

IDENTIFICATION OF PSYCHOLOGICAL DEFENSE MECHANISMS IN NON-PSYCHOTIC MAJOR DEPRESSIVE DISORDER. USING THE ROMANIAN VERSION OF THE DEFENSE STYLE QUESTIONNAIRE – 60

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Abstract

Related to the topic of the study, the first objective aims to identify the psychic defense mechanisms specific to major depressive disorder without psychotic elements, respectively, in the case of objective number two, to identify gender differences in the psychic defense mechanisms used by patients diagnosed with major depressive disorder without psychotic elements.

Thus, the identification of psychic defense mechanisms specific to major depressive disorder without psychotic elements was performed by comparing two groups, clinically (N = 103; 42 male participants [40.8%] and 61 female participants [59.2 %], age = 51.16 years; 12.6% of participants are graduates of higher education) and non-clinical (N = 770; 330 male participants [42.86%] and 440 female participants [57, 14%], age = 31.16 years; 54.4% of participants are graduates of higher education).

For this purpose, one used the only psychological defense analysis tool that includes all psychological defense mechanisms present in DSM IV R (APA, 2003/2000); and also one of the most common psychological defense analysis tools, namely Defense Style Questionnaire – 60/DSQ 60 (Thygesen *et al.*, 2008), the translated version being adapted to the Romanian sample (Crașovan & Maricuțoiu, 2012). The results confirm a number of five psychological defense mechanisms specific to non-psychotic major depressive disorder: passive-aggressive, projection, dissociation, withdrawal and help-rejecting complaining. Thus, the identification of patients' specific defense mechanisms may increase the efficiency of psychotherapeutic treatment.

Cuvinte-cheie: tulburarea depresivă majoră fără elemente psihotice; analiza apărării psihice; mecanisme de apărare psihică; DSQ-60, diferențe de gen.

Keywords: non-psychotic major depressive disorder; psychological defense analysis; psychological defense mechanisms; DSQ-60, gender differences.

Author's Note

In the first stage of research (years 2010–2014) and deployment phase of research in psychiatric clinics in western Romania, the author was affiliated with Department of Psychology, University of Bucharest, Romania, respectively during the completion of the study (years 2017–2020) at Babeș-Bolyai University (UBB University Center in Reșița), Romania.

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In the same time period (2010–2014) other questionnaires were applied on the clinical group, respectively, the Romanian version (Crașovan & Sava, 2013) of the COPE Scale (Carver, Scheier & Weintraub, 1989) and the Romanian version (David, 2006 a) of the DAS-A Dysfunctional Attitude Scale form A (Weissman & Beck, 1978).

1. INTRODUCTION

The study is focused on identifying psychological defense mechanisms used by patients diagnosed with non-psychotic major depressive disorder applying the latest version of the Defense Style Questionnaire – 60 (DSQ 60 [Thygesen *et al.*, 2008] translated and adapted to the Romanian sample [Crașovan & Maricuțoiu, 2012]). DSQ 60 is considered the most widely used tool for the analysis of psychological defense (Bond, 2004), and which is included in the American Psychiatric Association's Handbook of Psychiatric Measures (APA, 2000, in Drapeau *et al.*, 2011), while DSQ 60 includes all psychological defense mechanisms accepted in DSM IV R (APA, 2000/2003).

By introducing a psychological defense analysis tool – Defensive Functioning Scale (APA, 2000/2003) – in the latest edition of the DSM – IV-R, it was acknowledged that the approach of psychopathology is impossible without psychological defense analysis. In this context, the study used the Defense Style Questionnaire – 60 / DSQ 60 (Thygesen *et al.*, 2008) adapted and translated into Romanian (Crașovan & Maricuțoiu, 2012). The Defense Style Questionnaire – 60/DSQ-60 (Thygesen *et al.*, 2008) is an instrument designed for the assessment of the psychological defense mechanisms compatible with the psychological defense mechanisms included in the DSM IV (APA, 2000/2003). From a conceptual perspective, DSM IV R (APA, 2000/2003) offers a definition for psychological defense mechanisms: “*automatic unconscious psychological processes, through which the human subject protects himself against anxiety and the acknowledgment of danger and internal or external stressors*” (APA, 2003, p. 807).

According to the World Health Organization (2017), five percent of the world population suffers from depression in its various forms (Stiemerling, 2006), the development of depression being a contemporary issue, affecting all age groups and walks of life, and becoming the major disease of contemporary times (David, 2006 b; World Mental Health Day, 2012; World Health Organization, 2017).

