ISSN 2078 6999. Вісник Львівського університету. Серія філософські науки. 2013. Випуск 16. С. 208–217
Visnyk of the Lviv University. Series philosophical science. Issue 16. P. 208–217

USC 159.9.07

FEATURES OF PSYCHOLOGICAL DEFENCE WITHIN IPD STRUCTURE IN DIFFERENT SOMATIC DISEASES

Larysa Didkovska

Ivan Franko National University of Lviv,
Doroshenko str., 41, Lviv, 79000, Ukraine,
e-mail: didkovska@gmail.com

The research was conducted on the basis of several Lviv city clinical hospitals, it studied 52 patients of all ages with a variety of somatic pathologies. The objective of the study was to examine the role of psychological defence in the development and distortion of IPD patients. Analysis of the results showed the impact of psychological defence on the development of IPD each of the patients studied. This enabled us to take clinically informed decision on the choice of psychotherapeutic targets and methods for psychotherapeutic correction in each individual case, which should be primarily aimed at stimulating the body's own resources and adaptive styles of responding to disease.

Keywords: psychological defence mechanisms, the concept of disease, internal picture of disease, maladaptive behaviour and constructive psychological defence.

Nowadays, worldwide we can observe an increase of interest in the psychological problems of patients with various somatic diseases, especially in terms of prevention of mental health disorders and development of effective psychological compensatory adaptation mechanisms [1-16]. Specialized journals are full of studies on this issue. There is scientific evidence that supports the effectiveness of psychocorrective interventions in patients with psycho somatic profile [14]. The distress was proved to be able to be mitigated and the risk of anxiety or affective disorder can be minimized if during a conversation with the patient the doctor can analyze what kind of information he/she needs, inform about the dangers of the disease more subtly and selectively and provide adequate psychological support to patients and their families [11].

Among the above-mentioned studies a prominent place is taken by works devoted to the study of internal picture of disease (as well as internal health picture) of men, women and children with different somatic pathology [1; 2; 8; 9; 13;16], but the focus on psychological defence was still insufficient [4; 6; 7; 15; 12; 10].

Attitude to disease is always significant, as it influences other systems of attitude to personality. Psychotherapeutic methods of influence can be of great help to the patient in the somatic hospital, when a specialist, referring mainly to secondary violations of significant relationship between the individual, may contribute to the correction of inappropriate reactions of the individual to the disease, create more realistic mindset connected with treatment, recovery of family and other social relationships. Psychological methods for correcting the wrong attitude of patients contribute not only to improving their condition, but also to the prevention of recurrence of the disease, preventing

distress that lead to decompensation in patients. However, it is important to know which form of psychological defence the patient applies to make clinically informed decision on the choice of psychotherapeutic targets and methods of psychotherapeutic correction (psychotherapeutic methods) in each individual case.

The concept of psychological defence has gained significant importance in all fields of psychology and psychotherapy. In diseases with the biological mechanisms, the disease has always seen as a result of harmful factors and "physiological defence mechanisms" aimed at the restoration of the homeostasis of the body. Similarly, we consider psychological defence mechanisms. Inflammation and pain on the one hand, are adaptive physiological responses, on the other - being included in the pathogenesis of the disease, they play a harmful role. Psychological defence mechanisms are also adaptive and aim to protect the patient's consciousness from painful feelings and memories, however in the course of therapeutic work they create some obstacles, resistance to processing traumatic content of the experiences.

Psychological defence is an unconscious process that regulates the level of emotional stress. Psychological defence eliminates the associated feelings that prevent other mechanisms of adaptation that may help the individual cope with the situation rather than resolves the controversy [4].

Features of psychological defence mechanisms functioning in patients influence the development of types of responses to the disease [12]. Thus, at present it is difficult to improve treatment and recovery measures excluding the role of the individual response to the disease, the effectiveness and adaptability of its own compensatory mechanisms, including psychological defence, which largely shape the cognitive, emotional and volitional side internal picture of disease in terms of desire and focus on patient's recovery.

Internal picture of the disease is a special form of mental adaptation which, according to V. Myasishchev, is an important subsystem of psychological regulation of human behaviour and is considered as part of the secondary psychological defence that is unconscious use of methods that ensure the safety of the operation of the destructive primary psychological defence by patients. Internal picture of the disease (IPD) contains the following components: perception of the disease (sensitive and emotional component); attitude to the disease (predictive component); mindset on the disease (behavioural component); attitude to treatment (compliance) [2]. IPD is involved in the mechanisms of developing psychological maladjustment, is based on the basic adaptation mechanisms, in the development of the disease and is one of the meaningful targets of correction.

