Chapter

The Role of Psychodynamics on Quality-of-Life Interventions

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Abstract

This chapter aims to demonstrate that psychodynamics can contribute to intervention programs in quality of life. The authors conducted a study in Brazil (already published) showing a proportional relationship between psychodynamics and quality of life. This study has also shown that quality of life is unrelated to monthly income, workplace, or working hours. But it is related to the psychological maturity of the individuals, evaluated by their psychodynamics. The greater the psychological maturity is, the better the quality of life, and vice versa. This chapter presents the concept of psychodynamics, psychological maturity, and how it relates to the quality of life. It also offers original psychodynamic guidelines to improve the psychological development of human beings and, consequently, their quality of life.

Keywords: psychodynamics, quality of life, interventions, ego defense mechanisms, object attachment, psychological maturity

1. Introduction

Psychodynamics is a branch of Psychoanalysis that studies the activity of psychological processes underlying human behavior. It also analyzes the relationship between two opposing psychological forces involved in the psychological conflict.

Psychodynamics brings the concept of psychological maturity. In this way, an individual's psychodynamics interferes with how he sees the world and, therefore, can influence his assessment of his quality of life. So, quality-of-life interventions can consider resources that improve the psychological development of human beings and, consequently, their quality of life.

2. Quality of life

Lyndon Johnson first used the expression quality of life (QoL) in 1964, when he was the president of the United States of America (U.S.A.). He declared: "to evaluate the objectives of a government, the quality of life of the people is better than the balance sheet of the banks" [1]. The originality of this expression was so great that it started to be used in the U.S.A. and soon afterward in Europe in the field of Economics and Sociology when the idea was to study the notion of social welfare in a better way since the economic indicators proved to be insufficient for this purpose.

Although the use of this expression can be considered recent in the history of humanity, some studies claim that the underlying concept is as old as human civilization itself. The idea of life with quality has existed in philosophical references since ancient times.

In Aristotelian thought, for example, the concept of a good life is associated with feeling fulfilled and complete through the practice of virtues. Modern authors see in the course of virtues the roots of the notion of citizenship that we have today [2].

The notion of quality of life (QoL) began to gain meaning in medicine from 1970 onwards, with the observation of an increase in people's life expectancy. If, on one hand, the medical progress has been significant enough to prolong life; on the other hand, it is necessary to ask under what conditions this prolongation takes place. In other words, it is not enough to add years to life but also to add life to years. Therefore, the concept of QoL began to be studied and evaluated [3].

The introduction of the concept of QoL in the health field found other existing constructs. An eminently biological view, such as health status, can support some of these constructs. Others are social and psychological, such as well-being, satisfaction, and happiness. A third group is of economic origin and based on the theory of preference: it presumes the individual's choice when comparing a given health status with another.

QoL presents intersections with several of these concepts. Still, its specificity lies in that it includes other aspects of life and health, such as environment, social relationships, spirituality, and level of independence in everyday life [4].

It is a comprehensive and complex concept since QoL includes health, well-being, self-esteem, and a sense of personal accomplishment from a subjective point of view. From an objective point of view, it has lifestyles, socioeconomic conditions, political aspects, and ideology.

Thus, one can study QoL in healthy populations, where health is just one of the items evaluated. Economic factors or working conditions, rather than lack of fitness, can affect QoL in such people.

Therefore, a first classification of the concept arises:

1. Health-related quality of life, and

2. Non-health-related quality of life.

The World Health Organization's (WHO) definition of health in 1947 clarifies the importance of "a state of physical, psychological, and social well-being" in addition to the absence of disease. Insofar as health goes beyond the absence of disease, the WHO quality of life concept goes beyond the presence of health. It includes an individual's perception of their position in life and considering their goals, expectations, and concerns [1].

It is worth highlighting three fundamental aspects of the quality of life construct, which are:

a. Subjectivity is the psychic activity considered proper to the subject working through the individual's perception. Objective reality only counts to the extent that the individual perceives it.

b. Multidimensionality is the dimension presented in the quality-of-life concepts, such as physical, psychological, level of independence, social relationships, environment, and personal beliefs.

c. Positive and negative dimensions are necessary to complete the construct. Thus, for a good quality of life, some elements must be present, such as mobility, and others absent, such as pain [4].

2.1 Quality of life assessment

The quality of life assessment is surrounded by controversies, which start by questioning whether it is possible to measure Q.L. to even discussing the value of the statistical analyses performed.

Randall and Downie summarize their criticism of attempts to measure QoL in five points:

1. Since there is no consensus about the concept of QoL, one cannot be sure what is measured. When someone says they are satisfied with their life, we don't know which aspects they are referring to;

2. In ordinal scales, often obtained from questionnaires, it is difficult to identify distinct points on a continuum of experiences and meanings;

3. Ordinal scales, frequently used in QoL assessment, are not helpful for statistical analysis except to reveal the average score. Nevertheless, they give credibility to the publications because only statistical knowledge allows the generalization of conclusions. On the other hand, statistically valid interval scales have not yet found their place in QoL assessments;

4. The act of thinking and reflecting on the questions presented in the QoL questionnaires can interfere with the research result, whether through an interviewer or not. That is, the measurement instrument itself can distort its results;

5. The results of QoL assessments will always be specific to a given population, making it difficult to compare different studies even with the same measurement instrument.