Under these circumstances, in recent years, researchers' interest has grown considerably despite different theoretical orientations, all aiming to analyze psychological defense mechanisms and coping mechanisms in personality assessment (Cramer, 1991 a, b, 1998, 2006; Granieri *et al.*, 2017) and psychopathology, with mental defense analysis becoming a useful tool in assessing progress and outcome of psychotherapeutic treatment (Bond, 2004). As different authors indicated (Blackman, 2004; Ionescu, Jacquet & Lhote, 2002; Vaillant, 1993 a, 1993 b), the identification of defense mechanisms employed both by human subjects with no history of psychiatric illness or psychiatric disorders and patients with mental

disorders, is often decisive for the subject's further development and the treatment of the disease and also for choosing how to approach the subject and method of intervention (psychotherapy or medication), in order to prevent any relapse following improvement or treatment. At the same time, the maturity of defense mechanisms represents a good predictor for the realization of social relations and for proper physical health (De Page *et al.*, 2018; Laczkovics *et al.*, 2018; Malone *et al.*, 2013).

It is well known that there is a defensive operation specific for each psychopathological condition, or a plurality of defensive mechanisms (Blackman, 2004). Thus, depressed and anxious patients (depression and anxiety groups can be significantly differentiated by defense mechanisms used [see Olson, Presniak & MacGregor, 2009]) differ from other category of patients with psychopathological conditions and from subjects without psychiatric treatment as far as the defensive mechanism is concerned, as they usually use projection, as demonstrated by other authors (Blay *et al.*, 2006). The results of this last study lead towards the idea of developing psychotherapeutic interventions specific to disorders and psychological defense mechanisms used by the patient. Also, clinical trials indicate that depressive disorder patients use defense mechanisms with a low level of adaptability, so that recovery from these types of disorders requires the identification and improvement of the patient's mental defense mechanisms (Akkerman, Lewin & Carr, 1999; Kneepkens *et al.*, 1996). Furthermore, in long-term psychotherapy psychological defense mechanisms may be considered important for facilitating improvement in functioning and symptoms (Perry & Bond, 2012).

Recent research studies stress that, in the context of the role of defense and coping mechanisms in depressive disorders, defensive styles and levels may have a predictive value in the planning and success of psychotherapeutic strategies (for short-term psychotherapeutic treatment) both for depressive individuals (Van *et al.*, 2009) and for the general population, where the maturity level of defense strategies is an effective predictor of mental health and social functioning, ensuring good lower costs in healthcare (Vaillant, 1993 a, 1993 b; MacGregor *et al.*, 2003). Hoglend & Perry (1998) also investigated the predictive ability of defensive functionality level in major depressive disorder and their results highlight the mediating effect of psychological defenses of low and high level adaptive evolution in major depression, pointing out that high adaptive level defenses are apparent in patients with significant improvement in their depressive condition. Moreover, the use of more image-distorting mechanisms was the best predictor of current suicide attempt (Hovanesian, Isakov & Cervellione, 2009).

Porcerelli *et al.* (2009) conducted research focused on the efficiency of psychological defense in major depression (focus group of American women of African descent). Their study highlights the use of mid-level defense mechanisms, such as mental inhibition, minor image distortion, major image distortion, dissociation, isolation and devaluation. Another study (Plutchik, 1991 apud Ionescu, Jacquet, Lhote, 2002) performed on participants diagnosed with non-psychotic major

depressive disorder, diagnosed according to DSM IV R (APA, 2000/2003), which applied the Index lifestyle, highlights the existence of higher scores for reactive formation, projection, regression, repression and more generally, a significant increase in psychological defense compared to participants who are diagnosed with psychiatric disorders. These results are consistent with results of other studies (Bond *et al.*, 1993; Plutchik, Kellerman & Conte, 1979, Vaillant, Bond & Vaillant, 1986, Wong, 1989 apud Ionescu, Jacquet & Lhote, 2002) underlining the way depressed participants make use of two types of defenses (both categories having as benchmark the adaptive nature of defenses), the type of primitive or immature defenses (regression, projection) and intermediate defenses or neurotic (reactive formation, repression) along with an increase in the intensity of depressed participants' defense, compared to participants who are not diagnosed with any disorder or mental illness.

Other studies (Kennedy, Schwab & Hide, 2001; Kwon, Lemon, 2000) indicate an association between depression and immature, neurotic defenses. It is known, as well, that recovery from depression is also due to the transition from immature defenses to mature ones (Akkerman *et al.*, 1999).

As far as the effectiveness of either type of treatment for depression (psychotherapy or antidepressant medication), some authors (Mullen *et al.*, 1999) have highlighted a number of defenses that reduce the effectiveness of prescribed antidepressants, though different studies indicate different results, but the treatment come from the field of psychotherapy (Bond & Perry, 2004; Hersoug, Sexton & Holglend, 2002; Hoglend & Perry, 1998), notwithstanding the fact that an important part of psychotherapeutic results relies on understanding patients' defensive features (Petraglia, *et al.*, 2018).

2. METHOD

2.1. OBJECTIVES

The following two objectives were proposed in relation to the theme of the study: (1) to identify specific psychological defense mechanisms of non-psychotic major depressive disorder; (2) to identify gender differences at the level of the psychological defense mechanisms used by the participants diagnosed with non-psychotic major depressive disorder.