Based on the foregoing, the **aim of the study** is to investigate the role of psychological defence in the process of developing IPD and responding features in patients with somatic illness, depending on the nosological identity.

The study involved 52 patients aged 17 to 81 yearsold, most of them were men (44 persons).

The survey was conducted in 8thLviv city hospital (16 people), dermatovenerologic hospital (14 people) and a military hospital (22 people) following the principles of bioethics and ethics. We have examined patients with various somatic diseases (skin and kidney) of varying intensity and severity. Some of the patients required surgery (14 people), so the patients were staying in the surgical ward.

Based on demographic data, the sample of patients can be considered representative, the only irregularity in the distribution of the respondents in the sample is based on sex (85% male and 15% female), hence the results obtained in the study and the findings based on these results should be considered more characteristic of men.

Information on diseases and health conditions of the subjects is presented as follows. At the time of examination, the patients were in hospital from 3 to 60 days. During the period of treatment, improve in condition was experienced by 38 people (73%), 14 persons (27%) experienced no change; deterioration of health was not recorded in subjects. By the nature of the disease, weidentified several groups: acute diseases (sudden deterioration of health and injury, i.e. sudden illness which the patients were not expecting), exacerbation of chronic disease (chronic disease in the acute stage, accompanied by a sharp deterioration in health), chronic diseases (long-term disease that is not accompanied by significant changes in health for the worse during hospitalization).24 people (47%) were hospitalized due to acute diseases,16 people (31%) had exacerbations of chronic diseases, 12 people (23%) – chronic diseases.

Thus, by the duration of hospital stay, health condition, severity and degree of improvement following treatment, the sample can be considered normally distributed. In terms of localization of somatic illness, the sample consisted of three nosological groups SKN – a group of patients with skin diseases (16 people), RNL – a group of patients with renal pathology (20 people) and SRG – a group of patients with diseases that require surgery (16 people).

The study used:

Kellerman-Plutchik Questionnaire. The questionnaire is intended to diagnose psychological defence mechanisms such as reaction formation, negation, substitution, regression, compensation, projection, rationalization and displacement as well as degree of detection with respect to each other.

Personality questionnaire of Bekhterev Institute (PQBI). The questionnaire aims to determine the type of personal reactions to illness and other related personal attitudes of patients with somatic diseases.

This set of psychodiagnostic methods allows us to study internal picture of somatic disease and psychological defence mechanisms used by patients to protect the positive image of "Me" from the destructive impact of the disease.

All psychodiagnostic examination data were calculated using algorithms. Since there wereno standardized data for Kellerman-Plutchik method sand raw data are not easy to compare with one another in terms of a quantitative representation, standardizing procedures were applied based on the sample by the formula:

$$ST = 5{,}5 + 2\frac{X_i - \overline{X}}{\sigma},$$

where:

ST standardized scores (stans, standard ten, scores from 0 to 10), X_i– evaluation of the i-th respondent, $\overline{X}$ – the arithmetic mean of the sample.

Therefore, the data were transferred to the 10-point scale where scores lower than 4 points can be considered as low, while higher than 7 points –as high.

In this research, we used the procedure of comparative analysis based on Student's t-test, the significance of which at $p \leq 0.0500$ indicates non-randomness of the revealed differences between the average scores in the compared groups. The index of probability (or accuracy) p indicates the percentage of sample for which this pattern may be random (level $p \leq 0.0500$ generally used for psychological research corresponds to 5% reliability threshold).

The results of the comparative analysis based on the parameters of the method "Type of attitude to the disease" (PQBI) found significant differences in the concepts of disease given different nosologies (table 1 and figure 1).

Table 1.

