Journal of Abnormal Psychology
1994, Vol. 103, No. 1, 44-50

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0021-843X/94/$3.00

Ego Mechanisms of Defense and Personality Psychopathology

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It is often not just life stress but also a person's idiosyncratic response to life stress that leads to psychopathology. Thus, despite problems in reliability, the validity of defenses makes them a valuable diagnostic axis for understanding psychopathology. By including a patient's defensive style as part of the diagnostic formulation, the clinician is better able to comprehend what seems initially most unreasonable about the patient and to appreciate what is adaptive as well as maladaptive about the patient's defensive distortions of inner and outer reality. Clinical appreciation of the immature defenses (e.g., hypochondriasis, fantasy, dissociation, acting out, projection, and passive aggression) is particularly useful in classifying and caring for individuals with personality disorders.

In no area of psychology is the need for a synthesis of frames of reference greater than in the field of personality psychopathology. Two vantage points are in special need of integration. First, there is the descriptive, categorical classification system of personality disorder, epitomized by Axis II of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*; American Psychiatric Association, 1980). Second, there is the more inferential, psychodynamic viewpoint of personality shaped by mental conflict and ego mechanisms of defense. After all, if both phenomenology and pathophysiology are important in the understanding of disease, they are both crucial in the understanding of personality disorder. Nineteenth-century medical phenomenologists viewed pus, fever, pain, and coughing as evidence of disease; 20th-century pathophysiologists regard these same symptoms as evidence of the body's healthy efforts to cope with physical or infectious insult. In similar fashion, much of what modern phenomenologists classify as mental disorders may be reclassified as the outward manifestations of the mind's adaptive efforts to cope with psychological stress.

For example, hypochondriasis and somatization are treated as discrete disorders in the *DSM-III*. According to the *DSM-III* the hypochondriacal individual complains of an illusory disease, and the individual afflicted with somatization disorder complains of illusory symptoms—a hair-splitting distinction without justified empirical foundation. It may be more useful to view both reactions as reflecting defense mechanisms, not diseases. Hypochondriasis and its associated help-rejecting complaining often conveys unconscious reproach and devaluation. Hypochondriasis makes the observer annoyed. In contrast, somatization characterized by the defense mechanism of displacement often results in secondary gain and may serve as a means of communicating an unconscious, or at least unverbalized, affective state. Somatization often captures the observer's attention. When the distinction between somatization and hypochondriasis is made in this way, it becomes clinically useful.

In his efforts to lay the groundwork for the 10th edition of the *International Classification of Diseases*, Norman Sartorius (Sartorius, Jablensky, & Regier, 1990), the director of the Division of Mental Health of the World Health Organization, wrote that

> research during the past two decades failed to provide evidence that could help to create disease concepts and disease entities in psychiatry . . . . Other ways of thinking about health and disease, mind and body, mental and physical, individual and social are needed . . . . I believe that in selected instances a return to the allegedly outdated Meyerian reaction patterns and Freudian defense mechanisms is warranted. (p. 2)

Defense mechanisms refer to innate involuntary regulatory processes that allow individuals to reduce cognitive dissonance and to minimize sudden changes in internal and external environments by altering how these events are perceived. Defense mechanisms can alter our perception of any or all of the following: subject (self), object (other), idea, or feeling (Vaillant, 1971). There is increasing evidence that the choice of defensive style makes a major contribution to individual differences in responses to stressful environments (Vaillant, 1992b). Nowhere is Sartorius's "return to allegedly outdated defense mechanisms" as warranted as in the domain of personality disorders (Skodol & Perry, 1993). Thus, as an aid to describing personality disorders, the revised third edition of the *DSM-III* (*DSM-III-R*; American Psychiatric Association, 1987) has included a glossary of defense mechanisms, and the *DSM-IV* will probably contain hierarchically arranged defenses as an optional axis.

S. Freud (1894/1964) observed that affect could be dislocated or transposed from ideas (by the unconscious mechanisms that he would later call dissociation, repression, and isolation) and that affect could be reattached to other ideas (by the mechanism of displacement). He also noted that subject and object could be reversed by the process that he called projection. Over a period of 40 years, Freud and his daughter (A. Freud, 1937) outlined most of the defense mechanisms of which we speak today and identified five of their important properties: (a) Defenses are a major means of managing conflict and affect; (b) defenses are relatively unconscious; (c) defenses are discrete from one another; (d) although often the hallmarks of major psychiatric syndromes, defenses are reversible; and (e) defenses are adaptive as well as pathological.

