5

Primary Defensive Processes

In this chapter and the next, I cover the major common defenses. The concept of defense has been central to psychoanalytic character diagnosis. The major diagnostic categories that have been used by analytic therapists to denote personality types refer implicitly to the persistent operation in an individual of a specific defense or constellation of defenses. Thus, a diagnostic label is a kind of shorthand for a person's habitual defensive pattern.

The term "defense" is in many ways unfortunate. What we refer to as defenses in adults begin as global, inevitable, adaptive ways of experiencing the world. Freud is responsible for originally observing and naming some of these processes; his choice of the term "defense" reflects at least two aspects of his thinking. First, he was fond of military metaphors. When he was trying to make psychoanalysis palatable to a skeptical public, he frequently made analogies, for pedagogical purposes, comparing psychological operations to army tactical maneuvers, or compromises over military objectives, or battles with complex outcomes.

Second, when he first encountered the most dramatic and memorable examples of processes that we now call defenses (repression, conversion, dissociation) he saw them when they were operating in their defensive function. The emotionally damaged, predominantly hysterical people he first became fascinated by were trying to avoid reexperiencing what they feared would be unbearable pain. They were doing so, Freud observed, at a high cost to their overall functioning. Ultimately it would be better for them to feel fully the overwhelming emotions they were afraid of, thereby liberating their energies for getting on with their lives. Thus, the earliest context in which the defenses were talked about was one in which the doctor's task was to diminish their power.

Construed that way, the therapeutic value of weakening or breaking down a person's maladaptive defenses was self-evident. Unfortunately, in the climate of excitement surrounding Freud's early observations, the idea that defenses are somehow by nature maladaptive spread among the lay public, and the word acquired an undeservedly negative cast. Calling someone "defensive" is universally understood to be a criticism. Analysts also use the word in that way in ordinary speech, but when they are discussing defense mechanisms in a scholarly, theoretical way, they do not necessarily assume that anything pathological is going on when a defense is operating. In fact, analytically influenced therapists have sometimes understood certain problems, notably psychotic and close-to-psychotic "decompensations," as evidence of insufficient defenses.

The phenomena that we refer to as defenses have many benign functions. They begin as healthy, creative adaptations, and they continue to work adaptively throughout life. When they are operating to protect the self against threat, they are discernible as "defenses," a label that seems under those circumstances to fit. The person using a defense is generally trying unconsciously to accomplish one or both of the following: (1) the avoidance or management of some powerful, threatening feeling, usually anxiety but sometimes overwhelming grief, shame, envy, and other disorganizing emotional experiences; and (2) the maintenance of self-esteem. The ego psychologists emphasized the function of defenses in dealing with anxiety; object relations theorists, who focus on attachment and separation, introduced the understanding that defenses operate against grief as well; and self psychologists have stressed the role of defenses in the effort to maintain a strong, consistent, positively valued sense of self. Analysts in the relational movement have emphasized the shared nature of defenses that emerge in couples and systems.

Psychoanalysts assume, although this is seldom explicitly stated, that we all have preferred defenses that have become integral to our individual styles of coping. This preferential and automatic reliance on a particular defense or set of defenses is the result of a complex interaction among at least four factors: (1) one's constitutional temperament, (2) the nature of the stresses that one suffered in early childhood, (3) the defenses modeled—and sometimes explicitly taught—by parents and other significant figures, and (4) the experienced consequences of using particular defenses (in the language of learning theory, reinforcement effects). In psychodynamic parlance, the unconscious choice of one's favorite modes of coping is "overdetermined," expressing the cardinal analytic principle of "multiple function" (Waelder, 1960).

Defenses have been extensively researched. Phoebe Cramer (2008) has reviewed empirical findings supporting seven core psychoanalytic observations; namely, that defenses (1) function outside of awareness; (2) develop in predictable order as children mature; (3) are present in normal personality; (4) become increasingly used in times of stress; (5) reduce the conscious experience of negative emotions; (6) operate via the autonomic nervous system; and (7) when used excessively, are associated with psychopathology. Substantial agreement exists among psychoanalytic scholars that some defenses are less developmentally mature than others (Cramer, 1991; Laughlin, 1970; Vaillant et al., 1986). Cramer (2006) has demonstrated, for example, that denial occurs very early, projection develops later, and identification arrives still later (though I discuss here the archaic precursors of both projection and identification as primary defensive processes). In general, defenses that are referred to as "primary" or "immature" or "primitive" or "lower order" involve the boundary between the self and the outer world. Those conceived as "secondary" or "more mature" or "advanced" or "higher order" deal with internal boundaries, such as those between the ego or superego and the id, or between the observing and the experiencing parts of the ego.

Primitive defenses operate in a global, undifferentiated way in a person's total sensorium, fusing cognitive, affective, and behavioral dimensions, whereas more advanced ones make specific transformations of thought, feeling, sensation, or behavior, or some combination of these. The

conceptual division between more archaic and higher-order defenses is somewhat arbitrary. Ever since Kernberg (e.g., 1976) called attention to borderline clients' use of archaic forms of projection and introjection (a precursor of identification), however, many therapists have followed him in identifying the following defenses as intrinsically "primitive": withdrawal, denial, omnipotent control, primitive idealization and devaluation, projective and introjective identification, and splitting. In 1994 I suggested adding extreme forms of dissociation to that list. And now, based on the work of Vaillant (e.g., Vaillant et al., 1986) and other researchers with which I was not so familiar in 1994, and at the suggestion of several colleagues, I have added somatization, acting out, and sexualization to the more primitive defenses. There are mature expressions of those processes, but that is also true of some other lower-order defenses, such as primitive idealization and withdrawal.

To be considered primary, a defense typically has two qualities associated with the preverbal phase of development: a lack of attainment of the reality principle (see Chapter 2) and a lack of appreciation of the separateness and constancy of those outside the self. For example, denial is thought to be a manifestation of a more primitive process than repression. For something to be repressed, it has to have been known in some way and then consigned to unconsciousness. Denial is an instant, nonreflective process. "This is not happening" is a more magical way of dealing with something unpleasant than "This happened, but I'll forget about it because it's too painful."

Similarly, the defense mechanism known as "splitting," in which a person segregates experiences into all-good and all-bad categories, with no room for ambiguity and ambivalence, is considered primitive because it is believed to derive from a time before the child has developed object constancy. The perception of mother when one feels gratified is thought to be an overall sense of "good mother," whereas the perception of the same person when one is frustrated is "bad mother." Before the infant is mature enough to appreciate the reality that it is the same person in each situation, one whose presence sometimes feels good and sometimes feels bad, we assume each experience has a kind of total, discrete, defining quality. In contrast, a defense like rationalization is considered mature because it requires some sophisticated verbal and thinking skills and more attunement to reality for a person to make up reasonable explanations that justify a feeling.

