3.8. Defense mechanisms, coping strategies and depression

DEPRESSION: ITS TRUE NATURE

(Section Three)

DEFENSE MECHANISMS & COPING STRATEGIES

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The purpose of this presentation is to identify the prominent role of defense mechanisms and coping strategies in the creation of the experiences and behaviours that have to be called, “depression”.

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No. 2: People diagnosed with depression generally live
in a heightened state of fear and anxiety, generally feeling close to or on the edge.
It does not take much for them to feel like they could fall over the edge of the precipice.
Already doubting themselves and having little trust in their ability to emerge
from any apparent crisis,
they continue to rely on the defense mechanisms
and coping responses in which they have come to trust over the years.

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No. 3: Many of the experiences and behaviours
that have become synonymous with depression are in fact
defense mechanisms and coping strategies.

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No. 4: These defense mechanisms and coping strategies serve a number of purposes:

1. To minimize our contact with the distress caused by the woundings
   we have experienced to date.
2. To minimize the risk of further wounding.

However, many defense mechanisms and coping strategies themselves
cause secondary wounding and distress.

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No. 5: The range of coping responses that people may choose from is considerable.
They are testament to the creativity of the person,
and the immense creative ability of us human beings.
The defense mechanisms and coping strategies we create
always serves some purpose, otherwise we would not create them,

come to rely upon them, and use them so frequently.
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No. 6: We will now look specifically at some of defense mechanisms and coping strategies that form part of what has come to be called “depression”.
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No. 7: Anhedonia is generally considered by doctors
as one of the most important features of depression.
This is reflected in the Medicine.net website’s description of anhedonia as
“a core clinical feature of depression”.
The medical definition of anhedonia is as described on this site -
“Loss of the capacity to experience pleasure.
The inability to gain pleasure from normally pleasurable experiences.”
One of the big problems within the medical approach to emotional and mental health problems
is revealed in this definition, and the subsequent three examples given on this webpage:
A mother who finds no joy from playing with her baby;
A football fan who is not excited when his team wins;
A teenager who feels no pleasure from passing the driving test,
Are all described as “anhedonic”.
Doctors divide experiences into normal and abnormal.
In emotional and mental health,
this process of division is not based on any biological abnormalities,
as they are in real diseases,
but on arbitrary notions of normal and abnormal based
on what is generally seen as a common reaction in the circumstances.
So, feeling pleasure is considered normal,
not feeling pleasure is considered abnormal.
(http://www.medicinenet.com/script/main/art.asp?articlekey=17900
accessed 23rd March 2016.)
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No. 8: Doctors compound this error by further assuming that
there must be a fundamentally biological cause.
Here is one example of this common medical practice,
from the Science Direct website,
the last line of which reads,
“Anhedonia has been proposed as a psychological marker for **biological** depression.”
As we have seen earlier in this course, while doctors like to refer to biological depression,
scientifically, no such entity has been found to exist.
Later in this course, I explain why doctors have deluded themselves in this manner,
and why it is important for them to continue to delude the public also.
The authors of claims such as these do not seem to notice the obvious weakness
that is inherent in such claims.
Those claiming the existence of “biological depression” owe it to the public they serve
to have identified biological markers, biological evidence for the existence
of the claimed so-called “biological depression”.
Claiming the existence of a “psychological marker” and taking this as evidence
of a biological condition is not a valid scientific approach,
which is why you will not find such claims occurring in any other area of medicine
apart from psychiatry.
(http://www.sciencedirect.com/science/article/pii/S0010440X97900572 , accessed 23rd March 2016.)
……..
No. 9: There is, in my opinion, a more accurate way to understand
what doctors call “anhedonia”, that is, not feeling pleasure.
Rather than interpreting is simply as an inability to experience pleasure,
this is more accurately understood as an unwillingness to experience pleasure.