These authors conclude that research on QoL is qualitative and cannot be satisfactorily quantified. Likewise, its results cannot be generalized as in quantitative analysis. They recommend that researchers reflect on why they want to quantify QoL [5].

The World Health Organization, realizing the topic's growing importance in several countries and aware of the methodological difficulties described above, developed the WHOQOL Group (World Health Organization quality of life) in the late 1990s within its Division of Mental Health.

The primary mission of this group was to characterize the concept of QoL and build an instrument for its assessment from a cross-cultural perspective, that is, through an international multicenter study conducted in 15 countries simultaneously.

The WHO introduced the WHOQOL-100, a questionnaire for assessing the quality of life, in 1998.

The increasing use of this questionnaire began to show its advantages and limitations. If, on the one hand, its psychometric properties prove robust, in part due to the number of constant items; on the other hand, it shows limitations due to its extension.

The interest in using QoL measures in population-based and epidemiological studies has prompted the WHO to develop an abbreviated version of that instrument.

WHOQOL-BREF has 26 questions and presents a very satisfactory index in the confirmatory analysis of its structure [1]. It assesses the quality of life across four domains: physical health, psychological health, social relationships, and environmental health.

3. Psychodynamics

3.1 History

Sigmund Freud introduced the term "psychodynamics" in 1915. When he systematized his knowledge about the human psyche into three points of view: the economic, the topical, and the dynamic, he called this theoretical conception psychoanalytic metapsychology because he considered it as broad and deep as metaphysics [6].

The dynamic point of view refers to the activity or movements of psychic processes, particularly the confrontation of two psychic forces. From these stems the concept of "psychic conflict" underlying most mental functioning.

Goldsmith and Mandell state that philosophers already used the term "dynamic" in a psychological sense long before psychology. They give, as an example, Epicurus, who, by valuing the health of the body and the peace of the spirit, distinguished, alongside his disciples, dynamic pleasure (achieved with effort and suffering) from static pleasure (coming from the state of equilibrium).

These authors also state that during Freud's medical training, there were significant advances in physiology, which borrowed the term "dynamic" from physics. Thus, Freud used the notion of opposing forces in his first models of the mind, which explained the dynamics of psychic conflict.

Still, according to these authors, it was thanks to the significant advance of Dynamic Psychiatry in the U.S.A. that the term "dynamic" gained notoriety, even within modern psychiatry [7].

3.2 Concept

In 2006, Ivey published a paper dealing with the nature of psychodynamics. Early on, he writes that a psychological formulation is a hypothetical explanation of the factors contributing to the precipitation, development, and maintenance of the patient's problems. This formulation should focus on the nature, origin, and meaning of the difficulties presented by the person.

He describes the psychodynamic formulation as one based on the theoretical assumptions of psychoanalysis about the functioning of personality. From this perspective, personality is a dynamic system characterized by inevitable psychological conflict between opposing mental forces and unconscious defenses used to avoid or lessen the mental discomfort resulting from competition.

For this author, psychodynamics has the following characteristics:

1. The relationship between conscious and unconscious is essential in the understanding of psychopathology, whether in terms of feelings, meanings, representations, or motivations;

2. Sexual and aggressive impulses, feelings, and fantasies, along with attachment and dependency needs, are central motivating forces in human beings;

3. All psychological life involves conflicts between opposing aspects of motivations, feelings, and representations of oneself and others, conflicts that cause anxiety or psychic discomfort;

4. The individual defends himself from this anxiety through unconscious defense mechanisms;

5. All functional symptoms and pathological personality traits are the significant expressions of the psychic conflict and the way of dealing with them;

6. Personality is shaped mainly by the subjective emotional quality of interactions with primary caregivers and siblings in early childhood [8].

When the study of psychodynamics progressed, two essential concepts emerged: "ego defense mechanisms" (E.D.M.) and "object relations" (OR).

This chapter presents the study of these topics separately. Still, it is essential to say that although they are different concepts, they are interconnected (see below the issue of psychodynamics and quality of life).

3.3 Ego defense mechanisms

The expression ego defense mechanism (E.D.M.) refers to the set of defenses of one neurosis and a particular defense. The central idea in both cases is that of protection, which is a mental operation that consists in rejecting any threat to the individual's well-being. The ego seeks to maintain the psyche's constancy. Thus, it can simultaneously be the instance in play in these operations and its agent [6].

The concept of defense mechanisms has come to the present day somewhat reformulated.

Psychologists and psychiatrists face difficulties defining ego objectively, partly because our conception of mental health is based more on theoretical constructs than operationally defined behaviors. Consequently, problems arise in quantifying it [9].

On the other hand, the same author states that the concept of E.D.M. remains one of the most remarkable theoretical contributions of psychoanalysis to medicine as it describes a "mental process" used in resolving internal conflicts. This process usually occurs unconsciously and can be identified in the clinic of both standard and pathological psychic situations [10].

From realizing that there are defenses in the psyche, they began to study them in more detail. Here is the concept of ego defense mechanism. The human mind pushes unpleasant ideas away from consciousness to maintain psychic equilibrium. The nature of the various defense mechanisms guides their classification.

