

Defense Mechanisms in the 21st Century

JEROME S. BLACKMAN

Defenses can be found in language, entertainment, humor, and literature. We use defense theory to explain various types of human behavior, thought, and psychopathology. Defenses inform the research of some neuroscientists. We can also use defense theory to refine ideas about supportive and interpretive types of psychotherapy.

Defenses in Language, Music, Humor, and Organizations

We use the concept of defense in English idioms. For example, we reference specific defenses in expressions such as: “The acorn doesn’t fall far from the tree,” referring to the defense of *identification* with parents; “He’s a glutton for punishment,” referring to the defense of *masochistic provocation* – usually to relieve unconscious guilt; “Mid-life crisis,” referring to the middle-aged man who starts acting like a teenager (sports car, new “hot” girlfriend) – i.e., the defense of *libidinal regression* used to relieve the depressive feelings that go along with aging; “I’m not angry, you are!” referring to the defense of *projection*; “He’s a pushover!” – the defense of *passivity*; and *denial*, the defense of not seeing something that is quite evident because it is painful.

Denial is mentioned in the country song lyrics, “call me Cleopatra . . . , Cause I’m the Queen of *Denial*”, where the singer observes that her fear of losing love has caused her to (defensively) overlook her lover’s negative character traits. In a more serious vein, Alcoholics Anonymous’s Step 1 involves confronting alcoholics’ *denial* of addiction, a defense they had used to avoid shame.

Ideas about defense also are used by the Big Brothers organization, which, due to Ernest Coulter’s astute observations in 1904, recognized the need of fatherless boys to have a kind, helpful, and honest male adult with whom the boys could have contact. Once the boy felt attached to a Big Brother, the boy could *identify* with that man’s value system (superego) and thus be better able to manage (i.e., defend against) delinquent (hostile-destructive) urges. And, of course, it is widely known that physically abused children tend to *identify with the aggressor* – they may become abusive toward others as a way to avoid feeling angry and afraid regarding their own mistreatment.²

In literature, Dave Barry, in his new book, *I’ll Mature When I’m Dead*,³ jokes about trying to disentangle “the five-thousand-bulb string of [Christmas tree] lights that has, using its natural *defense mechanism*, wadded itself into a dense snarl the size of a croquet ball.” (Italics added.) In addition, over 10 rock bands have put out a song called “Defense Mechanism.”

So what are Defenses?

To answer that question, it turns out that we have first to define emotions, or as mental health types call them, “affects.” Brenner (1982)⁴ clarified that, clinically, every affect is made

“Defense mechanism” is a common term that, in the 21st-century, we occasionally use in everyday conversation.

INSIDE

| | |
|--------------------------------|----|
| Editor’s Note | 2 |
| A Man for all Reason | 8 |
| The Language of Psychiatry | 11 |
| Psychotherapy in a Digital Age | 14 |
| Intrusion | 15 |

Welcome to the spring 2011 edition of Synergy

This is our first themed edition of the journal: *The Psychotherapy Issue*.

Our cover essay takes a popular topic – defense mechanisms – and adds enough scholarly heft to satisfy the academics and therapists among our readership while explaining the concepts and using popular examples for a general audience.

Albert Ellis died four years ago this summer, leaving a legacy which our second article both explains and evaluates. This extended tribute, which shows a clear affection for its subject, is anything but an obituary for the man's work and his theories.

Also in this issue we continue our series "The Language of Psychiatry," which attempts to explain common psychiatric terms for the non-psychiatric clinician (while maybe even explaining them for the psychiatric community, too). The term chosen for this the psychotherapy issue is, fittingly, *Insight*.

Previous issues have included a column called "Librarian's Corner". We welcome this space once again with a short article about psychotherapy in a digital age, where the internet, Facebook, and Twitter may change the face-to-face interaction common to most encounters.

Our back pages go again to a personal essay exploring the intrusive nature of so much in medicine and psychiatry, of which psychotherapy is no exception but rather the rule.

We hope you enjoy the prose and, as always, welcome your comments.

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Articles may be submitted in the form of a Microsoft Word document as an email attachment.

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up of 1) a sensation, and 2) a thought. We then define *defense* as the mental operation that shuts out of consciousness the sensation, the thought, or sometimes both. Shutting the thought content out of consciousness is called "*repression*" (if you don't realize you are forgetting). Shutting out the sensation is termed "*isolation*" or "isolation of affect" (again, if you don't know you are doing this). If you are aware of trying to forget, most analysts name this "*suppression*."

For example, anxiety comprises an unpleasurable sensation plus a thought that something terrible will happen in the future. The thoughts of the anticipated danger include loss, bodily harm, punishment, death, disorganization, humiliation, and failure. People who suffer from panic attacks experience the unpleasurable sensation of the anxiety, but usually the thought content is shut out of consciousness (*repressed*) – i.e., they don't know what they are afraid of. An aspect of treating some people with panic attacks, therefore, might be to discuss the repressive mechanisms and, through obtaining other material about their conflicts, to figure out what thoughts had been repressed and why. Once people can see the conflicts that had been repressed, they can better solve those conflicts using reason and intellect.

Depressive affect includes an unpleasurable sensation plus a thought that something terrible has already happened. People who have lost a loved one but who are bottling up their emotions may go about their daily work, but develop irritability and sleep problems. In your office, they tell you about the recent loss, but say they are "over it." Typically, we formulate that they are aware of the thought content of the depressive affect (the loss), but not aware of the unpleasurable sensations. Treatment involves bringing the *isolation of affect* to the patient's attention (dynamic interpretation), which often leads patients to become overtly tearful and upset. The conscious recognition of sadness over the loss, plus understanding whatever guilt is felt over residual anger toward the deceased⁵ (for leaving, for getting sick, or for mistreating the bereaved), seem to help mourners detach some of their powerful feelings from the memories of the lost loved one, and go on with their lives. In

other words, when the sensation, which had been shut out of consciousness (*isolation of affect*), becomes conscious, people can often better grieve and reintegrate.⁶

What does Neuroscience have to say about Defenses?

The short answer: just a bit, but it is encouraging.⁷ Anderson and colleagues at St. Andrews University in Scotland⁸ have delineated, using fMRI, that affects, generated in the limbic system and hippocampus, are shut off by the defense mechanisms (of suppression and repression) in the prefrontal (cerebral) cortex. This finding correlates not only with Freud's later concepts, but also with Brenner's.