Many defensive processes have more primitive and more mature forms. For example, "idealization" can denote an unquestioning, worshipful conviction that another person is perfect, or it can refer to a subtle, subdued sense that someone is special or admirable despite some visible limitations. "Withdrawal" can refer to the full renunciation of reality in favor of a psychotic state of mind, or it can refer to a mild tendency to deal with stress by daydreaming. For this chapter on primitive defenses, I have called a defense "extreme" if it also has more mature manifestations.

The so-called primitive defenses are ways we believe the infant naturally perceives the world. These ways of experiencing live on in all of us, whether or not we have significant psychopathology; we all deny, we all split, we all have omnipotent strivings. Such processes pose a problem only if we lack more mature psychological skills or if these defenses are used to the exclusion of possible

others. Most of us also supplement them with more sophisticated means of processing anxiety and assimilating a complex and disturbing reality. *It is the absence of mature defenses, not the presence of primitive ones, that characterizes borderline or psychotic structure.*

It is much harder to describe the primitive defenses than the more advanced ones. The fact that they are preverbal, prelogical, comprehensive, imaginal, and magical (part of primary process thought) make them extremely hard to represent in prose; in fact, the representation of preverbal processes in words is to some degree an oxymoron. The following summary gives an overview of those defenses that are conventionally understood as primary.

EXTREME WITHDRAWAL

An infant who is overstimulated or distressed will often simply fall asleep. Withdrawal into a different state of consciousness is an automatic, self-protective response that one sees in the tiniest of human beings. Adult versions of the same process can be observed in people who retreat from social or interpersonal situations, substituting the stimulation of their internal fantasy world for the stresses of relating to others. A propensity to use chemicals to alter one's consciousness can also be considered a kind of withdrawal. Some professionals, including contributors to recent editions of the DSM, prefer the term "autistic fantasy" to withdrawal; this label refers to a specific version of the general tendency to shrink from personal contact.

Some babies are temperamentally more inclined than others toward this way of responding to stress; observers of infants have sometimes noted that it is the babies who are especially sensitive who are most likely to withdraw. People with this constitutionally impressionable disposition may generate a rich internal fantasy life and regard the external world as problematic or affectively impoverished. Experiences of emotional intrusion or impingement by caregivers and other early objects can reinforce withdrawal; conversely, neglect and isolation can also foster that reaction by leaving a child dependent on what he or she can generate internally for stimulation. Schizoid personality styles are the characterological outcome of reliance on the defense of withdrawal.

The obvious disadvantage of withdrawal is that it removes the person from active participation in interpersonal problem solving. People with schizoid partners are frequently at a loss as to how to get them to show some kind of emotional responsiveness. "He just fiddles with the TV remote control and refuses to answer me" is a typical complaint. People who chronically withdraw into their own minds try the patience of those who love them by their resistance to engaging on a feeling level. Those with serious emotional disturbance are hard to help because of their apparent indifference to the mental health workers who try to win their attention and attachment.

The main advantage of withdrawal as a defensive strategy is that while it involves a psychological escape from reality, it requires little distortion of it. People who depend on withdrawal console themselves not by misunderstanding the world but by retreating from it. Consequently, they may be unusually sensitive, often to the great surprise of those who write them

off as dull nonparticipants. And despite their lack of a disposition to express their own feelings, they may be highly perceptive of feelings in others. On the healthier end of the schizoid scale, one finds people of remarkable creativity: artists, writers, theoretical scientists, philosophers, religious mystics, and other highly talented onlookers whose capacity to stand aside from ordinary convention gives them a unique capacity for original commentary.

DENIAL

Another early way in which infants can handle unpleasant experiences is by refusing to accept that they are happening. Denial lives on automatically in all of us as our first reaction to any catastrophe; the initial response of individuals who are informed of the death of someone important to them is typically "Oh, no!" This reaction is the shadow of an archaic process rooted in the child's egocentrism, in which a prelogical conviction that "If I don't acknowledge it, it isn't happening" governs experience. It was processes like this one that prompted Selma Fraiberg to title her classic popular book on early childhood *The Magic Years* (1959).

Examples of people for whom denial is a bedrock defense are the Pollyana-like individuals who insist that everything is always fine and for the best. The parents of one of my patients continued to have one child after another even after three of their offspring had died from what any parents not in a state of denial would have realized was a genetically implicated affliction. They refused to mourn for the dead children, ignored the suffering of their two healthy sons, resisted advice to get genetic counseling, and insisted that their condition represented the will of God, who knew what was best for them. Experiences of rapture and overwhelming exhilaration, especially when they occur in situations in which most people would perceive some negative aspects to their circumstances, are similarly assumed to reflect the operation of denial.

Most of us occasionally use denial, with the worthy aim of making life less unpleasant, and many people use it frequently in dealing with specific stresses. A person whose feelings get hurt in situations in which it is inappropriate or unwise to cry is more likely to deny the hurt feelings than to acknowledge them fully and inhibit the crying response consciously. In crises or emergencies, a capacity to deny emotionally that one's survival is at risk can be lifesaving: Denial may permit the most realistically effective and even heroic actions. Every war brings tales of those who "kept their heads" in terrifying, life-threatening conditions, and saved themselves and their fellows.

Less benignly, denial can contribute to the contrary outcome. An acquaintance of mine refuses to get annual Pap smears, as if by ignoring the possibility of cancer she can magically avoid it. Spouses who deny that their abusive partner is dangerous, alcoholics who insist they have no drinking problem, mothers who ignore the evidence of sexual molestation of their daughters, elderly people who will not give up a driver's license despite obvious impairment—all are familiar examples of denial at its worst. This psychoanalytic concept has made its way more or less undistorted into everyday language, partly because the word "denial" is, like "withdrawal," not

jargonized and partly because it is a concept of singular significance to 12-step programs and other enterprises that attempt to confront people on their use of this defense and thereby help them out of whatever hell it has created for them.

A component of denial can be found in the operation of most of the more mature defenses. Take, for instance, the consoling belief that the person who rejected you really desired you but was not ready for a full commitment. Such a conclusion includes denial that one was rejected as well as the more sophisticated excuse-making activity that we refer to as rationalization. Similarly, the defense of reaction formation, in which an emotion is turned into its opposite (e.g., hatred into love), constitutes a specific and more complex type of denial of the feeling being defended against than a simple refusal to feel that emotion.

