International
Journal of Neurorehabilitation
ISSN: 2376-0281

Mini Review Open Access

Human Mechanisms of Psychological Defense: Definitions, Historical and Psychodynamic Contexts, Classifications and Clinical Profiles

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Abstract

The present work aims to investigate in a schematic and organized way all the main human mechanisms of psychological defense identified in the psychodynamic studies of world history, from Sigmund and Anna Freud to Perry, passing through Klein. The claim is therefore to offer the reader a reasoned analysis of the individual psychological mechanisms that underlie the defense of the ego, as a contact structure with reality. Each mechanism is then investigated in all its components: from levels to areas, from sources to analytical descriptions, complemented by practical examples. Finally, the work ends with a quick examination of the psychodiagnostic tools mainly used to investigate these defenses and with practical applications about the subjective interpretations of reality.

Keywords: Psychological defense; Psychodynamic; Behavioral; Defense mechanisms; Conflict management techniques

1. Introduction

General definition and basic historical and psychodynamic contexts

The "defense mechanisms" are psychological processes, often followed by a behavioral reaction, implemented to deal with difficult situations, to manage conflicts, to preserve their functioning from the interference of disturbing, painful and unacceptable thoughts, feelings and experiences. They are generally, but not necessarily, automatic, as they often work without a conscious effort, as they are a preferential tool for dealing with a real or perceived danger [1].

Dozens of authors and researchers have studied these psychological processes for about two centuries. The most representative, for systematicity, innovation and argumentative coherence, were undoubtedly the scholars closest to the psychodynamic schools.

Sigmund Freud, father of the classical psychoanalytic current, first spoke of a defense mechanism, identifying repression as an "unconscious operation for defensive purposes", and then hypothesizing others, extending the function to "conflict management techniques". In addition to removal, he also identified sublimation, displacement and reactive formation [2].

With a thirty-year clinical study on the subject under examination, her daughter, **Anna Freud**, succeeded in drawing up a classification of defense mechanisms much broader than that of her father, merged and identified with the name of "Index Hampstead" [3].

Hartmann, an exponent of ego psychology, also made his contribution to the specific cause, stating that the defenses were nothing more than operations carried out by the ego, using partially neutralized, then depulsionalized aggressive energy [4], while **Kohut**, exponent of psychology of the self, supported the thesis of the adaptive role of defenses to safeguard the integrity of the Self [5]. On the other hand, **Kernberg** instead emphasized the function of defensive mechanisms not so much as tools for resolving and managing conflicts but as means necessary to build and develop the Self, with respect to the representation of objects and the regulation of object relations (themes dear to **Klein**) [1].

More recently, **Vaillant** advocated defensive causality for the purpose of an adaptive response consolidated over time; [1] together with **Perry** [1], they then drafted (with separate but complementary contributions) a fairly exhaustive list of defense mechanisms, proceeding to a hierarchization in seven levels: from the most adaptive to the least, up to the partial or total distortion of the plan of reality. In fact, the maladaptive potential of a defense depends on: a) exclusivity, as a specific defense is used repetitively, rigidly and narrowly; b) the intensity, ie the quantitative impact of the defense; c) age adequacy, as defenses may be more or less functional based on the age of the subject and the life cycle stage; d) adequacy to the context.

The defensive mechanisms thus identified were classified according to the following criteria:

a) **"Maturity level":** "Mature" (if functional and adaptive) / "Immature" (if dysfunctional and maladaptive, distinguishing between obsessive, neurotic, narcissistic, disavowal, borderline and pure instinct defenses, up to total compromise and therefore psychotic fall);

b) **"Clinical area":** "Absence of psychopathological condition" / "Neurotic" / "Borderline" / "Psychotic" (based on the level of compromise of the reality plan);

c) **"Source of formation":** "Primary" (if it is primitive, formed in the first years of life) / "Secondary" (if it originates in a post-birth moment, during an adaptation).

