

*PsychContinuingEd.com “Examining the Evidence” series
presents...*

Depressive Personality Disorder

2 CE credits, \$15,
Answer 15 quiz questions online and get your CE certificate
automatically.

2 continuing education credit hours are available for reading
this article from PsychContinuingEd.com. This article was last
updated November, 2010.

Author: Todd Finnerty, Psy.D.*
Clinical Psychologist
toddfinnerty@toddfinnerty.com

*Portions of this course were derived from the book Depressive
Personality Disorder: Understanding Current Trends in
Research and Practice; 2009, Columbus, OH:
WorldWideMentalHealth.com.*

About PsychContinuingEd.com and the “Examining the Evidence” Series:

PsychContinuingEd.com is approved by the American
Psychological Association to sponsor continuing education for
psychologists. PsychContinuingEd.com maintains
responsibility for this program and its content.

PsychContinuingEd.com is offering a series of “Examining the
Evidence” courses leading up to DSM-5 which take a look at
the research behind some of the proposals which may or may
not make it in to the final version of the DSM-5. For example,
depressive personality disorder was included in the appendix
of DSM-IV and DSM-IV-TR, however it may never become a
“fully-fledged” diagnosis due to competing proposals such as
coding “depressive” traits like neuroticism or negative
emotionality under a single personality disorder for DSM-5

(see dsm5.org for draft proposals). One thing that is certain is that we can expect changes to personality disorders in DSM-5.

About Dr. Todd Finnerty:

Todd Finnerty, Psy.D. is a psychologist in Columbus, OH and cofounder of PsychContinuingEd.com. Dr. Finnerty also reviews disability claims for a state social security disability determination service.

Course Outline:

- Introduction
- Reliability and Validity
- Depressive Personality and severity
- Depressive Traits and potential new directions with DSM-5
- Cognitive Vulnerabilities and Depressive Personality Disorder
- Conclusions
- References
- Quiz Questions and instructions on how to obtain CE credit

Objectives:

Participants will be able to describe the relative research support for depressive personality disorder.

Participants will be able to list other alternatives to depressive personality disorder which may be used in DSM-5.

Introduction

Can you think of a person you may have met or treated whose usual mood was gloomy and unhappy, and did they have feelings of low self-esteem? Were they critical of themselves and did they brood and tend to worry? Did they tend to be negative and judgmental toward others? Were they pessimistic and prone to feeling guilty or remorseful? Did this person have a Depressive Personality Disorder (as defined by the DSM-IV-TR research criteria, 2000) which may have itself led to discomfort or possibly a co-occurring disorder which brought them in to treatment. Did it create difficulties for them in their daily life? We may suggest that this person has a depressive

personality disorder, however we may also talk about these individuals as having maladaptive expressions of personality traits such as neuroticism or negative emotionality. This course is the first in the “Examining the Evidence series” and presents an overview of evidence related to the merits of the Depressive Personality Disorder diagnosis.

While clinicians recognize that few “textbook” patients tend to present in their practices, it is quite likely that all clinicians have met patients who would satisfy the DSM-IV criteria for Depressive Personality Disorder (DPD). Individuals with Depressive Personality Disorder are prone to not just chronic depression, but to harbor negativity towards themselves, others and the world which creates significant interpersonal problems as well as distress. In addition, while we may not consider some individuals to have depressive personality disorder, they may have a less functionally impairing form of chronic depressive traits or cognitive vulnerabilities to depression which can be associated with depressive personality disorder.

Depressive Personality Disorder (DPD), according to the research criteria in DSM-IV-TR (published by the American Psychiatric Association), is:

(A.) A pervasive pattern of depressive cognitions and behaviors beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) usual mood is dominated by dejection, gloominess, cheerlessness, joylessness, unhappiness
- (2) self-concept centers around beliefs of inadequacy, worthlessness, and low self-esteem
- (3) is critical, blaming and derogatory toward self
- (4) is brooding and given to worry
- (5) is negativistic, critical and judgmental toward others
- (6) is pessimistic
- (7) is prone to feeling guilty or remorseful

(B.) Does not occur exclusively during Major Depressive Episodes and is not better accounted for by Dysthymic Disorder.

(2000).

To categorize DPD under DSM-IV, the very first criterion for DPD offered begins with a description of the individual's "usual mood." This inclusion of mood and affect is not unique to DPD among the Personality Disorders, in fact the "General Diagnostic Criteria for a Personality Disorder" in DSM-IV-TR (pg. 689) includes "affectivity (i.e. the range, intensity, lability, and appropriateness of emotional response" as one of the potential criteria associated with a stable, enduring pattern of "inner experience and behavior that deviates markedly from the expectations of the individual's culture" and can be traced back to adolescence or early adulthood. While some researchers and clinicians may choose to erect firm barriers between mood disorders and personality disorders, the DSM-IV general criteria for personality disorders recognizes the likelihood of shared signs and symptoms with affective and anxiety disorders. While firm distinctions may be convenient in research, Axis I and Axis II disorders are "often conceived of as more distinct than they actually are" (Krueger, 2005). In this vein, the individuals working on DSM-5 have proposed to eliminate the separation of Axis I and II similar to the ICD.

Reliability and Validity

Depressive Personality Disorder has been found to be a valid and reliable diagnosis with adequate stability over time comparable to other personality disorders. Phillips, et. al. (1998) note that DPD is a "relatively stable condition, involving impairment, that is not otherwise covered by DSM-IV mood or personality disorders."

One concern about DPD (and the personality disorders in general), is the rate of co-occurrence with other disorders.

There have been a range of figures published in regards to diagnostic overlap. Skodol, et. al. (1999) found that 49% of their DPD subjects did not have a current major depressive disorder, 22% did not have a lifetime major depressive disorder and 72% did not have dysthymic disorder. In reviewing past studies Lipton, et. al. (2006) noted that about half of participants with DPD did not have dysthymic disorder and ½ the participants with dysthymic disorder did not have DPD. DPD has rates of overlap with other disorders which are comparable to the other DSM-IV personality disorders. Depressive PD is not “redundant with any Axis I or II disorder” and the construct validity of Depressive PD is supported. (McDermut, et. al., 2003) McDermut et. al. offer the opinion that under a framework similar to DSM-IV DPD fits on Axis II as a personality disorder. While some have criticized depressive personality disorder as simply a “trait form of depression,” this still implies traits suggesting personality involvement and overlooks anxiety and other functionally impairing processes outside of the typical description of depression. The disorder is still present even in the absence of depression and is associated with personality traits and other factors which have been shown to lead to a wide range of difficulties. The structure of depressive personality disorder includes a potential dimensional relationship of depressive pd with a group of enduring cognitive vulnerabilities that should make comorbidity and co-occurrence with other disorders expected by definition, given its close ties to these underlying pathological processes which lead to distress and interpersonal problems.

Researchers have explored aspects of normal personality which may be related to the Depressive PD criteria, adding a dimensional conceptualization of DPD constructed of traits and facets which may be associated with the DPD diagnosis from DSM-IV. There have been predictions made related to the Five-Factor Model personality traits and facets which a number of researchers have assessed using the NEO-PI-R (Costa & McCrae, 1992). For example, Huprich (2003) among others have supported the construct validity of this approach.

Huprich (2009) reviewed the DPD literature and noted DPD-related “dimensions” associated with the Five-Factor model have been replicated across studies. While individuals identified with DPD typically have similar profiles on the NEO PI-R, more work needs to be done to refine psychological testing instruments for the purpose of assessing DPD. However, according to Huprich (2009), “multiple measures of DPD have considerable support for their construct validity.”