The clearest example of psychopathology defined by the use of denial is mania. In manic states, people may deny to an astonishing degree their physical limitations, their need for sleep, their financial exigencies, their personal weaknesses, even their mortality. Where depression makes the painful facts of life supremely unignorable, mania makes them seem insignificant. Analysts may refer to those who use denial as their main defense as hypomanic (the "hypo" prefix, meaning "a little" or "somewhat," distinguishes them from those who suffer full manic episodes). They have also been termed "cyclothymic" ("alternating emotion"), because of their tendency to cycle between manic and depressed moods, usually short of diagnosable bipolar illness. We understand this oscillation as the repetitive use of denial followed by its inevitable collapse as the person becomes exhausted in the manic condition. Although this personality diagnosis has not been in the DSM since its second edition because of a decision to put all mood-related phenomena into a "mood disorders" section, it is described in the PDM and in Chapter 11.

As with most primitive defenses, unmodified denial in adults is usually cause for concern. Nonetheless, mildly hypomanic people can be delightful. Many comedians and entertainers show the quick wit, the elevated energy, the playfulness with words, and the infectious high spirits that characterize those who successfully screen out and transform painful affects for long periods of time. Yet the depressive underside of such people is often visible to their closer friends, and the psychological price exacted by their manic charm is often not hard to see.

OMNIPOTENT CONTROL

For the newborn, the world and the self are felt more or less as one. Fonagy's research (Fonagy et al., 2003) suggests that infants live for about 18 months in a mental state of "psychic equivalence," in which the external world is felt as isomorphic with the internal one. Piaget recognized this phenomenon (e.g., 1937) in his concept of "primary egocentrism" (a cognitive phase roughly equivalent to Freud's [1914b] "primary narcissism," during which primary process thought prevails). It may be that the source of all events is understood by the newborn as internal in some way; that is, if the infant is cold, and a caregiver perceives this and provides warmth, the baby has

some preverbal experience of its having magically elicited the warmth. The awareness that there is a locus of control in separate others, outside the self, has not yet developed.

A sense that one can influence one's surroundings, that one has agency, is a critical dimension of self-esteem, one that may begin with infantile and unrealistic but developmentally normal fantasies of omnipotence. It was Sandor Ferenczi (1913) who first called attention to the "stages in the development of a sense of reality." He noted that at the infantile stage of primary omnipotence or grandiosity, the fantasy that one controls the world is normal; that this naturally shifts, as the child matures, to a phase of secondary or derived omnipotence in which one or more caregivers are believed to be all-powerful; and that eventually, the maturing child comes to terms with the unattractive fact that no one's potency is unlimited. A precondition for the mature adult attitude that one's power is not boundless may be, paradoxically, the opposite emotional experience in infancy: a secure enough early life that one can freely enjoy the developmentally appropriate illusions of, first, one's own omnipotence, and second, that of those on whom one depends.

Some healthy residues of the sense of infantile omnipotence remain in all of us and contribute to feelings of competence and effectiveness in life. There is a natural kind of "high" that we feel when we effectively exert our will. Anyone who has ever "had a hunch" about impending luck and then won some kind of gamble knows how delicious is the sense of omnipotent control. The conviction that individuals can do anything they set their mind to is a piece of American ideology that flies in the face of common sense and most human experience, but it nonetheless can be a powerfully positive and self-fulfilling fiction.

For some people, the need to feel a sense of omnipotent control, and to interpret experiences as resulting from their own unfettered power, remains compelling. If one's personality is organized around seeking and enjoying the sense that one has effectively exercised one's power, with all other practical and ethical concerns relegated to secondary importance, one's personality is in the psychopathic range ("sociopathic" and "antisocial" are terms of later origin). Psychopathy and criminality are overlapping but not equivalent categories (Hare, 1999). Nonprofessionals frequently assume that most criminals are psychopaths and vice versa. Yet many people who rarely break the law have personalities driven by the defense of omnipotent control, as in the corporate "snakes in suits" described by Babiak and Hare (2007). They use conscious manipulation as a primary way of avoiding anxiety and maintaining self-esteem.

"Getting over on" others is a central preoccupation and pleasure of individuals whose personalities are dominated by omnipotent control (Bursten, 1973a). Such people are common in enterprises that require guile, a love of stimulation or danger, and a willingness to subordinate other concerns to the central objective of making one's influence felt. They can be found in leadership roles in business, in politics, in covert operations, among cult leaders and evangelists, in the advertising and entertainment industries, and in other walks of life where the potential to wield raw power is high. Once when I was consulting at a military base, making myself available for anyone who wanted to confer on a question within my expertise, the commander of the base

wanted an hour with me. His question was "How can we prevent psychopaths from becoming generals?"

EXTREME IDEALIZATION AND DEVALUATION

Ferenczi's formulation about how early fantasies of omnipotence of the self are gradually replaced by fantasies of the omnipotence of one's caregivers continues to be valuable. One can see how fervently a young child would need to believe that Mommy or Daddy can protect him or her from all the dangers of life. As we get older, we forget how frightening it is to children to confront for the first time the realities of hostility, vulnerability to illness and harm, mortality, and other terrors (C. Brenner, 1982). One way that youngsters cushion themselves against these overwhelming fears is to believe that someone, some benevolent, all-powerful authority, is in charge. (In fact, this wish to believe that the people who are running the world are somehow more inherently wise and powerful than ordinary, fallible human beings lives on in most of us and can be inferred by our degree of upset whenever events remind us that such a construction is only a wish.)

The conviction of young children that their mother or father is capable of superhuman acts is the great blessing and curse of parenthood. It is an undisputed advantage in the boo-boo curing department, and there is nothing more touching than a child's total and loving trust, but in other ways it creates in parents a barely controllable exasperation. I remember one of my daughters, then about 2½, throwing a full-scale tantrum when I tried to explain that I could not make it stop raining so that she could go swimming.

We all idealize. We carry remnants of the need to impute special value and power to people on whom we depend emotionally. Normal idealization is an essential component of mature love (Bergmann, 1987). And the developing tendency over time to deidealize or devalue those to whom we have childhood attachments seems to be a normal and important part of the separation–individuation process. It would be unusual for an 18-year-old to leave home feeling it is a much better place than the life that awaits. In some people, however, the need to idealize seems relatively unmodified from infancy. Their behavior shows evidence of the survival of archaic and rather desperate efforts to counteract internal terror by the conviction that some attachment figure is omnipotent, omniscient, and omnibenevolent, and that through psychological merger with this wonderful Other, they are safe. They also hope to be free of shame: A by-product of idealization and the associated belief in perfection is that imperfections in the self are harder to bear; fusion with an idealized object is an attractive remedy.

Longings for the omnipotent caregiver naturally appear in people's religious convictions; more problematically, they are evident in phenomena like the insistence that one's lover is perfect, one's personal guru is infallible, one's school is the best, one's taste is unassailable, one's government is incapable of error, and similar illusions. People in cults have been known to die rather than devalue a leader who has become crazy. In general, the more dependent one is or feels, the greater the

temptation to idealize. Numerous female friends have announced to me during pregnancy, a time of awesome confrontation with personal vulnerability, that their obstetrician is “wonderful” or “the best in the field.”

