

# [Unconscious communication and defence mechanisms](https://assignbuster.com/unconscious-communication-and-defence-mechanisms/)

According to Frayne [1] unconscious communication is one of the three types of communication, the other two being conscious and preconscious. To the clinician, it is critical to understand the full nature of unconscious communication, defence mechanisms and the manner in which these interact in the therapeutic environment [2] . The therapeutic environment is often prey to issues of transference, countertransference and a multitude of defence mechanisms. As a result, it is essential that the clinician understand how issues of transactional analysis impact both the patient and therapist.

The therapeutic setting is one based on a close relationship, that of patient and clinician. Both parties bring their own beliefs and perceptions, personality, stages of development and behaviours to the therapeutic experience. As a result, both parties are prey to their own types of unconscious communication and use of various defence mechanisms. Frayne [3] states “ Contemporary psychoanalytic interventions (require that)… the analyst be able to work in that transitional field that joins the unconscious of the patient and the analyst.”

This paper will highlight the many concepts involved in the roles of unconscious communication, defence mechanisms, transactional analysis and the transference and countertransference experience. In order to highlight these issues and how they can manifest themselves, this paper will present the case of B. A., a 13-year-old child who has been in the therapeutic setting for 5 months. Following the case presentation, topics will be explored in a reflective manner.

Case Presentation

B. A. is a 13-year-old Caucasian male who presented to the therapeutic setting as a result of maladaptive behaviour displayed at home and in the school setting. B. A. is one of four children born to working class parents, both of whom work a traditional 8: 30 – 6: 00 work day. B. A. is second oldest and the only male child. His other sisters are 15, 10 and 7 years of age, respectively.

B. A. has had history of excellent grades, mostly A’s and a few B’s for the majority of his public education and has been cited as a good citizen by his teachers. Five months ago, B. A.’s grades significantly dropped to near failing, his attitude was oppositional, he was frequently truant and B. A. became involved with numerous fights with other children. When school counsellors brought the issues to B. A.’s parents, his parents acknowledged that B. A. changed at home as well, being oppositional and defiant. Both his teachers and parents cited increased frequency of lying and his parents stated “ It is getting impossible to tell the difference between when he is telling us the truth or a lie. We wonder if he even knows the difference anymore, whether he believes his lies really are the truth.”

Upon closer familial examination, B. A.’s parents admitted they had been having marital problems, including issues of betrayal and infidelity such that there have been “ regular loud shouting matches” and arguments in the house. During those times B. A. would stay in his room and turn the volume on his stereo up, causing more stress within the household. The infidelity was first uncovered six months ago at which time B. A.’s parents discussed divorce options, which B. A. overheard.

A precipitating incident involving night time vandalism four months ago at his school led to court involvement and mandated psychological counselling for a period of one year.

The reflective nature of this paper is based on two months of bi-weekly therapeutic sessions.

Unconscious Communication

Frayn [4] tells us that unconscious communication can only be inferred, as it cannot be tangibly seen, but only sensed in the therapeutic setting, primarily during those times of silence. There were many times that B. A. maintained his silence, primarily during those times when he was challenged to explain his behaviour, justify his actions or explain his thought processes. Although his overt actions during these silent periods could be interpreted as insolent behaviour, there was no way to truly know what unconscious mechanisms were engaged, but a series of defence mechanisms were evident in his therapy and were inferred as greatly influenced by the unconscious process [5] .

Defence Mechanisms

Frayn [6] believes that unconscious processes are often a form of “ acting out” in the therapeutic environment, in particular those under age seven, where children find it easier to act instead of talk [7] . This is particularly evident in the transactional analysis approach when dealing with dysfunctional or challenged adolescents, like B. A. who respond with childlike reactions when stressed. In particular, Araujo, Feldman and Steiner [8] state that defence mechanisms are a function of age, sex and status of mental health. In particular, those unconscious actions and reactions are involuntary but serve to reduce a perceived threat as reality-distorting mechanisms postulated to form themselves in the unconscious [9] . Araujo et al. [10] state that youths with psychological issues have a tendency to display less mature defence mechanism such as “ denial, projection, regression, passive aggression and displacement” even though they are considered ineffective coping strategies for an adolescent. More mature defence mechanisms are considered “ sublimation, anticipation, affiliation, suppression and humour.”

