

Self-Esteem in a Psychotherapeutic Setting: A Comparison of Anxiety and Depressive Disorders

M. Arafa

This study was conducted with the aim of assessment of features of self-esteem in patients undergoing psychotherapy for a variety of anxiety (N= 43) and depressive (N= 17) disorders. The method consisted of a semistructured therapeutic situation evaluating the patients' concepts of themselves in terms of positive and negative traits or attributes. The requested self-evaluations included both qualitative and global quantitative dimensions. Responses were subjected to content analysis as well as an assessment of the global quantitative evaluations. Results indicate that low or disturbed self-esteem may be equally significant in relation to anxiety as it is in relation to depression. Both anxiety and depressive disorders were associated with similar global impairment of self - esteem though differences may exist in some qualitative aspects.

(Egypt. J. Psychiat., 1992, 15: 27-37).

Introduction

Self-esteem has long been identified as a significant psychological phenomenon both in health and in relation to psychiatric disorder. However, its definition, nature and possible value or role in psychic life is still a subject of debate and controversy. As reviewed by Robson (1988) attempts to understand and elaborate our conception of this phenomenon have a rather long history. Among the early workers emphasising its significance, McDougal was clear in considering "self-regard" as the most important and influential motivating sentiment. More recently, Rogers again places the need for self - regard at the center of intrapersonal problems and considers it the most potent and compelling need of the developing person (Prochaska, 1984), while Maslow was clear in regarding esteem needs as a major level in his hierarchy of human motivating needs (DiCapiro, 1974). To Maslow, self-esteem has two major components: an internally based component related to

self-respect and self-valuation in terms of competence, independence, mastery.. etc. and an externally based component related to acceptance, respect and appreciation from others. As in most other theorizations in this field, however, he makes it clear that the two components are mutually interrelated and that in its development, esteem is externally based before it becomes internally based (Calvin, 1985). Other recent definitions of self-esteem tend to be more operational. Based on his major empirical studies in this. Field Rosenberg (1965) proposed a global concept of self-esteem comprising self- evaluations of such components as competence, adequacy, worth, goodness, health, appearance, skills, sexuality and social competence. Along similar lines, Coopersmith (1967) argued that the major components of self- esteem can be grouped in terms of a sense of competence, significance, virtue and power, while Robson (1988) tried to define it more precisely as "the sense of contentment and self- acceptance that stems from a person's appraisal of his own wo-

Magdy M. Arafa, M. D., Assistant Professor. of Psychiatry - Cairo University.

rth, significance, attractiveness, competence and his ability to satisfy his aspirations".

As indicated by Robson (1988) opinions on the value of this construct vary between those, mostly from behavioristic orientations, who tend to deny or devalue its relevance or significance to those who see that "the enhancement of self-esteem is the main purpose of all human activity."

Clinically speaking, disturbance of self-esteem has been implicated in relation to various psychiatric disorders. The link between low self-esteem and depression is universally acknowledged and well document (Ingham et al, 1986). Also a possible significant relation between low self-esteem and anxiety disorders seems to receive an increasing attention and confirmation (Bagley et al., 1979; Ingham et al, 1986). In addition, it has also been related to such disturbances as alcohol and drug abuse, child abuse, personality disorders, adolescent interpersonal problems and various kinds of deviant behaviour (Robson, 1988). However, the nature of the link between low or disturbed self-esteem and clinical disorder is still debatable. Some view disturbed self-esteem as a consequence of disorder while others consider it a definite aetiological or contributing pathogenic factor (Ingham et al, 1986). A third more elaborate view originated by Brown and Harris (1978) suggests that it is a sort of a common pathway through which original aetiological or vulnerability factors (e.g separation or pathological parental influences) act to produce a variety of disorders.

