

## **Depressive Personality Disorder: Understanding Current Trends in Research and Practice**

Can you think of a person you may have met or treated whose usual mood was gloomy and unhappy, 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?

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This book answers the question “**Does Depressive Personality Disorder exist?**” with a concise, readable review of current research. **DPD is a valid and clinically useful concept** which should be included in DSM-V and ICD-11. DPD was offered as both a diagnosis for further study and an example of a diagnosis that can be made under Personality Disorder NOS in the DSM-IV and DSM-IV-TR. The book is intended for professionals, students and anyone else interested in character traits which impact mood. It offers a view of depressive personality disorder supported by current research. Gain a firm background in recent research and theory on DPD and understand its relationship to chronic depression, dysthymic disorder, cognitive vulnerabilities to depression and the Five-Factor Model of Personality.

**Published by WorldWideMentalHealth.com**

*an integrated print and online publisher™*

*Columbus, Ohio*

Depressive Personality Disorder: Understanding Current Trends in Research and Practice/ by Todd Finnerty –1<sup>st</sup> edition.

Includes bibliographic references

ISBN-10: 0981995500, ISBN-13: 9780981995502

1. Depressive Personality Disorder 2. Mental illness(disorders)—classification 3. Mental illness(disorders)—Diagnosis. 4. Personality disorders 5. Depression, Mental  
140 pages.

A scholarly text for professionals and students related to

Psychology, Psychiatry, Counseling and Mental Health  
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on sale 5/15/09; publication date 6/22/09

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Publisher- Columbus, OH: WorldWideMentalHealth.com

First Edition, First Printing

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# **DEPRESSIVE PERSONALITY DISORDER:**

***Understanding Current Trends  
in Research and Practice***

**Todd Finnerty, Psy.D.**

**WorldWideMentalHealth.com**

**<http://www.DepressivePersonality.com>**

This book includes a free online website (no purchase necessary) where you can read up to date information on Depressive Personality Disorder and discuss the topic with other readers.

Register to get notices of important developments about DPD such as new research articles delivered to your inbox by sending an e-mail to:

**[info@depressivepersonality.com](mailto:info@depressivepersonality.com)**

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*Reader discussions and online supplements are available at **www.DepressivePersonality.com** and updates from the author will be added leading up to and after the publication of DSM-V and ICD-11.*

*List your clinical practice in the directory or view professionals who will assess for depressive pd and depressive traits at **www.depressivepersonalitydisorder.com***

## Dedication

*To my wife Jennifer and daughter Erin, and to my mother Linda and father Kenneth and the rest of my family and friends, and to the many teachers and others who have helped make who I am today possible, with love I thank you.*

## **Introduction**

*This book is published by WorldWideMentalHealth.com, an integrated print and online publisher™ The book includes evolving online supplements as well as the ability to register for free electronic delivery of updates related to the topic (including information related to the publication of DSM-V and ICD-11). You can also go online to discuss the topic with other readers. While the next print edition of this book is not expected until after the publication of DSM-V in 2012, before then you can still get updated information and more details at: [www.depressivepersonality.com](http://www.depressivepersonality.com).*

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? 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 PD 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 depressive traits or cognitive vulnerabilities to depression which can be associated with depressive pd.

The concept of a depressive personality is not new and is in current use. In my work reviewing social security disability applications I have come across professionals who diagnose depressive traits under Personality Disorder NOS (as allowed under DSM-IV). In addition, to see how the concept is used with the general public one simply needs to use a search engine or set a Google alert to “depressive personality” and watch the search results from blog posts made by individuals viewing themselves or someone else as having a “depressive personality” roll in. The general thrust of this book is admittedly one of support for including DPD in DSM-V as a personality disorder, and while this may lead to an increase in the assessment for and diagnosis of DPD among practitioners, many professionals and lay people already recognize the influences in one form or another and find the concept valuable.

DPD can be considered to involve a predisposition to depression (and anxiety symptoms) and more than likely may in some circumstances reflect cognitive

vulnerabilities. However, DPD is a disorder itself and includes its own impact on mood and functioning. Without this, we are talking about traits or elevated scores on a measure of normal personality as opposed to an actual disorder.

The first edition of this book is intended as an overview of some of the recent research supporting the inclusion of DPD in DSM-V as a personality disorder. It also is geared toward helping clinicians feel more confident in the support for the current use of the concept in treatment situations, and to provide background for further discussion and updates on the book's associated online site at <http://www.depressivepersonality.com>

A broad review of the historical underpinnings of the depressive personality concept is beyond the scope of the first print edition of the book. In addition, while topics related to the treatment of depressive personality disorder as well as the psychological assessment of DPD are briefly discussed, they will be more the focus of online supplements as well as a future text that is targeted for publication after the public release of DSM-V scheduled for 2012. The research literature is growing rapidly and there are many changes in store with DSM-V.

Current trends and influences impacting the DSM-V appear to be favoring the inclusion of a view of disorders at least in part as dimensional, particularly for the personality disorders. The DSM-IV includes a

discussion of Dimensional Models for Personality Disorders (pg. 633) and this was expanded slightly in the DSM-IV-TR (pg. 689). It is noted that “The diagnostic approach used in this manual represents the categorical perspective that Personality Disorders are qualitatively distinct clinical syndromes. An alternative to the categorical approach is the dimensional perspective that Personality Disorders represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another.” The five factor model and other models typically associated with “normal” personality traits are referenced in the DSM-IV-TR. In addition, the view that “DSM-IV Personality Disorder clusters (i.e. odd-eccentric, dramatic-emotional, and anxious-fearful) “may also be viewed as dimensions representing spectra of personality dysfunction on a continuum with Axis I mental disorders” is noted (DSM-IV, pg. 634; DSM-IV-TR, pg. 690). As Akiskal (2005) notes, “The boundaries among temperament, character, personality, and personality disorder are not clearly demarcated.”

The American Psychiatric Association’s DSM FAQ includes the question- What does it mean if a diagnosis is not included in the DSM? “It means that, as of 1994, there was not sufficient data to justify its inclusion in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. Just because a category is not included in *DSM-IV* does not necessarily mean that it is not worthy of being a focus of research or treatment.” It was also

noted by the online FAQ that “because the data requirement for consideration of new categories has become more stringent, some proposed categories that were ultimately rejected may have had more data available than grandfathered categories already in the *DSM*.” (2008).

The DSM-IV-TR breaks personality disorders in to Cluster A, B and C, though on p.686 indicates “It should be noted that this clustering system, although useful in some research and educational situations, has serious limitations and has not been consistently validated. Moreover, individuals frequently present with co-occurring Personality Disorders from different clusters.”

### **Practical Postmodernism for Psychiatric Nomenclature**

To fans of Thomas Kuhn or one of the various schools of thought in postmodernism, the notion that there may not be a currently achievable, exact one-to-one relationship with our diagnostic system and the “real world” is no surprise. While additional research will always be needed, we need to proceed with and utilize the concepts which hold clinical and research value. While research does support that specific genes are associated with a vulnerability to depressive symptoms, there will likely be no smoking biological gun which fully accounts for all early onset depressive traits any time soon, nor will we be able to

reduce the many factors impacting personality and psychopathology down to the most essential elements in a universally agreed upon way. There will also be no grand unifying theory for DSM-V and ICD-11 which will remove any and all anomalies from our diagnostic system. While Thomas Kuhn's book may be back to basics in the history and philosophy of science for many readers, it is worth reviewing here in the introduction. While Kuhn's ideas are not perfect, they offer helpful reminders for communities of scientists coming together to debate, revise and construct a diagnostic system.

