Broadly speaking, we can say that defenses are a type of response to situations that people have difficulty managing and that they originate in experiences that could not be assimilated or digested when they happened. The role of the defense is to protect them from situations or realities they cannot cope with.

Usually, defenses are automatic mechanisms that are not the result of a thoughtful decision. Clients are not aware of them, nor do they activate them voluntarily, although they may partially notice them. In general, they are very effective in the short term, tend to be counterproductive in the medium to long term, and interfere greatly in the quality of life and in the therapeutic process for people with BPD. They are one of the most frequent interferences we will find when doing EMDR work with these clients, and they will appear not only during the processing of memories, but in each of the 8 phases that structure this therapy. We will see direct defenses that are easily identifiable and subtler manifestations that are indirectly expressed. This chapter describes some of the most common defenses (based on Mosquera 2004b, 2013b).

Frequent Defenses

Defenses may appear during phase 1 when we explore the problem, become activated during the processing of memories in phases 3-7, or arise when analyzing the previous session in Phase 8.

1. Pleasing Others

One way to avoid conflict, which is experienced as intolerable, is trying to make everyone happy. This sounds good in theory, but there is a small problem: in the real world it is impossible to please everyone. The emotional wellbeing of others does not depend on us. Their happiness or unhappiness depends mostly on what they do with their lives and their inner feelings.

Conflict is also part of life, whether we like it or not. Sometimes people focus on trying to please others to avoid problems, because they cannot deal with confrontation, yelling, or anger. It is not uncommon for people who try to avoid anger at all costs to end up being unpleasant or hostile toward others. Generally, in trying to please everyone, people become overwhelmed until they reach a certain point at which they end up causing problems to others. Subsequently, they will also feel bad about themselves, because they have ended up behaving just as they do not want others to behave toward them: aggressively or rudely.

Sometimes, accumulated resentment from always pleasing others and never thinking about oneself, about personal needs and desires, ends up creating an internal tide of resentment against others. People feel that others “never step into their shoes, never think about them.” When they see that other people do not respond with gratitude or do not reciprocate to the care they give, they cannot help feeling disappointed or angry. However, this does not lead them to the only possible alternative: to give less. They continue focusing on the needs of others, hoping that someday the world will return more than what they have given.

In therapy, clients that are concerned about pleasing others will not be focusing on regulating what they need, they will not help the therapist to calculate the pace of the therapy or to choose what is best for them, since, of course, they are trying to please the professional. During processing, they could say what they think the therapist wants to hear or block the spontaneous flow of associations trying to be a "good client" and to relax.

2. Idealizing

The tendency to idealize is included in the borderline criteria. It is usually followed by absolute devaluation, when any small detail breaks the idealized image. For example, if they meet a person, they tend to believe they have finally found a "real" friend, but when this friend inevitably fails or makes a mistake, they will feel that "he has failed me, as everyone does." Idealization is simply a screen that prevents us from seeing and accepting others as they are. Nobody can compete with an idealized image. And such an image, sooner or later, will lead to disappointment. One of the ways to suffer less, when things are not as we would like, is to change our expectations for more realistic ones. However, intermediate pathways and a balance between extremes are often deficient in borderline clients.

We can also see an idealized self-image: clients "boost themselves" to overcome their own underlying feelings of undervaluation, to the point that they end up believing their own character. If this defense is well established, clients will cling to this image at all costs, and may tend to surround themselves with those who will reflect back to them the image that they want to display. They can do this by having a partner who defines them as a successful person, relating to people with "a certain level" or "a certain style" with which they identify, or tending to always make clear how badly others do things in order to indirectly highlight their own effectiveness or worth. This artificial exaltation of the self does not allow individuals to get in touch with their true inner resources and real worth as a person.

In working with EMDR, clients who tend to idealize will give us distorted information about the reality they live in, their early history, or themselves. This makes it difficult to draw a good map from which to make good decisions in therapy. When it is time to work, this idealization may appear in the processing, e.g., with idealization of attachment figures, which is common in insecure attachment and blocks access to disturbing memories associated with those figures.