Today, one of the most accepted criteria for classifying defense mechanisms is the individual's psychological maturity. Thus, there are three classes of defense mechanisms: mature defenses, neurotic defenses, and immature defenses, according to Freud [6].

George Vaillant proposes a theoretical hierarchy for the various E.D.M. The organizing concept of this hierarchy is that of psychic evolution. That is, the human psyche develops parallel to physical growth. In other words, the mind of a newborn is naturally immature, uses immature defenses, and will gradually evolve to maturity when it uses mature mechanisms.

To carry out this hierarchy of defenses, Vaillant considers the mechanisms as they manifest themselves in the lifestyle, that is, in the individual's external behavior. He

left out the intrapsychic manifestations of these mechanisms. Because besides being fleeting, they are imperceptible externally, which makes it impossible to evaluate them in an objective investigation.

This author carried out a prospective study for 25 years with a group of men selected from a sample of 268 university students. The original selection criterion was to be healthy, physically and psychologically.

General practitioners, psychiatrists, psychologists, and anthropologists assessed the level of health and then came up with a group of 30 subjects.

The author himself conducted a two-hour individual interview with each of the 30 participants in the group. Since graduation from the university, this group has been evaluated, on average, every two years, using extensive questionnaires with many open autobiographical questions and periodic interviews to characterize the defense profile of each member.

From the material accumulated about each participant over the 25 years, the author mapped each one's defense style and classified them as "mature," "neurotic," and "immature."

In parallel, an independent evaluator assessed the degree of adaptation of the participants in the following areas of life: work, marriage, and health.

He performed this task based on the same material produced over 25 years and rated the individuals' adaptation as "great," "good," and "fair."

At the end of the research, each participant ranked regarding defenses and adaptation to life.

By cross-referencing these data, the author concluded that individuals with mature defenses had optimal adaptation to life, while individuals with immature defenses had regular adaptation to life.

The hierarchy proposed by Vaillant is, in fact, the same as that of other authors. The big difference lies in this "clinical assessment," that is, in searching for objective evidence of the results, carried out by crossing data from the hierarchy of defenses and adaptation to life [10].

Recently, he proposed to classify ego defense mechanisms into four groups after studying primitive states of mind in psychotic patients.

1. Narcissistic-psychotic defenses

These defenses usually occur as part of a psychotic process but can also happen in young children's and adults' dreams or fantasies. They share the common goal of avoiding, denying, or distorting reality.

2. Immature defenses

These mechanisms are pretty standard in preadolescence and adult character disorders. Although socially inappropriate or undesirable, they usually subside as interpersonal relationships improve or as personal maturity increases. Anxieties related to intimacy or its loss subsidize such mechanisms.

3. Neurotic defenses

These defenses are common in apparently normal and healthy individuals, as well as in neurotic disorders. They generally alleviate the disturbing effect and are in

neurotic forms of behavior. Depending on the circumstances, they also appear as an adaptive or socially acceptable aspect.

4. Mature defenses

These mechanisms are healthy and adaptive throughout the life cycle.

They are socially adaptive and valuable in integrating personal needs and motives, social demands, and interpersonal relationships. They may underlie behavior patterns that appear to be admirable and virtuous [11].

In her classic book "The Ego and the Mechanisms of Defense," Anna Freud argues that such mechanisms are how the ego avoids displeasure and anxiety, in addition to controlling impulsive behaviors and affective urgencies.

Thus, for this author, defense mechanisms represent an essential dimension of personality, as they participate in the elaboration of the behavior patterns of each human being [12].

American Psychiatric Association presents the concept of a defense mechanism as an automatic psychological process that protects the individual from anxiety and awareness of internal or external stressors or dangers. Defense mechanisms mediate the individual's reaction to emotional conflicts and external stressors [13].

To conclude this topic, remember that Vaillant states that ego defense mechanisms can change the individual's perception of both internal and external reality [10].

3.3.1 Assessment of the ego defense mechanisms

The concept of ego defense mechanisms has long attracted clinicians and disappointed researchers. With their tendency toward subjective assessments, clinicians find this concept a valuable way to decipher the secrets of mental life. On the other hand, researchers consider the evaluations of defenses unreliable and unacceptably subjective [14].

The task of empirically validating defenses paralyzed experimental psychology for almost a century. After reviewing 250 articles, Moss concluded that evaluating defense mechanisms is inadequate and that, generally, experimental reliability comes from clinical assessments [15].

The methodological difficulties in objectively assessing ego defense mechanisms are in four groups.

3.3.1.1 Defenses are not visible in the behavior

Just as Pluto was not visible in nineteenth-century astronomy, psychological defenses are invisible in the twenty-first century. The behavior of the human being only contains characteristics of E.D.M. and does not present them entirely. Thus, it is necessary to find them from these fragments.

To read defenses evaluator needs to know, as deeply as possible, both the internal and external reality of the patient and himself in the same depth.

Therefore, the clinical evaluation of defenses necessarily involves the subjectivity of the evaluator, which makes such an evaluation unreliable.

Even using a hierarchy of defenses (mature, neurotic, and immature), difficulties arising from the subjectivity of the evaluator remain [10].