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No. 10: At first glance, this might seem to make no sense.
Feeling pleasure seems like one of the most natural things in life.
Why would anyone choose not to feel pleasure?
A person may choose to block experiencing pleasure
if for that person, the risks of experiencing pleasure
has come to outweigh the benefits.
Initially, this may seem to make no sense either.
What risks could there possibly be associated with experiencing pleasure?
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No. 11: If we have experienced a considerable degree of psychic wounding
that has not been brought full circle and healed,
we will have amassed within us an equivalent degree of distress, in many forms.
Experiencing great distress on an ongoing basis can be excruciatingly painful.
People understandably want their distress to stop.
If resolution of our distress has rarely seemed possible for us in our lives, for various reasons,
Then we may choose what appears to be our best option –
To disconnect and detach ourselves as much as we can from our unhealed distress.
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No. 12: Attempting to disconnect and detach from our distress
necessarily involves disconnecting from our fully feeling, fully sentient selves.
This is a pretty difficult thing to do,
and we pay a big price for it, but it is a price we may be willing to pay.
Maintaining this disconnection requires up to be constantly vigilant,
our guard always up for anything that might sneak under our radar and catch us unawares.
Those of us who choose to attempt this are not always as successful as we might like to be.
Our distress often breaks through the defenses we create
to keep our distress and painful emotions at bay.
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No. 13: When this happens, we often respond
by reinforcing the defenses we have created against our distress and painful emotions,
and being increasingly on guard for any possible breaches in these defenses.
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No. 14: Maintaining these defenses at all costs becomes our number one priority.
Anything that risks bringing us into contact with our distress is to be studiously avoided,
even if we pay a price for so doing.
And this is why we may choose to avoid feeling pleasure.
Feeling pleasure means coming more fully into our sensual, feeling aspect,
the aspect we have already decided we must avoid at all costs.
If we were to allow ourselves to fully feel pleasure,
we would also open the door to our unfinished emotional business that we still carry within us.
Within the person's private hierarchy of needs and priorities,
the need to detach from feelings, as much as possible,
has become more important that the need to feel pleasure.
We humans generally meet whatever need we perceive as our greatest need.
And this is why people who have experienced considerable wounding and subsequent distress
that remains unresolved frequently do not feel pleasure.
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No. 15: This perceived need to detach from our distress and keep our distress at a distance
infuses many of the experiences and behaviours that are seen as characteristic of depression.
Self-hatred and major self-criticism are common themes
in people who meet the medical criteria for depression.
Many of these people are very gentle and empathic towards others,
but are extremely harsh and unforgiving towards themselves.
On the surface, this seems to make no sense.

These people treat others well
because they believe that this is how people should generally be treated,
yet they adopt an entirely different approach to themselves.
When this apparent paradox is pointed out to them,
They generally acknowledge the difference in how they treat others compared to themselves.
If they make a commitment to be kinder and more loving to themselves,
this generally does not happen.
Aware that all human behavior is to some degree purposeful,
I spent a lot of time trying to make sense of this.
Then one day, about 5 years ago, it dawned on me.
In my 2011 book *Selfhood: A Key to the Recovery of Emotional Wellbeing,*
Mental Health and the Prevention of Mental Health Problems, I included this diagram.
A reason – and perhaps the main reason – why many people
adopt polar opposite attitudes towards themselves
is because doing so serves an important purpose.
The fundamental issue is an accumulation of painful unhealed wounding and distress.
Fearing full contact with their wounding and distress, coming to hate themselves
becomes an attempt to distance themselves from themselves.
It is far easier to push something away when we hate it, than when we love it.
It is however impossible to really distance ourselves from ourselves,
so it is something we can never relax about.
Maintaining ongoing self-hatred becomes virtually a necessity,
in order to keep some semblance of distance
between the person and their deeper unhealed woundings and distress.

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No. 16: To maintain this defense, many also choose to reject or dismiss love,
affection and warmth from others.
Many routinely dismiss compliments and studiously avoid genuine expressions
of caring from others.
They do so because the warmth in these gestures risk melting the defenses
they have methodically constructed around their heart and emotions.
Letting such love and warmth in would also risk
the emergence of long-suppressed sorrow and sadness.
The person has concluded, usually a long time ago,
that for them it is better to miss out on experiences of love and warmth,
instead opting to continue pushing their distress as far away as possible
from their experience and awareness.
They have decided that for them,
distancing themselves from their deeply held distress is their priority, their main need,
and they set out to meet this need,
being ultimately prepared, albeit with regret, to pay whatever price is required by so doing.