Another common situation, in the early stages, is the idealization of the therapist. Clients will work enthusiastically in the initial phase of therapy, but sooner or later this will change to devaluation, risking rupture or deterioration of the therapeutic relationship. The clinician must handle these changes with perspective, by bringing up these issues before they occur and by gaining perspective so as to not react to them in a personal way. There may also be an idealization of EMDR in itself and clients may consider it a magical and fast solution to all problems. If these situations are not channeled, they will interfere with psychotherapy or even make it impossible.

Idealization can also be directed toward oneself. We will see this in borderline clients with narcissistic traits. To be able to deal with beliefs such as "I´m inadequate," they develop a compensatory false self, "I´m far superior to others." And to deal with feelings of guilt, they develop a compensatory belief where "everyone is bad." In these cases, it is virtually impossible to establish a negative belief.

3. Projection

Sometimes, emotion is in the air, but no one knows where it started or who generated it. We can be aware of something, but rejecting that the feeling can be ours, we attribute it to another, we "project" it. It bounces on us because we cannot assume the reaction as our own and we see it in another. Projection allows a person to get rid of their discomfort and everything that is causing it, to place it outside of the self. It is as if they could place their negative thoughts, their dissatisfaction, doubts, and insecurities on another. This sometimes happens in an interaction with another person and it takes place in a sequential manner. I am angry, so I start looking for trouble, "ruffling the other person´s feathers," until they finally explode. I do not like to function in this way, so when I analyze what has happened, I "omit" seeing how I contributed to the process and I just see the other person´s anger and the final result, what the other person has said to me. When I tell the story, it is a rather modified version of reality: "He was furious with me," "people always treat me badly." When we asked how it this came about, it is easier for the client with little reflective capacity to say, "He just got like that suddenly, with no reason."

4. Avoidance

A common, but very pernicious, psychological mechanism is avoidance. If something causes me anxiety, I avoid facing it. When I decide this, I feel immediate relief, but soon, or whenever I have to face the same problem or a similar one again, anxiety has increased a notch. Avoidance is a psychological trap, which causes exactly what we most want to avoid.

This mechanism can manifest in many ways, some very subtle. For example, every time we decide to deal with an issue, clients bring up another important problem that needs immediate attention. The emotional intensity with which borderline clients present their problems to the therapist can make him or her consider that it is essential to address it urgently. But often, one "serious crisis" is followed by another. Clients are used to living in the midst of emotional storms, but working with their inner discomfort, with the way they see themselves, or the origins of their problems can be intolerable. Crises can work sometimes as "smokescreens" that hinder therapeutic progress.

5. Objecting to Everything or the "Yes, but…" Style

Focusing on what is going wrong, on how hard things are, or on why a new option will not work does not allow for possible solutions. The most typical example of this mechanism would be the "yes, but..." response to any proposal. This serves the purpose of protecting against the risk of trying some kind of change in life, although it may be for the better. It is an automatic mechanism and can lead to significant frustration in the therapist when seeing that people do not accept the help that is being provided. Clients may complain bitterly about how friends turn away from them, how their families give up on them, and how a long list of professionals threw in the towel considering them a "lost cause." But they are not aware of how they contribute to making this happen.

The fear behind the "yes, but style" may not only be the fear of failure or change, but also the fear of being helped, because that means establishing bonds and having to show their vulnerability. When the bonds from the past were painful, feeling vulnerable became synonymous with being severely hurt. So people will tend to protect themselves against any bond as an instinctive protection mechanism.

Attempting to process a memory with EMDR on a client focused on this defense can be full of obstacles or nearly impossible. We can enter into a debate about whether EMDR will really do any good, if we should work on this memory or the other, what the negative belief is, whether or not the person needs to talk... And by the time we arrive to phase 4, hopefully, end up with a "nothing comes up..." or "this doesn´t work."

6. Unattainable Requirements

Sometimes people ask for help, but set the bar so high that no one can "keep up." If they seek therapy, the therapist must be the most famous, the most experienced. If the professional gives any sign of ineffectiveness, fatigue, or clients feel that "he or she has failed," it will be impossible to do therapy, and thus, they will start running out of options. The same can happen with couples and friends. No one is good enough.