The Solmses⁹ and others (such as Jack Panksepp) have been studying neural correlates of attachment, as well as brain mechanisms associated with anxiety. Again, the limbic system and the hippocampal gyrus are implicated regarding affects.

Morton Reiser, when he was Chair of Psychiatry at Yale, published studies correlating primary process (condensed, symbolic) thinking with findings from neuroscience.¹⁰ The fact that defenses make something unconscious, at least for awhile, complicates neuroscience research, as the nature of consciousness and unconsciousness is so poorly understood brain-wise. Gerald Edelman, the director of the Neurosciences Institute in La Jolla, California, has studied memory, but not the brain factors related to memory retrieval¹¹.

Why would anyone use Defenses?

Defensive operations, which can be adaptive or maladaptive, are generally called up by the mind under one of three conditions. First, the affect generated by a reality event or by inner conflict may be extraordinarily intense. For example, when a friend's son became ill, he *adaptively* used *isolation of affect* and *intellectualization* – that is, he didn't experience the terrible sensation of his fear and used intellect to keep the sensations unconscious. His defenses allowed him to use his intellect, speech, and executive functions to get the child to the hospital. On the contrary, a male patient of mine reported it was "no big deal" when, after a fall, he could not raise one arm up more than parallel to the floor. I confronted his *maladaptive mini-*

mization; he then consulted an orthopedist, who performed rotator cuff surgery on the patient within days.

Second, a person's capacity to withstand powerful affects may be weakened (as in small children and in adults with borderline personality). After his wife realized he was cheating on her, for example, a middle-aged man first admitted guilt; but within days of promising his wife he would break off with his girlfriend, he visited and had sex with his girlfriend, and then confessed this to his wife. His therapist pointed out to him that he was *provoking punishment* (by confessing to his wife) to relieve guilt; and *using sexual intercourse* with his girlfriend to relieve his pain over giving her up. Both defenses were maladaptive.

Finally, an affect may be generated by a symbolic conflict, as in sexual inhibitions and phobias, where the mind responds to the symbolism as though the danger were real. A young married woman, for example, developed an acute phobia of telephones. In treatment, she eventually remembered that after a fight with her husband, her old boyfriend from college had called to ask her out. She had responded that she was married but having problems, and that she would call him back soon. At that moment, she had had an angry wish to cuckold her husband, which conflicted with guilt. She *projected* those urges onto the telephone, which now *symbolized* her conflict, and then avoided the phone. Once she realized all this, she had a serious talk with her husband that straightened out some of their problems.

Cinematic Defenses

Those moviemakers who are interested in character development often depict life-like defensive operations in their *dramatis personae*, and demonstrate through the plot how the characters' pathological defenses change to healthier defenses or not. Since people I have taught have found dissecting movie roles instructive in understanding the ubiquity and utility of defense theory, I have described some of my favorite examples in what follows.

Narcissism as a way of *avoiding* (i.e., *defending against*) anxiety about emotional closeness is a theme in many movies. Recent

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ones include *Eyes Wide Shut* (1999), *Notting Hill* (1999), *Jerry Maguire* (1996), and *Closer* (2004).

The Lion King (first produced as an animated movie in 1994, and since revived several times, including as a Broadway musical) is a particularly good example of a movie that involves multiple defenses. The protagonist, Simba, *regresses*, after his father's death, by gallivanting around with the warthog and the meerkat. As many delinquent teenagers do, he misbehaves with them in a "hakuna matata" (no worries) lifestyle, thereby *avoiding* his guilt and depression over his father's death. Simba also is *punishing himself* (by giving up his line to the throne) to relieve guilt over his belief that his disobedience had caused his father to get trampled in a stampede.

Simba is unable to resume his normal development until three things happen. First, Nala, his childhood girlfriend, encourages him to save the pride from the hyenas (sets an ego ideal). Second, Simba's father's ghost, seen in a thunderstorm, admonishes Simba to do his duty (stimulates *superego identification with the lost object*¹² – that he should act responsibly toward that ideal). Simba's aggression is not released from *isolation* (the defense of not sensing emotions), however, until his uncle, who had actually caused Simba's father's death, admits this to Simba during a fight. Upon realizing he is not guilty of patricide, Simba's guilt is relieved. No longer *inhibited* by guilt, Simba can now kill his uncle, return to save the kingdom, marry Nala, and give her a baby. His success neurosis is cured.

Sex and procreation are not always the result of relief of pathological defenses, however. Sometimes, *sexual activity*, itself, is used defensively. For example, to *improve* (i.e., defend against) her poor self-esteem, Cameron Diaz sleeps with her sister's boyfriend in the movie, *In her Shoes* (2005). Her character winds up living with her grandmother, Shirley MacLaine, in the grandmother's retirement village. While she is there, Diaz is serendipitously seduced by a dying professor into reading to him. She *introjects* (takes in) his praise of and confidence in her, which leads her to develop better self-esteem, especially after he dies (*identification with the lost object*).

Up in the Air (2010) is a tragedy in which George Clooney's brief transition to mental health is sadly fleeting. At the beginning of the movie, he is a slick traveling businessman who *idealizes* his use of defensive *emotional distancing* as a lifestyle. His value system (superego) is modified after a younger female colleague chides him for avoiding a commitment with Vera Farmiga, with whom he has been having an affair. Finally, after being persuaded by his older sister to help his younger sister's future husband get over cold feet about the wedding, Clooney *identifies* with his sisters' values, and drops the distancing as an ideal in relationships. He is therefore shocked to find, on surprising Vera Farmiga at home, that she is married with children. She clarifies that she was just using Clooney as an "escape," i.e., a defense against boredom and loneliness when she was traveling alone. He then reacts to his depressive affect (disappointment) defensively by going back to his old ways: *identifying with the aggressor* – after the fact and *regressing* to more distancing.

Finally, the *Star Wars* saga (6 episodes, 1977-2005) is a treasure trove of developmental and political conflicts that bring about a plethora of defensive maneuvers in its characters. One of the most notable is the transformation of Anakin Skywalker into Darth Vader. In Episode III, Anakin is seduced toward "the dark side of the Force" through a series of manipulations by the future Emperor; this plus Anakin's nightmares of his wife's dying in childbirth cause him (defensively) to turn from the Jedi to the dark side – where he feels he will have more power to save his wife, and therefore prevent the pain of loss. (His wife does eventually die in childbirth.)