The history of science (and practice) has been marked by differences between scientists (Kuhn, 1996/1962; Sulloway, 1996). It is a postmodern idea that this is the nature of science itself. In 1962, Thomas Kuhn's book The Structure of Scientific Revolutions (SSR) was first published (1962/1996). The SSR has been called one of the most influential books of the 20<sup>th</sup> century (Fuller, 1992), and has had widespread influence in a number of fields outside the history and philosophy of science, particularly in Psychology (O'Donohue, 1993). Kuhn proposed a cyclical model of scientific development in which sciences go through a number of stages. Sciences, according to Kuhn, develop by alternately creating and destroying paradigms. During a period of normal science there is one overarching paradigm that is supported by the entire field. The paradigm guides the work of the scientist. Paradigms consist of a number of elements that are shared by the entire

community of scientists in a particular discipline. A paradigm allows the field to take their foundations for granted and thus concentrate on more specific problems. Kuhn characterized the increasingly specific, paradigm-guided work during the “normal science” stage as “puzzle solving.” During normal or “mature science,” there is agreement concerning what are to be the legitimate methods, problems and standards of solution. This allows for a more cumulative progress, since a field does not have to constantly reinvent or debate foundational principles and assumptions- they can be taken as given, and are transmitted to new members of the field through textbooks. Normal Science is characterized by a dogmatic adherence to “one ruling theory,” the paradigm. Anomalous findings are generally set aside or blamed on the inadequate problem-solving ability of the scientist, and thus the results may often go unpublished or unrecognized. There is no way to make these results ‘fit’ in to the current worldview of the scientists. More important anomalies may become research problems within the paradigm, while still others, which may be in a more fundamental position for the current paradigm, may loosen the ties of the paradigm and help pave the way for revolution.

Kuhn’s model suggests that when anomalies become obvious, despite resistance, the field goes in to a period of crisis in which scientists attempt to patch the holes in the paradigm. The assumptions of the paradigm, previously unconsciously accepted and

unquestioned, are suddenly challenged and must be made explicit. At this time, other scientists (mostly either new to the science or from other disciplines) begin to propose alternative paradigms. A science is said to have undergone revolution when a new paradigm is embraced by the field, having solved some of the anomalies and having become more promising than the old paradigm. Adherents of the old paradigm fail to recruit new members and die off while the strength of the new paradigm grows. Kuhn would not say that the new paradigm is necessarily better than the old paradigm, since it often addresses different problems and theories. Kuhn suggested that paradigms were incommensurable, they could not be compared since they were fundamentally different.

Kuhn (1962/1996) also suggested that there is a period of pre-paradigmatic science that is characterized by immature “sciences” that have never had a paradigm. These young sciences are not dominated by a single paradigm, but a number of competing schools which debate the fundamentals of the discipline. Kuhn used the social and behavioral sciences as examples of pre-paradigmatic sciences. While they are ruled by “something like a paradigm,” it does not reach the level of specificity or acceptance of a true paradigm.

The SSR created controversy across a number of fields. A traditional view of science was that it was carried out at a perfectly objective level. Scientists held opinions very lightly and abandoned them at the

first sign of error. Kuhn challenged this view, pointing out the conservative and subjective nature of scientific procedures (Marx & Cronan-Hillix, 1987). Kuhn's work makes it apparent that the underlying, unproven assumptions of a discipline have a profound effect on that science. Kuhn's theory of science has at its core the effects of the underlying beliefs of the scientific community on science and the individual scientist. "Facts" do not speak for themselves, but gain their meaning from human theoretical and ideological commitments. The practice and beliefs of scientists are embedded in a greater social context. In his book, Born to Rebel, Sulloway (1996), attempted to describe the variable of individual scientists participating in normal science and revolutions. While his methods and results may be debated, the central thrust that factors related to the scientist impact the science can not be ignored.

Sulloway (1996) examined the biographies of thousands of individuals to determine the effects of family dynamics and birth order on the likelihood of supporting radical scientific revolutions or the more conservative, established scientific position. He found that historically, first-borns are much more likely than later-borns to support the social status-quo, and make strides in technicalities, while later-borns are much more likely to support radical scientific revolutions. He also suggested a number of other factors contributing to later-born's support of scientific revolutions including youth (.39), high

amounts of conflict with parents growing up (.45), liberal political attitudes (.52), atheistic religious attitudes (.58) [though this could also possibly be due to the methods and historical sample], extensive travel (.53), and personal contact (supported by friends)(.39)(pg. 35). Sulloway's results are based on a historical analysis of individuals during 28 different scientific controversies (1996).

This is not meant as an exhaustive review of relevant thought in the philosophy of science, social constructionism, constructivism or postmodernism in general. However, if we take the examples of Kuhn's work, we can see that science is not an enterprise of machine-like individuals objectively perceiving the outside world, science is a human enterprise controlled by human communities of scientists. A point that is well made by the committee discussions leading up to publications of DSM-V and ICD-11.

Maser, et al. (2009) titled their article "Psychiatric Nosology Is Ready for a Paradigm Shift in DSM-V," and suggested that a "mixed categorical-dimensional format" is likely to be incorporated in to DSM-V, particularly for the personality disorders. A number of authors have made similar calls for including a dimensional conceptualization of disorders to varying degrees. A categorical structure, like much of the current DSM-IV diagnostic criteria, assumes discrete entities which are very distinct from "normality," while dimensional views are more reflective of a

spectrum or continuum which gradually moves from more typical or normal to a level consistent with disorder. There are of course distinctions between the notion of a spectrum and a continuum, however the definition of each tends to blur depending on the specific use of the concepts. A type of mixed categorical-dimensional approach, however, would likely be most consistent with how clinicians currently approach the patients in practice and “conform to the way [they] think.” Interestingly, the authors note that “All DSM editions have relied on face validity and consensus” and multiple approaches have had to be taken in addressing the validity of diagnoses in the absence of a “gold standard.” While past critics of the depressive personality disorder diagnosis have questioned whether there is enough evidence to show that it is a discrete diagnostic entity, this is overly reliant on strict categorical assumptions. The current trend of viewing many disorders as not only dimensional but different while also having related underlying structures will be discussed throughout this book.

Achenbach (2009) also offered recommendations for the DSM-V diagnostic system in a commentary. He takes the term “dimensional” further by suggesting the use of “quantitative,” including the severity and frequency of symptoms. In addition, it is noted that maintaining a developmental perspective in that different behaviors may be more or less appropriate in certain phases of life is important (and one can also include the need to consider cultural factors and

gender differences). An example used by Achenbach would suggest that we should beware of making normal curve assumptions which apply to everyone in relation to our “dimensions.” For example, Achenbach noted that the “base rates for problems such as difficulty concentrating and sitting still are significantly higher for boys than for girls” in the general population. Without adequate data on specific traits which may be used as dimensional constructions a normal curve assumption may misrepresent specific groups or the general population as a whole. While personality traits, for example, are not likely to be bimodal and reflect two separate and distinct groups, that does not mean every group is normally distributed. Achenbach also notes that there is only modest agreement between reports of a person and collaterals who know them well, supporting the notion that obtaining 3<sup>rd</sup> party information may be useful in diagnosis. It is also suggested that the specific diagnostic threshold used may be impacted by who the person providing the information was. This is consistent with the notion that different people may interpret things differently.

Stein (1998) described three positions: reductionist, dualist and emergent. According to the reductionist position described by Stein (1998), “explanations of mental phenomena can be reframed in terms of explanations of somatic or behavioral phenomena. The basic laws of the universe are those of physical science, and these laws ultimately govern the phenomena studied by all other sciences.” In the

dualist or dualistic position, explanations of mental and somatic phenomena are ultimately incompatible and different kinds of laws govern mental and somatic phenomena. Stein also describes the “emergent view” of the mind-body problem. In this instance, “explanations of mental phenomena may address their physical underpinnings, but they must also address more complex (psychological) structures and mechanisms.” Stein further states that “Given the sophistication of current psychobiological research on psychiatric disorders, the reductionist and dualist positions may appear to be strawmen.”