2.2. PARTICIPANTS

The *clinical sample* used includes 103 adult patients diagnosed with non-psychotic major depressive disorder assessed during the period August 2010 – September 2014. Participants included in the study were hospitalized in university clinics and psychiatric hospitals in western Romania (Timișoara University Clinic of Psychiatry, Timișoara Stationary Psychiatry, the Psychiatry Department of the Municipal Hospital Lugoj, Psychiatry Clinics Arad, and Psychiatry Hospital Gătaia).

The participation in the study was based on free will and informed consent. The development of the study assumed the application of the Beck Questionnaire (Beck *et al.*, 1979; Beck, Ward & Mendelson, 1981), the Zung Scale (Biggs, Wylie & Ziegler, 1978; Zung, 1965), the Defense Style Questionnaire – 60 (Crașovan & Maricuțoiu, 2012; Thygesen *et al.*, 2008) and of the Demographic Questionnaire to a number of 124 subjects. Out of the total of 124 applied questionnaires, 103 sets of answers were filled in and introduced in subsequent analyses ($n = 103$).

The eligibility criteria of the participants follows. Inclusion criteria: patients diagnosed with non-psychotic major depressive disorder (APA, 2000/2003) without psychological comorbidity; presence of depression is confirmed by the results obtained after the application of the Zung Scale ($M_{Zung} = 66.11$) and Beck Questionnaire ($M_{Beck} = 28.77$) self-assessment scales; individuals aged between 21 and 73.

Descriptive statistics data of the clinical sample ($n = 103$). Regarding the demographic features of the sample tested related to the number of scores selected for analysis, the questionnaires mentioned were applied to a number of 42 males (40.8 %) and 61 females (59.2 %), $M_{age} = 51.16$ years and age range: 21–73. About 12,6 % of the participants had a university education.

The *non-clinical sample* includes 770 participants. In this case, out of the total of 800 questionnaires (DSQ 60 questionnaires and the Demographic questionnaire) we applied the 770 sets of answers which were filled in and entered in subsequent analyses ($n = 770$). Regarding the demographic features of the sample from the general population, related to the number of scores preserved in the analysis, the mentioned questionnaires were applied to a number of 330 males (42.86 %) and 440 females (57.14 %), $M_{age} = 31.16$ years, age range: 18–66). About 53.4 % of the participants had a university education.

2.3. INSTRUMENTS AND PROCEDURE

Demographic questionnaire used for the recording of demographic data and the research participants' details.

The Defense Style Questionnaire – 60 (DSQ 60) drafted by Thygesen *et al.*, 2008 [The DSQ 60 Questionnaire Romanian version was validated in Romania on a general sample $N = 1011$ subjects (Crașovan & Maricuțoiu, 2012)] is a self-report measure with 60 items used for the assessment of the 30 defense mechanisms included in the DSM IV (APA, 2003/2000). The score for each psychological defense mechanism is obtained by adding the answer (1 – *not at all applicable to me*; 9 – *completely applicable to me*) from the 2 items corresponding to the particular defense mechanism. The evaluation of the global defensive functioning implies computing a general score for the answers to all of DSQ-60 items. This score represents a measure of the general maturity of the defensive functioning, with the high scores indicating a pronounced defensive functioning (Trijsburg *et al.*, 2003). Still, similar to the results previously reported in literature (Thygesen

et al., 2008; Trijsburg *et al.*, 2003, Vaillant, 2000), analysis of internal consistency of the Romanian version (Crașovan & Maricuțoiu, 2012) indicated that these 30 scales of DSQ-60 have major limitations when it comes to the internal consistency, values between .10 (for repression) and .77 (for retraction), with an average value of .38).

The Zung Scale (Biggs, Wylie & Ziegler, 1978; Zung, 1965) is a depression self-assessment scale with a higher degree of probability in measuring the patient's mirroring of his/her dominant emotional experience than a scale evaluated by an observer. The Zung Scale has 20 items and a score range from 1 to 4 (with 1 – being low agreement, symptoms present rarely or never; 4 – strong agreement, symptoms present most of the time or all the time). This scale determines the following degrees of depression: 0–50 absence of depression, 50–60 mild depression, 60–70 average depression, 70 severe depression. The Zung Scale was standardized on the population of New Zealand, having an internal consistency of 0.79. Cronbach's Alpha coefficient has the value of .80 on Romanian clinic population (Crașovan, 2014). Further studies support the validity of the Zung scale in relation to the BDI.