Therefore [1,3]:

1) The seventh defensive level is the "highly adaptive" level and includes defenses such as altruism, affiliation, repression, humor and sublimation. These defenses promote functional, balanced and socially useful behaviors, allow gratification and often presuppose an awareness of emotions and their consequences. They are therefore not dysfunctional and indeed guarantee a good adaptation with the subjective reality perceived by the subject;

2) The sixth level groups the "obsessive defenses", such as retroactive cancellation, intellectualization and isolation of affection.

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Received January 16, 2020; **Accepted** January 30, 2020; **Published** February 06, 2020

Citation: Perrotta G (2020) Human Mechanisms of Psychological Defense: Definitions, Historical and Psychodynamic Contexts, Classifications and Clinical Profiles. Int J Neurorehabilitation Eng 7: 360.

These defenses, while necessary to maintain the psychic balance of the subject, are oriented towards an obsessive assessment of reality, leading the subject to perceive it in an exaggerated, phobic and dangerous way. However, without these defenses, constructed by the mind in this way, balance would be lacking, leading the subject to psychotic sliding. In this case, the therapist must work first on the obsessive condition and then on the mechanism that automatically activates in the presence of a danger or a feeling of danger (even non-existent) perceived by the subject;

3) The fifth level groups the "neurotic defenses", such as removal, reactive formation and displacement. As for the obsessive, this subject is strongly oriented towards neurosis, according to the concept theorized by the first schools of psychodynamics. The subject's high vulnerability conditions his interpretation of reality, leading him to close himself up and interpreting reality as damage and therefore to be removed. Also in this case, the therapist must intervene first on the origin of the neurotic disorder and then on the associated defense mechanism;

4) The fourth level groups the "narcissistic defenses", such as idealization, omnipotence and devaluation. These mechanisms, although functional as mentioned above in maintaining balance, essentially represent the armed arms of the narcissistic disorder, categorized in the DSM-V in the personality cluster B. They are defenses able to feed the disturbance at the origin, from time to time able to adapt to the person and the present situation, to strengthen the unconscious idea about that particular person, positive or negative. Working from a therapeutic point of view on a subject belonging to cluster B is a very complex undertaking; even more is it works on the defense mechanism that holds this relationship with reality firmly in place. It is essential to make a transition here with an integrated psychotherapy with a drug therapy, to ensure that the subject is stable and supported, and therefore work on the internal psychic processes that strengthen the pathology;

5) The third level groups the "disavowal defenses", such as negation and projection. They are very powerful defense mechanisms, capable of modifying the perceived reality in a totally dysfunctional way but they are also necessary mechanisms in the presence of a strong trauma capable of sliding the subject into the psychotic curvature. The mind, in this way, puts a veil, puts a brake on the danger far more serious than a psychosis. However, denying does not mean eliminating the drive: deep down, that energy continues to work and produce, even against the conscious will of the subject. The therapist here has to work on the patient's emotional literacy and the recognition of their needs and requirements. Only after this step will it be possible to work on these mechanisms, which hide really difficult knots to untie;

6) The second level groups the "borderline defenses", such as projective identification and splitting. Here too we are in cluster B of the DSM-V and working on these mechanisms means working on the patient's borderline disorder; perhaps, the most difficult undertaking for any therapist. What has been said for narcissistic defenses also applies in this case;

7) The first level, also called "instinctive action", is the level of "acting out", which consists in dealing with stress with a direct and often impulsive action, implemented without worrying about the consequences. It is the case of a student who, after having taken a bad grade in the interrogation, throws the books with violence. There is the use of the same mechanism in the presence of senile dementias or cerebral vasculopathies.

Then there is another level of defense, level zero, which indicates a defective regulation failure condition up to a break with reality. It includes psychotic denial, psychotic distortion and delusional projection. Here is evident the psychotic sliding and the curvature heavily oriented towards the most serious psychopathologies, those where the compromise of the plane of reality is evident.

