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Research Paper

Ego Functions, Defense Style & Conflicts: A Psychodynamic Study on Bipolar & Depressive Disorders

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ABSTRACT

The mechanisms of Ego have been proved to play a pivotal role in the psychopathology of mood disorders. The present research endeavors a comparative study on Bipolar and Depressive disorder, from the psychodynamic perspective of Ego functions, Defense style and Conflicts. The study was conducted on 8 Bipolar disorder and 9 Depressive disorders patients in comparison to 10 normal controls. Data were collected using Information Schedule, MINI, HAM-D, YMRS, Ego Functions Assessment Scale-Modified, DSQ-40, SSCT and GHQ-28. Analysis of data was done employing descriptive statistics, Kruskal-Wallis One way Analysis of Variance by Ranks, and Mann-Whitney U test. Results revealed significant difference between bipolar and depressive disorder groups with respect to ego function of Reality testing and defense style of Acting out, but not in any of the areas of conflict. Significant differences between each clinical group and normal control were further obtained with respect to ego functions of Reality testing, Judgment, Regulation and control of drives, affect, impulses, Object relations, Adaptive regression, Synthetic-Integrative functioning, and Mastery competence, with respect to defense styles of Sublimation, Humour, Suppression, Acting out, and Splitting, and in conflict areas of attitude towards Father, Family, Heterosexual relationship, Friends and acquaintances, Own abilities, Past, Future and Goals.

Keywords: *Ego Functions, Defense Style, Conflicts, Psychodynamic Study, Bipolar, Depressive Disorders*

Mental illness is a major concern of distress and disability across the globe. Among all diseases, one psychiatric illness that has come into greater prominence, incidence, and has become a leading cause of global burden in the present-day world is Mood disorders. Mood disorders encompass a large group of disorder in which pathological mood and related disturbances dominate the clinical picture. The two major mood disturbances are the Depressive disorders and bipolar disorders, characterized by "discrete episodes of atleast two weeks duration involving clear cut changes in affect, cognition, and neuro-vegetative functions and inter-episode remissions" (DSM-V, 2013). In depressive disorders, the clinical picture is predominantly characterized by low or depressed mood, loss of interest or pleasure

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and increased fatigability. Bipolar disorder, on the other hand is an unstable emotional condition characterized by cycles of abnormal, persistent high mood called mania, characterized by elation, expansiveness, irritability, pressure of speech, flight of ideas and inflated self-esteem and depression. Psychodynamic theorization can be considered to be the pioneers in endeavouring to explain the psychopathology of mood disorders in a scientific way. This study, therefore, with due reverence to its contributions, endeavours to look into the "inner mind" of mood disorders from the psychodynamic perspective.

According to the psychodynamic conceptualization, Ego development occurs through meeting basic needs, identification with others, learning, mastery of developmental tasks, effective problem-solving, and successful coping. The ego develops operative capacities to function in the world, known as "ego functions" which enable people to function in a coherent and organized manner enabling successful coping with internal demands and environmental conditions, expectations, stresses, and crises. Among the modern ego psychologists who identified the basic ego functions characterizing operations of the ego, Bellak and his co- workers elaborated them into a set of twelve (1973). These are, Reality Testing, Judgment, Sense of reality and self, Regulation and control of drives, affects and impulses, Object relation, Thought Processes, Adaptive Regression, Defensive functioning, Stimulus barrier, Autonomous functioning, Synthetic integrative functioning, and Mastery competence. The usefulness of rating these twelve ego functions lies in the understanding of the etiology of mental disorders aiding for its treatment, prognosis and prevention.

Anna Freud focused her attention on the ego's unconscious, defensive operations and introduced many important theoretical and clinical conceptualizations. In *The Ego and the Mechanisms of Defense* (1936), Anna Freud argued, the ego was predisposed to supervise, regulate, and oppose the id through a variety of defenses. She maintained that everyone, whether normal or neurotic, uses a characteristic repertoire of defense mechanisms, but to varying degrees. Defenses are unconscious and thought to originate in certain psychosexual developmental phases. The purpose of ego defense mechanisms is to protect the self from anxiety or social sanctions and to provide a refuge from a situation with which one cannot currently cope. These are psychological strategies brought into play by the unconscious mind to manipulate, deny, or distort reality in order to defend against feelings of anxiety and unacceptable impulses to maintain one's ego integrity.