The Beck Questionnaire (Beck *et al.*, 1979; Beck, Ward & Mendelson, 1981). The Beck Questionnaire is a 21-item designed to measure the presence of depression in adults and adolescents. Each of the 21 items assesses a symptom or attitude specific to depression, inquiring its somatic, cognitive and behavioural aspects. So the 21 survey items include: mood, pessimism, sense of failure, dissatisfaction, suicidal intentions, feelings of guilt, irritability, social isolation, indecision, distorted body image, sleep disturbances, fatigue, loss of appetite, decreased performance at work, somatic concerns and decreased libido. For each item the participant may receive between 0 and 3 points, the minimum score is 0, maximum score is 3. By its assessments, single scores are produced, which indicate the intensity of the depressive episode. The Beck Questionnaire scores ranging: 0 to 9 represent normal levels of depression; between 10 and 18 represent mild to moderate depression; between 19 and 29 represent moderate to severe depression; scores above the value of 30 represent severe depression. Internal consistency indices of the BDI are usually above .90. Cronbach's Alpha coefficient has the value of .90 on Romanian clinic population (Crașovan, 2014).

As regards the application procedure on clinical population, the eligible participants were informed of the purpose of the research and their informed consent was requested, while the following questionnaires were subsequently applied in the presence of a research assistant: Demographic Questionnaire, Beck Scale, Zung Scale and Defense Style Questionnaire – 60/DSQ – 60 (Romanian version).

Data analysis was run using the factorial Anova method (bifactorial) under the statistic program of data analysis SPSS version 16 (Howitt & Cramer, 2010) and PowerStaTim 1.0 (Sava & Maricuțoiu, 2007).

2.4. DESIGN

The study has a non-experimental design, where independent variables are not manipulated, being of a descriptive nature, and the relationship between independent variables and the dependent variable is only potentially causal. Independent variables: (1) group type: clinical and non-clinical; (2) gender: men and women. Dependent variables: psychological defense mechanisms.

3. RESULTS

The tests performed with 2×2 factorial ANOVA method for each dependent variable identified main effects and/or interaction of the two independent variables (*type of group participants*: non-clinical [general population] and clinical [non-psychotic major depressive disorder] and *gender participants*: male and female) for 24 of the 30 psychological defense mechanisms operationalized with DSQ 60 (see Tables no. 1, 2 and 3).

Table no. 1

Mean and standard deviation for the 30 psychological defense mechanisms

psychological defense mechanisms	(men + women)				men				women			
	non-clinical sample n = 770		clinical sample n = 103		non-clinical sample n = 330		clinical sample n = 42		non-clinical sample n = 440		clinical sample n = 61	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
1) altruism	14.65	3.42	15.16	3.46	14.11	3.60	14.14	4.58	15.05	3.23	15.85	2.18
2) passive-aggressive	6.85	4.02	10.25	4.45	7.35	4.16	11.00	4.74	6.48	3.88	9.74	4.20
3) suppression	11.47	3.75	10.19	4.00	11.45	3.67	10.52	4.07	11.49	3.81	9.97	3.97
4) sublimation	10.05	4.50	9.18	5.41	9.75	4.31	9.02	4.92	10.28	4.64	9.30	5.75
5) splitting/other	9.82	4.63	11.55	4.05	9.95	4.37	11.02	4.02	9.72	4.81	11.92	4.07
6) rationalization	12.20	3.44	11.18	3.59	12.16	3.39	11.38	3.73	12.23	3.48	12.08	3.50
7) humor	11.39	4.10	9.52	4.87	11.19	4.12	10.17	4.50	11.55	4.08	9.08	5.10
8) projection	8.66	4.46	12.55	4.31	8.57	4.15	11.14	4.65	8.73	4.69	13.52	3.81
9) reaction formation	10.49	3.90	11.03	4.51	9.96	3.79	10.33	4.43	10.89	3.94	11.51	4.54
10) self-observation	13.25	3.69	13.31	4.15	12.84	3.60	12.57	4.47	13.57	3.72	13.82	3.87
11) denial	9.28	4.12	11.54	3.75	9.30	3.99	10.79	3.85	9.27	4.23	12.07	3.62
12) devaluation of other	8.73	4.09	8.41	4.21	8.98	4.06	7.71	3.94	8.55	4.10	8.89	4.35
13) projective identification	8.80	3.97	10.35	4.61	8.82	3.83	9.67	4.57	8.78	4.08	10.82	4.62
14) dissociation	7.97	4.01	10.63	4.58	8.11	3.88	10.83	4.77	7.86	4.10	10.49	4.48
15) self-assertion	13.58	3.54	13.07	3.94	13.36	3.38	13.19	3.80	13.74	3.66	12.98	4.06
16) omnipotence	9.03	4.31	6.83	4.01	9.02	4.22	6.71	3.77	9.04	4.38	6.92	4.20
17) acting-out	10.38	4.78	12.00	5.14	10.56	4.38	12.31	5.43	10.23	5.06	11.79	4.96
18) devaluation/self	6.10	3.88	8.16	4.13	6.13	3.71	8.57	4.26	6.08	4.01	7.87	4.04
19) fantasy	6.75	4.56	9.14	5.05	6.75	4.34	8.98	4.83	6.75	4.72	9.25	5.24
20) withdrawal	11.14	4.97	15.01	4.26	10.36	4.78	14.14	5.27	11.73	5.04	15.61	3.33
21) intellectualization	9.62	4.19	10.73	4.63	9.78	4.05	10.57	5.32	9.50	4.30	10.84	4.14
22) splitting/self	7.72	4.30	9.31	4.28	7.52	3.96	8.98	4.10	7.88	4.55	9.54	4.42
23) displacement	9.10	4.14	10.16	4.39	8.60	3.99	9.14	4.41	9.47	4.22	10.85	4.27
24) repression	8.36	3.99	10.15	4.56	8.20	4.14	9.90	5.12	8.49	3.88	10.31	4.16
25) idealization	9.20	4.62	11.79	5.19	8.87	4.39	11.21	5.78	9.44	4.78	12.18	4.75

