Archives of Psychiatry and Psychotherapy, 2017; 2: 7–14

DOI: 10.12740/APP/69642

Do therapists practicing psychoanalysis, psychodynamic therapy and short-term dynamic therapy address patient defences differently?

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Summary

Background: Defense mechanisms are a central component of psychodynamic theory [1,2] and their interpretation is key to psychodynamic practice. Over the years, varying perspectives on dealing with patients' defense mechanisms have been outlined [3].

Aim of the study: To examine how psychodynamic therapists deal with patient defenses in their clinical practice.

Method: This study asked psychodynamic therapists (*N*=114) practising different theoretical models (psychoanalysis, short-term psychodynamic psychotherapy and psychodynamic therapy) to complete an online survey.

Results: Respondents (*N* = 114) indicated that defense mechanisms are a very important component of practice for psychodynamic psychotherapy. Significant differences were found between short-term psychodynamic therapists (STDP) and psychodynamic therapists in how they address defenses in their clinical practice.

Discussion: Clinical implications of these results and directions for future research are discussed.

defense mechanisms / interpretation / therapist technique / psychodynamic therapists / psychodynamic psychotherapy

Defense mechanisms have been a central feature of psychodynamic theory since Freud [4] observed that his patients would "repress" painful memories in order to protect themselves from psychic pain and anxiety. Later, Anna Freud [5] began to systematically outline different defense mechanisms that patients would use to deal with conflict. Since then there has been a proliferation of perspectives on how to understand defenses [6–10]. It is clear that the understanding and interpretation of defenses is considered an important aspect of psychodynamic psychotherapy [1,2], both in long term [11] and short-term modalities [12,13].

Despite the importance of defenses both theoretically and clinically, very little attention is placed on understanding just how psychodynamic therapists are using psychodynamic theory and techniques with their patients in clinical practice. Most surveys of psychodynamic therapists have examined: the popularity and frequency of psychodynamic therapy use in clinical practice [14]; use of homework assignments in therapy [15]; ethical beliefs and behaviours in practice [16]; and actions to take when faced with treatment failure [17,18]. However, few studies have examined the types of therapeutic techniques that therapists use in their private practice [19,20]. For example, Wogan & Norcross

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[21] surveyed over 300 psychotherapists of all theoretical orientations (humanistic, cognitive and psychodynamic) on their use of 99 therapeutic techniques and skills. In terms of findings specific to psychodynamic theory, the authors found that psychodynamic therapists frequently reported analysing transference and interpreting patients' past more often than therapists from other theoretical orientations. These findings support the idea that psychodynamic psychotherapists follow the theoretical underpinnings of psychodynamic psychotherapy in practice.

Despite the importance of these studies and their attempts to continually increase our understanding of therapist activity in practice and to bridge the gap between theory and practice, there still remains a lack of studies reporting on psychodynamic clinicians' activities in-session with respect to psychodynamic principles. For instance, the Wogan & Norcross [21] study did not examine defenses or the interpretation of defenses when surveying dynamic therapists. This is surprising as there is a growing body of research demonstrating the importance of adaptive patient defense use and its relationship to positive therapy process and outcome [9,22]. Additionally, there is a body of research that demonstrates positive relationship between the interpretation of defenses and outcome [23].

DIFFERENT PSYCHODYNAMIC MODELS OF THERAPY

Psychodynamic therapy is not a single entity. Over the years, psychoanalytic thought on human behaviour and personality development has evolved and three major schools emerged: ego psychology, object relations and self-psychology [24]. It is beyond the scope of this paper to provide a comprehensive analysis of the numerous schools of psychodynamic therapy, but it is important to note that psychodynamic therapy is filled with a multitude of theoretical orientations that share similarities and differences in terms of length of treatment, role of therapist, and the frequency and intensity of therapeutic technique (for a comprehensive review of these models see Summers & Barber [24] and Mitchell & Black [25]).

Research examining similarities and differences in how therapists of varying theoretical orientations incorporate therapeutic technique in their practice is virtually non-existent. Given the importance of defenses and their interpretation to psychodynamic theory and practice [1], and the limited research exploring clinician self-reports on the importance of defenses in their own practice, this study focused on exploring the attitudes of therapists who self-identified as practicing different variants of psychodynamic therapy and the importance of defense mechanisms in their practice.