In reviewing past research Huprich (2009), an author who has published extensively on DPD, concluded that DPD is a useful diagnostic construct and suggested it was a “viable diagnostic construct that can no longer be ignored” and should be recognized as a “real entity.” In regards to reliability, Huprich found that across studies DPD shows “marginal to excellent” internal consistency, test-retest, item-total, interrater agreement and diagnostic agreement. Huprich rightly cautions in this article however that studies of DPD can be impacted by the measurement(s) of DPD used, and there is less than perfect agreement among the tools currently being developed to assess Depressive PD.

Klein & Shih (1998) noted that DPD was moderately stable over a 30 month period. DPD was associated with a “poorer course of depression” in the study. In the study only 9-10% of individuals with DPD qualified for a diagnosis of self-defeating personality disorder. The authors concluded that the “construct of DPD contributes unique information over and above that provided by” essentially neuroticism and extraversion. Laptok, et. al. (2006) published the results of a longitudinal study following individuals with DPD at 2.5 yrs, 5 yrs, 7.5 yrs and 10 yrs. Rates of DPD declined with time and DPD was noted to be “moderately stable” comparable to the DSM-IV personality disorders. While some critics have suggested that differential diagnosis of DPD with other disorders such as dysthymic disorder could be difficult, the authors noted good inter-rater reliability suggesting different raters diagnosed DPD similarly in patients.

In a 3 year follow up of college women with the sole diagnosis of DPD (and no lifetime comorbid Axis I or II disorders at the time of recruitment), Kwon et. al. (2000) noted that 73.6% retained the DPD diagnosis at 3 year follow up, whereas 92% of the non-clinical control group continued to not be diagnosed with DPD. The authors note that the percentages of diagnostic retention “revealed estimates of good diagnostic stability.” This is even after individuals who had been diagnosed with a co-occurring disorder were excluded from the study

Depressive Personality and severity

“State” factors such as an acute depression can impact reports of personality “traits,” which according to Huprich (2009) can make assessing DPD “challenging.” A trend in many research studies to date is an attempt to separate out the effects of problems with mood (at least those potentially qualifying for an Axis I diagnosis) from DPD, despite the possibility that many of those very symptoms may be related to distress associated with Depressive Personality Disorder itself. Huprich noted little success with removing Depressive Personality Disorder Inventory items which were similar to BDI-II items (as reported in Huprich, 2009). While certainly in researching a “new” diagnosis one desires to isolate the effects of only that diagnosis, we must be cautious not to be overly reliant on a categorical model suggesting separate, discrete entities that exist in isolation from each other. In short, a personality disorder is expected to itself be associated with distress and the co-occurring diagnosable Axis I symptoms may be manifestations of this distress. This is particularly true of a disorder which may sit at the crossroads of mood and personality categories. Given that DPD may also be constructed of traits or enduring, maladaptive tendencies which make one vulnerable to depression as well as to a recurrence of depression, the idea that individuals may endorse symptoms of depression or anxiety is not surprising, particularly in a clinical sample.

Researchers in Korea conducted a 3 year follow up study on female undergraduate students with the sole diagnosis of depressive personality disorder as compared to a matched control group with no diagnosis at baseline. Jun Soo Kwon, et. al. (2000) recruited 173 participants who had a confirmed diagnosis of depressive personality disorder. They wanted to see if “subjects with the sole diagnosis of depressive personality disorder are at higher risk for developing dysthymia and major depression than are healthy comparison subjects.” Unfortunately, since their inclusion criteria were individuals with a sole diagnosis of DPD, they had to exclude more than one half of the individuals originally identified as having DPD due to the presence of co-occurring disorders including both Axis I and II. 173 participants had a confirmed diagnosis of DPD, however 88 of these “with a current or lifetime axis I disorder, comorbid axis II personality disorder, or a history of brain trauma, seizure, or ADHD were removed from the study, which left 85 women” for the DPD group. It is not clear what percentage of their excluded participants already had developed the Axis I mood disorders that they hypothesized the DPD participants might later develop. It is not clear if there would have been a difference in the functional severity of this group as compared to the group that included individuals meeting criteria for an Axis I or other Axis II disorders, etc., however it is possible that individuals with additional co-occurring diagnoses may have been more severe cases of DPD or exhibited more “extreme” personality dysfunction, however this is not well-known currently. Meeting the criteria for an Axis I disorder may be a signal that the clt is experiencing more distress potentially at least partially as a consequence of their DPD.

Perhaps consistent with the notion that individuals with DPD alone will still experience distress, Kwon, et. al. (2000) found individuals with a sole diagnosis of Depressive Personality Disorder and no additional, lifetime Axis I or Axis II diagnoses still had significantly higher Beck Depression Inventory scores than a non-clinical control group. Hartlage, et. al. (1998) attempted to exclude questions on the BDI which they

perceived to have a cognitive component and thus potential overlap with DPD symptoms, however given that mood difficulties and distress are a part of the disorder, researchers will need to be cautious that they don't end up studying individuals with depressive traits as opposed to individuals who are truly experiencing functional impairment and symptoms consistent with a depressive personality disorder. This concern also applies to Ryder, et. al.'s (2001) suggestion that "It should also be notable that there may be specific advantages to including studies of nonclinical groups as part of the research literature on DPD. Several researchers have demonstrated that such samples may prove useful because they are less often confounded with severity of dysfunction and comorbid psychopathology and appear to differ from clinical samples in quantitative but not in qualitative ways." DPD is likely to be a dimensional construct and individuals will have varying degrees of "severity." While some individuals may "barely qualify" for the diagnosis, we must use caution that we aren't studying only those individuals with significant depressive traits or who "barely qualify," and excluding those individuals with more severe functional impairment from being studied.

Functional impairment level and comorbid diagnoses may have in fact impacted a longitudinal study of DPD. However, despite excluding over ½ the undergraduates identified with DPD, including those who had already had a past or current major depressive episode or dysthymia, Jun Soo Kwon, et. al. suggest that individuals with the sole diagnosis of DPD (and who had apparently had no previous Dysthymia or Major Depressive episode) are at a greater risk of developing Dysthymic Disorder than controls. While possibly slightly more likely to develop major depression, studies have not been fully consistent on the likelihood of individuals with DPD to develop a major depressive disorder. While some have found individuals with DPD to be significantly more likely than those without the diagnosis to develop MDD, this and other studies have not. Individuals with DPD are more likely to experience the symptoms of dysthymic disorder and have a high co-

occurrence of axis II pathology. Kwon, et. al. (2000) suggested that depressive personality disorder may serve as an important risk factor and early indicator of axis I mood disorders.

Some argue that depressive personality disorder simply falls on a continuum or spectrum of axis I mood disorders and note that it is the least severe disorder, with dysthymic disorder being the next severe and major depressive disorder being the most severe. For example, Ryder, et. al. (2001) suggested that “although DPD is not synonymous with Dysthymia, it may be a milder subtype.” However, for a continuum model to be useful and have explanatory power, individuals with major depression would presumably meet criteria for all the “less severe” disorders. This is obviously not the case, particularly if the differences in course criteria and presumed etiology are added in. In addition, there is not only valuable clinical information lost in this distinction, it is actually misleading. Individuals with chronic depression may actually require a greater degree of intervention than those without, suggesting that depending on your perspective and the degree of simplification utilized, the continuum could look much differently depending on what factors were valued in its construction. The use of the term spectrum implies uncertainty, and that while possibly related, the exact blending and gray area in between remain undefined and unexplored. This is like the many different variations of the colors of red, orange, yellow, green, blue, indigo and violet in the rainbow (such as pink, teal or chartreuse). However, oversimplifying such an analogy to force DPD to fit one “rainbow” of mood disorder is unsupported and reduces clinical utility. DPD research also does not support this. McDermut, et. al. (2003) noted that “our data are incongruent with the notion that DPD is less severe than dysthymic disorder.” Individuals with DPD also tended to have more co-occurring difficulties and “greater psychosocial dysfunction.” Fawcett (2008) suggested that comorbidity may be the most important “severity dimension.” While there may be nebulous underlying factors and facets associated with these disorders,

some of which may be related to an overlap, they do not suggest a simple ordering of mild to moderate to marked mood disturbance.