Table no. 1 (continued)

psychological defense mechanisms	(men + women)				men				women			
	non-clinical sample n = 770		clinical sample n = 103		non-clinical sample n = 330		clinical sample n = 42		non-clinical sample n = 440		clinical sample n = 61	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
26) isolation	9.37	4.31	10.77	4.33	9.86	4.09	10.12	4.38	9.00	4.44	11.21	4.27
27) help-rejecting complaining	7.38	4.16	11.29	4.33	7.61	3.93	10.24	3.95	7.20	4.32	12.02	4.46
28) undoing	8.86	4.20	10.85	4.14	8.85	4.14	11.12	4.17	8.87	4.25	10.67	4.15
29) anticipation	11.71	3.89	11.24	4.01	11.64	3.91	11.26	4.39	11.77	3.88	11.23	3.77
30) affiliation	11.14	4.58	11.64	5.33	10.90	4.45	11.76	5.61	11.33	4.68	11.56	5.17

Table no. 2

Summary of analysis of variance for the 30 psychological defense mechanisms

psychological defense mechanisms	source of variation	sum of squares	df	mean square	F	p
1) altruism	group	15.73	1	15.73	1.36	< .001
	gender	153.93	1	153.93	13.34	
	group-gender	13.11	1	13.11	1.31	
	error	10,024.28	869	11.53		
2) passive-aggressive	group	1,051.01	1	1,051.01	63.79	< .001
	gender	100.95	1	100.95	6.12	< .05
	group-gender	3.19	1	3.19	0.19	
	error	14,316.64	869	16.47		
3) supression	group	130.51	1	130.51	9.09	< .01
	gender	6.06	1	6.06	0.42	
	group-gender	7.58	1	7.58	0.52	
	error	12,469.85	869	14.35		
4) sublimation	group	64.13	1	64.13	3.01	
	gender	13.69	1	13.69	0.64	
	group-gender	1.34	1	1.34	0.06	
	error	18,548.05	869	21.34		
5) splitting/other	group	235.50	1	235.50	11.28	< .01
	gender	9.90	1	9.90	0.47	
	group-gender	27.41	1	27.41	1.31	
	error	18,134.75	869	20.86		
6) rationalization	group	18.55	1	18.55	1.54	
	gender	2.54	1	2.54	1.04	
	group-gender	9.18	1	9.18	0.76	
	error	10,450.71	869	12.02		
7) humor	group	267.19	1	267.19	15.19	< .001
	gender	11.54	1	11.54	0.65	
	group-gender	45.85	1	45.85	2.60	
	error	15,285.77	869	17.59		
8) projection	group	1,089.18	1	1,089.18	60.87	< .001
	gender	140.51	1	140.51	7.13	< .01
	group-gender	109.74	1	109.74	5.57	< .05
	error	17,117.30	869	19.69		
9) reaction formation	group	22.23	1	22.23	.41	
	gender	95.92	1	95.92	6.11	< .05
	group-gender	1.49	1	1.49	0.09	
	error	13,633.19	869	15.68		

Table no. 2 (continued)