Anakin's anticipation of grief is inflamed because his wife, Queen Amidala, had been a *replacement* (symbolic substitute), to a degree, for his mother. In Episode I, we learned that Anakin had been removed from his mother, for Jedi training, when he was nine; Anakin's violent anger about the loss of his mother was noted by Yoda when Anakin was first interviewed, and had caused Yoda initially to object to Anakin as a potential Jedi Knight trainee.

By Episode III, fatherless Anakin has become a Jedi Knight, trained by Obi-Wan

Kenobi (his Big Brother, sort of). But Obi-Wan must leave, alone, on a mission. Enter the future Emperor, Chancellor Palpatine (secretly the evil Sith Lord, Darth Sidious), who induces Anakin to *disidentify* from the stepfather-figure, Obi-Wan, to *displace* his rage about the losses (mother, Obi-Wan, and dreamed-of wife) onto the Jedi and later the Rebel Alliance, and to *identify with the grandiosity* (power) of Palpatine to relieve pain and anger. When Obi-Wan, Anakin's (defensively) *devalued* father substitute, returns, Anakin fights him (at Palpatine's behest) and is almost killed. Palpatine restores Anakin as a cyborg, who, as Darth Vader, inflicts death instead of being the victim of pain and loss himself (*identification with the aggressor* and *turning passive to active*, both defenses).

In the final episode, VI: *Return of the Jedi*, Vader has a final battle with Luke Skywalker. Luke turns out to be Vader's own son. Luke refuses to kill Vader, but Vader cannot tolerate seeing his son tortured with lightning by the now Emperor Palpatine. Vader therefore relinquishes his identification with the evil Sith Emperor (*disidentification*), and sacrifices himself to kill the Emperor and save his son. Just before Vader dies, he drops his *hostility* as a defense against pain, stops *disavowing* his Anakin-as-father identity, and requests that his vile helmet be removed by Luke so that they can see each other.

Defenses and Psychiatric Diagnosis¹³

Although the *DSM* suggests annotating defensive operations on Axis II, I have found that this is rarely done. This is of some interest since serious mental illnesses (SMIs), including major depression, bipolar disorder, and schizophrenia, only afflict about 6 per cent of the U.S. population¹⁴. If you factor in the probable overestimate of the frequency of bipolar disorder¹⁵, the percentage is no doubt a bit lower. In comparison, approximately 20 per cent of the population has a diagnosable condition that is not psychotic. In spite of the prevalence of nonpsychotic disorders, SMIs account for the vast majority of cases seen by psychiatrists and other counselors. People with SMIs usually suffer with *deficits in functioning*, and their various defensive operations are less useful

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both in diagnosing them and treating them. Defense theory can be used in formulating supportive comments¹⁶ (for example, by offering patients with schizophrenia education, which partly engenders *intellectualization*), but usually not for interpretations.

Specifically, people with SMIs often have deficits in their abstraction ability (they don't understand symbolism and metaphors), integrative function (they are loose, tangential, circumstantial, disorganized), reality testing (they can't tell what's real), and/or self-preservation (they make suicide attempts). Further, some people can't keep bizarre, symbolic, dream-like thoughts out of consciousness; one woman complained of "day-mares." When such so-called breakthroughs of primary process (condensed, symbolic) thinking occur *and* people can't tell that their bizarre thoughts are fantasies (reality testing damaged), they experience delusions and hallucinations. Defense interpretation is not of much use with most people who suffer with deficits such as these; these patients may benefit from antipsychotic medicines, antidepressant medicines, mood stabilizers, and/or minor tranquilizers, along with supportive psychotherapy, rehabilitation (when possible), and sometimes hospitalization for their own safety. (For poignant personal descriptions about deficit phenomena, see Willick¹⁷ and Saks¹⁸.)

There are other people who show up wanting treatment who do not have deficits in major functions, but they cannot sustain close relationships. They present with disturbances based on "object relations" deficits and conflicts. Briefly, this refers to weaknesses in their capacities for warmth, empathy, trust, and emotional closeness. With these patients, defense clarification is of some utility, but they also need much "relational" work¹⁹.

Another reason many practitioners do not routinely mention defenses in the formulation of people's problems (even when people show very few if any deficits in functioning) is that defensive operations are quite difficult to find. The vast majority of the time, defensive functioning happens out of the range of people's awareness (like Simba [*supra*]). Most nonpsychotic patients

complain of symptoms, unpleasant emotional states, and tangled relationship issues. They would like relief or advice as to how to make things better. It is quite uncommon for someone to complain of pathological defensive operations or to express a wish to be confronted about them.

In *101 Defenses: How the Mind Shields Itself*, I describe several deductive and inductive methods of finding people's defensive operations. One useful method of locating unconscious defense involves noticing, as a therapist, when you want to ask a question. When you find yourself wanting to ask a question, there are two common reasons for this: 1) the patient is disorganized (integrative deficit) – which requires that you structure the session; or more commonly, 2) the patient is using defenses. If people were not using defenses, you would not need to ask them questions!

So when Jennifer, a 34-year-old depressed attorney, complains that her husband never does what she would like, you want to ask, "What doesn't he do that bothers you so much?" If she hasn't already told you, likely there's a reason (a defense). So instead of asking her that question, you might say, "It's interesting that you're kind of *vague* on the details there. It seems hard for you to give me the whole story." What the therapist may find is that Jennifer had not given the details because she feels guilty that she is so childishly demanding of her husband (a mother-transference [defense]). A therapist who simply expresses understanding of how difficult it is to live with a man who doesn't pay attention will only be correct part of the time. Just as likely, that seemingly empathic comment may represent a concordant identification (type of countertransference described by Racker²⁰), and miss Jennifer's unconscious conflict between oral demandingness and guilt, which led her to use *projective blaming* as a defense in complaining about her husband.

After all this, there is a final layer of complexity. After ascertaining that people do not have major deficits in ego functions and object relations, the evaluator must determine which unconscious shutoff mechanisms are *maladaptive*. When people com-

plain of symptoms like airplane phobia, sexual inhibition, procrastination, or cowardice, we look for maladaptive defenses that are usually embedded in *pathological compromise formations*.