From a dynamic perspective the development of self-esteem and its possible disturbances are thought to stem from the early parent-child relationships. As indicated by Storr (1979 and 1983) the child acquires a kind of built-in self-esteem from an early positive relation with his parents, particularly the mother. This seems to depend initially upon being ac-

cepted and irrationally loved merely for existing without any conditions or qualifications. Thus the child will gradually introject the parent as a good object so that repeated affirmation of worth is no longer required since a basic sense of approval and worth has become part of the personality. This basic conception of the dynamics i.e., an external consistent message of acceptance, love and positive valuation from parents or significant others internalized into an inner component of the personality system, has been expressed in different terms by different dynamic theories including those of Erikson, object relation theorists and Bowlby's attachment theory. A conception along similar lines is also provided by the more recent self-psychology of Kohut (Baker and Baker, 1987). "Mirroring" (i.e. feedback) responses of the parents are concerned with the development and maintenance of self-esteem. Positive or delighted responses mirror back to the child a sense of self-worth and value creating internal self-respect. On the other hand responses of indifference, hostility or excessive criticism reflect low worth, create feelings of inadequacy and inhibit assertiveness. Consequently the development of healthy internal structures (self-objects) that regulate and maintain self-esteem is impeded.

The important psychopathological role played by disturbed self-esteem in psychiatric disorder is probably best recognized and appreciated by those who practice psychotherapy. As indicated by Robson (1988) the central effect of many forms of psychotherapy seemed to be an improvement in self-esteem although this may not be specifically targeted or monitored. Unfortunately, however, there is a conspicuous lack of empirical work probing this area. Only few studies, mostly from a cognitive approach (e.g. Gauthier et al, 1983 and Fennel and Zimmer 1987), seem to be available to document such observations.

The present study was stimulated by consistent observations of the remarkable psychopathological impact of negative self-conception or low self-esteem as revealed in neurotic patients undergoing psychotherapy. It was particularly interesting to notice that this impact is not limited to depressed patients but is probably equally common and significant in those suffering from anxiety disorders. The study represents a preliminary attempt at a comparative assessment of the features of disturbed self-esteem in these two groups of patients conducted within the psychotherapeutic context.

Subjects and Method

The sample of this study consisted of two groups of patients suffering from anxiety disorders (N=43) and depressive disorders (N= 17) who were undergoing a management program in a psychiatric outpatient clinic in Riyadh (Saudi Arabia). The anxiety disorder group included patients diagnosed as social phobia (N= 30), panic disorder (N=4), generalized anxiety disorder (N= 5) and obsessive - compulsive disorder (N= 4) while the depressive group included patients diagnosed as dysthymic disorder (N= 12) and major depression (N= 5). All diagnoses were established according to criteria of DSM-III-R (American Psychiatric Association 1987).

In addition to appropriate pharmacotherapy all patients were undergoing an individual psychotherapy program. The used approach was an eclectic one integrating concepts and strategies from dynamic and cognitive approaches. Based on consistent previous observations of a remarkable disturbance of self-esteem in such patients this aspect has become a major target in the therapeutic process. As part of this process all patients were subjected to a semistructured situation in which they were requested to make a self-evaluation in terms of negative and positive attributes or traits along two dimensions:

1- A qualitative Dimension

In two opposite columns each patient was asked to state and describe qualities, traits or attributes of his "self" which he considers negative or "bad" contrasted with other qualities considered positive or "good"

2- A quantitative Global Dimension

Each patient was requested to make a global percentage evaluation of the negative qualities (i.e. the bad me) and the positive qualities (good me) in relation to whole self or personality. e.g. a patient may estimate that his global negative qualities account for 70% of his "self" while the good qualities are represented by the remaining 30%.

The patients' responses along the qualitative dimension were subjected to a thorough content analysis conducted according to the basic known principles of the methodology (Lewin, 1979). Content categories for both positive and negative traits or attributes described by patients were identified and listed for coding after several trials and revisions of all responses. Most of the identified coding categories (e.g. those regarding competence, worth, virtue, physical appearance and health ... etc.) match components of self-esteem already identified and tested in literature. Other categories represent contents that were common or significant in the spontaneous reports of our patients (e.g. being fearful and over-anxious, naive, hesitant, sinful or guilty of bad deeds... etc). Patients' responses were lastly coded in order to estimate the identified categories in different diagnostic groups.

Though aware of the presence of more structured and sophisticated measures of self-esteem developed in the West, the above semistructured and open method was preferred in this study for some considerations. Besides the wish not to interrupt the spontaneity of the therapeutic process, we felt a need to

make a preliminary assessment based on fresh phenomenological data from patients in our culture. In addition, as indicated from the review of Robson (1988), sophisticated psychometric instruments are not necessarily superior in the assessment of self-esteem: "... on some occasions, simple subjective self-ratings by patients have performed as well as complicated questionnaires".