The results of the comparative analysis of different nosological groups of patients based on performance the parameters of the method PQBI

Para-meters	Arithmetic mean of nosological groups			Results of comparative analysis among the groups					
				SKN-RNL		SKN-SRG		SKN-SRG	
	SKN	RNL	SRG	t-test	p	t-test	p	t-test	p
H	9.38	13.56	5.50	-0.551	0.590	0.452	0.659	1.113	0.286
R	11.50	15.67	8.00	-0.773	0.452	0.593	0.564	1.182	0.258
S	6.75	21.44	3.17	**-2.813**	**0.013**	0.696	0.500	**3.544**	**0.004**
A	11.50	2.67	18.50	**2.156**	**0.048**	-1.047	0.316	**-3.321**	**0.006**
Hy	11.25	4.78	16.50	2.108	0.052	-1.214	0.248	**-3.338**	**0.005**
N	8.13	4.22	12.50	1.437	0.171	-1.006	0.334	**-2.672**	**0.019**
M	8.13	3.11	13.50	**2.842**	**0.012**	-1.554	0.146	**-3.466**	**0.004**
Ap	3.75	3.00	8.50	0.385	0.706	-1.665	0.122	-1.673	0.118
St	19.13	10.67	20.67	**2.591**	**0.020**	-0.338	0.741	**-3.151**	**0.008**
I	7.50	9.67	12.00	-0.833	0.418	-1.477	0.165	-0.717	0.486
P	4.38	4.22	11.00	0.068	0.947	-1.924	0.078	-1.875	0.083
D	4.88	5.78	10.33	-0.374	0.714	-1.688	0.117	-1.295	0.218

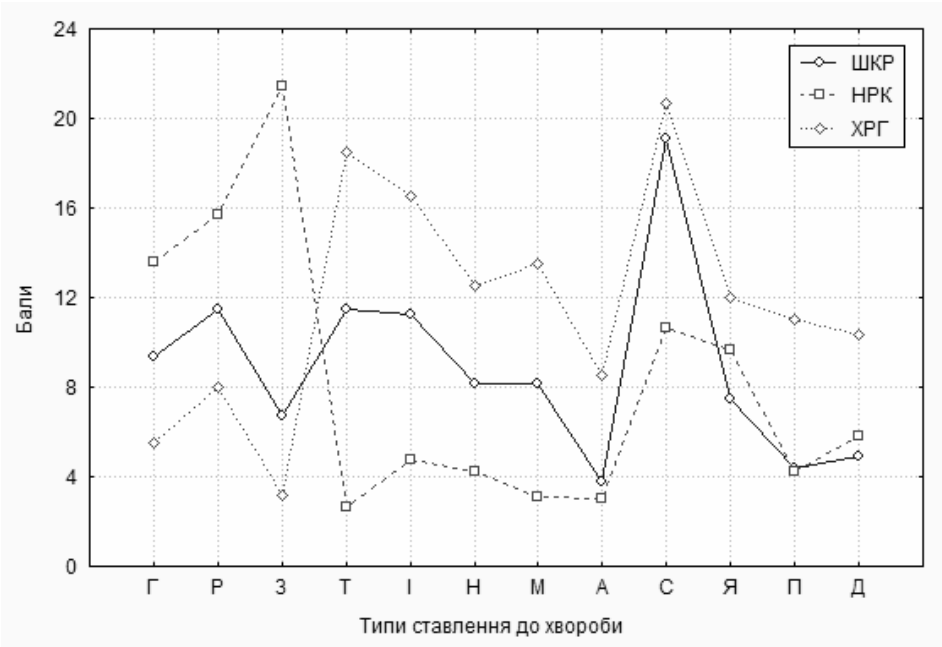

Fig. 1. Profiles of attitude to the disease in skin, renal and surgical pathology

H – Harmonic type, R – Ergopatic type, S – Anosognostic type, A – Anxious type, Hy –Hypochondriac type, N – Neurotic type, M – Melancholic type, Ap –Apathetic type, St – Sensitive type, I – self-centred type, P – Paranoiac type, D – Dysphoric type.

Table 1 and fig. 1 show that differences in IPD patients with skin and surgical diseases do not reach the level of statistical significance, profile of skin patients is placed between the groups of skin and renal patients by almost all parameters; while differences between renal and surgical pathology are large and numerous.

Algorithm of PQBI method in the diagnosis of the type finds a scale with a maximum value. It determines whether the profile has scale that is within the diagnostic area, i.e. whose scoresdiffer from the maximum one by no more than 7 points. If the scale with the maximum score is only one and there are no other scales that fall behindby no more than 7 points, the only type that corresponds to this scale is diagnosed. If the diagnostic area (interval 7 points) in addition to the scale with the maximum score also includes one or two scales, amixed type is diagnosed, it is entitle daccording to the names of the scales that form it. If the diagnostic area includes more than three scales, diffuse type is diagnosed. Harmonious type is diagnosed only as clean, i.e. only when the scale of this type has the maximum score and has no other scales that fall to the diagnostic area. In the mixed type, if the diagnostic area along with other scales includes the scale of harmonic type, it is excluded from consideration as a component.