Dunner (2005) reviewed multiple studies noting that dysthymic disorder is often associated with greater impairment in psychosocial functioning “than other forms of depression.” He also reviewed studies suggesting that individuals with dysthymic disorder typically required more psychotherapy sessions than individuals with major depression. Skodol, et. al. (1999) noted that co-occurring dysthymic disorder and major depressive disorder predicted a significantly greater likelihood of borderline personality disorder or depressive personality disorder diagnosis, as did early-onset dysthymic disorder. Skodol, et. al. noted that the “more severe the current episode of major depression” the more likely it was to be associated with borderline, dependent or depressive personality disorders. This would suggest viewing depressive personality disorder as simply falling on a proposed spectrum of mood severity is oversimplified and inconsistent with the data. It would of course be a similar error to suggest depressive personality disorder as the most “severe” disorder on a spectrum with dysthymic disorder being the next most severe and major depressive disorder being the least severe. In addition, dysthymic disorder groups in past studies are likely to have been heavily contaminated with individuals who would also meet criteria for DPD, particularly those individuals with an early onset. It is difficult to interpret past studies of dysthymic disorder in this regard as they may include individuals with co-occurring depressive personality disorder (given the overlap or people meeting criteria for both disorders).

Dunner (2005) argued against dysthymic disorder as an axis II condition. He noted that “emerging data from biological, family history and treatment studies point toward great similarities between axis I mood disorders” and noted specifically the “high frequency of complicating major depressive episodes in dysthymic disorder.” While Axis I mood disorders occur more

often in family members, this may potentially be an interactive function of both genes and shared environments. Orstavik, et. al. (2007) note that “family studies cannot distinguish between genetic and shared environmental causes of familiar aggregation.” This is similar to concerns that have been raised about depressive personality disorder, in that family members may be more likely to experience mood symptoms. The axis I and II distinction in this respect certainly may be artificial (and it may not be retained in DSM-5). Interestingly, not only are personality disorders in general often associated with the presence of axis I disorders, there is a strong genetic component to normal personality (McCrae, et. al., 2005). McCrae, et. al. note in referring to personality disorders that “some psychiatric problems are not acute episodes of mental disorder caused by life stress or organic illness; instead they are more-or-less chronic difficulties in living that are manifestations of enduring dispositions of the individual.” They note based on their research on the Five-Factor Model of Personality and other evidence that “there is clear evidence that much, perhaps most, of the variance in adult personality traits is genetic in origin.” According to McCrae, et. al., individuals have “Basic Tendencies” which are determined by biological factors, and “Characteristic Adaptations” which are psychological features which are developed as the person encounters their environment. The authors note that “the personality pathology is found in the characteristic adaptations, not the basic tendencies.” The research on normal personality and Axis II along with the significant overlap of Axis I and Axis II significantly confounds arguments against DPD or chronic depressive personality traits based simply on the similar high rates of mood disorders in families. It is overly reliant on categorical assumptions related to psychiatric disorders, including discrete boundaries between Axis I and II conditions. In addition, past studies of individuals with early onset chronic depression may not have adequately assessed for personality characteristics which may also impact an individual’s susceptibility, including personality traits, which may or may not be adaptively expressed. It would not be

surprising for evidence to continue to emerge reflecting similar genetic structures among many psychiatric conditions.

Orstavik, et. al. (2007) performed a population-based twin study on Norwegian twins. They concluded that major depressive disorder and depressive personality disorder had overlapping but not identical etiologies. The authors reviewed a past study in which major depressive disorder and generalized anxiety disorder shared essentially 100% of the same genetic liabilities. In relation to major depressive disorder and DPD, however, they note that about “50% of the genes involved contribute to one but not the other syndrome.” While some studies have tended to find a higher incidence of lifetime mood disorders in family members of those with DPD, Phillips, et. al. (1998) did not find this in their sample.

The utility and distinctness of depressive personality disorder is supported, however viewing depressive personality disorder as a mild form of depression or simply a depressive predisposition on a basic continuum or spectrum of mood disorders is not supported by the evidence.

Arguments against DPD as a personality disorder based on overlap and relationships with mood disorders may be victims of selective attention. The same argument can be used for why DPD should be associated with the personality disorders. Bagby & Ryder may have shown earlier criticism for DPD and its relationship to dysthymic disorder, however in 2004 Bagby, et. al. published a study noting overlap with other personality disorders. The most notable overlap was with avoidant personality disorder. In addition, they noted that while DPD overlapped significantly with other Personality Disorders, it is “distinguishable in its unique relation with traits from” the Five-Factor Model. This study’s results are viewed with some caution given that there were only 15 members of the DPD group (9 of whom met criteria for another PD) which left only apparently 17 personality-disordered participants without DPD in the sample. 60% of individuals with DPD qualified for another PD diagnosis, however there was no greater than a

20% overlap with any individual PD diagnosis, leading Bagby, et. al. to note that “The uniqueness of the DPD diagnostic criteria set is strongly supported by the results...”

Andrews, et. al. (2007) found that the number of depressive symptoms were highly correlated with measures of “well-being, distress, disability and neuroticism.” Huprich (2000) compared a small sample of individuals with depressive personality disorder, dysthymic disorder and a control group on the NEO-PI-R. The DPD and dysthymic disorder groups had scores which were relatively similar on the BDI (average of 9.6 for DPD and 10.4 for dysthymic disorder). Both individuals with DPD and dysthymia both scored significantly higher than controls on Neuroticism and its facets, however in this small sample a “clinical difference” emerged with the DPD group scoring higher than the dysthymics on Neuroticism. It would be beneficial to continue to replicate this finding with larger groups and clinical populations. It would be an interesting finding if individuals identified as DPD tended to have greater Neuroticism scores than individuals with chronic mood disorders who do not meet criteria for DPD. This distinction may be somewhat challenging, however, given that many of the DPD criteria may be synonymous with Neuroticism and other cognitive vulnerabilities to depression. However, given that Neuroticism has been linked to greater severity of depression it would now seem counter-intuitive to simply suggest the related DPD phenomenon is a mild or subthreshold mood disorder as opposed to a maladaptive expression of these traits.

