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Styles and Defense Mechanisms in People With Depression, Anxiety Disorder, Obsessive Compulsive Disorder, Eating Disorder, Social Phobia Disorder, and Substance Abuse*

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We need a way to compromise with the unpleasant inherent in the human condition and that creates conflict, as we do not be affected in this way. The ways we use to compromise, called defense. This study has been done with the aim of examining and comparison of defense mechanisms and styles, anxiety disorder, obsessive compulsive disorder (OCD), eating disorder, social phobia disorder, and substance abuse. This study consisted of 180 patients (30 patients per group) that were selected by convenience sampling. The instrument used to measure defense mechanisms was Defensive Style Questionnaire with 40 questions, by Andrews, Singh, and Bond (1993). Data were compared with statistical methods of mean comparison, statistical and one way Analysis of Variance (ANOVA) and post hoc tests. Statistical analysis showed that immature defense mechanisms in patients with substance abuse with mean of 26.87 is the most mechanism used and in patients with anxiety, with the mean of 19.23, is the least mechanism. In developed mechanism, patients with eating disorder with the mean of 12.13 are the most and in patients with substance use is the usage with the mean of 6.45. In neurotic mechanisms, patients with social phobia took the most mean of 13.96 and patients with eating disorders took the least mean of 9.24. The present study investigated the importance of defense mechanisms in patients with psychiatric disorders that effected how people's lives and interpersonal relationships, domains, and problem solving method of people in life. For this reason, defense mechanisms require more attention.

Keywords: defense style, defense mechanisms, depression disorder, anxiety disorders, obsessive compulsive disorder (OCD), eating disorder, social phobia disorder, substance abuse

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Introduction

The psychoanalysis innovation is the second revolution in the science of psychiatry (Shoja-shafti, 2001). It is one of the effective and dynamic plans according to today's turbulent society (Costa, Paul, Robert, McRae, 1995). It is an overall term that is defined to all models of the mind which is essentially about the unconscious processes of mind. The origin of all models psychodynamic return (and some of them that currently do not have any follow to psychodynamic thinking) to Freud and psychoanalyst (Holmens, 1994).

System of psychological analysis in Freud has great effects on theory and action in psychology and psychiatry, our image of human nature and understanding of character (Schultz, Schultz, & Sydney, 1998; as cited in Afzali, Fathi Ashtiani, & Azadfallah, 2009). A fundamental assumption that distinguishes psychodynamic model from other models is the subconscious is dynamic and, therefore, it is a source of our behavior motivation, feelings, and fantasies. It is not just something to be aware of (Solmz, 2004). As mentioned, psychoanalysis is performing to translate (interpret) the patient's speech, according to regulation of meanings, motivations, and structures of thought (Spiegel, 1994) and the main theory is considered acceptance of unconscious mental processes, recognition of resistance and repression, confirming the importance of sexual desire and aggression and the Oedipus complex (Joseph, 1996).The simple method of mental purification (Katarzys) always used to free association of ideas at contemporary, to reduce the increasing nervous pressure (Gabbard, 1995).

Psychodynamic models are considered as a starting point for the project that we have an inner world with strong effect on the way of thought, feeling, and behavior. Our inner world is formed of feelings, memories, beliefs, and fantasies. Part of it is self-conscious, based on the definition, which means we have access to it but the most of it is unconscious and that we are not notified of it and simply do not have access to it (Baker, 1993).

Freud raised three systems or levels of consciousness: the conscious, subconscious, and unconscious (Greene, 2003). The level of the conscious works at the mind and it is concerned to what we already are aware of it or think about it. The subconscious is under the conscious mind that all of the memories, feelings, and ideas that can have relatively easy access to them, but it is not in your conscious awareness. There are keeping different depths of the subconscious; there is very easy access to some contents of the subconscious. The unconscious is below the subconscious and it is the source of mental issues with much more anxious that has the permission to iterance of consciousness. The unconscious includes sexual and violent drive, defense and some memories and feelings (Holmnz, 2001). The unconscious mind follows a set of rules of the conscious mind. He argued that the life of unconscious mind placed under the control of the primary processes, however, the life of the conscious mind controlled by secondary processes run by the conscious mind while living (Sygarvdy, 2008). His purpose was that the conscious mind organized under the laws of logic, in touch with reality, could delay satisfying and understood the concept of time and the difference between objects and people. n contrast, primary or unconscious processes are not within the scope of reality (Brouer & Freud, 1974)

