

PERSONALITY PROFILES OF DYSTHYMIC DISORDER

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B.Sc. Honnours (U.O.F.S.)  
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M.B. Ch.B. (Cape Town)

A Dissertation submitted to the Faculty of Medicine in  
part fulfilment of the requirements for the Degree of  
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Witwatersrand.

Johannesburg  
November 1991

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DECLARATION

I declare that this dissertation is my own, unaided work. It is being submitted for the degree of Master of Medicine in Psychiatry to the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other University.

References which I have used have been duly acknowledged.

SIGNED :  .....

DATE : SEVENTH ..... day of NOVEMBER, 1991

Committee For Research on Human Subjects (Medical)  
Ethical Clearance Certificate  
Ref : R14/49 (Registry)  
Protocol No: 08/4/91

DEDICATION

This work is dedicated to my parents for their continued support and understanding.

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ABSTRACT

The motivation for undertaking this study stems from the confusion that reigns in the literature regarding the relationship between personality, personality traits and dysthymic disorder. A large body of theorists and researchers still claim a definite association between dysthymia and personality. Their views arose to an extent from the concept of dysthymia as it developed through the past few decades. Dysthymia grew out of the concept of depressive neurosis which had a stronger basis in personality pathology. Other terms like neurotic depression and depressive reaction preceded depressive neurosis.

With the advent of DSM-III and DSM-III-R, dysthymia was moved from the neuroses to the mood disorders category. The DSM-IV Mood Disorders Work Group has also reinforced the classification of dysthymia with the mood disorders. The Work Group has embarked on research to determine the symptomatology that should be used for the diagnosis of dysthymia. It is proposed that cognitive, functional and vegetative symptoms be included in DSM-IV to further entrench dysthymia as an affective disorder and extricate it from the personality disorders.

With this persistent dichotomy in the conceptualization of dysthymia, this study was undertaken to explore the relationship between dysthymia and personality. In the first part of the study a literature survey was done, looking at :

1. An overview of dysthymic disorder.
2. Some concepts of personality.
3. An overview of the relationship between personality traits / personality disorders and dysthymia.

In the second part of the study the methodology and results are discussed. A group of 38 dysthymic patients in remission (selected according to DSM-III-R criteria) was compared to a group of 45 mentally healthy individuals. The Millon Clinical Multiaxial Inventory - II (MCMII-II) was used to establish a possible characteristic premorbid personality pattern for dysthymics.

Statistically dysthymic subjects were found to differ from mentally healthy subjects on six scales of the MCMII-II. Dysthymic patients have an avoidant and self-defeating personality pattern with links to the borderline personality disorder. On the clinical scales comorbidity exists between anxiety and somatoform



disorder and dysthymia. Finally, a strong association was found between major depression and dysthymia.

These findings are discussed in relation to the literature available on the relationship being investigated.

PROLOGUE

Psychiatric conditions and symptoms are often described in the literature (Stone and Stone, 1966). Equally so depression in all its presentations.

The neurotic depression (dysthymia) is often precipitated by current circumstance. The predominance of depressed mood, however, is maintained, and usually the person cannot mobilize himself to alter it. Loneliness and feelings of worthlessness and inferiority are prominent, but not so severe as in a psychotic depression. Colette, in 'The Vagabond', captures this mood of chronic neurotic depression :

"..... As always, I give a great sigh when I close the door of my ground-floor flat behind me. Is it a sigh of weariness, or relaxation, or relief? Or does it spring from the bitterness of solitude? Better not think of it, far better not !

But what on earth is the matter with me tonight? It must be this icy December fog, like particles of frost hanging in the air, quivering in an iridescent halo round the gas lamps and melting on one's lips with a taste of creosote. And besides, this new quarter where I live, looming up all white behind Les Ternes, is enough to discourage both one's eyes and one's spirit.

My street, under the greenish gas at this hour, is a morass of toffee-like, creamy mud-coffee-coloured, maroon and caramel yellow - a sort of crumbling, slushy trifle in which the floating bits of meringue are lumps of concrete. Even my house, the only one in the street, has a sort of 'it can't be true' look. But its new walls and thin partitions offer, at a modest rent, a shelter sufficiently comfortable for 'ladies on their own' like me.

When you are a 'lady on your own', in other words the landlords' abomination, outcast and terror all rolled into one, you take what you find, lodge where you may and put up with newly plastered walls.

The house where I live compassionately shelters quite a colony of 'ladies on their own'. On the mezzanine floor we have the acknowledged mistress of Young, of Young-Automobiles; above, the girl-friend, very much 'kept', of the Comte de Bravailles; higher up are two fair-haired sisters, both of whom are visited every day

by the same man, a very-correct-gentleman-in-industry; higher still a terrible little tart makes as much of a racket night and day as an unleashed fox-terrier, screaming, playing the piano, singing and throwing empty bottles out of the window.

'She's a disgrace to the house', Madame Young-Automobiles said one day.

Finally, on the ground floor, there is myself who neither screams, nor plays the piano, nor ever receives gentleman and still less ladies. The little tart on the fourth floor makes too much noise and I not enough, as the concierge does not fail to remark to me. 'It's funny, one never knows whether Madame is there because one doesn't hear her. One would never think she was an artiste !'

What an ugly December night it is! The radiator smells of idioform, Blandine has forgotten to put my hot-water bottle in my bed, and even my dog is in bad mood. Grumpy and shivering, she merely casts on black and white glance at me, without leaving her basket. I must say! I don't expect triumphal arches and illuminations, but all the same ....

No need to search the place, to peer in the corners or look under the bed, there is no one here, no one but myself. What I see in the big looking-glass in my bedroom is no longer the painted image of an itinerant music-hall artiste. It reflects only - myself.

Behold me then, just as I am ! This evening I shall not be able to escape the meeting in the long mirror, the soliloquy which I have a hundred times avoided, accepted, fled from, taken up again and broken off. I feel in advance, alas, the uselessness of trying to change the subject. This evening I shall not feel sleepy, and the spell of a book - even a brand-new book with that smell of printers' ink and paper fresh from the press that makes you think of coal and trains and departures ! - even that spell will not be able to distract me from myself.

Behold me then, just as I am ! Alone, alone, and for the rest of my life, no doubt. Already alone; it's early for that. When I turned thirty I did not feel cast down because mine is a face that depends on the expression which animates it, the colour of my eyes, and the defiant smile that plays over it - what Marinetti calls my gaezza volpina. But if I look like a fox, it's a fox without guile, which a hen could catch ! And a fox without rapacity, one that remembers only the trap and the cage. A gay-looking fox, if you like, but only

because the corners of its mouth and eyes look as if they were smiling. A captive fox, tired of dancing to the sound of music.