George Eman Vaillant (1977) classified, defenses into a continuum related to their psychoanalytical developmental level. These are Narcissistic or pathological, immature, neurotic and "mature" defenses. Narcissistic-Psychotic or Pathological defenses include psychotic denial, delusional projection and distortion that are found in psychotic processes or in dreams or fantasies. The Immature defenses found in neurotic and character disorders include Acting out, Blocking, Hypochondriasis, Introjection, Passive aggression, Projection, Regression, Schizoid fantasy and Somatization. Much common in apparently normal and healthy individuals as well as in neurotic patients, the Neurotic defenses function in channelizing distressing affects into adaptive or socially acceptable forms. These include Controlling, Displacement, Dissociation, Externalization, Inhibition, Intellectualization, Rationalization, Isolation, Reaction formation, Repression, and Sexualization. Finally, the Mature defenses consisting of Altruism, Anticipation, Asceticism, Humour, Sublimation and Suppression, operate in the adaptive integration of personal needs and motives, interpersonal relationships and societal constraints.

Conflict is an inevitable element of human existence. Conflict, be it conscious or unconscious, is an opposition or a tug-of-war between contradictory impulses. According to Freud's structural theory, an individual's libidinal and aggressive impulses are continuously in conflict with his or her own conscience as well as with the limits imposed by society. Unresolved intrapsychic conflict leads to restlessness, uneasiness and disturbance, and can even cause mood dysregulation, anxiety and a variety of psychiatric manifestations. Also interpersonal conflicts in relationship patterns can provoke maladaptive personality characteristics and disturbed adjustments. According to Erik Erikson's (1959) theory of psychosocial development, a conflict is a turning point during which an individual struggles to attain some psychological quality. Karen Horney also maintained that unconscious psychological conflicts formed the basic elements of psychoneurotic difficulties. An important measure for assessing conflicts is the Sentence Completion Test by Joseph M. Sacks & colleagues (1950). It assesses the principal areas of conflict and disturbance of humans in four primary areas of Family, Sex, Interpersonal relationships and Self concept which will be considered in the present study.

The role of the 'ego', its functions, the interpersonal and intrapersonal conflicts it faces, and the defenses it adopts in response to a situation have huge influences in an individual's survival and adaptation, and most importantly on the psychopathology of the disorder or distress he or she suffers. With due regard to the psychodynamic perspective, this present study, therefore, attempts to explore the nature of the ego functions, defense style and conflicts among patients with bipolar and depressive disorder, and in what way they differ to influence the two kinds of mood disorders in individuals.

LITERATURE REVIEW

Scientific studies have provided significant findings that effort to single out and study the factors contributory to mood disorders. The psychodynamic perspective, in terms of the Ego's role have also been studied by many investigators in the context of their contributions to the development of mood disorders, especially bipolar and depressive disorder. Rorschach protocols of three different mood disorder groups: unipolar depressed, bipolar depressed, and bipolar manic demonstrated considerably more impairment in reality testing in Manics as compared to the other two groups (Singer & Brabender (1993). A study conducted by Acharyya and Mukherjee (2012) on the ego-functions, locus of control and cognitive style of the tribal depressive patients of Tripura state showed that the clinically depressed group, compared to the normal control group perceived self as incompetent , and lagged behind in cognitive and motivational aspects having mainly negative Cognitive Style and maladaptive attributional pattern to event outcomes with poorer Ego-Functions of Regulation and control of drives, affect and impulses, Thought process, Object Relation, Adaptive regression, Stimulus Barrier, Defensive functioning, Synthetic Integrative Function and Mastery Competence. A study comparing the ego functions characteristic among 10 destitute women, 15 depressed female patients and 15 normal female subjects using the modified version of Ego Function Assessment (EFA-M), revealed that the normals had significantly better ego functions in all aspects except Sense of reality, and Synthetic Integrative Function (Basu and Chakraborty,1996). Sharma and Sinha (2010) in their study on *Defense mechanisms in mania, bipolar depression and unipolar depression*, compared the use of defense mechanisms in 10 bipolar manic, 10 bipolar depressed and 10 unipolar depressed patients. Both bipolar manic and depressed groups used the defense mechanism of denial where positive relationships were found between severity of manic symptoms and the defense mechanisms of denial as well as the narcissistic level defenses. The bipolar