The semistructured assessment procedure was conducted with all patients by the same senior psychiatrist. For the purposes of statistical evaluation of differences among diagnostic groups chi-square analysis (Fisher's exact formula) was used to test the significance of differences on categorical data while t-test was used to evaluate differences on continuous data.

Results

As indicated from table I showing the basic demographic data of both the anxiety and depressive groups the two groups are fairly comparable. No statistically significant differences were found as regards age, sex, level of education or occupation.

A- Quantitative Global Evaluation

Both the depressive and anxiety disorder patients showed a clear tendency towards negative rather than positive global self-evaluation. As seen in table 2 mean percentage evaluation of the negative aspects compared to whole self reaches about 70% in depressive patients and 62% in anxiety disorder patients. However, the apparently higher figure in depressed patients was not statistically significant. Subgrouping of the anxiety disorder patients did not reveal statistically significant differences among the social phobic, other anxiety disorder and depressive groups as well.

Evaluation of the percentage of patients rating their negative aspects more than 50% confirms the higher tendency towards negative self-evaluation in both groups. It is interesting to notice that rel-

Table 1
Demographic Data of the Two Groups Compared

	Anxiety Disorders (N= 43)	Depressive Disorder (N= 17)	P *
Sex:			
- Male	36 (84%)	13 (77%)	
- Female	7 (16%)	4 (23%)	N. S. (0.7)
Age:			
15-19	1	1	
20-24	17	2	
25-29	13	9	
30-34	9	5	
35-39	3	0	N. S. (0.2)
Mean age (+ S.D.):	27.03 ($\pm$ 4.98)	27.79 ($\pm$ 4.18)	
Education			
- Primary	1	0	
- Middle	7	4	
- Secondary	14	4	
- High	21	9	N. S. (0.8)
Occupation			
- Student	5	2	
- Semiprofessional	18	6	
- Professional	20	9	N. S. (0.9)

* Chi-Square (Fisher's exact formula).

atively more anxiety disorder patients tended to evaluate themselves on the negative side although the depressives' mean score is relatively higher.

B- Qualitative Evaluation

Content categories (i.e. attributes or traits) evaluated as being negative or positive in the patients' reported view of themselves are shown along with frequencies in different groups in tables 3 and 4:

1- Traits And Attributes Evaluated Negatively

As seen in table III sixteen categories were evaluated as being lacking, defective or generally bad in the contents of the patients' self-descriptions.

In both the anxiety and depressive

Table 2
Global Self - Evaluation of the Negative Aspects of the Self in the
Anxiety and Depressive Groups Compared

	Mean ($\pm$ SD) Global Percentage Evaluation of Negative Aspects In Relation to Whole Self	Evaluation of Negative Aspects Rating $> 50\%$ (N=1)
Social Phobia	62.83%	
(N=39)	(± 14.89)	
Other Anxiety Disorders	61.54%	9 (69.2)
(N=13)	(± 20.96)	
Total Anxiety Disorders	62.44%	36 (79.5)
(N=43)	(± 16.7)	
Depressive Disorders	70.29%	13 (76.4)
(N=17)	(± 19.64)	

t-Test: No statistically significant differences among the mean percentage evaluations of all group

groups a relatively high frequency can be observed in relation to competence (65% and 94% respectively), social competence (77% and 53%) and being fearful and overanxious (79% and 53%). Most other categories show a relatively moderate frequency while a few (e.g. sexuality, virtue and lovability) were infrequent. In comparing the total of anxiety disorder patients with depressive disorder patients

statistically significant differences were revealed in relation to four categories only. Significantly more depressed patients tended to see themselves as lacking in competence, worth, as being withdrawn and as being sinful or guilty of bad deeds (actually none of the anxiety group reported this last attribute).

Traits And Attributes Evaluated Positively

Eleven categories were reported as being positive or good attributes of the self by both anxiety and depressive groups of patients (Table 4). In both groups a remarkably high frequency is seen in relation to virtue and moral traits (91% and 100%). This is a rather global category under which were included responses in which patients consider themselves positive in having certain moral traits such as being honest, faithful, generous, courageous, altruistic, polite, kind... etc.

A relatively high frequency is also noticed in relation to intelligence (84% and 59%) but it is contrasted by a low frequency in relation to intellectual skills (26% and 12%).