psychological defense mechanisms	source of variation	sum of squares	df	mean square	F	p
10) self-observation	group	0.001	1	0.001	0.01	
	gender	85.10	1	85.10	6.11	< .05
	group-gender	6.13	1	6.13	0.44	
	error	12,098.25	869	13.92		
11) denial	group	404.27	1	404.27	24.22	< .001
	gender	33.56	1	33.56	2.01	
	group-gender	38.51	1	38.51	2.30	
	error	14,502.97	869	16.68		
12) devaluation of other	group	19.25	1	19.25	1.14	
	gender	12.32	1	12.32	0.73	
	group-gender	55.76	1	55.76	3.31	
	error	14,616.19	869	16.82		
13) projective identification	group	182.59	1	182.59	11.11	< .01
	gender	26.99	1	26.99	1.64	
	group-gender	31.52	1	31.52	1.91	
	error	14,279.77	869	16.43		
14) dissociation	group	633.11	1	633.11	37.93	< .001
	gender	8.12	1	8.12	0.48	
	group-gender	0.12	1	0.12	0.01	
	error	14,503.42	869	16.69		
15) self-assertion	group	19.27	1	19.27	1.49	
	gender	0.73	1	0.73	0.05	
	group-gender	7.81	1	7.81	0.60	
	error	11,234.04	869	12.92		
16) omnipotence	group	432.69	1	432.69	23.57	< .001
	gender	1.11	1	1.11	0.06	
	group-gender	0.73	1	0.73	0.04	
	error	15,952.05	869	18.35		
17) acting-out	group	237.47	1	237.47	10.17	< .01
	gender	15.53	1	15.53	0.66	
	group-gender	0.91	1	0.91	0.03	
	error	20,277.86	869	23.33		
18) devaluation/self	group	393.98	1	393.98	25.66	< .001
	gender	12.79	1	12.79	0.83	
	group-gender	9.05	1	9.05	0.59	
	error	13,341.04	869	15.35		
19) fantasy	group	491.42	1	491.42	22.94	< .001
	gender	1.41	1	1.41	0.06	
	group-gender	1.79	1	1.79	0.08	
	error	18,610.34	869	21.41		
20) withdrawal	group	1,288.64	1	1,288.64	54.68	< .001
	gender	177.26	1	177.26	7.52	< .01
	group-gender	0.16	1	0.16	0.01	
	error	20,477.39	869	23.56		
21) intellectualization	group	9.93	1	9.93	5.52	< .05
	gender	0.01	1	0.01	0.01	
	group-gender	6.72	1	6.72	0.37	
	error	15,710.91	869	18.07		
22) splitting/self	group	214.98	1	214.98	11.59	< .01
	gender	18.26	1	18.26	0.98	
	group-gender	1.04	1	1.04	0.05	
	error	16,114.83	869	18.54		

Table no. 2 (continued)

psychological defense mechanisms	source of variation	sum of squares	df	mean square	F	p
23) displacement	group	81.99	1	81.99	4.75	< .05
	gender	145.51	1	145.51	8.43	< .01
	group-gender	15.72	1	15.72	0.91	
	error	14,983.43	869	17.24		
24) repression	group	276.75	1	276.75	16.67	< .001
	gender	10.16	1	10.16	0.61	
	group-gender	0.39	1	0.39	0.02	
	error	14,424.51	869	16.59		
25) idealization	group	571.04	1	571.04	25.94	< .001
	gender	51.01	1	51.01	2.31	
	group-gender	3.66	1	3.66	0.16	
	error	19,125.15	869	22.00		
26) isolation	group	136.21	1	136.21	7.36	< .01
	gender	1.01	1	1.01	0.05	
	group-gender	85.53	1	85.53	4.62	< .05
	error	16,070.07	869	18.49		
27) help-rejecting complaining	group	1,222.15	1	1,222.15	70.10	< .001
	gender	40.47	1	40.47	2.32	
	group-gender	106.31	1	106.31	6.10	< .05
	error	15,124.91	869	17.40		
28) undoing	group	365.36	1	365.36	20.72	< .001
	gender	3.95	1	3.95	0.22	
	group-gender	4.84	1	4.84	0.27	
	error	15,319.32	869	17.62		
29) anticipation	group	18.05	1	18.05	1.17	
	gender	0.18	1	0.18	0.01	
	group-gender	0.54	1	0.54	0.03	
	error	13,299.21	869	15.30		
30) affiliation	group	25.66	1	25.66	1.17	
	gender	1.20	1	1.20	0.05	
	group-gender	9.09	1	9.09	0.41	
	error	19,060.91	869	21.93		

Table no. 3

Presence of main effects and interaction effects for both independent variables, effect size, statistical power (reported at alpha .05) and statistical significance

psychological defense mechanisms	gender effect (men/women)	group effect (clinical/non-clinical)	interaction effect (gender * group)
1) altruism	$\eta_p^2 = .02$, st. power = .95, $p < .001$		
2) passive-aggressive	$\eta_p^2 = .01$, st. power = .69, $p < .05$	$\eta_p^2 = .07$, st. power = 1, $p < .001$	
3) suppression		$\eta_p^2 = .01$, st. power = .85, $p < .01$	
4) sublimation			
5) splitting/other		$\eta_p^2 = .01$, st. power = .91, $p < .01$	
6) rationalization			
7) umor		$\eta_p^2 = .02$, st. power = .97, $p < .001$	
8) projection	$\eta_p^2 = .01$, st. power = .76, $p < .01$	$\eta_p^2 = .06$, st. power = 1, $p < .001$	$\eta_p^2 = .01$, st. power = .65, $p < .05$

