The Arabic Version of Defense Style Questionnaire-40
II- Defense Style in Major Depressive Disorder

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The aim of this work was to investigate whether patients with major depressive disorder use a defense style different from that of normal subjects. 28 patients with major depressive disorder and 27 age and sex matched normal subjects completed the Arabic version of DSQ-40.

The results showed that patients tend to use less mature defenses (anticipation, suppression, humor& sublimation) than normal subjects, while they use more immature defenses (projection, passive aggression, devaluation, autistic fantasy and somatization). Reaction formation, a neurotic defense, was also higher in the depressive group. The significance of the findings to the psychopathology of depression, especially in terms of cognitive theories, and the implications for psychotherapy are considered.

Investigating defense style related to other axis-I diagnosis and its correlation with symptom patterns was recommended.
(Egypt.J. Psychiat., 1997, 20: 75-83).

Introduction

Though the concept of defense mechanisms abounds in psychiatric and psychoanalytic literature, there is still confusion and inconsistency about their definition and relation to diagnosis (Bond et al, 1982). A great advance in this field, however, was the introduction of valid methods of assessment of defense mechanisms (Bond et al, 1983; Andrews et al, 1993).

In a trial to avoid the criticism addressed to the DSM-III as ignoring psychodynamic formulation, the DSM-IV (1994) proposed a defensive functioning axis for further study. In this proposed axis, the concept of defense mechanisms as coping styles was adopted.

The question whether a particular diagnosis is associated with the use of certain defense mechanisms remains controversial. Pollock and Andrews (1989) demonstrated that patients with specific anxiety disorders endorse specific defense style that is consistent with the diagnosis. However, contamination with the 'state', i.e., symptoms characteristic of the clinical picture might have contributed to those results. Removing the symptom items from the 72-item DSQ, the instrument used in the above mentioned study, patients with anxiety disorders still showed differences from normal subjects, but no differences between subcategories of anxiety disorders were found.

The results of research on defense style in depressed patients are also controversial. While Bond and Sagala Vaillant (1986) found that the pattern of defenses did not differ in depressive patients, as compared to normal subjects, Akkerman et al (1992) demonstrated that patients with major depressive disorder tended to use less mature and more immature defenses.

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The aim of the present work was to investigate whether patients with major depressive disorder use a defense style different from that of normal subjects.

Subjects and Methods

28 patients attending outpatient clinic (El-Minia university hospital) over the time period from August to October, 1996 who fulfilled criteria for major depressive disorder (DSM-IV), completed the Arabic version of Defense Style Questionnaire-40 (Andrews et al,1993; Soliman, 1996) (Appendix). The patients had a current depressive episode. Mean age (±SD) was 31.6 (±11.9). Most of the subjects were females (n=24), while the sample included 4 male patients.

27 age-and sex-matched normal subjects were recruited from the population in the same area served by the clinic.

Comparison between the two groups on all items of the DSQ was carried out using two-tailed T-test. To test the sensitivity of the DSQ in detecting subjects with psychopathology, discriminant function analysis was performed.

Results:

The differences between the depressive patients and control group are shown in table 1 (showing differences on mature defenses), table 2 demonstrating differences on immature defenses), and table 3 (showing differences on neurotic defenses). In comparison to normal subjects, depressive patients showed markedly lower scores on all mature defenses, viz., sublimation, suppression, humor and anticipation, and more so in the latter. As regards immature defenses, the depressive patients scored higher than normal subjects on projection, passive aggression, somatization, devaluation of the self (devaluation2) and autistic fantasy. On the other hand, they showed less devaluation of others (devaluation 1). Reaction formation was the only neurotic defense mechanism where patients differed significantly from control group, as they seem to endorse this defense more often than normal subjects.

Results of discriminant function analysis are displayed in table4. the sensitivity of the DSQ-40 to discriminate patients was very high (85.7%). Its specificity was also high, as 88.9% of the control group were ceorrectly identified as normal. The variables that discriminated between the two groups were anticipation, devaluation of the self, somatization, projection, autistic fantasy and passive aggression.