Some defenses (e.g., altruism and suppression) appear much

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Table 1
Ego Defenses Defined in the DSM-III-R, Arranged in Order of Their Empirical Association With Global Assessments of Mental Health

Category	Defense
Psychotic defenses	Denial (of external reality)
	Distortion (of external reality)[a]
Immature defenses	Passive aggression
	Acting out
	Dissociation
	Projection
	Autistic fantasy
	Devaluation, idealization, splitting[b]
Neurotic (intermediate) defenses	Intellectualization, isolation
	Repression
	Reaction formation
	Displacement, somatization
	Undoing, rationalization
Mature defenses	Suppression
	Altruism[a]
	Humor[a]
	Sublimation[a]

Note. *DSM-III-R* = revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders.*
[a] *Altruism, humor, sublimation,* and *distortion* are terms used in the text of this article but not in the *DSM-III-R.* [b] Devaluation and to a lesser degree splitting are included under my term *hypochondriasis,* a term not included in the *DSM-III-R* glossary.

healthier than others (e.g., projection and distortion). In the last 50 years Anna Freud (1937), George Engel (1962), Richard Lazarus (1983), and Karl Menninger (1963), among others, deserve special credit for underscoring the need to define a hierarchy of defense mechanisms. Every one of these investigators, however, presented a different nomenclature; no one supplied mutually exclusive definitions; and few sought rater reliability or provided empirical evidence beyond clinical anecdotes. This lack of empirical study has retarded the acceptance of defense mechanisms by academic psychology. Because it offers a tentative glossary of consensually validated definitions, the *DSM-III-R* is a step forward.

In the last 10 years, several empirical studies (reviewed by Cramer, 1991, and Skodol & Perry, 1993) finally avoided these limitations and replicated earlier studies showing that defenses could be organized into a hierarchy of relative psychopathology (Haan, 1977; Vaillant, 1977; Weinstock, 1967). Table 1 arranges these defense mechanisms into four general classes of relative psychopathology. The so-called immature defenses in Table 1 are the ones that underlie much of personality disorder.

Defense mechanisms of the class mentioned by Sartorius must be distinguished from two other major classes of coping response. One form of coping involves eliciting help from appropriate others, for example, by mobilizing social support. A second form of coping includes voluntary cognitive efforts, such as information gathering, anticipating danger, and rehearsing responses to danger. But seeking social support and using conscious cognitive strategies are quite distinct from the more involuntary adaptive mechanisms often subsumed under the term *ego mechanisms of defense.*

The use of ego mechanisms of defense usually alters perception of both internal and external reality and often, as with hypnosis, the use of such mechanisms compromises other facets of cognition. Like hypnosis, defense mechanisms involve far more than a simple neglect or repression of reality. In short, defenses reflect integrated dynamic psychological processes for coping with reality rather than either a deficit state or a learned voluntary strategy.

Table 2 summarizes how the defenses most closely associated with personality disorders allow an individual to deal with sudden stress by discrete styles of denial or self-deception. The table offers brief operational definitions of defense and a means of distinguishing them in a mutually exclusive manner. In real life, individuals characteristically deploy several defenses, not always from the same level. Just as forests are not made up of just one kind of tree, or rocks of just one element, of necessity, Table 2 oversimplifies. Nevertheless, the ability to identify trees, elements, and defenses helps us to classify our complex world.

As Table 2 suggests, defenses also alter the relationship between self and object and between idea and affect. In projection, for example, "I hate him" becomes "He hates me." In addition, defenses dampen awareness of and response to changes in drives, in conscience, in relationships with people, and in reality. First, defenses allow individuals a period of respite to master changes in self-image that cannot be immediately integrated, as might result from puberty, an amputation, or a promotion (i.e., changes in reality). Second, defenses can deflect or deny sudden increases in biological drives. Awareness of instinctual wishes is usually diminished; alternatively, antithetical wishes may be passionately adhered to. Third, defenses enable individuals to mitigate unresolved conflicts with important people, living or dead. Finally, ego mechanisms of defense can keep anxiety, shame, and guilt within bearable limits during sudden conflicts with conscience and culture.