McDermut, et. al. (2003) refute the notion that DPD falls as a disorder representing a less severe mood disorder on a scale with dysthymic disorder and major depressive disorder. Their data was not consistent with the notion that DPD was less severe than dysthymic disorder. They compared individuals with DPD only to those with dysthymic disorder and the results “clearly showed greater psychiatric morbidity and poorer psychosocial functioning” in the DPD group. In addition, viewing these disorders as on a continuum would

suggest that the more severe disorder would meet all the “less severe” disorders, however this is easily demonstrated that this is not the case. The heterogenous nature of major depressive disorder and dysthymic disorder, both with potentially diverse etiology and onset, suggest a high potential for losing the ability to quickly convey clinically useful information should DPD be thrown in as simply a mood disorder or if clinicians lost the opportunity for enhanced conceptualization and assessment of individuals with enduring traits impacting their psychosocial functioning. There are important distinctions and useful information which would be lost if DPD was simply viewed as chronic depressive disorder, dysthymic disorder, minor depressive disorder or subthreshold depression. DPD should be viewed as a personality disorder which is sufficiently distinct from other diagnoses, particularly under a dimensional system without excessive, arbitrary boundaries between categories. An additional option proposed for DSM-5 would be to include the ability to encode facets of traits such as Neuroticism or the more maladaptively worded version: “Negative Emotionality.” Neuroticism and Negative Emotionality are relatively synonymous. This would simply provide a different name and mechanism for coding many of the same underlying processes involved in depressive personality disorder.

Depressive Traits and potential new directions with DSM-5

In reviewing trends related to an emerging reconceptualization of personality disorders, Lee Anna Clark (2007) suggested approaching the diagnosis of personality differently than the “current symptom/criterion method, distinguishing assessment of more acute symptoms” from an individual’s basic temperament. Individuals with personality disorders generally present with both short-term acute symptoms as well as more resistant or “enduring” pathology. Many of the “acute symptoms” that may lead someone with a personality disorder to seek treatment may be due to characteristic maladaptations, influenced by personality traits which will remain in the absence of acute symptoms such as a depressed

mood. As McCrae et. al. noted (2005), “the goals of realistic therapy for PDs should not be to change personality, but to rechannel it into more socially acceptable and personally satisfying adaptations.” Certainly enhancing diagnostic distinctions between the “acute” expression of discomfort which is often seen as consistent with axis I disorders and the underlying personality structure will be useful, however it is unlikely to be easy. A related difficulty is in the assessment of PD, where mood state may impact the person’s reports of stable traits. In a review of past studies, Clark (2007), noted in relation to complications with comorbidity/ co-occurrence with Axis I that personality disorders in general are associated with earlier age of onset, greater clinical severity, poorer treatment outcome, longer time to remission, lower long-term social, cognitive and occupational functioning, greater medical utilization, suicide attempts and suicide completion, and greater risk of psychopathology in offspring. While there may be limitations related to the research behind these findings, studies on depressive personality would suggest it shares many of these same qualities as the other personality disorders.

Much of the thrust of recent research and theory has involved incorporating models of “normal” personality such as the Five-Factor Model (FFM) in to the diagnostic structure of personality disorders. The notion is that personality disorders may involve extreme variants on one or more dimensions of normal personality. While research is showing some relationship with pathology to the FFM, as noted by Huprich and Bornstein (2007) in reviewing past studies- having a high or low level of one or more facets or traits associated with a PD does not itself indicate the presence of pathology.

The Five-Factor model (FFM) was originally developed through a factor analysis of trait-related adjectives. Words or expressions that described the same underlying concept were lumped together or discarded. The Five-Factor model consists of the “big five” broad dimensions: Neuroticism, Extraversion, Openness to Experience, Agreeableness and

Conscientiousness (Costa & Widiger, 2002). These are personality traits which are more “enduring” than mood or “state” factors. Each of these dimensions are viewed as including lower order “facets.” McCrae, et. al. (2005) indicate that the 30 facets are not a comprehensive listing of traits. In addition, they noted that traits themselves are not pathological. They consider personality traits to be “basic tendencies” determined by biological factors, while “characteristic adaptations” and “maladaptations” are shaped as the individual encounters the environment. This is an important point in deciding between coding personality descriptions from the Five-Factor Model or coding specific diagnoses which may be a result of characteristic maladaptations of personality characteristics.

The individuals responsible for planning DSM-5 have proposed a “Pathological Five” version modified from the FFM: Negative Emotionality, Introversion, Antagonism, Disinhibition, Compulsivity, Schizotypy (with some possible wording changes likely prior to final publication). See DSM5.org

One of the more salient of the FFM personality dimensions in relation to DPD is Neuroticism (most like DSM-5’s proposed “Negative Emotionality”). Costa & Widiger (2002) note that high Neuroticism “identifies individuals who are prone to psychological distress.” It also includes “having unrealistic ideas, excessive cravings or difficulty in tolerating the frustration caused by not acting on one’s urges, and maladaptive coping responses.” The facet scales for Neuroticism are anxiety, angry hostility, depression, self-consciousness, impulsivity, and vulnerability.” The concept of Neuroticism also has some relationship to concepts described as cognitive vulnerabilities later in this article, and has itself been described as a cognitive vulnerability to depression [though it may be better represented as a collection of ‘traits’ (facets) that may be related to such factors]. Costa & Widiger (2005) include an appendix describing these facets on Pg. 463. Their descriptions of individuals with facet N1: Anxiety includes that they are “prone to worry.” Interestingly, criterion

#4 of Depressive PD in the DSM-IV-TR (American Psychiatric Association, 2000, pg. 789) includes “given to worry.” Facet N2: Angry Hostility, per Costa & Widiger, includes the “tendency to experience anger” as well as “frustration and bitterness. They note that “...disagreeable people often score high on this scale.” The DSM-IV-TR DPD criteria include criteria for both being critical and derogatory toward the self (#3) and negativistic and critical toward others (#5). Facet N3: Depression, per Costa & Widiger, is the “tendency to experience depressive affect.” They note that individuals high on this scale would be “prone to feelings of guilt.” This would appear to be fairly consistent with DSM-IV-TR DPD criterion #1 describing the patient’s “usual mood,” and certainly criterion #7 which includes almost the same phrase “prone to feeling guilty...” Costa & Widiger’s description of Facet N4: Self-Consciousness included “shame and embarrassment,” feeling uncomfortable around others, sensitive to ridicule and feeling inferior. The DSM-IV-TR DPD criterion #2 includes “self-concept centers around beliefs of inadequacy...” Costa & Widiger noted this facet was also similar to “shyness and social anxiety.” Facet N5: is Impulsiveness, and Costa and McCrae describe it as an “inability to control cravings and urges.” They note that “Low scorers find it easier to resist such temptations, having a high tolerance for frustration” (pg. 464). The tendency to feel anger/frustration was also a factor in the description of N2: Angry Hostility. In addition, Costa & Widiger’s description of this facet of neuroticism also includes that they “...may later regret their behavior” and DSM-IV-TR DPD criterion #7 includes “prone to feeling guilty or remorseful” as noted in the discussion for N3: Depression. The last Neuroticism facet described by Costa & Widiger is N6: Vulnerability (to stress). They suggest that individuals scoring high on this facet will “feel unable to cope with stress, becoming dependent, hopeless, or panicked when facing emergency situations.”

Given the many theorized cognitive vulnerabilities to depression and depressive personality styles, it is possible that this facet may include many variables which have been found to potentially be independent of each other. The only DSM-IV-

TR DPD criterion I have not yet mentioned in this discussion of the descriptions of Neuroticism facets and descriptions of DSM-IV criteria is DPD DSM-IV-TR criterion #6, “is pessimistic.” I would not argue that pessimism and hopelessness are exactly the same construct given its relationship to depressogenic inferences about the self and consequences (Adams, et. al., 2007), however hopelessness may potentially be considered a similar notion. The notion of hopelessness appears to be considered by Costa & Widiger under the description of two different facets, i.e. [“hopelessness” (N3: Depression) and “hopeless” (N6: Vulnerability)]. In addition, Costa & Widiger describe a facet of Extraversion (E6: Positive Emotions), as predicting whether individuals will “experience positive emotions such as joy, happiness, love, and excitement.” This would likely not describe an individual with DPD given criterion #1’s inclusion of “usual mood is dominated by... joylessness...” There is some face validity to the assumption that the criteria for depressive personality disorder load across the different facets of Neuroticism, and the correlation with the concept of Neuroticism’s facets (though not excessive overlap) is demonstrated by multiple studies.