Only two categories showed statistically significant differences in comparing the depressive and total anxiety disorder groups. Lovability or being worthy of love was significantly more reported by the anxiety group (67% Vs. 35%) while the capacity for empathy was significantly more reported as a positive attribute by depressed patients (41% Vs 9%). Perfection seeking was reported as a good attribute by a prominent frequency of the anxiety disorder group (42%) but less so by the depressed group (18%) the difference, however, was not statistically significant.

Apart from the above categories it may be noticed that most of the remaining positive categories show a modest or low frequency in both groups.

3- A subsequent attempt was made

Table 3
Frequency of Content Categories of Traits and Attributes of the Self Evaluated "Negatively"

Content Categories	Social Phobia	Other Anxiety Disorders	Total Anxiety Disorders	Depressive Disorders
	(N= 30)	(N= 13)	(N= 43)	(N= 17)
	N (%)	N (%)	N (%)	N (%)
1- Competence, Adequacy	18 (60)	10 (76)	28 (65)*	16 (94)*
2- Worth., Significance.	10 (33)	1 (8)	11 (26)*	9 (53)*
3- Virtue & Moral Traits.	2 (6)	1 (8)	3 (7)	2 (12)
4- Social Competence.	27 (90)	6 (46)	33 (77)	11 (65)
5- Lovability.	1 (3)	4 (31)	5 (12)	5 (29)
6- Intelligence.	5 (17)	2 (15)	7 (16)	6 (35)
7- Intellectual Skills.	2 (6)	1 (8)	3 (7)	0 (0)
8- Physical Appearance & Health.	8 (27)	4 (31)	12 (28)	5 (29)
9- Sexuality	3 (10)	0 (0)	3 (7)	1 (6)
10- Avoidance of Problems & Confrontations.	14 (47)	5 (39)	19 (44)	4 (24)
11- Approval Seeking.	8 (27)	2 (15)	10 (23)	4 (24)
12- Fearful and Overanxious.	25 (83)	9 (69)	34 (79)	9 (53)
13- Hesitant.	14 (47)	5 (39)	19 (44)	6 (35)
14- Withdrawn.	1 (3)	1 (8)	2 (5)*	5 (29)*
15- Guilty, Sinful.	0 (0)	0 (0)	0 (0)**	6 (35)**
16- Naive.	8 (27)	1 (8)	9 (21)	3 (18)

* $P < .05$,

** $P < .01$ (Chi-square analysis of depressive vs. total anxiety disorder groups)

Table 4*Frequency of Content Categories of Traits and Attributes of the Self Evaluated "Positively"*

Content Categories	Social Phobia (N= 30)	Other Anxiety Disorder (N= 13)	Total Anxiety Disorders (N= 43)	Depressive Disorder (N= 17)
	<u>N (%)</u>	<u>N (%)</u>	<u>N (%)</u>	<u>N (%)</u>
1- Competence,	3 (10)	3 (23)	6 (14)	1 (6)
2- Virtue & Moral Traits.	29 (97)	10 (76)	39 (91)	17 (100)
3- Lovability.	21 (70)	8 (62)	29 (67)*	6 (35)*
4- Intelligence.	25 (83)	11 (85)	36 (84)	10 (59)
5- Intellectual Skills.	10 (33)	1 (8)	11 (26)	2 (12)
6- Physical Appearance & Health.	5 (17)	0 (0)	5 (12)	2 (12)
7- Religious Faith & Commitment.	3 (10)	2 (15)	5 (12)	2 (12)
8- Empathy.	2 (6)	2 (15)	4 (9)**	7 (41)**
9- Ambition.	5 (17)	3 (23)	8 (19)	4 (24)
10- Socioeconomic Status.	5 (17)	0 (0)	5 (12)	3 (18)
11- Perfection Seeking.	14 (47)	4 (31)	18 (42)	3 (18)

* $P < 0.05$,** $P < 0.01$ (Chi-square analysis of depressive vs. total anxiety disorder groups)

to detect possible significant differences among the depressive group and the social phobic and other anxiety disorder subgroups (chi-square analysis). The results were generally consistent with the previous overall comparison with only few additions:

a- In the comparison between social phobic and other anxiety disorder patients significant differences were only

present in relation to lack of social competence ($P < .01$) and being unlovable ($P < .05$).

b- In the comparison between depressive and other anxiety disorder patients the frequency in relation to guilt and worth were still significantly more in depressives ($P < .05$) but differences in relation to competence, withdrawal and the positive evaluations of lovability and empathy were not significant.

c- In the comparison between the social phobic and depressive groups it was interesting to notice that both groups were not significantly different as regards the negative evaluations of social competence and worth. Apart from fearfulness being significantly more frequent in social phobic patients ($P < .05$) other differences were consistent with the previous overall comparison.