3.3.1.2 The defenses are not clinical entities

Psychiatrists and psychologists generally work with reasonably well-defined clinical situations from the study of human behavior, and defenses are not clinical entities cataloged in a diagnostic manual. They are much more a "psychic process" than a clinical entity, which requires a detailed understanding of all the possible unfolding of these processes in the patient's expressed behavior. The small number of qualified evaluators to identify E.D.M. can also be considered a methodological difficulty, in addition to the psychic process, in general, being difficult to measure due to its conceptual complexity [9].

3.3.1.3 Defenses are fleeting phenomena

The appearance of a specific ego defense results from a complex "play of forces" mediated by the ego between the psychic instances (superego and id) and external reality. Since this is a dynamic game, the defenses change instantly, which makes it more challenging to evaluate. In this way, the profile of defenses becomes more important than one in isolation. And therein lies the difficulty because direct observation in a diagnostic interview, for example, only flashes of the defenses are identified, thus making long-term tracking necessary [9].

3.3.1.4 The evaluation is uncomfortable

As the elaborative process of the defenses is predominantly unconscious, it is already possible to assume the level of psychic depth at which it occurs. And nothing is unconscious by chance, but rather, because the individual cannot tolerate becoming aware of specific contents that are active in his mind. Thus, addressing these issues will be uncomfortable for the subject, making assessment more difficult, especially in research. The patient expects some therapeutic benefit in a clinical situation and may bear a little more discomfort in the investigation than in the study [9].

Bond et al. developed the "defense style questionnaire" (DSQ), considering the above methodological difficulties. It is a self-reporting questionnaire with 67 items to assess the conscious derivatives of defense mechanisms. This instrument aims to identify the characteristic style of defenses from the way people consciously or unconsciously deal with psychic conflict. Precise comments that the person can make about their behavior can indicate the defense's profile [16].

Andrews et al. reorganized the instrument into 40 items related to the 20 defenses described in the DSM-III-R. Two statements will evaluate each defense. Thus, the DSQ-40 emerged, which assesses and classifies defenses into three groups: mature, neurotic, and immature [17].

3.4 Object relations

By object relations, one should understand how a person relates to his world, that is, how he seeks to satisfy his interests by connecting to other people. One can think that a human being seeks in the other what they lack; in this sense, the other is the object of the former's satisfaction.

One should also consider that the object can be real or imaginary, depending on the individual's ability to have contact with reality or how much he dives into his fantasies [6].

Thus, the object relation that a baby establishes with its mother when demanding the immediate satisfaction of its hunger differs from the object relation that another baby sets with its mother when supporting a few moments for its need to be satisfied. In the first case, one can perceive the urgency for satisfaction, and in the second, tolerance in the face of dissatisfaction.

However, it is worth pointing out that throughout the history of the theory of object relations, this concept has received marked specifications from several authors.

In 1915, Freud introduced the concept of drive that moves the human being.

The drive has the following characteristics: source, force, purpose, and object. The strength varies from one situation to another, depending on the individual's needs. As a rule, the source is organic and located in the erogenous zones.

The purpose of the drive is always to seek satisfaction, no matter the means. The object is everything that can provide this satisfaction. It can be a complete person or part of it or a remarkable characteristic.

It is important to emphasize that, within this model, the object relation consists of a constant search for the satisfaction of the subject's needs. And the most expected quality of the object is that it is "satisfactory." Otherwise, it must be replaced by another [6].

In 1917, in a further theoretical study of the theme, Freud described the process of internalizing the lost object when studying the dynamics of mourning. He states that the resolution of grief occurs when the person internalizes the qualities he admired in the person who died.

In other words, he recognizes that during coexistence, one person "feeds" on the qualities of the other. In this way, the grieving person can separate from the one who passed away and, simultaneously, stays with them inside them as an internal object. In this case, the subject-object relation is an entirely intrapsychic relationship [6].

Melanie Klein observed environmental features within the infant's mind from her clinical work with children.

She noticed, for example, that children relate to their toys by imitating how their parents (or adults in general) relate to them. From there, she theoretically developed the notion of the introjection of objects, which made it possible to classify them as internal and external. Internal ones make up the raw material of fantasy. The internalization process clarifies the mechanism by which the environment influences the individual.

The fact that Melanie Klein valued the intrinsic qualities of the object in the constitution of the infantile mind is considered, by several authors, as a theoretical advance concerning Freud, for whom the emphasis was on the drive. The subject-object relation in the Freudian view was on the subject, specifically on the satisfaction of his needs, and the object would enter only as a compliment.

In the Kleinian view, the subject-object relation is on the relationship itself. The subject's needs are as important as the object's. In other words, for Melanie Klein, object relation is a proper interaction between the subject's characteristics and the object's [18].

Since "object relations" designate the subject's mode of relating to their world, one might ask: how does the pattern of object relations interfere with that person's quality of life?

3.4.1 Assessment of object relations

Attempts to empirically study object relations date back many years, but interest in formal assessment has not yet approached clinical application.

However, in recent years, several researchers developed scales that intend to assess OR, having as one of the objectives to assist in evaluating the results of psychotherapies [19].