depression group also used more action level defenses as compared to the unipolar depression group. The neurotic level defenses were used most frequently by unipolar depression group, followed by the bipolar depression group and manic group. Not many studies have been documented to have explored the role of conflicts in the psychopathology of mood disorders in the past. Findings, however, have shown high intrapersonal conflicts with regard to the goals and values and interpersonal conflicts in depression (Stangier et al.,2007, Michalak et al. 2011).

Objectives of the present study:

Keeping in view of the concepts, findings and reports of the past studies, the present study endeavours to deal with the following objectives:

1. To determine whether there is a significant difference among the three groups of subjects, viz., Bipolar disorder, Depressive disorder and Normal control with respect to each of the twelve Ego functions, namely, Reality Testing, Judgment, Sense of reality and self, Regulation and control of drives, affects and impulses, Object relation, Thought Processes, Adaptive Regression, Defensive functioning, Stimulus barrier, Autonomous functioning, Synthetic integrative functioning, and Mastery competence.
2. To determine whether there is a significant difference among the three groups of subjects, viz., Bipolar disorder, Depressive disorder and Normal control with respect to the different Defense styles, under the domains of
    - Mature defenses that include Sublimation, Humour, Anticipation and Suppression,
    - Neurotic defenses that include Undoing, Pseudo-altruism, Idealisation and Reaction formation, and
    - Immature defenses that include Projection, Passive aggression, Acting Out, Isolation, Devaluation, Autistic fantasy, Denial, Displacement, Dissociation, Splitting, Rationalization and Somatization.
3. To determine whether there is a significant difference among the three groups of subjects, viz., Bipolar disorder, Depressive disorder and Normal control with respect to the various Conflicts under the following areas:
    - Family Area that includes attitude towards Mother, Father and Family unit
    - Sex Area that includes attitude towards Women and Heterosexual relationship
    - Interpersonal relationship that includes Friends and acquaintances, Superior at work or school, People supervised, and Colleagues
    - Self-Concept Area that includes Fears, Guilt feelings, Own abilities, Past, Future and Goals.

Sample

The sample for the present study comprised of 8 Bipolar depression patients, 9 Unipolar depression and 9 normal controls with age between 25 to 40 years, being residents of suburban and urban areas of West Bengal, with minimum educational qualification of class X and having Bengali as mother tongue were taken using purposive sampling technique and matched with respect to the socio-demographic variables of gender, age, educational qualification, marital status and family income. Those with severe depressive and/or manic state with psychotic symptoms were not included.

Tools used

The instruments used in the present study included an Information Schedule, The Mini International Neuropsychiatric Interview (M.I.N.I.) (Sheehan et al. 1998), The Hamilton Depression Rating Scale (HDRS) (Max Hamilton, 1960), Young Mania Rating Scale (YMRS) (Young, 1978), Ego Functions Assessment Scale- Modified (EFA-M) (Basu J and Bannerjee M,1998), (Defense Style Questionnaire-40 (DSQ-40) (Bond M.,1992), Sack's Sentence Completion Test (SSCT) (Sacks, Joseph M., and Levy, 1950), and General Health Questionnaire Bengali adapted version(GHQ-28) (Basu & Dasgupta, 1996).