Unlike psychosis and neurosis, personality disorders almost always occur within a social context. It is difficult to imagine a hypochondriac or paranoiac becoming symptomatic on a desert island. Thus, if neurotic symptoms are a means of coping with unbearable instincts, the symptoms of personality disorder are a means of coping with reactions to unbearable people—in past or present time. Thus, the understanding of immature defenses requires conceptual models that focus more on attachment theory, scripts, and role-relationship models (Horowitz, 1988) than on drives and instinctual wishes.

The projection used by a paranoid person, by which unacknowledged feelings are attributed to others, is well known. So is the capacity of schizoid individuals to relieve loneliness by creating fantasized human relationships within their own minds. The capacity of histrionic personalities to disassociate themselves from painful emotion and to replace unpleasant with pleasant affect, as if they were on stage, is familiar. So is the fact that passive-aggressive and masochistic individuals turn anger against themselves in a most annoying and provocative manner.

The mechanisms of acting out and hypochondriasis are less familiar. In the antisocial personality, acting out reflects a process through which the direct motor expression of an unconscious wish or conflict allows the individual to remain unaware of either the idea or the affect that the action accompanies. Thus, acting out produces the clinical illusion that all socio-

Table 2
Scheme for a Differential Identification of Immature Defenses

	Source of conflict				Expression of impulse			
Style of defense	Affect or drive	Conscience or culture	Relationships or people	Reality	Self or subject	Idea	Affect	Object
Projection	Externalized		Distorted	Exaggerated	Made object			Made self
Fantasy		Ignored	Taken inside		Omnipotent		Diminished	Within self
Hypochondriasis	Distorted		Devalued	Distorted		Altered	Anger becomes pain	Displaced
Passive aggression	Turned on self	Exaggerated	Exaggerated		Made object			Ignored
Acting out	Disinhibited	Ignored	Displaced		Omnipotent	Ignored	Ignored	Generalized
Dissociation	Altered	Altered	Exaggerated				Altered	

Note. From *The Wisdom of Ego* (pp. 36–37) by G. E. Vaillant, 1993, Cambridge, MA: Harvard University Press. Copyright 1993 by Harvard University Press. Adapted by permission.

paths do not experience the painful affects of guilt, anxiety, or depression. In fact, nothing could be further from the truth (Vaillant, 1975).

Hypochondriasis disguises reproach (Brown & Vaillant, 1981). The help-rejecting complaints of a person with borderline personality that clinicians make him or her worse may conceal grief and unacceptable aggressive impulses. By exaggerated focus on current somatic or psychic pain that cannot be relieved, the hypochondriac attempts to manage past unbearable grief or abuse. This point is more fully elaborated elsewhere (Vaillant, 1992a).

Table 3 puts the defenses underlying Axis II disorders in the perspective of both the psychodynamic and the genetic and temperamental domains. When conceptualized in terms of reversible defenses, rather than as the result of a largely irreversible, genetically ordained temperament, personality disorders can be viewed as potentially more plastic and more dynamic. Such plasticity is supported by prolonged follow-up studies (Perry, 1993; Stone, 1990; Thomas & Chess, 1984; Vaillant, 1993).

Table 3
Congruence of Different Domains of Classification of the Personality Disorders

	Classification domain	
DSM–III and *ICD–9* diagnostic domain	Genetic or temperament	Psychodynamic or adaptive
Paranoid, schizoid, schizotypal	Schizophrenic spectrum, psychoticism	Projection, schizoid fantasy
Antisocial, narcissistic, borderline, histrionic, explosive	Psychopathic spectrum, extraversion	Acting out, splitting, devaluation, dissociation
Avoidant, dependent, compulsive, passive–aggressive, affective, anankastic	Introversion, neuroticism	Passive aggression, hypochondriasis

Note. *DSM–III* = third edition of the *Diagnostic and Statistical Manual of Mental Disorders*; *ICD–9* = ninth revision of the *International Classification of Diseases.*

Empirical Evidence

Too often, different frames of reference or different nosologies are contrasted by studying them in different groups of individuals. This technique makes real comparison of vantage points impossible. For this reason, I discuss a single sample studied from multiple vantage points. A cohort of relatively unselected junior high school boys (Glueck & Glueck, 1950) were followed for 35 years (Vaillant, 1983). The sample originally included 456 boys studied by the Gluecks between 1940 and 1963 as a control group for their well-known investigations of juvenile delinquency (Glueck & Glueck, 1968). The boys had been carefully matched with a sample of Boston youths remanded to reform school for age, IQ, ethnicity, and high crime neighborhood. Their mean age was 14 years (SD = 2), and their average IQ was 95 (SD = 12). They attended inner-city schools. None of the boys was African American, but 278 (61%) had at least one parent who was foreign born.