It is true enough that I do look like a fox. But a slender, pretty fox is not an ugly thing, is it? Bague says too that I look like a rat when I purse my lips and blink my eyelids so as to see better. I see nothing so mind in that.

But how I dislike seeing myself with that drooping mouth and those slack shoulders, the weight of my whole sad body slumped on one leg! My hair hangs dank and lank and in a little while I shall have to brush it for a long time to give it back its shining beaver brown. My eyes are still faintly ringed with blue eye-shadow and there's a wavering trace of red on my nails. It will take me at least fifty good minutes of bathing and grooming to get rid of all that.

It is one o'clock already. What am I waiting for? A smart little lash with the whip to make the obstinate creature go on again. But no one will give it me because ... because I am alone. How clearly one sees, in that long frame which holds my reflection, that I'm used already to living alone!

No matter what visitor, for a mere tradesman, or even for my charwoman Blandine, I should raise this drooping neck, straighten that slouching hip and clasp those empty hands. But tonight I am so alone.

Alone! Really one might think I was pitying myself for it!

'If you live all alone,' said Bague, 'it's because you really want to, isn't it?'

Certainly I 'really' want to, and in fact I want to, quite simply. Only, well ... there are days when solitude, for someone of my age, is a heady wine which intoxicates you with freedom, others when it is a bitter tonic, and still others when it is a poison which makes you beat your head against the wall.

This evening I would much prefer not to say which it is; all I want is to remain undecided, and not to be able to say whether the shiver which will seize me when I slip between the cold sheets comes from fear or contentment.

Alone ... and for a long time past. The proof is that I am giving way to the habit of talking to myself and of holding conversations with my dog, and the fire, and my own reflection. It is an idiosyncrasy which recluses and old prisoners fall into; but I'm not like them, I'm free. And if I talk to myself it is because I

have a writer's need to express my thoughts in rhythmical language.

Facing me from the other side of the looking-glass, in that mysterious reflected room, is the image of 'a woman of letters who has turned out badly'. They also say of me that I'm 'on the stage', but they never call me an actress. Why? The nuance is subtle, but there is certainly a polite refusal, on the part both of the public and my friends themselves, to accord me any standing in this career which I have nevertheless adopted. A woman of letters who has turned out badly: that is what I must remain for everyone, I who no longer write, who deny myself the pleasure, the luxury of writing.

To write, to be able to write, what does it mean? It means spending long hours dreaming before a white page, scribbling unconsciously, letting your pen play round a blot of ink and nibble at a half-formed word, scratching it, making it bristle with darts and adorning it with antennae and paws until it loses all resemblance to a legible word and turns into a fantastic insect or a fluttering creature half butterfly, half fairy.

To write is to sit and stare, hypnotised, at the reflection of the window in the silver ink-stand, to feel the divine fever mounting to one's cheeks and forehead while the hand that writes grows blissfully numb upon the paper. It also means idle hours curled up in the hollow of the divan, and then the orgy of inspiration from which one emerges stupefied and aching all over, but already recompensed and laden with treasures that one unloads slowly on to the virgin page in the little round pool of light under the lamp.

To write is to pour one's innermost self passionately upon the tempting paper, at such frantic speed that sometimes one's hand struggles and rebels, overdriven by the impatient god who guides it - and to find, next day, in place of the golden bough that bloomed miraculously in that dazzling hour, a withered bramble and a stunted flower.

To write is the joy and torment of the idle. Oh to write! From time to time I feel a need, sharp as thirst in summer, to note and to describe. And then I take up my pen again and attempt the perilous and elusive task of seizing and pinning down, under its flexible double-pointed nib, the many-hued, fugitive, thrilling adjective .... The attack does not last long; it is but the itching of an old scar.

It takes up too much time to write. And the trouble is, I am no Balzac! The fragile story I am constructing

crumbles away when the tradesman rings, or the shoemaker sends in his bill, when the solicitor, or one's counsel, telephones, or when the theatrical agent summons me to his office for 'a social engagement at the house of some people of very good position but not in the habit of paying large fees'.

The problem is, since I have been living alone, that I have had first to live, then to divorce, and then to go on living. To do all that demands incredible activity and persistence. And to get where? Is there, for me, no other haven than this commonplace room done up in gimcrack Louis XVI? Must I stay for ever before this impenetrable mirror where I come up against myself, face to face?.

Tomorrow is Sunday; that means afternoon and evening performances at the Emyree-Clichy. Two o'clock already! High time for a woman of letters who has turned out badly to go to sleep .....

(This passage taken from Colette (1960) : The Vagabond ; pages 9 to 13).

The symptoms of neurotic depression often focus on a preoccupation with death. Dread is more central than fear. Loneliness and emptiness pervade the feelings of the person. Emily Dickinson illustrates these feelings in her two poems :

TWO POEMS : Emily Dickinson (1830 - 1886)

A I felt a funeral in my brain,  
And mourners, to and fro,  
Kept treading, treading, till it  
seemed  
That sense was breaking through.

And when they all were seated,  
A service like a drum  
Kept beating, beating, till I thought  
My mind was going numb.

And then I heard them lift a box,  
And creak across my soul  
With those same boots of lead, again.  
Then space began to toll.

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As all the heavens were a bell.  
And Being but an ear,  
And I and silence some strange race,  
Wrecked, solitary, here.

B Bereaved of all, I went abroad,  
No less bereaved to be  
Upon a new peninsula, -  
The grave preceded me,

Obtained my lodgings ere myself,  
And when I sought my bed,  
The grave it was, reposed upon  
The pillow for my head.

I waked to find it first awake,  
I rose, - it followed me;  
I tried to drop it in the crowd,  
To lose it in the sea,

In cups of artificial drowse  
To sleep its shape away, -  
The grave was finished, but the spade  
Remained in memory.

(From Stone and Stone (1966) : The Abnormal Personality  
Through Literature, pages 197 and 198)

INTRODUCTION

The symptoms of depression are amongst the most common that patients complain about to their doctors. The severity of the moodchange spans a spectrum from mild depression related to everyday situations, bereavement, transient sadness and melancholy to the profound despair of the person suffering a major depressive episode. Some depressions are shortlived and remit spontaneously or on medication, while others tend to be chronic. With advances in psychiatric research, the nature, aetiology, classification and treatment of depression has become more diverse and more specific. Though an area neglected in the literature, clinicians have for a long time been interested in the relationship between depression and character (personality).

