Chapter 08

Persistent Depressive Disorder: Personality or Mood Disorder? Implications for Practice

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Abstract

The domains of personality can be summarized in five dimensions. However, this conceptualization has undergone some modifications and evidence emerged for a sixth dimension on personality traits. The study of personality tests with a sixth dimension has contributed to an increase in the accuracy of the diagnosis of mood disorders. However, difficulties in diagnosing mood disorders remain, and so the difficulties associated with the diagnosis of persistent depressive disorder (PDD; dysthymia). These difficulties have raised questions in relation to its maintenance in mood disorders. Some studies have demonstrated an association between depressive personality with specific personality traits: avoidance, fear, introversion and self-criticism, high scores on negative emotions, neuroticism and low scores on positive emotions, like openness to experience, hope, and perfectionism. Data obtained in studies with Portuguese samples indicate that these patients are less extroverted, less anxious, have a lower social self-esteem, have less vitality, are less patient, and quite the contrary they are more neurotic, more careful and meticulous and more flexible than the subjects who do not have this diagnosis. Several studies also demonstrate that there are some difficulties in diagnosing mood disorders, specifically the PDD, because there are significant correlations between depressive symptoms and personality traits, and so evidence have emerged suggesting the need for reformulation of this diagnosis. To improve the diagnosis and reduce errors associated with this disorder a modification in the diagnosis of PDD by framing it in Personality Disorders is presented with definition of the basis of these disorders that rests and operates on a continuum, rather than being classified into categories or the presence or absence of symptoms. It is also accepted a review of the way of classification of the diagnosis of persistent depressive disorder can contribute to the improvement of the intervention in this symptomatology, with the adoption of interventions more directed to the flexibilization of the personality traits. In sum, we conclude that evaluation, diagnosis

and clinical intervention of PDD should be rethought considering the connection of the personality traits that seems to be related to this symptomatology, with implications on improvement of diagnosis precision, and reduction of associated errors.

Introduction

Personality appears, inherently, associated with the notion of person, being understood as a unit that surpasses concrete reality, acting as an organizing center that directs psychological structures [1], reflecting its complexity [2]. Due to this, personality has been the focus of several investigations over the years, and it is classified and grouped according to certain characteristics that include or exclude subjects with a condition/diagnosis [3]. The available instruments for studying personality include a range of scales, questionnaires, batteries and inventories, which vary in view of the public it is intended, and can be projective or self-report. Several studies show that clinical practice is accompanied mainly by instruments to assess personality [4], or personality traits in its five dimensions or factors [5], allowing operate and measure constructs vulnerabilities present in different forms of psychopathology [6].

Most researchers accept that personality domains can be summarized in five dimensions. However, this conceptualization has undergone some modifications after the incongruities detected when replicating studies in different languages, which culminates in the omission of important personality variations [7]. In spite of the great acceptance by the researchers of the five dimensions, the lexical studies carried out in the most diverse languages indicated the need to study an additional dimension [8], demonstrating evidence for an alternative representation on personality structure [9] in order to increase the correct diagnosis.

According to Lima and Albuquerque [2], the most important assumption of current theories is the study of traits, which are defined as functional units of personality and general cognitive-dynamic dispositions, which direct behavior. Thus, personality traits work as

self-regulatory mechanisms that self-sustain, predicting the behavior [2]. The authors suggest that traits can be used to summarize, predict and/or explain the conduct of an individual in order to consider the context as an explanation for the behavior [10]. Therefore, personality traits appear as psychological characteristics that are presented as relatively stable trends influencing thoughts, feelings and behaviors as individual interactions product with its context, featuring, however, it is not immutable [10].For Ramklint and Ekselius [6], the context in which the child or adolescent is inserted influences the development of the personality and its traits, being that an early contact with depressive disorders increases the probability of affecting personality development in this sense. According to Martins [1], emotions emerge as brain develops, resulting in perceptions regarding the context based on the individual's experience.