Compromise Formations and Psychoanalysis

Of the many rock bands that have recorded songs entitled, "Defense Mechanism," *State of Being* has lyrics that are the most astounding, to wit:

"... i have not resolved my internal abundance
of instinct drives motivation of fantasy
is punished by my social state
result of the conflict produces anxiety
formulating pressure into hate
neuroticism engulfs all...
defense mechanisms call..."²¹

It turns out that this is a fairly good description of the concept of compromise formation, first explained by Freud in 1926²², codified by Waelder in 1936²³, and refined by Brenner in 2006.²⁴ As *State of Being* formulated, compromise formations are the end results of inner conflicts that arise throughout child, adolescent, and adult development. The structure that results from the resolution of the conflicts usually contains five warring elements: 1) wishes (especially dependent, loving, and hostile-destructive ones); 2) conscience reactions (such as guilt and shame); 3) perceptions of reality; 4) affects (different types of anxiety, anger, and depressive affect); and 5) defensive measures. The final common pathways for resolution of these conflicts can be adaptive or maladaptive. When maladaptive, the resolutions make up the structure of psychiatric symptoms and personality problems ("neuroticism").

So why is John late to every meeting? After ruling out deficits in his reality testing or sense of time, we may find, prototypically, that he suffers from a compromise formation where: 1) he wishes to be destructive toward authority, 2) he feels guilty about the hostile-destructive wishes, 3) he hates boring meetings, 4) he defensively (partly) *avoids* what he dislikes, and 5) he simultaneously relieves his guilt by getting himself *punished* (*defenses*). Thus we have a common profile of the procrastinator.

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John may also wish to be lazy, and in him this wish conflicts with reality and with shame. His lateness may therefore also be caused by a partial expression of his wish to be lazy at the same time he gets himself humiliated to relieve (defend against) his shame. This scenario can occur at the same time as the compromise formation engendered by his hostility. It's just a short step from such a conceptualization to realizing that there may be further complications from the reality of John's history with the group at work. In addition, perhaps the work group has taken on symbolism from John's adolescence, and his lateness is also a leftover from rebellious/self-punishing reactions he had to his father and mother as a teen (the defense of "transference").

In John's case, if someone just tells him to be on time (a logical first step), it may actually have the paradoxical effect of inflaming his procrastination because of the transferences, conflicts, and defensive operations. If so, John will probably need an interpretive (psychoanalytic) approach, where the therapist explains, after gather-

ing the specific information, how John's compromise formations are tripping him up. Considering that John can use abstract and symbolic thinking, he should be able to understand, with help, the symbolism of what he is doing. And if he also has an intact integrative function, he should be able to make use of his new understanding to *reintegrate*, and stop "acting out" his conflicts.

A Brief History of Defense

(with apologies to Stephen Hawking²⁵)

The history of the defense concept is fascinating and lengthy. The short version is that it started, not surprisingly, with Sigmund Freud. He realized, in 1894²⁶, that some type of mental activity was shutting certain thoughts out of awareness. By 1900²⁷, Freud named this activity "the censor," and by 1923²⁸, "repression," which seems to have lasted. Anna Freud made the first list of defenses in 1936²⁹. Fast-forward to 1982, when Brenner clarified that *anything* can be used as a defense – even golf or surfing the internet.

The Electrified Mind: Development, Psychopathology and Treatment in the Era of Cell

*Phones and the Internet*³⁰ contains many chapters regarding *autistic defenses* used by teenagers to avoid painful feelings; they can get lost on the internet in such sites as "Second Life," and "World of Warcraft."³¹ Finally, when Ellen Pinsky³² reviewed my book, *101 Defenses*, she recognized that my title, although referring to the number of defenses I describe, was also kind of a joke – the number of things the mind can use defensively is virtually infinite.

Using Defense Theory in Conjunction with Other Therapeutic Approaches

In the mental health field, we have several different treatments to offer people who are suffering emotionally. For example, when people are depressed, there are a variety of efficacious therapeutic approaches, including medication, cognitive-behavioral therapy, and dynamic (interpretive) therapy. The set of indications for each, and the exact techniques utilized, are matters of ongoing study and discussion.

Sometimes different therapeutic approaches can be used effectively in combi-

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nation. Sarwer-Foner³³, a psychiatrist and psychoanalyst, was one of the first to publish a textbook about the symbolic and defensive implications of prescribing medication.³⁴ I.e., for some patients and therapists, it can be useful to think of the symbolic and defensive meanings of prescribing and taking medicine, in addition to the physical effects.³⁵ In recent years, it has become common for psychoanalysts to prescribe (or refer patients for) medication.³⁶ In addition, some cognitive-behavioral therapists have integrated certain dynamic concepts and techniques, such as exploring why patients (defensively) “forget” to do the homework.

As far as dynamic approaches go, Blatt³⁷ has described defensive causes of depressive affect, such as *avoidance* of mourning over losses (also see Volkan³⁸, 1987) or *turning anger on the self* (as revised by Menninger³⁹ in 1933) to avoid guilt. If the patient shows enough healthy functioning (abstraction, integration, reality testing, self-preservation), then interpretation of those

defenses and the conflicts that caused them is often useful.

Ironically, as defense theory has been redefined⁴⁰, some groups of psychoanalysts have sidelined the concept. They tend to focus instead on “attachment”⁴¹ among people, including how the therapist interacts with the person requesting help for almost any problem. The challenges that therapists face about how to determine diagnosis and how to select the correct treatment led me to write my recent book, *Get the Diagnosis Right: Assessment and Treatment Selection for Mental Disorders* (Routledge, 2010).

Some Parting Thoughts

The concept of defense starts with the common-sense observation that most people tend to avoid things that are unpleasant unless they, for some reason, cannot do so. We can then define defense as a sort of circuit breaker brought into play by the brain to guard against unpleasurable affects associated with reality or with unconscious inner conflict. Defense (everything from

garrulousness to *reticence*) acts to shut some aspect of mental contents out of consciousness. When those contents are stored in memory, they can often be retrieved, as during interpretive therapy.

Defenses, although present in severe mental illnesses (psychoses and near-psychoses⁴²), are not the cause of such disturbances, and interpretation of them is generally not part of the treatment approach. Defense theory, on the other hand, facilitates diagnosis of people who do not show much deficit in basic mental functions; highlighting defenses for those people can be extremely useful to them in rethinking their problems and reorganizing their thoughts and actions.

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A Man for all Reason

IRWIN F. ALTROWS

ALBERT ELLIS AND RATIONAL EMOTIVE BEHAVIOUR THERAPY

You feel the way you think: change your thinking to change your feelings, your actions, and your life. Sounds easy? Sure, it's as easy as riding a Krebs cycle.

