, 1958).

In contrast to the above, the client-centered school of counseling and psychotherapy disagrees with the psychoanalytic and learning theory approaches of dealing with the client's defense mechanisms. The client-centered therapist does not confront the client with his utilization of defense mechanisms and more than likely would not discuss them unless the client, through his own insight, realizes such defenses as aspects of his problems. The client-centered therapist does not probe, there is very little stress on diagnosis, and unconscious motivation is completely ignored (Rogers, 1951).

The above discussion indicates that disagreement exists among the major therapeutic schools of thought regarding the therapeutic utility of confrontation of the client's defense mechanisms. Thus, the question becomes: does the therapist degree of focus on defense mechanisms increase or decrease

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therapeutic outcome? This question, along with an investigation of the interaction effects of the level of therapist empathic understanding on client improvement, was the focus of the present study.

No previous research could be located which dealt precisely with the question as to whether or not the degree of focus on defense mechanisms by the therapist and his level of accurate empathy made a difference in therapeutic outcome. However, Berenson, Mitchell, and Moravec (1968) did an investigation concerning the level of therapist functioning, patient depth of self-exploration, and type of therapeutic confrontation. They compared thirteen therapists who were considered high functioning on empathy, positive regard, genuineness, and concreteness with 43 therapists who were considered below average on the same dimensions. Their findings indicated that the low level therapist was as likely to confront a client with his weaknesses as the high level therapist. However, the effects on therapeutic outcome were not studied. Truax (1969), in a study concerning the therapist's degree of evaluative statements on client outcome, found that clients seeing therapists making fewer evaluative statements showed greater improvement than clients in psychotherapy with therapists who make relatively more frequent evaluative statements. Thus, although there is no direct evidence, it would appear that a difference would exist between the therapeutic outcome among the clients of those therapists who employed confrontation and those who did not employ confrontation of the client's utilization of defense mechanisms. Evidence has been reviewed by Truax and Carkhuff (1967) and Truax and Mitchell (1970) that indicates the therapist's level of accurate empathy is positively related to client outcome. It would be expected that if focus on defense mechanisms was therapeutic, then there might be potentiation interaction effects between degree of therapist empathy and degree of therapist focus on client defense mechanisms.

PROCEDURE

Forty psychoneurotic clients between the ages of 18 and 55 applying to the Henry Phipps Psychiatric Clinic Outpatient Department for treatment were used in the present investigation. Those clients with a history of alcoholism, brain damage, or mental deficiency, and those with prior psychotherapy were excluded from the population. The sample utilized in the analysis included 17 males and 23 females.

All 40 of the clients were given screening interviews and were rated by a psychiatrist as to their attractiveness as a psychotherapy client. This was a global rating based on variables such as age, education, general appearance, psychopathology, ability to relate to others, and warmth. This rating made possible an equal assignment of good or poor therapy prospects to the participating therapists.

Twenty of 40 clients used in the present research were given role-induction interviews subsequent to the initial screening interview and the remaining 20 received no such role structuring. The clients were assigned to four resident psychiatrists in such a manner so that each of the therapist's rosters contained 10 clients: 3 attractive, role-induction clients, 3 attractive non-role induction clients, 2 unattractive role-induction clients, and 2 unattractive non-role induction clients. The therapists met with their clients at least once a week for one-hour sessions. The specific therapeutic techniques

such as scheduling the session and further treatment were left to the discretion of the four therapists.

All the therapy sessions were tape recorded and a five point Likert scale for "Degree of Focus on Defense Mechanisms" was applied to six three-minute samples taken from each client's set of tape recordings. Two of the samples were taken from the first interview, two from the tenth, and two from the fifth interview before the final one. In each case, one sample was taken from the middle third and one from the final third of the interviewing session. For those cases terminating prior to the twentieth interview, the available sessions were utilized. Thus, all the data deals with the effects of short-term psychotherapy as all cases were terminated at the end of 4 months.

