

The impact of the study of personality on the diagnosis of dysthymic disorder

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Dysthymia is a moderate form of chronic depression, with a slow onset of symptoms that lasts for at least 2 years, as specified by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria (1). Depressive personality disorder is a diagnostic entity that has been temporary accepted into the DSM as part of the appendix of this diagnostic manual. Its diagnostic criteria have

to be confirmed in the future using generally accepted studies. Until then, this issue represents the center of several current debates. Thus, there are two possibilities: first, that the two nosologic entities would overlap entirely (2), and second, as some studies suggest, that the existence of depressive personality disorder is already proven. The second possibility is supported by its co-existence with dysthymia in some groups of patients (3, 4). □

About 80 % of the dysthymic patients will be diagnosed in their lifetime with major depression (5), while 25 – 50 % of the patients with major depression have comorbid dysthymia (6). When a depressive episode is added to dysthymia, we can speak of double depression. A 9-years prospective study found that double depression can be seen in 3 % of the general population (6). The clinical relevance of this association resides in its resistance to antidepressant treatment (7, 8).

In primary medical practice, the prevalence of dysthymia is estimated at 3 -4%, while the prevalence of major depression is between 4,8 - 9,2 %. The prevalence of all forms of depression is 9-20%, making them the most commonly seen psychiatric disorders in a family physician's practice (9). Therefore, dysthymia represents an important issue for the public

health, regarding the epidemiological and therapeutic points of view.

In this issue Birt et al. (*Mædica*, 2006; 1:p29-34) discuss the modality of assessing the personality profile of the individuals with dysthymic disorder in order to establish the existence of some stable personality traits that would support its inclusion among the personality disorders. The authors used the TCI questionnaire, aiming at the investigation of the two defining dimensions of personality, temperament and character, for which this questionnaire has been created and thoroughly verified.

The Personality Questionnaire "*Temperament and Character Inventory*" (TCI) designed by Cloninger and colleagues (10) is represented by a battery of tests that aim at measuring the differences between individuals on seven dimensions of temperament (the genetic com-

ponent of personality – 4 dimensions) and character (the learned component during the individual's existence - 3 dimensions). The inventory proved its efficacy in clinical practice as it is useful in defining the clinical diagnosis, the treatment, pharmacotherapy and psychotherapy plan in various psychiatric disorders. Its clinical applicability is extremely wide: anxiety disorders, eating disorders, alcohol and other substance abuse disorders or personality disorders (11). TCI proves its value in the assessment of psychopathological comorbidities since the differences among the various psychopathological syndromes (e.g. anxiety, mood, eating disorders, substance abuse) are emphasized by the differences recorded by the TCI profiles. These differences, as well as the response to the psychotropic medication treatment, including antidepressants and anxiolytics, are strongly related to the temperament items of the TCI. For example, antidepressants and cognitive therapy increase the individual's self-directedness, one of the three components of character, together with cooperativeness and self-transcendence (12, 13).

The research of Birt et al could join the group of approaches that implicitly consider dysthymia as a possible form of personality disorder since it attempts to describe a mild form of depression, dysthymia, by resorting to personality parameters and not to a list of depressive symptoms accompanied by their somatic, sleep, etc equivalents. The result obtained by the authors does not seem to support this approach, due to the heterogeneity of the traits expressed by the subjects in the studied group and the unstable profile of their personalities, even when compared with control subjects suffering from monopolar or bipolar depression. □

The role of personality in the onset, development and treatment of mood disorders is still controversial. In the case of dysthymia, as we already showed, some conceptual issues still remain to be clarified. The suppositions regarding the relationship between personality traits and mood disorders have attempted to give answers to several questions (14):

1. Are personality traits vulnerability predisposing factors to a mood disorder or a psychiatric disorder? Is there a premorbid personality type that is specific for mood or psychiatric disorders?

2. Are personality traits expressions of the actual clinical disorder? Are there forms of bipolar disorders that can be considered as personality disorders?
3. Are the specific aspects of personality after-effects of the mood disorder? Is it possible to identify a post-morbid personality that is specific to bipolar, unipolar mood disorders and dysthymia?
4. Do personality traits influence the evolution of the mood, psychiatric disorders? □

Initially, it was thought that a specific premorbid personality type could be identified. Studies supported the skepticism that such a hypothesis was met with. Currently, the personality traits described by the classic authors that supposedly were characteristic to unipolar, bipolar depression or schizophrenia are considered not to be specific. Some of them could be a consequence of the illness itself, of the treatment with antidepressants and neuroleptics or even methodological artefacts of those initial studies. Despite all the shortcomings and limitations, the personality structure of the patients suffering from mood disorders and other clinical psychiatric disorders is thought to be a risk factor in the onset of these illnesses. The comorbidity of personality disorders with other psychiatric disorders may be different phenotype expressions of common etiological factors, with the personality disorder being an index of vulnerability for a major disorder. Clinically, the disease develops differently: only after the onset of a major psychotic/depressive disorder, the personality disorder becomes apparent too (15).

Recent studies have investigated the personality profiles of the patients suffering from unipolar and bipolar mood disorders. The bipolar patients tend to be cautious, easily discouraged, pessimistic, asthenic, inefficient, dependent, scrupulous, lack empathy, idealistic. The unipolar patients though (patients suffering from recurrent depressions only, with no intercurrent manic episodes) seem to worry more, cautious, undecided, pessimistic, less sociable, unsure, withdrawn (14). Considering these aspects, rather than a personality disorder, the present study supports the view that includes dysthymia within the spectrum of depression disorders and a vulnerability factor for later onset of comorbid major depression as often proved by clinical experience. □

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