METHOD

Recruitment

Recruitment involved inviting psychotherapists to respond to an online survey. Potential participants were selected from several institutions' listservs: the Society for Psychotherapy Research, the International Psychoanalytic Association, Division 39 of the American Psychological Association, the American Psychoanalytic Association, and the Canadian Psychological Association Section on Psychoanalytic and Psychodynamic Psychology. The invitation informed potential participants of the purpose and duration of the study (19 questions; approximately 10–15 minutes) and that ethical approval had been obtained. No compensation was offered and there were no inclusion criteria beyond being a practicing psychodynamic psychotherapist. Participants were explicitly asked to provide informed consent by clicking on a link that directed them to the online survey. As third parties sent out the invitations, it is not possible to determine how many individuals were contacted or what proportion responded to the invitation to participate.

Participants

In total, 139 individuals consented to participate in the study: 114 practicing psychodynamic psychotherapists completed questions 1 to 6; 112 completed questions 1 to 13; and 107 completed the entire survey, questions 1–19. More than half (53.5%) of the participants were male ($N = 61$) and 46.5% were female ($N = 53$). Data regarding the participants' theoretical orientation, profession, highest educational degree obtained and years of experience as a clinician can be found in Table 1.

Table 1. Demographic Information

Variable	N	%
Gender		
Male	61	53.5
Female	53	46.5
Age		
<30	6	5.3
30-35	10	8.8
36-40	17	14.9
41-45	9	7.9
46-50	17	14.9
51-55	18	15.8
56-60	11	9.6
61+	25	21.9
License		
Counsellor	7	6.1
Psychiatrist	20	17.5
Psychologist	72	61
Family Physician (G.P.)	1	0.9
Social Worker	6	5.2
Non-licensed	7	6.1
Did Not Respond	1	0.9
Highest Degree		
Ed.D.	1	0.9
D.Ps/Psy.D.	8	7
Masters	35	30.7
M.D.	21	18.4
Ph.D.	49	43
Years Practicing		
<5	9	7.9
5-10	23	20.2
11-15	21	18.4
16-20	16	14
21-25	13	11.4
26-30	13	11.4
31+	19	16.7
Number of Sessions		
<10	4	3.5
10-20	15	13.2
21-40	30	26.3
41-60	21	18.4
61+	43	37.7
None of the above	1	0.9

THEORETICAL ORIENTATION

As part of the survey, participants were asked to self-report what type of psychodynamic therapy they practice. These were subsequently divided into three broad categories: short-term psychodynamic psychotherapy (STDP), psychodynamic psychotherapy and psychoanalysis. Participants who identified as practicing "short-term psychodynamic", "intensive short-term psychodynamic", "accelerated experiential psychodynamic", "experiential dynamic psychotherapy" or any other variation of "short-term" were categorized as practicing STDP. Participants who identified as practicing "psychoanalysis" were classified as psychoanalysis. The psychodynamic psychotherapy category consisted of participants who practiced "psychodynamic psychotherapy", "psychoanalytic psychotherapy", "object relations" or "relational psychotherapy".

Overall, 49 participants (41.5%) were assigned to the "psychodynamic psychotherapy" group, 44 (37.3%) were assigned to the "STDP" group, and 21 (17.8%) were identified as practicing "psychoanalysis". Four additional participants completed the survey but because they did not practice psychodynamic therapy (one identified as cognitive–behavioral therapist (CBT), one as "integrative constructivism", one as practicing "interpersonal therapy" and one did not identify their theoretical orientation) they were removed from all analyses. The majority of participants held a PhD (43%), were licensed psychologists (61%), and had been practicing for between 5 and 10 years (20.2%; see Table 1).