According to the above algorithm for the diagnosis of the type of attitude to the disease, the renal group is diagnosed with mixed anosognostic-ergopatic(S-R) type of attitude to the disease, a group of surgical pathology – sensitive-anxious-hypochondriac type of attitude to the disease and group of skin nosology - sensitive type.

Thus, patients with skin and surgical pathology are overly concerned about possible adverse impression the information about their disease may produce on the surrounding people. They are afraid that others will avoid them, considered them inferior, or that they will be neglected, or that others will gossip or spread negative information about the cause and nature of the disease. Fear of becoming a burden to family due to illness and hostile attitude on their part in this regard (sensitive type of attitude to the disease, parameter S).

In addition to the features of sensitively type, patients with surgical pathology are also characterised by high expression of anxiety symptoms and hypochondriac types. Continuous care, concern and mistrust regarding adverse clinical course, possible complications, inefficiency and even danger of treatment. Search for new treatments, need for more information about the disease and treatments, continuous search for authorities. Anxiety, depression as a result of anxiety. The obsessive-phobic version of this type is characterised by disturbing mistrust which primarily concerns unlikely complications of the disease, treatment failures, and possible (but not grounded) failures in life, work, and family due to illness rather than fear of real complications. Imaginary hazardsworry these patients more than real ones.Rituals and signs (signs of anxious type, parameter A) become a way to protect against anxiety. In addition, the focus on subjective painful and other unpleasant feelings.The desire to constantly speak about them with others. On this basis of exaggerating real ones and finding non-existent diseases and suffering.Exaggeration of side effects of drugs. The combination of the desire to be healed and disbelief in success demands a thorough examination of fear of harm and painful treatment (hypochondriac type, parameter Hy).

The type of response to the disease in patients with renal disease is significantly different. They are characterised by anosognostic-ergopatictype of attitude to disease. Active rejection of

thoughts about the disease, its possible consequences.The denial of the obvious.The attribution of the disease symptoms to fortuitous circumstances or other not serious conditions. Refusal to have examination and treatment. The desire to "draw upon own resources". The euphoric version of this type is characterised by unreasonably elevated mood. Neglectful, carefree attitude to the disease and treatment. Hope that "all things must pass".The desire to continue living life to the fullest, despite the disease.Noncompliance with the treatment that adversely affects the course of illness (anosognostic type, parameter S). In addition, patients with renal nosology are characterised by "escape from the disease by going to work". Desire to continue working despite the severity of illness and suffering. Super-responsible, obsessive, stheniac attitude to work, in some cases – expressed to an even greater extent than before the illness. Selective attitude to screening and treatment due to the desire by all means keep working and the possibility of continuing active employment (ergopatic type, parameter R).

The comparative analysis shows that the signs of anosognostic attitude to the disease are more typical for patients in the RNL group compared with SKN and SRG groups, while the signs of sensitive type are rather typical for the respondents from SKN and SRG groups compared with patients with renal disease. In addition, patients in the skin and surgical nosology groups are characterized by higher scores of anxiety and melancholic type, which is also confirmed by the presence of statistical significance, when comparing their scores with the scores of RNL group. Signs of anxiety are provided above; melancholic type differs by depression from illness, lack of faith in curability, possible improvement, the effect of treatment. Active depressing ideas up to suicidal thoughts.Pessimistic outlook on everything around.Disbelief in the success of treatment, even under favourable objective data.

In addition to the abovementioned, the group of patients with surgical pathology differs significantly from the renal group by signs of hypochondriac (Hy) and neurotic (N) types. Response in the hypochondriac type is described above. In neurasthenic response type, behaviour of patients can be described as irritable weakness. Outbreaks of irritation, especially due to pain, discomfort, unfavourable examination data, treatment failure. Irritation is often released at those people who are nearby, and it often ends with remorse and tears. Intolerance of pain.Impatience.Failure to wait for relief. Later – remorse for worries and expansiveness.

Growth in scores of the first block of scales (H, R and S) is characterized by a lower expression of social exclusion of patients due to disease that occurs in patients with renal disease. The second and third blocks include scales which are characterized by the presence of personal maladjustment caused by the disease.