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No. 17: These people are not picking their ideal solution, their ideal way of being or living.
Regularly relying to defense mechanisms and coping responses
becomes the least difficult way to get by in life, but it is still very difficult.
They are choosing the coping responses they have come to rely on,
the responses they feel are the one most likely to put the fire out for that moment at least.

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No. 18: Some of the experiences and behaviours that become interpreted as “depression”
are actually the person’s attempts at a solution,
or the consequences of their attempts to find solutions.
Many of these coping responses are themselves distressing.
They seem to be a major part of the person’s problem, and in a way they are,
but not as interpreted generally.
They are primarily a coping response,

and they cause problems because of their consequences.
Doctors often miss this crucial point.
Seeing them as solely problems,
they convert these coping responses into symptoms and work from there.
Many of the coping reactions are difficult if not impossible to achieve and maintain.
The person often feels caught in a double-bind in which they cannot win
no matter how hard they try.
They often feel damned if do and damned if they don't.
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No. 19: Defense mechanisms and coping strategies
that are regularly and erroneously taken as features
of a so-called "mental illness" called "depression" include
withdrawal, cut off and shut-down are regular experiences of many people
diagnosed with depression.
These are choices, made for that person,
these choices appear to be the best option available to them.
The fact that some other people might make different choices
has no relevance to the fact that, for that person, at that time,
based on their previous experiences, their perception of themselves and of life,
these choices appear to them to be the best options.
Many regularly withdraw, cut off and shut down from people,
from perceived challenge and threat.
They cut off from themselves, from their feelings
and from many of the aspects of their life, interactions and experiences.
Many feel completely disconnected with themselves and life.
They attempt to disconnect and cut off from their distress.
These are understandable choices and behaviour patterns
for people who experience levels of emotional distress and overwhelm
that are very difficult to sustain.
Emotional distress and overwhelm are very difficult to tolerate,
particularly when prolonged and the person feels helpless to alleviate it.
Many therefore create strategies including withdrawal, cut-off and shut-down
in an effort to minimise their exposure,
both to further woundings and to peak full-on contact with their unfinished emotional business,
by which I mean the degree to which significant old woundings remain unhealed
within the person, bearing in mind that the significance of a wounding
is determined not by public consensus
but by the effects of the woundings experienced by the person.
Both of these are likely to result in further emotional distress and overwhelm,
therefore many want, as a major priority, to avoid any risk of this happening.
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No. 20: We human beings tend to meet whatever needs seem uppermost, most important.
I may have many needs that are important. When two important needs arise at the same time,
I will be inclined to meet the need I deem most important.
If I have experienced considerable wounding and distress,
Then my need to protect myself, to get by and survive as best I feel I can in life,
is likely to regularly be my top priority.
The strongly-felt desire to protect myself,
a desire that might over time become far less obvious to me but is nevertheless there,
will tempt me to regularly over-ride other needs I may have at that time.
I deal with this issue in more detail in the next presentation, presentation 3.9,
on choices and patterns of choice-making.
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No. 21: The theme of defense mechanisms and coping strategies
may influence how we choose to deal with and express emotions,