Kernberg, when dealing with the difficulties of elaborating these scales, states that the current controversies regarding the definition of the construct on object relations can be summarized in the following terms: The concept of OR is not sufficient to conform to psychoanalytic principles, such as the notion of conflict, defense, or transference. The idea lacks specificity, indicating the need for an object relations theory [20].

On the other hand, British school theorists, notably Melanie Klein, define OR as unconscious fantasy [21]. Although the work of this group is influential in terms of clinical guidelines, it does not stand up to scientific criticism because one canot validate its assumptions [22].

This author states that this dilemma becomes even more evident when one intends to research in OR.

This difficulty is because the analysis of the OR variables shows a vast disparity between them. For example, hostility is a relatively quantifiable and consistent variable within most theories. At the same time, mutuality is so abstract that it cannot be measured or imagined within a theoretical framework.

Although the methodology for evaluating object relations is still in its early stages, several strategies for measuring these relations exist.

The same author describes twelve OR assessment scales in detail, each with its theoretical construct and quantifiable variables. Although all the constructs are psychoanalytic, it is curious to observe how each author chooses a particular approach. For example, Blatt et al. [22] use the concept of ego and developmental psychology to structure the "concept of the object scale," and Diamond et al. use the separation and individuation theory to build the "object relations inventory" [23].

Among the twelve scales mentioned above, one stands out for the multidimensionality of objective relations. This one is the bell object relations and reality test inventory (BORRTI - Form O), a scale that considers the conceptual depth of psychoanalytic ego psychology and advances in test theory and method [19].

This scale originated from the operating model of OR developed by Bellak et al. [24]. These psychologists described the multidimensionality of OR along a continuum. From pathologically absent relationships to good relationships that are relatively distortion-free and rewarding from the point of view of ego needs. BORRTI - Form O is a scale covering the entire spectrum of object relations functioning. So, it can evaluate OR as defined by these authors.

3.5 Psychological maturity

Psychological maturity can be defined as the ability to love and work; self-control and self-acceptance contribute to this. It can also be defined as the ability to interact with a wide range of people and be socially appropriate without being supervised; increasing levels of role performance make this possible.

On the other hand, psychological maturity should be defined from both the observers' and the actor's perspectives. From the observer's perspective, maturity concerns having a good reputation, which involves being liked and respected [25]. From the actor's perspective, maturity involves (a) self-acceptance, which we interpret as not being guilty, anxious, and moody, and (b) being attentive and responsive to others' needs, expectations, and feelings.

More specifically, psychological maturity can also be defined as the individual's ability to use mature ego defenses and have normal object relations, in contrast to psychological immaturity (immature ego defenses and pathological object relations).

4. Psychodynamics and quality of life

What kind of relationship is there between Psychodynamics and Quality of Life?

Considering that perceptions and relationships are core elements of the concept of QoL, one might assume that ego defense mechanisms and object relations are associated with a person's quality of life. Vaillant [10] states that ego defense mechanisms can change an individual's perception of both internal and external realities, which can compromise QoL, which, according to the WHO, is the individual's perception of their position in life [1]. Similarly, Bell points out that the standard profile of object relations (an indicator of psychological maturity) reveals the ability to sustain healthy relationships. At the same time, the pathological one indicates a failure of this capacity [26].

Both psychodynamic concepts (E.D.M. and OR) are interconnected, although they are different.

E.D.Ms are characterized by trying to avoid (or reduce) the psychic discomfort caused by anxiety, while OR are how the subject relates to their world.

Defense mechanisms mediate the individual's reaction to emotional conflicts and external stressors [13]. To American Psychiatric Association, E.D.M. is an automatic psychological process that protects individuals from anxiety and awareness of internal or external stressors or dangers. In other words, E.D.M. mediates how individuals relate to internal and external objects (OR).

Both concepts are indicators of psychological maturity. E.D.Ms range from the most immature (splitting) to the most mature (sublimation) [17], and OR are within a spectrum that begins with pathological relations and ends with normal relations [26].

Since pathological relations occur through immature ego mechanisms (in an adult) and healthy relations occur through mature mechanisms, the parallelism between such concepts becomes apparent, even though one cannot speak of a complete theoretical equivalence between them. Again, both formulations are indicators of psychological maturity.

What is the relation between psychological maturity and quality of life?

Psychological maturity is directly proportional to the quality of life.

A study in Brazil demonstrated this conclusion.

The first hypothesis was a relationship between the physician's QoL and their monthly income, working hours, and workplace. The authors designed a cross-sectional survey to test this hypothesis. They also investigated a relationship between a physician's QoL (Whoqol-bref) and their psychodynamics (DSQ-40 and BORRTI Form O) **Figure 1**.

The authors concluded there were:

1. No significant associations of quality of life scores with working hours, workplace, or monthly income.

2. A positive association between the quality of life scores with mature defense mechanisms and normal object relations.

3. A negative association between the quality of life scores with immature defense mechanisms and pathological object relations [27] **Figures 2** and **3A** and **B**.