The second block includes the types of response with in trapsychological direction: anxious (A), hypochondria (Hy) and apathy (Ap) typical of the group of SRG patients. Emotional-affective aspect of attitude in patients with these types of response is clinically expressed in reactions of irritable weakness, depression, flight into illness, refusal to fight – surrender to the disease, etc.

The third block of scales contains the individual types of responses to the disease with intrepsychological direction. These types reflect a sensitized attitude to the disease, which is probably most associated with premorbid personality characteristics of patients: sensitive (S), self-centred (I) paranoid (P), dysphoric (D). The above analysis of personality characteristics of patients in different nosological groups suggests that one of these premorbid features is symptoms of cyclothymic type of accentuation, which were found in the groups where sensitive type of attitude to the disease was diagnosed - a group of skin and surgical nosology. Given different

emotional and affective reactions these patients are also characterized by maladaptive behaviour that leads to disruption of their social function: they are either ashamed of their illness, or use it for their own purposes, build paranoid concepts regarding their health, show heterogeneous aggressive reactions blaming surrounding people for their disease, etc.

Thus, the differences underlying the classification of types of attitudes to the disease to the second and third blocks lie in the fact that at close range of emotional and affective reaction of types that make up these blocks reflect the different orientation of maladaptive behaviour. Based on the above analysis we can conclude that the most adaptive response to somatic illness is observed among patients with renaldisorders; respondents with skin diseases are non-adapted by interpsychological direction, and patients requiring surgical intervention (group SRH) also by intrapsychological orientation.

We can also consider the role and place of psychological defence mechanisms in IPD patients with renal, skin and surgical pathology. The results of the comparative analysis are presented in Table 2; based on mean group scoresof compared groups, we developed profiles of psychological defence mechanisms (Fig. 2).

Table 2.

Results of comparing psychological defence mechanisms in SKN, RNL and SRG groups

Para-meters	Arithmetic mean of nosological groups			Results of comparative analysis among the groups					
				SKN-RNL		SKN-SRG		SKN-SRG	
	SKN	RNL	SRG	t-test	p	t-test	p	t-test	p
1	2	3	4	5	6	7	8	9	10
RF	5.52	5.38	6.48	0.189	0.852	-0.857	0.408	-0.992	0.338
DEN	5.18	5.55	5.21	-0.376	0.712	-0.027	0.979	0.336	0.742
SUB	5.27	6.57	4.83	-1.562	0.138	0.436	0.670	1.775	0.098
REG	6.98	5.11	4.80	1.998	0.063	**2.423**	**0.032**	0.386	0.705
COM	5.37	6.12	4.79	-0.841	0.413	0.492	0.631	1.121	0.281
PRO	5.10	5.59	5.06	-0.621	0.543	0.034	0.973	0.529	0.605
DPL	5.09	5.68	6.31	-0.624	0.542	-1.175	0.263	-0.557	0.587
RAT	5.30	5.47	5.87	-0.157	0.877	-0.474	0.644	-0.407	0.690
SKN	5.50	5.76	5.36	-0.260	0.798	0.141	0.890	0.320	0.753

Fig. 2 shows that the shape of psychological defence mechanisms profiles differssignificantly, however, the values from the Table 2 show that statistical significance is only observed at difference in terms of REG (regression) in SKN and SRG groups. This suggests that patients with skin disorders tend to use this mechanism of PD unlike respondents with surgical pathology, who mostly do not use this mechanism to protect the self-concept. In defence mechanism of *regression*, we observe return to earlier, infantile personality reactions that occur in the demonstration of helplessness, dependency, childlike behaviour to reduce anxiety and escape from the demands of reality. Being a psychological defence mechanism, regression refers to a group of manipulative mechanisms. Of the total sample of subjects, it is most peculiar to patients with skin diseases. We can assume that its effect was observed during the comparative analysis by the level of awareness of internal conflicts. A higher level of awareness of the conflict between the level of

achievement and opportunity by SKN respondents may have actually been caused by the effect of regression mechanism rather than by real awareness; when answering the questionnaire abdication of responsibility“ triggered”, typical for the mechanism of regression.