Approximately 80% of the surviving subjects received semistructured interviews at age 25 (n = 360), age 31 (n = 349), and age 47 (SD = 2, n = 369). Questions regarding alcohol use and social and occupational functioning were specifically included in these interviews. In addition to interview data, psychiatric, medical, and arrest records were obtained over the 33-year follow-up period. In addition, estimates of both childhood social class (Hollingshead & Redlich, 1958) and ratings of multiproblem family membership were made by raters unaware of adult adjustment (Vaillant, 1983).

The entire sample of men was assessed by independent sets of raters along three contrasting diagnostic axes. The first axis was each man's global psychiatric impairment as measured by the Health Sickness Rating Scale of Luborsky (1962), the prototype of Axis V of the *DSM–III–R*. The second axis was the *DSM–III*'s Axis II: Which diagnoses, if any, did each man meet? The third axis was the maturity and nature of each man's predominant defense mechanisms as outlined in Tables 1–3. The assessors of each axis were kept unaware of both the men's ratings on the other two axes and their childhoods (Drake & Vaillant, 1985; Vaillant & Drake, 1985).

Over the 33-year follow-up period, attrition was modest. Of the original 456 subjects, 33 (7%) had died, 29 (6%) had withdrawn from the study, and 25 (5%) were not interviewed directly

Table 4
Association of Individual Defenses With Axis II Personality Disorders

Category	*N*	Immature defenses predominate	Hypochondriasis	Fantasy	Dissociation	Acting out	Projection	Passive aggression
No personality disorder	233	10	2	2	7	12	7	12
Personality disorder	74	66	17	15	32	27	27	34
Cluster A								
Schizoid	12	39	17	33	17	6	17	11
Paranoid	6	100	33	17	33	75	100	33
Cluster B								
Narcissistic	18	78	11	17	83	61	39	33
Antisocial	8	75	0	0	63	75	39	25
Cluster C								
Avoidant	12	58	17	8	25	17	17	25
Passive-aggressive	14	71	0	7	43	21	14	64
Dependent	23	78	26	17	56	30	26	30

Note. Values presented are percentages. Numbers of Axis II diagnoses add up to 99, not 74, because in 25 cases men met criteria for two diagnoses. Underlined cells highlight the association of Axis II categories with an individual's dominant use of the defense considered characteristic of that category. Defense choice and Axis II diagnosis were determined by independent raters.

for a variety of reasons. The other 369 (87% of the survivors) were evaluated for personality disorder. Blind estimates of maturity of defenses were available for 307 of the 369 interviewed subjects.

Relative immaturity of defenses was assessed with a 9-point scale (1 indicating *mature* and 9 *immature*). Examples of adaptive behavior at times of crisis and conflict were excerpted as vignettes. On the basis of a glossary (Vaillant, 1977), each vignette was labeled as one of 15 different defenses. These 15 defense headings were grouped into immature (schizoid fantasy, projection, passive aggression, hypochondriasis, acting out, and dissociation); intermediate (intellectualization or isolation, repression, displacement, and reaction formation); and mature (sublimation, suppression, anticipation, altruism, and humor) categories. Interrater reliability for scaling of the maturity of the three groupings of defenses has ranged from .72 to .84. Methods for identifying individual defenses, rationale, and reliability are described in detail elsewhere (Perry & Cooper, 1989; Skodol & Perry, 1993; Vaillant, 1992b).

Although mature defenses are arguably more conscious and certainly more successful as coping strategies than immature defenses, to dichotomize defenses as either coping or defending has proven both arbitrary and unhelpful. Both functions are encompassed by each defense. The defense most highly associated with mental health is suppression, by which individuals deal with emotional conflict or internal or external stressors through stoicism, by postponing but not ignoring wishes, and by subjectively minimizing but not ignoring disturbing problems, feelings, and experiences.