This can serve a defensive function. It is like when we try to sell a house but do not really want to get rid of it, so we price it exorbitantly high for the market value, not expecting anyone to pay it. If against all odds, a buyer shows up, a problem will occur to make the purchase impossible. Sometimes clients want one thing and also something opposed to it, making the dilemma impossible to solve, in order to protect themselves from feeling that they have made the wrong decision by choosing any of the options. A person who does not decide, cannot make bad decisions.

If we are able to address the processing of a memory with these clients, they will probably not recognize the relaxing effect that is visible for the therapist, the SUD will never be 0 (we will see SUD of 0.5) and during phase 8 they will state that they do not notice any effect with this therapy. It is important to understand these statements in the context of their dominant defense.

7. Rationalization

Clients stay in their heads and make all kinds of interpretations, but do not really connect with what happened. They disconnect from the body and all emotions and feelings related to the subject being addressed. They can make long and elaborate analysis of what is happening to them, but there is no real awareness. If clients have previously been in cognitive or verbal therapies, this tendency can be much more pronounced. In interpersonal relationships, clients who tend to rationalize talk a lot, but do not resolve issues. They can get into long discussions with those around them that never lead to productive changes or practical solutions. They do not move forward in their lives; they have the feeling of going around and around in circles, usually along the same path, without getting anywhere.

During processing they tend to analyze everything that comes up and sometimes between sets they stop to give long explanations or ask the therapist questions. Although helping them focus on physical sensation can be useful, we believe that in this case we are not dealing with an inadequate understanding of the procedure or an alexithymia. On the contrary, it is an active defense, so helping clients to connect with their bodies could activate them more. The therapist must be aware of the development of the process.

8. Conviction

Sometimes borderline clients show volatile and changing opinions or ideas about themselves, others, or the world, or are extremely insecure about their beliefs, values, or thoughts. At times, precisely because of this insecurity or lack of a defined or integrated identity, they develop extreme convictions that function as an overcompensation for their basic insecurity.

Individuals may show a strong adherence to an ideology and, defending it vehemently, often going to the extremes. At other times, as we will discuss in the chapter on beliefs, they cling to certain ideas about themselves, even though they are extremely harmful. This conviction may be learned from authoritarian or rigid environments, where influential figures function from the absolute certainty of “being right” and that their views are “the truth.”

The degree to which clients are fused with their thoughts and opinions is variable and is an aspect to consider when doing our work, in order to allow change during therapy (Hayes, Strosahl, & Wilson, 2003). Clients may, for example, guide the communication in the session toward a discussion about a particular social situation in which they are involved, as a way to avoid more personal topics; but it can also be a way of feeling in control of something, given the emotional lack of control and the chaos in their own lives.

9. Changing the Subject

Clients change the subject to avoid getting into what is hard for them to see. It is not always conscious and they will have difficulty understanding how this may be an interference. They are so used to relying on this defense, that they understand it as a normal thought process.

In some cases, dispersion in speech or thought is not a defense but a deficiency. Some people with BPD have ADHD traits, among which we find attentional dispersion. They jump from one topic to another, because they do not follow the conversational thread. Although this and the previous aspect can be mixed, in the first case, changing subjects can be seen as a defense because of the timing.

During processing, the transition from one topic to another can be a normal type of association. At other times, changing the subject is a disconnection from the experience that we are trying to process, or it can even be dissociation. In this case, the session may end with an apparent decrease or absence of disturbance, but the processing has been partial or only apparent.

10. Denial and Evasiveness

Clients can deny to the therapist, or to themselves, the importance of an issue or an event. They can evade a question or ignore it. This evasiveness may be obvious or may be expressed with vague and imprecise responses and generalizations, such as the inability to specify with examples or the changing of focus. When we have chosen a theme to work on, clients immediately highlight the importance of another one, which will later not be considered a priority either.

Not infrequently, very significant issues are discussed after long periods of therapy, even when the therapist had initially asked about them. This may be due to the fact that, in order to reveal certain subjects, clients need to feel that the therapeutic relationship is strong enough. At other times, they cannot even tell themselves, ie., “If I don´t talk about it, if I don´t think about it, it´s like it never happened.” They may also need to become stronger with the initial therapy work in order to gather the resources they need to tackle tough or complex issues.

During the processing of a memory, the issues that are denied or that clients do not want to see are more likely to come up. Perhaps clients´ difficulty in revealing them can be reduced by the effect of bilateral stimulation, as it affects both explicit and implicit information. This difficulty may, however, persist and block the processing. The therapist must always be attentive to non-verbal language and consider this possibility.