We need a way to compromise with the unpleasant inherent in the human condition and the conflict that creates, and we do not be affected in this way. The ways we use to compromise, called defense. We can fully use the defense style completely conscious and intentional, but especially the psychodynamic model that is interested to those defenses we use unconscious. Freud found that this is a way to be unconscious and keep

unconscious way any desire or thought that is threatening, and can be a source of anxiety. His objective of psychoanalysis was to do self-conscious of the unconscious through the termination of the repression (Seyed-Mohammadi, 2006). We have to manage the challenges of coping with inevitable human good, our defense of our early life. We shaped our defense from the early life to manage the challenges of reconciliation. We need our defenses to be able to live in the world. So the goal of psychodynamic work is not to remove them. It is not only irrational but impossible. At the same time, we need our defense to be flexible enough to allow us to provide reaction based on the specific situation. We behave in all such situations similarly. The defenses are used with tenacity and are not useful, because it decrease the choices we use to how to react, and it is likely that even we create a bigger problem for ourselves just because we have reacted disproportionately. If a defense has been stubbornly used, how it can prevent a real understanding (Freud, 1953a).

Defenses are part of our character and an important indicator of our personal approach in relations with the world. Psychodynamic thinking tends to focus on how we can apply the defensive experience or feeling. Freud argued that the most important instinct is our sexual drive and having more psychological defenses to keep the instinctive needs of the conscious awareness (Greene, 2003).

Only when unconscious processes can enter into consciousness that will be deformed enough to escape the grip of censorship. Ego or self is the area of mind that contact with reality and creates in an infancy period through id, however, it is the only source of communication with the outside world. The ego is under the domination of reality principle and attempts to replace this principle with id. The ego is the area of the mind that contacts with the outside world. The ego is the branch of decision-making or executer of personality. Ego should consider unreasonable and inconsistent demands of ego and superego while doing cognitive and intellectual tasks. Ego should serve to third master in addition to other two masters: the outer world. So the ego attempts repeatedly to establish compromise between the blind and unreasonable requests of id and superego with the reasonable requests of outer world. When the ego is surrounded by three different opposing forces, it is expected to react predictable: to be anxious. Since then, the ego forced to use repression and other defense mechanisms to defend itself against this anxiety (Freud, 1953a).

Freud invented the concept of defense mechanisms for the first time in 1926 (Freud, 1953b). And then his daughter, Anna Freud, is corrected and organized this concept. Although the defense mechanisms are normal and all people use them. But if it used excessively, it leads to obsessive, frequent, and neurosis behavior. As we need to spend mental energy for the creation and defense mechanisms, so when we will be more defensive, then we remain less mental energy to satisfy the id impulses. Of course, this is precisely ego task that creates defense mechanisms, because ego has to avoid direct deal with the demands of instinct and defending himself against anxiety with them (Freud, 1953a).

Each mental disorder is along with specific non-conformity defense mechanisms (Offer, Lavie, & Gothelf, 2000; Cramer, 2000; Andrews, Pollock, & Stewarttuart, 1989; Bond & Perry, 2004) and defenses play an important role in mental health of people. In addition, identifying defenses of different disorders has acceptable use in order to help differential diagnosis (Cramer, 2000). Freud knew personal defense mechanism, the frequency for using defense mechanism in contrast with others, as the main variable to identify personality, psychopathology and the level of compromise. The assumption that has been confirmed based on research

results (Freud, 1976; as cited in Besharat, 2009).

The main defense mechanisms identified by Freud, consisted of: repression, undoing, isolation, reaction formation, displacement, fixation, regression, projection, introjections and sublimations (Freud, 1905/1960).

Individuals use specific defense styles encounter with stress on the basis of psychodynamic approach that these styles divided in four groups based on the level of maturity called immature, neurotic, Narcissistic and mature (Vaillant, 1992).

Each of these styles included special defense mechanisms. The defense style is immature in individuals suffering from mental disorders, and the defense style is more mature among non-clinical population (Cramer, 2000). So what it has been done in most studies related to mental defenses psychological performance to there at first level is evaluating defense style and in second level is about outstanding defense mechanisms that individuals use them.

Therefore, the aim of this study is to evaluate and compare those with mechanisms and defensive style, in individuals with anxiety disorder, OCD, eating disorder, social phobia disorder, social, substance abuse and impulsivity.

