Defense Generated Impasse:
The Patient’s Experience of the Therapist’s Defensiveness

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When therapist's and patient's primary vulnerabilities have been activated and intersect problematically, patient and therapist have become entangled in a relational knot to which both have contributed and from which they cannot extricate themselves. Like a Chinese puzzle, the knot becomes tighter the harder they try to loosen it. They each become dangerous to the other and increasingly defensive. Their perspectives on what is occurring differ and collide. Fearful of losing their perspective, and thus jeopardizing their hold on reality, they cannot tolerate hearing the other's point of view. Anger and anxiety escalate (Elkind, 1995, p. 333).

The Therapist’s Defensiveness: Definition

I am defining defensiveness in this paper as behaviors and/or attitudes which the therapist employs out of a need to protect her sense of self (to self-regulate) at the expense of the patient’s efforts to articulate his reality. These behaviors and attitudes may be expressed verbally or nonverbally, subtly or blatantly, and they may be within or outside of the therapist’s awareness. Some examples of behaviors which the therapist may employ defensively include: interrupting the patient; blaming the patient; shaming the patient (putting the patient in the “hot seat” in order to get herself “off the hook”); refusing to seek consultation; and, in Racker’s (1968) descriptive words, maintaining a “vengeful silence.” Some examples of attitudes which the therapist may employ defensively include: the assumption of being right (and the patient is wrong); hostility; condescension; and pseudo-compliance, as in tailoring one’s interventions in order to preserve harmony - to keep the patient liking the therapist, or at least to keep the patient unprotesting.

The first half of this definition of defensiveness speaks of the therapist’s experience of the need to protect her sense of self (self-regulate). Every person is self-regulating virtually all the time, and therapists, being persons, do so as well, even (and maybe especially) in relation to their patients (I know I do). In this sense therapists are always needing to be in some manner self-protective. The examples of therapists’ behaviors mentioned in the previous paragraph are complex, since most of them, from making interpretations to remaining silent, are multilayered in their motivations. There may be a self-protective element in these behaviors, and this is not necessarily, or even frequently experienced as a problem in the psychotherapy. However, if for some reason it becomes a problem for the patient, (esp. if the behavior is motivated by defensive self-protectiveness) the therapist’s response is crucial and makes the difference between a temporary derailment and a chronic impasse which could lead to an untimely and injurious termination, a termination perhaps experienced as deleterious by the therapist, as well as by the patient.
The second half of my definition of defensiveness distinguishes more benign self-regulation from defensive, potentially destructive self-regulation. The deciding element lies in whether the therapist self-regulates at the expense of the patient’s efforts to articulate and explore his reality. The therapist is being defensive when it becomes crucially important for her to express and/or preserve her own perspective (defend and regulate herself), uninfluenced by the patient’s perspective or his needs. The therapist is self-regulating at the patient’s expense if she is trying to persuade the patient to see her in a particular manner, which might alleviate the therapist’s anxiety about how she is being seen by the patient. The therapist is being defensive when she is behaving in such a way as to coerce, dampen, or manipulate how the patient sees her, rather than being willing to be seen in the moment the way the patient is seeing her, willing to “wear the attribution” (Lichtenberg, et. al., 1992). The therapist is being defensive when she is needing the patient to align with her version of herself (e.g., her good intentions, or the legitimacy of her perspective). One of the things that happens interactionally with defensiveness is that the dynamics in the room change from a search for a dialogue between two subjectivities into a power struggle over which mind is going to define the interaction. The interaction between two people becomes a power play where only one mind matters, where both subjectivities feel in danger of annihilation.

If the patient is experiencing the therapist as being defensive, the therapist may want to view this as the patient’s problem (as a transference distortion), because she may be more in touch with aspects of her motivations other than the self-protective one. It is understandable that the therapist may view the patient’s reaction as “his problem” since the self-protective aspect of her motivation may not have been conscious, or it may not have been her predominant motive. But when the patient is not allowed to comment freely on his reaction to the self-protectiveness of the therapist, when the therapist is not open to seriously considering what it is about her part in the interaction that might lead the patient to perceive her this way, this is when she is being defensive. When the therapist’s (self-protective) behavior or attitude inhibits the dialogue, the patient is more likely to feel impinged upon.