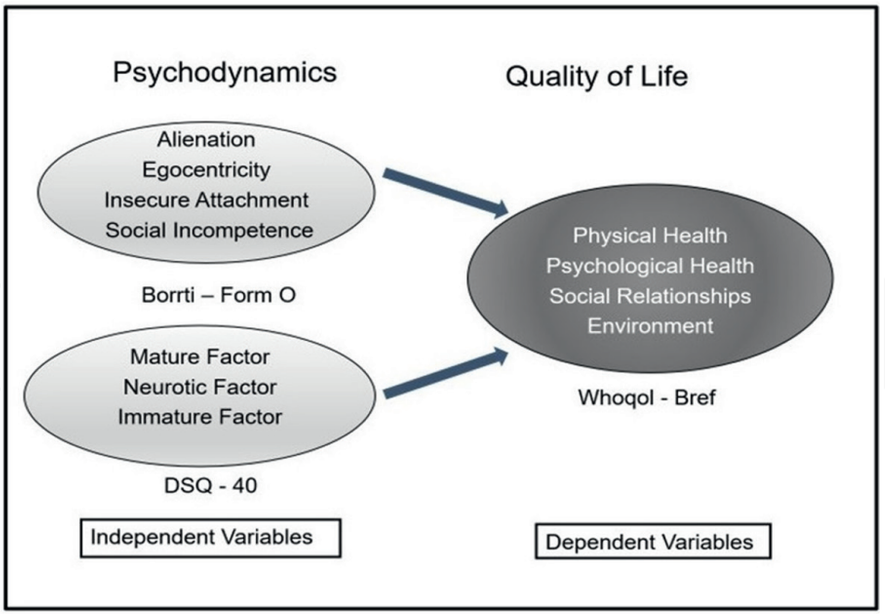

Figure 1.
Diagram representing the relationship between the independent and dependent variables.

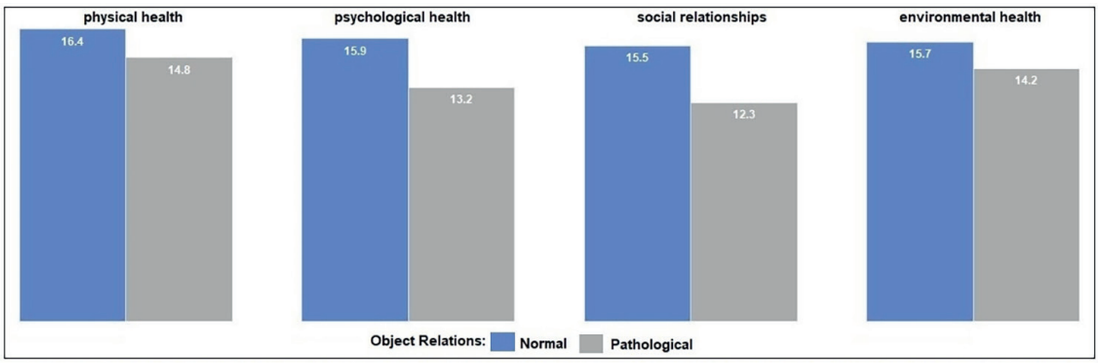

Figure 2.
Comparison of quality of life scores, assessed by the Whoqol-Bref, between participants with normal and pathological object relations profiles.

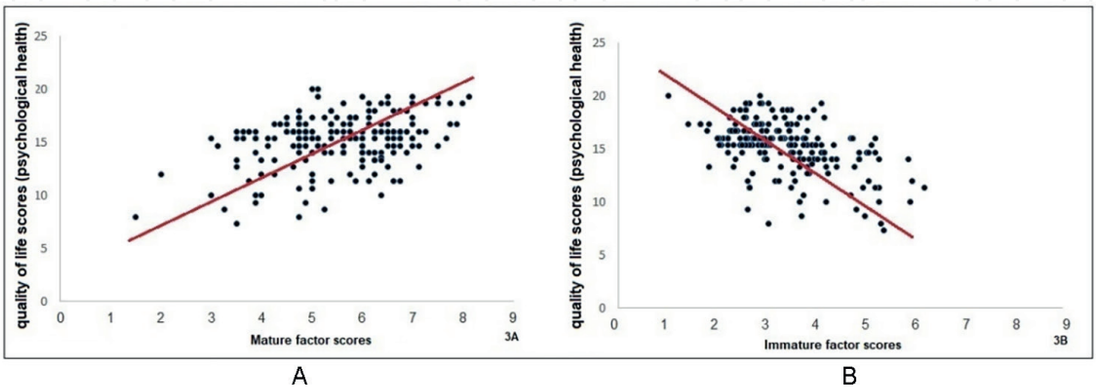

Figure 3.
Relationship between mature factor scores (DSQ-40) and quality of life scores (psychological health) (A) and Relationship between immature factor scores (DSQ-40) and quality of life scores (psychological health) (B).

Another study in Germany demonstrated the same conclusion.

The authors intended to demonstrate long-term psychodynamic psychotherapy's effectiveness in treating children and adolescents with different psychiatric disorders.

They compared two groups of patients (treatment and control) and evaluated the level of symptoms and quality of life before and after treatment.

The authors concluded:

1. Long-term psychodynamic psychotherapy can reduce internalizing symptomatology of children and adolescents with different psychiatric problems under routine care conditions.

