

Identifying Psychotic Defenses in a Clinical Interview

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The Defense Mechanisms Rating Scales (DMRS), one of the most widely used and validated instruments in the study of defense mechanisms, does not include psychotic defenses. The Psychotic-DMRS (P-DMRS) has been developed to include 6 psychotic defense mechanisms: psychotic denial, autistic withdrawal, distortion, delusional projection, fragmentation, and concretization. We discuss psychotic defenses, including the difference between psychotic defenses and psychotic symptoms. Six clinical illustrations demonstrate how the 6 P-DMRS defenses can be identified in patients' narratives selected from the transcripts of dynamic interviews. Implications with respect to patient evaluation and treatment are discussed. © 2014 Wiley Periodicals, Inc. *J. Clin. Psychol.: In Session* 70:428–439, 2014.

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The concept of defense mechanisms, while originating and featured within the psychodynamic tradition, is also considered clinically valuable within other therapeutic systems (Kramer, Despland, Michel, Drapeau, & de Roten, 2010). Defense mechanisms mediate the individual's reaction to emotional conflicts arising from internal and external stressors. Thus, they provide a means of understanding the affective dynamics that occur in all individuals and are particularly useful for considering both in routine clinical work and in process-outcome research in psychotherapy.

According to Vaillant (2011), defenses have six important properties: They mitigate the distressing effects of emotions and mental representations associated with conflict; they are unconscious; they are discrete from one another; they are dynamic and reversible; they can be adaptive, even creative, as well as pathological; and, though typically invisible to the user, to the observer they appear odd, even annoying. Since Vaillant's (1971) first empirical publication on defenses, researchers in this field have developed many classification systems, using self-report scales, projective techniques, or clinical evaluation methods (see Hentschel, Smith, Draguns, & Ehlers, 2001 for an extensive review).

Perry (1990) developed the Defense Mechanisms Rating Scales (DMRS), which is one of the most widely used and validated instruments in the empirical study of defense mechanisms. In the DMRS, defenses are divided conceptually and empirically into related groups that are referred to as Defense Levels. The DMRS allows a researcher to rate the qualitative presence of a defense in a 50-minute dynamically oriented interview (on live or recorded interviews without transcripts) and perform a quantitative assessment when interview recordings and transcripts are available. In this scoring method, trained raters precisely identify each use of the defense on standardized transcripts.

An individual Overall Defensive Functioning (ODF) score can be obtained by adding all the defenses and by calculating a weighted average. Using this scoring method allows studying defensive change as a measure of psychotherapy outcome. In this regard, Perry and Bond (2012) showed that change in defensive functioning in long-term psychotherapy largely follows the hierarchy of defense adaptation; they also suggested that because of the relationship of changes in defenses to long-term improvement in outcome, defenses should be considered candidates for assessing improvement in functioning and symptoms.

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Other studies (Drapeau et al., 2005; Hersoug et al., 2009; Perry et al., 2012) measuring defensive change over the course of dynamic psychotherapy among different patient populations have shown very similar overall defensive functioning scores, despite the fact that these populations presented important differences in term of symptom intensity. This suggests that the DMRS may not capture a broad enough spectrum of defensive functioning.

Psychotic defense mechanisms are important to take into account in the study of severe personality disorders, bipolar disorders, paranoid patients, and patients with schizophrenic disorders. Based on Valliant's (1971) listing of three psychotic defense mechanisms (delusional projection, psychotic denial, and distortion), psychotic defenses in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994) are described as being part of the most dysregulated level. This level is characterized by failure of defensive regulation to contain the individual's reaction to stressors, leading to a pronounced break with objective reality. According to Vaillant, such mechanisms are common in young children, in our dreams, and in psychosis. To the user they alter reality, and to the observer they seem strange. This functional description of psychotic defenses does not include any etiological considerations, nor does it link psychotic defenses to any specific disorder.

Following these considerations, we developed in collaboration with J. C. Perry an additional scale to measure psychotic defense mechanisms to work in combination with the DMRS. This project was based on the following five hypotheses:

- H1. Psychotic defenses can be identified in transcripts of psychodynamic interviews of clients.
- H2. Discrete episodes of psychotic defenses can be quantitatively scored.
- H3. Psychotic defenses can be present in a wide range of ODF (subjects use other defensive levels that contribute to the variation).
- H4. Psychotic-DMRS (P-DMRS) has the same psychometric characteristics as DMRS.
- H5. Using P-DMRS together with DMRS allows for a more valid evaluation of defensive functioning, thus permitting better discrimination between different patient populations.