What is the nature of dysfunctional thinking, and what are the paths and barriers to emotionally healthy change? Albert Ellis developed a theory to address these questions.

Albert Ellis was born on September 27, 1913. Drawing on science, philosophy, and his own experiences as a psychoanalyst, he devised a theory of emotional disturbance and its remediation. In 1955, he delivered his seminal talk on Rational Therapy. He proposed that people are biologically predisposed to think in a manner that creates emotional and behavioural disturbances, he elucidated the specific nature of the common disturbing thoughts, and he developed creative prevention and treatment methods. He twice renamed his approach, eventually calling it Rational Emotive Behaviour Therapy (REBT) to reflect its comprehensive nature.

Although practice of Ellis' therapy is not easy, its fundamentals are as simple as ABC: it is not solely an Adversity of life, but one's philosophical Belief about it, that produces emotional and behavioural Consequences. In other words, you feel and act the way you think. Therefore, he reasoned, where there is evidence of emotional or behavioural disturbance, one is likely to find dysfunctional thinking. Once the dysfunctional thinking has been identified, therapy proceeds by Disputing the upsetting beliefs, weakening them and replacing them by more functional beliefs. Identifying the A, B, and C of dysfunctional emotion constitutes assessment, whereas D – the heart of treatment – is the disputing of irrational beliefs by cognitive, emotional, and behavioural techniques.

The philosophy endorsed by Ellis, which might be called *active acceptance*, is designed to enhance both resilience and resourcefulness. Ellis helps people first to develop *acceptance* of themselves, others, and life as they are now – he calls these attitudes Unconditional Self Acceptance (USA), Unconditional Other Acceptance (UOA), and Unconditional Life Acceptance (ULA). Next, he helps people to get *active* and work – in a calm but determined manner – toward favourable changes in themselves or their environment.

Ellis was not shy in expressing his opinions or in his manner of doing so; while many have delighted in his humour and directness, not all have, and some have decided to reject REBT for this reason. This seems unfortunate, as the usefulness of a therapeutic model does not depend on the quirks of its founder. REBT does not especially favour specific ideas, but rather promotes flexibility of thinking. Regardless of one's views on any topic, REBT advocates holding these views as hypotheses, subject to scientific and experiential scrutiny, rather than as inviolable truths.

Ellis distinguished between "rational" and "irrational beliefs" on the basis of logic, empiricism, and pragmatics. The distinction is not categorical but on a continuum. In general, preferences are considered rational, whereas absolute demands are not. If a belief is provable and realistic, helps you feel better in the long run, and helps you achieve your goals, it is considered more rational than a belief without these qualities.

At first, Ellis made lists of ten to twelve classical "irrational beliefs" to which people unfortunately tend to adhere. Later, Ellis distilled his set of irrational beliefs to one: demanding (as opposed to preferring) that you, others, and life be exactly as you would prefer. For example, "I must always win success and approval, others must treat me well, and life

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must be fair and easy." It is fine to prefer these things, but if you demand them – good luck! When Ellis refers to these demands as Jehovian commands, many clients see that they are trying to control things that are outside their human control; they often become amenable to learning how to surrender these demands, while working to getting their preferences met.

Presently, irrational beliefs are considered to have some of the following four elements:

- 1 "demandingness" (for example, "I must receive approval, you should treat me well, and life must be easy");
- 2 low frustration tolerance (that is, "I-can't-stand-it-itis");
- 3 global evaluation or the labeling and rating of self or others (for example, applying epithets as labels to people);
- 4 "awfulizing" or "catastrophizing" (it is noted that "catastrophizing" has been found to mediate the association between pain and disability).

Ellis' theory and his keen sense of observation led him to anticipate developments in society as well as in psychological research. For example, he long held that the association between Type A personality and medical problems was not due to achievement motivation but to hostility (and its underlying demandingness), a hypothesis that research has since supported. His views on the risks and benefits inherent in the nosology of psychiatric disorders anticipated, and may have largely provoked, improvements in description and classification as well as development of anti-stigma campaigns. Perhaps most importantly, he has indicated that his greatest dream was to have REBT widely taught in schools (e.g., through programs such as Knaus' Rational Emotive Education). He was concerned about people who failed to question extreme positions and their potential for obtaining extremely powerful weapons to follow their unexamined ideas; he hoped that widespread rational education of children might help prevent disasters that might follow.

Ellis was an iconoclast. For example, when most of the self-help world was telling people to increase their self-esteem, Ellis suggested that they forget about self-esteem. High self-esteem, he said, is as irrationally based as low self-esteem, for it involves self-rating and leads to conditional self-acceptance; the internal dialogue associated with self-esteem is along the lines of "I am acceptable because, and only so long as, I have the following attributes." Instead of concerning themselves with self-esteem, he suggested that people rate their behaviours with reference to the goals they wish to attain. Perhaps Ellis' most important icon-smashing involves the self-defeating language of everyday life, such as "This problem is depressing" or "You're making me angry." According to REBT, although adversities contribute to people's responses, people anger or depress themselves via their irrational thinking. With practice in REBT, one's inner dialogue changes and so do one's feelings.

Ellis never dogmatically defended his theory. He would listen intently to critics and incorporate their observations into revisions of his theory or improving its delineation. He recognized the reciprocal influences of events, thoughts, emotions, behaviours, biology, and culture. REBT is a flexible therapy that remains distinct from its derivatives (e.g. CBT, multimodal therapy) to the extent to which it emphasizes philosophical evaluations of events – the "shoulds", "musts", and "awfuls" involved in dysfunctional thinking. As other cognitive therapies increasingly address philosophical matters, and as REBT continues to borrow from these therapies, integration proceeds. This integration is reflected in the various name changes of Ellis' journal, first called Rational Living (in 1962), and eventually renamed the Journal of Rational Emotive and Cognitive Behavior Therapy.

Instead of concerning themselves with self-esteem, he suggested that people rate their behaviours with reference to the goals they wish to attain.

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Prior to formally studying psychology, Ellis obtained a Master's degree in English literature. His use of language is seen in the following quotations:

- On family conflict: "Blood is sicker than water."
- On reminding REBT therapists to be vigilant for irrational beliefs: "Cherchez le Should."
- On accepting life on its own terms: "Life is spelled h-a-s-s-l-e."
- On cognitive restructuring of a feared event: "It's a hassle, not a horror."
- On the consequences of a demanding philosophy: "Musturbation is self-abuse."