Table 1
Differences Between Groups on Mature Defenses

Defense Mechanism	Depressive Patients Mean (± SD)	Control Group Mean (± SD)
Sublimation 1	3.7 (3.02)	5.6 (2.98)*
Humor 2	4.2 (1.60)	5.6 (3.37)*
Anticipation 1	5.1 (2.27)	7.7 (1.28)***
Suppression 1	3.1 (3.02)	4.7 (2.61)*

* : P< 0.05
*** : P< 0.001

Table 2
Differences Between Groups on Immature Defenses

Defense Mechanism	Depressive Patients Mean (± SD)	Control Group Mean (± SD)
Projection 1	4.4 (3.28)	2.4 (1.934)**
Projection 2	7.2 (2.29)	4.5 (2.77) *
Passive aggression 1	4.1 (2.76)	2.4 (1.76) **
Passive aggression 2	6.3 (3.07)	5.0 (2.7)*
Devaluation 1	4.4 (3.08)	6.07 (2.5)*
Devaluation 2	7.5 (2.44)	4.4 (3.04)***
Autistic Fantasy 1	6.8 (2.28)	5.1 (2.85)*
AutisticFantasy 2	6.1 (2.73)	4.5 (2.97)*
Somatizaion 1	7.6 (2.07)	5.4 (3.44)***
Somatization 2	7.7 (2.35)	4.89**

* : P< 0.05
** : P< 0.01
*** : P< 0.001

Table 3
Differences Between Groups on Neurotic Defenses

Defense Mechanism	Depressive Patients Mean (± SD)	Control Group Mean (± SD)
Reaction formation 1	5.3 (3.26)	3.5 (2.45)*
Reaction formation 2	7.1 (2.34)	5.9 (2.94)*

* : P < 0.05
**: P< 0.01
*** : P< 0.001

Table 4
Results of Discriminant Function Analysis

Actual group	Predicted group membership	
	Control	**Patient**
Control group	24 (88.9%)	3 (11.1%)
patients	4 (14.3 %)	24 (85.7%)
Discriminant function	coefficient	
Anticipation 1	-.66	
Devaluation 2	.58	
Somatization 1	.39	
Somatization 2	.35	
Projection 1	.38	
Autistic fantasy 1	.37	
Passive aggression 1	.29	
Passive aggression 2	.28	

Discussion

Defenses are major means of managing instinct and affect. Although they are adaptive in nature, they can as well be pathological (Vaillant, 1988). In the present work, depressive patients were characterized by using less mature defenses, more immature and neurotic defenses, when compared with normal subjects.

In spite of the fact that mature defenses distort reality, they are still better, morally accepted, more successful modes of accommodation with painful situations or emotions. Anticipation was the mature defense that highly differed between the groups and also correctly identified depressive patients in discriminant function analysis. In the DSM-IV (1994), the proposed scale for defensive functioning includes anticipation in the high adaptive level defense mechanisms. Such defenses usually maximize gratification and allow the ' conscious' awareness of feelings, ideas and their consequences. This is different , to some exent, from the classical psychoanalytic view of defense mechanisms as unconscious. Vaillant (1988) recognized voluntary cognitive effectors like information gathering, anticipating danger, and rehearsing responses to danger as aa component of coping, but their place was in the midway between defense mechanisms and mobilizing social resources. Whatever its place might be, depressive patients are deficient in using anticipation as a coping style. This is consistent with the 'helplessness' attitude of those patients, which is one of Beck's cognitive triad of depression (Alloy et al, 1988). One of the basic assumptions of the hopelessness theory of depression (Abramson et al, 1988) is that highly desired outcomes are unlikely to occur, or that highly aversive outcomes are probable, and that no response one can make will change the probability of these items. Such cognitive views account for predisposition to depression. It seems that deficient use of anticipation is more specific to and characteristic of depression than other mature defenses (humor, suppression and sublimation) which were found to be less unlikely endorsed by depressive patients in the present study, but also by anxiety patients in a study by Andrews et al (1993).

The only neurotic defense mechanism on which depressive patients differed from normal subjects is reaction formation. Unlike undoing and displacement which are essential for discrete symptom formation, reaction formation is a defense mechanism that results in the creation of enduring behaviour patterns determining the individual's character structure and personality (Nemiah, 1988). According to Nemiah, reaction formation against aggression leads to behaviour characterized by excessive concern for other people and by an undue tolerance of unpleasantness in them. The role of aggressive feelings towards the object in the depressive situation and depressive psychopathology was stressed by Rakhawy (1979). The aggression, instead of being directed towards others, might also be directed unto oneself, in the defense mechanism known as passive aggression which was more endorsed in depressive patients in the present study.

In accordance with other studies on patient populations (Andrews et al, 1993; Brennan et al, 1990) the depressive patients scored higher on the immature defenses as compared to the control group. However, the pattern of immature defenses in depressive patients in the present work is not the same as that demonstrated by Andrews et al (1993) in patients with anxiety disorders. While

both groups share endorsement of projection and somatization,the depressive group are also characterized by passive aggression, as noted earlier, as well as devaluation and autistic fantasy.