11. Minimization

Experiences are recognized but are downplayed. Clients cannot assume the reality of what they have experienced, or are currently experiencing, and diminish the importance of the facts. The can say things like, “Sometimes he becomes aggressive, but he´s a really good person and doesn´t want to hurt me,” “It´s not so bad, I really think I magnify things,” “This happens to everyone who has had lived through experiencies like mine, right?” Sometimes, clients tell a small part of what happened, e.g., regarding their problems with their partner. It is as if putting words to it and explaining everything would make it impossible to continue with the idealization that maintains a relationship alive, a relationship that is felt as indispensable.

Other times, minimization is associated with emotional disconnection. Clients speak from an apparently normal part of their personality that is not fully aware of the weight of the disturbance associated with certain memories. This discomfort is stored in an emotional part of the personality, which is at least partially disconnected. Clients may talk with conviction about terrible things, stating, "I´m completely over this." If the therapist chooses to propose the processing of these memories, bilateral stimulation can get clients in touch with such intense emotions that they may not be able to assimilate them. When clients minimize or are disconnected from their experiences, probably a therapeutic plan that starts with the processing of memories that the therapist assesses - from his knowledge of the client - as more tolerable, may be advisable.

12. Laughter, Sense of Humor

With some clients, it can be really difficult to focus the session productively. Everything becomes laughable, even during EMDR processing. Phase 3 questions, eye movements, or tapping seem "funny" or "ridiculous." Other people are constantly making jokes or ironies about what they are telling, which may give the false impression that it does not affect them too much. Since many clients present with a negative, pessimist, or even victimized style, individuals who laugh about their problems can seem much more functional and stronger. But even though humor is an excellent resource, it is often a shield that protects people from getting in touch with an extremely vulnerable self.

Some people have turned to humor as the main coping mechanism for their difficulties and this becomes activated while they are telling their story. In other cases, an automatic smile protects them from showing a discomfort that had brought them negative consequences or that was not allowed in the family. It is important to see its meaning in each particular individual, as well as its role in the therapeutic relationship and the treatment process.

13. Somatic Symptoms

Different somatic symptoms, which the person may not necessarily understand, may appear. Clients may describe them in detail because they are annoying, but this does not make them aware of what triggers them. It is important to explore when they appear, what inner experience they are associated with and to understand what was happening just before. Somatic symptoms often are indirect communication that needs to be understood.

Of special interest is the presentation of somatic symptoms during the session or in the period immediately before or after. They can sometimes give us more information than the explicit information that clients provide us with and it is important to be attentive to when it occurs. In the more extreme dissociation cases, they may correspond with the activation of dissociative parts, which the client may or may not be aware of.

14. Self-Criticism

Paradoxically, criticizing oneself harshly and constantly can sometimes prevent clients from connecting with reality. They are accustomed to being constantly hurt and, faced with the idea of connecting with their deeper self or with certain stories; they can somehow use it to "stun themselves" and not think or feel.

At other times, clients´ own criticism makes what they most fear impossible: criticism from another. Clients that are continuously putting themselves down encourage in the therapist a role of "facilitator" that tells them positive things. This, paradoxically, further reinforces their negative view about themselves. This is an interesting therapeutic trap.

In the desensitization phase of EMDR, an inner discourse full of judgment and undervaluation can interfere with or completely block the processing. Therapy will become another way to criticize and insult themselves, as discussed in the chapter on self-care patterns. They may even use the material from the therapy itself to continue putting themselves down: they will think they are doing it wrong, that they are not being good clients, that EMDR therapy does not work because they are defective, etc.

15. Procrastination

When deciding generates uncertainty or fear of making a mistake, when people want to avoid the effort involved in the process, or not confirm that they are unable to carry it out, individuals may postpone the decision or action. The issue is that this only increases the discomfort because the problem or difficulty that has originated it is not resolved. And although at times it can be useful (for example, leaving a conversation for another time if one is unable to speak calmly), in many other situations it is usually harmful.