McCrae; Lockenhoff and Costa (2005) reviewed articles suggesting that while the “facets” of the NEO-PI-R assess distinct “traits,” they “cannot and do not claim to be a comprehensive listing of traits.” This certainly opens the door to questions about the many different lines of research on depressive styles and cognitive vulnerabilities to depression, many of which have been found to be stable tendencies. In addition, the characteristic maladaptive expressions of these underlying traits and facets of traits may lead to a wide disparity of presentations in individuals scoring highly on particular facets of the NEO-PI-R. The broad traits of the Five-Factor Model of Personality will miss the many subtle distinctions inherent in disorders, and simply adopting a system of expressing the underlying facets of the Five-Factor Model as opposed to personality disorders may oversimplify and damage clinician’s abilities to convey the many

maladaptive expressions of traits and conceptualize with more relevant clinical information. This is particularly true when higher-order personality presentations may occur with different combinations of personality facets and traits, including personality variables that may or may not be well-represented by the NEO-PI-R facets. For example, clinicians are unlikely to quickly abandon the concept or borderline personality disorder or at least a “borderline type.” However, certain vulnerability concepts which are not always associated with personality have also been useful to clinicians and may be related to the depressive personality disorder concept.

Concepts such as Dependency, Self-Criticism, Sociotropy and Autonomy are closely related concepts but are distinguishable from one another. They have been correlated with NEO-PI facets, though some sex differences have been noted. (Zuroff, 1994). Zuroff (1994) suggested that “Neuroticism is a broadly defined variable that implies vulnerability to a wide range of troubling feelings, thoughts and behaviors.” Dependency, Self-Criticism, Sociotropy and Autonomy “are more narrowly defined and can be conceptualized as specific forms of neuroticism.” For example, the author noted that Dependency and Sociotropy can be described as “agreeable forms of Neuroticism” and that “In women, Self-Criticism and Autonomy can be described as disagreeable forms of Neuroticism.” Self-criticism was associated with Neuroticism in men but not with disagreeableness in this study. Autonomy in men was unrelated to Neuroticism and negatively related to Agreeableness and Openness.

Adams, Abela & Hankin (2007) found that cognitive and interpersonal vulnerability factors through their factor analysis were distinct from depressive symptoms. They examined 12 different depression related constructs (including dependency, rumination, negative inferential styles, social support) and suggested that, while they overlap, they are “distinct entities.” They also noted “important sex differences” were observed in higher-order constructs related to the vulnerability factors and concluded that “sex has a significant

impact on the manifestation of cognitive vulnerability to depression...”

Hankin, et. al. (2007) performed factor analyses on constructs from hopelessness theory, Beck’s cognitive theory, and the response styles theory. They found four factors, 3 of which corresponded to the vulnerability from each theory (negative cognitive style, dysfunctional attitudes and rumination). They also looked at depressive symptoms, self-esteem and neuroticism which each best fit the same fourth factor lumped together. Self-esteem may tend to be related to cognitive and vegetative symptoms of depression in general and self-esteem and depression may “tap a single construct.” Neuroticism mildly correlated with the other vulnerabilities assessed. Hankin, et. al. noted that “cognitive vulnerability is not reducible to general trait neuroticism.” They reviewed past studies as well noting “partial support” for a two factor model of rumination that separated “brooding” from “reflection.” With the degree likely depending on how it is conceptualized and measured, rumination did not overlap with dysfunctional attitudes or negative cognitive style. This is important given the potential relationship to criterion #4 of DPD in the DSM-IV-TR (pg. 789), “is brooding and given to worry.” It may also lend support to viewing the criteria for depressive personality disorder as a collection of multiple, independent personality-related factors.

Neuroticism is correlated mildly with multiple independent cognitive vulnerabilities (Hankin, et. al., 2007), and these independent vulnerabilities likely do not all translate over directly to the facets on the NEO-PI-R or even combinations of facets (more research is needed). For instance, continued research may explore whether facets such as N3:Depression and N6:Vulnerability include the expression of multiple independent depressive personality styles/ vulnerabilities or just one overarching cognitive vulnerability. However, given the many conceptualizations of underlying traits and disparate lines of research these are not issues that are likely to be resolved prior to DSM-V. For instance, both N3 and N6 include

the concept of hopelessness in the description. Given the many conceptualizations of factors involved in hopelessness and their different expressions, the utility of the facets alone in the absence of other modifying or moderating information is suspect. In addition, the utility of the Five-Factor Model alone is suspect given that it was too ambiguous and clinicians judged it “less useful than the DSM-IV” per Rottman, et. al, (2009). Calls for hybrid models of personality disorders such as made by Skodol & Bender (2009) appear supported by these issues.

While there has not been exhaustive research yet on the relationship between measures of depressive vulnerability concepts and depressive personality disorder, factors that have been identified as cognitive vulnerabilities are not just identified through reasonable, face valid assumptions. Research has shown a relationship between them. Ryder, McBride and Bagby (2008), for example, assessed dependency/self-criticism and sociotropy/autonomy. They found correlations with personality disorders and depressive personality disorder was associated with each vulnerability. DPD was significantly correlated with measures of sociotropy (.25), dependency (.17), autonomy (.31) and self-criticism (.47). Hartlage, et. al. (1998) found that in individuals with DPD self-criticalness was a trait independent of current depression while “low self-esteem, feeling burdened, and counterdependency” had both state and trait components. Some of the DPD characteristics may be personality traits, consistent with a view of personality disorders as consisting of both acute symptoms and relatively more enduring patterns. While there are many factors which may be involved in a hybrid system of diagnosing PD, it is clear that DPD would be a useful concept with relationships to stable vulnerabilities expressed across theories.

Using the NEO-PI-R, which attempts to measure the five factors as well as the underlying facets, Huprich (2003) noted that the Anxiety, Depression and Self-Consciousness facets were significantly correlated with the 3 measures of DPD used

in the study. In addition, low tender-mindedness may also be involved.

Widiger & Samuel (2005) reviewed Mixed anxiety-depressive disorder (MADD), and indicated it was characterized by a patient presenting with subthreshold symptoms of both depression and anxiety. They reviewed studies reflecting that “a substantial proportion of the empirical basis for including MADD in DSM-IV was obtained from research on the general personality trait of neuroticism...” and in discussing issues with symptom overlap and diagnostic categories noted Mixed anxiety depression “could then be reasonably classified as a personality disorder, as well as a mood or an anxiety disorder.” It is interesting to note that along with depressive symptoms, DPD also has an anxiety component.