People who live their lives seeking to *rank* all aspects of the human condition according to how comparatively valuable they are, and who appear motivated by a search for perfection through merger with idealized objects, efforts to perfect the self, and tendencies to contrast the self with devalued alternatives, have narcissistic personalities. While other aspects of narcissistic organization have been emphasized in much of the psychoanalytic literature, a structural way of construing the psychology of such people is in terms of their habitual recourse to primitive idealization and devaluation. Their need for constant reassurance of their attractiveness, power, fame, and value to others (i.e., perfection) results from depending on these defenses. Self-esteem strivings in people who need to idealize and devalue are contaminated by the idea that one must perfect the self rather than accept it.

Primitive devaluation is the inevitable downside of the need to idealize. Since nothing in human life is perfect, archaic modes of idealization are doomed to disappointment. The more an object is idealized, the more radical the devaluation to which it will eventually be subject. The bigger one’s illusions, the harder they fall. Clinicians working with narcissistic people can ruefully attest to the damage that may ensue when the client who has thought that a therapist can walk on water decides instead that the therapist cannot walk and chew gum at the same time. Treatment relationships with narcissistic clients are notoriously subject to sudden rupture when the patient becomes disenchanted. However sweet it can feel to be the object of total idealization, it is nevertheless onerous, both because of the irritating aspects of being treated as if we can stop the rain and because we have learned the hard way that being put on a pedestal is only the precursor to being knocked off. My colleague Jamie Walkup (personal communication, May 1992) adds that it is also a straitjacket, tempting the therapist to deny normal ignorance, to find intolerable the modest goals of help and assistance, and to think that only one’s best performance is “typical.”

In ordinary life, one can see analogues of this process in the degree of hate and rage that can be aimed at those who seemed to promise much and then failed to deliver. The man who believed that his wife’s oncologist was the only cancer specialist who could cure her is the one most likely to initiate a lawsuit if death eventually defeats the doctor. Some people spend their lives running from one intimate relationship to the next, in recurrent cycles of idealization and disillusionment, trading the current partner in for a new model every time he or she turns out to be a human being. The modification of primitive idealization is a legitimate goal of all long-term psychoanalytic therapy, but that enterprise has particular relevance in work with narcissistic clients because of the degree of unhappiness in their lives and in those of the people who try to love them.

PROJECTION, INTROJECTION,

AND PROJECTIVE IDENTIFICATION

I am combining the discussion of two of the most primitive defensive processes, projection and introjection, because they represent opposite sides of the same psychological coin. In both projection and introjection, there is a permeated psychological boundary between the self and the world. As mentioned earlier, in normal infancy, before the child has developed a sense of which experiences come from inside and which ones have their sources outside the self, we assume that there is a generalized sense of "I" being equivalent to "the world." A baby with colic probably has the experience of "Hurt!" rather than "Something inside me hurts." The infant cannot yet distinguish between an internally located pain like colic and an externally caused discomfort like pressure from diapers that are too tight. From this era of relative undifferentiation come the processes that later, in their defensive function, we refer to as projection and introjection. When these processes work together, they are considered one defense, called projective identification. Some writers (e.g., Scharff, 1992) distinguish between projective and introjective identification, but similar processes are at work in each kind of operation.

Projection is the process whereby what is inside is misunderstood as coming from outside. In its benign and mature forms, it is the basis for empathy. Since no one is ever able to get inside the mind of another person, we must use our capacity to project our own experience in order to understand someone else's subjective world. Intuition, leaps of nonverbal synchronicity, and peak experiences of mystical union with another person or group involve a projection of the self into the other, with powerful emotional rewards to both parties. People in love are well known for reading one another's minds in ways that they themselves cannot account for logically.

In its malignant forms, projection breeds dangerous misunderstanding and untold interpersonal damage. When the projected attitudes seriously distort the object on whom they are projected, or when what is projected consists of disowned and highly negative parts of the self, all kinds of difficulties can ensue. Others resent being misperceived and may retaliate when treated, for example, as judgmental, envious, or persecutory (attitudes that are among the most common of those that tend to be ignored in the self and ascribed to others). A person who uses projection as his or her main way of understanding the world and coping with life, and who denies or disavows what is being projected, can be said to have a paranoid character.

I should note that paranoia has nothing inherently to do with suspiciousness (which may be based on realistic, unprojected observation and experience, or may derive from posttraumatic vigilance), nor with whether or not an attribution is accurate. The fact that a projection "fits" does not make it any less a projection; and although it is easier to spot a projection when the attribution does *not* fit, it is also possible that there is some other, nondefensive reason for a misunderstanding of someone else's motives. Popular misuse of the word "paranoid" has wrongly equated it with "fearful" or "unreasonably suspicious," much to the detriment of precision in language, even though it is true that what people project is usually unpleasant stuff to which they then may react

with fear and distrust (see McWilliams, 2010).

Introjection is the process whereby what is outside is misunderstood as coming from inside. In its benign forms, it amounts to a primitive identification with important others. Young children take in all kinds of attitudes, affects, and behaviors of significant people in their lives. The process is so subtle as to be mysterious, although recent studies of mirror neurons and other brain processes are starting to shed light on it. Long before a child can make a subjectively voluntary decision to be like Mommy or Daddy, he or she seems to have "swallowed" them in some primal way.

In its problematic forms, introjection can, like projection, be highly destructive. The most striking examples of pathological introjection involve the process that has been labeled, somewhat inappropriately in view of its primitivity, "identification with the aggressor" (A. Freud, 1936). It is well known, from both naturalistic observations (e.g., Bettelheim, 1960) and empirical research (e.g., Milgram, 1963), that under conditions of fear or abuse, people will try to master their fright and pain by taking on qualities of their abusers. "I'm not the helpless victim; I'm the powerful perpetrator" seems to be the unconscious attraction to this defense. This mechanism crosses all diagnostic boundaries but is particularly evident in characterological dispositions toward sadism, explosivity, and what is often misleadingly called impulsivity.

Introjection is also implicated in some kinds of depressive psychology (Blatt, 1974, 2004). When we are deeply attached to people, we introject them, and their representations inside us become a part of our identity ("I am Tom's son, Mary's husband, Sue's father, Dan's friend," etc.). If we lose someone whose image we have internalized, whether by death, separation, or rejection, not only do we feel that our environment is poorer for that person's absence in our lives but we also feel that we are somehow diminished, that a part of our self has died. An emptiness or sense of void comes to dominate our inner world. We may also, in an effort to feel some sense of power rather than helpless loss, become preoccupied with the question of what failure or sin of ours drove the person away. The critical, attacking voice of a lost object can live on in us as a way of keeping that person internally alive. When mourning is avoided, unconscious self-criticism thus takes its place. Freud (1917a) beautifully described the process of mourning as a slow coming to terms with this condition of loss, in which "the shadow of the object fell upon the ego" (p. 249). A person who is unable over time to separate internally from a loved one whose image has been introjected, who consequently fails to invest emotionally in other people (the function of the grieving process), will continue to feel diminished, unworthy, depleted, and bereft.