Discussion

The link between negative self-conception or low self-esteem and depression is well documented and widely accepted. It has actually been argued that negative attitudes towards the self are not merely symptomatic of the depressive syndrome but are, in association with negative value judgements, central to its pathogenesis (Beck, 1967). The results of this study are interesting in indicating that this psychopathological phenomenon is probably equally significant in relation to anxiety as it is in relation to depression. Both anxiety and depressive disorder patients demonstrated comparable global changes in self-esteem although differences between the two groups may be reflected in some qualitative component aspects.

As seen in the results the quantitative global self-evaluation indicates a clear higher tendency towards negative rather than positive self-conception in both depressive and anxiety disorder patients. Although depressive patients show a relatively higher mean negative evaluation the difference is not statistically significant. The importance of this result is not merely related to its value as a quantitative index but also lies in the global quality of the expressed self-evaluation. Though the concept of self-esteem is analyzable into component contents as done in most measures it has a global gestalt quality that is equally important in reflecting the true essence of the phenomenon. The defect in most available measures lies in losing this global aspect for the sake of more measurable truncated

concepts (Robson, 1988). This fact was clear during the conduction of this work. Some patients, though stating few negative attributes would give themselves a highly negative global score, while others would give themselves low global scores inspite of enumerating long lists of negative attributes.

In the study of Ingham et al (1986) which involved both anxiety and depressive disorder patients it was found that major depressive disorder was associated with marked or maximal impairment of self-regard while cases diagnosed as having "minor depressive disorders" showed generally similar impairment of self-esteem as those diagnosed as anxiety disorders. Nevertheless, the authors indicate that: "in the sample as a whole self-esteem correlates at about the same level with anxiety as with depression". In conclusion, however, they suggest that the impairment of self-esteem associated with anxiety compared to that associated with depression may differ in some qualitative aspects. The former may reflect a judgement of impaired performance especially in social situations while the latter reflects a more general negative view of the self and the world. A similar view is expressed by Robson (1988) who sees that anxiety and depression are associated with similar global changes in self-esteem but the balance of components giving rise to this change may be quite different.

The general trend of our results is probably in main line with such observations. What may be considered a global evaluation of self-esteem as assessed in this study does not indicate significant differences between the two groups. Moreover, the overall assessment of qualitative component contents probably also indicates that both groups undergo similar impairment in many respects. The frequency of most reported contents in the two groups were not significantly different. However, the qualitative assessment does show some possibly

meaningful differences. Depressed patients seem to have a more basic or pervasive negative view of themselves. This is probably reflected in their more frequent self-judgment as lacking a basic sense of worth or significance. Along the same direction is probably their much less inclination to consider themselves lovable or worthy of love while their guilt ridden conception of themselves possibly represents an extreme of self-condemnation. Patients with anxiety disorder, though considering themselves defective in many respects, did not as much question their basic worth, would much more frequently consider themselves as lovable and would not reach the degree of guilt ridden self-condemnation which was exclusively expressed by depressed patients. These inferences probably match the suggestion of Ingham et al., (1986) that the impairment of self esteem in depressed patients is qualitatively different in reflecting a more general or pervasive negative view of the self and the world. On the other hand, however, our findings do not clearly support their opinion that the impairment in anxiety disorder patients reflects a judgement of impaired performance especially in social situations. Overall lack in competence was significantly more reported by depressed patients while lack of social competence was not significantly more indicated by anxiety disorder patients even when the depressed patients were compared with the social phobic subgroup. This study, however, has its methodological limitations and further more elaborate work is definitely needed for a more accurate assessment of the qualitative differences.