The rating on the degree of focus on defense mechanisms was done by two advanced graduate students in clinical psychology. The inter-rater reliability on the Likert type scale yielded a Pearson r of .74 and the intra-class r_{kk} was .92.

The measurment of accurate empathy was obtained by utilizing the Accurate Empthy Scale (Truax, 1961). Utilizing the above mentioned tape samples, four undergraduate college students naive with respect to psychotherapy theory were trained in the use of the rating scale and did the rating of accurate empathy. The raters used their respective scales on the coded samples in different orders. The reliability as measured by intra-class correlation for combined judges on the accurate empthay scales was .63.

The measurment of client outcome was obtained by utilizing two measures of overall improvement and three more specific measures of improvement. These five measures were as follows: (1) client and global improvement scale filled out by the therapist; (2) the client and global improvement scale filled out by the client; (3) change score on the discomfort scale filled out by the client; (4) the socio-ineffectiveness ratings filled out post-therapy by a research interviewer; and (5) the target symptom improvement scale filled out by the client post-therapy. Six of the forty clients utilized in the present study did not return for their post-therapy evaluation, thus only the client global improvement scale filled out by the therapist was available on all forty subjects.

TABLE 1
Analyses of Variance F Values for Effects of Level of Accurate Empathy and Level of Therapist Focus on Defense Mechanisms Upon Measures of Patient Improvement

Source	*df*	Global Improvement (Therapist)	*df*	Global Improvement (Patient)	Target Symptoms Improvement	Discomfort Scale	Social Ineffectiveness
High vs Low Accurate Empathy	1	6.37*	1	6.03*	1.00	1.04	.78
High vs Therapist Focus on defense mechanism	1	4.40*	1	2.10	4.46*	1.13	.94
High low AE High low FDM	1	2.16	1	1.05	4.80*	.89	1.30
Error	36		30				
Total	39		33				

*$P<.05$

The 40 clients were divided into the 20 receiving the highest levels of accurate empathy from their therapist and the 20 receiving the lowest levels. The sample was further subdivided into high and low levels of degree of therapist focus on defense mechanisms, thus forming a 2x2 factorial design with 10 clients in each of the four basic cells.

RESULTS

There was a significant difference between high and low levels of empathy (F=8.04, P<.001) and between the high and low levels of degree of focus on defense mechanisms (F=144.96, P<.001).

Since the data formed a 2x2 factorial design (high versus low levels of accurate empathy and high versus low levels of focus on defense mechanisms) with two therapists nested within high conditions and two within low conditions, analysis of variance for that design was used to evaluate the effects of high and low accurate empathy and high and low focus on defense mechanisms and their interaction upon the five measures of outcome. The unweighted means method was used in the analysis of measures involving six clients who did not return post-treatment for evaluation. Since the client's initial level of disturbance might be expected to effect therapy outcome, correlations were computed between the measures of the client's adjustment pre-therapy and the five improvement measures. All proved low and non-significant with the exception of the change score for the discomfort scale (L=.67, P<.001) indicating, in general, that the degree of improvement was not related to the initial level of adjustment. Since differences in initial level of adjustment were related to improvement on the discomfort scale, analysis of covariance was used on that measure to control the level of initial adjustment. The findings relating the level of accurate empathy, the degree of focus on defense mechanisms and their interaction using the two overall measures of improvement and the three specific measures of improvement is given in Table 1. It can be seen that accurate empathy has a significant effect on global improvement as measured by both the therapist and the client. Also, the level of therapist focus on defense mechanisms has a significant effect on the global improvement as measured by the therapist and upon mean target symptom improvement. Further, there is a significant interaction between the level of accurate empathy and the level of focus on defense mechanisms in terms of the mean target symptom improvement. In all cases there is a positive outcome effect of high focus on defense mechanisms and a negative effect of low focus on defense mechanisms. In terms of the interaction, the greatest client improvement is seen under high focus on the defense mechanism and high level of accurate empathy as measured by the target symptom improvement scale. The least improvement was found under low empathy conditions and low focus on defense mechanisms.

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