JEROME S. BLACKMAN

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How the Mind Shields Itself

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Preface

Steve, 26, wanted testosterone shots so he could function sexually with his wife. He had a good reason for the shots; he had undergone surgical removal of his pituitary gland several months earlier[1] and now needed hormone replacement therapy.

I was an intern at the time, on the internal medicine service in the hospital where Steve had been admitted for monitoring and adjustment of his replacement hormones. I didn't know much about psychology or defenses at the time, but one day on rounds, when I had a few moments alone with Steve, I mentioned my interest in his need for the testosterone shots. He explained that testosterone relieved his impotence with his wife. His embarrassment lessened as we talked, and I was able to complete the sexual history by inquiring if his sexual problems included lack of morning erections or inability to masturbate.

At that point, Steve sighed. He looked over at the door to his room, making sure it was shut, and said, "Well, since we're talking about this honestly, there's something I should tell you. The truth is, I only need the shots to have sex with my wife. I have a girlfriend I don't need the shots for."

Steve complained that his wife had never enjoyed sex. She had been a virgin at marriage. Since the birth of their two-year-old son, sex had been relatively infrequent. He said his surgery didn't have much to do with the problem. Although he loved his wife, he could not think of a way of solving the problem, which, he said, she acknowledged was hers. He expressed a fervent desire to be able to enjoy sex with her; she had been a good wife in many other ways—helping him through his illness, for example.

The following day, when I made rounds, Steve's wife was at his bed-side. They apparently had discussed the situation. She expressed a wish to get over her serious sexual inhibition and asked whom she might consult for help. I obtained some referrals for her in the community from the internal medicine resident who was my immediate supervisor.

Years after completing my psychiatric and psychoanalytic training, I was able to formulate about what had occurred in my interactions with Steve. By asking about other areas of sexual difficulty, I had actually "confronted" (chapter 5)

Steve about various defenses he was using, including: *prevarication (lying) (23)*[2] about his impotence; *displacement (19)* of his sexual wishes from his wife to his girlfriend; and *rationalization (42)* and *concretization (52)*—finding an excuse by seeing his sexual problem as having a purely medical origin. In a supportive way (chapter 7), I also had expressed enough interest that Steve trusted me and turned to me with his maladaptive compromise formation (see chapter 1)—*avoiding* his wife and *lying* to her to avoid guilt, *suppressing* his frustration, and *displacing* his sexual wishes elsewhere.

In other words, Steve knew that he was physically capable of sexual performance even without the testosterone shots, as evidenced by his activities with his mistress. However, he had convinced himself that he needed the shots in order to perform with his wife; they were like Dumbo's magic feather (Aberson & Englander, 1941).

Steve's favorable response to my confrontation of his defenses had led him to reveal his conflicts. Rather than take testosterone shots the rest of his life and depend on destructive extramarital contacts for sexual gratification, he and his wife now could face their psychological problems and resolve the conflicts that were interfering with their ability to enjoy sex within the marriage.

Thirty years later, Dr. C asked me, "Would you really say that? It's so aggressive!" He was a U.S. Navy lieutenant finishing his psychology internship at the Naval Medical Center in Portsmouth, VA. I had just explained to his class that when they could see, during evaluation, that someone was *lying* about suicidal intentions in order to get out of the service, they could say to the person something like, "My impression is that you're not being truthful with me" and could add, "And you're trying to manipulate me into going along with you. So you also are not treating me as your therapist; you're basically attempting to use me."

After Dr. C's interjection about how "aggressive" these interventions sounded, I pointed out that *lying (23)* and *devaluation (50)* are *defenses*. If Dr. C confronted the defenses, as I suggested (see chapter 5), perhaps a sailor would admit to using them and then elaborate on the conflicts he had been avoiding. In other words, some of the interns' cases, who secretly carried the sardonic diagnosis of "WOOTEN" (Want Out Of The Navy), might actually be treatable with dynamic psychotherapy, and not be just a pain in the neck. In addition, confrontation of the defenses could help in diagnosis: the psychopathic (antisocial) types would probably per sist in lying, and the grandiose psychotic ones would probably verbally attack Dr. C for daring to question their motives.