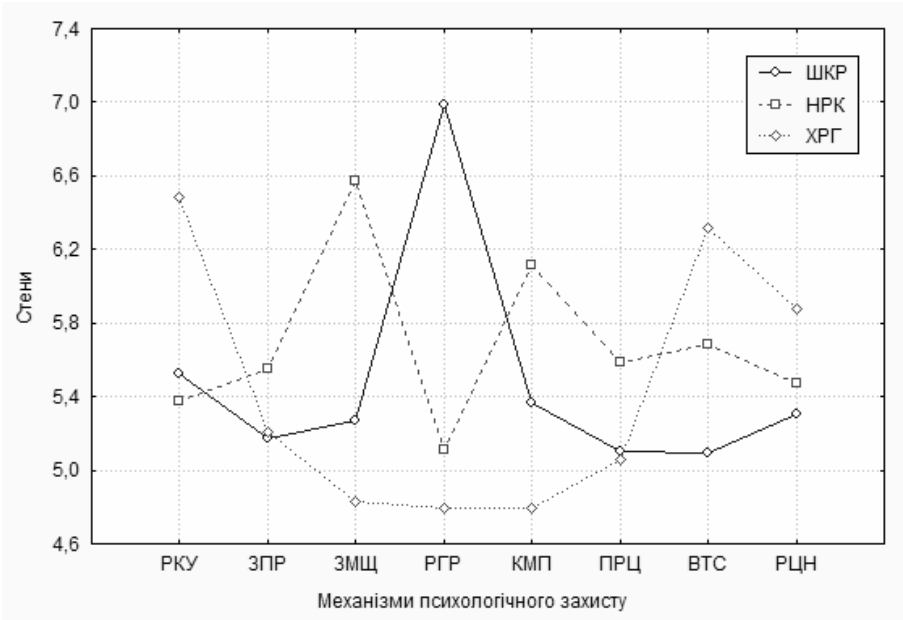

Fig. 2. Psychological defence mechanisms in concepts
of illness of patients with skin, renal and surgical diseases:

RF – reaction formations, DEN – denial, SUB – substitution, REG – regression, COM –compensation, PRO – projection, DPL – displacement, RAT – rationalization.

Analyzing the profiles of psychological defence of patients with skin, renal and surgical pathology, we can say that surgical patients are more prone to reactive formations (RF) and displace ment (DPL), whilerenal patients – to substitution (SUB) and compensation (COM).

Thus, the psychological defence of surgical patients is based on the formation of reaction, which is characterized by the control over negative impulses, emotions, personal qualities by replacing them with the opposites (for example, a patient focused on sexual relationships tends to show anger or disgust reactions to various expressions of sexuality, such as pornography, nudity appearance, kissing of young couple at the park, etc.). At the same time they tend to overlook, ignore the evidence of own misconduct or symptoms, up to complete rejection. Perhaps it is unhelpful prolonged use of displacement mechanism has led to the need for surgical intervention: because most diseases are treated with medication at an earlier stage, and require surgery only in advanced stages.

Psychological defence mechanisms of renal patients (substitution and compensation) are very similar. Substitution is that the real object, which negative feelings can be directed to, is replaced by less dangerous one (e.g., aggression towards authoritative person shifts to dependent people: the person was angry with the bossand scolded at his/her son). Compensation is based on the desire

to achieve success in any field and thus to compensate for failure in the other field due to, for example, lack of physical ability, lack of talent, speech defects. Compensation is often observed where the lack or absence of internal satisfaction with one self, achievements, and spiritual world is replaced by external attributes. For example, a woman can compensate for internal inferiority complex due to a lack of education with the abundance of precious jewellery. A feature common for substitution and compensation is that the efforts of the individual, mental and physical activity are channelled in the wrong direction, replaced or compensated.

Thus, based the above analysis of psychological defence mechanisms in different nosological groups we can make the following conclusions.

1. Patients with skin diseases are mostly characterised by mechanism of regression, surgery patients – reaction formation and displacement, and renal patients – substitution and compensation. Of the three studied nosological groups, patients with renal disease are the most adapted ones, symptoms of anxiety and melancholy are the least pronounced. Behaviour and worries of skin patients are characterised by maladjustment and interpsychological direction (intra personal), and surgical patients by for inter – and intrapsychological orientation, which is characterized by depression, flight into illness and abandonment of the struggle, and maladaptive behaviour, which leads to the violation of social functioning. Thus, the most effective and constructive psychological defence mechanisms in various types of nosological diseases were substitution and compensation (when defence was not carried out in own body or individual, it moved to other object), the ineffective ones are regression, reaction formation and displacement;

2. Long-lasting defence through the mechanism of displacement in surgical patients may explain the psychosomatic disease. Figuratively speaking, repressed psychic energy was 'embodied' in a variety of lesions, which must be removed (all patients, constituting a SRG group require removal of tumour, stones, or purulent accumulations in the maxillary sinuses);

The data obtained force us to use a holistic approach aimed at enhancing adaptive rather than the reduction of maladaptive forces. Under the terms of this approach, efforts in the work with this group of studied patients should be directed primarily at stimulating the body's own resources and adaptive styles of responding to disease.