Method

The Design of the Study

It is the fundamental research that aims to clarify the relationship between events and add to the existing knowledge in the field of the role of defense mechanisms. The general design of the study is descriptive design in terms on causative-comparative.

The population of the study is all the individuals that met the diagnostic criteria for depression, anxiety disorder, OCD, eating disorder, social phobia, substance abuse in the context of revision of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 3rd edition, 2000). The sample includes 350 patients with mental disorders that referred to private medical centers at Hamadan 2013. Among them, 180 patients with mental disorders would meet the criteria for the study. These criteria include: (1) having criteria by diagnostic according to the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 3rd edition, 2000) and structured clinical interview for DSM-IV-axis I disorders (SCID-I), Diagnosis Psychiatry; (2) At least, diploma education; (3) domain age between 25-50; and (4) no need for hospitalization.

Exclusion Criteria

Exclusion Criteria consisted of: (1) Mental disorders axis 2 and 3; (2) psychotic patients; (3) patients with a history of hospitalization in mental hospital. Sampling has been done on the basis of convenience sampling. In this regard, the individuals meet required criteria was selected and people that meet entrance criteria were at research process and in case of approval, they were selected as the sample of study and completed the questionnaire.

Research Tools

They were (1) structured clinical interview of Diagnostic and Statistical Manual for DSM-IV-axis I disorders and (2) Defense Styles Questionnaire (DSQ).

SCID

SCID is a structured clinical interview to evaluation species different disorders Axis I and II. This Diagnostic interview spread for the first time in 90s for diagnostic evaluation based on the text revision of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 3rd edition, 2000) and the current copy was updated on the basis of diagnostic evaluation of the fourth edition of Diagnostic and Statistical Manual of Mental Disorders, Us Psychiatric Association and included two versions for disorders axis I and II. SCID-I has been evaluated seven diagnostic groups of disorders Axis I include mood disorders, psychosis, addiction to drug, anxiety and physical disorders, eat and compatibility. Evaluating the psychometric features of this tool Show that the reliability of it for severity disorders is better than mild disorders and the validity of it is reported in range of 0.81 to 0.84. However, the interview is more valid because of comprehensiveness and strict compliance of the Diagnostic and Statistical Manual of Mental Disorders criteria of US Psychiatric and it is a standard and comprehensive diagnostic evaluation in research, legal and clinical areas that has been used widespread (Sadock & Sadock, 2005). In Iran, Sharifi (2005) examined the reliability and implementation for Iranian population. Results revealed diagnostic agreement to most diagnosis as average up to good (kappa greater than 0.6) and most interviewers evaluated as good tool the ability of implementation in Persian copy. Bakhtiari (2001) used this tool for Iranian population Iranians. The test-retest reliability was reported 0.95 for SCID-I with one week distance (as cited in Mazaheri, Borjali, Ahadi, & Golshani, 2011).

Defense Styles Questionnaire

This questionnaire is measured defense behavior through empirical evaluation of awareness derivatives by defense mechanisms in everyday life (San-Martiniet, Roma, Sarti, Lingiardi, & Bond, 2004). The questionnaire was made based on the hierarchical model of defense. The questionnaire developed for the first time by Bond and his colleagues to investigate defense mechanisms in normal and patient's individuals in 1983 that consisted of 88 items and evaluated 24 mechanisms (Andrews et al., 1993; Muris & Merckelbach, 1996; Hayashi, Miyake, & Minakawa, 2004).

Bond and colleagues identified four defense styles in defense in the level of defense mechanisms using factor analysis that include: (1) maladaptive style, (2) image-distorting style, (3) self-sacrifice style, and (4) adaptive style (San-Martini et al., 2004). They studied the relationship between defense styles of four groups of mental disorders after developing this tool and examined a group of normal subjects. The results were not satisfactory enough in separation research groups as well as the separation of normal and patients subjects based on the defensive style. Therefore, Andrews and colleagues in 1989 were reviewed Defense Style Questionnaire according to the diagnostic assessment classification on the text revision of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 3rd edition, 2000) and presented definition of defense mechanisms. Then, they made Defense Styles questionnaire with 72 questions that assessed in three levels of mature, neurotic, and immature. The new version of questionnaire was developed with 40 questions by Andrews et al. (1993) because of inequality weaknesses of factors which included 40 questions and assessed 20 defense mechanisms in 3 levels (Andrews et al., 1993; Sinha & Watson, 2004). Coefficient Cronbach Alpha in questions for each mature, immature and neurotic style of Persian form in student sample for all of subjects was 0.75, 0.74, and 0.74 for boy students and 0.75, 0.74 and 0.74 for girl

students. That shows the satisfaction internal consistency for Iranian form of Defense Style Questionnaire (Besharat, 2007).