Huprich (2005) reviewed studies noting that the largest degree of overlap between DPD and other personality disorders were with avoidant and borderline personality disorders. Huprich looked for ways in which depressive personality disorder and avoidant personality disorder (APD) could be differentiated. While they both desire relationships and fear negative evaluation, Huprich suggested that individuals with APD experience anxiety about being negatively criticized and avoid social contact because of this while individuals with DPD “experience considerable psychological conflict in their interpersonal relationships which is centered on the affects of frustration, irritation, and sadness (over the lack of relationships).” It was suggested that this “irritation with others” may help differentiate individuals with DPD from APD, consistent with reports related to “angry hostility” on the NEO-PI-R. While individuals with APD tended to score higher on the anxiety facet, this facet was also related to DPD. Bagby, et. al. (2004) noted that the four-facet trait set from the Five-Factor Model proposed to be related to DPD “actually shows stronger associations with dimensionalized DPD scores relative to the main text personality disorders.” The four-facet trait set failed to differentiate DPD from avoidant PD in this study, though the authors noted that DPD individuals are more likely to load

heavier on the depression facet while individuals with avoidant pd are more likely to have highest scores on Self-Consciousness. The Anxiety and Depression facets were the strongest predictors of DPD in this study. Huprich (2005) noted that the relationship between avoidant and depressive personality disorders isn't surprising given criterion #4 of DPD, "is brooding and given to worry" (American Psychiatric Association, 2000). Huprich suggested "Thus, as DPD is further evaluated for inclusion in the diagnostic nomenclature, it may be useful to drop or modify criterion #4 as a core component of DPD." However, this criterion actually appears to be consistent with other stable factors which may also be at work in DPD. We can view criterion #4 through a categorical lens as a symptom of an anxiety disorder or we can also see it as a tendency similar to conceptualizations of cognitive vulnerabilities described in this chapter. Individuals with DPD may be "prone" to display cognitive vulnerabilities like ruminating and focusing excessively on negative events, and criterion 4 can be viewed as at least very similar to a cognitive vulnerability. Regardless, removing category #4 could prove fruitless given that it may not resolve all overlaps seen on the NEO-PI-R and that the depression vs anxiety dichotomy may not involve as firm a boundary as is sometimes implied. Some "anxiety" symptoms might still be present in the identified DPD individuals regardless of how they were sorted similar to the presentation described by the mixed anxiety-depressive disorder. In addition, Andrews, et. al. (2008) for instance, proposed grouping depression and anxiety disorders together under "internalizing disorders" (with subgroupings of distress disorders and fear disorders) given their relationships. Shahar & Gilboa-Schechtman (2007) suggest that a cognitive vulnerability to depression, self-criticism, predicted elevated levels of social anxiety even when controlling for depressive symptoms. Cognitive vulnerabilities such as rumination may be related to a tendency to brood and worry as well. Criterion 4 appears well supported and related to the overall processes at work in an individual with Depressive PD, including rumination.

Rumination can be described “loosely as experiencing repetitive, intrusive, negative cognitions” and studying rumination, according to Siegle, et. al. (2004), involves issues associated with measurement. There are many different measures available as well as different ways of conceptualizing rumination. The authors found that there “may be many constructs referred to in the literature as rumination, which may not strongly covary.” However, across measures rumination “was associated with dysphoria.” In this way, while potentially viewed as an anxiety symptom, DSM-IV-TR criterion #4 may also reflect a stable trait which is both distressing and a cognitive vulnerability to additional distress.

Incorporating solely aspects of the Five-Factor Model is not the only alternative for DSM-5, and certainly it may be premature to rely on it alone given the evidence for other approaches and the potential utility of a mixed or hybrid system.

O'Connor & Dyce (1998), in reviewing models of personality disorder, reported finding the strongest support for the FFM and a 7 factor model by Cloninger & Svrakic. They suggested, however, that a 4 factor model (without openness) “seems preferable and sufficient.” There was also statistically significant support for dimensionalized DSM clusters, however they noted it was “less than perfect.” Skodol, et. al. (2005) assessed 668 patients with semistructured interview diagnoses of schizotypal, borderline, avoidant, or obsessive-compulsive personality disorders or with major depressive disorder and no personality disorder. “Both the categorical and dimensional representations of DSM-IV personality disorders had stronger relationships to impairment in functioning in the domains of employment, social relationships with parents and friends, and global social adjustment and to DSM-IV axis V ratings than the three- and five-factor models. DSM-IV dimensions predicted functional impairment best of the four approaches. Although five-factor personality traits captured variance in functional impairment not predicted by DSM-IV personality disorder dimensions, the DSM-IV dimensions accounted for significantly more variance than the

measures of personality.” The authors concluded that “scores on dimensions of general personality functioning do not appear to be as strongly associated with functional impairment as the psychopathology of DSM personality disorder” and that “a compromise in the ongoing debate over categories versus dimensions of personality disorder might be the dimensional rating of the criteria that comprise traditional categories.” It is of course noted that depressive personality disorder was not specifically assessed in this particular study. Some compromise may seem to be a workable starting point for DSM-5, particularly if other dimensions that have shown promise in the literature could also be incorporated in to the diagnostic picture along with a mixed dimensional and categorical approach such as proposed by Maser (2009) and others. Simply placing the results of a NEO-PI-R on Axis II is unlikely to hold as much value. A dimensional representation of some of the criteria for DPD may be related to traits on the FFM such as neuroticism, as well as some of the cognitive vulnerabilities that are noted in this chapter. A dimensional view of many of the DSM-IV criteria is unlikely to be foreign to clinicians, as such an approach is often needed in clinical practice. While the Five Factor Model is supported in the literature for normal personality, the specific traits and facets alone may not be sufficient to capture presentations consistent with a disorder and observed in clinical practice. The DSM-5 personality disorders work group has also proposed multiple scales which would also need to be evaluated in a relatively qualitative and subjective manner in order to include an assessment of extent of impairment.

In addition to dimensional, categorical and mixed/hybrid approaches to diagnosis, some have proposed using a prototype or template matching approach. This would involve a narrative protocol reflecting a typical presentation of a patient and clinicians would suggest how closely a patient matches. It is difficult to see how categorical and/or dimensional assumptions would not be embedded in the narrative, however, with possibly more subjective and less standardized application by clinicians resulting. Sprock and

Fredendall (2008) for example sent out surveys to clinicians and asked them to rate pre-supplied criteria and found a “blurring” of ratings of prototypic patients between individuals responding about DPD and individuals responding about dysthymic disorder, though no attempt was made to separate out patients with only DPD or only dysthymic disorder. Clinicians may have rated some of the same symptoms for DPD and dysthymic disorder, however a well-developed, accompanying narrative in DSM-V with increased background information on the disorder (as occurs for “official” diagnoses already in DSM-IV) will also assist in educating clinicians on DPD for use with DSM-V. While there may be limitations to using only a narrative protocol or template for making diagnoses, a narrative description of a disorder is useful for helping clinicians address diagnostic issues and formulate a picture of how patients with a specific diagnosis might present to them in the office. It could be beneficial in pointing out issues such as the presence of relatively stable personality traits. These narratives are used by clinicians in addition to the diagnostic criteria, though this may not always be reflected in research as at times categorical self-report instruments and cut-off thresholds must at times be substituted for the diagnostic process.

Interestingly, personality traits such as neuroticism from the Five Factor Model have some relation to research on underlying cognitive vulnerabilities. In addition, the criteria for DPD can be viewed as similar to theory and research on cognitive vulnerabilities.

Cognitive Vulnerabilities and Depressive Personality Disorder

There appears to be a history of a psychodynamic/ object relations conceptualizations of DPD in the literature. In reviewing past studies, Huprich (2009) noted DPD was associated with difficulty “managing aggressive impulses,” “low paternal benevolence” and with “maternal punitiveness.” Individuals with DPD may report significantly lower support

from family and friends and may experience more alienation. Interestingly, this object relations focus on early caregiver experiences is also consistent with some of the hypothesized mechanisms by which cognitive vulnerabilities may arise reported in cognitive-behavioral literature (as reviewed in Pettit & Joiner, 2006). It is also consistent with a review of studies reflecting poorer parental bonding and insecure attachment in individuals with chronic depression compared to nonchronic depression reviewed by Riso, et. al. (2007). More research is of course needed on how cognitive vulnerabilities, maladaptive schemas and depressive personality disorder arise, however the concepts may have some relation and research and theory from each may inform the other. Concepts related to a vulnerability to depression have a high value across many theories and therapeutic approaches, including cognitive-behavioral ones.