William James, from a pragmatic viewpoint, suggested that the human mind can not achieve a single, unified concept of the world, nor did he think it important to achieve such a concept. According to James, all we can know are certain parts of the universe which look different to different people, and that this provides the basis for a pluralistic view of the world. The main thing about these plural views is not whether they are consistent with one another but whether they lead to successful action, whether they work or not (Stumpf, pg. 309, 1993).

### **Does Depressive Personality Disorder Exist?**

The adolescent that still resides in me somewhere can not resist bringing up the question “Does Depressive Personality Disorder exist?” so that I can bring in the over-simplified but honest conclusion “If

we say it does.” This is not to make light of the research reflecting an incomplete overlap of the concept of Depressive Personality Disorder with the concept of Dysthymic Disorder (or other Personality Disorders including Avoidant Personality Disorder) or the research noted in Chapter 2 supporting the validity of Depressive Personality Disorder. However, clinicians find value in the concept of a depressive personality disorder and depressive traits and ultimately, we should choose to include depressive personality disorder in DSM-V and ICD-11. This would confirm the support found for the concept in the research literature and endorsing its “existence” as a useful, powerful concept in both research and practice. While certainly our science and theory will need to continue to advance beyond DSM-V & ICD-11 and we can not fully grasp what discoveries may be ahead, the time for depressive personality disorder is today. Depressive PD offers the ability to communicate additional information relevant to etiology and treatment and is more than a mild mood disorder. Chapter 2 will focus more in depth on the question of validity which is at the heart of viewing DPD as a concept which should “exist.” In addition, Chapter 4 reviews multiple lines of research on related concepts such as Neuroticism and cognitive vulnerabilities to depression. We should not lose sight of the idea that scientists and practitioners continue to try to explain some of the same underlying phenomena regardless of the theories and methods which are most endorsed by scientific and professional associations at any one time. It is the

bias of the author that an interaction between clinical utility and simplicity of alignment with current theory, data and practice should help motivate scientists and practitioners in this area.

## **Chapter 1. An Overview of Depressive Personality Disorder**

The term “depressive” calls to mind the mood disorders which are so often associated with some Axis II personality disorders, and controversy has existed in the past whether DPD is distinct enough from early onset, chronic “mood” or affective disorders to be included in diagnostic manuals. There is growing recognition that some distinctions made in our classification system, while useful, may also be artificial and arguments attempting to limit diagnoses presenting with emotional disturbance to a pure mood (or anxiety) category may be oversimplifying. This is particularly salient given the level of co-occurrence and overlap of existing diagnoses. Arguments suggesting DPD should simply be classified as a mood disorder or a subtype of dysthymia (as opposed to recognizing the significant characterological nature as a personality disorder) are unsupported by the research which will be outlined in subsequent chapters. This book presents the case for the validity of DPD which has already been established by recent research in the field. It also argues for the clinical utility of Depressive Personality Disorder and assessing for it in your clinical practice.

DPD can be viewed as a disorder in itself and not simply the expression of a predisposition to depression. Not only does DPD involve signs and symptoms of mood disorder typically coded on Axis I

(and to some degree anxiety disorders as well), the use of DPD suggests relatively stable personality characteristics which tend to be resistant to change (though can be changed). While the expression of traits related to depressive personality disorder can be viewed dimensionally, it is not simply a statistical location on a continuum which leads to a disorder cutoff score. In addition, conceptualizing it and other personality disorders as a collection or “profile” of different dimensions may prove useful, while viewing them as simply one dimensional or the extreme version of one specific personality trait or facet may be misleading and not particularly useful. In addition, it may be too easily confused with a continuum of functional severity. The “maladaptations” as noted by McCrae, et. al. (2005) as well as the resulting functional impairment are what help to define disorder. It would be misguided to attempt to define a disorder which did not lead to limitations or experiencing some related distress on the part of the person or those around them. A depressive personality would be expected to lead to pervasive problems (including possibly with mood and anxiety) that impact the individuals functioning in one or more aspects of their daily life. While the framers of DSM-V may seek to reduce its reliance on a categorical listing of symptoms and criteria for personality disorders, it should be noted that practitioners already tend to incorporate dimensional views of personality disorder both from a severity perspective and from the use of personality disorder “traits” or “features.” While individuals may score in

a similar, elevated range on a normal personality measure, the expression of those traits and facets may prove to be different. It could be a mistake to suggest removing the concept of a disorder entirely from phenomena that have proven to create enduring pathology, and also could lead to a filtering out or difficulty incorporating advances in other areas outside of personality research should the conceptualization of personality disorders become excessively reliant on one theory of personality. That is not to say that theories like the Five-Factor Model (among others) are not beneficial in conceptualizing Depressive PD.

Conceptualizing a depressive personality has a rich clinical tradition taking form across a number of theories over the course of the last century. Sass & Jünemann (2003) offer a brief, historical overview of depressive traits and affective disorders. However, the focus of this book is on recent research and trends leading up to the publication of the DSM-V, ICD-11 and beyond. Depressive personality disorder, while having the weight (and baggage) of the history of theory on depressive traits, was offered in Appendix B in DSM-IV and DSM-IV-TR as one of multiple “Criteria Sets and Axes Provided for Further Study (American Psychiatric Association, 2000, pg. 788) and has also taken some form in other past editions of the DSM. A depressive personality is noted in ICD-10 under Dysthymia.

Depressive Personality Disorder (DPD), according to the research criteria in DSM-IV (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).

This dysthymic disorder pseudo-exclusion criterion would certainly be in conflict with the ICD-10, of course, and would likely need to be worked out as

the framers of DSM-V and ICD-11 are attempting to move the manuals toward closer agreement. The use of “better accounted for” however is vague, particularly when considering DPD may better account for the patient’s presentation in situations where enduring personality characteristics significantly contribute to the presentation, and many “non-textbook” patients will likely meet DSM-IV-TR criteria for both disorders since both include chronic mood states. What guidelines could help clinicians evaluate whether dysthymic disorder “better” accounts for the DPD presentation, and exactly how did dysthymic disorder acquire primacy over Depressive PD? Many mood disorders, including dysthymic disorder, are categorized via broad lists of symptoms leading to heterogeneous groups of individuals with diverse etiologies and presentations. Also impacting the “not better accounted for” criterion is the assumption that DPD is more mild than dysthymic disorder, however later chapters will discuss flawed arguments that DPD represents only a mild form of mood disorder lower on the spectrum of mood disorders than dysthymic disorder. This argument is not supported by recent research in to DPD. The vague statement about it not being better accounted for by dysthymic disorder unnecessarily interferes with clinical judgment, introduces excessive subjectivity impacting standardization and should not be included in DSM-V. The authors of a multi-year follow up study on DPD noted that “The DSM-IV exclusion of depressive personality disorder that is ““better accounted for”” by dysthymic disorder

was not employed, as it is unclear how this can be determined” (Laptook, et. al., 2006). This long term study (10 years) not using this criterion would offer support for choosing to not use the criterion under DSM-V.