Some people are really stuck in this mechanism, which greatly distorts their ability to function. However, individuals may not be aware, and therefore will not explain it to the therapist, unless he or she explores it. And the excuses they can give themselves can be really convincing, "Now is not the time for this, it is best to leave it for later" or "now I have to do this which is very important..."

16. Complaining

Some people are focused on the resentment for all the damage they suffered and for all the offenses they received. Their story is a description, filled with emotion, of how badly they have been treated by others, the world and life itself. Not all people who have been through the same kind of adversity devote their thoughts and mental energy to spinning around in their heads things like, "How can people be like this?" or "How could they do this to me?" Those who do are usually people who live in a constant state of tension and say "they cannot stand injustice."

Although anger is absolutely natural when we have been hurt, getting stuck in that emotion ends up poisoning us and causing even more suffering, without making our life more satisfying or rewarding.

Like magical solutions, constant complaining leads people to focus on the part of the solution that is not in their hands, as if they give others the control of their life. This leaves individuals in utter helplessness, as if whatever happens does not depend on them and they were at the mercy of fate, which has turned its back on them. Somehow, this immobility may protect them from making decisions and from the everpresent possibility of making the wrong decision. Looking outside may protect individuals from looking inside. But that way, life is lived "outside the self" and people cease to be the protagonists of their own existence.

A particular risk we can take with such clients, when working with EMDR, is to take their complaints as targets to work on. Chances are that we will run into "pseudo-processing," in which sets of bilateral stimulation just momentarily interrupt the clients´ discourse, which continues at the same point where it left off when we stop each set. Although clients are able to cry or express emotions, they are not really connected with their true emotions. In some of these cases, when clients have been in therapy for a long time and finally get in touch with their pain, they sometimes state, "I think today is the first time I´ve really cried."

17. Selective Mood Changes or "Letting Go of the Reins"

Obviously, mood changes cannot always be controlled, and generally, they are related to something that has happened. But, there are times when people learn that crying makes arguments stop or that only when others see how bad they really feel they stop attacking them or start caring about them. Sometimes, they realize that getting angry stops the demanding or reduces the chances that someone will oppose them and make them hear something they do not like. Symptoms are felt paradoxically as the only way, or the most effective way, to communicate something. But, obviously, this complicates things, because even if in the short term the other person ends up doing or not doing what the client wanted, it is very possible that their discomfort toward the client will increase. These situations generate rejection, hostility, distance, and many other things that are precisely what clients usually feel as most terrible. People may become caught up in a very harmful relational trap or suffer a deterioration in personal relationships, to the point of losing them.

Sometimes, people may feel an undetermined emotion or discomfort and do not make any effort to control it, not so much for achieving a purpose in interacting with another, but because in these explosions they can obtain a relief that is not easily achieved otherwise. Thus, during an argument they may not stop it or they may even "add fuel to the fire" in order to release previously accumulated tension. This mechanism is often more related to learning and therefore, it can become more conscious, though it can end up being automatic.

This tendency to let emotions run wild can occur during the processing of a memory and take the form of an abreaction that continues to increase in intensity. This situation is different from letting

an emotion or a feeling flow, which is necessary for processing and needs the therapist´s intervention to help introduce regulation.

18. Magical Thinking

It involves thinking that a person, place, thing, or idea can make problems disappear instantly or make people feel safe and happy. This feeling is something like, "If I have or get X, I will feel good," "If my mother would change, I would be fine," or "If I had money, all my troubles would be over." To think that "something" will make all our wishes come true and that the solution for our problems will come from others or the world, rather than ourselves, is a very typical childhood thought, which often persists or leaves its residue into adulthood. Although we have included magical thinking as a defense, we could also see it as the permanence of a primitive thinking style, associated with the lack of development of reflective thinking and higher order mental actions (Gonzalez & Mosquera, 2012). However, the use of magical thinking at the same time fulfills a defensive function.

The ways to solve problems from a magical thinking point of view are: "To get out of here and go to a place where people treat me well," "To find someone who understands me and really loves me," or "To be in a place where I can rest and not think about anything or anyone." Since these solutions are unfeasible, the conclusion is "there is no way out." Changes that are possible are not seen or valued, so they are discarded without trying, or at first try. These magical solutions may end up becoming day dreams where the client takes refuge in order to leave the place they truly are with their imagination, which is another type of psychological trap, as discussed in the following section. The person may see their desire as logical, not realizing that there is no chance of that happening here and now. Seeing that the desire is not fulfilled, there is only room for frustration and disappointment. The tendency toward this type of thinking lowers people´s capacity to take over the reins of their own life. Only realistic solutions, based on options that are feasible at that time and which are in our hands, will lead to real changes.