Yet, even this degree of defensiveness is not necessarily destructive to the process or to the patient, as the therapist still has the opportunity to respond to her defensiveness in salutary ways. That is, she has not yet become defensive about becoming defensive. There is an important difference between becoming defensive and getting embroiled in an impasse. When the therapist’s defensiveness (and her defensiveness about her defensiveness) remains out of awareness, when the therapist cannot re-regulate herself (or right herself) back into an empathic listening perspective once she is able to acknowledge her defensiveness (whether or not she shares this with the patient), when the threat to her self-integrity is too high, then a temporary derailment is likely to devolve into an impasse.
The Therapist’s Defensiveness: Potential Problematic Outcomes

1. A therapist’s defensiveness is likely to contribute to the hardening of disruption into impasse when the therapist cannot recognize or acknowledge (take seriously) her defensiveness.

As I have stated above, there may be theoretical reasons that a given therapist might be limited in her capacity to know when she is defensive. For example, the therapist could become (and remain) defensive in reaction to certain behaviors, perceived attitudes, etc., of the patient which the therapist finds to be threatening in ways that other of the patient’s behaviors and attitudes are not. However, her theory may not allow for much possibility that the therapist can truly become defensive, since all disruption in the patient is assumed to be based on transference distortion, attributable to the patient’s pathology alone. The difficulty here is that this defensiveness in the therapist could, in turn, easily initiate, perpetuate, or exacerbate a disruption with the patient, whether minor or major, articulated or suppressed.

There may also be personal reasons a given therapist might be limited in her capacity to know when she is defensive. Whatever values the therapist holds about doing her absolute best to help a patient, they may conflict with another value pertaining to her psychological survival (i.e., preserving her sanity) and when these two values conflict, survival will predominate. For example, a therapist who is narcissistically brittle may find that her values shift, when push comes to shove in a given psychotherapy. She may begin to consciously experience herself in a power struggle with a patient, where she is “fighting for her life.” If she feels the patient is intentionally threatening her grasp on reality, this would allow her to make self-preservation her first priority, without feeling guilty or conflicted about it. She may even rationalize her position as being in the best interest of the patient. It may not occur to her that the patient is having a similar experience of struggling to keep himself from drowning.

In any of these cases, there are substantial clinical implications that need to be examined and kept in mind. Disruptions may be overlooked, minimized, or actively avoided by one or both parties (patients may follow the therapist’s lead and try not to “notice” the disruption), only to erupt later in the psychotherapy. When the patient is able to protest, the therapist may not take seriously the patient’s assertion that there is a problematic disruption in which the therapist is being experienced as defensive, if she does not experience herself as defensive. While it is certainly possible that the therapist is not, in fact, being defensive (e.g., she may not yet have enough information about the patient, she may be unskilled at attunement, she may have a difficult time remembering and/or adapting to the nuances of certain dynamics with a particular patient), it needs to be considered as a distinct possibility.

2. A therapist’s defensiveness is likely to contribute to the hardening of disruption into impasse even when the therapist has the capacity to recognize and acknowledge her defensiveness, if she cannot overcome it or learn to manage it.
If the therapist’s psychological survival is at stake, the therapist may not have the capacity to deal adequately with her defensiveness, even when she is aware of it. The difficulty here is that the patient may not be able to move beyond this point if he is reacting to the therapist’s defensiveness, and temporary disruption could harden into impasse. Even a relatively nondefensive (e.g., a less narcissistically brittle) therapist may experience herself as simply unable to move past the sticking point with a patient when her sense of reality is at stake. Doing her best to help the patient may be no less of a value to her at these moments (as manifested by her capacity to feel remorse and guilt about it), but in terms of behavior, she cannot do otherwise unless there is some way to work through that personal piece (that jeopardizes her sense of reality). As I have already stated, when these two values clash in conflict, survival comes first.

It may be that the therapist’s theory dictates that she should attempt to manage her defensiveness internally (purely as a countertransference issue), and continue to make the interpretations to the patient that seem best. The difficulty with this stance is that if the patient perceives and reacts to the therapist’s defensiveness, that defensiveness could be perpetuated, especially if the patient is experienced by the therapist as provocative in his protests. If the cycle escalates, temporary disruption could harden into impasse. Even if a therapist’s theoretical model says that the patient is doing the wrong thing by terminating for the wrong reasons, it does the patient no good for the therapist to point out the error of his ways. If the patient can leave with a shred of dignity and self esteem, he might seek therapy again because he will not be as likely to hate what psychotherapy did to him. Indeed, if the therapist believes the patient is acting out of his pathology, it serves no purpose to beat him over the head with it, because most likely he is still going to do what he feels he needs to do in order to protect himself in this interpersonal situation from which the therapist cannot extract herself.