Similarly, children in destructive families prefer to believe there is something wrong with them (preserving hope that by changing, they can improve their lot), than to take in the terrifying fact that they are dependent on negligent or abusive caregivers. Fairbairn (1943) called this process the "moral defense," noting that it is "better to be a sinner in a world ruled by God than to live in a world ruled by the Devil" (pp. 66–67). If one regularly uses introjection to reduce anxiety and maintain continuity in the self, keeping psychological ties to unrewarding objects of one's earlier life, one can reasonably be considered characterologically depressive.

Melanie Klein (1946) was the first analyst to write about a defensive process that she found to be ubiquitous in more disturbed patients, which she called “projective identification.” This fusion of projective and introjective mechanisms has been compactly described by Ogden (1982):

> In projective identification, not only does the patient view the therapist in a distorted way that is determined by the patient’s past object relations; in addition, pressure is exerted on the therapist to experience himself in a way that is congruent with the patient’s unconscious fantasy. (pp. 2–3)

In other words, the patient both projects internal objects and gets the person on whom they are projected to behave like those objects, as if the target person had those same introjects. Projective identification is a difficult abstraction, one that has inspired much controversy in the analytic literature (e.g., S. A. Mitchell, 1997). My own understanding of the term involves the ideas implied in the previous paragraph; that is, projection and introjection each have a continuum of forms, running from primitive to advanced (cf. Kernberg, 1976), and at the primitive end, those processes are fused because of their similar confusion of inside and outside. This fusion is what we call projective identification. In Chapter 4 I discussed briefly the operation of projective identification in psychotic and borderline states.

To illustrate how that process differs from mature projection, consider the contrast between the following hypothetical statements from two young men who have come for an intake interview:

> PATIENT A: (*somewhat apologetically*) I know I have no reason to believe you’re critical of me, but I can’t help thinking that you are.
>
> PATIENT B: (*in an accusatory tone*) You shrinks all love to sit back and judge people, and I don’t give a shit what you think!

Let us assume that in reality, the therapist began the session with a genuinely friendly, interested, nonjudgmental attitude toward each client. The content of what is bothering each man is similar; both are worried that the therapist is taking a harsh, evaluative stance. Both are projecting an internalized critical object onto the therapist. Three aspects of their respective communications, however, make them very different from each other.

First, Patient A shows evidence of the capacity for self-reflection (observing ego, reflective functioning), the ability to see that his fantasy may not necessarily conform to reality; his projection is ego alien. Patient B, on the other hand, experiences what is projected as an accurate depiction of the therapist’s state of mind; his projection is ego syntonic. In fact, he believes in the reality of his attribution so absolutely that he is already launching a counterattack against the assault that he is certain the therapist is planning. The fusion of cognitive, affective, and behavioral dimensions of experience typical of primitive processes is discernible here.

Second, these patients differ in the extent to which their projective process has successfully

done the job for which the defense was called upon, namely, to get rid of a troublesome feeling. Patient A has ejected the critical attitude and presumably feels some relief in reporting it, while Patient B both projects it and keeps it. He ascribes a critical attitude to the other person, yet that does not relieve him of feeling censorious himself. Kernberg (1975) has described this aspect of projective identification as "maintaining empathy" with what has been projected.

Finally, these patients' respective communications will likely have very different emotional effects. The therapist will find it easy to like Patient A and will readily form a working alliance. With Patient B, however, the therapist will rapidly begin feeling like exactly the sort of person the patient is already convinced he is sitting with: uncaring, ready to judge, and disinclined to exert the energy it will take to try to care about this man. In other words, the countertransference toward the first man will be positive and mild, while toward the second it will be negative and intense.

The late Bertram Cohen once explained the "self-fulfilling prophecy" quality of projective identification to me as a natural consequence of a person's being disturbed enough to have very primitive *but not psychotic* perceptions. A woman who is invested in staying anchored in reality will feel less crazy if she can induce in someone else the feelings she is convinced the other person already has. A frankly psychotic woman will not care whether her projection "fits," and will therefore spare others the pressure to confirm its appropriateness and hence her sanity.

Projective identification is a particularly powerful and challenging operation, one that strains the therapist's capacities. While all the defenses in this section are considered primitive, this one, along with splitting, which I discuss next, has a special reputation for causing headaches to clinicians. When one is caught in the patient's certainty about how the therapist "really" feels, along with the patient's unrelenting struggle to induce just those feelings, it is hard to withstand the emotional barrage. Moreover, since all of us share in the predicament of being human, and hence contain already within ourselves all the different emotions, defenses, and attitudes that get projected onto us, there is always some truth in the projective identifier's belief. It can be very confusing to figure out in the heat of the clinical moment where the patient's defense ends and the therapist's psychology begins. Perhaps the capacity of this defense to threaten the therapist's confidence in his or her own mental health accounts for the fact that projective identification, along with splitting, is implicated in borderline personality organization. In particular, because the projective piece of it is so powerful, it is associated with borderline levels of paranoid personality.

Contrary to professional popular opinion, however, projective identification is not used exclusively by people whose character is essentially borderline. There are numerous subtle and benign ways that the process operates in everyday life irrespective of psychopathology. For example, when what is projected and identified with involves the loving, joyful affects, a contagion of good feeling can occur in a group. Even when what is projected and identified with is negative, as long as the process is not relentless, intense, and unmodulated by other interpersonal processes of a more mature sort, it is not unduly harmful. There has been a tendency in recent American psychoanalysis to reframe the unconscious as an intersubjectively shared phenomenon rather than

as one's individual "stuff" (see Aron, 1996, or Zeddies, 2000, on the relational unconscious) and also to see it as creative and positive rather than as Freud's seething cauldron of dangerous desire (Eigen, 2004; Grotstein, 2000; Newirth, 2003; Safran, 2006). The positive aspects of projective identification are implicit in such formulations.

SPLITTING OF THE EGO

Splitting of the ego, usually referred to simply as "splitting," is the other interpersonally powerful process that is understood as deriving from a preverbal time, before the infant can appreciate that his or her caregivers have good and bad qualities and are associated with good and bad experiences. We can observe in 2-year-olds a need to organize their perceptions by assigning good and bad valences to everything in their world. That tendency, along with a sense of the difference between big and little (adult and child, respectively), is one of the primary ways in which young human beings organize experience. Before one has object constancy, one cannot have ambivalence, since ambivalence implies opposite feelings toward a constant object. Instead, one can be in either a good or a bad ego state toward an object in one's world.