Based on an extensive review of the literature on psychotic defenses (see Berney et al., 2009), 16 psychotic defenses were submitted to a panel of clinical experts and researchers. Five psychotic defense mechanisms were included that were readily observable in clinical practice and that could be identified in sequence as they occurred in transcripts. At the same time, a scale independently developed by colleagues in Montreal included five psychotic defense mechanisms, among which four were identical to ours (Constantinides & Beck, 2010).

We combined these scales, leading to the final P-DMRS, which includes six psychotic defense mechanisms: psychotic denial, autistic withdrawal, distortion, delusional projection, fragmentation, and concretization (Table 1). As is the case in the DMRS, each defense of the P-DMRS is extensively described in a manual (definition, function, discrimination, and rating examples). To calculate ODF, psychotic defenses are considered to be level 0 (see Table 1), yielding a number between 0 (lowest) and 7 (highest). A first validation was done on a sample of 80 patients: 20 with depressive or anxiety disorder; 20 with bipolar disorder; 20 with personality disorder; and 20 with schizophrenic disorder, showing promising results (Berney et al., 2011).

The term "psychotic" may provoke confusion. Depending on the context, it can be understood in a syndromal way, referring to psychiatric diagnosis, or it can refer to a description of the dynamic functioning of the personality, in the sense of Kernberg's (1984) description of personality organization. In the P-DMRS, we understand psychotic defenses as being part of the dynamic manifestations of patients' functioning. Furthermore, we do not mean that the use of psychotic defenses implies the presence of a psychotic symptom or a psychiatric diagnosis. Psychotic symptoms can be used in a defensive way, but not all symptoms are defenses. In other words, symptoms per se should be distinguished from their defensive use, which occurs in a precise context. If a psychotic symptom occurs when a person is obviously confronted by a stressor that elicits a defensive move, then we consider it as a defense, as long as the description of what is happening corresponds to a given defense mechanism.

Psychotic symptoms can be considered as defenses only when the person is obviously dealing with the anxiety related to an emotional conflict. In such a situation, the defensive move can lead to delusion. Psychotic defenses can be related to identifiable fears and conflicts. Defense

Table 1
DMRS and P-DMRS Hierarchy of Defense Levels and Individual Defense Mechanisms

Levels	Individual defense mechanisms
7. High adaptative (mature) defense	Affiliation, altruism, anticipation, humor, self-assertion, self-observation, sublimation, suppression
6. Obsessional defense	Isolation of affect, intellectualization, undoing
5. Neurotic defense	Repression, dissociation, reaction formation, displacement
4. Minor image-distorting (narcissistic) defense	Devaluation (of self and others' images), idealization (of self and others' images), omnipotence
3. Disavowal defense	Denial, projection, rationalization, autistic fantasy
2. Major image-distorting (borderline) defense	Splitting (of self and others' images), projective identification
1. Action defense	Acting out, help-rejecting complaining, projective identification
0. Psychotic defense	Psychotic denial, autistic withdrawal, distortion, delusional projection, fragmentation, concretization

Note. DMRS = Defense Mechanisms Rating Scales; P-DMRS = Psychotic-Defense Mechanisms Rating Scales.

mechanisms are theoretical constructs and are rated on the basis of inference from observations. An important point to remember when working on defenses is always to try to identify the function of the observed mechanism.

Case illustration

We present clinical illustrations for each of the six psychotic defenses of the P-DMRS. This clinical material was obtained when validating the P-DMRS by performing 50-minute dynamic interviews (Perry, 2005) with 80 patients presenting different psychiatric diagnoses.

The dynamic interview has been developed as a research tool from clinical practice of psychodynamic psychotherapy and has been widely used in psychotherapy research. In the dynamic interview we ask the patient to talk about his or her current life and significant past episodes. Relationships, conflicts, and affects are questioned and discussed. The interviewers were trained with this instrument, were blind to the patients' psychiatric history, and were not part of the patients' treating team. All interviews were tape-recorded and transcribed according to a standardized method. Interviews were rated on transcripts by trained raters with the DMRS and the P-DMRS. Based on four raters coding independently 30% of the interviews, reliability was excellent, with mean Intraclass Correlation Coefficient ICC (2, 1) = .83 (range = .59–.96).