2. The Different Classifications

By doing an extremely brief work on the defense mechanisms, we can proceed to an alphabetical listing as complete as possible, assessing the level, area and training source for each defense [1,3]:

Level: Mature / **Immature**

Area: Absence of psychopathological condition / Neurotic / **Borderline** / **Psychotic**

Training source: Primary / **Secondary**

Defense mechanism: **ACTING OUT**. The subject activates impulsive behaviors without reflecting on the possible negative consequences. Example: the student who is rejected by an exam, throws himself with violence against the teacher, holding him responsible for the failure.

Level: Mature / Immature

Area: Absence of psychopathological condition / Neurotic / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **AFFILIATION**. It is the tendency to bind to others, to make a group, to cooperate with other people. If extremized, however, it could be an expression of a neurotic fall of an obsessive matrix. Example: Collaborate in a team game with all the components to achieve the victory.

Level: Mature / Immature

Area: Absence of psychopathological condition / **Neurotic** / Borderline / Psychotic

Training source: Primary / Secondary

Defense mechanism: **ALTRUISM**. The person overcomes the prohibition of the Super-ego by transferring his desires to another subject and engages altruistically to contribute to their satisfaction, thus obtaining indirect satisfaction through a third party, not being able to obtain it directly. Example: dedicating oneself to voluntary oncology because a loved one and in this way one tries to remember it or to stay close to those who suffer from the same problem trying to cure a piece of their wound.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / Neurotic / Borderline / Psychotic

Training source: Primary / Secondary

Defense mechanism: **RETROACTIVE CANCELATION**. Staging of a reparative behavior with respect to the damaging event produced. Example: wash your hands immediately after the murder committed in a fit of rage, to wash away the blood, as if this canceled the gesture.

Level: Mature / Immature

Area: Absence of psychopathological condition / Neurotic / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **ANTICIPATION**. A mature search for a solution to the present anxiety, imagining the situation, fantasizing about it, thus reducing the anxiety itself. Example: Deceiving the wait while receiving an important phone call with behaviors that anticipate the event itself, organizing the possible subsequent moves.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / Neurotic / **Borderline** / **Psychotic**

Training source: Primary / **Secondary**

Defense mechanism: **ASCETICISM**. Any drive that gives pleasure is frustrated, frustrating a desire or drive, even leading to isolation, the imposition of limits or its exact opposite, mortification and neglect, and in the most extreme cases to the catatonic state and psychosis. Example: Taking refuge in a remote mountain area, after a disappointment, canceling any possibility of giving up that idea.