Procedure

After the initial decision and procedures regarding the design of the study, permissions and legal consent from the ethical committee for the research purpose of collection of data were sought from a government hospital of Kolkata. Data were obtained from patients attending the out patients department of the hospital who were already diagnosed and undergoing treatment by the psychiatrists of that hospital. Data for the normal control group was taken from the community, who were screened for absence of any psychiatric disorder using the Mini International Neuropsychiatric Interview (M.I.N.I.), and for other psychiatric morbidity using the General Health Questionnaire (GHQ-28). It took about one hour to take data from each subject. The total data collection procedure was completed in about a month time. Each datum was scored according to the standard procedure and the obtained data were arranged systematically and treated statistically.

RESULTS

The obtained data were treated statistically using nonparametric statistical tests. Kruskal-Wallis One way Analysis of Variance by Ranks was used to test the significance of difference among the three groups, viz., Bipolar Disorder, Depressive Disorder and Normal Controls in each of the measures of Ego Functions, Defense Styles, and Conflicts. If the Kruskal-Wallis test showed a significant difference, the subsequent analysis was attempted for multiple comparisons using Mann-Whitney U test by which the significance of difference between the two groups taken at a time was tested for the same measure (Siegel, S. 1956).

When the three groups of Bipolar, Depressive and Normal Controls were compared using Kruskal Wallis ANOVA, the findings revealed significant difference with respect to the Ego functions of Reality testing ($KW= 12.620$; $df=2$; $p<0.01$), Judgment ($KW= 10.635$; $df=2$; $p<0.01$), Regulation and control of drives, affect and impulses ($KW= 7.648$; $df=2$; $p<0.05$), Object relations ($KW= 9.648$; $df=2$; $p<0.01$), Adaptive regression ($KW= 6.330$; $df=2$; $p<0.05$), Synthetic-Integrative functioning ($KW= 11.945$; $df=2$; $p<0.01$) and Mastery competence ($KW= 6.878$; $df=2$; $p<0.05$).

Significant differences among the three groups were found with respect to the Defense styles of Sublimation ($KW= 11.217$; $df=2$; $p<0.01$), Humour ($KW= 6.290$; $df=2$; $p<0.05$), Suppression ($KW= 9.969$; $df=2$; $p<0.01$), Acting out ($KW= 8.029$; $df=2$; $p<0.05$), and Splitting ($KW= 6.878$; $df=2$; $p<0.05$) .

In case of Conflicts significant differences were shown in the areas of Father ($KW= 9.405$; $df=2$; $p<0.01$), Family unit ($KW= 9.958$; $df=2$; $p<0.01$), Heterosexual relationship ($KW= 7.958$; $df=2$; $p<0.05$), Friends and acquaintances ($KW= 8.054$; $df=2$; $p<0.05$), Own abilities

(KW= 14.130; df=2; p<0.01), Past (KW= 8.513; df=2; p<0.05), Future (KW= 7.908; df=2; p<0.05) and Goals (KW= 8.941; df=2; p<0.05).

The final part of the study, constituted comparing two clinical groups at a time using Mann Whitney U Test. On comparing the Bipolar & Depressive disorder groups it was found interestingly that significant difference exists with respect to the ego functions of Reality testing (U=13.000; p<0.01) and the defense styles of Acting out (U=9.000; p<0.01) no difference with respect to any areas of conflicts.

While comparing Bipolar & Normal Control groups significant differences were obtained in the Ego functions of Reality testing (U=2.000; p<0.01), Judgment (U=2.000;p<0.01), Regulation & Control (U=15.500; p<0.05), Synthetic-Integrative functioning (U=5.000;df= 1;p<0.01) and Mastery competence (U=14.500 ; p<0.05); with respect to Defense styles of Sublimation (U=4.500;p<0.01), Suppression (U=7.000;p<0.01) and Splitting (U=9.000;p<0.01) and in the Conflict areas of Father (U=7.000; p<0.01), Family unit (U=11.500; p<0.01), Own abilities (U=2.000;p<0.01), and Past (U=9.500; p<0.01).