To identify defenses on a transcript, the reader has to pay attention to the patient's narrative content and the dynamic that takes place between patient and interviewer. For example, a defensive move can be detected when the patient manifests no affect even though one would expect this, or when he or she shows a different affect from the expected one or changes topic suddenly. If such episodes are observed, the defensive function of the episode has to be considered. If a defensive function can be inferred, a precise description of how the defense operates permits a determination of which defense is in use.

In some narratives, we find many defense mechanisms, sometimes mixed together (typically delusional projection, concretization, or distortion). In such cases, we choose to take into account only the main defense mechanism concerning one sequence in the narrative about the same object and the same affect. This decision rule prevents "hair-splitting" and improves reliability.

Table 2
Defensive Profiles for the Six Patients

	C	B	A	D	E	F
Number of defenses	47	37	40	56	38	85
Psychotic	8%	11%	15%	27%	49%	63%
Action	8%	8%	11%	11%	13%	3%
Borderline	5%	5%	9%	16%	2%	0%
Disavowal	18%	27%	34%	21%	24%	18%
Narcissistic	15%	3%	15%	7%	4%	3%
Neurotic	3%	11%	9%	0%	1%	11%
Obsessionnal	33%	22%	4%	18%	6%	3%
Mature	13%	14%	4%	0%	1%	0%

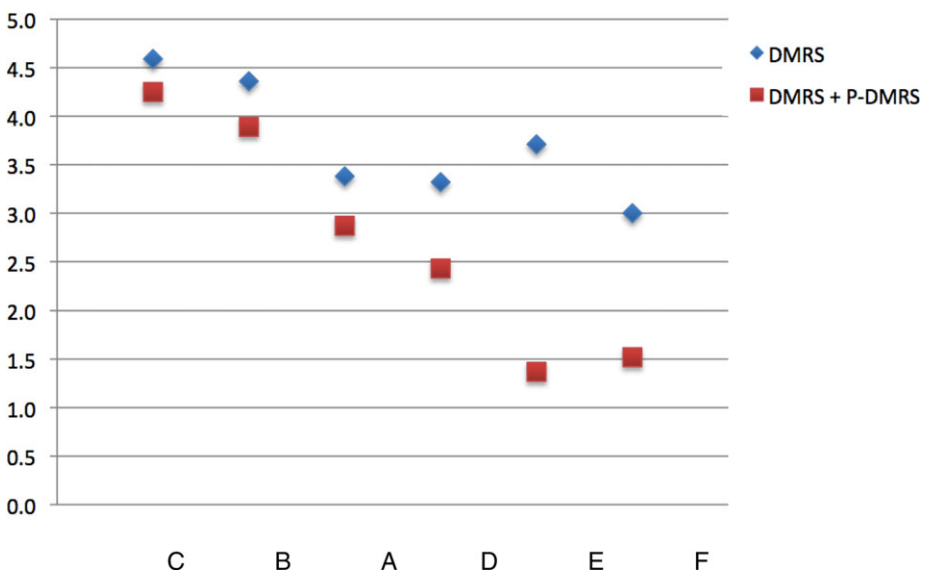


Figure 1. Overall Defensive Functioning scores comparing DMRS and DMRS + P-DMRS for the six patients.

For each psychotic defense, we present a selection of transcript and then discuss the reason why we inferred the presence of a defense mechanism at that particular moment and how we understood the function of the defense at play. Relevant differential diagnoses between defenses of the DMRS and of the P-DMRS are discussed. We provide few elements of patients' history to prioritize what is taking place in the session. Defensive profiles (Table 2) and defensive scores (Figure 1) are presented for each case.

Psychotic Denial

In psychotic denial, the subject deals with internal or external stressors by refusing to acknowledge some aspects of the reality of his or her experience (internal) and some aspects of the external reality (a physical object, a life event). The subject is blind to the perceptual, the ideational, and the emotional content of what is denied. In the narrative, the denial can be about things that the patient should mention but does not. Therefore, this mechanism is often difficult to identify on transcripts of dynamic interviews. Other sources of information (e.g., the content of previous psychotherapy sessions; information from the ward or from the family) are sometimes necessary for the clinician to become aware of its use by the patient.

