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Defenses Can Sabotage the Therapy

By Douglas Berger, M.D., Ph.D.

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Psychotherapy has an interesting paradoxical twist to it in the therapist's attempt to provide help. When one goes to a surgeon, for example, to remove a lump, the patient recognizes they have a lump and agrees to have the surgeon remove it. With a psychological problem, however, patients may recognize that they have some problem, but they often do not see it as a result of their own life strategies (defenses or personality styles), and in trying to protect themselves with these defenses, patients may actually sabotage their own therapy.

Even if they do have some insight into their maladaptive use of defenses, patients often show resistance to changing their life strategies. They would prefer that things go smoother in the world using the same life strategies they have been using up to now. In fact, patients may seek validation on their style from the therapist or even advice on how to make their maladaptive defenses work better. Can you imagine a patient with a lump telling the surgeon to remove the lump but at the same time trying to convince the surgeon why it is better to live with the lump?

This is where the unconscious nature of defenses, and the resistance to changing one's defenses, comes into



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play. Resistance is often unconscious in patients as they may provide many rationalizations on why their maladaptive life strategies are valid. This resistance may occur even in the face of significant psychosocial troubles arising from these defenses as seen from the outside. The work of the therapy needs to overcome these barriers.

These maladaptive life strategies have been used by the patient both in past and present relationships, so it is no surprise that these personality styles will also manifest in the relationship with their therapist. It is the therapist's challenge to find the common thread that runs through the patient's interpersonal style and then guide the patient to use new and more adaptive life strategies. The therapist attempts to remain neutral in attitude and does not disclose personal material to the patient. In this way therapists try to keep their countertransference issues out of the session. Thus, the therapist and patient can begin to create a picture of the patient's personality style without undue influence of the therapist's style. If the patient's insight is poor and/or their defenses are of a certain quality that leads to dissatisfaction in the therapy, the defenses themselves can sabotage the help the patient needs to fix their defenses.

Concrete Examples

The terminator. These patients use the defense of rejecting others to protect themselves from the pain of being rejected first. They may have had some childhood experiences of feeling abandoned. They set up relationships to relive patterns of rejecting others. They find faults with others, often not getting into or terminating intimate relationships early on and complain that they cannot find the right partner. They tend to engage in relationships that clearly have problems from the start, thus planting the seeds for their next termination. They may report conflict and terminations with prior therapists. They often make detailed rationalizations about why their relationships do not go well.

These patients may fault-find with the therapist and complain that the therapist is not caring enough, especially if the therapist does not side with their misery and instead attempts to have them see how their tendency to reject others is actually undermining their own needs. They may request phone calls or e-mails between sessions in order to satisfy their underlying dependency needs; however, this will also lead to complaints that the therapist does not care enough when the therapist begins to put limits on these contacts.

Eventually these patients' rejecting nature will cause them to "fire" the therapist and terminate therapy. Complaints about the therapist may also grate on the



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therapist's own countertransference self-esteem issues, and the therapist may subtly or overtly reject the patient. The therapist may be able to manage these patients by getting them to see their rejecting nature in a neutral fashion, not too early in the therapy, but also not when it is too late.

The president. These patients use the defense of exhibiting greatness to protect themselves from the pain of feeling diminished. They may have had some childhood experiences of ungratified or invalidated strivings from their family or peers. They always need to show strength in everything they do, connect themselves with important people, devalue others and try very hard to be important themselves, e.g., to become the class president or the company president.

These patients can become very aggravated when they are not the center of attention or at the top of their social group, and challenges to their greatness or rejection from partners who are tired of their grandiosity are often the reason they have come for help. They often have a detailed rationalization on why they only need more greatness in order to gain mental stability.

These patients will look for validation of their greatness and seek advice from the therapist on ways to gain more greatness rather than ways to change their life strategies. They may subtly or openly devalue the therapist. If the therapist's countertransference causes them to retaliate the devaluations or if these patients think the therapist is not validating them or when the therapist attempts to guide them to use other life strategies or explores their underlying low self-esteem, these patients may begin to feel diminished and are at risk of terminating the therapy before they have really started to improve the underlying problem.

Sometimes these patients will invest their defense of greatness in becoming a great patient. They will read all about their problem and gain a considerable amount of knowledge of psychology to gain validation from and protect themselves from feeling diminished compared with the therapist. They profess that they have completely eliminated their problem of low self-esteem. It may be possible to enlist these patients' sense of greatness to the therapy's advantage if the therapist can convince them that great people are those that are able to really look at themselves and accept they use greatness as a defense against low self-esteem.

The air traffic controller. These patients use the defense of controlling others to protect themselves from the aggravation of being controlled. They may have had childhood experiences with controlling or authoritarian parents. They tend to try to control others, especially in intimate relations or in the workplace, and have conflict with people in these areas. This is often the main reason they come for therapy.