Since the introduction of the American multiaxial classification system of mental disorders, DSM-III, interest in assessing personality disorders of patients with clinical syndromes has increased. The placement of personality disorders on a separate axis in the DSM-III diagnostic system reflected an increased interest in personality diagnosis and treatment and encouraged clinicians to consider the effects of personality style on axis I clinical syndromes. The term comorbidity has



been used to describe the relationship between axis I and axis II pathology and has been an area of major concern in recent psychiatric literature.

Among the ideas proliferating for the future classification of mental illness is that of researching the subclassification of present psychiatric diagnoses. This research focusses on criteria for the DSM IV to be published in spring 1994 (Shaffer, 1991). According to current thinking and DSM-III-R, patients who present with depressive difficulties, yet who do not have sufficiently severe symptoms to fulfill the diagnostic criteria for major depression, are usually allotted the diagnosis of dysthymia. By definition, dysthymia entails at least a 2-year history of dysphoric mood with the presence of a minimum of three depressive signs and symptoms (Walton, 1990). As regards the management of dysthymia, clinical experience inclines practitioners to distinguish between those patients who respond to pharmacological intervention, and those who respond only to psychotherapy. The emergence of this distinction has led researchers to reflect on the nature of the relationship between dysthymia and character (personality).

Writing on the nature of character and dysthymia, Akiskal, Rosenthal, Haykal, et al. (1980) divided early-onset characterological depressions into 'subaffective

dysthymias' sharing many features of primary affective illness, and 'character spectrum disorders' representing a heterogeneous mixture of personality disorders such as passive-dependent, histrionic, antisocial, or borderline. Inherent in the concept of characterological depression is an intertwining of depression and character such that depression becomes an integral and prominent part of the personality.

Recognition of the foregoing features of dysthymia has led to criticism of the concept and the criteria for the DSM-III dysthymic disorder. Kocsis and Frances (1987) suggested that future DSM revisions should include further subcategorization of chronic depressive disorders, and that the term 'dysthymic disorder' should be limited to chronic depressive disorder with an insidious and early onset. Akiskal (1983) was of the same opinion although in his definition the term 'dysthymic disorder' is closer to the European (Schneiderian) concept of depressive personality with obsessoid features.

A review of the recently available literature on the relationship between personality and dysthymia makes it clear that some confusion exists regarding the association. There is little research on this relationship. In South Africa some research has been

done on the nature of depression, as well as on the relationship between depression and personality. Grinker (1988) explored the relationship between personality and bipolar affective disorder using the Minnesota Multiphasic Personality Inventory (MMPI). He found that bipolar subjects are more likely than healthy subjects to show such personality characteristics as impulsivity, sociability, immaturity, extraversion and manipulative behaviour. Bipolar subjects may also exhibit a degree of functional and/or cognitive impairment.

The only other investigation in South Africa regarding this area is the study by Lombaard (1984) who explored the relationship between unipolar endogenous depression and bipolar manic depression. Very recently, Bekker (1991) conducted a double blind placebo controlled dose-range finding study at the University of the Witwatersrand using the new antidepressive Ritanserin. The study included patients of the dysthymic type as well as patients suffering from an adjustment disorder with depressed mood (depressive neurosis).

Objectives of the Study

The aims of the present study are :

- To contribute to the body of knowledge already existing in South Africa which has explored the relationship between personality and the affective disorders (Lombaard, 1984 ; Grinker, 1988 ; Bekker, 1991).
- To investigate the nature of dysthymia, and in particular the personality traits / disorders among patients with dysthymic disorder. Findings will also be compared to those already published.
- It is hoped that results obtained from this study will contribute to the evolving body of knowledge on the nature of dysthymia, and ultimately provide clinicians with a better understanding of the different types of affective disorders and their management. As in all areas of medicine, optimal treatment is contingent on initial diagnosis.

Format of the Study

In order to explore these objectives, the study will consist of two parts. Section A is a literature review which will include an overview of dysthymia and personality, and the relationship between personality and dysthymic disorder.

Section B comprises the study itself in which the personality pathology as measured on the Millon Clinical Multiaxial Inventory - II of dysthymic patients is compared with a group of mentally healthy subjects. The experimental design will be a cross-sectional comparative descriptive study.

SECTION A

LITERATURE REVIEW

CHAPTER 1

DYSTHYMIC DISORDER

1.1 DEFINITION OF DYSTHYMIA

1.1.1 Introduction

Since the last century the concept of depression has undergone many changes. The reason for this was the previous lack of knowledge, as well as ever changing definitions and classification systems. Today we have come closer to the understanding of the illness due to the advances in psychobiology, an awareness of the relationship of depression to other psychiatric and medical disorders, its clinical course, and its treatment. Regarding the classification of mood disorders, the 1950's first saw the distinction between bipolar and unipolar depressive illness. Since then various systems have been proposed for classifying depression, most of them dichotomous and based on aetiological assumptions. These included the endogenous / reactive, neurotic / psychotic, and primary / secondary distinctions (Hirschfeld, 1991).

This first part of the chapter will provide some historical background to the concept of dysthymia. Dysthymia in relation to the American Diagnostic and Statistical Manual of Mental Disorders, as well as other classification systems will be discussed.

#### 1.1.2 Historical Background of Dysthymia

Dysthymia was first described in the last century and since then the understanding of 'dysthymic disorder' has undergone various changes. In general, dysthymia is perceived as being intermediate between the normal and the pathological. For this reason, dysthymia has often been linked to personality or temperament.

Karl Kahlbaum (mid-19 th century) first used the term dysthymia to describe depression in individuals with no history of mania. The extent to which those people suffered from chronic characterological / personality problems is not clear (Hirschfeld, 1990). Kraepelin described extensively chronic depression in patients. He referred to a 'depressive temperament' and believed that it was the personality from which manic-depressive illness developed, or that it was 'a rudiment' of fully developed manic-depressive insanity. A notion of a depressive spectrum was thus created between depressive temperament and episodic full-blown depression, the latter presenting with acute symptoms that were more

severe (Kocsis and Frances, 1987; Scott, 1988).

European psychiatrists like Kretschmer in Germany, Slater and Roth in England, supported the above mentioned theme that mild chronic states of depression represent mild variants of typical manic-depressive illness and were present in the prepsychotic personality of the manic-depressive. Schneider viewed depressive psychopathy, presently termed personality disorders, on a spectrum with normal personality traits and types and not related to the affective disorders (Murphy, 1991).

We now turn to the development of the concept of dysthymia according to the American diagnostic systems.