We understand psychotic denial as being the fundamental mechanism underlying any psychotic defense, similar to the role played by repression in higher level defenses. It is rated *per se* when presented alone without subsequent withdrawal (autistic withdrawal), projection (delusional projection), distortion, or concretization.

Example 1. Patient A is a 34-year-old female diagnosed with bipolar disorder and followed at an outpatient clinic, a specialized section for patients with personality and mood disorders. The patient explains that she was recently hospitalized for a depressive episode with continual suicidal thoughts. Before being hospitalized, she would hide crying at home and not tell her husband anything about it. She reports that her husband often became nervous with her and reproached her for not tidying their home well enough before he returned from work in the evening. She stated that she could not tell her husband about what she feels.

Therapist: What makes it so difficult for you to talk to him?

Patient: It stresses me. You, I know that you are not part of my family. You are not going to judge me. I can tell you, but I cannot tell my family.

T: What makes it difficult for you to talk to your family?

P: Well, there is no reason for me to be depressed. I have everything I need. Things are fine with my husband, and with my children. I have a house and they all like me, so things are fine [psychotic denial].

Later on in the interview, the patient reports that she sometimes gets nervous with her children (a 4-year-old girl and an 8-year-old boy) because they do not tidy up their toys. If she has to take care of both of them, she feels overwhelmed. So she has organized an alternate day care for each of them to stay with one at a time.

P: With my son, I get tired quickly. I give him handicrafts, I begin to do them with him and then I leave. So he tells me that I never do anything with him and that hurts.

T: It hurts?

P: Yes. I would like to do more things with him, but I am not able to. With my daughter things are easier, she does not need me [psychotic denial].

In this transcript, the patient reports that she cannot talk to either her husband or her family about her difficulties. When the interviewer tries to clarify what prevents her from doing so, she suddenly refuses to acknowledge some aspects of the reality of her experience ("I have no reason to be depressed") and some aspects of the external reality ("things are fine with my husband and with my children"; "a 4-year-old child does not need her mother").

For the patient, talking about these difficulties and having to remember them to be able to think about them triggers so much anxiety that the only recourse is to deny the existence of the stressor involved. This defense is psychotic denial, which differs from minor denial (which concerns only internal reality) in the way that it regards both internal and external reality. It implies that some aspects of the reality are kept out of consciousness. It can be about an entire part of life (pregnancy denial, death denial) or about more limited aspects (as in the present example).

Autistic Withdrawal

In autistic withdrawal, subjects deal with internal or external stressors by clearly cutting themselves off from their environment. Stressors induce a clear breach of contact between subjects and their perceptions or environment. This leads to a loss of contact with reality and a loss of the ability to respond to the reality. Unlike action defenses, to the observer, autistic withdrawal is a defense mostly expressed through behavior. It can take place either in the course of the interview (the patient gets mute or seems absent, out of touch) or outside and be narrated by the patient.

Severe conditions, such as stupor and catatonia, cannot be rated as psychotic defense mechanisms when they occur. When patients present such states, it is not possible to perform a clinical interview. However, after the patient is able to talk, he or she may make it clear that at that time

he or she was using autistic withdrawal. An example can be found in Norman Bates' behavior at the end of Alfred Hitchcock's movie *Psycho*, when after being arrested he sits with catatonic stillness in the police station and says to himself that he'll show everyone that he is good by not moving or even hitting a fly.

Example 2. Patient B is a 37-year-old male diagnosed with paranoid schizophrenia and followed at the outpatient clinic. The patient states that he is currently stabilized and was last hospitalized 6 years ago. He reports that he sometimes experiences a change in his perception of lights; for example, he perceives lights in the streets as brighter, and when noticing that he feels scared and has an impression of danger, without being able to tell more about what might happen.

T: This fright that you experience, this impression of danger, do you experience it on other occasions?

P: No, not at all, it is just that I am scared.

T: How do you react when this happens?

P: Well, I have a tendency to isolate myself when it is like this.

T: How do you do that?

P: I go isolate myself in my room, I lay in bed and sometimes I listen to music.

T: What music do you listen to?

P: Always the same pop music.

T: Does this help?

P: I just don't think and listen to music.

T: How long does it last?

P: I don't know.

T: Are you kind of trapped in such a state or can you get out of it?

