

Differences in Ego Functions between Those with Tendency to Atypical Depression and Those with Tendency to Melancholic Depression

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Abstract

This study aimed to clarify ego functions of the university students having a tendency to atypical depression by comparing those with other students having a tendency to melancholic depression and borderline personality disorder. The answers to the questionnaires were obtained from 278 university students. The results showed that no difference was found in the total scores of ego functions and the scores of the sub-scales such as “synthetic-integrative functioning,” “sense of reality,” “control of impulses,” “objective relation,” “stimulus barrier,” and “autonomous functioning” between the students having a tendency to atypical depression and those having a tendency to melancholic depression; while the scores of the “defensive functioning,” one of the ego functions, were significantly higher in the students having a tendency to atypical depression than in those having a tendency to melancholic depression. This suggested that the students having a tendency to atypical depression may have a higher function of protecting their ego from conflicts than those having a tendency to melancholic depression.

Keywords

Tendency to Atypical Depression, Ego Functions, Tendency to Melancholic Depression, Defensive Functioning

1. Introduction

As the percentage of students enrolling in universities has been increasing in Japan, special attention has been paid to the problem of university students' mala-

daptation. In particular, “escape” can be mentioned as one of the behaviors exhibited by the maladaptive university students, but may be often mistaken for idleness or dependence (Takehata & Sase, 2015). However, some of the university students whose behaviors appear to be idle or excessively dependent may actually suffer from certain mental problems.

Atypical depression is one of the mental diseases often mistaken for idleness and dependence. The number of patients with atypical depression has been recently increasing, especially among the younger generation. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) defines the cardinal symptom of atypical depression as “mood reactivity.” More specifically, patients with atypical depression usually indicate a depressive mood, but brighten the mood in response to actual or potential positive events. For example, the university students with atypical depression indicate a depressive mood in attending a lecture or taking an examination, but they can enjoy dating without indicating a depressive mood. Such clinical pictures of the patients with atypical depression may occasionally be mistaken for the signs of idleness and dependence (Denda, 2009). There is a possibility that not a few university students suffer from maladaptation due to atypical depression among the students appearing idle or dependent. In light of this, it is necessary to take measures for supporting such latent patients in addition to the students slightly indicating the clinical pictures of atypical depression.

Drug therapy with monoamine oxidase inhibitors has been considered to be an effective method for treating the patients with atypical depression. However, this method has the problem of the serious side effect. In the clinical field, therefore, the selective serotonin reuptake inhibitors with fewer side effects are frequently used (Nierenberg, Alpert, Pava, Rosenbaum, & Fava, 1998). However, it is reported that the efficacy of the selective serotonin reuptake inhibitors on the patients with atypical depression is limited (Singh & Williams, 2006). Meanwhile, the patients with atypical depression and those with borderline personality disorder show some similarities in the clinical pictures and the attitudes (Perugi et al., 1998; Perugi & Akiskal, 2002), which leads to the assumption that atypical depression may stem from the problem of patient’s personality (Fukunishi & Fukunishi, 2013). Understanding of the psychological mechanisms of atypical depression is therefore considered to reveal clues about how to effectively support the students having a tendency to atypical depression.

The case studies of psychotherapy become useful means for understanding the psychological mechanisms of the corresponding diseases. The case studies dealing with the clinical pictures related to atypical depression are present (e.g., Tokioka, 2015), but the number is not sufficient. In other words, the psychological mechanisms of atypical depression have not yet been fully clarified.

There is a report about the comparison of the therapeutic effects on the depressions, not specifying atypical depression, between psychoanalysis and cognitive behavioral therapy (Huber, Zimmermann, Henrich, & Klug, 2012). The

results indicate that both the psychoanalysis and the cognitive behavioral therapy produce the respective effects, but the effect of the psychoanalysis is found to last longer. It is speculated that the reason for this is that the psychoanalysis could bring some changes to the patients' personality structure (Huber et al., 2012; Fonagy et al., 2015). With the problem of personality in atypical depression being taken into account, it is considered useful to go into the psychological mechanisms of atypical depression from the viewpoint of psychoanalysis.

In the psychoanalysis, great importance has been placed on assessment of the patients' ego functions (Bellak, Hurvich, & Gediman, 1973). The ego functions mean psychological functions to support individual adaptation, including the capacity of evolving the interpersonal relationships (objective relation), the defensive functioning to adjust individual adaptation against conflicts and stresses, the function of testing reality that provides the basis for perceiving the external events and understanding those events correctly, and the like. However, the ego functions of patients with atypical depression have not yet been fully studied. In contrast to this, the ego functions of the patients with melancholic depression and borderline personality disorder have been understood to some extent. In addition, the relations of melancholic depression with atypical depression have been studied (Rodgers et al., 2016), and similarities between borderline personality disorder and atypical depression have been demonstrated (Perugi et al., 1998). In light of the above, studies on melancholic depression and borderline personality disorder should help us understand the ego functions of patients with atypical depression.