1.1.3 The Concept of Dysthymia in the American Diagnostic and Statistical Manual of Mental Disorders - Second Edition (DSM II) Classification System

Psychiatry in the United States was initially mainly under the influence of the psychodynamic school. Chronic depressive illness and dysthymic states were viewed as character neuroses with an aetiology embedded in early environmental influences (Kocsis and Frances, 1987). With the publication in 1968 by the American Psychiatric Association of the Diagnostic and Statistical Manual of Mental Disorders - Second Edition (DSM-II), manic-



depressive disorder and other affective states were classified under the psychotic disorders. Chronic and mild forms of depression were considered to belong to the neuroses and personality disorder sections. No clear provision was made in DSM-II for the classification of dysthymic disorder.

Commenting on the DSM-II classification of dysthymia, Torgersen (1986 (a)) and Snaith (1987) wrote that chronic dysthymic patients had to be classified either under cyclothymic or asthenic personality disorder or as having neurasthenic or depressive neurosis. At the time DSM-II was in use, Schildkraut and Klein (quoted by Kocis and Frances, 1987) emphasized the importance of the link between personality and dysthymia. They subsequently proposed that chronic characterological depressive syndromes described chronic depressions that were an inherent part of a lifelong personality problem. A specific personality pathology was not, however essential for the diagnosis, but to this concept was characterized by a particular constellation of symptoms and mood reactivity to environmental or interpersonal events.

1.1.4 The Diagnostic and Statistical Manual of Mental Disorders - Third and Third Revised Editions (DSM-III and DSM-III-R) Criteria for Dysthymia

With the publication in 1980 of the Diagnostic and Statistical Manual of Mental Disorders - Third Edition (DSM-III) there was an important theoretical shift and a reconceptualization of the aetiology, pathogenesis, and treatment of mood disorders as a whole and dysthymia in particular. DSM-III relabeled chronic depressions with the new designation of dysthymic disorder. These disorders were also reclassified in the affective disorder sections with dysthymic disorder representing a mild, chronic form of depression on a spectrum with the more florid and acute manifestations of affective disorders. The distinction between dysthymic disorder and major depression rested on the severity of the depression.

The DSM-III was revised in 1987, and the Diagnostic and Statistical Manual of Mental Disorders - Third Revised Edition (DSM-III-R) was published by the American Psychiatric Association. The criteria for dysthymic disorder were once again modified. The DSM-III-R list of diagnostic criteria for dysthymia is presented in Appendix 1. The overall idea in setting up the new criteria for the DSM-III-R included changes in the severity of symptoms and criteria for dysthymic disorder (Akiskal, 1991; Murphy, 1991). Thus the presence of depressive symptoms were decreased from three out of thirteen to two out of six. Another major change was the

exclusion of those patients whose chronic depression began with an episode of major depression. Such patients are now being viewed as having a chronic form of major depression. Furthermore, two methods of subtyping dysthymia were introduced, ie. primary versus secondary and early versus late-onset.

Delivering critique on the DSM-III-R classification of dysthymic disorder, Kocsis and Frances (1987), and Frances, Kocsis, Martin, et al., (1989) summarize the changes in DSM-III-R as reducing the heterogeneity of chronic depression by allowing it to be categorized in a variety of different ways. These categories further subclassify dysthymia as :

- a residual syndrome following major depression,
- being primary versus secondary, ; with an early versus late-onset,
- related to chronic severe stress,
- with or without and accompanying personality disorder diagnosis on axis II, and
- with or without an accompanying major medical disorder labeled on axis III.

#### 1.1.5 Present Concepts of Dysthymia

Researching and working extensively on the concept of dysthymia, Akiskal (1983) developed his own nosological

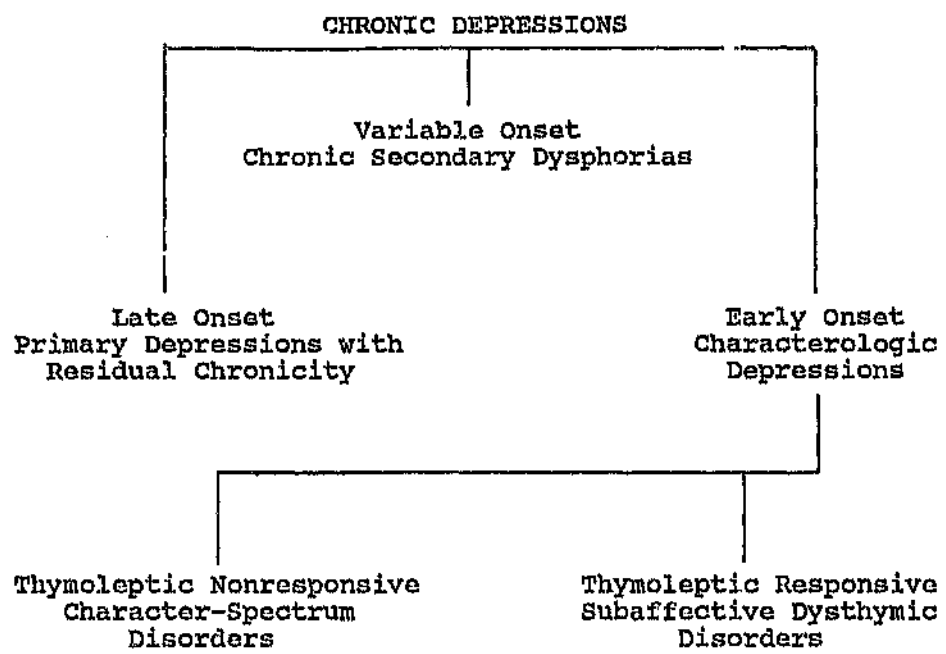
framework for understanding the psychopathology of low-grade chronic depressions. He identified subgroups of dysthymia consisting of:

- 1) late-onset primary depressed patients, in whom dysthymia represents residual chronicity,
- 2) chronic secondary dysphorias, having a variable onset age and considered part of the symptomatic picture of nonaffective 'neurotic' disorders or reactions to longstanding incapacitating medical diseases (age at onset is variable, and the course is similar to that of the primary disorder), and
- 3) early-onset characterological depressions, which include
  - a) character-spectrum disorders developing in the setting of tempestuous early object relationships, and
  - b) subaffective dysthymic disorders, conceptualized as genetically attenuated forms of primary affective illness.

(see Figure 1)

Akiskal (1983), supported by Hirschfeld (1991), expands on this last group of characterological depressions, pointing out that dysthymia has an early and insidious

FIGURE 1 : CLASSIFICATION OF CHRONIC DEPRESSIONS  
(Akiskal, 1983, p. 11)



onset and fluctuating course. The sub-groups of 'character-spectrum' and 'subaffective dysthymic' disorders differ in personality, family history, and pharmacological variables. Individuals with a character-spectrum disorder have a dependent, histrionic, or sociopathic personality, a family history of alcoholism, do not become hypomanic after taking tricyclic antidepressants, and are not responsive to pharmacological treatment.