Level: Mature / Immature

Area: Absence of psychopathological condition / Neurotic / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **AUTO-CLAIM / AUTO-OBSERVATION**. Acceptance of one's own desire or drive, even if this causes discomfort, learning to manage it in a healthy and functional way, thus reducing the disturbing effect. Example: The subject accepts and lives in a serene way his paraphilias, without these controlling his life, causing discomfort.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / Neurotic / **Borderline** / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **SUBDIVISION**. Two conflicting conditions are placed in a condition that does not create anxiety (or other negative feelings) on the conscious plane. Example: consider your violent husband a good person or be in violent private life while you are human and sensitive in public.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / **Borderline** / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **CONDENSATION**. It is a representation that merges with a multiplicity of images and words. It is the typical mechanism of phobias. Example: having the irrational fear of the pigeon, without knowing why.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / **Borderline** / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **CONVERSION / SUMMER**. Symbolic representation of a psychic conflict in physical terms [2]. In psychoanalytic literature, however, the concepts of "conversion" and "somatization" are used differently. In some cases they are interchangeable (as they can be superimposed); in others, they are quite distinct. However, both describe specific diagnostic entities such as conversion disorder and somatization disorder. Rodin [5] describes somatization as a complex phenomenon that leads to somatic symptoms (in the absence of organic pathology) found in various psychiatric disorders, including conversion disorder and hypochondria. In contrast, Aisenstein and Gibeault [6] see somatization as a process distinct from hypochondria and hysterical conversion and associate it only with the development of an organic disease. Other authors have also proposed abandoning the word somatization altogether (like Gedo [7], Mumford [8]) but others, such as Yorke [9] point out that it, like the term psychosomatic, is used inaccurately for the purpose of bypass the difficulty of understanding what the different mechanisms involved in the formation of somatic symptoms are. Yorke notes that in reality similar symptoms can involve underlying heterogeneous mechanisms and is convinced of the importance of a good psychological diagnosis alongside that of formal nosology. The most accepted thesis appears to be that which considers these two distinct profiles, with some points of convergence. The psychiatric perspective of DSM-5 categorizes the neuroses identified by Sigmund Freud in three distinct disorders: the panic disorder (which replaced anxiety neurosis), the undifferentiated somatoform disorder (which replaced neurasthenia) and hypochondria, considered one of the somatoform disorders. Freud's conversion hysteria became the conversion disorder that is classified among the somatoform disorders but is also distinguished from the somatization disorder. The somatization disorder derives from the concept of hysteria of the French neurologist Briquet [10], who actually described three associated syndromes: the hysterical personality, the conversion phenomena and the unexplained multiple chronic somatic symptoms. The association is not at all constant but the three syndromes frequently overlap; in fact, according to Briquet's observations, Freud [11] maintained that some patients could present with a mixture of symptoms of psychoneuroses and current neuroses. Gediman [12] also believes that current neuroses and psychoneuroses can coexist in the same individual, even if the former are probably much more often elaborated to the point that they can be linked to any available mental content. A similar mixture is present in the description of DSM-V, in the somatization disorder, where patients may exhibit some conversion symptoms along with others that are simply the manifestation of somatization. Wickramasekera [13] defines the "somatizers" as "people transducing psychosocial conflicts into somatic disorders such as musculotensive or vascular headache, irritable bowel and chronic low back pain". This definition is similar to Stekel's concept of somatization and is equivalent to conversion. Ford [14] instead defines somatization as "a process whereby the body (soma) is used for psychological purposes or for personal gain" and Bridges and Goldberg [15] as "a common and important psychological mechanism". Lipowski [16] defines it as "the tendency to live and communicate psychological distress in the form of somatic symptoms, and to seek medical help for them". Lloyd [17] similarly sees somatization as "the presentation of psychological distress through somatic symptoms". All these definitions suggest a causal relationship between psychological distress and presentation of somatic symptoms. However, Lipowski subsequently modified his definition when he realized that "the somatizers live and communicate primarily not the psychological distress but the somatic one, and this is precisely what characterizes them". This is an important modification since it allows us to put in opposition somatization and conversion. Conversion symptoms always imply "a mysterious leap from mind to body". As pointed out by McDougall [18], the body lends itself and its functions to the mind to be used according to the will of the mind: in all cases, the