Finally on comparing Depressive & Normal Control groups significant differences were found with respect to the Ego functions of Judgment (U=18.500;p<0.05), Regulation & Control (U=10.000 ;p<0.01), Object relations (U=2.000; p<0.01), Adaptive regression (U=11.500; p<0.01), Synthetic-Integrative functioning (U=8.000; p<0.01) and Mastery competence (U=13.000; p<0.01); in the Defense styles of Sublimation (U=11.000;p<0.01), Humour (U=12.500; p<0.01), Suppression (U=13.000; p<0.01), Acting out (U=17.500; p<0.05), & Splitting (U=9.000; p<0.01); and in the conflict areas of Family unit (U=10.000; p< 0.01), Heterosexual relationship (U=7.500; p< 0.01), Friends and acquaintances (U=9.000;p< 0.01), Own abilities (U=11.500; p< 0.01), Past (U=14.000; p< 0.05), Future (U=11.000; p< 0.01), & Goals (U=8.000; p< 0.01).

DISCUSSIONS

The findings obtained from the present study appear to have revealed certain interesting trends with respect to the Ego's influence in development of psychopathology of Mood disorders. The results obtained with respect to the difference between Bipolar and Depressive disorder have shown significant difference only in the ego function of Reality testing (p<0.05), and have provided non-significant differences in all of the other ego functions. The Bipolar group have been found to be more vulnerable than patients suffering from Depressive disorder, in their ability to rightly test reality.

As bipolar disorder, also known as affective psychosis or manic-depressive psychosis (a term coined by Emil Kraepelin in 1902) involves underlying psychotic process and also share some psychosocial and genetic psychopathology similar to schizophrenia, reality testing is one ego function which becomes impaired highly in case of bipolar disorder. In similar terms, it can be said that an absence of psychotic process in depressive disorders (neurotic depression) safeguards one's ability to accurately test the reality of one's internal and external environment. This findings appear to be supported by a study by Hansen et al., (2012) conducted with patients suffering from schizophrenia and bipolar disorder, and healthy controls who assessed their reality testing using the Reality Testing Inventory (BORRTI) and concluded presence of Reality Testing deficits both in Schizophrenic and Bipolar Disorder patients. Another study conducted in Israel by Mandel, Last, Belmaker, & Rosenbaum (1984), evaluated Rorschach protocols of 35 bipolar patients in a euthymic state

with Exner's normative group (Exner, 1978) and found low Reality testing. Further support has been obtained from an investigation by Singer & Brabender (1993) who compared Rorschach protocols of three different mood disorder groups: unipolar depressed, bipolar depressed, and bipolar manic. The results found that Manic subjects demonstrated considerably more impairment in reality testing compared to the other two groups.

In the ego functions of Reality testing, Judgment, Regulation of control, Object relations, Adaptive regression, Synthetic-Integrative functioning and Mastery competence, both the clinical groups of Bipolar and Depressive disorder have shown significant vulnerabilities and weaker ego functioning as compared to their normal counterparts which have been corroborated with a number of researches found in the literature. A study conducted by Basu et al. (1998) on ego functions with depressives, diabetics and normals revealed that the depressive group showed greater impairment in ego functions than the normals and diabetics.

Furthermore, in this study, the depressed patients' *Regulation of control over drives, impulses and affects* was found to be poorer than the Normal Control group which was also shown by an Egyptian study on depression by El Ray (1988) where ego functions of reality testing, sense of reality, regulation and control, object relations, defensive functioning were assessed for major depressive patients using the Bender Gestalt test viz., revealing that disturbances were of a moderate degree (approximately 60% impairment) with the lowest score for regulation and control and highest for defensive functioning. Also, finding of poor *Adaptive regression* among the depressive group is also found to be in line with the research finding of Basu and Chakraborty (1996) who compared the ego functions of 10 destitute women, 15 depressed female patients and 15 normal female subjects, and found that depressed patients had lower flexibility or adaptive regression than the other groups. The scores on *Synthetic Integrative Functioning (SIF)* and *Mastery Competence* were found to be lower than the normals which holds support by a similar study by on tribal depressive patients which showed that poor competence mastery, poor cognitive functioning and lack of integrity between the thought and action, as reflected by their poorer (SIF) further contributed to their depressed status. Lower scores on *Object Relation* in case of depressives, as obtained in the present study has been also corroborated revealing that subjects reporting more depression had significantly earlier developmental levels of object relations and cognition than those reporting less depression (Goldberg, 1984; Acharyya et.al 2012). In the present study, patients with depression had significantly lower capacities for *Judgment* than normals. The ego functioning of judgment which involves the capacity to identify a possible course of action and to anticipate and weigh the consequences of behavior in order to engage in appropriate action, becomes significantly impaired during a depressive reaction and manifests in the form of difficulty to make decisions appropriately.