Ellis hoped that his successors would address the limitations of REBT. For example, the theory seems to apply most readily to cognitions that are available to verbal awareness, as well as to preconscious material, but not as obviously to material that is currently unavailable to consciousness. Thus, there remains room for development in application of REBT to disorders arising from posttraumatic stress and to some other clinical conditions.

Furthermore, REBT may undervalue the importance of interpersonal attachments, for Ellis has recommended placing self-interest somewhat above that of others. He helpfully notes – especially to people who lack assertiveness – that self-interest is not the same as selfishness. In the words of Rabbi Hillel: "If I am not for myself, who will be for me?" However, Rabbi Hillel also said, "But if I am only for myself, who am I?" Research in the psychology of attachment suggests that our connection with others is as fundamental as our personal survival needs, as confirmed by the ubiquity of benevolent actions. (I am reminded of a friend who told of trading in a defective car, stating, "I didn't want it to crash with my wife and kids in it" and, after a pause, adding the afterthought, "or even myself".) Ironically, Ellis did not seem to take his own advice on the matter of self-interest, for his sixteen hour work days showed a dedication to humanity; if confronted with this observation, however, he would have likely shrugged, declaring that he was merely following his own interests.

Through the Albert Ellis Institute, Ellis trained innumerable therapists in his approach. On his 90th birthday, he received the praises of numerous prominent figures, including two U.S. presidents and the Dalai Lama.

Consistent with his thesis that life need not be fair, he bravely faced the numerous hardships encountered in his latter years (please see www.rebnetwork.org for details and video recordings). His personal example, especially at this point of his life, is an indelible part of his legacy.

Dr. Ellis died on July 24, 2007, but his influence continues through his writings, his students, and his patients. Foremost among his posthumous honours is a Legacy Book Series, with Dr. William Knaus as senior editor, dedicated to Dr. Ellis' life and work. Dr. Albert Ellis will long be remembered for his compassion and tenacity in helping people find peace in the face of difficult conditions.

If I am forever describing the porterhouse with truffles at a certain restaurant in Tribeca, I am just a snob. A steak supper in New York City is all that really happened. However, precision in language is not always a result of pretention. I tell my friends I broke my arm playing hockey, but I tell other physicians that I broke my distal radius, not because I want to insult my friends' intelligence or because I want to traffic in technical jargon with other doctors, but simply because I want to be precise when appropriate.

Medical language is rich in Latinate phrases (*status epilepticus*), food allusions (blueberry muffin baby, chocolate cyst), and eponyms (Smith fracture, Capgras Syndrome). Some terms are of little but historical use, but many serve to describe symptoms and diseases with precision: *Status Epilepticus* denotes diagnosis, urgency, and prognosis all in one splendid fusion of Greek and Latin.

The language of psychiatry should not be foreign to other physicians. It is not different in quality from the accurate and useful language all doctors use to describe signs, symptoms, and disorders. Its vocabulary may be larger and the symptoms described sometimes bizarre; nevertheless, the meanings of common psychiatric terms must be familiar to all physicians so that, at the very least, we can communicate in consultation letters. It is as basic and necessary as pointing to the clavicle or finding the carotid pulse.

Insight

After a few days on the psychiatric emergency service, it is common for medical students to observe that the patients who need admission seldom want it, while the ones who would not benefit desire it most. This is unlike many specialty medical services: while patients with bowel obstructions or renal failure seldom enjoy admission to hospital, they usually don't require involuntary admission. Security guards are not called when the internist breaks the news to the elderly woman with labored breathing that she will need to stay in hospital overnight. And when the young man with testicular cancer is told he can go home, he usually does not need security to escort him out to ensure his exit.

This phenomenon, which should carry an eponymous label, exists because of insight – or its conspicuous absence.

Sir Aubrey Lewis, the first professor of psychiatry at London's Institute of Psychiatry, defined insight as a "correct attitude to morbid change in oneself"¹. This definition has not been surpassed. While he clearly was defining insight in the context of psychiatric illness, his definition can be used about any "morbid" change, whether in the body, mind, conscience, or soul. While he parsed and defined each of the words in the above quotation (as a meticulous scholar and sometimes pedantic prose stylist would), by leaving them broad and ill-defined, the definition is more interesting.

As I grow older I become more surly and my views begin to ossify. What is my attitude toward these changes in myself? Grumpiness and inflexibility are surely morbid changes. Can I reflect upon alterations in my own outlook and character and arrive at "correct" attitudes toward the changes? As I begin to drive more aggressively on my way home from work, can I reflect upon the reasons for this – a bad day in clinic, a night on-call ahead, house repairs waiting – and develop a correct attitude toward my behavior?

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Insight is also important if the morbid change is exclusively a physical one. After a stroke, a diagnosis of cancer, or a limb amputation, the patient has to observe the effects of the illness, absorb the impact of the differences, practise using the body with its change in function or anatomy, and settle on a new, and even correct, attitude to the change. Lewis wrote, too, of the “secondary evidence of change,” the less immediate and more subtle evidence that change has occurred. Only with time and living with the new body does one appreciate the mistakes that one makes since the surgery, or the apprehension when getting up in front of a crowd since the diagnosis, or just how uncomfortable one’s innards now seem after certain curries are consumed late in the evening. It all takes time to even realize let alone get used to. Insight.

The ability of the mind to view itself is not understood. Recent attempts to map the capacity for insight onto different parts of the brain are tantalizing but so far unsatisfying. We don’t understand how a mind is capable of harbouring an anxious mood as well as reflecting on that mood and evaluating it, commenting on it, and attempting to change it. Lewis noted this human capacity when he wrote, “it is an old and familiar observation that we have an attitude – one of notice or regard – towards our own mental experiences”.

This vital capacity may be lacking in some psychiatric disorders. No single psychiatric diagnosis always carries with it a lack of insight. However, the symptoms of psychosis – delusions and hallucinations – and thus the diagnosis of schizophrenia are the most likely. Most studies of insight recruit patients suffering from schizophrenia, and scales to measure insight are most often

used in this population. These have shown that the presence of insight may favourably affect study and treatment adherence and thus outcomes² as well as encouragingly showing that insight can increase with medication treatment and cognitive behavior therapy.

While musing about the mind making editorial comments upon its own functions may be fun, and while measuring the thickness of the prefrontal cortex in patients with schizophrenia and little insight may be scientific, what is the utility of insight to day-to-day practice?