This concept is particularly important to the therapeutic environment as the defence mechanisms among mentally healthy early adolescents differ from the mentally healthy mid-adolescent. The older the individual on the child to mid-adolescent continuum, the less the patient should be employing immature defence mechanisms [11] . Similarly, the higher the level of emotional intelligence, the less one relies on maladaptive defence mechanisms that often prove inconsistent and illogical [12] . B. A.’s impulsive and acting out behaviour coupled with his lies made therapy particularly difficult. Elaad [13] tells us that lying is a method of deceptive communication that provides an advantage to the deceiver, stating that those with poor social skills use methods of deception more frequently than others with lesser levels of guilt over their deception. From a transactional analysis standpoint, Elaad [14] states that the bad-child indulges in defence mechanisms that feel natural, as the ego state attempts to rid itself of parental pressure.

Clinicians need to be aware of developmental stages and influences, such as emotional intelligence in order to effectively intervene for the patient, especially if significant unconscious communication mechanisms are in place [15] . Given B. A.’s familial discord, it was not difficult to see that when B. A. acted out or displayed other defence mechanisms, including his frequent lying, issues of transference were part of the therapeutic process.

Transference

The defence maturity model postulated by Vaillant [16] believes that defence projection is the result of unacceptable feelings or relations with another that are displaced and redirected away from one person and directed at a less-cared-for-person, often a therapist. For those patients experiencing unconscious emotions, many times patients will shift their unconscious feelings towards another person instead of dealing with them personally [17] . B. A. appears to be transferring and projecting his own unresolved parental/authoritarian conflicts on his therapist and although he displays occasional glimmers of wanting to please and receive the favour of his therapist and gain a feeling of security, the security he used to feel with his parents before the familial discord.

Countertransference

Haarhoff [18] tells us that for the therapist, an awareness of countertransference, whereby the therapist unconsciously projects their own unresolved conflicts on the patient can have negative repercussions and consequences if the therapist ignores “ or fails to understand his or her own emotional reactions” including the inability to set limits with a patient, feel inhibited to discuss various topics and other manifestations of avoidant behaviour. As a therapist, issues of countertransference are also paramount in B. A.’s therapy, as feeling of anger at being lied to or suspecting that B. A. is lying during therapy sessions creates feelings of wasted time when time in for sessions is limited and B. A. avoids various topics and time management is one of the personal stressors this writer experiences. Awareness of countertransference creates boundary issues with a therapist [19] . In particular with B. A., it appears that a more demanding and controlling nature seems to overshadow the therapeutic process.

Conclusion

The use of defence mechanisms in the therapeutic environment is important to identify, as, according to Reisner [20] different types of neuroses are associated with different types of defence mechanisms. For example, those who are high in hysterical identifiers are more likely to employ repression as a defence mechanism where those who are obsessive compulsive, considered sensitizers, are hypervigilant to any kind of threatening stimuli [21] .

Feldman and Steiner [22] believe that the more a therapist knows about defence mechanisms, particularly those who deal with children and adolescents, that knowledge can be used to predict levels of pathology among their patients. Aalto-Setala et al. [23] tell us that unconscious behaviours, such as communication and defence mechanisms are associated with an effort by the patient to manage their conflict. In particular, researchers found that the greater levels of immature defence mechanism use by adolescents “ is associated with the onset of mood disorders in adults [24] .” Successful therapeutic intervention must assess both conscious and unconscious communication in the patient and therapist.

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### Footnotes

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[2] Frayn 208.

[3] Frayn 207.

[4] Frayn 208.

[5] Frayn 210.

[6] Frayn 211.

[7] Frayn 211.

[8] K. B. Araujo, S. S. Feldman and H. Steiner, Defense Mechanisms in Adolescents as a Function of Age, Sex and Mental Health Status, Journal of the American Academy of Child and Adolescent Psychiatry, 1996.

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[19] Haarhoff 2006.

[20] A. D. Reisner, Repressed Memories: True and False. The Psychological Record, 1996.

[21] Reisner 1996.

[22] Feldman and Steiner 1995.

[23] Aalto-Setala et al. 1997.

[24] Feldman and Steiner 1995; T. Aalto-Setala, J. Lonnqvist, K. Poikolainen and A. Tuulio-Henriksson, Psychological Defense Styles in Late Adolescence and Young Adulthood: A Follow-up Study, Journal of the American Academy of Child and Adolescent Psychiatry, 1997.