Positive aspects of self-evaluation in the two groups show some interesting features that deserve attention. Rather than reflecting true positive evaluations of the self some of the expressed positive attributes may be interpreted as defensive attempts that actually reflect the deeper inner low self-esteem. This is possibly the case with the very high fre-

quency of virtuous or moral attributes which may reflect a defensive compensation for the pervasive feelings of practical inadequacy and inefficacy by claiming or stressing some ideal values. Similarly, the relatively prominent frequency of perfection seeking in anxiety disorder patients may be interpreted as indicating a defensive compulsion created by the conflict between the perceived inadequate self and a neurotic high self-ideal. On the other hand, the capacity for empathy which was valued as a positive attribute by a significantly prominent frequency of depressed patients may also reflect defensive dynamics. As explained by Storr (1983) depressives seem to lack an inner source or base for self-esteem and largely depend on outside sources to maintain it. Thus, they require repeated reassurance, love, acceptance and concern from others. In order not to lose these outside sources they become experts at identifying themselves with the needs of others and develop sensitive antennae which tell them what others are feeling.

Such observations are probably significant in indicating that, besides the manifest phenomenological or conscious aspects of self-esteem, interpretations at a dynamic level are usually necessary for a proper understanding of the phenomenon as a whole.

Conclusions and Implications

In spite of its methodological limitations as a preliminary assessment, this study reasonably indicates that low self-esteem or negative self-conception is a major psychopathological phenomenon that is probably equally significant in relation to anxiety as it is in relation to depression. Both anxiety and depressive disorders were associated with similar global impairment of self-esteem though differences may exist in some qualitative aspects of the negative self-appraisal. Two main implications are probably warranted in the present context:

- 1- The significant role of disturbed self-esteem in relation to both anxiety

and depression as well as its possible role in relation to other disorders (Robson, 1988) probably favours its conception as a common pathway through which different aetiological factors may act to produce or contribute to the development of a variety of manifest disturbances. In this sense it is probably best conceptualized in terms of a dynamic model (i.e. as a major dynamic process related to a major human motivation or need) rather than in terms of the regular causal model. As cogently theorized by Jaspers psychodynamic conceptions, which are actually based on "interpretation" or "genetic understanding", should not be confused with the regular model of "causal explanation" as they belong to different epistemological orders (Ebmeier, 1987). This confusion has probably been responsible for methodological defects and misdirections in much research conducted in this area.

2- The demonstrated significance of disturbed self-esteem in relation to depression, anxiety as well as other disorders highlights the need to give it proper attention and value as a major target in psychotherapy of such disorders. Also, more research work needs to be directed to verify and elaborate this purpose.

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L'Estime de Soi en Psychothérapie: Une Comparaison Entre les Troubles Anxieux et Dépressifs

Cette étude a pour but d'évaluer les composantes de l'estime de soi chez des patients en psychothérapie souffrant de troubles anxieux (N:43) et dépressifs (N:17).

Les résultats indiquent une association significative entre l'altération globale de l'estime de soi et les troubles anxieux et dépressifs, que cet estime soit bas ou troublé. Quelques différences qualitatives ont été toutefois remarquées.

دراسة مقارنة لملامح تقدير الذات لدى المرضى

باضطرابات القلق والاكتئاب خلال العلاج النفسي

أجريت هذه الدراسة بهدف تقويم ملامح تقدير الذات أثناء العلاج النفسي لمجموعتين من المرضى الذين يعانون من أشكال مختلفة من اضطرابات القلق (٤٣ مريضاً) والاضطرابات الاكتئابية (١٧ مريضاً). وقد تم البحث بواسطة موقف علاجي شبه مقنن جرى خلاله تقويم مفهوم المرضى عن أنفسهم من خلال وصف ذاتي للصفات والخصائص الإيجابية والسلبية في شخصية كل منهم كما يراها. وشمل التقويم المطلوب البعد الكيفي بالإضافة إلى بعد كمي كلي. ثم اخضعت استجابات المرضى إلى عملية تحليل للمضمون بالإضافة إلى تقويم للنتائج الكمية. وتشير النتائج إلى أن التقدير السلبي أو المضطرب للذات ظاهرة بارزة وذات دلالة ليس فقط في مجموعة الاضطرابات الاكتئابية وإنما أيضاً - وبدرجة مكافئة - في مجموعة اضطرابات القلق، وبالرغم من بعض الفروق الكيفية فإن الاضطراب الكلي في تقدير الذات كان متقارباً إلى حد بعيد لدى المجموعتين.