symptoms tell a story. In somatization, on the other hand, symptoms begin in the body and follow somatic rather than psychic laws (Sharpe and Bass [19]). Ron [20,21] is very critical of the conceptual distinction between conversion and somatization, arguing that distinctions are always difficult and of little clinical significance. Instead, he prefers to use a broad definition of somatization that includes neurological and non-neurological symptoms, for which there are no obvious organic explanations. Ron is also critical of the relationship between conversion disorder and conflicts or other previous psychological stressors because, in his experience, this diagnostic criterion is vague and difficult to establish. It therefore poses a problem of conversion and somatization on the same continuum and suggests that they can share similar underlying mechanisms. His notation is however only descriptive: the main difference is in the number and duration of symptoms. A contrasting view with the psychoanalytic one is offered by Shoenberg [22] who, although he recognizes that the symptoms of conversion can coexist with those of somatization, maintains that the two entities must be distinguished since they imply completely different psychopathologies. Therefore it seems plausible to assume that, being both (somatization and conversion) of the constructs called into question to explain the formation of somatic symptoms, despite the lack of conceptual clarity begun with Stekel (who used them to denote the same process), the distinction can be to carry out in these terms: 1) one speaks of "somatization" when the subject is affected by organic diseases and conversion symptoms; 2) we speak of "conversion" when the subject is suffering from conversion symptoms without the active manifestation of a well-identified pathology. Furthermore: conversion symptoms imply higher-level neuro-cognitive functioning, somatization symptoms imply lower-level psychological disturbances (Kirmayer and Santhanam [23]); conversion is an active process of the ego (Rangell [24]) while somatization is a passive phenomenon, namely the lack of symbolization of emotional states and emotional excitement which therefore escapes psychic processing and directly affects the soma; conversion symptoms require a psychoanalytic therapy aimed primarily at identifying, interpreting and resolving the unconscious conflict (Temple [25]), while somatization symptoms require psychotherapy aimed at strengthening referential connections between sub-symbolic and symbolic elements within the emotional patterns of the patient, thus transforming the meaning attributed to the symptoms [26,27].

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / **Borderline** / Psychotic

Training source: Primary / Secondary

Defense mechanism: **DISCLAIMER** or **DENEGATION**. Unconscious and involuntary exclusion of a circumstance that disturbs the reality plan. The very reality of perception is denied (example: denying the death of a loved one); different from the "mechanism of denial", since in this latter case the subject first formulates a desire / thought removed until then and then defends itself by denying belonging to it (example: experiencing carnal desire for a relative).

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **AVOIDANCE FOLLOWING**. Avoid contact with feared situations or things. Example: going to crowded places where I can meet people who know me.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / **Borderline** / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **DETERMINATION**. Stopping evolutionary, emotional-affective development, remaining locked to a precise and previous evolutionary phase, due to its unconscious need to protect its balance. Example: continue to suck your thumbs, in stressful situations, despite adulthood.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **REACTIVE TRAINING**. Opposing / contrary behaviors occur in response to content deemed inappropriate, prohibited and unacceptable. Example: excessive bigoted moralism in response to a repressed sexual desire). Typical in obsessive disorders.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / Neurotic / **Borderline** / **Psychotic**

Training source: Primary / **Secondary**

Defense mechanism: **IDEALIZATION**. The person constructs images of himself, of objects and external events, unrealistic, totally positive and omnipotent, rather common in falling in love. Typical in personality disorders, in narcissistic and psychotic profiles.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / Neurotic / **Borderline** / **Psychotic**

Training source: Primary / **Secondary**

Defense mechanism: **IDENTIFICATION**. The ego is identified with the external object that generates anxiety, to overcome fear. Example: identify yourself with your attacker. A particular form has been identified by M. Klein with the name of **PROJECTIVE IDENTIFICATION**, in which one wants to introduce oneself or split parts of oneself within the object (mother or caregiver), in order to possess it and control it (this mode is perfectly normal in the early stages of age, it becomes pathological if it continues in the following phases).