Kernberg (1976) proposed the organization of character pathology. The organization of character pathology is a concept related to ego functions because the character pathology is classified based on the object relations, defensive functioning, development of superego and the like. The organization of character pathology assumes the following three levels: 1) higher level of organization of character pathology, including hysterical character and depressive-masochistic character; 2) intermediate level of organization of character pathology, including sadomasochistic character and narcissistic personality; and 3) lower level of organization of character pathology, including paranoid personality and borderline character. According to Kernberg (1976), the patients with melancholic depression are considered to have a depressive-masochistic character, so that they are assumed to be in the higher level of organization of character pathology. In contrast, the patients with borderline personality disorder are considered to have a borderline character, so that they are assumed to be in the lower level of organization of character pathology. Although there is no explicit suggestion about the organization of character pathology of the patients with atypical depression, they may be assumed in the lower level because the patients with atypical depression and those with borderline personality disorder are alike in the clinical pictures and attitudes (Perugi & Akiskal, 2002; Kaiya, 2008). Accordingly, the ego functions of the patients with atypical depression and borderline personality

disorder are assumed to be lower than those of the patients with melancholic depression. However, when compared with the patients with borderline personality disorder, the patients with atypical depression are considered to be able to more properly evaluate the relationships with other people except their therapists (Kaiya, 2008), so that the level of their reality testing ability may be higher. For these reasons, it is speculated that the ego functions of the patients with atypical depression may be better than those of the patients with borderline personality disorder. For clarifying the ego functions of the university students having a tendency to atypical depression in this study, we tried to examine the above-mentioned hypotheses by comparing the university students having a tendency to atypical depression with those having tendencies to melancholic depression and borderline personality disorder. This study can reveal the ego functions of those having a tendency to atypical depression, which have not been fully found out in the past. We therefore believe this study will contribute toward discussing how to support the university students with a tendency to atypical depression.

2. Methods

2.1. Sample

We conducted a questionnaire study, targeting Japanese students of a provincial private university. Questionnaires were distributed to the students in a liberal arts class, who belonged to various departments and totaled 278. First, we orally informed the students about what our study consisted of and that participation into this study was optional. Then, we asked the students to fill in the questionnaires after obtaining their consent. By excluding the questionnaires not completely filled in, 244 valid responses were received from 77 male students and 167 female students, with the average age of 19.8 ($SD = 1.2$). This study was conducted after gaining approval from the Ethical Review Committee of Kawasaki University of Medical Welfare (No. 16-063).

2.2. Measurements

2.2.1. Depression Subtypes

The Global Scale for Depression (GSD; Fukunishi & Fukunishi, 2012) was used to determine the depression subtypes. The GSD is a 30-item instrument designed to assess the potential presence of depressions in two stages. The presence and the degree of depression can be evaluated from 17 items on the first stage. The subjects responded to each question on a three-point scale, and the subjects having the total scores of 30 or more were assessed to have any depression. Then, the depression subtypes were determined on the second stage using 13 items. Each of the 13 items has three response options: the first response option corresponding to a clinical picture of atypical depression, the second response option corresponding to a clinical picture indicating neither atypical depression nor melancholic depression, and the third response option corresponding to a

clinical picture of melancholic depression. The subjects having the total score of -3 or less were assessed to have clinical pictures of atypical depression; and those having the total score of $+3$ or more, clinical pictures of melancholic depression. The reliability and the validity of the GSD have been confirmed by Fukunishi & Fukunishi (2012).

2.2.2. Borderline Personality Disorder

The Millon Clinical Multiaxial Inventory-II Borderline Scale short version (MCMI-II; Izawa, Ohno, Asai, & Okonogi, 1995) was used for determining the presence of borderline personality disorder on a two-point scale. This scale is shorted through the results of the item analysis of MCMI-II Borderline Scale designed by Millon (1987). The MCMI-II consists of 17 items. The subjects having a total score of 10 or more were assessed to have borderline personality disorder. The reliability and validity of the MCMI-II have been repeatedly confirmed by Izawa et al. (1995), Izawa (1999) and the like.