Patients may get in power struggles about scheduling, cancellation policy or other issues, and begin to argue about the therapist's opinions and complain that the therapist will never see things their way. They need to feel they are right about everything; tend to be argumentative; want the therapist to validate their rationale in arguments they have had with others; will not easily agree to see the types of defenses they use; and eventually terminate the therapy before the therapist can begin to address the process of how to get better. The therapist's countertransference may provoke counter-arguments with these patients.

The therapist may be able to enlist these patients' need to be correct by praising them about how they seem to usually be on the mark and that the challenge now is to see if they can be on the mark about the analysis of their own deficits.

The invisible patient. These patients use the composite defense of obedience and passive defiance to protect themselves from the aggravation of being controlled or belittled. They may have had belittling or authoritarian parents. They seem to be very compliant and cooperative on the surface, but on deeper interaction they are withholding and uncooperative and seem to have a wall around themselves against real intimacy. They tend to not show up for important events, are late for work, do not complete chores they agree to do at work or with significant others, and have conflict with people in these areas; this usually being the reason they have come for therapy.

Patients may often be late for sessions, not show for the sessions and often be in arrears with fees. They set up relationships so that they can relive a pattern of being oppositional to a scolding person in authority (e.g., spouse, boss, therapist). They will often use intellectualization and rationalization to describe their behavior, and while they ostensibly agree with everything the therapist has said, there is no effective change in their life strategy. If the therapist does not terminate the therapy because of either reasonable or oversensitive (countertransference) reactions to these patients because of their invisibility (e.g., poor attendance, late fees), these patients may eventually terminate the therapy using an excuse such as "work or family duties" that are only more displays of passive defiant behavior.

Standard approaches to gain insight may be of help. In some patients, however, the passive defiance may be so ingrained that a paradoxical approach, where the therapist tells the patient that the problem is unfixable and that the therapy should focus on how to live with the defiance, will engage this patient in a defiant stand to fix the problem.

The rubber cement patient. These patients use the

defense of clingy "object hunger" (intense persistence to avoid separation from significant others) in order to protect themselves from the fear of being alone. They may have had some childhood experiences of feeling abandoned or, in reverse, of never practicing being on their own. Some children are also born with intense dependency needs that can develop into a maladaptive style when mixed with a particular upbringing.

These people often get into and/or stay in relationships that are clearly unhealthy from the start, causing conflict that brings them to therapy; or they may present to therapy when their partner proposes a breakup. They may get involved with partners who are inappropriate for them (e.g., violent, alcoholic, promiscuous). It is not necessarily that these patients are "looking for" difficult people, but because most people would avoid entering or continuing in these unhealthy relationships, these potential partners naturally do not realize relationships until they come across a dependent person willing to cross these hurdles and stick with them. The patients also tend to have trouble realizing relationships because the intensity of their neediness pushes people away. They may have a repertoire of rationalizations for their behavior.

These patients will implore the therapist to help them find ways of improving a destructive relationship or try to get the therapist to convince their partner not to break up with them rather than change their maladaptive defensive strategy. They may request phone calls or e-mails from the therapist between sessions to hold on to a connection with the therapist to tide themselves over their pain. They may push for the therapist to give them the answer on how to prevent a breakup.

These patients are mainly interested in having their defense of object hunger work better for them and will terminate the therapy when they sense that the therapist cannot or will not collude with their determination to promote their defense of clingy dependency. The therapist may react by trying to save these patients too much and thus break boundaries by trying to give too much concrete help, or the therapist may devalue these patients because their clingy behavior becomes annoying to the therapist.

Again, the problem itself has sabotaged the treatment of the problem. In addition to giving insight into the nature of their defenses, a potential method of treatment for these patients is to encourage them to tolerate activities they can do without a partner. However, patients still need to use the therapeutic relationship as a transitional object that can help them move out of bad relationships and/or to help them avoid getting into future bad relationships.

Conclusion

While some patients exhibit only one of the major traits exemplified above, some patients may have a mix of the different styles. I have purposely avoided the use of diagnoses here in order to keep the focus on the interpersonal mechanisms involved rather than a label. Everybody has some amount of one style or another, no matter how subtle. The examples above are also not an exhaustive list of potential life strategies. In addition, this paper is mainly a description using personality styles and does not discuss situations complicated by depression or other psychiatric illnesses.

One can see how the problem itself can sometimes sabotage its own treatment. It takes a considerable amount of courage to admit that one's personality style needs changing, so it is natural that one will have resistance to this endeavor. This is the challenge that faces the psychotherapist and the patient in the sessions. Many patients do, of course, get better without sabotaging their therapy.

If the therapist can gain the trust of the patient and effectively explain the way therapy can work and the pitfalls involved, then progress can be made. It is often not easy for the therapist to articulate this process; and if the patient is relatively mature and uses rationalization and other intellectual defenses (as in the examples above) that "hide" the more underlying defense, these patterns can be subtle and not evident to the therapist until it is too late.

Dr. Berger is in private practice and consults with pharmaceutical companies in Tokyo.

Further Reading

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