P: Well, I am kind of trapped, it happened to me recently. What was your question about? Oh yes, the duration, I don't know, at a certain point, I fall asleep [autistic withdrawal].

The interviewer asks the patient to describe a difficult experience, a state in which he feels scared and perceives some kind of danger. The patient describes his reaction to such feelings: when they occur, he reacts by cutting himself off both from internal ("does not think any more") and from external reality ("isolate himself") to deal with the mental distress induced by the stressor (perceiving brighter lights). By doing so, he wards off difficult sensory stimuli (which in the present case are replaced by listening to music), and he avoids interacting with others. We identify this mechanism as autistic withdrawal.

Autistic withdrawal refers to losing a sense of continuity of what is experienced. This disconnection can be either active, as in the present case (the subject momentarily cuts himself off from his environment), or passive (the subject gets the impression that everything is drifting away from him). In the present case, this defense as described in the P-DMRS is mainly to be distinguished from two DMRS defenses: dissociation and autistic fantasy.

The subject using dissociation may display an altered state of consciousness such as being mute or appearing indifferent (e.g., hypnotic state, amnesic fugue). Apart from the fact that dissociation (as defined in the DMRS) usually occurs in a traumatic situation, the major difference between the two mechanisms is that in contrast to what happens in autistic withdrawal, in dissociation the subject can interact with others even if it is in an unusual and modified way.

In autistic fantasy, the subject avoids conflicts by escaping into a fantasy world as a substitute for active problem solving. The main difference is the absence of a scenario in autistic withdrawal as compared to autistic fantasy; in autistic fantasy, a fanciful scenario allows the subject to be temporarily satisfied. The subject using autistic withdrawal, by contrast, loses contact with reality and remains unable to interact normally with the environment.

Distortion

In distortion, the subject deals with internal or external stressors by grossly altering or reshaping internal or external reality. The object is distorted in something the subject can react to. This

defense modifies the representation of the reality. Distortion can occur in three different ways: elational and manic, depressive, or structured (a new structured reality with a narrative coherence). The subject using distortion tends to act in accordance with the new reality he or she has created.

Example 3. Patient C is a 44-year-old female diagnosed with mixed schizoaffective disorder and followed at the outpatient clinic. Previously in the interview, we learn that the patient is married. She reports that her husband sometimes speaks to her badly, insults her. She is afraid that he might cheat on her with a common female friend and that he might leave her. He sometimes comes back home very late at night after work, with no explanation. She waits for him and serves him as soon as he is back (takes care of his clothes, prepares him a meal). The selection below takes place after she talks about the first time she was hospitalized, which was just before she met her husband.

P: Everything was very confused then. I did not know how to deal with that.

T: So, you had the impression that you were not able to go through that state of confusion?

P: So I found this role: housewife, teacher, sportswoman, and, well, bride of a husband. I have my husband. I have to take care of him. And I want to do it right according to my faith. He does not believe in God, and I want to save him. I will be the one who will save him.

T: What do you mean by saving him?

P: Well, I mean, by sacrificing myself, he will be saved! I do everything I can to help him, and I think that somewhere, I have a divine mission to accomplish. I give myself to him, my body and my soul, so that I will save him [distortion].

The patient is remembering being hospitalized and in a state of confusion. The interviewer is questioning how she felt at that time. Rather than remembering how things were then (which triggers anxiety), the patient jumps to the fact that she has found a divine mission to accomplish after that hospitalization: sacrificing herself for her husband who does not believe in God (but who we know is mistreating her and might leave her). By doing so, she grossly alters both internal reality (painful affects about what she experienced when hospitalized and about her current marital relationship, and fears are denied) and external reality (she behaves according to a distorted perception of the reality in which her husband is a lost soul and she is a savior).

The present distortion occurs in an elational way, which transforms a threatening perception into a more bearable reality. Such a mechanism reestablishes the representations that have been brought into question by the stressors and transforms the reality into something the patient can react to. With respect to the alteration of reality, distortion goes further than narcissistic defenses. Elational distortion may serve the same function as omnipotence in protecting the subject's self-esteem, but it alters and reshapes external reality to the extent that the subject becomes clearly delusional. External reality is treated as being part of the self.

Delusional Projection

In delusional projection, the subject deals with internal or external stressors by attributing his or her own needs and attitudes to an internal or external object (individuals, partial objects). The individual can treat an element of his or her internal psychic life as part of the external reality.