2.2.3. Ego Functions

The Ego Function Inventory (EFI; Nakanishi & Sakata, 1989) was used for rating ego functions on a five-point scale. The EFI was prepared by revising the Ego Function Inventory (Nakanishi & Furuichi, 1981), which was a short version of the Ego Function Assessment designed by Bellak et al. (1973). The EFI has 42 items, each of which has five response options. The higher the total score, the more smoothly the whole ego functions are considered to work. The ego functions consist of seven subscale functions, which can separately be rated by the six items. As the score of each subscale function becomes higher, the condition of the corresponding function is considered to be better. The reliability and validity of the EFI have been confirmed by Nakanishi & Sakata (1989).

3. Results

3.1. Group Classification

The cutoff points obtained from the results of the GSD (the second stage) and the MCMI-II were used for classification, and the subjects were classified into four groups. Consequently, the group with a tendency to atypical depression consisted of 33 subjects (including 11 males and 22 females) showing the clinical pictures of atypical depression; the group with a tendency to melancholic depression consisted of 46 subjects (including 16 males and 30 females) showing the clinical pictures of melancholic depression; the group with a tendency to borderline personality disorder consisted of 8 subjects (including 5 males and 3 females) showing the symptoms of borderline personality disorder; and the last group consisted of 145 subjects (including 43 males and 102 females) showing neither clinical pictures of atypical depression or melancholic depression, nor symptoms of borderline personality disorder. The twelve subjects' data were omitted because their data can be classified into a plurality of groups. However, the number of the subjects belonging to the group having a tendency to borderline

personality disorder was considered to be too small to be subjected to generalization, so that this group was removed from the analysis.

3.2. Differences between the Sexes

The *t*-test was used to assess whether the males and the females were different from each other in the results from the above-mentioned scales (Table 1). The males showed significantly lower scores than the females in one of the subscale functions, “synthetic-integrative functioning.” This result was the same as that in Nakanishi & Sakata (1989). In contrast, the males showed significantly higher scores than the females in another subscale function, “control of impulses.” The function of “control of impulses” is proved to decrease until about thirty and then gradually increase both in males and females (Nakanishi & Sakata, 1989). In addition, the function of “control of impulses” is found to be higher in males than females at lower ages (Nakanishi & Furuichi, 1981). In light of the above, the sexual differences in “synthetic-integrative functioning” and “control of impulses” recognized in this study are not considered to be peculiar results.

3.3. Differences in Ego Functions

This study aimed to clarify ego functions of the university students having a tendency to atypical depression by comparing those with other students having a tendency to melancholic depression and borderline personality disorder. However, the number of the students having a tendency to borderline personality disorder was so small that they were excluded from the following analyses. Accordingly, the students having a tendency to atypical depression were compared with those having a tendency to melancholic depression in the analyses to be described later.

The one-way analysis of variance (one-way ANOVA) was conducted, with the groups, i.e., the group having a tendency to atypical depression (AD), the group having a tendency to melancholic depression (MD), and the group having no tendency to atypical depression or melancholic depression (ND) being set as the

Table 1. Means (*SD*) of scores in males and females and results of *t*-test.

	Males	Females	<i>t</i>
GSD (First stage)	28.77 (6.71)	30.59 (7.52)	1.73
MCMII-II	3.33 (2.59)	3.11 (2.66)	0.57
Ego functions	132.31 (16.50)	129.98 (18.88)	0.89
Synthetic-integrative functioning	16.89 (3.54)	18.44 (3.54)	3.05**
Sense of reality	19.76 (3.83)	19.88 (4.48)	0.20
Control of impulses	19.50 (4.15)	17.65 (4.01)	3.17**
Objective relation	18.73 (3.60)	18.40 (3.80)	0.61
Defensive functioning	19.24 (3.35)	18.65 (3.36)	1.23
Stimulus barrier	21.00 (3.80)	19.92 (4.22)	1.83
Autonomous functioning	17.20 (3.35)	17.03 (3.57)	0.33

Note: ** $p < 0.01$.

independent variables and the means of the total scores of ego functions as the dependent variables. The results showed a significant main effect ($F(2, 221) = 4.77, p < 0.01$), so that multiple comparison was made according to the Bonferroni method. The results showed that the mean total score of the ND was significantly higher than that of the MD ($p < 0.05$), but no significant difference was found between the AD and the MD, and between the AD and the ND.