Survey

The survey was designed to document the opinions of clinicians about the importance of various psychodynamic techniques in working with patients' defense mechanisms in clinical practice. The first three authors created the survey by examining the existing literature on defense interpretations. The survey was then piloted to 5 practicing clinicians for feedback that was integrated to aid in the creation of the final version. The survey consisted of two parts. Part I comprised demographic questions (see Table 1) whereas part II asked respondents to rate 19

questions on a 5-point Likert scale (where 1 was "not important" and 5 was "very important") to determine the importance of the defense principles in their own practice. Mean scores were tabulated for responses to the survey questions based on the participants' theoretical orientations (see Table 2).

Table 2. Means and Standard Deviation across Theoretical Orientations

Question	STDP		Psychodynamic		Psychoanalysis	
	Mean	SD	Mean	SD	Mean	SD
1. In your opinion, are defense mechanisms an important construct in psychodynamic psychotherapy?	4.75	0.61	4.61	0.79	4.67	0.48
2. Rate the importance of interpreting patient defenses	4.30	0.95	4.20	0.88	4.33	0.66
3. Rate the importance of interpreting the patient's most common defense.	4.36	0.92	4.24	0.88	4.52	0.51
4. Rate the importance of interpreting the patient's out of character defenses (e.g., Healthy Neurotic patient who infrequently acts out).	3.95	0.94	3.67	0.88	4.48	0.75
5. Rate the extent to which a therapist's choice of defense to interpret in-session should be based on psychodynamic theory.	3.86	1.07	3.86	1.04	3.95	1.32
6. Rate the importance (as a therapist) of adjusting one's therapeutic technique to patients' defensive maturity level.	4.36	0.69	4.53	0.81	4.33	1.2
7. Rate the importance of correctly timing an intervention that aims to address some aspects of defensive functioning.	4.53	0.63	4.43	0.78	4.42	0.93
8. Rate the importance of accurately identifying and addressing the defenses used by patients in-session (e.g., interpreting the defense Isolation when the patient is in fact using that defense).*	4.50	1.1	3.85	1.15	4.14	1.15
9. Rate the importance of making "deep" interpretations in psychodynamic psychotherapy (that include motives, wishes, repressed or latent content).	3.40	1.28	3.93	0.95	3.76	1.14
10. How important is it to address the defense used by the patient as opposed to what is defended against (unconscious motive, wish, impulse or drive)?	3.70	1.12	3.67	1.01	4.00	1.23
11. Is it important in psychotherapy to use increasingly "deeper" interpretation with patients as therapy progresses (the so-called "surface-to-depth" rule)?**	3.00	1.18	3.72	0.96	3.57	1.21
12. Rate the importance of naming the affect associated with each defense mechanism when making interpretations in psychotherapy.	4.14	1.01	4.07	0.90	4.55	0.61
13. Rate the importance of interpreting a defense when it is emotionally charged (meaning that the emotional content associated with the defense is readily observable to the therapist).	4.16	1.11	4.15	0.82	4.33	0.66
14. Rate the importance of interpreting a defense when it is emotionally detached or "cold" (meaning that the emotional content associated with the defense is not readily observable to the therapist).	3.60	1.28	2.98	1.35	3.00	1.18
15. How helpful do you believe it is to use interpretive techniques with "Immature" defense such as Splitting, Projection, & Acting Out?	3.38	1.19	3.51	1.28	3.95	1.02
16. On average, how long do you believe it takes for therapeutic techniques aimed at addressing defensive behavior to promote more adaptive defense use by patients?***	2.70	0.61	3.77	0.97	3.90	0.89

17. How important do you believe it is to support the use of adaptive/ mature defenses by patients?****	3.80	1.09	4.42	0.91	3.81	0.87
18. How often do you interpret defenses used by patients in their lives outside of therapy as opposed to defenses used within the session?	3.53	0.99	3.60	0.90	3.52	1.08
19. How important do you believe it is to avoid the use of technical language when expressing the interpretation of defenses to patients?	4.43	0.87	4.23	1.09	4.38	0.87

*Significant mean difference between STDP and Psychodynamic group, p =.04.