and this reality regularly surfaces in relation to the experiences and behaviours
that become categorized as “depression”.
I discuss this in presentation 3.12 of this course, the presentation entitled
“Emotions and depression” in this section of the course.
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No. 22: Many people who are considered to have a so-called “mental illness”
we have come to call “depression” appear very “private” or “deep”.
They hold back a considerable amount of who they are
and how they really feel, from others,
locking away aspects of themselves very deeply within them.
They rarely express their true self, their vulnerability, fear, emotions.
They keep these very private, under lock and key even from themselves,
greatly and deliberately restricting their own access to them.
This too is a defense mechanism,
chosen for similar reasons to the defense mechanisms discussed earlier in this presentation -
to minimize risk, in particular, to minimize the risk of further wounding that,
from that person’s perspective, might arise from risking to express themselves more,
for example, expressing their true feelings and their needs, and also,
in attempting to bury their true feelings and needs as deeply within themselves as possible,
out of their awareness, in an attempt to reduce and ideally eliminate
the chances of coming into peak contact with their unfinished emotional business.
In a later presentation, presentation 3.13,
I discuss the recurring issue of imbalances in depression,
in which I address how it is that some people
who would be or are diagnosed with depression are as I have just described,
private and deep, while others appear to at the opposite end of the spectrum.
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No. 23: I discuss anxiety in relation to depression in presentation 3.12,
entitled “Emotions and depression”.
I refer to the connection between anxiety and depression here, in this presentation,
in relation to defense mechanisms and coping strategies.
I will also in the near future be creating a comprehensive course on anxiety
for mental health therapists.
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No. 24: Anxiety is frequently a recurring experience of people diagnosed with “depression”.
This is no co-incidence.
The issue of defense mechanisms and coping strategies
is one of the links between anxiety and “depression”, in a number of ways.
I have frequently observed that progressively distressing anxiety
is often followed by experiences and behaviours that are considered
within the prevailing medical approach to mental health to be features of “depression”.
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No. 25: Most doctors know that what they term depression is often preceded by
considerable and sometimes prolonged anxiety.
This pattern has also been noted by many medical centres, including the Mayo Clinic.
For example, in an article on Depression on the Mayo Clinic website, it is stated that
“it is common to have depression that's triggered by an anxiety disorder”.
As is generally the case, no explanation is offered on the Mayo Clinic website
regarding why this pattern regularly occurs.
No such explanation is offered because of the lack of psychological-mindedness
within the medical profession in relation to mental health that I discussed earlier,
in presentation 3.1, the introduction to this section of this course, section three.
The best effort generally made by the medical profession
regarding links between anxiety and depression is to refer to then as “co-morbid” illnesses,
which in plain English simply means that they can both be present within the same person.

(http://www.mayoclinic.org/diseases-conditions/depression/expert-answers/depression-and-anxiety/FAQ-20057989, accessed 14th June 2016.)

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No. 26: In fact, this pattern, in which periods of intense anxiety
is followed by what doctors would describe as “depression”
is eminently understandable psychologically.
Anxiety can be a very intense experience, even when experienced for brief periods.
Intense anxiety is an extremely uncomfortable experience,
often prompting to person to do whatever they can to stop experiencing this anxiety.
Shutting themselves down emotionally and cutting themselves off from their emotions
therefore – which are common features of what has come to be called “depression” –
becomes a practical and attractive option,
an often relatively successful attempt to shut down – to some extent at least –
the internal tornado that is intense anxiety.
Because it is often relatively successful, shutting down may be resorted to regularly,
and in time and through repetition, continuously.
Links between anxiety and depression can also occur in the opposite direction.
For example, avoidance is a common coping strategy utilised
by people who might be diagnosed with depression.
While patterns of avoiding may temporarily provide relief,
they are also likely to increase anxiety levels.
Avoiding attending to things we need to do and complete may increase our anxiety levels
in several ways, for example, through increasing our fear levels
regarding the tasks or experiences we are choosing to avoid;
by creating agitation and frustration at the accumulation of more and more unattended to
and uncompleted things in our life,
and the progressive sense of powerlessness and effectiveness we feel
when we repeatedly avoid dealing with what we need to deal with.
In the presentation on emotions and depressions, presentation 3.12,
I describe various patterns of dealing with emotions that I have over the years
noticed in people diagnosed with depression.
One of the most common patterns is the regular blocking of fully feeling certain emotions.
For some people, the emotion they disconnect from most
is the full feeling and expression of their sadness.
For others, it might be anger.
In my work, I have regularly observed that,
in situations where the emotion that is habitually blocked might be provoked,
the person generally experiences a surge of anxiety.
Having given this much thought over the years,
My best answer as to why this happens is that in this situation anxiety is a defense mechanism,
Rising up as a smokescreen, to keep the more feared emotion at bay.
If a pattern for a person has become the habitual avoidance of feeling anger,
or the fullness of their sadness, then, unpleasant as it is,
feeling anxiety is less unpalatable than risking feeling fully an emotion or experience
that the person may have set out to avoid contact with many years previously,
so long ago that they may have lost all awareness of this recurring pattern of theirs.
I have regularly found that working with people
to recover their ability to feel and engage with the emotion or emotions
that have habitually avoided, results in a significant reduction in their anxiety.