Results

The inferential statistics in this study include chi-square test and Analysis of Variance (ANOVA) for comparison of the means related to demographic data in groups which can be seen in Table 1 and Table 2.

Table 1

Comparison of the Prevalence of the Four Groups by Age, Sex, Marital Status, Educational Level and Job

Group Variable		Depression		Anxiety		OCD		Eating	
		Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Gender	Man	9	30	11	36.67	12	40	6	20
	Woman	21	70	19	63.33	18	60	24	80
Education	Diploma	2	6.67	7	23.33	15	50	8	26.67
	Assosiation Degree	14	46.67	9	30	9	30	9	30
	Bachelor	10	33.33	11	36.67	4	13.33	6	20
	Master	4	13.33	3	10	2	6.67	7	23.33
Relationship	Single	11	36.67	7	23.33	21	70	16	53.34
	Married	19	63.33	23	76.67	9	30	14	46.66
Job	Employee	20	66.67	19	63.33	14	46.66	17	56.67
	Without job	10	33.33	11	36.67	16	53.34	13	43.33

Group Variable		Social phobia		Substance abuse		Compare chi-square	
		Frequency	Percent	Frequency	Percent	Frequency	Percent
Gender	Man	8	26.67	16	53.34	180/000	0.465
	Woman	22	73.33	14	46.66		
Education	Diploma	13	43.33	17	56.67		
	Assosiation Degree	8	26.67	6	20		
	Bachelor	7	23.33	5	16.67	540/000	0.465
	Master	2	6.67	2	6.67		
Relationship	Single	19	63.33	23	76.67	180/000	0.465
	Married	11	36.67	7	23.33		
Job	Employee	11	36.67	11	36.67		
	Without job	19	63.33	19	63.33	180/000	0.465

It can be seen according to the data in the above table that most of the frequency is related to female based on *sex*. It is formed 65.56% of the group sample, and most of them (80%) placed in group with eating disorders (anorexia nerve). In terms of *education*, most of the frequency 34.44% is related to the diploma degree and lower that most of them was in the group of patients with the substance abuse and the lowest frequency is related to students and master graduated students that formed 11% of the sample group and it is higher than other groups in patients with eating disorder. In terms of *marital status*, the highest rate of frequency is related to single people that are formed 53.89% of the group. Most of them are in group of patients with substance abuse and the least of them are in the group of patients with anxiety disorder. In terms of *job status*, most of frequency is related to housewives and men who are currently without a job that is surrounded by 55.56% of patients in both groups of substance abuse and social phobia.

According to the table, it can be said that the groups in terms of sex, education, marital status, employment and job status did not have significant different from their peers.

Table 2

Mean Comparison of the Six Age Groups

Group	The age range	Average	Standard Deviation	*f* test	*p*
Patients with depression	21-48	34.70	7.433		
Patients with Anxiety	23-43	32.53	5.877		
OCD sufferers	27-43	33.30	6.271		
Mbtlayanbh eating	18-33	26.03	3.417		
People with social phobia	20-39	29.10	5.933		
Patients substance abuse	19-36	28.71	5.100		
Total	19-48	30.74	6.467	9.56	0.00

The highest and lowest mean age in the group of patients suffering anxiety and social phobia, 36.50 and 24.09 respectively, and the subjects did not have significant difference and are parallel.

The ANOVA used for the evaluation of the pattern in defense mechanisms of subjects and comparison of pattern in defense mechanisms of the groups. The Post Hok test-Tukey (HSD) and matched subgroups are used for the comparison of mutuality in groups according to equality of subjects in groups. The results can be seen in the below Table 3. The results of ANOVA (see Table 3) and Tukey tests showed that:

Patients with depression used more immature defense mechanisms (22.3) in proportional to the neurotic styles (9.43) and mature (7.43) that the greatest mean in immature defense mechanism including passive aggression (14.03), projection (13.93), somatization and autistic fantasy (13.26), and isolation (13.23). In neurotic defense mechanism formed of the reaction (13.40), false-like others (11.13) used with more proportion.