The second subgroup of subaffective dysthymic individuals, on the other hand, evidence the classic Schneiderian depressive personality of being non-assertive, brooding, pessimistic, and self-critical. They have a family history of affective disorder including both unipolar and bipolar disorders. This subgroup often respond to tricyclic antidepressants if they have brief hypomanic swings. Lastly they frequently demonstrate a good response to lithium or tricyclic antidepressants.

Reformulating the key characteristics of dysthymia, Akiskal (1990) uses the following criteria :

- low-grade chronicity (> 2 years) which is not residual of a major depression,
- insidious onset with origin often in childhood or adolescence,

- persistent or intermittent course,
- concurrent 'character' pathology, and
- ambulatory disorder compatible with 'stable' social functioning.

Returning to DSM-III-R, Akiskal stressed that it is noteworthy that in DSM-III-R, personality disorder is considered to be present concurrently with dysthymia. According to him this is an important change from DSM-III which, despite its philosophy of considering personality disorders (Axis II) as orthogonal to the major psychiatric syndromes (Axis I), contained the ambiguous statement that 'often the affective features of [dysthymia] are viewed as secondary to an underlying personality disorder'.

Concerned about the DSM-III-R definition of dysthymia, Saxena and Das (1989) wrote that the concept behind dysthymia appears to be quite different from the concept of neurotic depression. They argue that for adults, dysthymia according to DSM-III-R represents a chronic disturbance of mood of at least 2 years' duration. On the other hand, chronicity is not an essential feature of neurotic depression. Neurotic depression usually has a recognized reaction following a distressing experience. In contrast to this, the description and criteria for dysthymia do not mention any psychosocial stressors.

Most stress-induced cases of non-major depression would be diagnosed as adjustment disorders according to DSM-III-R.

Frances, Kocsis, Marin, et al., (1989) and Hirschfeld (1991) with the DSM-IV in mind, consider the areas of greatest controversy regarding dysthymic disorder to be whether :

- early onset, primary dysthymic disorder should be redefined as depressive personality and placed on Axis II ;
- double-depression represents a real clinical phenomenon or a definitional artifact ; and
- the content of the diagnostic criteria can be made more specific for chronic depressions.

These concepts will be discussed later in this chapter.

The criteria for the diagnosis of dysthymia were also reviewed by the World Health Organization. The draft proposals for diagnostic criteria and diagnostic guidelines for dysthymia to be described in the International Classification of Diseases - Tenth Edition (I.C.D. - 10) were published in 1990 by the World Health Organization (W.H.O., 1990). For details see Appendix 2.

After discussing the present concepts in dysthymia above, some of the subtypes mentioned will now be considered in more detail.



## 1.2 SUBTYPES OF DYSTHYMIA

The DSM-III-R subtypes of dysthymia, together with the proposed subaffective dysthymic disorder (SDD) and character spectrum disorder (CSD) subtypes will now be discussed.

### 1.2.1 DSM-III-R Subclassification of Dysthymia

DSM-III-R subdivided dysthymia into primary and secondary type. A further subclassification was an early or late onset of the disease (see Appendix 1). Up to date, very few studies made an attempt to differentiate between these subtypes according to demographic, clinical and familial variables and short-term outcome.

In their study on the early-late distinction in DSM-III-R dysthymia, Klein, Taylor, Dickstein and Harding (1988 (a)) found that compared to the late-onset dysthymics, the early-onset group had higher lifetime rates of superimposed major depressive episodes and anxiety disorders. The early-onset group also sought treatment significantly more frequently, had a higher rate of major affective disorders in first-degree relatives, and exhibited higher levels of depression throughout the course of a 6-month follow-up study.

An investigation by McCullough, Braith, Chapman, et al., (1990 (a)) compared early and late-onset community

dysthymia groups on insidious onset patterns, cognitive, coping and symptom measures testing the assumption implicit in DSM-III-R that the 2 groups are qualitatively dissimilar. Results from their study suggest that, regardless of age of onset, the groups did not differ except on some features of coping style. Homogeneity, not heterogeneity, was the predominant finding.

In a further study, Klein, Taylor, Dickstein and Harding (1988 (b)) compared primary early-onset dysthymia with primary nonbipolar nonchronic major depression. As a result of their study they found 59 % of the dysthymics they investigated to be in a current major depressive episode, and 97 % to have had a history of major depression. Compared with the episodic major depressives, the early-onset dysthymics exhibited significantly higher rates of melancholia, greater global impairment, and an earlier age of onset of major depression. The early-onset dysthymics were also more likely to have recurrent major depressive episodes, and had higher rates of personality and substance use disorders. In addition, significantly higher proportions of early-onset dysthymics than the nonchronic major depressives had family histories of affective and antisocial personality disorders. The dysthymics also exhibited significantly higher levels of depressive personality traits and self-criticism, lower levels of

extraversion and social support, and higher levels of chronic strain and perceived stress than did the major depressives. Finally, the early-onset dysthymics exhibited significantly greater depression and poorer social and global functioning over the course of a six-month follow-up.

In an attempt to further subclassify early-onset dysthymia, Akiskal (1983, 1990), and Akiskal, Cassano, Musetti, et al., (1989) proposed a classification system where early-onset chronic depressive conditions (dysthymic disorder) are called characterological depressions. These are further subdivided into two groups. The group that did not respond to medication was called the character-spectrum disorders. The other group that had a response to medication was called the subaffective dysthymic disorders. Subaffective dysthymic disorder (SDD) represents a minor form of affective disorders whereas character-spectrum disorder (CSD) represents a form of personality disorder (see Figure 1, and Section 1.1.5 above).

Summarizing the literature, the following characteristics have been ascribed to the above mentioned subgroups :

1.2.2 Subaffective Dysthymic Disorder (SDD)

These patients are characterized by the following :

- Shortened rapid eye movement (REM) latencies -less than 70 minutes on consecutive nights - characteristic of acute primary major depressions, and favourable response to tricyclic antidepressants, lithium, or both.
- These patients were habitually long sleepers - more than 9 hours at night - or intermittently insomniac.
- Anhedonic, guilt-ridden, or hypersomnic retarded features - similar to primary affective disorder - thus exhibiting more continuous dysphoria.
- Patients with subaffective dysthymic disorder had a positive family history for both unipolar and bipolar affective disorder.
- A depressive temperament, based on Schneider's (1958) depressive typology of depressive personality characteristics as follows :
  - 1) Introverted, passive, or lethargic.
  - 2) Gloomy, humourless, or incapable of fun.
  - 3) Given to worry, brooding, or pessimism.
  - 4) Preoccupied with inadequacy, failure and negative events.
  - 5) Self-critical, self-reproachful and prone to guilt.
  - 6) Sceptical, overcritical, or complaining.