To examine the ego functions in detail, the one-way ANOVA was conducted, with the groups, i.e., the AD, MD and ND being set as the independent variables and the mean score of each subscale from ego functions as the dependent variables. As a result, there was no significant difference in the subscale scores of “synthetic-integrative functioning,” “objective relation” and “autonomous functioning” ($F(2, 221) = 2.39, ns$; $F(2, 221) = 2.32, ns$; and $F(2, 221) = 1.47, ns$, respectively). On the other hand, there were significant main effects in the subscale scores of “sense of reality,” “control of impulses,” “defensive functioning” and “stimulus barrier” ($F(2, 221) = 7.79, p < 0.001$; $F(2, 221) = 3.11, p < 0.05$; $F(2, 221) = 5.57, p < 0.01$; and $F(2, 221) = 3.64, p < 0.05$, respectively), so that the multiple comparison was made according to the Bonferroni method. The results showed that the mean score of the AD was significantly lower than that of the ND in “control of impulses ($p < 0.05$),” and the mean score of the AD was significantly higher than that of the MD in “defensive functioning ($p < 0.05$).” As for “sense of reality” and “stimulus barrier,” the mean scores of the ND were significantly higher than those of the MD ($p < 0.05$), but there was no significant difference in the mean scores between the AD and the MD, and between the AD and the ND. **Table 2** shows the mean total scores of ego functions and the mean

Table 2. Mean scores (*SD*) of three groups and results of one-way ANOVA and multiple comparison.

	AD	MD	ND	<i>F</i>	Bonferroni
Ego functions	128.30 (12.71)	124.30 (17.70)	133.29 (18.87)	4.77**	ND > MD
Synthetic-integrative functioning	16.70 (3.10)	18.17 (3.57)	18.17 (3.69)	2.39	
Sense of reality	19.97 (3.93)	17.72 (4.52)	20.49 (4.09)	7.79***	ND > MD
Control of impulses	16.61 (5.40)	18.30 (3.87)	18.57 (3.82)	3.11*	ND > AD
Objective relation	18.85 (2.95)	17.46 (3.75)	18.76 (3.85)	2.32	
Defensive functioning	19.21 (3.64)	17.39 (3.07)	19.21 (3.28)	5.57**	AD > MD ND > MD
Stimulus barrier	20.15 (4.21)	18.87 (4.48)	20.72 (3.90)	3.64*	ND > MD
Autonomous functioning	16.82 (3.06)	16.39 (3.49)	17.37 (3.57)	1.47	

Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$. Note: AD = Group with a tendency to atypical depression, MD = Group with a tendency to melancholic depression, ND = Group with no tendency to atypical depression or melancholic depression.

subscale scores, with the standard deviations in parentheses; and the results of the one-way ANOVA and the multiple comparison.

4. Discussion

We aimed to clarify the ego functions of university students having a tendency to atypical depression. For this purpose, we compared those students with other students having a tendency to melancholic depression and borderline personality disorder to examine the hypothesis as mentioned above. However, the subjects having a tendency to borderline personality disorder were removed from the analysis because the number of the subjects was too small for analysis. Therefore, the discussion shown below is based on the comparison between the group having a tendency to atypical depression (AD) and the group having a tendency to melancholic depression (MD).

Our findings indicate no significant difference in the total score of the ego functions between the AD and the MD. The total score of the ego functions is considered to represent the overall functioning conditions of ego and the individual's adaptability as shown in [Nakanishi & Sakata \(1989\)](#). Further in our study, no significant differences were found in the scores of "synthetic-integrative functioning" and "autonomous functioning," i.e., the subscale items of ego functions, between the AD and the MD. As described in [Bellak et al. \(1973\)](#), the "synthetic-integrative functioning" is defined as the capacity to organize the disparate aspects of the personality, including intelligence and emotion into a unified structure; and the "autonomous functioning," as the competence in operating one's memories and thoughts to control oneself in such a way as one intends to do. Both of the above-mentioned functions are considered to form the basis of overall ego functions and support the individual adaptability. In light of this, our findings prove that fundamental and overall ego functions are not significantly different between the AD and the MD. In other words, the hypothesis built up for this study was not verified.

The hypothesis has been extracted from the findings about similarities between atypical depression and borderline personality disorder ([Perugi & Akiskal, 2002](#); [Kaiya, 2008](#)) and the findings about the organization of character pathology related to the ego functions ([Kernberg, 1976](#)). To be more specific, atypical depression is similar to borderline personality disorder in the clinical pictures, so that the atypical depression is considered to be connected to the borderline character and assumed to be in the lower level of organization of character pathology. Therefore, the patients with atypical depression are assumed to show lower ego functions than those with melancholic depression. On the other hand, as shown in [West & Dally \(1959\)](#) and [Sargant \(1962\)](#), the patients with atypical depression are considered to have a hysterical character because those patients tend to become too reactive to stimulus and get hyperactive and aggressive, and then such a hysterical character is assumed to lead them into depression. According to the findings of [West & Dally \(1959\)](#) and [Sargant \(1962\)](#), it is considered that the patients with atypical depression have a hysterical character, not a

borderline character, so that the organization level of character pathology of the patients with atypical depression is different from that of the patients with borderline personality disorder. The hysterical character is regarded as the higher level of organization of character pathology (Kernberg, 1976), which is the same level of the depressive-masochistic character of the patients with melancholic depression, so that the conditions of the ego functions in the patients with atypical depression may not be different from those in the patients with melancholic depression. From the above, we can infer the reasons for our findings that there are no significant differences in the total score of ego functions and the respective scores of “synthetic-integrative functioning” and “autonomous functioning” between the AD and the MD.