The relationship between somatization and depression is well documented. In a study by Soliman (1997) on Egyptian psychiatric patients, depressed mood correlated with the number of somatic symptoms, especially pain symptoms. A number of writers have stressed the improtance of viewing pain as a multidimensional experience with more similarity to emotional states than sensory processing (Pearce & Miles, 1993). According to Ahrens and Lamparter (1989) the inner organization of pain is formed in compliance with the pattern of an "inner object choice". The pain, thus, is functioning as a personalized, imaginary internal object. Such an "internal structuring" has a depression reducing quality.

As we preferred to analyze individual items, rather than the mean on two items to represent one defense mechanism, depressed patients showed higher devaluation of the self, but less devaluation of others, as compared to normal subjects (table2).The role of low self-esteem as a crucial aetiological factor in depression was stressed by Brown and Harris (1978) and more recently by Brown et al (1990). Low self-esteem is also a hallmark among the cognitive symptoms of depression (Musson & Alloy, 1988).

In spite of the fact that the DSQ-40 has a high sensitivity in detecting depressive patients and also high specificity as indicated by high identification of normal sunjects. It is still not clear whether it will be sensitive in discriminating patients with different diagnoses.

Limitation of the Study and Recommendations:

1- Although the defense style of depressive patients demonstrated in the present study is consistent with the psychopathology of depression, investigation of defense style in other patient groups is needed to conclude that it is specific to this disorder.

2- A study of defense mechanisms after recovery is also needed before extrapolation on the aetiological significance of the findings is made.

3- A more depth study of the correlation between symptom profile and defense style is also needed.

References

Abramson, L.Y. Alloy, L.B. Metalsky, G.I. (1988) The cognitive diathesis stress theories of depression. Toward an adequate evaluation of the theories' validity. In Alloy L.B. (ed) Cognitive Processes in Depression. *The Guilford Press: New York.* pp 3-30.

Ahrens, S. Lamparter, U. (1989) Object related fucntion of pain and depression. *Psychother-Psychosom-Med-Psychol.;* **39** (6):219-22.

Akkerman, K. Carr, V. Lewin, T. (1992) Changes in ego defenses with recovery from depression. *J Nerv. & Ment. Dis.*, **180**: 634-638.

Alloy, L.B. Hartlage, S. Abramson, L. (1988). Testing the cognitive diathesis stress theories of depression. Issues of research design, conceptualization and assessment. In Alloy L.B.(ed) Cognitive Processes in Depression. *The Guilford Press: New York.* pp 31-70.

American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM- IV).

Andrews, G. Singh, M. Bond, M. (1993). The Defense Style Questionnaire. *J. Nerv. & Ment. Dis.*, **181**:246-254.

Bond, M. Gardner, ST. Christian J, Sigal JJ (1982) Empirical study of self rated defense styles. *Arch Gen Psychiatry*, **40:** 333-338.

Bond, M. Sagala, Vaillan,t J. (1986) An empirical study of the relationship Between diagnosis and defense style. *Arch Gen Psychiatry*, **43:** 285-288.

Bond, M. Gardner, T. Christian, J. Sigal, J. (1983). Empirical study of self rated defense styles. *Arch Gen. Psychiatry*, **40**:333-338.

Brennan, J. Andrews, G. Morris- Yates, A. Pollock, C. (1990) An examination of defense style in parents who abuse children. *J. Nerv & Ment. Dis.*, **178**:592-595.

Brown, GW. Harris, T. (1978) Social Origins of Depression. *Tavistock Press: London.*

Brown, G.W. Andrews, B. Bifuclo, A.Veiel, H. (1990) Self- esteem and depression. 1. Measurement issues and prediction of onset. *Soc Psychiatry K Psychiatr Epidemiol*, **25**:200-209.

Musson, R.F. Alloy, LB. (1988) Depression and self-directed attention. In Alloy L.B. (ed) Cognitive Processes in Depression. *The Guilford Press: New York.* pp 193-215.

Nemiah, J.C. (1988) The psychodynamic basis of psychopathology. In Nicholi E.M. Jr. (Ed), The New Harvard Guide to Psychiatry. *Belknap Press of Harvard univ., Cambridge.* pp. 208-233.

Pearce, S. Miles, A. (1993) Chronic pain. In Granville- Grossman (ed): Recent Advances in Clinical Psychiatry. Churchill Livingstone, Edinburgh.

Pollock, C. Andrews, G. (1989) Defense styles associated with specific anxiety disorders. *Am J. Psychiatry*, **145:** 1500-1502.

Rakhawy, Y. (1979) A Study in PSychopathology. *Dar Al- Ghad: Cairo.* p 195. (In Arabic).