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / Borderline / Psychotic

Training source: Primary / Secondary

Defense mechanism: **INTROJECTION**. The ego absorbs something from the outside, making it its own. Example: identify yourself as a public figure.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **INTELLECTUALIZATION**. Instinctual conflict is overcome with an approach focused on the speculation of one's rational activity. Example: extinguish social relations almost completely to dedicate oneself entirely to reading and academic life.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / **Borderline** / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **INHIBITION**. Unconscious and involuntary defense that determines the decrease or loss of the motivation necessary to carry out a certain activity. The aim is to avoid the anxiety associated with unacceptable impulses. The activity in question is also pleasant for the individual but is avoided because it would create a conflict about primitive impulses. Examples include writing blocks, social shyness that prevents certain activities, such as public speaking or sports.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **REVERSAL TO THE CONTRARY**. The fantasy succeeds in reversing a real and unpleasant situation, transforming it into the opposite situation. Example: an aggressive drive is transformed into the fear of being attacked.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **AFFECTIVE INSULATION**. The connection between the trauma and the emotions felt is disconnected, rationalizing what happened, with cold detachment, as if someone else had experienced it.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **OMNIPOTENCE**. The subject becomes convinced that it is enough to desire something that will be obtained by modifying reality at will.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / Neurotic / **Borderline** / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **DENIAL**. The subject denies to himself the existence of a desire or drive considered unacceptable. Denial that can occur through words or deeds. Examples: denying feelings or stopping sports for fear of competition. If the child is frequent and normal (to the extent that the fantasy does not pervade reality, causing obsessions to emerge, in the adult it is always an expression of significant disturbance or serious disorders. It differs from the "denial", as in the latter, the subject unconsciously and involuntarily excludes a disturbing aspect of reality, denying the very reality of perception (eg denying the death of a loved one).

Level: Mature / Immature

Area: Absence of psychopathological condition / Neurotic / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **REPRESSION**. The subject realizes that his drive is unacceptable or socially uncommon and decides to oppose, not seeking satisfaction.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **REMOVAL**. It is the cancellation of a memory, experience or drive considered unacceptable or traumatic. Example: physical violence suffered in childhood.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **UPHEAVAL AGAINST YOURSELF**. The drive is not removed and the object is moved from the outside to the inside. Example: self-harming acts.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / Neurotic / Borderline / **Psychotic**

Training source: Primary / Secondary

Defense mechanism: **PRIMITIVE WITHDRAWAL**. The subject is detached from reality by entering into withdrawal from the external world. Example: Convince yourself that someone is spying on us. It is typical in psychotic forms.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: **SHIFT**. An internal threat, resulting from an unacceptable impulse, is moved to a replacement object. The link between the two objects is symbolic and unconscious. Through the displacement this threat, which was not avoided by repression, is now perceived and recognized as an external danger, no longer apparently connected to the unacceptable internal impulse. Example: the irrational fear of an animal. It is typical in phobias.

Level: Mature / Immature

Area: Absence of psychopathological condition / Neurotic / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: SUBLIMATION. The drive is not denied but differently oriented and finds satisfaction in some activity weakened in its dangerousness (example: nudism in places used for this activity) or in any case socially accepted (example: dedicating oneself to sport to vent a violent impulse).

Level: Mature / **Immature**

Area: Absence of psychopathological condition / Neurotic / Borderline / **Psychotic**

Training source: Primary / **Secondary**

Defense mechanism: SPLIT / DISSOCIATION. A separation is made between what we like and what we don't like to keep the relationship with the desired object. The basis of the split is therefore an archaic mechanism that tends not to tolerate the contradictory component of affective reality, and evolutionarily aimed at the search for "good", gratifying relationships, without causing the individual to be discouraged from frustrating experiences (eg. if we relate to a person considered "friend", who reveals an aspect of himself that we do not share or a behavior that hurts us, it can happen that we will succeed in splitting the "good" qualities of the person from those "bad", in order not to renounce the our object of relationship - "transformed" into a good object and clearly distinguished from the bad, devalued - In other cases we can enhance the bad object, the unpleasant qualities of the friendly person, strongly denying the accepted and loved component). In extreme cases we arrive at a real dissociation of reality, leading to pathological aspects such as borderline disorder and multiple personality.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / Neurotic / **Borderline** / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: DEVALUATION. Indicates devaluation attitudes in order to make a situation, object or person harmless to promote one's self-esteem and trust and to hide feelings of inferiority. Example: a new person arrives at work who we believe makes very big mistakes and we devalue it, just because we perceive it as a threat to our career. It is the opposite ofidealization.

Level: Mature / **Immature**

Area: Absence of psychopathological condition / **Neurotic** / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: TRANSLATION. It is the transformation of an unexpressed or unmanifested emotional charge onto another object that can cover the same characteristics. Example: I can't have children; I fill the house with animals.