When these associations appear during EMDR processing, it is important not to confuse them with the connection to positive networks that appear at the end of a productive associative chain.

19. Parallel Worlds

Some clients take refuge in a fantasy world where everyday life problems do not exist and which serves as an escape. These fantasies can become very elaborate (Seijo, 2012). The client may spend time dreaming of what they would want, the person they would like to fall in love with, or the life they would like to live. But this fantasy only delays or hinders taking steps to move forward in the real world, toward a truly fulfilling life.

Clients´ parallel worlds may not be a dream, but a modified version of their surrounding circumstances. If there is anything I do not like, I throw some color on it. If a relationship is problematic, I deny the negative situations and amplify the few good moments until it looks like a real fairy tale in my mind. The version that clients tells their therapists is often the same one they

tell themselves, but has little to do with objective facts. Those around them see things very differently, although especially in the case of the immediate family, they may also have an unrealistic and extremely skewed view of reality.

This parallel world that clients see may result from their low reflective capacity, analysis of situations based on emotional thoughts, generalizations, and unsubstantiated conclusions. But it may also exist because clients are able to avoid seeing what they really do not want to see, omitting from the story they tells themselves everything they feel is their fault. Clients have to learn to tell a realistic story, based on facts, in which their participation is specific. Only with a true map of their reality, will we be able to orient ourselves in the therapeutic work.

20. Perfectionism

Some clients are very focused on doing everything right. Although it has to do with the desire to please, perfectionism is more internal. Some people cannot allow themselves to fail. Failure gets them in touch with deep feelings of undervaluation and core beliefs such as "I´m useless," "I do everything wrong," or "I´m not worth anything." Sometimes, perfectionism is based on the feeling that whatever they do will never be enough, which they try to soothe unsuccessfully by doing more and more.

In some clients, perfectionism is related to control and demand, and may be directed outwardly and not just inwardly.

In any case, perfectionism interferes with processing, as it is associated with rigidity and control, contrary to the "mindful" position of observing without interfering and "letting whatever has to happen, happen," from which the EMDR model works. Understanding where this defense comes from in each client can help therapists introduce the most appropriate interweaves to help them overcome the obstacles that arise in session.

21. Learned Helplessness

Clients with a history of early traumatization often end up developing a protection mechanism known as learned helplessness. Since they know that nothing will work, they do not even try, not even when there are viable options. Their body has given up and caved in. Resignation, which in very adverse situations protects from suffering, becomes paralyzing when circumstances have become more favorable and prevents a healthy evolution.

Clients with complex trauma, among which there are many with BPD, have difficulty using proactive fight/flight responses in adaptive ways (Levine & Frederick, 1997). They do not effectively fight for what they want and they do not know how to leave negative situations on time. Anger and fear are very present, but in a maladjusted way, disproportionate to what the circumstances require at the time. Passive defensive responses, however, tend to be predominant and persistent, like submission, paralysis, or deeply regressive states based on the activation of the attachment cry

(infant states). Clients must learn to "activate" themselves in an adaptive way, instead of alternating between "hypoarousal" and "hyperarousal" (going from a neglecting depressive state, to an aggressive outburst, or even to a panic attack). However, an active position involves taking risks, making mistakes, going out into a relational world that awakens their fears. That is why this seemingly inhospitable place of resignation and despair paradoxically works as a safe place that clients are reluctant to leave.

In the processing of a memory with EMDR, clients fixed on learned helplessness may tend to enter into hypoactivation states, in which looping occurs and is difficult to resolve. When working with a memory, it would be adaptive that, in phase 4, the whole range of responses that could become activated would appear, ie., the entire set of emotions that it would be logical to feel. These emotions are not only sadness and despair, but also anger and fear. These two emotions are often blocked in clients with early trauma and their activation may explain some obstacles in the processing. If we have worked on emotional regulation in phase 2, we can minimize this problem and if it does appear, it would be easier to neutralize.