Soliman, H. (1996) The Arabic version of DSQ-40. I-A study of ego defenses in medical students. *Egypt. J. Psychiat.*, **19**:129-136.

Soliman H. (1997) Comorbidity of somatoform disorders. Egypt. J. Psychiat (in this issue).

Vaillant G. (1988) Defense mechanisms. In Nicholi E.M. Jr. (Ed), The New Harvard Guide to Psychiatry. *Belknap Press of Harvard Univ., Cambridge.*

Appendix
أ.م.ش – ٤٠

الاسم ..... السن ..... النوع ....

العمل ..... أعلى مؤهل دراسى ....

هذه أسئلة تتعلق بالميول الشخصية . لا توجد اجابات صحيحة أو خاطئة.

المقياس التالى (من ٩ درجات يدل على مدى انطباق المواقف المطروحة عليك يرجى وضع علامة دائرة على الدرجة التى تتناسب معك.

لا أوافق بشدة ١ ٢ ٣ ٤ (غير محدد : ٥) ٦ ٧ ٨ ٩ أوافق بشدة

مثلا:

١ تعنى أن الجملة المذكورة لا تنطبق عليك اطلاقا.

٣ لا توافق ولكن بدرجة متوسطة

٥ تعنى أنك لا تستطيع أن تحدد

٧ توافق ولكن بدرجة متوسطة.

٩ توافق بشدة.

المواقف:	لا بشدة غير محدد نعم بشدة
١ – أجد سعادتى فى أن أساعد الآخرين، واذا لم أستطع أشعر بالحزن الشديد.....	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
٢ – أستطيع أن أبعد المشاكل عن ذهنى حتى يتوفر لى الوقت فى التفكير فيها وحلها.....	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
٣ – أتخلص من القلق بأن أقوم بنشاط ايجابى وخلاق (كالرسم أو الأشغال الفنية).....	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
٤ – أستطيع أن أجد أسبابا قوية لتصرفاتى وأفعالى.....	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
٥ – يمكننى أن أسخر من نفسى (أضحك من نفسى) ببساطة.....	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
٦ – يميل الناس الى اساءة معاملتى	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
٧ – اذا ما قام لص بمهاجمتى وسرقتى أتمنى له الهداية أكثر من العقاب.....	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
٨ – يقول الناس اننى أتعامل مع المشاكل كأنها لم تكن (غير موجودة).....	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
٩ – أتجاهل الأخطار كما لو كنت شخصا ذا قوى خارقة (سوبرمان)	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
١٠ – أشعر بالفخر لقدرتى على جعل الآخرين يعرفون قدر أنفسهم (أعرفهم مقامهم).....	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
١١ – أميل للتصرف باندفاع اذا كان هناك ما يضايقنى.....	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
١٢ – أشعر بأوجاع فى جسمى أو امرض اذا لم يكن كل شىء على ما يرام.....	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
١٣ – أشعر أننى شخص مكبوت (أعانى من القمع).....	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
١٤ – أحب الحياة فى الخيال أكثر بكثير من الحياة الواقعية.	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
١٥ – لدى مواهب خاصة تجعلنى أشق طريقى فى الحياة دون مشاكل	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
١٦ – فى حالات الفشل تكون هناك أسباب قوية خارجة عنى	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
١٧ – أحل مشاكلى فى أحلام اليقظة أكثر مما فى الحياة الواقعية	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
١٨ – أخاف من كل شىء	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
١٩ – فى بعض الأحيان أشعر ملاك وفى أحيان أخرى أشعر أننى الشيطان نفسه	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩
٢٠ – اذا أذى أحد مشاعرى أكون عنيفاً	١ ٢٠٠ ٣٠٠ ٤٠٠ ...(٥٠٠) ٦ ٧ ٨ ٩