In the past, Ryder, et. al. (2002) have offered criticism of the DSM-IV depressive personality construct, though generally their concerns about DPD may be directed at personality disorders under DSM-IV in general. They criticize DPD in light of its potential overlap with dysthymic disorder and suggest viewing the construct dimensionally under a changed DSM-V system based on the Five-Factor Model of personality, yet in this study at least they also appear to continue to use a categorical view of dysthymic disorder as opposed to a dimensional view of mood disorders. It is not fully clear if dysthymic disorder would even be needed in DSM-V if a dimensional expression of mood disorders includes relevant course specifiers for depression and revisions to how severity is communicated, though the diagnosis currently is useful and would be expressed in some manner. Dysthymic disorder is currently a diagnosis made by what it is not. Major depressive disorder with a chronic specifier communicates the two year duration found in dysthymic disorder. A mildly severe major depressive disorder that is chronic under DSM-IV is not dysthymic disorder, though depending on how severity is communicated and in what way the categories may change dysthymic disorder may

become redundant with major depression/ depression. This is particularly salient when considering a diagnosis of dysthymic disorder should not be made if there was a major depressive episode within the first 2 years of the dysthymic disorder and the disorder should not be “better accounted for” by “chronic Major Depressive Disorder” (p 380, American Psychiatric Association, 2000). Hirschfeld (1991) expressed the opinion that “Many clinicians and researchers believe that dysthymia is too similar to major depression in its emphasis on depressive symptomology (especially vegetative). They believe that it fails to consider characterological aspects, in particular cognition.” Dunner (2005) noted that there were significant similarities between the various subtypes of chronic depression, including dysthymia, and suggested collapsing them in to one category called “chronic depression.” If there is a move towards less categorical thinking and more dimensional approaches toward mood disorders, dysthymic disorder may become overly redundant with a chronic depressive disorder; whereas DPD would continue to offer additional, clinically useful information and can be differentiated from a “milder form” of chronic depression. Though it is not best classified as a mood disorder, depressive personality disorder like other personality disorders, should be viewed as involving a mood component.

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).

Regier (2007) notes that nosologists have been “...confronted with the reality of patient populations who, while appearing to have similar clinical presentations, proved to be highly heterogenous.”

It may be an error to question the construct validity of a diagnosis because it involves signs and symptoms from more than one of the categories we have created. The categories of mood disorder, anxiety disorder and personality disorder are useful, however in reality patients will likely present with problems that transcend these artificial boundaries.

A diagnostic system should be flexible and realistic enough to allow for the overlaps given the many influences on human behavior. DSM-V will likely continue the move toward a less strictly categorical approach to classification, and DPD has proven to be a concept worthy of inclusion in such a system.

## **Chapter 2. The Reliability, Validity and Stability of Depressive Personality Disorder**

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 Laptook, 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. Criticisms related to diagnostic overlap with other disorders are also addressed in chapter 3. 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. As will be seen, 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 pd includes a potential dimensional relationship of depressive pd with a group of enduring cognitive vulnerabilities that should make comorbidity and cooccurrence with other disorders expected by definition, given its close ties to these underlying pathological processes which lead to distress and interpersonal problems (see chapter 4 for more discussion on this topic).

Researchers have explored the concept of DPD as expressed by the categorical criteria of DSM-IV & DSM-IV-TR by viewing aspects of normal personality which may be related to the criteria and the phenomenon itself, adding a dimensional conceptualization of DPD constructed of traits and facets which may be associated with the DPD category. Predictions have been made related to the Five-Factor Model of personality 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.” More information related to using the NEO PI-R and other assessment instruments and procedures is covered in Chapter 5 and will be a focus of information published on the website. You can learn more about the NEO PI-R and other psychological tests and find related resources at: [www.psychologicalassessment.org](http://www.psychologicalassessment.org)

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. DPD measures do assess the proposed DPD construct, however.

While some critics have crafted arguments targeting the stability of Depressive PD over time, it is comparable to the stability of other personality disorders and grounded in personality traits and enduring cognitive vulnerabilities which are expected to persist (see chapter 4). A dimensional view that would allow for an assessment of personality traits or features below a cut off score or threshold for the diagnosis may allow for a better assessment of the stability of diagnoses in general. Stability, according to Krueger (2005), does not reliably distinguish personality disorders from the clinical disorders (nor does treatment response).

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. Laptook, 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.

Despite some past criticisms, current DPD research demonstrates the value of depressive personality disorder.

### **Chapter 3. Evaluating Trends in Current DPD Research**

“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 from 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 (as opposed to attempting to explain the range of human experience while recognizing that there will be overlap in the boundaries we have created). 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. That is not to say that studies comparing individuals who met only the criteria for DPD to individuals who met only the criteria for an affective disorder like

dysthymic disorder are not valuable. However, 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 (more on this in chapter 4).

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.

While Kwon, et. al. (2000) compared a sample of undergraduates with DPD to a nonclinical sample of undergraduates, other studies may or may not be more impacted by failing to take in to account the extent of functional impairment experienced by their participants. Studies also often use a diagnostic category to make conclusions about a specific diagnosis, yet do not always compare or control well for the extent of functional limitations and severity in the individuals meeting those categories when comparing different diagnostic groups from clinical samples. While they can simply be avoided or treated as possibly confounding, taking action to control for varying levels of functional impairment should be included in the design of studies. The level of

functional impairment is also important in clinical practice and perfecting how we assess and communicate it is a focus of the DSM-V Task Force.

While the GAF (Global Assessment of Functioning) is in current use (as well as research scales), the individuals creating DSM-V hope to include additional, meaningful methods of quickly conveying functional limitations and it remains to be seen what this may look like. Some studies have managed to control for the extent of overall functional impairment and researchers should emphasize this in their studies (in addition to simply meeting the criteria for a specific diagnosis). The degree of functional impairment should be focused on both in research and practice. Revisions with DSM-V hold the potential to greatly improve the manner in which clinicians convey degrees of functional impairment across multiple domains of functioning, particularly if standard scales become employed which are well anchored and defined by activities of daily living and other criterion examples to reduce the subjectivity of ratings and inter-rater variability.

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.

In proposing changes for DSM-V, Dunner (2005) notes the 4 “subtypes” of chronic depression he identified from DSM-IV [chronic major depression, recurrent depression and incomplete remission, dysthymic disorder and double depression (dysthymic disorder and major depressive disorder simultaneously)] should be included together as “chronic depression.” He notes the reasoning for this to be that patients with chronic depression have elevated rates of chronic depression compared to normal controls in family members and similar treatment indications. He also suggested that “Clearly, the study of the human genome and possible linkage factors associated with chronic forms of depression will provide a better genetic basis for classification of these disorders.” This presumes

the outcome of knowledge we did not have at that time, though research from Orstavik, et. al. (2007) now note that of the genes involved in major depressive disorder and DPD about half contribute to one but not the other. While Dunner's desire to simplify classification of individuals presenting with chronic depression is commendable, it would significantly impact clinicians' abilities to quickly and effectively convey important clinical information about their patients. The evidence related to differences in course and treatment response is by no means conclusive, particularly in relation to emerging studies of individuals with DPD. Regardless of your definition of spectrum, it would be premature and likely an oversimplification to ignore the differences in these diagnoses. While common factors do exist and true distinctions sometimes difficult to trace, clinicians and researchers can not simply give up on the task of imperfect classification simply because it is imperfect. One of the guiding principles, clinical utility, would suggest that while clinicians do have to remember distinctions and multiple disorders and simplicity would assist them, these labels are useful and meaningful to them and worth the effort of differential diagnosis.

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. While certainly 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. While depressive PD includes mood symptoms, it is more like the personality disorders than the mood disorders in its emphasis on more stable, characterological qualities of an individual.

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 whether or not it is retained in DSM-V is beyond the scope of this book). 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 DPDs, 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. In addition, while a spectrum model allows for differences, 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 dysthymic disorder, mild 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.

## **Chapter 4. Towards an Integrated Conceptualization of Depressive PD Including Dimensional DSM-IV Criteria, The Five-Factor Model and Cognitive Vulnerabilities**

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. Bagby, et. al. (2004) suggested that using dimensional traits rather than categorical nosology to characterize DPD "has the potential to enhance the conceptualization and description of this disorder."

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.