Example 4. Patient D is a 50-year-old male diagnosed with bipolar disorder and followed at the outpatient clinic. The selection below takes place at the beginning of the interview. The patient is describing his living conditions.

P: I do not own much. I only receive a 2,000 francs monthly pension from the insurance. I am sorry but I live very well with this [minor denial]. People pushed me to ask the insurance for more money. But if no one tries to influence me or to push me to buy bad things, the money I receive is enough to live with. But I have been pushed to ask for more money [projection].

T: How is it that some people tried to push you asking for more?

P: The drug market, sir, the drug market that tries to make its way because there will be elections in June and they are frightened.

T: I do not really understand.

P: Well, heroine goes that far. I do not dare to vote because I am scared of being stabbed in the back if I vote against cannabis smoking [psychotic projection].

The patient is reporting a precarious financial situation, denying the fact that his pension is not enough money to live on. He attributes his own needs (receiving enough money) and his own potential attitude (asking for more money) to an external object (some people). This defense is a projection. When the interviewer questions this statement by confronting this projection, the patient gets delusional. This “paranoid” delusional projection is strongly associated with an object (“the drug people”) and structured in a scenario (linked to a voting that is indeed going to take place some weeks ahead and the risk for the patient of being stabbed in the back).

Undesirable drives are treated as parts of the external reality with which he is no longer familiar. A psychic event takes the place of the reality. Whereas in minor projection, the subject attributes his or her own feelings, affects, or thoughts to others without being anxious; delusional projection leads to delusional construction and does not allow the subject to deal effectively with anxiety.

Fragmentation

In fragmentation, representations of self and others as well as the link between them are fragmented. Fragmentation involves multiple and total splitting: an active and strong splitting (keeping apart) of different aspects of experience. This defense can be considered an active disorganization, which leads to a disorganized and confused narrative.

Example 5. Patient E is a 43-year-old male diagnosed with paranoid schizophrenia and followed at the outpatient clinic. The selection below takes place 10 minutes after the interview begins. The interviewer is questioning a stressful episode that the patient just mentioned. He was at his girlfriend's home, in her bedroom with her, when his girlfriend's mother entered the room. At that moment, he experienced the urge to tell the mother that she was a whore.

T: So you were there with your girlfriend, her mother came and this word came into your mind?

P: Appeared, rebounded in my head. I did not want to call her a whore! It can come out any when, when we make love, for instance, you see, we hear such words.

T: Was it your own voice inside of you that you heard, or do you have the impression that it was someone else's voice?

P: It's my little devil, it's my little devil Roger, who comes and who tempts me! [concretization] This is called temptation! I should have begun by saying that I am a believer. There is this sentence that we learn at school. I don't know if you remember it. The sentence is “the sleeper has to wake up.” This sentence made me aware of the fact that there are two spheres in me: the negative one and the positive one. I have to know when I want to be negative and I have to know when I want to be positive. When I'm negative it's when I'm driving my car and there's a fool who doesn't use his flasher, who turns without respecting the rules! There are rules! One has to respect them. I get nervous. I get angry. It's my negative side.

T: Is it the same negative side that brought this word?

P: Here it's voluntary. Here it's me. I have this hot-tempered side—playing chess against my computer gets on my nerves! He beats me because it's strategic. You have to try to checkmate it, but it does things and I try to understand.

T: And what happens when you get nervous?

P: Well I cuss! I cuss! I have had many games I played with, electronic games, but I was cussing! I was hearing myself cussing and it was coming out! There was nobody around me though [fragmentation].

The patient tells about a stressful situation: We can infer that his girlfriend's mother interrupting their intimacy triggered uneasy affects to deal with. The first defense we identify is

concretization (discussed later in example 6), which in this specific example happens with both the word “whore” and the phrase “little devil Roger.” A mental representation (being ill at ease and angry at his girlfriend’s mother when she entered the room) is transformed into a concrete object (the word “whore” concretely appeared and rebounded in his head and he experienced the urge to speak the word so that it got out of his head). The patient cannot acknowledge that this word was originating from himself, but attributes it to a concrete character, his little devil Roger, who tempts him. Talking about this might in turn trigger more anxiety for the patient.