Table no. 3 (continued)

psychological defense mechanisms	gender effect (men/women)	group effect (clinical/non-clinical)	interaction effect (gender -group)
9) reaction formation	$\eta_p^2 = .01$, st. power = .69, $p < .05$		
10) self-observation	$\eta_p^2 = .01$, st. power = .69, $p < .05$		
11) denial		$\eta_p^2 = .03$, st. power = .99, $p < .001$	
12) devaluation of other			
13) projective identification		$\eta_p^2 = .01$, st. power = .91, $p < .01$	
14) dissociation		$\eta_p^2 = .05$, st. power = 1, $p < .001$	
15) self-assertion			
16) omnipotence		$\eta_p^2 = .03$, st. power = .99, $p < .001$	
17) acting-out		$\eta_p^2 = .01$, st. power = .89, $p < .01$	
18) devaluation/self		$\eta_p^2 = .03$, st. power = .99, $p < .001$	
19) fantasy		$\eta_p^2 = .03$, st. power = .99, $p < .001$	
20) withdrawal	$\eta_p^2 = .01$, st. power = .78, $p < .01$	$\eta_p^2 = .06$, st. power = 1, $p < .001$	
21) intellectualization		$\eta_p^2 = .01$, st. power = .65, $p < .05$	
22) splitting/self		$\eta_p^2 = .01$, st. power = .92, $p < .01$	
23) displacement	$\eta_p^2 = .01$, st. power = .82, $p < .05$	$\eta_p^2 = .01$, st. power = .58, $p < .05$	
24) repression		$\eta_p^2 = .02$, st. power = .98, $p < .001$	
25) idealization		$\eta_p^2 = .03$, st. power = .99, $p < .001$	
26) isolation		$\eta_p^2 = .01$, st. power = .77, $p < .01$	$\eta_p^2 = .01$, st. power = .57, $p < .05$
27) help-rejecting		$\eta_p^2 = .08$, st. power = 1, $p < .001$	$\eta_p^2 = .01$, st. power = .69, $p < .05$
complainning			
28) undoing		$\eta_p^2 = .02$, st. power = .99, $p < .001$	
29) anticipation			
30) affiliation			

4. DISCUSSION AND CONCLUSIONS

For the first objective of the study, the statistical analysis revealed significant effects (differences) between the clinical and non-clinical groups following 21 psychological defense mechanisms: passive-aggressive, suppression, splitting/other, humour, projection, denial, projective identification, dissociation, omnipotence, acting-out, devaluation/self, fantasy, withdrawal, intellectualization, splitting/self, displacement, repression, idealization, isolation, help-rejecting complainning and undoing. The other 6 psychological defense mechanisms streamlined with DSQ 60,

namely sublimation, rationalization, devaluation of other, self-assertion, anticipation and affiliation, were removed from subsequent analysis due to their failure to produce significant effects, or interaction effects, while suppression, humour and omnipotence are not considered specific psychological defense mechanisms for non-psychotic major depressive disorder, as their non-clinical group average result tops the clinical group's. Reporting the effect size (with the reference values given by: Popa, 2008, Sava, 2011; Sava & Maricuțoiu, 2007) and statistical power for psychological defense mechanisms analyzed, a total of 18 defense mechanisms have been identified as typical of non-psychotic major depressive disorder, balanced by an acceptable degree of effect size and statistical power in relation to the authors mentioned, namely: passive-aggressive, splitting/other, projection, denial, projective identification, dissociation, acting-out, devaluation/self, fantasy, withdrawal, intellectualization, splitting/self, displacement, repression, idealization, isolation, help-rejecting complaining and undoing, with some reservations about the effect size of intellectualization, displacement and isolation.

With a .04 effect size value as the criterion for delimiting psychological defense mechanisms, out of 18 defense mechanisms only the following 5 may be considered relevant for the present discussion of psychological defense mechanisms (see Tables no. 2 and 3): passive-aggressive, projection, dissociation, withdrawal and help-rejecting complaining.

Compared with psychological defense mechanisms reported by other research carried out on non-psychotic major depressive disorder and other depressive disorders, this study has identified a large number of defenses specific to the clinical population sample evaluated in this study, mainly due to the instrument used in the analysis of psychological defense mechanisms – DSQ 60. Some of the psychological defense mechanisms identified as specific non-psychotic major depressive disorder in this study have recently been reported in other research (Porcerelli *et al.*, 2009) that indicated dissociation, isolation and devaluation as defense mechanisms specific to major depressive disorder, or by Plutchik (1991, apud Ionescu, Jacquet & Lhote, 2002) in a research conducted on participants diagnosed with non-psychotic major depressive disorder according to DSM IV R (APA, 2000/2003), with the Index lifestyle applied and later indicating that higher scores for projection.

These results are consistent with results of other studies (Bond *et al.*, 1983; Plutchik, Kellerman & Conte, 1979, Wong, 1989 apud Ionescu, Jacquet & Lhote, 2002; Vaillant, Bond and Vaillant, 1986) supporting the idea that depressed participants use two types of defenses (category having as benchmark the adaptive character of defenses) primitive or immature defenses and neurotic or intermediate ones, with the obvious increase in the intensity of the depressed patients' defenses in comparison with those of participants with no mental disorder.