One of the more salient of the FFM personality dimensions in relation to DPD is Neuroticism. 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 chapter, 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). After a visual inspection of the criteria for DPD a specific criterion does not immediately jump out at you for this one, however 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 described later in this chapter, it is not entirely clear if this facet would 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 studies cited elsewhere in this text.

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.

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 tendermindedness 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 “MADD 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.” 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-V, 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-V, 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.

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.

### **The Utility of Cognitive Vulnerabilities in Conceptualizing DPD**

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 over-looked. 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 deficient and less useful in describing clinical realities.

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-V remain to be seen, however clinicians are no strangers to assessing the impact of an individual’s difficulties on their daily life under the current system.

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 degree associated with a disorder may remit 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-V 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.

Want to discuss conceptualizing depressive personality disorder from multiple approaches? Come to the discussion forums at

<http://www.depressivepersonality.com/forum>

and/or join the **depressive personality groups** on **linkedin.com** and **facebook.com** which are moderated by the author of this book.

## **Chapter 5. Differential Diagnosis, Psychological Assessment and Treatment of Depressive Personality Disorder**

Chapter 5 will be a central focus of the online supplements to this book as well as the next edition planned for the book. It also outlines some broad but important research questions. More treatment studies specific to DPD would be beneficial, and certainly with inclusion as an official diagnosis in DSM-V more researchers will look to address DPD in their samples. Clinicians generally take the approach that psychological assessment is only one source of information contributing to diagnostic decisions and treatment planning, however research on improving the assessment of depressive pd would be beneficial. The issues in chapter 5 are likely to make for good discussion at the website as well as interesting research questions:

To learn about ways you can network and connect with other clinicians and researchers interested in this topic please go to

<http://www.depressivepersonality.com/forum>

There you'll find a growing list of options including a message board as well as links to groups on social networking sites.

**Making a Diagnosis of DPD or Personality Disorder NOS with depressive traits under DSM-IV-TR**

Individuals with negative cognitive styles, including those seen in cognitively vulnerable individuals and those with depressive traits and depressive pd, are more likely to experience negative psychiatric outcomes. Iacoviello, et. al. (2006) noted that individuals with negative cognitive styles had more episodes of depression, more severe episodes and more chronic courses. This is consistent with findings that cognitive vulnerabilities may lead to mood problems as well as relapse and consistent with descriptions of depressive traits.

In making any diagnosis one considers the frequency, intensity and duration of symptoms. If available, using collateral information such as reports from a 3<sup>rd</sup> party regarding activities of daily living (ADLs) or otherwise using multiple sources of data that do not just rely on self-report is beneficial. This is particularly true of the personality disorders. When considering severity, we must keep in mind that there are different domains of functional impairment, such as a person's ability to care for themselves; relate to others; understand, remember, concentrate and persist at tasks, tolerate stress and frustration, etc. These considerations may be important when making any diagnosis, but when making a hybrid dimensional/categorical diagnosis they may be even more important given the grey

areas where distinct diagnostic thresholds may not be present. For example, if we view depressive personality disorder as a grouping of maladaptive personality characteristics which have become present to the level which they dramatically interfere with function, we also will keep in mind that “lower” on the dimension may exist presentations of individuals with depressive traits/features or a few specific cognitive vulnerabilities to depression or distress. Under DSM-IV, we have general guidelines to follow in making any diagnosis of disorder as well as making a diagnosis of a personality disorder. Ultimately, it is a clinician’s judgment using all the information they have available, whether an individual “meets criteria” for the disorder. If the clinician feels that they do not meet full criteria, under DSM-IV many clinicians will still code “traits” or features of a personality disorder. A personality disorder, of course, may be a collection of many traits as well as characteristic, maladaptive expressions of those traits. It is useful to have a diagnostic shorthand, however, such as “borderline traits” or “depressive traits.” While sometimes traits alone are coded without an actual diagnosis, when sufficiently severe this is also done under Personality Disorder NOS, a diagnosis which DSM-IV-TR also allows for Depressive Personality Disorder.

It is not abundantly clear what the fate of PD NOS is under DSM-V, but it is clear that it currently plays a large role in clinical practice. Johnson, et. al. (2005) note that it may be the most common personality

disorder diagnosis in clinical settings and found that individuals with a Personality Disorder NOS diagnosis were “more likely than individuals with anxiety, depressive, disruptive, or substance use disorders to experience adverse outcomes.”

While depressive personality disorder is included as a diagnosis for further study in DSM-IV and DSM-IV-TR, it also specifically allows for depressive personality disorder to be diagnosed under Personality Disorder NOS. Given the research that has been reviewed in this text as well as the many traits and maladaptive expressions of those traits and stable vulnerabilities which can be viewed dimensionally with depressive personality disorder, it would appear that depressive PD is both a useful concept under the DSM-IV system of diagnosis, and will continue to have clinical utility under a hybrid categorical-dimensional system which may occur with DSM-V.

### **Depressive Personality Disorder compared to Dysthymic Disorder, Mild Depressive Disorder and similar concepts**

*Depressive Personality Disorder should not be considered a “mild form” of anything, severity exists on its own “dimension” and this statement is inconsistent with findings of increased vulnerability, longer treatment, greater chance of relapse and greater co-occurrence of other disorders.*

Ryder, Bagby and others have in the past criticized the concept of Depressive PD. They have over time gone from suggesting that it is a subtype of dysthymia (1999, 2001) to offering criticisms consistent with criticisms of the other personality disorders and that depressive traits should be viewed dimensionally in DSM-V consistent with facets of Neuroticism and Extraversion (low) of the Five-Factor Model (2002), and finding that while depressive pd overlaps significantly with other personality disorders it is “distinguishable in its unique relationship with traits from the FFM (Bagby, et. al., 2004) and as well as indicating that “consideration of personality features is critical to the understanding of depression and potentially of considerable utility in the optimization of its treatment” (2008). They reviewed studies noting that “criterion sets for depressive PD and dysthymic disorder can be empirically separated” and “the best results are obtained when the 2 psychological symptoms of dysthymic disorder are considered to be part of both categories.” They indicated that low self-esteem and feelings of hopelessness are present “in the overwhelming majority of overlapping cases.” This is consistent with cognitive vulnerability research in chapter 4 suggesting that self-esteem tends to load on a factor with experiencing depression. They suggest that depressive PD could be reconceptualized as a “clinically relevant personality dimension” in DSM-V. However, some researchers may have moved too far towards including statistically “extreme” personality traits in an attempt to discard

personality disorder categories, however such an attempt will fail to incorporate the many varied, adaptive and maladaptive expressions of those personality traits which can be represented by a disorder such as depressive pd. In addition, two individuals who fall at the same score on a measure of a personality facet such as on the NEO-PI-R may not necessarily present similarly or experience the same level of functional impairment.

Depressive personality disorder is, as the name implies, a personality disorder. The DSM-IV diagnostic criteria for DPD are relatively enduring traits or maladaptive characterological tendencies which have been shown to confer risk of depression and other problems as well as prolong them. They can be viewed dimensionally, and when they are present together in sufficient degree such as in depressive pd or as reflected in a diagnosis of depressive traits they can be distressing in themselves as well.

Conversely, mild, subsyndromal or subthreshold depression implies a variant of normal mood which may be beginning to create some concerns for the individual but do not meet criteria for another mood disorder. This is not consistent with the evidence on depressive pd as previously reviewed in this text. The concept of chronic depression is a broad one and includes dysthymic disorder, and individuals with personality disorders including DPD may be chronically depressed. In addition, individuals may

over-report PD symptoms during an active mood disorder, however this should not exclude individuals with a mood disorder from being diagnosed with a personality disorder, including DPD. Depressive pd and depressive personality traits continue to be present in the absence of the experience of depression and would continue to impact a patient's functioning. However, it may be misguided to focus excessively on comparing dysthymic disorder to depressive pd. Dysthymic disorder is simply a grouping of symptoms and may be an overly heterogenous concept defined by what it is not and reflecting distress which may be common to many chronic psychiatric conditions. While depressive personality disorder may share similar symptoms with dysthymic disorder and other ways of communicating chronic depression, when present it is a preferable diagnosis given its ability to communicate distinct etiological processes including its relationship to cognitive vulnerability research, a common course and prognosis not dependent on subgroupings of dysthymic individuals, and communicating other severity factors such as its relationship with other personality disorders.