In everyday adult life, splitting remains a powerful and appealing way to make sense of complex experiences, especially when they are confusing or threatening. Political scientists can attest to how attractive it is for any unhappy group to develop a sense of a clearly evil enemy, against which the good insiders must struggle. Manichean visions of good versus evil, God versus the devil, cowboys versus Indians, the free world against the terrorists, the lone whistle-blower against the hateful bureaucracy, and so on, have pervaded the mythology of contemporary Western culture. Comparably split images can be found in the folklore and organizing beliefs of any society.

The mechanism of splitting can be very effective in its defensive functions of reducing anxiety and maintaining self-esteem. Of course, splitting always involves distortion, and therein lies its danger. Scholarly studies of the "authoritarian personality" (Adorno, Frenkl-Brunswick, Levinson, & Sanford, 1950) in the post–World War II era explored the far-reaching social consequences of the use of splitting (not by that name) to make sense of the world and one's place in it. The authors of the original study on authoritarianism believed that certain right-wing beliefs were particularly likely to be associated with this kind of inflexibility, but later commentators established that left-wing and liberal forms of authoritarianism also exist (see Brown, 1965).

Clinically, splitting is evident when a patient expresses one nonambivalent attitude and regards its opposite (the other side of what most of us would feel as ambivalence) as completely disconnected. For example, a borderline woman experiences her therapist as all good, in contrast to the allegedly uncaring, hostile, stupid bureaucrats who work in the same setting. Or the therapist may suddenly become the target of undiluted rage, as the patient regards him or her as the personification of evil, neglect, or incompetence, when last week the therapist could do no wrong. If confronted with inconsistencies in his or her attributions, the client who splits will not find it

arresting or worth pondering that someone who seemed so good has become so bad.

It is well known that in institutions like psychiatric hospitals and clinics, patients whose psychologies we describe as borderline not only split internally, they create (via projective identification) splits in the staff of the agency (G. Adler, 1972; Gunderson, 1984; Kernberg, 1981; T. F. Main, 1957; Stanton & Schwartz, 1954). Those mental health workers associated with a borderline client's care find themselves in repeated arguments in which some of them feel a powerful sympathy toward the patient and want to rescue and nurture, whereas the others feel an equally powerful antipathy and want to confront and set limits. This is one reason that splitting as a defense has a less than glowing reputation. Patients who use it as their customary way of organizing their experience tend to wear out their caregivers.

SOMATIZATION

When young children are not helped by their caregivers to state their feelings in words, they tend to express them in either depleted bodily states (illness) or action. Somatization is what analysts have called the process by which emotional states become expressed physically. Although it is common to conflate somatization with malingering, the somatic experience of being emotionally unwell in ways that are unverbalizable is not equivalent to pretending to be ill in order to extract sympathy or avoid a responsibility. Nor does it equate with a problem's being "all in your head." The brain is a part of one's physicality, not a detached overseer. Distinctions between body and mind, along with assumptions that the mind "controls" the body, have been long exposed as quaint myths of the Enlightenment era, with its smug assumption that "man" has natural dominion over nature, other animals, and his own body (cf. Meissner, 2006).

Our earliest reactions to the stresses of life are somatic, and many of these reactions remain basic to our responsiveness. The fight–flight–freeze response to stress seems pretty hard-wired. Blushing is an automatic aspect of the shame response. Under trauma, the brain is flooded with glucocorticoids, with multiple systemic consequences. The gastrointestinal system, the circulatory system, the immune system, the endocrine system, the skin, the breath, the heart—all get activated in different ways under emotional pressures. Part of maturation is the slow mastering of language to describe experiences that are originally felt as inchoate bodily arousal. If one has little help on making that transition, the automatic physical responses may be the only language one has for states of emotional activation (Gilleland, Suveg, Jacob, & Thomassin, 2009).

Analysts have long described somatizing patients as characterized by alexithymia, or lack of words for affect (Krystal, 1988, 1997; McDougall, 1989; Sifneos, 1973), an observation supported by a recent, comprehensive study by Mattila and colleagues (2008). Waldinger, Shulz, Barsky, and Ahern (2006) found that both insecure attachment and a childhood history of trauma are associated with somatization. Trauma has been implicated by a number of researchers (Reinhard, Wolf & Cozolino, 2010; Samelius, Wijma, Wingren, & Wijma, 2009; Zink, Klesges, Stevens, &

Decker, 2009). Contrary to the assumptions of many, there is little empirical evidence for the reinforcement of somatization by parental responsiveness to it (Jellesma, Rieffe, Terwogt, & Westenburg, 2009). Rather, it seems to correlate with childhood fear, insecure attachment, and a less integrated sense of self (Evans et al., 2009; Tsao et al., 2009).

When life is hard to bear, the immune system can break down. I can recall (more clearly now than I could see at the time) several instances when I became ill during a period of emotional overload, and I have often heard friends and clients describe such tipping points in the face of particularly taxing events. Several studies have found that DSM-IV-defined somatization disorder co-occurs with the majority of personality disorders (Bornstein & Gold, 2008; Garcia-Campayo, Alda, Sobradiel, Olivan, & Pascual, 2007; Spitzer & Barnow, 2005), suggesting that somatization is common in more serious character pathology. People who regularly and characteristically respond to stress with illness may be conceptualized as having a somatizing personality (PDM Task Force, 2006). Although the DSM has never included characterological somatization in its listing of personality disorders, the DSM-IV description of "somatization disorder" describes individuals who have problems in multiple organ systems, over many years, under many different circumstances. This is pretty hard to differentiate conceptually from a personality disorder.

Most of us can think of acquaintances who respond to stress by getting sick. Therapists see many clients referred by physicians who have been defeated by a patient's chronic physical fragility, whom they have finally sent to see whether psychotherapy can help. We see others who come to us as a last resort because nothing else has successfully treated their tension headaches or irritable colon or skin rashes or chronic pain. Expression of feelings is the ordinary currency of the psychoanalytic and humanistic therapies. Because somatizers suffer automatically and physically and lack the capacity for such expression, they can be difficult to help—especially when their physical suffering has been complicated by having encountered impatience, exasperation, and a sense of defeat in previous health professionals and therapists.

The conclusion that a person complaining to a therapist of physical pain or exhaustion is using the defense of somatization should not be reached unreflectively. For one thing, the stress of disease itself can cause a regressive reaction. People can get sick because they are unconsciously depressed; they can also get depressed because they are medically ill. In addition, some clients come from cultures in which it is normative to express psychological suffering by reference to bodily pain or malfunction. In traditions where the idiom of distress is physical, even psychologically mature individuals express their difficulties this way, and so the assumption of a primitive regressive process is unwarranted (Rao, Young, & Raguram, 2007; So, 2008).