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No. 27: Many other defense mechanisms and coping strategies
are erronously assumed to be features of a so-called “mental illness”
that has come to be referred to as “depression”.
I include some examples in the next few slides.
I go into further details on these and other common defense mechanisms

and coping strategies in relation to “depression”
in the pdf text that accompanies this presentation.

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No. 28: As I mentioned earlier, in people diagnosed with depression,
avoidance is a recurring theme.
Many adopted coping reactions reflect this fact.
Patterns of avoidance often become established in childhood or adolescence,
long before depression is diagnosed.
Initially, avoidance response may be barely noticeable and appear quite harmless.
Avoiding what we don’t want to do or experience, or don’t feel able to do or experience,
is an understandable reaction.
Avoidance causes problems if it becomes a major theme by which we live.
Avoidance may then become one of the few responses in which we come to trust.
Patterns of avoidance are then likely to escalate and become increasingly ingrained within us.
Patterns of avoidance, as with all defense mechanisms and coping strategies,
frequently reflect the degree of wounding and distress we have experienced, in particular,
the degree of unhealed wounding and distress we still hold within us.

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No. 29: When employed habitually, all defense mechanisms and coping strategies
have the capacity to result in short-term gain and long-term pain.
For example, when a person habitually employs avoidance as a response,
relief is the short-term gain, the relief of not having to deal with or face that particular situation,
the relief of not having to feel difficult feelings such as anxiety, fear, sadness,
or any other feeling that for that person has become one they would prefer to avoid.
Choosing to avoid situations because of the fear and anxiety they may trigger therefore
results in an immediate and welcome sense of relief.
This is often soon followed by a sense of failure, unease and increased anxiety.
This happens because by habitually avoiding dealing with situations or actions,
we repeatedly confirm to ourselves that we cannot deal with these situations
or take these actions.
This leads to further erosion of our sense of self, and an escalation of fear and anxiety
rather that the diminution of these we were hoping would ensue.
As the person increasingly relies on avoidance strategies,
their sense of self continues to diminish.
They feel progressively more isolated, helpless and powerless,
their self-doubt and their sense of feeling unsafe in the world increasingly steadily.
Their sense that they can engage,
risk and deal with the challenges of life diminishes accordingly.
As the months and years pass,
the level of relief experienced through avoidance tends to diminish.

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No. 30: We will now consider some other defense mechanisms and coping strategies
that are commonly adopted by people, that are mistakenly
interpreted as evidence of a “mental illness” called “depression”.
Apathy is a coping response used by people diagnosed with depression.
“I couldn’t be bothered” is a common response.
By becoming apathetic,
they disconnect from many things they want to disconnect with, including their feelings.
Losing interest and enthusiasm reduces the actions and activities they engage with,
thereby minimizing both the risks of feeling threatened in the action,
of making mistakes, of feeling their own distress,
of hoping and then having their hopes dashed - again.
Many people diagnosed with depression want to shrink, to disappear and become invisible.
Then at least they wouldnt have to feel such pain, no one would see them,
and they wouldn’t have to see or feel themselves.