Findings Obtained on Defense Style

Statistical comparison of the two clinical groups of Bipolar and Depressive disorder with respect to their defense styles revealed significant differences in the defense of Acting out ($p<0.01$) and non-significant difference in all of the rest defenses. These defenses have been further found to be higher in bipolar patients as compared to the depressives.

Acting out is an immature defense that refers to the direct expression of an unconscious wish or impulse in action to avoid being conscious of the accompanying affect. The unconscious fantasy, involving objects, is lived out and impulsively enacted in behavior, thus gratifying

the impulse more than the prohibition against it (Kaplan et al. 2009). The inherent tendency for the predominance of this defense in Bipolar patients, as compared to depressives and normal controls as found in the present study, can be well explained by the clinical manifestation of bipolar disorder, where patients tend to indulge in sexual and economic indiscretions along with aggressive and impulsive behaviours. According to Aiello (1999), "acting out is a manic defense, an attempt to deal with loss by moving too quickly into action that is ultimately destructive". Furthermore, A number of mature defenses work by helping people to gain perspective on their problems.

The two groups of Bipolar disorder and Normal control have shown highly significant differences with respect to the defense styles of Sublimation ($p<0.01$), Suppression ($p<0.01$) and Splitting ($p<0.01$) whereas on comparing depressives and normal controls, significant differences were shown on Sublimation ($p<0.01$), Humour ($p<0.05$), Suppression ($p<0.05$), Acting out ($p<0.05$), and Splitting ($p<0.01$). The obtained results further show that their median values and mean ranks are greater in Bipolar and depressive patients than that of normal controls. In Sublimation, people consciously redirect energies away from unacceptable impulses and put them to productive use into an acceptable and constructive activity. Suppression involves the conscious or semiconscious decision to postpone attention to a conscious impulse or conflict. Both of these mature defences are found to be lower in bipolar subjects as compared to normal controls in the present study. As also shown in a study by Sharma and Sinha (2010), both bipolar manic and bipolar depressed groups used the immature defenses significantly more than the unipolar depression group. The bipolar depression group also used more action level defenses as compared to the unipolar depression group according to their study.

Findings Obtained on Conflicts

Although the groups of bipolar and depressives was not found to differ among each other, the two groups on comparing with their normal counterparts have indicated presence of significantly higher level of conflicts with several conflict areas of Family, Sex, Interpersonal relationship, and Self concept.

Conflictual family environment and life stressors, are correlated with symptom severity in both bipolar and depressive disorders (Hammen et al., 1992; Ellicot et al., 1989). Conflicts in Self concept, especially with regard to *Own Abilities*, as found in the present study, were higher in the clinical groups. It has been found that similar to patients with depression, bipolar disorder patients also exhibit low self-esteem; attributions of failure are correlated with depression severity in both the disorders (Seligman et al., 1975). The obtained results show more severe *Goal* conflicts in depressives as compared to the non clinical group, which is also in line with the findings of a study by Michalak et al., 2011 which showed that high levels of goal conflicts were associated with increased levels of negative affect, depression, neuroticism, and psychosomatic complains. There was a significant conflict obtained in the Self concept area of *Future* when compared with controls which is in accordance with the depressive's negative views about future (Beck, 1967), hopelessness and an expectation that desirable outcomes will not occur (Abramson, Metalsky, & Alloy,1989). Also, a higher conflict in the Sex area of heterosexual relationship in depressed group is supported by Beach's (1990) Marital discord model of depression which suggests that disturbance in the marital relationship is a powerful predictor of future depression symptoms. The interpersonal relationship area of *Friends and Acquaintances* has also revealed higher conflict among depressives in the present study. A study by Christine A.