ACTING OUT (DEFENSIVE ENACTMENT)

As noted above, the other way young children express unverbalizable states of mind is by acting them out. In the first edition of this book, I put acting out with the more mature defenses because

in the chapter on primary defensive processes I was concentrating on the processes that Kernberg (1984) had explicated in connection with borderline and psychotic conditions. I think now that even though it characterizes healthy as well as more troubled individuals, it is a mistake to frame enactment as a second-order process: Putting into action what one lacks the words to express is by definition a preverbal operation. But I still want to issue my earlier caution: The label "acting out" gets applied to all kinds of behavior that the labeler happens not to like, often in a tone quite at odds with its original nonpejorative meaning. Most readers have probably heard the phrase bandied about disapprovingly and may not be aware of the more simply descriptive use of the term.

To my knowledge, the earliest uses of the phrase "acting out" occurred in psychoanalytic descriptions of patients' actions outside the analyst's office, when their behavior seemed to embody feelings toward the analyst that the person was unaware of having or was too anxious to let into awareness, especially in the analyst's presence (Freud, 1914b). Later on, the term became used more generally to describe behavior that is driven by unconscious needs to master the anxiety associated with internally forbidden feelings and wishes, with powerfully upsetting fears and fantasies, and with traumatic memories (Aichhorn, 1936; Fenichel, 1945). Still later, the related term "enactment" was applied to the representation in action of experiences for which the affected person had never had words and could not formulate verbally (Bromberg, 1998; D. B. Stern, 1997). Analysts in the relational movement emphasize that enactments are inevitable in therapy, as the unconscious worlds of both patient and therapist create mutually enacted dynamics, which the therapist is responsible to turn into speech and reflection. With respect to the individual function of acting out as a defense, by enacting upsetting scenarios, the unconsciously anxious person turns passive into active, transforming a sense of helplessness and vulnerability into an experience of agency and power, no matter how negative the drama that is played out (cf. Weiss, 1993).

A teacher, whose relationship to her judgmental mother had left her both frightened of and deeply hungry for intimacy, began a sexual affair with a colleague named Nancy a few weeks after entering therapy with me. I suspected she was beginning to feel some wish for closeness with me, was unconsciously assuming that I (like her mother) would be scornful of her longings, and was handling her unconscious and forbidden strivings by acting out aspects of what she wished and feared with someone who bore my name. This kind of enactment, assuming my interpretation of it is accurate, happens frequently in analysis, especially with patients who have a childhood basis for fearing an authority's rejection of their needs and feelings.

"Acting out" or "enactment" thus properly refers to any behavior that is assumed to be an expression of transference attitudes that the patient does not yet feel safe enough, or emotionally articulate enough, to bring into treatment in words. It may also be used to label the process by which any attitude, in or out of treatment, may be discharged in action with the unconscious purpose of mastering overwhelming, unverbalizable affects that surround it. What is acted out may be predominantly self-destructive, or predominantly growth enhancing, or some of each; what makes it acting out is not its goodness or badness but the unconscious or dissociated nature of the

feelings that propel the person into action and the compulsive, automatic way in which the acted-out behavior is undertaken. The current popularity of calling any unappreciated behavior—in obstreperous children, for example, or in rude acquaintances—"acting out" is psychoanalytically unjustified. The negative cast that the phrase has acquired may reflect the fact that beneficial kinds of acting out do not call attention to themselves in the way that destructive ones do.

Analysts have created several imposing labels depicting classes of behaviors that, when unconsciously motivated, fall under the general heading of acting out: exhibitionism, voyeurism, sadism, masochism, perversion, and all the "counter" terms ("counterphobia," "counterdependency," "counterhostility"). I am not, by the way, implying that these processes are inherently negative or even inherently defensive. We have normal exhibitionistic and voyeuristic needs that are ordinarily discharged in socially acceptable ways of looking and being looked at. Our masochistic and sadistic strivings may find positive expression in acts of personal sacrifice or dominance, respectively. All these tendencies may be integrated into pleasurable sexual experiences. But when applied to specific acts that are understood as defensive, such terms assume underlying fear or other disavowed or unformulated negative feelings. Freud's early observation that we act out what we do not remember remains astute, especially if we assume that the reason we do not remember is that something very painful went along with the unremembered and now-enacted state.

To the extent that there is an identifiable population of persons who rely on acting out to deal with their psychological dilemmas, that group would fall into the category of impulsive personalities. This nomenclature is misleading, as it implies an uncomplicated readiness to do whatever one feels like doing at the moment. Much of what may look like spontaneous, uncomplicated impulsiveness is often unconsciously and very complexly driven behavior, behavior that is anything but innocently expressive and random. Hysterically organized people are famous for acting out unconscious sexual scenarios; addicted people of all kinds can be conceptualized as repeatedly acting out their relation to their preferred substance (in such cases, of course, chemical dependency can complicate what was already a psychological addiction); people with compulsions are by definition acting out when they succumb to internal pressure to engage in their particular compulsive acts; psychopathic people may be reenacting a complicated pattern of manipulation. Thus, the defense may be seen in many contrasting clinical presentations.

SEXUALIZATION (INSTINCTUALIZATION)

Sexualization usually takes an enacted form and might be considered a subtype of acting out. I have chosen to present it separately, though, partly because it is possible to sexualize without acting out (a process that is more accurately referred to as erotization) and partly because it is a concept of such general and interesting significance that it deserves some special attention.

Freud (1905) originally assumed that basic sexual energy, a force he called "libido," underlies

virtually all human activity. (Later, impressed with the prevalence of human destructiveness, he decided that aggressive strivings are equally fundamental and motivating, but most of the language of his clinical theory derives from a time before that shift in his thinking.) One consequence of his biological, drive-based theory was his tendency to regard sexual behaviors as expressing a primary motivation, not a derivative and defensive one. Obviously, sexuality is a powerful basic dynamism in human beings, and much human sexual behavior amounts to relatively direct expressions of the reproductive imperative of our species. Clinical experience and research findings (see Celenza, 2006; Ogden, 1996; Panksepp, 2001; Stoller, 1968, 1975, 1980, 1985) over the decades since Freud's work, however, attest to how often sexual activity and fantasy are used defensively: to master anxiety, to restore self-esteem, to offset shame, or to distract from a sense of inner deadness.

People may sexualize any experience with the unconscious intention of converting terror or pain or other overwhelming sensation into excitement—a process that has also been referred to as instinctualization. Sexual arousal is a reliable means of feeling alive. A child's fear of death—by abandonment, abuse, or other dreaded calamity—can be mastered psychologically by turning a traumatic situation into a life-affirming one; many children masturbate to reduce anxiety. Studies of people with unusual sexual proclivities have often turned up infantile experiences that overwhelmed the child's capacity to cope and were consequently transformed into self-initiated sexualizations of the trauma. For example, Stoller's (e.g., 1975) work with sexually masochistic people, those for whom pain is a condition of sexual satisfaction, revealed that a significant number of them had suffered invasive and painful medical treatments as young children. At the other end of the sadomasochistic spectrum, rape is the sexualization of violence.