٢١ - أشعر كثيراً أن هناك شخصا أعرفه وكأنه ملاك	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٢٢ - أعتقد أن النسا اما أخيار أو أشرار	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٢٣ - اذا ما ضايقنى رئيسى فى العمل فاننى أتعمد الخطأ أو أعمل ببطء للانتقام منه	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٢٤ - أعرف شخصاً يستطيع أن يفعل أى شيء وهو عادل جدا.....	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٢٥ - أستطيع أن أخفى مشاعرى اذا كان اظهارها سيؤثر على أدائى فى العمل	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٢٦ - يمكننى أن أرى الجانب الهزلى فى ورطة أو موقف مؤلم	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٢٧ - أصاب بالصداع اذا اضطررت للقيام بعمل لا أحبه	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٢٨ - عادة ما أجد نفسى لطيفا مع أشخاص يجب بكل المقاييس أن أغضب منهم	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٢٩ - أشعر أننى انسان محظوظ في الحياة	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٣٠ - قبل مواجهة موقف صعب أحاول أن أتخيله وأخطط للتعامل معه.....	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٣١ - يستطيع الأطباء أن يفهموا مشكلتى الحقيقية	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٣٢ - بعد أن أصر على أخذ حقوقى أميل للاعتذار عن مبالغتى فى طلبها.....	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٣٣ - حينما أكون حزينا أو قلقا يجعلنى الأكل فى حالة أفضل.....	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٣٤ - عادة ما يقول لى الآخرون أننى لا أظهر مشاعرى	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٣٥ - اذا ما أمكننى معرفة أن شيئاً محزناً سيحدث تكون قدرتى على تحمله أكبر	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٣٦ - مهما اشتكيت لا أحصل على استجابة مرضية (من الآخرين)	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٣٧ - فى مواقف تستدعى الحزن الشديد، كثيرا ما أجد أننى لا أشعر بشيء	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٣٨ - الانهماك في ما أقوم به من أعمال يمنع الشعور بالقلق أو الحزن	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٣٩ - أفضل أصدقائى على نفسى اذا مررنا بأزمة	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٤٠ - اذا خطرت لى فكرة عدوانية تجاه شخص ما، أشعر بالحاجة للقيام بشيء يرضيه	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩
٤١ - أؤجل أمورا تخصنى للقيام بخدمات للآخرين.....	١ ٢٠٠ ٣٠٠ ٤٠٠ ... (٥٠.) ٦ ٧ ٨ ٩

DSQ-40 By : Andrews et al. (1993).

النسخة العربية اعداد : د. هناء سليمان. كلية الطب . جامعة المنيا

La version Arabe de l'échelle de Mechanismes de défénse (DSQ-40) II- Le style de défense chez les malades avec la dépréssion

Le but de cette rechreche était d'étudier le style de défense chez les malades avec la dépression. On a étudié 28 malades pendant l'épisode de dépréssion et 27 personnes normales du même âge et sexe. Ils ont rempli la version Arabe de DSQ-40.

Les résultats ont montré que les malades utilisent moins de défénses mûrs (l'anticipation, la suppréssion, la sublimation et l'humeur) et plus de défénses non - mûrs (la projéction, l'aggréssion passive, la fantasie autistique et la somatization) que le groupe de contrôl. La défense 'formation de la réaction, un méchanisme neurotique, est aussi utilisée beacoup par les malades.

La significantion des résultats pour comprendre la psychopathlogie de la dépréssion est proposée.

النسخة العربية لاستبار الأسلوب الدفاعى

II –الأسلوب الدفاعى لدى مرضى الإكتئاب

استهدفت هذه الدراسة بحث الأسلوب الدفاعى لدى مرضى الإكتئاب، ومدى اختلافه بينهم وبين الأسوياء. وقد تم تطبيق استبار الأساليب الدفاعية على ٢٨ مريضاً بالاكتئاب – أثناء وجود الأعراض الاكتئابية – وكذلك ٢٧ شخصاً من الأسوياء الذين ينتمون إلى نفس البيئة والخلفية الثقافية التى ينتمى إليها المرضى.

وقد أظهرت النتائج أن المرضى يستخدمون دفاعات ناضجة (التوقع المرح والتسامى) على نحو أقل من الأسوياء، بينما يستخدمون دفاعات غير ناضجة بمعدلات أعلى (الإسقاط والعنف السلبى وتقليل القيمة والتخيل والجسدنة)، وبين الدفاعات العصابية كان رد الفعل العكسى أعلى لدى المرضى عنه لدى الأسوياء. وتناقش هذه الورقة النتائج فى ضوء المفهوم الدينامى والمعرفى للإكتئاب.

ويوصى البحث بدراسة الأسلوب الدفاعى لدى مجموعات أخرى من المرضى وكذلك علاقته بنمط الأعراض.

Erratum

In part I of this work (issue No:19), table 3 was not complete. It is as follows:

Table 3

Differences Between the two groups classified by cluster analysis

Defense Mechanism	Cluster 1 Number = 21	Cluster 2 Number = 43	ANOVA P Value
Immature factor			
Projection	4.04	2.56	.001
Passive aggression	5.57	2.59	.000
Acting out	5.90	3.75	.001
Isolation	6.09	3.96	.000
Devaluation	4.83	3.39	.003
Autistic fantasy	7.28	3.53	.000
Denial	4.57	3.36	.03
Splitting	6.04	4.70	.02
Neurotic factor			
Idealization	5.73	4.57	.03