Many describe living as if on autopilot,
often an inevitable consequence of employing defense mechanisms such as withdrawal (which I referred to earlier in this presentation),
numbing, a defense mechanism employed to minimize experiencing pain and distress;
indecisiveness, a recurring pattern adopted to minimize risk-taking;
mind-reading, that is, regularly second-guessing what others are thinking,
especially about them, an attempt to feel safer and more in control
by knowing what others are thinking and therefore anticipate potential threats.
As is generally the case with habitually-employed defense mechanisms,
mind-reading does not work as the person hopes it will, and causes many problems.
It does not work because it cannot work.
We humans have not yet mastered reading other people's minds.
When we assume we can read people's minds, we generally get it very wrong,
regularly coming to wildly inaccurate conclusions regarding what people are thinking,
conclusions that are based far more upon the projection of our own feelings, thoughts,
fears, hopes and longings on to others than on any knowledge
of what others are actually thinking.
Many engage in regular day-dreaming and various forms of fantasy creation.
This often consists of regularly drifting off into self-created stories or adventures.
Repeated patterns of day-dreaming and fantasy creation are often employed
as a coping strategy, as a way of passing the time when one does not feel safe enough
to engage in more real and fulfilling activities.
In some cases, the person is the hero of their daydreams, playing a starring role,
an attempt to compensate for what feels painfully absent in their real life.
A person who feels completely unimportant and generally incompetent
may in their daydreams be a very important and effective person.
Attractive as daydreaming and fantasy creation might be, there are many downsides, not least,
the fact that they are not real.
Coming back into the reality of one's life can therefore become progressively more painful.
Many are tempted to increasingly live within their fantasies,
which often means choosing to further disconnect from reality and from the people in their life.
For some people, their daydreaming and fantasy creation is filled with fear and dread.
Their fantasy creations are generally projections of their powerlessness, woundedness
and distress onto the screen of life in various ways and various forms, often beginning with
"what if . . .", leading into the creation in their minds
of all sorts of disastrous and terrifying situations and experiences.
While these "what ifs" are a direct reflection of the person's woundedness,
distress and sense of powerlessness to adequately protect themselves
and deal effectively with various situations and challenges that might arise,
they are also in part a coping strategy.
The excess external preoccupation with what ifs, things that might happen,
compensates and validates to some degree for the lack of action-taking
that is so often a characteristic feature of "depression".
Habitually formulating perceptions of how difficult and dangerous
taking various actions might be, can be a way of providing myself
with a whole series of reasons why I should not take risks,
a way of dissociating myself with the real – and perhaps less palatable reason –
which may be, for example, that I am really scared of stepping out of my comfort zone.
Introversion is often considered to be a hallmark of many people who are depressed,
and that certainly is true to a degree. However, many who appear predominantly introverted
are in fact far more extraverted than might appear.

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No. 31: As is illustrated on the Dictionary.com website, the term "extroversion" literally means
"the act of directing one's interest outward or to things outside the self",
"the state of being concerned primarily with things outside the self,

with the external environment rather than with one's own thoughts and feelings".
A lesser-known yet common consequence of wounding is an exaggerated external focus,
often accompanied by a parallel degree of self-abandonment.
In other words, as a response to wounding,
many people become highly extrovert in terms of where their general focus lies,
prioritizing the needs, opinions and welfare of others
while having placing little or no importance on themselves, their worthiness,
their needs, opinions and welfare.
This too is a defense mechanism.
Becoming primarily externally focused is often an attempt to anticipate
Events and interactions that might result in further wounding to us.
(http://www.dictionary.com/browse/extroversion, accessed 17th June 2016.)
……..
No. 32: Mindreading is an example of this extroversion, as is people-pleasing,
another common theme in many people who are or might be diagnosed with depression.
People-pleasing too is a defense mechanism.
By habitually attempting to please others,
I seek to ensure that they are happy with and approve of me.
If I am not habitually being the main provider of my own esteem myself,
then my need for esteem from others is likely to be greatly increased,
in an often frantic attempt to compensate for the fact that,
not only do I not generally provide my own esteem and approval,
in addition, my self-talk is generally laced with self-criticism and self-belittling,
common features of people diagnosed with depression.
Many people diagnosed with depression tend toward a polarized approach to blaming.
Some blame themselves for everything.
Some blame others or the world for their life situation and experience,
taking little responsibility for themselves.
Sometimes there may be some justification for this.
Perhaps others did hurt the person, and life can be very cruel to some.
However, holding on to blame holds back the person who is doing the blaming.
Blaming has perceived benefits for the people who choose it as a coping reaction.
It may make the person feel better temporarily.
It can be convenient to have a scapegoat, someone or something to blame.
This takes our attention away from ourselves and our role in the situation.
We absolve ourselves of all responsibility for either creating the problem or solving it.
We are off the hook.
As long as we are in blaming mode,
we probably won't take appropriate action to deal with the situation,
resolve it as best we can and move on.
Blaming ourselves paralyses us with guilt and recrimination.
Blaming others also keeps us stuck.
Blaming mode ensures that we do not grow through and move beyond the problem,
but this may be why we employ this coping response
because we may not want to move beyond it.
While the resulting sense of self-righteousness is alluring,
our sense of selfhood suffers.
Our self-confidence, self-empowerment, and our need-meeting suffer
when we preoccupy ourselves with focusing on others
rather than on what we can do about the situation.
Also, it may be fundamentally dishonest.
We may well be aware of the inaccuracy of our pinning problems on ourselves or others.
This is a disconcerting reality, one we may seek to block out of our awareness too.
Blaming others habitually is a coping strategy in another way.
By resorting to blame, with anger, aggression and raised voices, we mask our sadness,