Most of us use sexualization to some degree to cope with and spice up troublesome aspects of life. There are some gender differences in what tends to be sexualized: For example, women are more apt to sexualize dependency and men to sexualize aggression. Some people sexualize money, some sexualize dirt, some sexualize power, and so on. Many of us sexualize the experience of learning; the erotic aura around talented teachers has been noted at least since the time of Socrates. Our tendency to erotize our reaction to anyone with superior power may explain why political figures and other celebrities are typically deluged with sexually available admirers, and why the potential for sexual corruption and exploitiveness is so great among the influential and famous.

The susceptibility of those in a relatively weak position to converting their envy, hostility, and fear of mistreatment into a sexual scenario, one in which they compensate for a relative lack of official power with recourse to a very personal erotic power, is one of the reasons we need laws and conventions protecting those who are structurally dependent on others (employees on employers, students on teachers, sergeants on lieutenants, patients on therapists). We all need to be discouraged not only from the possibility of crass exploitation by the authorities in our lives but also from the temptations created by our own defenses.

At the risk of belaboring a point that applies to all defensive processes, let me stress that sexualization is not inherently problematic or destructive. People's individual sexual fantasies,

response patterns, and practices are probably more idiosyncratic than almost any other psychological aspect of their lives; what turns one person on erotically may leave another cold. If I happen to sexualize the experience of someone's handling my hair (even if the childhood genesis of my doing so was a defensive sexualizing of my mother's abusive hair yanking), and my sexual partner loves to run his or her fingers through it, I am not likely to go into psychotherapy. But if I sexualize the experience of being frightened by abusive males, and I have repeated affairs with men who beat me up, I might well seek help. As with every other defense, it is the context and consequences of its use in adulthood that determine whether it is reasonable to be regarded (by self and others) as a positive adaptation, an unremarkable habit, or a pathological affliction.

EXTREME DISSOCIATION

I have put extreme dissociation with the primary defenses here, both because it works so globally on the total personality and because many dissociated states are essentially psychotic. Since the first edition of this book, however, I have become increasingly sensitized to the range of dissociative reactions and the inadvisability of restricting our use of the term "dissociation" to the overwhelming, shock-trauma versions of the defense. In 1994 I wrote that dissociation seemed different from the other lower-order defenses because it is so clearly a response to severe trauma, from which many of us are thankfully spared while growing up (the other processes, in contrast, represent normal modes of operating that become problematic only if one hangs onto them too long or to the exclusion of other ways of dealing with reality). But I have come to agree with many contemporary relational analysts (e.g., Bromberg, 1998; Davies & Frawley, 1994; Howell, 2005) that it is a matter of degree that separates one person's pain from another's trauma, and that dissociation exists on a continuum from normal and minor to aberrant and devastating.

Dissociation is a "normal" reaction to trauma. Any of us, if confronted with a catastrophe that overwhelms our capacity to cope, especially if it involves unbearable pain and/or terror, might dissociate. Out-of-body experiences during war, life-threatening disasters, and major surgery have been reported so often that only the most skeptical person can completely disregard the evidence for dissociative phenomena. People who undergo unbearable calamities at any age may dissociate (Boulanger, 2007; Grand, 2000); those who are repeatedly subject to horrific abuse as young children may come to dissociate as their habitual reaction to stress. Where this is true, the adult survivor is legitimately conceptualized as suffering from a chronic dissociative disorder, once labeled "multiple personality" and currently termed "dissociative identity disorder."

There has been an explosion of research and clinical reporting on dissociation and dissociative identity disorder in recent decades, all of which has underscored the fact that people who use dissociation as their primary defense exist in far greater numbers than anyone had previously suspected (see I. Brenner, 2001, 2004). Perhaps there has been an increase in the kind of horrific child abuse that creates dissociation, or perhaps some threshold of public awareness was crossed

with the publication of *Sybil* (Schreiber, 1973) that has encouraged people who suspect that they may be regularly dissociating to show themselves sooner and in greater numbers to mental health professionals. Neuropsychoanalytic studies are beginning to describe what goes on in the brain in states of dissociation (Anderson & Gold, 2003; Bromberg, 2003).

The advantages of dissociating under unbearable conditions are obvious: The dissociating person cuts off pain, terror, horror, and conviction of imminent death. Anyone who has had an out-of-body experience when in mortal danger, and even those of us without such a dramatic basis for empathy, can readily understand a preference for being outside rather than inside the sense of impending obliteration. Occasional or mild dissociation may facilitate acts of singular courage. The great drawback of the defense, of course, is its tendency to operate automatically under conditions in which one's survival is not realistically at risk, and when more discriminating adaptations to threat would extract far less from one's overall functioning. Traumatized people may confuse ordinary stress with life-threatening circumstances, becoming immediately amnesic or totally different, much to their own confusion and that of others. Outsiders, unless they also have a traumatic history, rarely suspect dissociation when a friend suddenly forgets some major incident or appears inexplicably changed. Rather, they conclude that their acquaintance is moody, or unstable, or a liar. There is thus a high interpersonal price paid by the habitual user of this defense.

SUMMARY

In this chapter I have described defenses that analysts conventionally consider primitive or primary: extreme withdrawal, denial, omnipotent control, extreme idealization and devaluation, primitive forms of projection and introjection, splitting, somatization, enactment, sexualization, and extreme forms of dissociation. I have reviewed the assumed normal origins of each defense and mentioned adaptive and maladaptive functions of each. I have also identified the personalities and syndromes associated with heavy reliance on each primary defense.

SUGGESTIONS FOR FURTHER READING

Primitive forms of projection and introjection have inspired a few worthy books (Grotstein, 1993; Ogden, 1982; Sandler, 1987; Scharff, 1992); other primary defenses tend to be discussed in different writers' speculations about psychic development. Klein's "Love, Guilt and Reparation" (1937) and "Envy and Gratitude" (1957) are highly illuminative of primitive processes and, unlike some of her work, not incomprehensible to beginning therapists. Balint (1968) was gifted in describing archaic dynamics in individuals; Bion (1959) was peerless at discerning their operation in groups. Grotstein's *Splitting and Projective Identification* (1993) is also a brilliant and useful exposition of these Kleinian concepts.

Phoebe Cramer's *Protecting the Self* (2006) reviews some fascinating studies of defenses and their development and offers empirical support for the longstanding psychoanalytic observation that maturation of defensive style is associated with psychological health, whereas reliance on more primitive defenses correlates with psychopathology. George Vaillant has devoted much of his remarkable career to the understanding of defensive processes; his 1992 book, *Ego Mechanisms of Defense*, is particularly useful to therapists.