Beck [11] proposed that the activation of certain idiosyncratic cognitive schemes are presented as the main problem in depression, having a primary role in the development of various depressive symptoms at a cognitive, affective, and behavioral level. However the author introduces two new concepts: 1) the notion of humor traits is the interconnection sectors of the personality that are designed to handle specific situations and problems; and 2) the notion of cathexes to explain the intensity fluctuations in cognitive structures being applied to sensitivity phenomena, revocation and remission, assisting in the fluctuations between normal or pathological changes in clinical observations of a particular disorder (e.g., anxiety, panic or depression). This formulation of the theory humor traits arises because of its difficulty in interpreting and grouping various psychological and psychopathological phenomena in the initial model schemes represented by stimulus, cognitive scheme, motivation, emotion and behavior [11]. Beck's model allows a comprehensive explanation of complexity, predictability, regularity and uniqueness of normal and pathological reactions.

Persistent Depressive Disorder (PDD) and Personality Traits

Depressive disorders have a common characteristic: the presence of sadness, emptiness or irritable mood, accompanied by both somatic and cognitive changes that affect, in a clinically and significant way, the functioning capacity of the subject, differing between the different diagnoses issues related to duration, timing or ethology [12]. Within the depressive disorders there is the PDD, involving changes in affection, cognition and neurovegetative functions, manifesting in a more chronic form than major depression. It is a disorder that, due to its early and insidious onset, makes it difficult to attribute symptoms, because they become part of the individual's daily life and there is a greater probability of having personality comorbidities and substance use disorders [12]. According to some authors, the diagnosis difficulties are related to an inappropriate classification that starts from whether these symptoms should be classified as being a mood disorder or a personality disorder (e.g., Ryder, Schuller, & Bagby, [13]). This difficulty arose when introducing disturbance disorders in Axis I from the DSM [12], rather than being included in Axis II, and considered to be a mood disturbance rather than a depressive personality disorder [13]. In the ICD-10 [14], dysthymia is present in the group of persistent disorders of mood (affective), and is considered a chronic depression of mood with the essential diagnostic feature of a very lasting mood depression, which usually begins in early adult life and lasts several years, sometimes indefinitely.

According to Ryder, Schuller, and Bagby [13], the diagnostic difficulties in dysthymia are related to issues in an appropriate classification of whether these symptoms should be classified as a diagnosis of a mood disorder or a personality disorder. Angst [15] states that dysthymia is central to the understanding of issues related to psychological disorders and the difficulty in diagnosis is linked with comorbidities that this disturbance is associated with, and the fact of being a disturbance that has an early beginning making it difficult to distinguish between a disturbance of mood or a personality disor-

der. Some studies have shown the association of depressive personality with specific personality traits, namely: 'avoidance of harm' or fear, introversion and self-criticism, high scores in negative emotions [13] (neuroticism) and low scores in positive emotions (extrovert), in openness to experience, in the feelings of discouragement [16] and perfectionism [13]. Brown and Di Nardo [17] concluded that dysthymia is a disorder that has less reliability at diagnosis, having existed little agreement among health professionals (with k = .22 being classified as having little agreement when obtained k < .40). While these enhancements were important in assigning a correct diagnosis, the difficulty in diagnosing this disorder arises from the fact that there is little reliability in diagnosing categories, as well as unreliability of the criteria that imply a change in the diagnose [17]. Indeed, it was found that the greatest difficulty for the allocation of a correct diagnosis associated with mood disorders are not directly related to differences regarding the definition of symptoms, but with the difficulties of applying a cut-off point that refers to another diagnosis [17].