Calmes (2008) on the relationship between co-rumination, relationship satisfaction and emotional distress, also reflect that depression was significantly positively correlated with friendship conflict and negatively correlated with friendship satisfaction. Moreover, depressed people may actually behave in ways that have a genuinely negative effect on other people, thus alienating themselves from friends (Coyne, 1976).

The two types of mood disorders are found to be close to each other in most of the psychodynamically oriented functions as investigated in the present study. The case histories and interview of the patients revealed that there were many similarities in the pattern of intrapersonal and interpersonal distress, events, life situations and factors that triggered the onset of their psychiatric suffering. Several stressful life events and factors such as death of loved ones, getting burnt in accident, sexual assault, marital disharmony, failure at work and romantic relationship, and economic deprivation were found to be common and similar in the patients of both the clinical groups of bipolar and depressive disorder, as found in the present study. Yet the emotional and behavioural manifestations, in the two disorders, seemed to be making their expression in extremes. Although much of the various cognitive, neurobiological and other psychological factors have their role to play in the genesis of these two affective disorders, it may be safely and humbly attributed to the characteristics of these two components of the structure of the ego, that is the ego function of reality testing and defense style of acting out, may have, thus, contributed to the development of psychopathology in these two forms of mood disorders differently.

Limitation

Due to time constraints compromises had to be made with respect to sample size. Larger sample taken from different parts of the city would have lead to greater generalizability of the findings.

TABLES

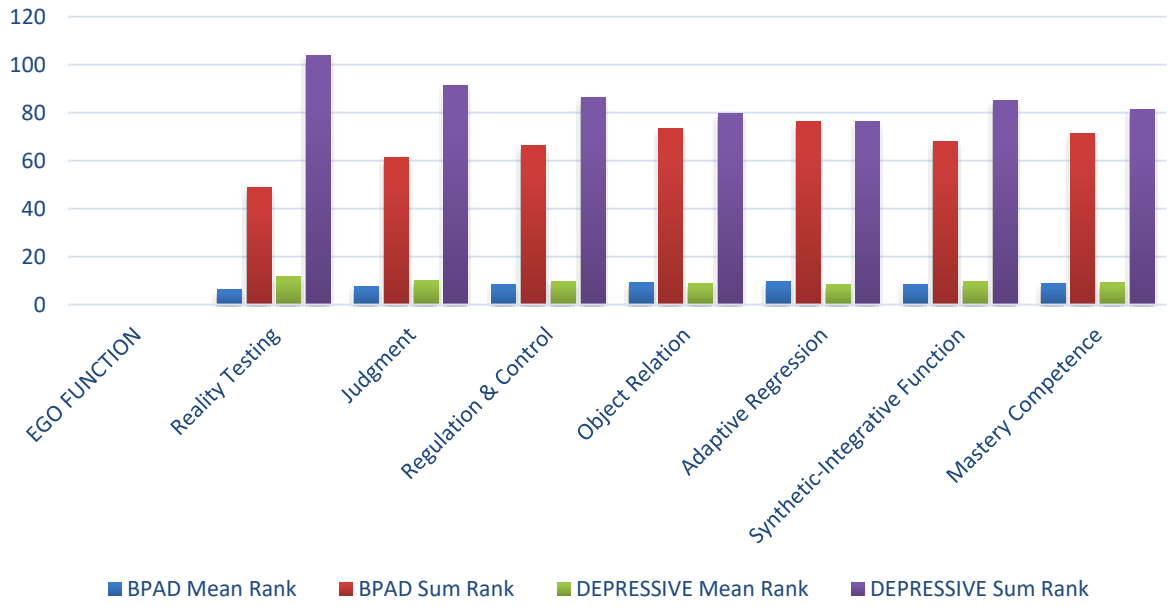
Tables representing the Mean rank, Sum of ranks and U values for the significance of difference between two groups, viz., Bipolar and Depressive disorders in each of the Ego functions (Table 1) and Defense Style (Table 2)