Patients with anxiety disorder used immature defense mechanism fewer in proportion to patients with depression and used the higher somatization mechanism of 13.46, which are common in both groups (depression and anxiety).Depressed group used Ability to work mechanism with mean of 7.83 and anxiety group used denial mechanisms with mean of 7.40 to a much lesser extent than other mechanisms as well.

Patients with OCD used high autistic fantasy (12.90), rationalization and make layer (12.76) in immature defense mechanism and used advance review (12.53) in the mature mechanism, the reaction formation (13.73)

and false-like others (13.56). Patients with OCD used higher mature defense mechanisms in proportion to anxious and depressed patients and the greatest used defense mechanism is immature mechanism like two groups of anxious and depressed.

Patients with eating disorders (anorexia nerve) used the autistic fantasy (14.31) in the mature mechanism, the sublimation mechanism (10.03) in the mature mechanisms, and rationalization (10.51) in the neurotic mechanism with greater proportion to other mechanisms as well.

Patients with social phobia used high isolation (14.06) in immature mechanism, advance review (12.46) in mature mechanism, and false-like others (12.36) in neurotic mechanism.

Patients with substance abuse used high autistic fantasy (14.35) in mature mechanism, sense of humor (11.45) in mature defense mechanisms, and reaction formation (12.77).

Table 3

Results of ANOVA Between Defense Mechanisms and Styles in Compared Groups

Index Defenses	Depression		Anxiety		Obsession	
	Mean	Standard deviation	Mean	Standard deviation	Mean	Standard deviation
Rationalization	9.00	1.80	8.90	1.446	12.76	2.387
Projection	13.93	2.13	8.80	1.74	10.96	2.63
Denial	12.23	1.83	7.40	2.28	11.26	2.77
Ability to work	7.83	2.30	8.96	2.49	12.43	2.48
make worthless	10:53	2.04	10.60	1.77	11.03	2.38
The transition to action	12.20	2.24	11.36	2.49	9.73	2.46
Somatization	13.26	2.75	13.46	2.37	11.30	2.66
Autistic fantasy	13.26	2.27	10.06	2.65	12.90	2.49
Make layer	11.63	1.99	10.46	1.88	12.76	2.76
Passive aggression	14:03	2.35	11:46	2.83	12:56	2.40
Displacement	11.63	2.79	7.90	2.56	8.03	2.94
Isolation	13.23	2.59	8.96	2.64	6.56	2.81
Immature style	22.03	3.37	19:23	3.33	20.60	3.50
Suppression	8.23	2.64	9.30	1.53	6.46	2.58
Sublimation	6.56	1.95	11.00	1.59	10.70	2.54
Sense of humor	4.30	1.23	6.46	1.47	8.63	2.44
Advance review	10:16	2.46	8.73	2.79	12:53	2.47
Mature	7.43	1.94	10.40	1.16	9.80	2.15
False-Like others	11.13	2.51	9.60	1.94	13.56	2.35
Reaction formation	13.40	2.85	11.80	2.44	13.73	1.89
Rationalization	10.96	2.63	9.46	2.60	12:40	2.41
Cancellation	9.90	2.63	9.60	1.90	11.60	2.49
Neuroticism	9.43	2.32	9.53	2.01	12.80	2.55

(Table 3 continued)

Index Defenses	Eating		Social phobia		Substance abuse		Total	
	Mean	Standard deviation	Mean	Standard deviation	Mean	Standard deviation	*f*	*p*
Rationalization	9.86	1.922	10.06	1.659	13.19	1.701	31.64	0.056
Projection	9.37	1.49	9.13	1.38	13.77	1.54	46.82	0.011
Denial	9.34	1.71	6.53	2.28	16.23	1.69	9.40	0.093
Ability to work	10:27	1.55	5.60	1.428	10.54	2.06	38.40	0.004
make worthless	9.72	2.11	9.76	1.69	13.19	1.60	13.00	0.127
The transition to action	14.06	1.64	7.33	2.07	11.77	1.89	33.85	0.123
Somatization	10.96	2.14	12.40	1.88	13.64	1.97	7.33	0.258
Autistic fantasy	14.31	1.71	13.90	1.66	14.35	1.37	17.91	0.002
Make layer	12.72	1.33	9.13	2.43	9.90	1.73	15.77	0.053
Passive aggression	10.13	2.08	12.46	1.79	12.45	1.89	9.77	0.171
Displacement	8.72	2.76	9.83	2.10	7.48	2.06	11.18	0.360
Isolation	11.37	2.78	14.06	1.52	12.29	1.84	41.14	0.004
Immature style	21.48	2.55	24.26	2.34	26.87	2.17	26.75	0.087
Suppression	9.65	2.49	8.06	2.03	6.25	6.25	12.172	0.004
Sublimation	10.03	1.88	11.80	2.20	6.93	2.70	30.890	0.055
Sense of humor	9.68	2.18	6.86	1.61	11.45	1.54	60.829	0.006
Advance review	9.65	1.98	12.46	1.19	10.97	2.57	18.366	0.000
Mature	12.13	2.35	11.76	1.75	6.45	2.91	35.336	0.000
False-Like others	9.62	2.12	12.36	2.45	10.77	2.33	26.052	0.591
Reaction formation	9.55	2.75	9.73	1.92	12.67	1.88	22.568	0.014
Rationalization	10.51	1.59	7.93	1.79	10.09	2.16	13.395	0.092
Cancellation	6.41	1.52	10.33	1.89	7.32	2.67	18.009	0.048
Neuroticism	9.24	2.14	13.96	2.29	12.70	2.16	13.769	0.761