Considering the literature reviewed, previous studies explored the personality traits in a clinical population diagnosed with PDD, using the HEXACO-60 [18]. These studies were important because of the difficulties listed above when allocating clinical symptoms associated with the diagnosis of dysthymia. In Torres and colleagues [18] study, a factor analysis was performed in 60 items, with varimax rotation. The authors also analyzed personality traits presented by patients with PDD, and applied t-test at PHQ-9. That analysis showed that there is a statistically significant difference for the presence of depressive symptoms between the groups (dysthymia and without that diagnosis) with an average of 5.80 for the non-clinical group and M= 13.33 for the clinical group, $t(58) = -4987$, $p < .001$. It was observed that the two study groups (clinical and non-clinical) differ therefore from each other with respect to depressive symptomatology, with the clinical group presenting a significantly higher mean depressive symptomatology [18]. The data collected showed that, in fact, the groups differed significantly with respect to their depressive symptoms and it was possible to evaluate the personality traits of each

one of them. With this significant difference, it was possible to test the hypothesis regarding the change from the diagnosis of mood disturbance to a personality disorder. It was also possible to verify that PDD is related to personality disorders and should be understood, evaluated and interpreted as such, in order to increase the therapeutic efficacy of patients suffering from this diagnosis.

Clinical Implications

Several studies have shown that the PDD (or dysthymia) should be a diagnostic of 'personality disorder' because of the low reliability of the actual diagnosis. This low reliability is attributed to causes such as: 1) differences in the classifications and interpretations of severity and duration of the presented symptomatology; 2) disagreement regarding the interference of the symptomatology that can meet the criteria presented for the diagnosis; 3) error on the part of the interviewer that erroneously includes or excludes important symptoms to the assignment of a correct diagnosis, or does not obtain information necessary for these attribution; 4) disagreement between the cause that refers to the mood disturbance; and 5) little clarity in the DSM's exposure to cut-off points and criteria that provide a clear direction when performing a differential diagnosis [17].

In order to increase the reliability associated with mood disorders diagnosis, it was defined that the basis of these disorders rests and operates on a continuum, rather than being classified into categories or the presence or absence of symptoms [17]. Although these improvements have been important in assigning a correct diagnosis for mood disorders, the difficulty of diagnosing PDD arises from the fact that there is little reliability in the categories of diagnosis, as well as little reliability in the criteria that imply the change of diagnosis, which were modified during the new DSM versions [17]. The study allowed to verify that the mood disorders are the ones that present greater difficulties with regard to cut-off points and that, in the case of dysthymia, the difficulty of diagnosis includes the attribution of other

mood disorders, and the maintenance of this disorder in the DMS-IV. It was also noteworthy that dysthymia shows greater reliability when analyzed in conjunction with major chronic depression [17], both of which were merged into one in the DSM-V, named PDD.

Some authors proved in their studies that PDD should be, in fact, a personality disorder rather than a mood disorder. Torres and colleagues [18] have discovered that, in a sample of Portuguese patients with depressive personality disorder, this acknowledgment corresponds to low scores on self-esteem, feelings of discouragement, sadness and unhappiness, and high scores on neuroticism, corresponding to negative affect and anxiety. These data are in agreement with the literature (cf., Huprich & Frisch, [16]), who determine that the characterization of depressive personality disorder also corresponds to low scores on self-esteem, feelings of discouragement, sadness and unhappiness, and high scores on neuroticism, showing that symptomatology associated to these patients refers to personality traits analyzed and tested in different languages and countries.

Assessments with the HEXACO-60 (with additional factors of assessment), tested for dysthymic patients, previously analyzed the correlation between depressive symptoms and personality traits, evaluated with the NEO-FFI-20. It appears that higher levels of depressive symptoms personality traits are associated with higher trait tendencies for 'neuroticism'; and that lower levels of depressive symptoms correspond in less marked personality traits in the 'extroversion' dimension in the NEO-FFI-20 [18]. These data were expected, considering Ryder, Shuller, and Bagby's [13] study, which determine that the specific traits associated with personality symptoms of depressed mood, are related to lower scores on extroversion, perfectionism, feelings of discouragement, openness to experience, and higher scores for symptoms of depressed mood in neuroticism and fear. Considering the new structure of the personality traits, some authors have studied the differences between a clinical group (diagnosed with dysthymia) and a non-clinical group in five subscales and one dimension of the