The results of this study also indicate that there is no significant difference between the AD and the MD in one of the ego functions, “sense of reality.” Bellak et al. (1973) defines the “sense of reality” as one of the ego functions that can provide the basis for the ability to feel one’s connection to the world as real and feel a sense of self. According to the diagnostic criteria of DSM-5 (American Psychiatric Association, 2013), atypical depression is characterized by experiencing frequent swing in mood, resulting from “mood reactivity,” and having heavy, leaden feelings in arms and legs, that is, “leaden paralysis.” In contrast, the patients diagnosed to have melancholic depression present severe depression in a chronic form, caused by excessive guilt or the like. Anyway, the conditions of the patients with atypical depression and melancholic depression are both considered too severe to fully gain the ability to feel one’s connection to the world as real and feel a sense of self. This is supposed to be the reason why there was no significant difference in the “sense of reality” between the AD and the MD in our findings.

Likewise, as for the subscale ego functions “objective relation” and “stimulus barrier,” the AD and the MD are not significantly different from each other. Bellak et al. (1973) defines the “objective relation” as the capacity to maintain mature interpersonal relationships; and the “stimulus barrier,” as the function of withstanding unpleasant stimuli. However, the diagnostic criteria for atypical depression provided by the DSM-5 (American Psychiatric Association, 2013) include “interpersonal rejection sensitivity,” i.e., an excessively intense or sensitive reaction to others’ trifling words. It can be therefore speculated that the AD may show lower functions than the MD with respect to the “objective relation” and the “stimulus barrier.” According to Klein, Gittelman, Quitkin, & Rifkin (1980), the core impairment of atypical depression is considered to be the vulnerability of emotion regulation; and the dependence on others and the sensitivity to stimulus, the secondary impairments. In fact, our findings indicate that the AD shows lower mean score of the “control of impulses,” which function is related to control of the impulses and emotions than the ND. The AD may represent more vulnerable emotion regulation, i.e., the core impairment of atypical depression. However, the university students belonging to the AD in this study are

just showing a tendency to atypical depression, so that they may not reach the stage where the secondary impairments are indicated. This is supposed to be the reason that the AD and the MD are not significantly different from each other in the “objective relation” and the “stimulus barrier.”

As previously discussed, significant differences are not found in many points between the AD and the MD in this study. However, only in the “defensive functioning,” there is a significant difference between the AD and the MD. The AD shows higher “defensive functioning” than the MD. As in Bellak et al. (1973), the “defensive functioning” is defined as a function of protecting the ego by coping with conflicts and stresses. That is to say, the AD is considered to have more ability to cope with the conflicts and stresses and protect the ego than the MD. This can be supported by the description that the patients with atypical depression do not show chronic depression unlike the patients with melancholic depression (American Psychiatric Association, 2013). However, the AD is supposed to have problems in coping with the conflicts and stresses according to a study on the defense mechanisms used for coping with the conflicts and stresses (Hayashi, Takei, Fujimori, Takeuchi & Hono, in press). The above-mentioned study on the defense mechanisms assumes that the patients with atypical depression mainly use primitive defense mechanisms. The primitive defense mechanisms are used to promptly find relief from conflicts or stresses by expulsion of the conflicts or stresses (Klein, 1946), and are regarded as the lowest-level defense mechanisms, observed in the severe psychotic state (Vaillant, 1986). Consequently, the students having a tendency to atypical depression are found to protect the ego from conflicts better than the students having a tendency to melancholic depression, but the protecting mechanisms are considerably maladaptive, which may result in their internal unstableness.

It has been pointed out that the clinical pictures of the patients with atypical depression are considerably different from those of the patients with melancholic depression (Singh & Williams, 2006). As is apparent from our findings, however, there is no significant difference in ego functions between the AD and the MD with the exception of defensive functioning. In light of this, the ego functions of the AD may be similar to those of the MD although the clinical pictures are different from each other. More detailed examination into the defensive functioning of the university students having a tendency to atypical depression will be important to understand their psychological mechanisms. It will be necessary to search for a more effective way of supporting those students through the examinations.

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