The term temperament, as opposed to the term personality, underscores its close link to the underlying affective biology.

- In short, these findings suggest that thymoleptic-responsive, early-onset dysthymia is best viewed as a milder, lifelong expression of primary affective disorder.

(Akiskal, Rosenthal, Haykal, et al., 1980 ; Akiskal, Lemmi, Dickson, et al., 1984 ; Akiskal, 1986 ; Akiskal, 1990 ; Akiskal, 1991)

The second subgroup that needs attention is the Character Spectrum Disorder classification idea.

#### 1.2.3 Character Spectrum Disorder (CSD)

The following aspects are important :

- The concept character here implies a mixture of dependent, histrionic, and antisocial traits.
- Patients in this subgroup failed to show appreciable response to clinical trials of medication.
- Their rapid eye movement (REM) latencies were in normal range (70 - 110 minutes).
- Superimposed syndromal depressive episodes, if any, lacked melancholic features.

- Other features included polydrug and alcohol abuse, high rates of familial alcoholism, and parental assortative mating. Assortive mating here implies that both parents have been diagnosed as suffering from alcoholism and personality disorder but not from any other affective illness.
- The above findings suggest that CSD is a lifelong disorder which is best characterised as a dysphoric condition. CSD develops in the context of an early unstable familial environment and represents a variant of histrionic - antisocial personality disorder.
- A subset of patients in this category may benefit from low - dose stimulants or imipramine given in the context of a psycho-educational approach. Monoamine oxidase-inhibitors may be useful for those with clinical features approximating the rare syndrome known as hysteroid dysphoria.

(Akiskal, Rosenthal, Haykal, et al., 1980 ; Akiskal, 1986 ; Akiskal, 1990 ; Akiskal, 1991)

Besides dividing dysthymia into various subgroups, dysthymia also has an important association with depression. Aspects about the relationship between dysthymia and depression will now be discussed.

### 1.3 THE RELATIONSHIP BETWEEN DYSTHYMIA AND DEPRESSION

Due to a continual shift in the meaning and application of the concept of dysthymia, various links have been made in the literature between dysthymia and depression. The most common areas of interest in the last decade centred around chronic depression, the concept of double depression, the association of chronic depression with personality, and the unipolar - bipolar distinction of depression. These aspects will now be considered in more detail.

#### 1.3.1 Chronic Depression

The literature on chronic depression can be divided into two main areas. Authors in the first place were concerned with the association of chronic depression to personality. The second area of concern was the subdivision of chronic depression into various subtypes. Scott (1988) in his review of the literature concludes that the term chronic depression has often been used synonymously with characterological depression or treatment-resistant depression. Akiskal (1983) however feels that characterological depression is always chronic, but not all chronic depression is the function of an underlying maladaptive personality.

Dividing chronic depression into early and late-onset types, Akiskal, Rosenthal, Robinson, et al., (1981) suggested that individuals whose chronicity of depression dates back to onset in early life, the so called characterological depressives, should be distinguished from late-onset chronic depressives, whose illness can be viewed as nonrecovery from one or more major episodes of depression. In a prospective study these writers followed up 137 outpatient probands. On this study they put forward a classification of chronic depressions on the basis of clinical clustering. This classification consisted of three groups :

- Chronic depression following clear-cut episodes of major depression in middle or late life,
- Chronic depression as a complication of other psychiatric or chronic medical illness, and
- Characterological depression with insidious onset in childhood or adolescence.

Reviewing the literature, and following trends in classification, Scott (1988, p. 288) proposed the following classification of chronic depressions :

- Chronic Primary Major Depression : usually of late onset, an unresolved major depressive episode without evidence of a pre-existing chronic minor disorder.

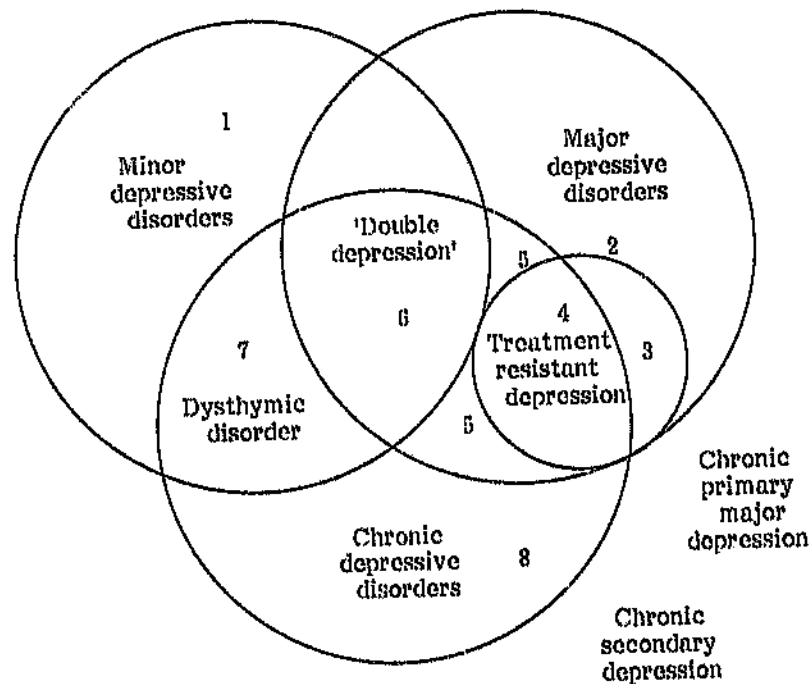


The individual may have a unipolar or bipolar disorder.

- Chronic Secondary Major Depression : an unremitting major depression arising secondary to physical ill-health or non - affective psychiatric disorder.
- Characterological or Chronic Minor Depression (Dysthymic Disorder) : This covers a heterogeneous group of patients. The disorder has an ill-defined onset in early adulthood and appears to be interwoven with character style. The symptoms are generally of a minor nature. This group best fits the DSM-III category of dysthymic disorder.
- Double Depression : In this group, acute major depressive episodes are superimposed on an underlying chronic minor disorder. On recovery from the major depressive episode, the individual returns to his or her premorbid dysthymic baseline. The prognosis of the minor depression is poor and recurrence of major depressive episodes is frequent.

Figure 2 is an attempt to demonstrate the relationship between the subtypes of chronic depression on the basis of current knowledge (Scott, 1988, p. 290).