HEXACO-60, and two equivalents dimensions of the NEO-FFI-20 were checked [18]. An explanation for this result may be the fact that there is evidence that the model of the six factors presented by the HEXACO accommodates many important personality constructs that are only briefly encompassed in the Model of the Five Factors [9]. These results demonstrate that patients with PDD have significantly lower scores in the dimension 'extroversion' and related subscales from the HEXACO (anxiety, social self-esteem, vivacity and solitude), and significantly higher scores for the dimensions 'neuroticism' and 'conscientiousness' from the NEO-FFI-20, and the subscale 'flexibility' of the HEXACO-60.

Conclusions

As shown by the literature, the results indicate that patients with PDD are less extroverted, are less anxious, have a lower social self-esteem, have less vitality, are less patient, and quite the contrary they are more neurotic, more careful and meticulous and more flexible than the subjects who do not have this diagnosis [18]. As mentioned, these data go in to the same direction as those reported by previous [16].

In this analysis, the only result that is against the literature is the fact that patients with PDD have significantly lower scores regarding the subscale 'anxiety' [18]. However, an appropriate explanation for this score may be that these patients believe, regardless of their efforts, that they have little chance of success, not being able to generate alternative solutions when negative outcomes arise [16].This interpretation of their own success makes them avoid new situations that could put into question their ability to succeed, thus decreasing their anxiety compared to the nonclinical group, which accepts new challenges regardless the increase of their anxiety [18]. However, further studies should include in their analysis this variable (expectation of success) to check this possible interpretation. In practice, these aspects can enhance the success of specific interventions targeting this group considering the underlying structural aspects.

With the results from the study conducted by Torres and colleagues [18], it is plausible to assume that it goes in favor of the literature and supports the arguments of other authors, like Angst [15], Huprich and Frisch [16], as well as Ryder, Schuller, and Bagby [13], since they argue that PDD should be a personality disorder diagnose. So, given the results, the depressive personality, in a Portuguese sample, is characterized by high scores in neuroticism, conscientiousness and flexibility and low scores in extraversion, anxiety, social self-esteem, vivacity and patience. These new data contributes, although preliminary, with the assertion of a valid tool for assessing personality (the HEXACO-60), which is presented as a valuable contribution to the range of instruments available and to support the validity of the model of the six factors in the study of personality [18]. Similarly, the study provides: 1) a description of personality traits in PDD; 2) the acceptance of a change in the diagnosis of PDD framing it in personality disorders; 3) a review, diagnosis and clinical intervention of dysthymia to be rethought, given the connection of personality traits that seem to be related to the symptoms; and 4) the review of the diagnosis form for PDD classification as a contribution to the improvement of intervention in this symptomatology, with the adoption of interventions more aimed at easing the personality traits.

Considering the literature review, it is acceptable that: 1) a modification in the diagnosis of PDD by framing it as a personality disorder; 2) a review of the way of classification of the diagnosis of PDD can contribute to the improvement of the interventions in this symptomatology, with the adoption of interventions more directed to the flexibilization of the personality traits; and 3) the evaluation, diagnosis and clinical intervention of dysthymia should be rethought, considering the connection of the personality traits that seems to be related to these symptomatology. All these occur to improve the diagnosis and reduce the errors associated with this disorder and its therapeutic intervention. Therapeutic intervention for dysthymia should consider the assessment of personality traits and focus in strategies to relaxing it, to achieve better clinical outcomes, as well as, better overall quality

of life of patients with this challenging condition. As always, psychology is a science that is always evolving, and so, more research in this field, namely testing theoretical implications pointed out, would be very important to continuously improve therapeutic outcomes.

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