Huprich (2000) suggested that the NEO-PI-R could assist in differentiating depressive personality disorder from dysthymic disorder (dysthymia). While the sample size was not large and could make significant effects difficult, individuals with depressive personality disorder scored significantly higher on the Self-Consciousness facet of

Neuroticism on the NEO-PI-R. In reviewing the literature, Huprich suggested that this may be due to reduced social engagement compared to dysthymics. In addition, individuals with a depressive personality scored significantly lower than individuals with dysthymia on Extraversion and Gregariousness as well as clinically lower on Openness and Agreeableness. Individuals with depressive personality were found to have average levels of Agreeableness “suggesting that they contain their negativity and anger” per Huprich. Additional research would be beneficial and the NEO-PI-R results should be viewed as tentative at this point.

Additional discussion of differential diagnosis as well as the relationship between depressive personality disorder and chronic depression symptoms will be available on the website  
<http://www.depressivepersonality.com>

### **Depressive Personality Disorder compared to Avoidant Personality Disorder**

Personality disorders do have a tendency to have symptoms which overlap with one another, as do other diagnoses. Avoidant personality disorder (with Borderline personality disorder coming in as a runner-up) tends to have the most overlap with depressive personality disorder.

Huprich noted that hostility towards others and attempts at perfection may differentiate individuals with depressive pd from those with avoidant pd. Individuals with avoidant personality disorder may be more likely to be anxious and avoid others. (Huprich, 2004; Huprich, 2005). This is consistent with theorizing on the Millon “depressive prototype.” Rasmussen noted (Pg. 260) that the difference between depressive and avoidant personality styles was in their “style of adaptation.” He noted that while the avoidant personality takes active efforts to avoid painful encounters, the depressive personality is “resigned to the occurrence of pain” and will do little to avoid unpleasantness. The depressive personality does care about interpersonal interactions, but tend to be “cynical” and “pessimistic in their outlook on themselves and others” (pg. 261).

It is important to note that a patient’s level of state and trait anxiety may not assist in differential diagnosis between depressive pd and avoidant pd. Many of the same facets are related to avoidant PD and depressive pd. (Huprich, 2005). As was discussed in Chapter 4, this may be due in part to the presence of maladaptive expressions of personality traits, including cognitive vulnerabilities as well as the non-distinct relationship between distressing symptoms typically classified as either anxiety or depression.

## **Treatment of Depressive Personality Disorder and implications for treatment of depression and other co-occurring disorders, prognosis and treatment selection**

We have seen throughout this text that in general, the presence of Depressive PD reflects a poorer prognosis and a greater length of treatment than if DPD was not present. It also suggests a greater risk of comorbid disorders including mood disorders, avoidant personality disorder and borderline personality disorder. Shahar, et. al. (2003) studied the role of perfectionism and personality disorder in brief treatment for depression. They noted that in their study DPD “predicted poorer outcome in brief treatment for depression.” Phillips, et. al. (1998) found that the duration of psychotherapy for individuals with DPD was significantly longer than for those without.

There are few treatment studies specific to DPD, currently, yet related constructs can be used in terms of preliminary treatment recommendations. When a finding of DPD is made, the course can be expected to last longer. This may lead clinicians to adopt protocols for chronic depression and other difficulties sooner in the treatment process. It may inform medication selection, dosing and the ordering of tests to determine rates of metabolism or biological vulnerabilities. It may prove to be more beneficial to attempt combined medication management and psychotherapy as early as possible in treatment and

also attend to the potential for relapse and comorbid difficulties.

As noted in chapter 4, given the structure of DPD as categorized by DSM-IV and DSM-IV-TR, the construct can be associated with literature on cognitive vulnerabilities to depression and distress. It may hypothetically involve the maladaptive expression of a collection of enduring traits which have shown to increase one's vulnerability to depression. Whether individuals with DPD also lack factors creating resiliency is also a subject for future research. One approach to treatment may be cognitive-behavioral and schema-focused, addressing the maladaptive expression of personality characteristics that may contribute to recurring major depressive episodes and other psychological distress. Laptook, Klein & Dougherty (2006) performed a 10 year study with multiple follow ups and found that depressive pd was a negative prognostic indicator for the treatment and course of Axis I mood disorders.

Future discussions on the website <http://www.depressivepersonality.com> will focus on integrating treatment approaches to Depressive PD including psychopharmacology and psychotherapy.

## **Depressive Personality Disorder and the Concept of Treatment Resistant Depression (TRD)**

What is the relationship between Depressive PD and treatment resistant depression? TRD involves a heterogeneous group of individuals generally with major depressive disorder who have failed multiple medications or treatment approaches. In March, 2009 the FDA approved Symbyax™ (a combination of Zyprexa™ and Prozac™) for the treatment of TRD. TRD certainly is a heterogeneous concept, however such studies can be useful.

Cytochrome P450 may be involved in the metabolism of many drugs (Sachse, et. al.; 1997). Cytochrome P450 Genotyping can create assumptions about how a specific individual's body metabolizes antidepressants and this can inform treatment decisions, particularly in individuals with TRD. Research should pursue whether genotyping is also a beneficial recommendation for individuals diagnosed with depressive PD, particularly if they have begun to show signs of slow or no response to treatment or frequent relapse.

## **Impact on other health concerns (including heart disease, chronic pain, and somatic distress disorders)**

In an attempt to differentiate DPD from dysthymic disorder, Huprich, et. al. (2005) hypothesized that

DPD would be less associated with measures of functional health status than affective disorders. Measures of DPD were associated with an impact on functional health status and depending on the measure, there were mixed results. For example, after controlling for symptoms of dysthymic disorder the DPD checklist (DSM-IV categories) was less related to an impact on functional health status. However, when the Depressive Personality Disorder Inventory (DPDI) was used, the correlation with negative functional health status was even greater than major depressive disorder. Additional research in this area may be beneficial, though it will likely be impacted by the measures used.

There is a significant relationship between depression and heart disease and other negative health outcomes. While this relationship is established for mood and other disorders, given the potential for common factors between mood and personality disorders including depressive pd, the potential impact of DPD on health status should not be overlooked.

Recalling the possibility of a relationship between DPD and cognitive vulnerabilities to depression, it is noteworthy that factors associated with DPD may play a role in prolonging or worsening the perception of chronic pain in some individuals. Sullivan; et. al. (2002) noted that rumination was a predictor of disability in individuals with chronic pain for 2 years or greater and both rumination and helplessness

predicted disability in individuals with pain for 4 years or more. Helplessness “was the strongest predictor of pain-related disability in the group of patients off work for more than 4 years” in this study. The authors noted that catastrophizing was a stronger predictor of pain-related disability “than the pain itself.”

While not a study of DSM-IV depressive pd itself, Grossardt, et. al. (2009), followed up on individuals who had taken the MMPI from 1962 to 1965 at the Mayo Clinic. They followed the individuals for 40 years. The authors noted that “personality traits related to neuroticism are associated with an increased risk of all-cause mortality,” essentially meaning that individuals with these traits are more likely to have perished at follow up during this study. One caveat is that the MMPI was used to assess “depressive personality traits” and this may not be completely analogous to depressive pd as defined in DSM-IV.