3. A therapist’s defensiveness is likely to contribute to the hardening of disruption into impasse when the therapist is unwilling to get consultation when indicated (whether she is aware of needing it or not).

The therapist’s refusal to seek consultation can have the effect of leaving the patient with the experience of having no advocate; it can leave the patient feeling terribly alone in the process, with no one to understand his side of things. This can be particularly traumatizing, since it often repeats the early childhood trauma of significant attachment figures not noticing or acknowledging or taking seriously one’s subjective agony and distress. The therapist’s refusal of consultation has the further effect of leaving the patient with the sense that the therapist believes it is completely the patient’s fault -- otherwise the therapist would seek help.

Refusing to seek consultation during a prolonged, escalating disruption epitomizes how the therapist has the last word in these difficult situations. Her ability to hear her patient may be impaired because of some limitation of her own; the patient may be protesting, but cannot make himself be understood; consultation on the patient’s part is not likely to benefit him (unless he seeks a parallel, concurrent psychotherapy that would ultimately allow him to approach his therapist in a less provocative way); the only other possibility of penetrating this
closed, stalled system seems to be if the therapist would seek consultation. With her refusal to seek help, she may well be communicating to the patient, “I cannot do this any differently. This is all you’re going to get from me. Your choice is to take it or leave it!”

The Therapist’s Defensiveness: Salutary Responses

1. The therapist is more likely to navigate disruptions successfully, even when she is defensive with the patient, when she works from a systems model. If she employs a systems approach, she will assume she has a contribution when there is a disruption. If the therapist can hold her theory lightly enough so that she can truly hear her patient, she is more likely to be able to respond in a way that mitigates the derailment in a growth promoting way for the patient.

2. The therapist is more likely to navigate disruptions successfully, even when she is defensive with the patient, when she makes disruptions a central focus of the ongoing dialogue. A therapist with this capacity will watch her patient for signs of disruption, assume there is a disruption if the patient says so, and actively investigate and pursue the possibility of disruption with the patient. She will also stay alert to the possibility that she is feeling/acting defensive and that the patient might detect it before she is aware of it, and undergo careful self-reflection to detect any defensiveness.

3. The therapist is more likely to navigate disruptions successfully, even when she is defensive with the patient, when she assumes that she is capable of reacting defensively, works to identify her trigger points and to recognize the signs that are specific to her, which can act as signals for her. For example, she may discover that she is feeling defensive when she is unable to let her patient’s perspective affect her. She is listening from a perspective of: “Yes, but . . .” rather than, “Oh, OK, then that is why what I say does this to you.”

Another example is the therapist who gets defensive when her hold on her sense of goodness and on the legitimacy of her perspective gets shaken in an interaction with a patient. If she is nondefensive, she will be able to welcome her shakiness as an emergence in the dialogue that is going to lead to something new for both her and the patient. If she is defensive, she might be worried that allowing her shakiness to continue is going to destroy her in some way, obliterate her sense of goodness, or threaten her grip on reality, so she is compelled to eradicate the patient’s perspective. A therapist can do this in very subtle ways, like making an (untimely or self-serving) interpretation, or giving an explanation that sounds benign but which rescues the therapist while confusing, hurting and/or silencing the patient.

Yet another signifier of defensiveness is when the therapist does not want to listen to what the patient is saying. When the patient says something to the therapist, and she is working from a defensive position, she may try to work it out in a way where she does not have to shift in any way, and the patient instead has to shift, and then the second or third time
he indicates to her that he is still upset, she may become aware that she simply does not want
to take it in. In her mind it might sound something like, “I don’t want to look at that, because
if I do, I’m going to feel ashamed/guilty/exposed.” Or she may feel righteous, like, “What are
you talking about?! That is not how it is!”

Another marker of defensiveness could be when the therapist listens with greater
intensity than usual for one particular aspect of what the patient is articulating. She could be
doing this in search of reassurance in what he is saying - something that would confirm her
own view, for example. Or she could be listening more intently than usual in order to detect
something in his language which she can point out as, say, a “transference distortion” (even if
she does not use that archaic language). However it specifically manifests itself in a particular
therapist, if she can learn to identify her reluctance to take in the patient’s perspective, she can
begin to use it as a sign that she is being defensive and that the patient may be reacting to that.