Anthony David has described insight in mental disorders as consisting of three overlapping dimensions: acceptance of mental illness, compliance with treatment, and the ability to re-label psychotic phenomena as abnormal.³ In clinical practice, and when completing the last category on the mental status examination, it is usually these three ingredients that we pay attention to when we write, “insight: minimal,” or simply scrawl “no insight”. What we usually mean, whether we are able to consciously reflect upon how our minds have come to this conclusion or not – whether we have insight – is that the patient we have examined does not believe he suffers from a mental illness or does not think that his hallucinations are abnormal or his delusions, in fact, delusional. More often, unfor-

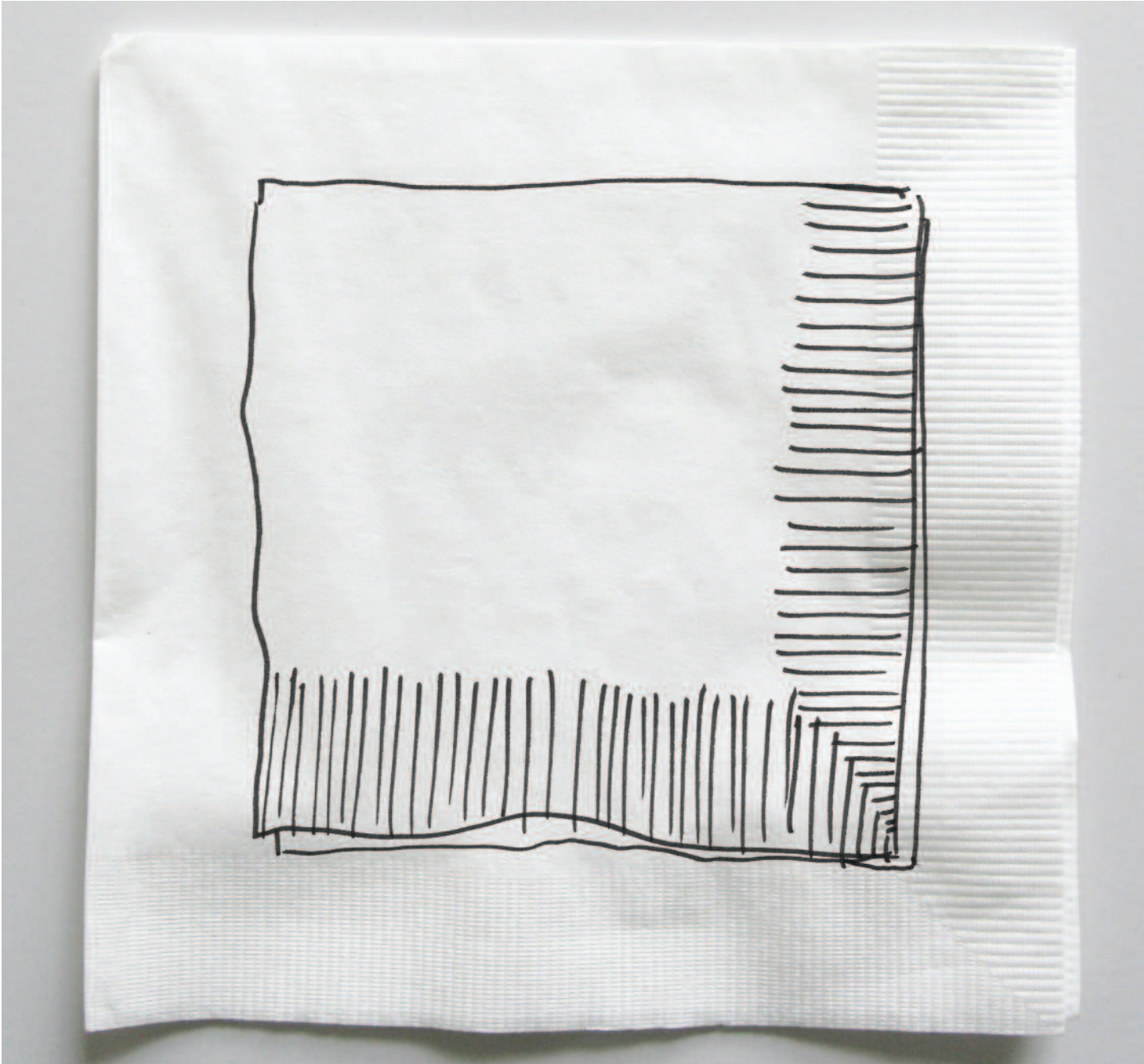
tunately, we conclude “no insight” because the patient is not compliant with treatment, David’s second dimension. Not following the physician’s treatment plan is not synonymous with poor insight: it may be synonymous with stubbornness, forgetfulness, or even wisdom. But it is often a part of poor insight when viewed in the context of the other dimensions. Aubrey Lewis, 75 years ago, acknowledged that a patient’s view of his illness and his treatment does not need to be identical to that of his physician for insight to be present. He conceded that the mentally ill patient should be expected to “arrive at an attitude between his former healthy self, and that of the physician”. Somewhere in the middle is all that can be expected, or even desired. For what physician would want his patients to think exactly the same way he does about their illnesses; and what patient would want to view schizophrenia or depression or ovarian cancer or a stroke with the same naive detachment he did before he fell ill?

In the end, insight in psychiatric disease – or any disease for that matter – comes down to whether the sufferer believes his symptoms are (again in the words of Aubrey Lewis) an “illness,” “demoniacal possession,” “a religious conversion,” or “some other remarkable intervention”.

ERIC PROST

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Paul Sahre *Thinking About Thinking*

Psychotherapy in a Digital Age KAREN GAGNON

Among the vast array of available psychotherapeutic approaches one thing is constant: face-to-face interaction. Psychotherapy is an interpersonal relationship between a therapist and a patient that primarily occurs through the spoken word. In contrast to this face-to-face approach is therapy over the Internet, which one could describe as the antithesis of the interpersonal approach. In the last decade, we have seen increasing use and expansion of the Internet and social networking sites, and psychotherapists are using these media to connect with patients, not only by advertising on Facebook and Twitter, but by providing Internet-based psychotherapy itself.