We notice that from then on his narrative becomes confused—it is first about the sentence at school, then about the negative and the positive sides, and then about chess play. A common theme in this narrative is about not being in control of the situation, a theme clearly linked to the initial episode of the mother entering the room and the patient not being able to control the situation. Fragmentation may be suspected when the narrative is desultory and confused. In the DMRS, splitting is about two opposite sides, whereas fragmentation comprises countless pieces that cannot be easily linked together.

Concretization

In concretization, the subject deals with internal or external stressors by transforming a mental representation into a concrete object, situation, or action. The concrete form is not a random choice but is symbolically related to its abstract representation.

Example 6. Patient F is a 48-year-old male diagnosed with paranoid schizophrenia and followed at the outpatient clinic. The patient is unemployed and tells the interviewer about his leisure activities. He likes to be occupied to prevent himself from thinking too much. He goes to movies, listens to music, and is interested in sporting events. He mentions that he has stopped reading the newspapers because he has the impression that everything is going wrong in the world and it makes him feel oppressed. The interviewer further asks about this feeling of oppression.

T: So, you are telling me that you don’t read the newspapers anymore because you then feel oppressed. Can you tell me more about this feeling?

P: Well . . .

T: How does it appear?

P: Well, there are scary things happening in the world. I am nonviolent. I respect everyone. I do not agree with what is happening sometimes. I have a car, I have a driving license but I don’t drive any more because it is pricy, and also because I am too frightened of being flashed.

T: Why so?

P: Because my spirit would then be prisoner in a box, and in possession of the police.

T: So if you were to drive too quickly or to jump a red light, there would be a flashgun and a picture would be taken. What would happen with this picture?

P: Well, I think that it would be a catch. My spirit would be caught and then it would never be quiet at night any more because it would then belong to a police-related repressive authority. I think that everyone should be allowed to drive full speed. Speed limits are excuses for the police to take pictures.

T: And with respect to the fact, as you mentioned, that your spirit would be caught, what do you mean by this—would a part of yourself be stolen from you when the picture is taken and that part wouldn’t belong to you any more, or would you remain preoccupied by the fact that the police have a picture of your car while you were driving it?

P: Well, I rather think that it is the first alternative. I am a prisoner somewhere and I have been stopped in my move. My spirit is caught. It is what usually happens with photography [concretization].

T: Are there other occasions on which people take pictures of you? Like with your family if there is a celebration or on holidays?

P: Well, yes, it can happen, but it does not have the same effect on me. For anniversaries or with my family, I trust people.

The interviewer is exploring the patient's feeling of oppression. The patient does not directly answer the question, but transforms a mental representation (feeling oppressed) into a concrete situation (being caught and prisoner in a box). As we can see in this example, the concrete form is not a random choice but rather symbolically related to its abstract representation. Concretization can lead to seemingly surprising behaviors or statements—in the present situation, not driving a car anymore, which does not appear as socially odd and can be easily rationalized, as done first by the patient, “it is too pricy”).

Concretization can occur in different ways: a word or a representation becomes a thing (see example 5) or an external object is thought to contain a part of the subject—in the present example, note what occurs with the flashgun. In this example, the fact that the patient does not react the same way, but changes depending on who takes the picture, reinforces the likelihood of the presence of a defense mechanism. As is often the case with concretization, some aspects are projected and distorted (police-related repressive authority limits cars' speed on purpose to take pictures and put people or their spirits into boxes). However, it is not possible to rate every aspect of the defensive move, and only concretization as the main defense mechanism is rated in this example.

Active concretization is conceptually similar to psychotic denial in that the symbolic aspect of an idea, representation, or affect is denied and transformed into a concrete object, action, or situation. In contrast with psychotic denial, which negates the perceptions of external stimuli, concretization not only uses denial but also involves the transformation of internal mental representations into concrete ones.

Implications for Clinical Practices and Summary

Psychotic defenses can be identified in dynamic interview transcripts, and it is possible to score discrete defensive episodes. Psychotic defenses are present along with other defensive levels, leading to various defensive profiles and a wide range of ODF scores. Using the P-DMRS together with the DMRS allows for a more accurate description and a more valid evaluation of defensive functioning. Furthermore, identifying psychotic defenses makes it possible to connect clinicians' observations to patients' experiences, thus partly restoring a human intelligibility to the psychotic experience. In everyday practice, defense evaluation can be achieved by paying attention to the patients' defensive profile (qualitative estimation), whereas defensive functioning scores are used in research.