**Significant mean difference between STDP and Psychodynamic group, p <.001

***Significant mean difference between STDP and Psychodynamic group, p <.001.

****Significant mean difference between STDP and Psychodynamic group, p <.001.

Data analysis

Descriptive statistics (means and standard deviations) and a MANOVA were produced for the theoretical orientation categories (STDP, psychodynamic, psychoanalysis) of participants' ratings of the 19 questions in part II of the questionnaire

RESULTS

The MANOVA showed an overall significant difference between STDP, psychodynamic and psychoanalytic therapists (F (2,38) = 3.25, $p < 0.001$). Post hoc pairwise comparisons were conducted between the different theoretical orientation groups with the exception of the psychoanalysis group because of the small size of that sample. Results showed significant differences between the groups on four questions.

Significant differences were found between STDP clinicians (M = 4.5, SD = 1.1) and psychodynamic clinicians (M = 3.85, SD = 1.15; F (2, 100) = 3.166, p = 0.04) on question 8 ("Rate the importance of accurately identifying and addressing the defenses used by patients in-session (e.g. interpreting the defense 'isolation' when the patient is in fact using that defense)"). Similarly, on question 11 ("Is it important in psychotherapy to use increasingly 'deeper' interpretation with patients as therapy progresses (the so-called 'surface-to-depth' rule)?"), STDP clinicians (M = 3.00, SD = 1.18) differed significantly from psychodynamic clinicians (M = 3.72, SD = 0.96; F (2, 100) = 5.792, $p < 0.001$). Further, on question 16 ("On average, how long do you believe it takes for therapeutic techniques aimed at addressing defensive behavior to promote more adaptive defense use by patients?"), significant differences were found between STDP (M = 2.70, SD = 0.61) and psychodynamic clinicians (M = 3.75, SD = 0.97; F (2,100) = 21.389, $p < 0.001$). And finally, significant differences were found between STDP clinicians (M = 3.89, SD = 1.09) and psychodynamic clinicians (M = 4.43, SD = 0.89; F (2,100) = 4.989, $p < 0.001$) on question 17 ("How important do you believe it is to support the use of adaptive/ mature defenses by patients?").

DISCUSSION

Despite the general agreement among the overwhelming majority of individuals surveyed regarding the importance of defense mechanisms as both a theoretical construct and clinical consideration (see Table 2), this study found significant differences among participants who identified as STDP and psychodynamic therapists on key clinical questions.

One of those questions asked clinicians to "Rate the importance of accurately identifying and addressing the defenses used by patients in session (e.g. interpreting the defense 'isolation' when the patient is in fact using that defense)" – STDP clinicians rated this as more important than psychodynamic therapists. Perhaps these differences emerge from the specific emphasis placed by STDP clinicians on addressing defenses as they arise within the session. As Malan [26] formulated psychodynamic conflict into three distinct poles (defenses, anxiety and feelings),

STDP clinicians view defenses as barriers to important feelings that need to be experienced and expressed, and perhaps more than other psychodynamic therapists focus intently and systematically on specific technical interventions aimed at defenses.

Additionally, significant differences were found between STDP therapists and psychodynamic therapists on the item that asked participants: "Is it important in psychotherapy to use increasingly 'deeper' interpretations with patients as therapy progresses (the so-called 'surface to depth' rule)?" This item tapped into the principle of moving from "surface" to "depth" [27] as an important guideline when interpreting patient defenses. Therapists should not interpret deeper, unconscious material at the onset; rather, they first focus on conscious, easily accessible patient material. STDP therapists rated this as being less important than psychodynamic therapists. These differences may be due in part to the short-term nature of STDP and its active, experiential focus early in therapy [12,13]. Additionally, "traditional" psychodynamic models may hold onto the conceptualization that in order to make deeper interpretations, transference must be well established, and that this process takes time to crystallize. In STDP, especially in intensive models [12], therapeutic intervention aimed at tackling transference can begin immediately. Davanloo identified the "pressure and challenge" system of attacking the defenses patients use and this culminates in the "head-on collision" technique, where the therapist challenges patients to face warded-off feelings as quickly as possible. In general terms, this leads to a rise in transference feelings towards the therapist, which are then systematically processed.