our vulnerability from others and from ourselves.
This is also true when we direct our blaming towards ourselves.
We do so because we fear feeling and expressing our vulnerability, our sadness, tears, our fear.
Some people adopt the blame game with considerable enthusiasiasm,
creating mayhem all round them.
People around them are like headless chickens, rushing around the place,
trying to deal with the complex and chaotic web that ensues.
Meanwhile, people around them are likely to become so preoccupied
by this powerful and convincing distraction technique
that the person is repeatedly off the hook regarding self-responsibility, which of course is one of the main purposes of habitually blaming others.
So-called “negative thinking” is a common feature of people
who are diagnosed with depression or who would be likely to be diagnosed with depression.
This term does not sufficiently describe or explain the nature of this type of thinking,
which is far more accurately understood as “protective thinking”.
For example, regularly attempting to anticipate what disaster might befall the person,
what could go wrong or against them becomes a way of preparing for the worst,
so that if the worst happens, well, they did anticipate it,
so it is less shocking and less disappointing.
It is a case of “forewarned is forearmed”.
Their desire to be so forewarned steps from their lack of belief
that they can protect themselves and make themselves feel safe.
This is a consequence of having experienced much wounding
and having come to see themselves as generally helpless and powerless,
which, as discussed in relation to learned helplessness in an earlier presentation in this section in this course, is a product of wounding.
Convinced that they will not be able to protect themselves or make themselves safe
in situations and interactions that might arise,
they compensate for this by focusing a great deal of attention on anticipating possibilities,
all the things that *might* happen, that *could* go wrong.
In the text that accompanies this presentation,
I provide many further examples of the defense mechanisms and coping strategies
employed by people diagnosed with depression or who might be diagnosed with depression.
I also refer briefly to defense mechanisms and depression in 1-2 ?? later presentations
in this section of this course (and include details in the slide also).

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No. 33: Avoiding eye contact is a pattern that many people exhibit,
including many people diagnosed with depression
or who would likely to be diagnosed with depression.
Making good eye contact similarly risks melting the defenses
we may have constructed around our unhealed woundings and distress.
It is often said that the eyes are the window to the soul.
Making good eye contact,
especially with a person with whom we have an emotional connection,
brings us not only into powerful contact with the other person, but also with ourselves.
Making eye contact with a person who is also looking directly at our eyes,
we may feel very uncomfortable.
We fear that they are looking right into us, seeing right through our defenses, our masks,
Seeing deeply into who we really are, including the parts of ourselves we do not want to see,
not least our woundings, distress, vulnerability, our sorrow.
While we may feel that it is their judgement and rejection of us,
based on what they can see upon looking into our eyes, that we fear,
this is a projection of our own judgement, rejection and lack of acceptance
of these aspects of ourselves.

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