4. The therapist is more likely to navigate disruptions successfully, even when she is
defensive with the patient, when she accepts responsibility for her contribution to the rupture
and for initiating and orchestrating the process of working through her defensiveness,
whether or not disclosing to the patient along the way, whether by herself or in consultation
(solo consultation or joint, with the patient), whether keeping the usual schedule with her
patient or taking time off in order for the therapist to get a handle on things, and so forth.

If she feels it would be facilitative for the patient, and if she could bear it herself, the
therapist can acknowledge her defensiveness as part of the psychotherapeutic dialogue. If she
chooses to do this, it would be helpful to own it thoroughly (i.e., rather than couching it in
language that blames the patient), though apology is not required, and not necessarily even
helpful.

This process of seeing the therapist involved in owning and dealing with her
defensiveness could be greatly relieving and reassuring to the patient that he and the therapist
are not stalemated yet. As long as the therapist is apparently in the process of actively
examining her defensiveness, the patient may experience hope. Once this process stops, and
the therapist takes the attitude of, “You are welcome to get consultation, but I do not need it”
or, “I’ve gotten consultation and we all agree that this is going as well as it can, so it’s up to
you whether to stay or leave,” the patient may begin to feel extremely trapped, alone in the
room with an adversary and no advocate.

5. The therapist is more likely to navigate disruptions successfully, even when she is
defensive with the patient, when she is willing to get consultation when needed. There is
growing recognition in the field of the need for “therapeutic dyad (joint) consultation” in the
event of impasse.2

Elkind (1994) has “discovered the value, when the therapeutic relationship is in
jeopardy of rupture, of taking the therapist-patient dyad out of a state of isolation and
exclusivity through providing ‘an enlarged relational context’ 3 to support it. A consultant
can support the patient and therapist in working at what Darlene Ehrenberg, Ph.D., refers to as
‘the intimate edge,’ often a risky phase for both, as the patient confronts the therapist's subjectivity” (p. 5).

It would be beneficial if the therapist could recognize at what point consultation is indicated in a given psychotherapy, but this is not always apparent. I suggest two potential guidelines. First, consultation may be indicated when a patient is still disrupted even after the therapist has drawn on everything in her repertoire (i.e., when the therapist is at a loss to come up with a new way of approaching the patient, when the patient still feels impeded). A second guideline is that if the therapist is in a quandary with one specific patient, it may well be a situation that calls for consultation. Whereas, if the therapist is having chronic difficulty with several or all of her patients, consultation may not even be enough - the therapist may need to consider further personal psychotherapy.4

Elkind’s model is a wonderful example of the type of therapeutic dyad consultation that is available currently. She consults with both therapist and patient (although she meets with them separately), or the therapist alone, or the patient alone, depending on whether one or both parties are willing. She is very empathic and nonblaming. “I have consistently found that patients who seek consultation for impasses want to untangle themselves and to learn from the impasse, to preserve the therapeutic relationship or at least the positive aspects of it, despite the tightrope that we all walk between the hope for, and fear of, change. When therapists recommend consultation to patients, patients may fear that it will not help, but they are grateful that their therapists are searching for ways to restore the relationship rather than giving up on it. Both have been relieved at the presence of a nonjudgmental third party who tries to understand the impasse and provide an empathic channel and holding environment for patient and therapist until a shift in the therapeutic relationship can occur” (1994, p. 5).

Elkind (1995) poignantly describes her role as consultant. “Metaphorically, I regard myself as an "oars-woman," who safely transports patient and therapist from their familiar shore, across a dangerous and choppy river, to a new shore on the other side, leaving them there with a new orientation and perspective” (p. 10). “A consultant is, after all, one imperfect person helping two other imperfect people in the complex shared undertaking of learning to sustain a relationship to self and other, and to tolerate the inevitable disruptions” (p. 346).

Some “terminations occur because therapist's and patient's primary vulnerabilities have been activated and intersect problematically, patient and therapist have become entangled in a relational knot to which both have contributed and from which they cannot extricate themselves. . . . . Opening up the therapeutic relationship at this precarious juncture to include a consultant, and hence a third perspective, can create a respite, a space, an empathic other, and can bring the hope of some relief” (Elkind, 1995, p. 333).
Members of the therapeutic dyad are equal, but not symmetrical. As therapists, we view the therapist and the patient as having equal value simply because they are both human beings. We do not view the therapist as being inherently more worthy. Although some theories do privilege the therapist’s perspective over the patient’s (I will not elaborate those implications here), I assert that even therapists of these persuasions would agree that they and their patients have equal value as human beings.