Level: Mature / Immature

Area: Absence of psychopathological condition / Neurotic / Borderline / Psychotic

Training source: Primary / **Secondary**

Defense mechanism: HUMOR. The subject is led to grasp the amusing or grotesque aspects of reality and to smile at it with ironic understanding. For S. Freud it is a predisposition of the soul.

3. Psychometric Tools [1]

In clinical psychology, investigating the defense mechanisms of the subject is very important, not only from a psychodynamic point of view, but also and above all from a psychotherapeutic point of view, beyond the approach used.

The most used tools in the international field for the evaluation of defense mechanisms are:

1) Christopher Perry's Defense Mechanisms Rating Scale (DMRS), is a measurement scale based on the "hierarchical model of defenses" studied by Vaillant since the 1970s. The scale tends to identify twenty-eight defense mechanisms (from the most primitive to the most mature), ordered hierarchically in seven defensive clusters: acting out, borderline, narcissism, denial, neurotic, obsessive, mature.

2) Defense Mechanism Inventory (DMI) by Gleser and Ihilevich, a projective test that, through the story of ten stories, detects five defensive styles, such as: aggressiveness, projection, falsification of reality, self-punitive behavior, minimization of internal threats or exterior.

3) Defense Style Questionnaire (DSQ) by Bond, a questionnaire of eighty-eight items on a nine-point Likert scale that reveals four defensive styles: acting out as passive aggression and projection; image distortion as splitting, primitive idealization and devaluation; self-sacrificing as reactive and pseudo-altruism training; mature defenses such as humor, suppression and sublimation.

4. Conclusion

In dynamic psychology, the "principle of reality" represents one of the central points of the theory of S. Freud, starting from his studies up to the theoretical evolutions of currents inspired by him and his dynamic processes. It is no coincidence that the principle of reality is considered the dominant component in the psychic life of the adult, subsequent and substitute (in the psychic development of the individual) of the reduced pleasure principle, which dominates the psychic life of the infant. If therefore, in the early years, we witness an overwhelming orientation of pleasure, in the following years, we should instead see an ever-increasing orientation linked to reality. The reality principle requires the acceptance of a state of tension in exchange, soon, for greater pleasure or less pain. While the pleasure principle seeks immediate satisfaction of need in a completely irrational way, the reality principle pursues the fulfilment of desire by setting extended goals over time and sublimating the impossible immediate fulfilment in substitute representations. In other words, faced with the impossibility of complete fulfilment, the reality principle acts to adapt the satisfaction of the desire to adverse situations. However, the principle of reality and that of pleasure are not to be considered antithetical; they do not act in opposition to each other. Instead, the former helps to resize the latter, forcing it to take into account the actual conditions of action. The principle of reality does not prohibit the pleasure principle of expressing itself but restores it within certain limits of action [4].

Among the various elements involved in the perception of sensory signals, in addition to the perceptual rules, the perceptive-reactive system, the human needs, the social categories and the systematic errors, we undoubtedly find the group of "defense mechanisms" directed by the ego, or those psychological processes, often followed by a behavioral reaction, implemented to face difficult situations, manage conflicts, preserve their functioning from the interference of disturbing, painful and unacceptable thoughts, feelings and experiences. As analyzed, they are generally (but not necessarily) automatic, since they often work

without conscious effort, as they are unique tools for dealing with a real danger or in any case perceived by the subject. Without these defense mechanisms, the subject would slip into the psychotic curvature, definitively compromising his perception of reality, as happens in schizophrenia. Therefore, the defense mechanism is not in itself negative, even if it keeps alive the subject's psychological pathological condition, feeding it, as it is - for the mind - the best possible solution to maintain the psychic balance.

In clinical psychology, investigating the defense mechanisms of the subject is very important, not only from a psychodynamic point of view, but also and above all from a psychotherapeutic point of view, beyond the approach used.

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