**FIGURE 2 : THE RELATIONSHIP BETWEEN CHRONIC AND NON-CHRONIC DEPRESSIVE DISORDERS**  
( Scott, 1988, p. 290)



1. Minor depressive disorder - a depressive illness that does not meet all the diagnostic criteria for major depression; it persists for more than 2 weeks but less than 2 years.
2. Major depressive disorder - a primary depressive illness that meets DSM-III criteria.
3. Treatment-resistant depression (non-chronic) a major depressive illness that fails to respond to standard treatments given in adequate dosages for sufficient time, but remits spontaneously.
4. Treatment-resistant depression (chronic) - as above, but does not remit and persists for more than 2 years.
5. Chronic primary major depression - that arises as a result of inadequate or inappropriate treatment.
6. 'Double depression' - a major depressive episode superimposed on a chronic minor depressive (i.e. 'dysthymic') disorder.
7. Dysthymic disorder - a chronic minor depressive illness, also described as "characterological depression".
8. Chronic secondary major depression - major depression of more than 2 years' duration that arises secondary to a physical or a non-affective psychiatric disorder.

From the classification systems proposed for chronic depression, double depression received the most prominence in the literature. Double depression will now be discussed in more detail.

### 1.3.2 Double Depression

The concept of double depression has also enjoyed prominence in the literature. Keller, Lavori and Endicott described this concept for the first time in 1983. Patients with double depression are described as having acute major depressive episodes, superimposed on an underlying chronic minor disorder. This chronic minor depressive disorder is often seen as synonymous with dysthymia.

In their follow-up article a year later, Keller and Lavori (1984) summarize the following six points about double depression and chronic depression that characterize the concept :

- Double depression should not necessarily be thought of as a distinct disease entity with a unique pattern of familial aggregation.
- Double depression is best understood as a cross-sectional state that is likely to occur in most patients identified clinically as having a dysthymic disorder and in a significant proportion of patients

identified as having a major depression.

- The course of the dysthymia will be protracted even after recovery from the major depression, and there is an extremely high likelihood of multiple recurrent episodes of major depression over time.
- Clinical predictors of recovery and relapse from a major depression have substantially less predictive power in patients with a double depression compared to patients with a major depression alone.
- Identifying this state will add substantial methodological clarity and predictive power for researchers and practitioners.
- Finally, the writers strongly recommend its use as a modifier for each of the approaches to classifying chronic depression that have been proposed to date.

After the above mentioned initial concept formation research, various other researchers conducted studies on double depression. Out of this subsequent body of research, it was found that the incidence of double depression varied. Alnaes and Torgersen (1989 (a)) found that 30 % of the patients in their study with major depression had a concomitant diagnosis of dysthymic or cyclothymic disorder. Miller, Norman and Dow (1986)

compared 39 patients with double depression to 38 patients with recurrent major depression without dysthymia. The group of patients with double depression consisted of major depressives and dysthymics. These two groups were compared with regards to severity of illness, as well as psychosocial and biological variables. This study found no significant differences on any psychosocial or biological measure.

McCullough, Braith, Chapman, et al., (1990 (b)) conducted a descriptive study to identify differences and similarities between community dysthymia and double-depression subgroups. They found that the double-depression group did differ from the non-major depressive disorder (MDD) subjects in terms of the intensity of the depressive symptoms at screening and over a 4-month untreated clinical course. From their results they postulate that the double-depressive patient might represent a more vulnerable type of chronically depressed individual who, when stressed, reacts in more extreme fashion on a severity continuum. Dysthymia may weaken such individuals and make them more susceptible to MDD episodes.

In order to determine the outcome of treatment in depression, some authors made an attempt to look at the effect of personality on chronic depression.

### 1.3.3 Association of Chronic Depression with Personality

The relationship of chronic depression with personality, as well as its relationship with other psychiatric illnesses received attention. Several studies have demonstrated lower recovery rates from acute depression and higher rates of chronicity when a coexistent personality disorder or high neuroticism is present in depressed patients (Julian, Metcalfe and Coppen, 1969; Kocsis and Frances, 1987; Scott, 1988).

The question of whether DSM-III axis II - personality diagnoses are more prevalent in chronic depression than in acute major depression and other DSM-III axis I - clinical syndrome disorders has been addressed by several studies. Koenigsberg, Kaplan, Gilmore, et al., (1985) found rates of 23 % for major depression, 50 % for chronic disorders, and 24 % for generalized anxiety disorders with a concomitant axis II diagnosis. Other studies reported rates of between 34 % and 53 % of axis II diagnoses in patients with a major depression (Kocsis and Frances, 1987). It can be concluded from this research that the exact nature of the association between chronic depression and personality remains unclear.

The last area of controversy between dysthymia and depression is the speculation on the unipolar-bipolar distinction and dysthymia as part of the mood disorder

spectrum.

#### 1.3.4 The Unipolar-Bipolar Distinction

The question of whether dysthymia is merely a form of unipolar depression is also debated in the literature. The DSM-III classification system (1980) recognizes different subtypes of unipolar depression which include major depression with psychotic features, major depression with melancholia, major depression without melancholia, dysthymic disorder, and atypical depression.

In an attempt to identify specific unipolar depressive characteristics, Troisi, Pasini, Bersani, et al., (1990) studied 44 outpatients with the DSM-III classification of unipolar nondelusional depression. This group of unipolar depressives included dysthymic disorder, major depression with melancholia and major depression without melancholia. This study found that these three subtypes of unipolar depression was not significantly associated with sex or level of education. However, patients with major depression (with or without melancholia) were significantly older than those with dysthymic disorder. The Hamilton Rating Scale for Depression (HR D) scores indicated a progressive increase in symptom severity across these unipolar depressive subtypes. Dysthymia had the least severe symptoms. Major depression without melancholia had slightly more

severe symptoms, and major depression with melancholia had the most severe symptoms.

Klein, Taylor, Harding and Dickstein (1990) conducted a study to explore the validity of the unipolar-bipolar distinction in the characterological mood disorders. Thirteen cyclothymic and 32 primary early-onset dysthymic outpatients diagnosed according to DSM-III-R were compared on demographic, clinical, personality, and family history variables. The cyclothymics exhibited significantly higher levels of depressive symptomatology and extraversion and had a higher rate of bipolar I disorder in their first degree relatives than the dysthymics. In addition, a significantly greater proportion of cyclothymics than dysthymics had a family history of drug abuse. The groups did not differ significantly on gender, overall rates of affective disorders in relatives, or a number of symptoms which have been reported to distinguish unipolar and bipolar depressives.

Once again, no conclusive results were obtained from these studies regarding the distinction between unipolar, bipolar and dysthymic conditions. An attempt to identify specific characteristics remains inconclusive. Continual changes in classification criteria of these depressive conditions in the DSM classification systems also make it



difficult to conduct ongoing research.