These new approaches to psychotherapy can produce ethical dilemmas for the therapist. The American Psychological Association's Ethics Director, Dr. Stephen Behnke, provides advice on this topic on the Association's website.¹ He generally recommends that therapists be mindful of what they disclose to the virtual world. Dr. Shirah Vollmer, a UCLA psychiatrist, has an interesting blog where she supports this technology and sees it as an opportunity for exploring new boundaries in psychotherapy.² Dr. Keely Kolmes, a clinical psychologist in San Francisco, describes how she expanded her professional Internet presence by creating a website, a blog, a Twitter account, and a Facebook page for her private practice.³ She sees her professional online identity as a form of community outreach, but stresses the need for professional, not personal, interactions. For those in need of more formal training on this topic, the Zur Institute offers an online course entitled, "Digital and Social Media Ethics for Therapists: Clinical & Ethical Considerations for Psychologists, Counselors, and Clinicians Using the Internet".⁴

Aside from the expanded boundaries and ethical questions that the new media bring to psychotherapy, how effective is it in the provision of therapy? Randomized trials do document its efficacy. A recent article in *Behaviour Research and Therapy* demonstrated that Internet-based guided self-help and email therapy were effective in the treatment of major depression.⁵ Additional research supports its use for treating depression⁶, anxiety⁷, and bulimia nervosa.⁸

Internet-based therapy has as many detractors as it does supporters. However, they are all in agreement on the need for professional standards, consistent terminology, and the need for therapist guidance of the therapy. Also needed is further research, with consistent and well-defined interventions and outcome measures.

Internet-based therapy has been compared to Internet banking.⁹ Both overcome distances, offer flexibility, but require controls to ensure that all professional standards are met.

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Intrusion

ERIC PROST

Last week I wore a wire.

It had been placed with care against my chest, the thin wires themselves neatly coiled up and taped close to avoid the appearance of bulk, the recording device slim and compact. When it was in place, I carefully slid my arms into my dress shirt and fastened the buttons, tucked in the tails and smoothed the front, and then observed the effect in a mirror to ensure nothing was visible through the cotton. Satisfied, I set out, anxiously, to record what I knew I must. No one would know unless, perchance, I was expertly frisked.

A warrant is often necessary if a stooge is to wear a wire and record a conversation in which he is not involved (and if he is discovered, the wire and his body might be found twisted and irreparable behind a dumpster). I had no need of a warrant, and yet I faced a libertarian quandary nonetheless. I didn't really fear discovery, and yet personal liberties seemed infringed.

Rather than recording, I was the recorded; rather than hunting, I was the hunted. The object of the wire's surveillance was me and the only warrant necessary for its application (with what seemed yards of adhesive) was my own consent. I was wearing a 24-hour cardiac holter monitor.

Medical techniques and tests are considered invasive if the skin is punctured or an instrument or foreign material is inserted into the body. That is why chemical restraint of a violent patient with an injection is often thought to be more invasive than physical restraint with leather wrist and ankle straps, even though the latter appear macabre and often remind the naive of sinister museum exhibits. But the most invasive test is the one that discovers the most personal information. This is true whether or not consent has been obtained. A colonoscopy and a brain biopsy are both invasive and both usually follow informed consent. The patient who lets a nurse fasten leads to his shaved torso is also about to undergo an invasion, not because the body barrier has been breached, but because 24 hours of personal information will be passed to strangers.

As a physician I usually read the disease memoirs of others with near disdain. Ill writers are forever musing about all the wrong things. Rather than extolling the glories and mysteries of their bodies in health and disease, they complain about the food (as Alan Bennett did while undergoing chemotherapy for colon cancer¹) or fear the needle before each dialysis session, never attempting to learn even what the kidneys do in a functioning body or what ailing ones mean. This is mostly because I am a curmudgeon, since the true meaning of failing kidneys is, for many, the tri-weekly needle before each dialysis, the fear, the loneliness, the claustrophobia of confinement all concentrated in the tip as it is inserted, with increasing difficulty, each week. In the same way, the quality of the food, to a frequent consumer, and a frequently nauseous one, is paramount. The disdain is also because my relatively short life has been a relatively healthy one. And yet I have been examined and prodded enough both as a medical student and a patient to think my continuing disdain warranted.

But none of the examinations or tests has ever seemed invasive: the extraction of foreign bodies from my eyes, the palpation of my prostate. While all unpleasant, none was subjectively invasive – not until a test extracted personal information over a sustained period.

Walking away wearing the wire I was conscious of what my heart was doing, just as an organized crime boss would be conscious of his every word if he knew an undercover officer was in the restaurant recording everything. I don't give extra information to authorities, I don't like my subscriptions to result in sales profiling, and I don't give my

But the most invasive test is the one that discovers the most personal information.

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postal code to store clerks to pad their demographic data. I don't even like completing the census. But now my heart rhythm was being recorded minute by minute, hour by hour. Would the strain of a valsalva be detectable and cause a tittering amongst the technicians? I kept reminding myself that it wasn't being read in real time and that only a narcissist would think his cardiac tracing likely of much interest to others. Would sudden rises in heart rate at certain times over the 24 hours expose my actions or my emotions? We may now know the heart to be a mechanical pump, but to the ancients, the poets, and most everyone else, it was the seat of emotions long before.

If I am the only patient who finds medical encounters more invasive because of their content than their mechanical technique, then as physicians we can go on apologizing for causing physical pain ("you're going to feel a little pinch") and discomfort ("swallow again," "now breathe") but extracting personal information without any preface. But if, as I expect, I am not alone in my libertarian paranoia, then trust is essential and the personal information gleaned must be both safeguarded and shown to be.

If extracting secrets – of a stillbirth, an affair, an alcoholic father – is more invasive than the removal of a gallbladder (and even the placement of a cardiac monitor), then psychiatry is certainly the most invasive of medical specialities. As infringements of civil liberties go, there are few more dramatic in a democracy than the real power wielded when a psychiatrist removes someone's civil liberties for three days by completing a Form 1 for involuntary confinement. But this is not what I mean. As this is the psychotherapy issue of *Synergy*, we could do worse than pause and meditate on the invasiveness of our lengthy diagnostic interviews, on the extraction of personal information during psychotherapy, and on the necessary bonds of trust and their potential for abuse. Because it doesn't take a libertarian who deems his cardiac rhythm personal information to realize that the personal is private and, if exposed, something to be protected.

My wire never breached the body barrier. It even exaggerated its impotence to do so by leaving an angry contact dermatitis of geometric shapes all over the surface of my torso instead. The intrusion lay in the secrets it threatened to reveal, to record forever, information that no longer belonged to me alone.

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