Psychopathological features can be observed from different angles. Over the last decade, there has been a growing interest in better describing and assessing patients' subjective experience. Measuring “basic symptoms” or “anomalies of self-experience” allows the capture of different aspects of subtle subjectively experienced subclinical disturbances (Parnas et al., 2005; Schultze-Lutter, 2009). Research on the interrelation between subjective experience measures and psychotic defenses would be clinically useful.

From another perspective, Lysaker et al. (2011) developed a rating scale focusing on metacognitive capacities that emerge spontaneously within narratives. This concept refers to knowledge about how subjects make sense of their own internal experiences and those of others. As both defensive functioning and metacognition are related to the ability to integrate emotions and are based on the study of patients' narratives, it would be of interest to study the association between defenses and metacognition.

Clinicians may well benefit from assessing the possibility of psychotic defenses while listening to patients. As seen in the above examples, the use of psychotic defenses has an effect on the shape of patients' narratives and patient-therapist interactions. This in turn has an effect on how clinicians perceive their patients, themselves, and the relationship during sessions. For example, when psychotic denial is not recognized, therapists tend to misunderstand patients and become perplexed.

Fragmentation makes it even more difficult to make sense of what is said, and causes confusion and helplessness in not only the patient but also the therapist. This confusion is minimized if the therapist identifies the presence of this defense and is able to link it to an affect and a related stressor. Carefully listening to what patients say and not assigning ready-to-wear

theoretical meaning to their specific individual experiences is something that needs to be taught and continually implemented.

So, how should psychotic defense mechanisms be addressed in the therapeutic process? The aim of addressing defenses is to help patients make sense of their personal experiences and develop more adaptive responses to emotionally difficult situations. Rosenbaum et al.'s (2012) clinical guidelines for supportive psychodynamic psychotherapy with psychotic patients are certainly useful to consider when working with patients who use psychotic defenses.

These guidelines underscore the importance of helping patients understand their feelings, attitudes, and subjective intentions in real interpersonal relationships and the importance of developing levels of mental functioning that enable them to deal with emotional experiences in a more adaptive way. Such therapeutic work aims at improving patients' ability to integrate affects and restore meaning to inner life. Theorists and researchers working on the phenomenological model of psychotic vulnerability have suggested that psychotherapeutic approaches should include strategies that provide an intersubjective space where patients can evolve a more robust prereflective self-awareness (Nelson, Sass, & Skodlar, 2009).

Whether or not to interpret psychotic defenses is a question that still needs to be studied; our sense is that the decision to do so must be made by conducting a very thorough case evaluation. In supportive psychodynamic psychotherapy with psychotic patients (Rosenbaum, 2012), it is recommended that the therapist adopt a nonpolarizing attitude and acknowledge both the helpful and the destructive aspects of the defense mechanisms in use. Supportive interventions are used, including clarifications, affirmations, responding to questions after having examined their possible meanings, and showing explicit empathy with the patients' painful state of mind. We can hypothesize that psychotic defenses can be interpreted when a secure therapeutic base is established, when the patient's anxiety level is lowered, and when and if the patient can also rely on more adaptive defenses.

More specifically, how can the clinician address psychotic denial? He or she first has to identify the defense and infer the denied affect and the related stressor (function of the defense). When this is clearer, the clinician should not interpret psychotic denial explicitly, which might trigger more anxiety and further confuse the patient. Rather, he or she first has to hold and contain the patient's painful state of mind. The clinician can then provide propositions related to the affect and try to explore them with the patient, and then propose alternatives to deal with the painful affect. This process is not a short one, and the patient's rhythm has to be respected. By doing so, the therapist helps the patient understand what is being experiencing and explores affects and interpersonal relationships in a supportive way. This implies the use of interventions like clarifications and explorations to make what the patient experiences meaningful. Such therapeutic work should allow the patient to get a better emotional and cognitive understanding of him- or herself, that is to say, better insight.

There is a need to tailor the therapist's interventions to the patient's level of functioning. To do so, the therapist must observe the amount and nature of psychotic defenses, as well as other defenses at play. It is important to understand the patient's difficulties in dealing with emotional experience and not to reinforce confusion and negative emotionality. As shown in the above examples, proportions of each defensive category vary between patients. As some defenses are adaptive and others not, by taking all defenses into account, the clinician will be more aware of both the patient's difficulties and resources.

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