Positions of patient and therapist are asymmetrical for at least two reasons. First, members of the therapeutic dyad are asymmetrical by virtue of the fact that they have different roles in relation to their joint task. It is in the therapist’s “job description” to deal rigorously with her defensiveness, but not in the patient’s. The patient is partially in psychotherapy for the very purpose of examining his defensiveness, so in this sense the patient is allowed, even expected, to self-protect defensively and to not manage his defensiveness well. It would undoubtedly make it easier for the therapist to be less defensive or resolve her defensiveness sooner if the patient was able to express his own attempts to self-protect in ways that were not provocative to the therapist, but in many cases this is one of the reasons he has come to psychotherapy in the first place - his defenses have become rigidified in ways that are off putting to the recipient, close down the dialogue in his close relationships where this is expressed, and limit his capacity and opportunity for intimacy.

Functionally, the therapist may be in a better position to work through her defensiveness. The patient may not be able to find a way to “supervise” his therapist in this kind of situation or to analyze himself and resolve his own defensiveness. The patient is likely to be feeling desperate, so that the therapist is likely to experience him as being defensive or provocative. The patient might even recognize what the therapist needs from him in order to become less defensive herself, but he is not likely to be able to be less provocative simply by willing it. Nor is the therapist likely to feel comfortable disclosing and working through her personal issues (that are causing and perpetuating her defensiveness) with a patient who she is experiencing as provocative. This situation can become dire and leave the patient with few options (e.g., insist that the therapist get consultation, or leave the psychotherapy).

Second, the therapeutic dyad is also asymmetrical in that the therapist holds considerably more power than the patient in certain crucial areas. And again, with power comes responsibility. The patient certainly has some power: the patient hires the therapist (and holds the right to fire the therapist at any time), the patient can be noncompliant, the patient can control the dialogue by insisting on staying with certain subjects or by refusing to engage with the therapist. However, the therapist holds tremendous power of a different kind. Patients generally perceive the therapist to be more powerful, e.g., because of the potent impact of transference. The therapist is frequently experienced as an authority figure. People do come to us, after all, because we have some kind of expertise. Patients see us on our territory, in our offices, which increases the power gradient. We even tend to occupy the better chair. Patients are the ones who come seeking help and do the majority of the self-
disclosing, which inherently leaves them feeling vulnerable to being shamed, unprotected, and open to attack.

One implication of holding the majority of the power in the relationship is that if (or when) the patient develops an attachment to the therapist, he has allowed the therapist to assume great power over him in order to work deeply in the psychotherapy and this puts him in a tremendously vulnerable situation. We therapists may not perceive ourselves as holding much power, but it can be utterly devastating to our patient when we lose sight of this phenomenon, when we deny or dismiss his subjective experience of the powerful attachment he is experiencing with us.

Bowlby (1980) simply but eloquently explains the impact in a relationship when the attachment is (perceived to be) threatened. “Since the goal of attachment behaviour is to maintain an affectional bond, any situation that seems to be endangering the bond elicits action designed to preserve it; and the greater the danger of loss appears to be the more intense and varied are the actions elicited to prevent it. In such circumstances all the most powerful forms of attachment behaviour become activated -- clinging, crying and perhaps angry coercion. This is the phase of protest and one of acute physiological stress and emotional distress. When the actions are successful the bond is restored, the activities cease and the states of stress and distress are alleviated” (p. 41).

A notable clinical implication of Bowlby’s thoughts is that this “phase of protest” is provocative by nature, not for the purpose of driving the other away, but in the hopes that the other will recognize the desperation behind the protest and repair the disruption in the attachment. If this “phase of protest” is happening in a disrupted psychotherapy, it would be born out by the diminishment of the protest upon restoration of the attachment bond. If it falls in the therapist’s theoretical category of “needed repetition of unconscious material” then perhaps even restoring the attachment bond would not alleviate the protest. In either case, restoring the attachment bond is central.

Elkind (1996), herself twice a wounded patient, describes her vulnerability firsthand. “I invested incalculable hope in both therapists, risking the surrender of defenses that, albeit with cost, functioned as protection. In a psychologically unprotected state, I was at risk of retraumatization. I understand viscerally what happens when core vulnerabilities are activated and not contained, when therapists fall into countertransference reactions and do not work with them, when therapists lack capacities that patients need, and when the disillusionment that patients sometimes endure feels unmanageable” (p. 169).