The ratings of personality disorder were made on the basis of a 2-hr interview by two research psychiatrists when subjects were 47 years old. Criteria from Axis II of the *DSM-III* were used exclusively. Interrater reliability for the presence or absence of personality disorder resulted in a kappa of .77, but for individual diagnoses the average kappa was .41.

Table 4 shows the distribution of Axis II diagnoses. Seventy-four (24%) of the 307 men with available ratings for maturity of defenses met *DSM-III* criteria for personality disorder. Raters attempted to select a most likely diagnosis among the 11 specific Axis II diagnoses and to specify all of the specific diagnoses present rather than use the categories atypical and mixed. Twenty-five of these men met criteria for more than one Axis II diagnosis. Diagnoses were skewed toward the interpersonally withdrawn disorders, such as schizoid, avoidant, and dependent, and away from the acting-out disorders, such as antisocial. This distribution reflects the original sample-selection criterion of nondelinquency in early adolescence. Compulsive traits were not a predominant response mode in this sample of men from lower class, less oversocialized backgrounds (Snarey & Vaillant, 1985); thus, no subjects met criteria for diagnosis of compulsive personality disorder.

Table 4 also depicts the relation of individual Axis II personality disorder diagnoses to the use of individual defenses as a major style. (If one rater scored a given defense as major and the other scored it as either major or present, men were considered to use that defense as a major style.) As might be expected, all men meeting the criteria for paranoid character used projection as a major defense. Both the narcissistic and antisocial characters seemed to use projection, acting out, and dissociation. However, narcissistic personalities did receive far lower scores on Robins's (1966) scale of deviant behaviors than did those who met Axis II criteria for antisocial personalities. Two thirds of the men meeting the criteria for passive-aggressive personalities tended to turn anger provocatively against themselves. A third of the men who met Axis II criteria for schizoid personality used fantasy—the least frequently identified defense—as a dominant style. Avoidant personalities did not appear to specialize in any one defense. These data lend support to the theoretical outline presented in Table 3.

Any scheme that classifies a community sample in terms of relative mental health will note that individuals with personality disorders are concentrated among the least healthy and that such individuals have difficulty in working and loving. Table 5 shows the relationship of selected immature and mature defensive styles to global mental health as measured by the Health Sciences Rating Scale. Studies from a companion cohort of col-

Table 5
Percentage of Individuals at Different Levels of Global Mental Health Using Selected Defenses

Major defense	HSRS score 0–65 (n = 53)	66–70 (n = 36)	71–84 (n = 143)	85–99 (n = 74)
Projection	30	17	7	0
Fantasy	19	11	1	0
Hypochondriasis	21	11	1	0
Passive aggression	32	36	15	1
Dissociation	55	36	15	1
Altruism	0	3	6	35
Suppression	2	14	27	59

Note. Low scores on the HSRS indicate impaired mental health, and high scores indicate good mental health. HSRS = Health Sickness Rating Scale.

lege-educated men has confirmed that maturity of defenses is as robust an indicator of adult mental health as any of the other adult outcome variables (Vaillant & Schnurr, 1988) and as good a predictor of future mental health as any other single variable (Vaillant & Vaillant, 1990).

It is tempting to view mature defenses as a by-product of middle-class socialization or at the very least of loving parents. However, there was not a strong association between the maturity of defenses and the quality of the men's childhoods. Table 6 illustrates that the correlation of maturity of defenses with global mental health, with the absence of sociopathic traits, with regular unemployment, and with adult social class were highly significant ($p < .001$) but that the correlations with childhood socioeconomic status and other childhood problems could have occurred by chance. Because all of the men had been raised in inner city neighborhoods and because parental social class did not affect defensive style, the association of low adult social class with immature defense deployment seemed a result, not a cause, of immaturity of defensive style. Although cross-cultural studies are sorely needed, the absence of socioeconomic status as a predictor of maturity of adult defensive style has been confirmed by contrasting these inner city men with a sample of Harvard graduates and with Lewis Terman's gifted women (Vaillant, 1992b). In other words, ego defenses, like the immune system, may represent an innate means by which humans protect themselves.