## **Suicide**

Individuals with a self-blaming, pessimistic explanatory style are at a greater risk of suicidal ideation and tend to attribute negative life events to “internal, stable and global self-characteristics” (Hirsch, et. al., 2009).

Johnson, et. al. (2005) found that adolescents with Personality Disorder NOS were more likely to have suicide attempts than adolescents with no personality disorders.

Given research on personality disorders in general as well as traits related to depressive pd, it would not be surprising to find that individuals with depressive PD are at increased risk for suicidal ideation and attempts.

### **Psychological Assessment of Depressive Personality Disorder**

*While some instruments are in the public domain, many of the psychological testing instruments noted are trademarks of their respective companies and protected by copyright. This section is written with the assumption that the reader has some background in psychometrics. In addition, the psychological assessment of depressive pd is only briefly reviewed in this text as it is not the intended focus of the first edition, however it will be a strong focus of the upcoming online content and future texts.*

Huprich (2008) noted that there is “no observed “gold standard” for assessing DPD.” Given the evolving nature of research on DPD and the impending changes with DSM-V, I am choosing to spotlight a few instruments that may be relevant to the assessment of Depressive PD, however as with

many topics in psychological testing the methods used for assessing DPD will likely be more increasingly refined with time.

There have been a number of research instruments which have been designed to measure constructs which may be related to depressive personality disorder, as well as multiple research instruments that have been published to assess DPD. One potential criticism of attempts to assess depressive pd are attempts to differentiate it from depression symptoms. Depression symptoms can be considered part of a very broad construct of depression which is itself a disorder, but it is also a component expected in many other disorders. Not all individuals who are depressed will have depressive personality disorder and not all individuals with depressive personality disorder will always be depressed, however given the many underlying cognitive vulnerabilities to depression in an individual with depressive pd, depression or a risk for depression should be considered inherent in the disorder.

### **Research Instruments and Measures specific to Depressive Personality Disorder**

Measures have been developed to directly assess for DPD, however their development has generally been for making a diagnosis for the purpose of research studies.

The Depressive Personality Disorder Inventory (DPDI) is a “41-item questionnaire [that] was developed to assess cognitions that are representative of the DSM-IV conceptualization” of DPD (Huprich; et. al., 1996\*). *\*The 1996 version of the DPDI is included as an appendix to this study in the Journal of Clinical Psychology.*

The validity of the DPDI has been demonstrated (Huprich, Sanford & Smith, 2002). In addition, results on the Depressive Personality Disorder Inventory (DPDI) were negatively correlated with measures of quality of life, hope and optimism (Huprich & Frisch, 2004).

Huprich compared the Diagnostic Interview for Depressive Personality Disorder (Gunderson, et. al., 1994) with the Depressive Personality Disorder Inventory and the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-IV), which assist raters in applying the DSM-IV criteria for depressive personality disorder. All three measures were positively correlated with each other, however only 16 of 46 individuals in the sample were diagnosed with DPD on all 3 measures. These 3 measures were also correlated with measures of paranoid, borderline, avoidant and dependent personality disorders. Huprich noted, however, that “in this study, DPD’s overlap with other personality disorders appears to be somewhat better compared to other DSM-IV personality disorders.”

Assessing the value of research instruments designed to measure self-criticism, other cognitive vulnerabilities and related constructs in depressive pd research may be an interesting area for future research.

Psychological testing instruments specific to depressive pd should be viewed as useful, however in a preliminary phase of development and only one cautiously-viewed piece of the diagnostic puzzle until further research and development is carried out.

### **Projective Testing (Rorschach, TAT, etc.)**

It is worth mentioning that Steven K. Huprich, at the time of publishing his book on Rorschach assessment of the personality disorders, noted that there had been “no published study on DPD and the Rorschach” (pg. 374). He does describe hypotheses related to the Rorschach scales which may be relevant to depressive personality disorder. The evidence from this area, like all of the psychological tests applied to DPD, is certainly a worthy subject for monitoring and discussion on the website for those interested.

**Millon Clinical Multiaxial Inventory (MCMI-III)  
and other Millon scales**

Millon describes a depressive prototype with a self-image of being worthless, feeling defenseless and vulnerable, cognitively pessimistic and fatalistic, brooding and engaging in “harsh self-judgments and self-destructive acts” (pp 30-31). There are 8 MCMI-III items which were noted to be parallel to this prototype (see pg. 31). The “Depressive” scale (2B) itself is made up of 15 total items with 8 “True prototypal items” and 7 “True nonprototypal items” (pg 167). The items themselves are partially consistent with the DSM-IV-TR criteria, however they may fail to capture the full extent of interpersonal concerns while also introducing other variables. While the MCMI-III Depressive scale may prove useful, some caution may be needed, including not necessarily viewing it as a direct measure of the DSM-IV depressive personality disorder. Additional research would be beneficial in refining the MCMI-III for assessing the depressive PD construct as identified in the DSM.

**Beck Depression Inventory (BDI-II) and other Beck scales:**

Kwon, et. al. (2000) found individuals with a sole diagnosis of Depressive Personality Disorder and no additional Axis I or Axis II diagnoses still had significantly higher Beck Depression Inventory

scores than a non-clinical control group. This suggests that individuals with Depressive PD do continue to experience distress, however the BDI or level of depression symptoms is not the best indicator of whether depressive pd is present or absent.

### **Minnesota Multiphasic Personality Inventory (MMPI, MMPI-2, MMPI-A, MMPI-2-RF)**

The MMPI-2 itself does not directly assess the DSM-IV concept of depressive personality disorder, though additional research may lead to profile recommendations. Additional research with supplemental scales may be beneficial, and this may be a topic of future postings on the website <http://www.depressivepersonality.com>

When do personality traits stabilize? It is a good question and we generally view a personality disorder as having an onset prior to early adulthood. It should be noted however that the expression of these traits can vary over time. In addition, depending on a variety of factors including how a test was normed, psychological tests may sometimes show differences depending on the test selected for measurement. Age is always a potential factor to consider in test selection, however this is not just in regards to the publisher's norms. For example, Osberg & Poland (2002) found that when compared to the MMPI-A (adolescent version), the MMPI-2 tended to

overpathologize 18 years olds. 18 years olds were administered both versions and there were a significant number of inconsistent profiles. This was generally in the direction of a normal MMPI-A profile and clinically significant MMPI-2 profile for the same individual. They noted that clinicians should “exercise great caution” when giving the MMPI-2 to 18 year olds.

### **Including a Measure of “Normal” Personality Traits, the NEO-PI-R, in your battery of tests**

There has been substantial focus on applying the Five-Factor Model of Personality to personality disorders, though many different perspectives on just how it should be done and what it would involve. However, incorporating both measures of “normal personality” such as the NEO-PI-R in with diagnostic batteries including personality tests normed on clinical samples such as the PAI, MCMI-III, MMPI-2/MMPI-2-RF (or other measures) could prove beneficial in general. In terms of assessing for depressive pd including the NEO-PI-R would allow for direct comparisons to profiles found in the current research literature, particularly in relation to Neuroticism and its facets. However, it should be cautioned that these facets tend to be elevated in individuals with others personality disorders and difficulties as well, and an elevated score does not necessarily imply pathology in all cases. Depressive pd loads across facets, as do many cognitive

vulnerabilities. However, there are meaningful differences in the literature currently.

Costa & Widiger (2002, p 459) hypothesized about potential relationships of depressive personality disorder to NEO-PI-R domains and facets. They suggested that the Neuroticism facets of Anxiety, Depression and Self-Consciousness would be high while the Tendermindedness facet of Agreeableness would be low. Additional research would be beneficial in testing these hypotheses.