Author's translation of the article

List of used literature

1. *Артеменко А.* Невротические расстройства у больных псориазом // Медицинская психология, 2008. Т. 3, № 1. С. 57–61.
2. *Вассерман Л., Трифонова Е., Федорова Е.* Внутренняя картина болезни в структуре качества жизни у больных с соматической патологией // Сибирский психологический журнал, 2008. № 27. С. 67–71.
3. *Даниленко Т.* Акцентуации характера и личностные особенности пациентов с кардиофобиями // Медицинская психология, 2010. Т. 5, № 2 (18). С. 62–64.
4. *Исаева Е.* Копинг-поведение и психологическая защита личности в условиях здоровья и болезни. СПб.: Изд-во СПбГМУ, 2009. С. 23–46.
5. *Исаева Е., Дейнека О.* Особенности и проблемные зоны в структуре адаптационных ресурсов личности при социальной и психосоматической дезадаптации // Обозрение психиатрии и медицинской психологии им. В. Бехтерева, 2009. № 3. С. 42–47.

6. *Коростий В.* Механизмы психологической защиты, алекситимия и агрессия у молодых лиц с психосоматическими заболеваниями: патогенетическая роль и подходы к психотерапии // Медична психологія, 2011. № 3. С. 19–22.
7. *Кудинова З.* Особенности стилевых защитных стратегий у девушек-подростков с хроническим гастродуоденитом // Медицинская психология, 2010. Т. 5, № 2 (18). С. 65–69.
8. *Лісова О., Ситник С.* Деформація внутрішньої картини здоров'я у хворих на виразкову хворобу // Психологія. Збірник наукових праць. НПУ ім. М. Драгоманова. К., 2004. Вип. 23. С. 18–29.
9. *Луценко А., Лях С., Аношкин Д.* Типы отношения к болезни у мужчин с ананкастным расстройством личности // Медицинская психология, 2010. Т. 5, № 2 (18). С. 28–30.
10. *Макаренко А.* Особливості механізмів психологічного захисту жінок із дезадаптивними станами внаслідок гістеректомії в ранньому післяопераційному періоді // Медицинская психология, 2010. Т. 5, № 2 (18). С. 95–99.
11. *Маркова М., Піонтковська О., Кужель І.* Проблеми повідомлення діагнозу і спілкування з онкохворою дитиною та її батьками // Медична психологія, 2013. № 1. С. 12–19.
12. *Махнач Л.* Копинг-стратегии у онкологических пациентов с различной степеню эмоциональной дезадаптации // Актуальне психологические исследования, 2010. С. 69–73.
13. *Петролюк З.* Психологічні проблеми жінок, хворих на рак молочної залози // Медицинская психология, 2008. Т. 3, № 1. С. 132–136.
14. *Поляков Ю., Спиваковская А.* Психологическая коррекция: её роль и место в профилактике заболеваний // Современные формы и методы организации психогигиенической и психопрофилактической помощи. Л. 1985.
15. *Ряполова Т.* Роль механизмов психологической защиты в формировании типов приспособительного поведения больных с впервые установленным диагнозом параноидной шизофрении // Медицинская психология, 2009. Т. 4, № 2–3. С. 36–40.
16. *Соколова З.* Психологические особенности больных и межличностные отношения в обеспечении функционирования семьи на ранних стадиях гипертензивной энцефалопатии// Медицинская психология, 2010. Т. 5, № 2 (18). С. 90–94.
17. Методика психологической диагностики способов совладания со стрессовыми и проблемными для личности ситуациями: пособие для врачей и мед. психологов. СПб.: Изд-во НИПНИ им. В. Бехтерева, 2009. С. 12–33.
18. Психологическая диагностика индекса жизненного стиля. СПб: Изд-во НИПНИ им. В. Бехтерева, 2005. С. 41–49.
19. Психологическая диагностика отношения к болезни: метод. пособие. СПб.: С.-Петерб. науч.-исслед. ин-т им. В. Бехтерева, 2005. С. 22–25.

An article received by the Editorial Board 5.02.2014
Accepted for publication 17.02.2014