Admittedly, pathophysiology is more difficult to study empirically than is phenomenology. Defenses are, after all, metaphors; they are a shorthand way of describing different cognitive styles and mental modes of altering inner and outer realities. Like creativity and intelligence, defense mechanisms reflect integrated mental processes and cannot be broken into component parts, reliably measured, and uniformly labeled. Thus, like creativity, defenses have not yielded easily to rating scales (Bond, Gardiner, Christian, & Sigal, 1983; Gleser & Ihilevich, 1969), to experimental analysis (Kline, 1972; Moos, 1974), to projective tests (Blum, 1956), or even to precise description (Siegel, 1968). In addition, the validity of defense assessment goes down as the ease of administration (e.g., multiple-choice questionnaire) and reliability (e.g., Q-sort techniques) go up (Vaillant, 1992b; Vaillant, Bond, & Vaillant, 1986).

Defenses, however, can be consensually validated on the basis of multiple observations or multiple observers or both. Thus, the clinical techniques used by Haan (1977), Vaillant (1977), and especially Perry and Cooper (1989) appear most helpful in identifying defenses. These techniques use the long view and the strategies that Runyan (1982) outlined for qualitative, as

Table 6
Percentage of Individuals in Each Category of Midlife-Defensive Maturity Manifesting Selected Childhood and Midlife Psychosocial Criteria

Criterion	Maturity of defensive style: Immature (n = 73)	Neurotic or intermediate (n = 164)	Mature (n = 70)
Midlife[a]			
HSRS score			
Healthy (85–100)	1	14	71
Impaired (0–65)	54	9	0
5+ on Sociopathic Traits Scale (Robins, 1966)	21	2	3
4+ years unemployed	44	10	4
Social Class V	21	4	1
Childhood[b]			
Social Class V	26	24	32
Multiproblem family membership	14	10	12
Emotional problems	36	29	26
Less than 10 grades of school	42	26	30

Note. HSRS = Health Sickness Rating Scale.
[a] Age 47. [b] Age 14.

opposed to quantitative, research in personality. Intrapsychic distortions (defenses) can also be inferred (triangulated) with some reliability by contrasting self-report (autobiography) with objective report (biographical record) with symptoms (creative product). With the use of such biographical methods, the subjectivity of clinical intuition is avoided, as is the artificiality of the psychological laboratory and pencil-and-paper instruments.

Conclusions

Despite problems in reliability, the validity of defenses makes them a valuable diagnostic axis for understanding psychopathology. There are several reasons why. First, clinicians now appreciate that the symptomatology of infectious disease is often caused not so much by the bacteria as it is by the idiosyncratic adaptive response of the host to the infectious agent. These same pathophysiological principles hold true in psychology. It is often not just life stress but also the patient's idiosyncratic response to life stress that leads to psychopathology. By deciphering defenses, we can begin to understand the underlying pathophysiology of our patient's disorder. In contrast, by thoughtlessly challenging irritating, but partly adaptive, immature defenses, a clinician can evoke enormous anxiety and depression in a patient and rupture the alliance.

Second, sometimes phobia is a primary illness to be treated with drugs or behavior therapy; sometimes it reflects a displacement of affect. Clinical medicine appreciates that almost half of all visits to general physicians are made by patients with functional disorders—in other words, by patients with psychological illness or problems in living who have displaced, projected, repressed, or transformed these problems into serviceable medical complaints (Vaillant, Shapiro, & Schmitt, 1970; Von Korff et al., 1987). Similarly, complaints of Axis I disorders should often be treated as clues to lead the clinician to the primary cause and not be mindlessly eradicated.

Third, attempts to mitigate the immature defenses of individuals with personality disorders are facilitated by strong social supports. But empathic social support of such difficult individuals requires a clear understanding of the dynamics of their defenses (Vaillant, 1992a). We all display more mature defenses when we feel understood.

A final reason for paying attention to defenses can be illustrated by the internist's understanding of referred pain. A pain in the right shoulder may reflect an inflamed gall bladder; a pain in the left shoulder may reflect coronary thrombosis. Proper diagnosis depends on the internist's seeing behind the symptom. By understanding that a function of much psychopathology is to distort and deny conflict, we learn not to take psychological symptoms too literally. In short, defenses provide a diagnostic template for understanding distress and for guiding the clinical management of psychology's most baffling and frustrating clients.

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Received April 15, 1993
Revision received July 27, 1993
Accepted July 28, 1993 ■

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