2. Long-term psychodynamic psychotherapy can improve a patient's quality of life by solving inner conflicts [28].

It is possible to say that "solving inner conflicts" means changing from pathological object relations to normal ones. Or even to change from immature defense mechanisms to mature ones. Or it is even getting more considerable psychological maturity.

In conclusion, improving the quality of life is related to enhancing the psychodynamics of the patients.

Another study carried out in the U.S.A. showed similar results.

The objective was to explore whether object relations (OR) functioning improves throughout psychodynamic psychotherapy and whether this improvement is related to decreased symptoms.

After psychodynamic therapy, the authors concluded that:

1. The overall functioning of object relations, including interpersonal relationships, significantly improved with a large effect size.

Although this study does not mention the quality of life, it showed that psychodynamic psychotherapy improves the object relations profile.

Since the previous study showed that normal object relations are associated with better quality of life, one might think the same thing occurred with these patients [29].

Another Brazilian study assessed chronic obstructive pulmonary disorder patients' defensive profiles and compared them with healthy participants to test whether specific ego defense mechanisms are associated with health-related quality of life and self-reported dyspnea severity.

The researchers point out two topics:

1. Clinicians and psychiatrists should consider the patients' underlying personality structure, especially somatization tendencies.

2. There is an association between immature ego defenses and lower quality of life [30].

Once again, the relationship between psychological maturity and quality of life is present.

A Canadian study evaluates whether disturbed relatedness accounts for the negative association between narcissistic pathology and quality of life.

The results showed that:

1. Narcissistic personality traits relate to the quality of life through the quality of object relations.

2. Problematic relationship patterns play a crucial role in the low quality of life evident among those high in pathological narcissism [31].

Quality of life is related to the quality of object relations. In other words, quality of life is related to psychological maturity.

A Brazilian naturalistic study evaluated psychodynamic and neurobiological factors in psychoanalytic psychotherapy.

The author studied the relationship between the pattern of object relations, defensive style, and quality of life.

The results demonstrated:

1. An association between mature ego defenses and healthy object relations.

2. An association between pathological object relations and low quality of life [32].

Once again, quality of life is associated with psychological maturity.

5. Psychodynamic Interventions

The quality of life of a human being is related to his psychological maturity, according to the previous pages. So an intervention in a person's QoL could be an intervention to improve their psychological maturity. In other words, quality-of-life intervention can be psychological maturity intervention.

How to improve psychological maturity?

There must be several answers to this question, and the concept of psychodynamics is undoubtedly one of them.

Let us see what each author says about this issue.

5.1 Sigmund Freud

For this author, the relationship between the analyst and his patient is fundamental to promoting psychological development.

This premise can be helpful when thinking about improving a person's quality of life through psychodynamics.

Initially, we need to think of a quality of life manager, a professional that will conduct the intervention on the quality of life of a target person or a group of people.

Let us draw a parallel between the analyst-patient relationship and the relationship of this professional with the target group of his intervention.

For Freud, the analytic relationship occurs within a technical framework in which the patient and the analyst have specific roles.

While the patient freely speaks what comes to mind, the analyst listens, trying to understand what is happening inside the patient.

The framework is the relationship space that allows deep listening by the clinician, relevant sharing by the patient, and therapeutic use of the relationship to foster

psychological healing. In Freudian theories, the frame is essential for discerning and using the unconscious to heal psychological conflicts that cause suffering or symptoms [33].

In the same way, the quality of life manager must know how to listen to his target audience to understand their personal needs. Thus, a quality-of-life intervention must offer conditions to reduce psychological conflict and promote the development of the human being.

5.2 Melanie Klein

This author's contribution focuses on the analyst's ability to contain the patient's emotional oscillations. She described as fundamental to the human experience a change between opposing states. She noted how infants swing between frenzied protestation and comfortable calm.

She also noted that the mother figure holds the extremes of feeling as the infant oscillates between anxiety and bliss. This holding, which allows the expression and metabolism of intense vicissitudes, is critical for finding a manageable way forward.

Here, we have a new model for thinking about the quality-of-life interventions.

The target group expects the quality of life manager to contain their emotional swings the same way a mother holds the extreme feelings of her baby's anxiety and bliss. This holding can allow adjustment and eventual settling into a sound decision [33].

The quality-of-life intervention process can be held and help metabolize feelings allowing them to live with and use those feelings.

The holding process enables the integration of opposing mental states, thus reducing the fear of separation.

The reduction of this fear promotes independence and maturation of the human being.

The quality of life manager should be able to contribute to the integration of opposing emotions, promoting independence and personal growth of the target audience.

5.3 Wilfred Bion

According to this author, feeling that it is normal and acceptable to have these swings, as described above, helps with thinking and talking about new realities.

It entails facilitating ways to think and feel about matters that were likely to be inchoate or suppressed to articulate.

From this point of view, the quality of life manager should be able to consider these swings as usual and hold people to deal with them as acceptable. This tolerance will help them to recognize their human nature which will be crucial for their personal development.

Wilfred Bion postulated psychological processes to describe how a child puts out raw feelings that are emphatically processed by the carer, resulting in nondisruptive understanding that can be verbalized or, in some way, symbolized.