Regarding the second objective of the study, the statistical analysis revealed significant differences between men and women in the clinical group for the following 7 psychological defense mechanisms of the 30 streamlined with DSQ 60 and taken into consideration (see Tables no. 2 and 3): altruism, passive-aggressive,

projection, reaction formation, self-observation, withdrawal and displacement. Of the 7 mechanisms identified no mechanism has a minimum effect size of .04, so that these mechanisms remain specific to women diagnosed with non-psychotic major depressive disorder, signalling though the low index of effect size.

Interaction effects are present at the levels of projection, isolation and help-rejecting complaining, but for each mechanism mentioned the effect size is low, .01. In these circumstances projection is identified as one of the psychological defense mechanisms specific to the clinical group participants, especially women participants, with isolation and help-rejecting complaining also employed by women in the clinical group. It can be seen that the interaction of the two independent variables, group and gender, determine a noticeable cumulative effect, especially for the women in the clinical group.

In conclusion, the following psychological defense mechanisms are specific to non-psychotic major depressive disorder: passive-aggressive, projection, dissociation, withdrawal and help-rejecting complaining. Regarding gender differences in the clinical group, with reservations for the low effect size, the following defense mechanisms are specific to female participants except passive-aggressive defense mechanism (specific to male participants from the clinical group) altruism (females), projection, reaction formation, self-observation, withdrawal and displacement.

Compared with other studies (Thygesen *et al.*, 2008) in which DSQ 60 was used, this study was conducted on two groups of participants, non-clinical (n = 770) and clinical group (n = 103), the number of participants being superior to other studies which used DSQ 60 and this is also the first time when DSQ 60 was applied to a clinical group.

The results obtained in this study helped to identify psychological defense mechanisms used to diagnose patients with non-psychotic major depressive disorder, and the way gender differences account for the use of psychological defense mechanisms in this medical condition, by using the latest version of DSQ 60 (Thygesen *et al.*, 2008) translated and adapted to the Romanian sample (Craşovan & Maricuţoiu, 2012) which includes all psychological defense mechanisms included in the DSM IV R (APA, 2000/2003).

Moreover, the results allow psychotherapists to tailor the treatment to the specific defense mechanisms of patients diagnosed with non-psychotic major depressive disorder or adapt the therapy to the patients' characteristics.

Therefore, as other authors also conclude (Bond, 2004; Hoglend & Perry, 1998), a thorough understanding of the specific defensive profile of patients diagnosed with non-psychotic major depressive disorder, and gender differences is considered important in improving the effectiveness of the psychotherapeutic treatment. In addition, any improvement of psychological defense is associated to a considerable improvement of the human subject's life (Vaillant, 2012).

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REZUMAT

Raportat la tema studiului, primul obiectiv are în vedere identificarea mecanismelor de apărare psihică specifice tulburării depresive majore fără elemente psihotice respectiv, în cazul obiectivului numărul doi, identificarea diferențelor de gen privind mecanismele de apărare psihică utilizate de pacienții diagnosticați cu tulburare depresivă majoră fără elemente psihotice.

Astfel, identificarea mecanismelor de apărare psihică specifice tulburării depresive majore fără elemente psihotice a fost realizată prin compararea a două loturi, *clinic* (N = 103; 42 participanți de gen masculin [40,8 %] și 61 participanți de gen feminin [59,2 %], Mvârsta = 51,16 ani; 12,6 % din participanți sunt absolvenți de studii superioare) și *non-clinic* (N = 770; 330 participanți de gen masculin [42,86 %] și 440 participanți de gen feminin [57,14 %], Mvârsta = 31,16 ani; 54,4 % din participanți sunt absolvenți de studii superioare).

În acest scop a fost utilizat singurul instrument de analiză a apărării psihice care include toate mecanismele de apărare psihică cuprinse în DSM IV R (APA, 2003/2000) și, totodată, unul dintre cele mai utilizate instrumente de analiză a apărării psihice, respectiv Defense Style Questionnaire – 60/DSQ 60 (Thygesen, Drapeau, Trijsburg, Lecours and de Roten, 2008), versiunea tradusă și adaptată pe eșantion românesc (Crașovan & Maricuțoiu, 2012). Rezultatele obținute confirmă un număr de cinci mecanisme de apărare psihică specifice grupului clinic: agresivitatea pasivă, proiecția, disocierea, retragerea și lamentarea însoțită de refuzul ajutorului. De asemenea, identificarea specificului apărării psihice în tulburările depresive poate determina creșterea eficienței intervenției psihoterapeutice prin identificarea și eliminarea acelor mecanisme de apărare psihică dezadaptative, sau cu eficiență redusă, respectiv înlocuirea lor cu mecanisme de apărare psihică adaptative, eficiente.