Discussion

According to the studies of Cramer (2005), defensive styles are immature and non-adaptive and the defensive styles are far mature in nonclinical population. Although defense mechanisms are normal and all of people use them, but if used excessively, it leads to obsessive behavior, frequent and neurotic. Because we use energy to create and maintain the defense mechanisms, the more we would be defensive, we put less mental energy to satisfy the impulses of id. Of course, this is precisely the task of ego to create defense mechanisms, because it must avoid of direct deal with the demands of instinct and defend himself against anxiety with them (Freud, 1905/1926).Defense mechanisms are distorting reality and the amount of distortion in immature and neurotic defenses are more than mature defenses. The rate of cognitive distortion has inverse relationship with

awareness, as the rate of cognitive distortion in one defense is more, it is diminished with the same rate in awareness and makes less effort to deal with cognitive distortions (Brad, 2004; as cited in Afzali et al., 2010). Although all defense mechanisms protect themselves against anxiety, since everyone has enough defensive behavior, these mechanisms are common and each defense mechanism combined with repression and each of them can leads to stage of trauma. However, there are some mechanisms which are harmful for individual and harmless to society as neurotic defense mechanisms and other mechanisms are obstacle to understand the reality in individual and deprive the individual of the implementation of the reasonable defense. Such as immature defense mechanisms and the defense mechanism—sublimation—usually brought benefits to the individual and society. In this light, it was found in this study with consideration of defense mechanisms in depression, anxiety, OCD, social phobia, eating disorder and substance abuse that:

Immature defense mechanisms (26.87) in patients with substance abuse are the most used mechanism, and in patients with anxiety, with a mean (19.23), are the lowest mechanism in corporation to other disorders. The sequence of other examined disorders are social phobia (24.26), depression disorder (22.03), eating disorder (21.48) and OCD (20.60). The highest mean among all defenses in mature mechanisms is reaction formation in patients with OCD and the lowest mechanism is denial in patients with eating disorder.

The result that psychodynamic researchers achieved is that people with OCD use greater immature defense mechanism (Afzali et al., 2010) and a study has not been yet conducted to compare mental defense mechanism in patients with mental disorders that compare their defense mechanism, but in patients with OCD, the reactions formation mechanism had the highest mean among the neurotic mechanisms that are consistent with studies by psychoanalysts research (Afzali et al., 2010).

Patients with eating disorder in mature mechanism with a mean of 12.13 in eating disorder had the most social phobia (11.76), anxiety disorder (10.40), OCD (9.80), and depression (7.43), and patients with substance abuse had lowest mean (6.45) and among the available mechanisms, the most usage was for advance review that had the lowest mean in OCD and sense of humor that is allocated in patients with depression.

In the neurotic mechanisms, patients with social phobia had the highest mean (13.96) and patients with eating disorder with the lowest mean (9.24) that no studies found consistent with this result.

Conclusion

This study showed that mental patients used very much immature defense styles (rationalization, projection, denial, ability to work, make worthless, the transition to action, somatization, autistic fantasy, make layer, passive aggression, displacement and isolation) and neurotic defense styles (false-like others, reaction formation, rationalization and cancellation). The results showed the importance of studying the defense mechanisms in patients with psychiatric disorders that impressed the quality of life, interpersonal relationships, domains, and problem solving way of individuals. Thus defense mechanisms require more attention.

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