The linkage between feelings and symbolizable (usually verbalized) thoughts is critical and depends on human interaction. This author considered this interaction between the two people essential for psychic existence. The absence of or trouble with this interaction is a devastating psychic loss or lack that can feel worse than tangible loss or death. Bion called the feeling of that failed interaction "nameless dread" [33].

Thinking about one's feelings is fundamental for the individual to know his truth. Thus, the quality of life manager must be able to do this exercise with himself before starting the quality-of-life intervention program.

Only then will he be able to help others identify and name their feelings, which will be essential to make meaning of themselves.

As we saw above, Freud, Klein, and Bion present their theoretical contributions to the psychological development of human beings.

One common element of these three authors is the concept of holding.

Let us now look at Winnicott's point of vision, who was the author who most worked on this concept.

5.4 Donald Winnicott

According to Donald Winnicott, maternal "holding" is both a physical and an emotional act. The good enough mother contains and manages the baby's feelings and impulses by empathizing with him and protecting him from too many jarring experiences. How she carries, feeds, speaks, and responds to her baby expresses her defensive holding and understanding of her needs and experiences.

Winnicott explored the early infant-maternal experience and relationship, drawing attention to the "importance of personal and environmental influences in the development of the individual's" [34].

According to this author, maternal provision protects (the young infant) from physiological insult by taking account of the infant's sensitivity to touch, temperature, sound and light, falling, and lack of knowledge of the existence of anything other than the self.

Using a theory about child-parent relationships is a means of explaining the needs and experiences of adults.

One advantage of using Winnicott's theory for quality-of-life intervention is that its primary concern is the growth and development of the human being.

The child-parent relationship can be an inspiring metaphor for psychological maturation. As a result, it is possible to associate such theoretical ideas with meeting the daily needs of individuals who are candidates for a QoL intervention program.

Some points should be highlighted:

1. Winnicott was a pediatrician before becoming a psychoanalyst.

2. As a pediatrician, he observed the way mothers related to their babies. Some mothers seemed to understand their babies better than others. From this observation, he developed the concept of a "holding environment." In this context, he realized that "the ordinary mother lays the foundations of health in her ordinary loving care of her baby" [35].

3. Winnicott extrapolated the concept of holding from mother to family and the outside world. He saw it as key to healthy development, "the continuation of reliable holding in terms of the ever-widening circle of family and school and social life" [36].

4. Central to the concept of holding is empathy. This point is the ability to put yourself in the other person's shoes.

5. Another critical point is not to judge but to understand why they act the way they do. It is an excellent way to help someone effectively.

6. Environment holding has the function of protecting the child from bodily and emotional discomfort. It is necessary to protect the child so that they can develop.

Let us look at two examples to understand the practical application of this concept with all its elements above:

5.4.1 Depression following an abortion

A social worker receives, in his office, a young woman with depression after an abortion.

She remains silent throughout the session, avoiding looking directly at the professional.

The session's atmosphere is tense as if there is no air for both of them.

The second session similarly takes place, with the young woman exuding anguish.

In the third session, the social worker, in a holding way, said: "I don't know exactly how you are feeling, but I have the impression that starting to talk seems like something frightening for you. But I can wait, in no hurry, for your moment."

The young woman remains silent but sheds a tear in each eye [37].

5.4.2 The mother is suspected of abusing her son

A hospital social worker waits in her office for a mother referred by the emergency physician.

The doctor suspects that the mother physically abuses her two-year-old son.

The doctor tells the social worker that the mother is cold and arrogant.

The social worker feels apprehensive and afraid while waiting for the mother.

When this professional becomes aware of her emotional state, she thinks the mother may be apprehensive and afraid.

Soon after, she returns to her normal state and receives her mother in a natural and welcoming way. In other words, the social worker could hold these disturbing feelings within herself and welcome the mother without judging her [37].

In the first example, the social worker's welcoming attitude offered security for the patient to express her emotion. Although she remained silent, she shed a tear as a sign of interaction with the professional.

In the second example, the social worker was gentle with herself, realizing that she was apprehensive and afraid. She soon realized these feelings were not her own. This awareness allowed her to feel free and open to receiving the patient without judgment.

The quality of life manager is expected to have this kind of sensitivity when approaching his target audience.

6. Recommendations

The objective of this chapter was to present the concept of psychodynamics as a tool for quality-of-life interventions.

However, mastering this concept requires theoretical and practical study, which is beyond the limits of this chapter.

As the original idea was to motivate readers to broaden their horizons, we recommend seeking the supervision of a psychoanalyst.

The International Psychoanalytical Association is a reliable source to guide professionals interested in this topic.

7. Conclusions

Psychodynamics is related to the quality of life through the concept of psychological maturity. Our study revealed that psychologically mature individuals had higher quality of life scores than immature ones. The WHOQOL-bref scores had a positive correlation with mature ego defenses and a negative correlation with pathological object relations, suggesting that psychological maturity is associated with quality of life. This chapter also provided original psychodynamic guidelines (Freud, Klein, Bion, and Winnicott) to improve the psychological maturity of the participants and, consequently, their quality of life. The common ground among these guidelines is the concept of holding, which can promote human development. Thus, quality-of-life interventions can consider the role of psychodynamics in their programs.

Conflict of interest

The authors declare no conflict of interest.

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