Another difference may lie in how STDP therapists and psychodynamic therapists conceptualize an "interpretation". A number of STDP participants in this study left comments at the end of the survey reflecting their view of what it means to "interpret" a defense. For example, one participant indicated that:

> "I have difficulty with your use of the word 'interpret'. In short-term dynamic work the process is not one of traditional interpretation but rather pointing out defenses, getting the patient to notice the defenses, addressing all the consequences of the defense and in that process getting the patient to a point of an emotional response to the way they have been defeating themselves by using that defense – e.g. sadness, self-compassion, etc. After that work is done, then motivating the will of the patient to change the defensive pattern. Finally, then, exploring with the patient alternative responses to using the defenses. I have answered the questions of this survey using this understanding of interpretation."

Significant differences also emerged between STDP and psychodynamic therapists on an item that asked participants: "On average how long do you believe it takes for therapeutic techniques aimed at addressing defensive behavior to promote more adaptive defense use by patients?" STDP therapists reported that it would take less time for patients to use more adaptive defenses than did psychodynamic therapists, who reported it would take longer. This difference is consistent with the tenets of STDP, as it is an active, shorter and accelerated treatment, which emphasizes the view that character change can occur "quicker" than it can in longer-term treatments.

Another item asked participants "How important do you believe it is to support the use of adaptive/mature defenses by patients?", and STDP therapists rated this as being less important than psychodynamic therapists. One possible explanation is in the conceptualization of defense mechanisms by both STDP and psychodynamic therapists. It may be the case that psychodynamic therapists in this study followed the model of defensive functioning outlined by Vaillant [10], which conceptualizes patient defenses being organized in a hierarchy from immature to mature defenses. The goal then is to move patients towards increasingly mature levels of defense. An important distinction in the STDP literature is the emphasis placed on reducing the patient's use of tactical defenses (e.g. non-verbal body language actions such as avoiding eye contact, inappropriate laughter), so that they can experience and express underlying feelings [12,13]. Again, this does not imply that STDP therapists do not see defenses as part of an individual's

character or that psychodynamic therapists do not appreciate the significance of working with tactical defenses. Rather, the discrepancy may be that of differences in focus of the therapeutic work.

LIMITATIONS

This study had some limitations that need to be considered when interpreting the results. First, there may be a discrepancy between what therapists say is important to their practice and what they actually do in-session, as research suggests that often therapists who claim to be practicing a particular therapy are in actuality practicing something quite different [1].

The study was limited by a small sample size. A larger sample may have increased differences between groups and enabled a comparison of both the STDP and psychodynamic groups with the psychoanalysis group. Using third party invitations did not allow us to determine the actual number of individuals who were contacted and therefore we could not determine the response rate. In addition, it was not possible to establish which association or region in the world survey completers came from. These factors limit the generalizability and representativeness of the study.

Using a Likert scale and asking psychodynamic clinicians to self-report on the importance of defense mechanisms created the likely conditions for a positive response bias. That is, most clinicians thought that these principles were "important" to "very important" in their own practices. Variability among responses was not high and confirms what we have already intuitively known: psychodynamic practitioners believe that working with defenses is important. Despite this, significant differences and a lack of uniform agreement on the definition and applications of these principles emerged between groups.

Many participants commented on the survey's inability to capture the different perspectives and understanding they had about defenses and interpretations. For example, there were varying views on the definition of defenses (e.g. tactical or characterological), and what it means to "interpret" a defense rather than "intervening" with defenses. These disagreements shed light on an important issue in that the psychodynamic community is a diverse group and that defense mechanisms are understood from many perspectives both theoretically [8,10] and clinically [12]. The results of this study definitely support that position and help us understand that just because psychodynamic therapists agree with the importance of defense mechanisms, this does not clearly translate to how, why and when they choose to address defenses in-session.

CONCLUSIONS

Overall, this study found that the overwhelming majority of psychodynamic practitioners surveyed believe that defenses are both an important construct in psychodynamic therapy, and that in their own clinical practice it is important to interpret patient defenses. Despite global agreement, in general, on the value of working with defenses in-session, differences emerged in a few areas between STDP therapists and psychodynamic psychotherapists. More research is needed to better understand the importance of defenses in clinical practice among the rich, diverse and unique theoretical varieties of psychodynamic theory and practice.

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