In regards to facets of the NEO-PI-R, Huprich (2000) noted that individuals with depressive personality had clinically higher scores on angry hostility than controls and significantly higher scores on the Anxiety, Depression and Self-Consciousness facets of Neuroticism compared to controls. As mentioned earlier, Huprich suggested that the NEO-PI-R could help differentiate individuals with depressive pd from individuals with only dysthymia.

Further formulation of a NEO-PI-R “profile” for Depressive PD is likely to be an important topic of discussion on <http://www.depressivepersonality.com> and the likely topic of blog posts at <http://www.depressivepersonalitydisorder.com/blog>

*You can learn more about Psychological testing instruments such as the MMSE / MMSE-II (mini mental status exam), BDI-II (Beck Depression Inventory) , NEO-PI-R, Personality Assessment*

*Inventory (PAI), versions of the Minnesota Multiphasic Personality Inventory: MMPI-A, MMPI-2, MMPI-2-RF, and Millon scales such as the MCMI-III at [www.psychologicalassessment.org](http://www.psychologicalassessment.org)*

Topics related to Chapter 5 will likely be well-represented in the updates published online (and in future editions of this text). Check out [www.depressivepersonality.com](http://www.depressivepersonality.com) for current details.

You may also wish to follow the development of a BETA version website offering Cognitive-Behavioral Therapy (CBT) resources and a practice directory of clinicians offering CBT and related therapies such as CBASP and Schema Therapy at <http://www.cognitivebehavioral.org>

## **Chapter 6. The Added Value and Clinical Utility of DPD (and why you should be assessing for it if you aren't already).**

As we have seen in this text, depressive personality disorder is a valuable and clinically useful concept. Depressive pd offers additional, clinically-relevant information above and beyond constructs it has been compared to. When the clinical information suggests the potential to make one or more diagnoses including depressive personality disorder, it is quite likely that the presentation is better accounted for by the concept of depressive personality disorder. It is not an atheoretical collection of symptoms which exist among many disorders, but a diagnosis anchored in history and multiple lines of research including enduring, cognitive vulnerabilities to depression and normal personality traits.

### **Conceptualization Revisited Dimensionally**

As we saw in Chapter 4, abstract concepts in Psychiatry and Psychology may often describe similar phenomena. While they may at times overlap (such as with DPD and dysthymia or avoidant pd), the subtle differences may have a big impact in some situations. While we have the option to oversimplify and lose beneficial clinical information, the ramifications of dismissing Depressive PD or treating the underlying “depressive personality” phenomena

as simply a mild or subsyndromal mood disorder would include a lost opportunity. There is a related precedent in considering a desired impact changes on a diagnostic system may have. For example, Axis II was in part designed to encourage clinicians to consider the impact personality disorders might have on Axis I and the overall presentation. Likewise, the recognition of depressive personality disorder and depressive traits in DSM-V would have the added benefit of encouraging clinicians to consider the associated personality vulnerabilities which impact the patients' presentation and prognosis.

With DPD as with other diagnoses, we likely see multiple dimensions as opposed to just one. We must talk about severity as a dimension or dimensions, and there are many dimensional factors that get combined together as a clinician in rating overall severity. We can break these down in to many ways such as in interpersonal and social functioning, adaptation, frustration or stress tolerance, concentration and memory, etc. Ultimately it is the clinician's task to put a nebulous cloud of information together in to a diagnosis, and this process has proven to be useful with the personality disorders. Guidance from the diagnostic manual, particularly in helping to standardize the process, makes the process and communication of the severity of a diagnosis meaningful to other users of that information down the line. This may be beneficial for many applications to name only a few such as treatment planning and reimbursement,

treatment continuity upon referral, or one that is near to the author's line of work- reviewing the functional limitations and severity expressed by clinician's to determine disability. In general, a simple rating of mild, moderate, marked or extreme often does not convey substantial, standardized information, particularly as past severity descriptors have often been vague (such as a definition of a marked limitation as reflecting a "severe" limitation of functioning that is not precluded). To what extent can it be "not precluded" as compared to limitations that would be associated with a moderate degree of severity? More meaningful and useful severity descriptions might include anchoring "criteria" or including prototypic narrative that act as suggestions for what that range of severity could possibly look like. In addition to severity, as we have seen with DPD many of the diagnostic criteria for a given category/diagnosis may each fall at different positions on a dimensional range. This notion can be summed up by the observation that individuals with the same diagnosis do not always present in the exact same manner. For the benefits of easy communication these multiple dimensions must be simplified in to a categorical expression, either as a diagnosis or another short communication similar to what now falls on Axis I, Axis II, Axis III, Axis IV and Axis V under DSM-IV. These short expressions need not circumvent a dimensional view of the underlying concept, however. It does not circumvent clinicians who currently diagnose personality disorder "traits" on Axis II for example.

Depressive PD is not a mild form of anything. Severity is a separate dimension from the diagnosis, though it may be natural to want to make categorical comparisons to other diagnoses. While individuals with depressive PD present with substantial co-occurring difficulties including major depression, traditionally we may have been inclined to attribute this to the fire and not the gasoline. We may have separated out the acute symptoms of the personality disorder from the trait symptoms and said “Look there, those specific symptoms are major depressive disorder” (or generalized anxiety disorder, or dysthymic disorder, etc.) and missed a view of the bigger picture of processes going on in the patient. The overall depressive personality disorder which may be the gasoline fueling the many fires which need to be put out with the patient.

For current practice under DSM-IV-TR, it is useful to recognize that many diagnoses have multiple dimensional factors which collectively construct them. In addition, abstractly a diagnosis itself can often also be viewed on a dimensional range. For Depressive PD, this would be a dimensional collection of maladaptive personality factors and their impact on functioning on a range gradually increasing from a range within “normal” personality variations to individual and combined, significant depressive vulnerabilities and what we refer to as depressive traits and then finally to a range of functioning sufficient to be considered a disorder.

Did you know that during the development of DSM-V you can register on the website <http://www.psych.org/dsmv.asp> and make your voice heard that depressive personality disorder should be included in DSM-V as a Personality Disorder.

You don't have to wait for DSM-V to start using the depressive personality disorder concept however. It is valuable in current practice and you can diagnose it under DSM-IV-TR as a Personality Disorder NOS, depressive traits or Personality Disorder NOS, Depressive Personality Disorder (there is no reason why you shouldn't go ahead and include the specifier depressive traits or depressive personality disorder on Axis II after PD NOS).

**Online Supplements Are Available At  
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Coming Soon: **Depressive Personality Disorder Talking Points** will be included on the website

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Todd Elliott Finnerty, Psy.D. is a Clinical Psychologist in Columbus, OH. Dr. Finnerty also offers services as a psychological consultant reviewing Social Security disability claims. Dr. Finnerty currently provides consulting services for the Ohio Rehabilitation Services Commission, Bureau of Disability Determination- the Ohio disability determination service (DDS). Dr. Finnerty is a graduate of Niagara University and Forest Institute of Professional Psychology. Dr. Finnerty has volunteered with the American Red Cross in the past, including traveling to the Mississippi Gulf Coast in response to Hurricane Katrina in 2005.

Dr. Finnerty grew up in Upstate New York and in addition to studying psychology enjoys watching hockey and taking trips to zoos. He is also a member of the American Numismatic Association. Dr. Finnerty maintains a growing number of mental health related websites and enjoys buying, selling and developing internet domain names. View his portfolio of future projects or domain names that may be for sale at <http://domains.toddfinnerty.com>

You can learn more about Dr. Finnerty at his website: [www.toddfinnerty.com](http://www.toddfinnerty.com)

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We also have a group on Facebook "Studying Depressive Personality Disorder..." that you may wish to join and connect with others interested in the topic and you can become a "fan" of Depressive Personality Disorder with a Facebook page. You can also join the "Depressive Personality Disorder" group on LinkedIn.com and the DepressivePersonality e-mail list on groups.yahoo.com

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