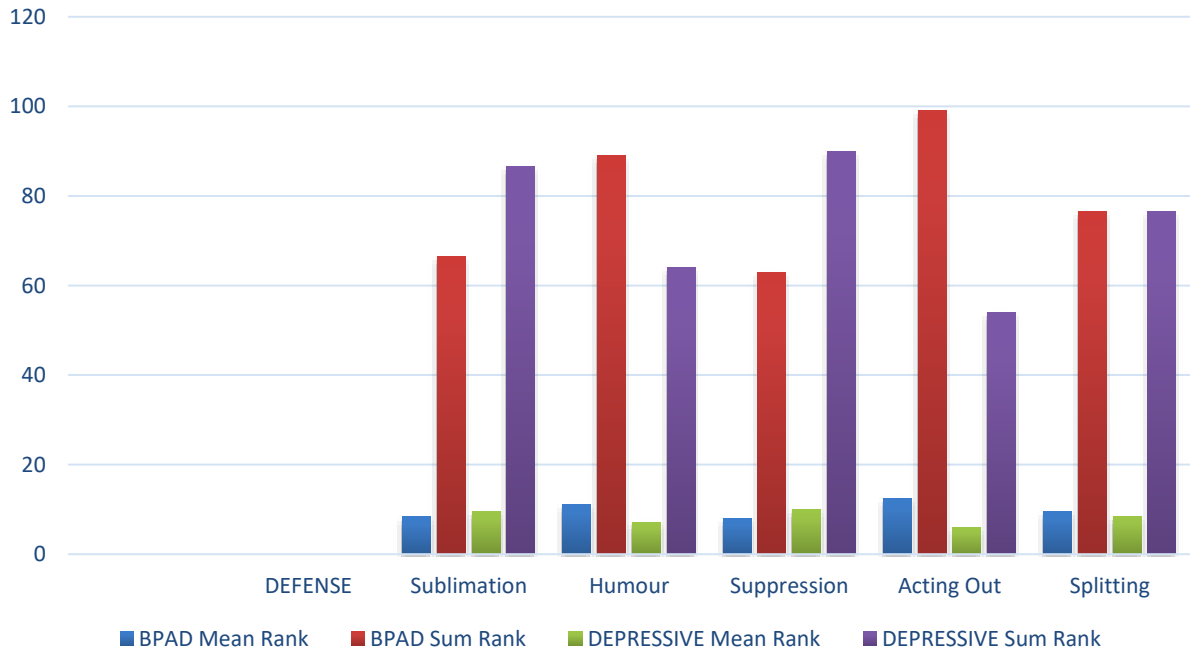
Table 1

GROUPS COMPARED	**BIPOLAR DISORDER (N=8)**		**DEPRESSIVE DISORDER (N=9)**		
STATISTIC EGO FUNCTION	MEAN RANK	SUM OF RANKS	MEAN RANK	SUM OF RANKS	U VALUE
Reality Testing	6.13	49.00	11.56	104.00	13.000*
Judgment	7.69	61.50	10.17	91.50	25.500
Regulation & Control	8.31	66.50	9.61	86.50	30.500
Object Relation	9.19	73.50	8.83	79.50	34.500
Adaptive Regression	9.56	76.50	8.50	76.50	31.500
Synthetic-Integrative Function	8.50	68.00	9.44	85.00	32.000
Mastery Competence	8.94	71.50	9.06	81.50	35.500

Table 2

GROUPS COMPARED	BIPOLAR DISORDER (N=10)		DEPRESSIVE DISORDER (N=10)		
STATISTIC DEFENSE	MEAN RANK	SUM OF RANKS	MEAN RANK	SUM OF RANKS	U VALUE
Sublimation	8.31	66.50	9.61	86.50	30.500
Humour	11.13	89.00	7.11	64.00	19.000
Suppression	7.88	63.00	10.00	90.00	27.000
Acting Out	12.38	99.00	6.00	54.00	9.000**
Splitting	9.56	76.50	8.50	76.50	31.500





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Conflict of Interest

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