In any case, Dr. C could prevent himself from hating his work because he was being used; at least he would not just *passively (62)* sit there, allowing the sailor to *intimidate (83)* him. Dr. C liked my suggestion and reported thereafter that he enjoyed employing confrontation of defenses with some of his WOOTENs, occasionally finding a treatable one. He commented to me that he realized he had

somehow equated being empathic with being passive, so that he had felt some guilt about being direct in his approach to people he evaluated or treated.

The human mind has an amazing capacity to invent mechanisms that shield a person from becoming aware of unpleasant emotions. These mechanisms often are disguised and operate outside of a person's awareness. Because of the stealthy quality of defenses, uncovering them and understanding their potentially detrimental effects can be useful. For example, a person who is unable to recognize anger toward a loved one may feel intense self-loathing instead. When that person shows up in the ER for severe depression, the ability to discuss the defensive operation of *turning on the self (15)* can be extremely helpful in preventing a suicide attempt or other self-destructive conduct (see chapter 8).

Understanding defenses is also valuable in other life situations. Recognizing a teenager's use of *minimization (75)* and *counterphobic behavior (44)* can be helpful to parents trying to steer their child away from dangerous activities. Understanding a *rival's grandiosity (63)* may enable an executive to gain the upper hand in a competitive business situation. Confronting *denial (6)* and *rationalization (42)* is important for family members who are concerned with a loved one's alcoholism. Noticing *identification with the lost object (37)* is helpful when comforting a grieving relative. Last but not least, the detection of *distancing/avoidance (61)* mechanisms in a romantic relationship can clue you in that someone is not inclined toward the fidelity and constancy required for a long and happy marriage.

In clinical situations, mentioning defenses to the wrong kind of person, or at the wrong time, can also be counterproductive. That's if you can even find the defenses, since they are so often unconscious. Intervening in a therapeutic way can be even more daunting.

In this book, I have tried to provide a framework that explains the origination, properties, and causes of defensive activity, and have included a chapter on differential diagnosis that describes who should be treated with interpretive techniques and who should not. There is a section on how to decipher the pathological defenses being used. I have included separate chapters on how to zero in on defenses, and then intervene supportively versus interpretively, depending on which techniques are indicated. And finally, I have included a chapter to demonstrate how to use confrontation of defenses as an adjunct to other techniques used in assessing suicidal propensities.

Acknowledgments

This book is dedicated to the many students, from many disciplines, that I have enjoyed teaching over the past 28 years, who encouraged me to organize my handouts in one place. I hope that others will also find it a user-friendly discussion of defenses, along with some ideas about how defenses can be used in diagnosis and treatment.

As with many important ideas about the mind, Sigmund Freud was the first to mention defenses, in 1894 (!). But his daughter, Anna Freud made the first list, in her pioneering study, *The Ego and the Mechanisms of Defense* (1936), utilizing material from adults and children she treated. I am likewise indebted to Percival Symonds, who authored a voluminous compilation of about 25 defenses: *The Dynamics of Human Adjustment* (1946). From his students at Columbia Teachers College, he gathered mountains of examples and commentaries about defenses.

For their many editorial criticisms and corrections of my manuscript, many thanks go to Cecilio Paniagua, M.D., psychoanalyst in Madrid, Spain; Janet L.Schiff, L.C.S.W., psychoanalyst with the New York Freudian Society; William R.Goldman, Ph.D., Director of Psychology Internship Training at Eastern Virginia Medical School; Steve Brasington, M.D., Chair of Child Psychiatry at Portsmouth Naval Medical Center; Dr. George Zimmar of Brunner-Routledge; my office manager, Jean Broughton; my wife, Susan; and my son, Theodore.