A second implication of holding the majority of the power in the relationship is that when the therapist engages in an argument or a power struggle with the patient, the therapist will always have the last word. By this I mean that it takes involvement from both parties to have a power struggle, and if the therapist allows herself to become part of the fracas (e.g., a difference of opinion or perception) by insisting on suggesting or asserting her view in order to get the patient to validate it, accept it or agree with it, she leaves the patient with little choice other than continuing in a deadlock, backing down in compliance, or terminating the relationship, none of which is likely to further the therapeutic goals of the dyad. No doubt the therapist who feels victimized by her patient is going to feel that when he stormed out of the
office, the patient “had the last word.” A more empathic stance might see this as simply the only option with which the patient was left because he had no hopes of getting in a word.

Another example of how the power of having the last word lies with the therapist is when the therapist essentially shuts down the therapeutic process with a particular patient, by withholding herself from emotional engagement out of anger or resentment or hurt (i.e., quieter forms of defensiveness). The patient is capable of doing the same thing of course, but then that can be examined in the therapy. When it is the therapist who defensively withholds herself, the patient (whose job description does not include analyzing the therapist - at least, to this degree) is again left with no viable options.

A third implication of holding the majority of the power in the relationship is that, should premature termination become inevitable (in the patient’s mind), the therapist has a tremendous amount of influence in defining the nature of that ending. If the therapist pathologizes the termination, that is likely to be more traumatizing to the patient than if the therapist attempts to understand this action as the best possible resolution given the circumstances in which they both find themselves. Granted, the therapist does not have control over how the patient is going to organize an experience of this magnitude, and the patient can certainly leave feeling absolutely devastated in spite of the therapist’s best efforts to ameliorate the patient’s pain. However, I believe the patient will be better served if the therapist does what she can to minimize the traumatic effects of a premature termination.

In doing so, the therapist could minimize the second level of trauma that Elkind identifies. “I think about the dual levels of trauma for patients when there is a rupture. The first level resides in the therapist's original upsetting action, and the second level in the therapist's subsequent failure to communicate a psychological understanding of why the action was upsetting, what primary vulnerability was activated in the patient, and that a primary vulnerability of the therapist might have been involved” (1996, p. 175).

For example, the therapist can frame the termination as one that has become necessary because she cannot take the next step required to get out of the impasse. By acknowledging her own contribution to the impasse, she can allow the patient to leave feeling less pathologized. In the situation where the therapist can recognize her defensiveness, but chooses not to share the details of her dynamic with the patient, merely to acknowledge that she is defensive and that she has been unable to work it out tremendously eases the patient’s tendency to feel blamed for the failed psychotherapy. In the situation where the therapist cannot recognize or pinpoint her contribution, she can at least assume its existence if she works from a dynamic systems model - and even to acknowledge the possibility immensely reduces the patient’s tendency to feel blamed for the failed relationship.

There are compelling reasons for the therapist to consider this last therapeutic act of minimizing patient blame in the case of premature termination due to impasse. If the patient does not feel blamed by the therapist, he will be able to leave in a less fragmented state than otherwise. Since it is virtually impossible to mourn while in a fragmented state, it follows that he will then be more likely to begin the complicated process of mourning a prematurely terminated treatment relationship. Likewise, if the patient does not feel blamed by the therapist, it is not hard to imagine that this would increase the possibility of the patient
seeking out another treatment that would be more beneficial to him. At the very least, I believe that a patient who does not feel blamed by his former therapist would encounter fewer hurdles in beginning a new treatment.

In conclusion, I want to reiterate that self-protection is utterly normal, ubiquitous, and necessary. Yet, if carried out defensively, it has the potential to be destructive, hemming in our own development and creating unnecessary barriers and disruptions between us and people with whom we wish to have significant relationships. Defensiveness can be a demon for all of us, in all the roles we fill. In this paper I have considered, from the patient’s point of view, the problematic aspects of defensiveness in the therapist (as one aspect of countertransference).
ENDNOTES

1 Many of the ideas in this section, I gleaned from personal communications with Lynne Jacobs, Ph.D., 1998.

2 There is also growing recognition in the field of the need for ongoing, regular consultation even when things are not going particularly badly at the moment, for example at the 1998 APA (American Psychological Association) convention, San Francisco, August 1998, Division 39 (The Division of Psychotherapy) in which consultation was normalized rather than left exceptional.

3 In an end note Elkind writes: “The term was provided to me by therapists who are members of the Stone Center: Jean Baker Miller, PhD, Irene Stiver, PhD, Janet Surrey, PhD, Judith Jordan, PhD, and Alexandra Kaplan, PhD.”

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