It is widely noted that Depressive PD criteria tend to be more associated with “cognitive” symptoms. For example DPD criteria in the DSM-IV include “beliefs of inadequacy, worthlessness, and low self-esteem;” being “negativistic” and “pessimistic;” prone to guilt or brooding and worry, etc. These cognitive symptoms could be associated with research literature on stable cognitive vulnerabilities or “traits” which lead to and/or prolong depressive symptoms in addition to creating risks of relapse for mood disorders. In addition, cognitive-behavioral approaches sometimes focus on core beliefs or schemas which may be stable over time. These beliefs may be pronounced in chronic depression, and may reflect the co-occurrence of cognitive vulnerabilities, depressive personality disorder and the symptoms and experience of a chronic depression.

Riso, et al. (2007) noted that “maladaptive core beliefs” (used interchangeably with schemas), discriminated groups of chronically depressed individuals from the nonchronically depressed. The core beliefs in their study which best did this were “impaired autonomy” which they described as a belief in low self-efficacy and a demanding environment as well as

“overvigilance” which they described as rigid expectations for performance and a fear of making mistakes. These maladaptive beliefs or schemas have also been conceptualized as factors creating vulnerabilities to depression. In fact, many of the DPD criteria are related to factors which have been conceptualized as vulnerabilities to not just depression, but a range of disorders. Cognitive vulnerabilities, maladaptive beliefs and the criteria for depressive personality disorder may have overlapping factors which may be an interesting target for future research.

While DPD should not simply be considered as consistent with one specific cognitive vulnerability, it may reflect similar processes and could potentially be conceptualized in a profile with groupings of vulnerabilities as well as other factors. Reviewing the research on cognitive vulnerabilities holds value in understanding and researching the phenomena associated with depressive personality disorder. It should be kept in mind however that DPD and its associated features are distressing in themselves in addition to creating a significant risk for other problems. Individuals with Depressive PD may fall at the more “pathological” end of multiple maladaptive characteristics which can each be assessed dimensionally.

There have been a large number of proposals across theories for factors which are depression vulnerabilities or a diathesis which when paired with stress may lead to depression. In their book on chronic depression, Pettit & Joiner (2006) noted that “certain characteristics or manners of perceiving and relating to the world may serve as persistent vulnerabilities to depression” and in the “propagation of existing depression.” Among the cognitive vulnerabilities they reviewed were hopelessness (negative attributional style), Sociotropy (dysfunctional attitudes described by Beck), self-regulatory perseveration (negative self-focused attention and evaluation)/ ruminative response style, dependency (if DPD were included in DSM-V there would be two DPDs with dependent personality disorder), shyness (interpersonal conflict

avoidance), social skills deficits and interpersonal stress, as well as neuroticism.

Hankin (2008) reviewed the stability of some cognitive vulnerabilities to depression including dysfunctional attitudes (rigid, extreme beliefs about the self/world), negative cognitive style (negative, stable and global attributions about the cause of an event; the tendency to catastrophize about the causes of that event; and inferring negative characteristics about the self after a negative event) and a ruminative response style (focusing attention repeatedly on depressive symptoms and their implications) in adolescents. Hankin noted that a negative cognitive style was most stable of the three vulnerabilities researched. These cognitive vulnerabilities tended to be stable over time and interact with stressors to lead to depressive symptoms.

Utilizing a cognitive diathesis-stress model, Morris, et. al. (2008) studied “attributional style, self-worth, and hopelessness” as cognitive vulnerabilities which were “among the most central cognitions relevant to depression.” They also note that in addition to cognitive vulnerabilities and the possibility that an individual’s resistance to depression may only be as strong as their most powerful cognitive vulnerability (or “weakest link”), a “keystone approach” in that an individual may only be as strong as their most positive cognitive style was suggested. Reviewing the relationship to resiliency and cognitive moderators may also be a valuable approach. In their call for further research the authors note that “Understanding how cognitive styles emerge as vulnerability or resilience factors, along with what accounts for individual differences in these styles, will help clinicians better identify children at greatest risk for depression.”

Some DPD factors which may be associated with cognitive vulnerabilities have begun to be addressed in the DPD research literature. For example, Hartlage (1998) noted that DPD had both state and trait aspects and noted that self-criticalness was found to be a trait independent of depression

in their study. Huprich and others have addressed factors such as perfectionism, interpersonal loss and negative interpersonal perceptions (2008; 2003). Huprich, et. al. (2008) noted that self-reported DPD, Dysthymia, and depressive symptoms were “correlated with three dimensions of perfectionism- Concern over Mistakes, Doubts about Actions, and Parental Criticism.” They noted in their nonclinical sample that variance in measures of DPD was “uniquely predicted” by these domains of perfectionism but not the clinical sample. However, the two samples also differed in that the nonclinical sample was a male sample and the clinical sample was a female sample. Given that these constructs can be viewed as potentially similar to the cognitive vulnerabilities studied by Morris, et. al., the possibility of gender differences related to the impact of cognitive vulnerabilities should not be overlooked. Studies on depressive personality disorder should therefore also be wary of the potential that underlying factors may be impacted by the sex of the participants.

Morris, et. al. (2008) noted that there have been inconsistent gender differences found in past research related to the interaction of stress and cognitive vulnerabilities. In their study, cognitive vulnerabilities were more likely to predict depressive symptoms in males in response to stress (since the females tended to respond to stress with depressive symptoms regardless of the presence or absence of cognitive vulnerabilities). Huprich & Frisch (2004) suggested that there may be potential sex differences in attributional style for those with and without DPD.

Huprich (2003) noted that in a primarily male, veteran sample scores on 9 out of 12 measures of interpersonal loss, negative parental perceptions and perfectionism were associated with DPD. These variables were also significantly higher in the DPD group than in psychiatric controls. Huprich noted that “one’s perception of familial support, global level of perfectionism, sense of alienation, ability to form trustworthy and caring relationships, concerns about making mistakes, and reports of

parental criticism are related to depressive personality disorder even when depressed mood is accounted for.”

Shahar; et. al. (2003) noted that in their study of personality disorders and perfectionism, perfectionism and personality disorder features were largely independent. They noted that poorer outcome was predicted both by perfectionism and depressive personality disorder features.

It is possible that further research would continue to support the view that cognitive vulnerabilities may be present to a greater degree in individuals with DPD than in individuals who are depressed but do not have DPD. As we have reviewed, it appears to be supported that we can take the liberty of viewing at least factors involved in the facets of the NEO-PI-R as trait vulnerabilities to depression. Harkness; Bagby and others (2002) assessed outpatients with major depressive disorder with the NEO-PI. In addition, a group of individuals with major depressive disorder (MDD) who also met research criteria for a chronic minor depression (a subsyndromal concept) were assessed. They noted that “despite remission of the depressive episode” patients with MDD and a chronic minor/subthreshold depression “exhibited significantly lower Agreeableness scores” and showed “higher Neuroticism scores” than patients with MDD alone. They suggested that the effect of Neuroticism in this group was specifically located in the angry hostility facet, and may “define a group who are pessimistic, disaffected, and frustrated, perhaps because they see their illness as an intractable and enduring part of their selves.” This appears quite similar to the depressive personality concept. The authors suggested that the results reflect that chronic minor depression “involves an enduring personality vulnerability that is characterized by high Neuroticism, specifically trait anger.” They also suggest that the results of past studies looking at concepts such as double depression using only the broad trait of Neuroticism may have been impacted by a “failure to examine more fine-grained trait differences” (such as the NEO-PI facets). It appears that the many independent concepts of trait-like cognitive

vulnerabilities which exist in nondepressed individuals and persist after remission of the disorder support the authors' observations of a personality-related minor depression though the minor depression description would appear to be an insufficient descriptor of these characterologically related "subsyndromal" groups (as opposed to simply suggesting a closer proximity to more normal variations of mood). Understanding this distinction and the impact factors related to DPD may have is important for treatment planning.

Abrams, et. al. (2004) noted that high harm avoidance, as described by Cloninger, predicted poor response to antidepressants in their subjects (only females were studied). They noted that harm avoidance scores after 12 weeks of antidepressant treatment were significantly higher in the depressive personality disorder group than in the dysthymic disorder and major depressive disorder groups. There is no question that studies of underlying personality traits and cognitive vulnerabilities in psychopathology have and will continue to provide valuable information, and many of these concepts are synonymous with or are very consistent with factors involved in the depressive personality disorder.

While the many conceptualizations of cognitive vulnerabilities are expressed differently across many theories, theory and research both reflect relatively stable and enduring traits which could be viewed dimensionally, inconsistent with only state factors such as a mood episode. In an extreme form and possibly when stress and other dynamic factors come in to play, one expression of these underlying traits may be as a depressive personality disorder. As seen in previous chapters, DPD itself tends to remain relatively stable, and even when the severity may decrease over time or symptoms ameliorate, these underlying traits are also likely to endure and possibly lead to a relapse of DPD. The presence of these traits and/or DPD without a mood disorder is also likely to suggest that other problems, including mood disorders, will likely recur in the future as well. However, while we may consider traits and the underlying facets of the five-factor model to be involved with

any individual, additional, characteristic maladaptations (as seen in the many different theories of cognitive vulnerabilities to depression expressed) also play a role in disorders. This may leave a system with only the five-factor model for Axis II (or a derivation of it) deficient and less useful in describing clinical realities.

Conclusions

Regardless of whether we view Depressive PD dimensionally, strictly categorically or in a hybrid/mixed fashion, in research and practice we still must make distinctions between “normal and abnormal,” at least in the sense of making decisions on a positive research finding or a need for treatment and to what degree. The exact mechanisms that will be put in place for DSM-5 continue to be debated, however clinicians are no strangers to assessing the impact of an individual’s difficulties on their daily life under DSM-IV-TR.

The depressive personality likely involves moderately stable traits expressed during the developmental period or by early adulthood, though personality traits are not necessarily “set-in-stone.” The underlying structure of the disorder is expected to endure though should not be viewed as completely resistant to treatment. Acute symptoms may wax and wane. Treatment would be expected to be more lengthy and involve a greater risk of reoccurrence. These traits may or may not have become a “full-blown disorder” depending on the degree to which they are present, moderating positive variables allowing for resilience, and possibly other factors including the occurrence of triggering stressors. A dimensional view of depressive personality disorder, consistent with the way clinicians often practice under DSM-IV despite the categorical nosology, would allow for “depressive traits” and degrees of presence. Individuals may show an expression of underlying traits with the full disorder being visible in response to a stressor, other dynamic influences or simply the presence of an “extreme form.” The relative contributions of and nature of the interaction between genes, environment and other factors are

subjects for further research and debate. The functional impairment associated with a disorder may be reduced with time and/or treatment though some underlying traits or maladaptive characterological influences will still be present, consistent with this dimensional view.

Depressive traits and Depressive PD involve the interpersonal difficulties often associated with PD in general. Concepts related to Depressive PD help support a view of a level of interpersonal difficulties regardless of mood state. For example, in discussing individuals with cognitive vulnerabilities who had dysphoric or depressive personality styles, Giordano, et. al. (2000) indicated that “dysphoric people tend to engage in social comparisons in domains that are congruent with their depressive vulnerabilities” and that both dysphoric and nondysphoric individuals’ moods are affected by their comparisons in those domains. An individual may selectively attend to negative social comparisons and experience DSM-IV-TR criterion #2 of DPD (“is critical, blaming and derogatory toward self”). This attending to a negative social comparison is one of many factors that would likely impact any individuals’ mood. However, when attending to negative social comparisons combined with factors involved in angry hostility, for example, are combined, even without depressed mood this may impact the individual’s relationships negatively. This could lead to a depressed mood as well, and it could relate to experiencing the interpersonal anger seen in DSM-IV-TR DPD criterion #5 (“is negativistic, critical, and judgmental toward others.”

Depressive personality disorder may often involve a chronically depressed mood and/or anxiety symptoms, however multiple lines of research reflect a dimensional, underlying, stable characterological structure which is not sufficiently addressed by a mood disorder diagnosis. While only time will tell what will happen in DSM-5 in relation to how we view the phenomena underlying Depressive PD, the best current recommendation is for clinicians to currently do what they do best: Incorporate the diagnostic criteria offered in the current

DSM with all of the other relevant information they have available for the purposes of diagnostic decisions and treatment planning. Under DSM-IV, making a diagnosis of Personality Disorder NOS which includes depressive traits is well supported by current theory and research, as is diagnosing Depressive Personality Disorder. You can simply code a Personality Disorder NOS with Depressive traits or a Personality Disorder NOS with a Depressive Personality Disorder specifier.

While depressive personality disorder shows utility and empirical support similar to other personality disorders, current trends may be shifting away from individual personality disorders to profiles of personality types or traits where each personality disorder may essentially become a “personality disorder nos.” A “depressive type” is possible, however under a system like the one drafted for DSM-5, facets of traits like negative emotionality or neuroticism will potentially take primacy in research over individual disorders. However, the basic fact should never be lost on clinicians that relatively stable “personality” traits may lead to anxious depression, increase the risk of recurrence and prolong the course of treatment of other diagnostic categories such as “chronic depressive disorder.”

References

References are available at

<http://www.depressivepersonality.com/references.html>

Quiz Questions

Answer whether the following statements are True or False in relation to the CE article.

1 Depressive Personality Disorder includes a pervasive pattern of depressive cognitions beginning by early adulthood.

2 Someone with depressive personality disorder is likely to be pessimistic, critical of themselves and negative and judgmental towards others.

3 One concern about personality disorders is their rate of co-occurrence with other disorders.

4 Like other personality disorders, DPD tends to be moderately stable over time.

5 Individuals with DPD simply have a mood disorder which is not severe.

6 Negative Emotionality is relatively synonymous to Neuroticism.

7 Neuroticism is not included in the Five-Factor Model of Personality.

8 Individuals with high levels of Neuroticism are prone to psychological distress.

9 Hankin suggested that cognitive vulnerability can be reduced to general trait neuroticism.

10 DPD has the largest degree of overlap with avoidant and borderline personality disorders.

11 Rumination is not associated with dysphoria.

12 Individuals with DPD may experience more alienation.

13 DPD, Neuroticism and cognitive vulnerabilities may have some overlapping concepts.

14 Under DSM-IV, a Depressive PD diagnosis could not be made on Personality Disorder NOS.

15 Depressive PD symptoms may predict a longer course of treatment than with depression alone.