After discussing the relationship between dysthymia and depression, it is also important to consider dysthymia in relation to other disorders.

#### 1.4 DYSTHYMIA AND OTHER DISORDERS

Patterns of comorbidity have important clinical and scientific implications. For example the course and response to treatments of a patient with more than one diagnosis may differ from that of a patient with only one diagnosis. On a scientific level the co-occurrence of certain disorders may provide information about the aetiology of the disorders, and also affect genetic epidemiology, and eventually treatment. There is considerable evidence that patients with principal diagnoses of depressive disorders like major depression or dysthymia manifest a variety of nondepressive symptoms as well (Sanderson, Beck and Beck, 1990).

The comorbidity of anxiety and somatization disorders that have been linked to depression and dysthymia will now be considered.

##### 1.4.1 Anxiety

The most frequent nondepressive symptoms reported by patients with depressive disorders are those typically

associated with anxiety. Sanderson, Beck and Beck (1990) reported a study to establish syndrome comorbidity in patients with major depression or dysthymia. The results of their study indicate that most patients with principal diagnoses of depressive disorders have a variety of nondepressive disorders as well. Anxiety disorders are the most frequently assigned additional diagnoses, followed by substance abuse disorders. In the majority of patients with comorbid disorders, the depressive disorder preceded the onset of the additional diagnoses. Overall, for patients with depressive disorders, generalized anxiety disorder was the most commonly assigned additional diagnosis, followed by social phobia and panic disorder, with and without agoraphobia. Dysthymic patients specifically had social phobia most frequently as an additional diagnosis.

In a further part of the study, Sanderson, Beck and Beck (1990) examined the temporal relationship between anxiety, dysthymia and major depression. They found that in 77 % of patients the diagnosis of dysthymic disorder preceded the onset of anxiety disorder, as to 60 % in major depression. This finding that a larger percentage of dysthymics than major depressives precede comorbid anxiety disorders is consistent with the notion that dysthymia often begins in late childhood or adolescence and thus is presumably more likely to predate any other

additional disorders, which often have a later onset. On the other hand, a later study done by Sanderson, DiNardo, Rapee and Barlow (1990) showed that only 33 % of anxiety disorders patients received an additional diagnosis of a major depression or dysthymic disorder.

The relationship between anxiety and depression has been debated for a long time. Some forms of anxiety and affective disorder, such as panic disorder and major depression, appear discreet, while other forms, such as generalized anxiety disorder and chronic depression or dysthymia, may lie on a continuum and blend with each other. However, even panic disorder and major depression have many common features. For reasons not yet clear, they frequently occur together, and their combined occurrence in the same patient has been associated with greater severity and chronicity; decreased treatment responsiveness, and possibly increased familial prevalence of anxiety and/or depression (Liebowitz, Hollander, Schneier, et al., 1990 ; Klass, DiNardo and Barlow, 1989).

#### 1.4.2 Somatization Disorder

Swartz, Blazer, George, et al., (1988) reported a high association between major depression, dysthymia and somatization disorder. About 65 % of the subjects in their study who had somatization disorder also met the

criteria for dysthymic disorder according to the DSM-III classification. They also found that 77,96 % of those with somatization disorder had more than one diagnosis. Somatization disorder was diagnosed predominantly in women.

The relationship between physical illness and dysthymic states was also investigated. A relationship was found between dysthymic states and hypertensives, ulcer patients, bronchial asthmatics, and people suffering from urticaria, psoriasis and alopecia (Lykacos, Stratigos, Tawil, et al., 1985).

#### 1.4.3 Comorbidity

Mezzich, Fabrega and Coffman (1987) studied 3455 depressive patients, which included diagnoses of bipolar depression, major depression, dysthymic disorder and atypical depression. This depressive sample was compared to 7837 nondepressive patients of all ages and sexes on the DSM-III classification system. The researchers found that, on Axis I, 26 % of patients received an additional diagnosis. The most frequent diagnoses were substance use disorder, anxiety disorder, and a condition not attributable to a mental disorder.

Mezzich, Fabrega and Coffman (1987) also compared the diagnoses on the other axes. Data suggested that Axis II

had a higher frequency of dependent personality disorder and what is described as the 'anxious / fearful cluster of personality disorders'. On Axis III, 47 % of depressive compared to 40 % of nondepressive patients had a positive diagnosis of physical illness. A significantly higher frequency of physical disorders was found among depressive patients, which disorders included acquired hypothyroidism, migraine, essential hypertension, unspecified abdominal hernia, and unspecified arthropathies.

In the last part of their study, Mezzich, Fabrega and Coffman (1987) found specific stressors differentially more frequent among depressive patients. The stressors were those of conjugal, parenting, and occupational types and those reflecting the impact of physical illness. Overall stressor severity was at severe, extreme, or catastrophic levels for 43 % of the depressive and 31 % of the nondepressive patients. The highest level of adaptive functioning in the past year was good, very good, or superior for 44 % of the depressive and 29 % of the nondepressive patients.

Although the classification and the relationship of dysthymia with other disorders remain important, the clinical characteristics of dysthymia in practice should be considered.

## 1.5 CLINICAL CHARACTERISTICS OF DYSTHYMIA

This section will firstly look at the term dysthymia, and then compare dysthymia with major depression.

### 1.5.1 The Term Dysthymia

Literally dysthymia means 'ill humoured'. In clinical practice it is a diagnosis used for individuals suffering from a condition of low-grade dysphoria. These people classically present as habitually gloomy, brooding, overconscientious, incapable of fun, and preoccupied with personal inadequacy. Diagnostically it can be extremely difficult for the clinician to separate the fluctuating course of this mood disorder from the patients' character structure. This difficulty is therefore often reflected in diagnostic uncertainties and therapeutic impasse (Akiskal, 1990).

In order to recognize the dysthymic patient, McCullough (1988) delineated the core clinical manifestations of dysthymia in his study. These characteristics were :

- 1) Mood      i) anhedonia  
              ii) depression
- 2) Vegetative    i) insomnia  
                  ii) hypersomnia
- 3) Cognitive    i) low self-esteem

- ii) guilty ruminations
  - iii) hopelessness
  - iv) suicidal ideation
- 4) Psychomotor
- i) poor concentration
  - ii) fatigue
  - iii) reduced interests
  - iv) social withdrawal

In an attempt to objectify these symptoms, Kocsis and Francis (1987) obtained data from a sample of 21 chronic depressive patients. They studied these patients over a 2 or more year period and found the presence of the following symptoms : depressed mood (100 %), low energy (81 %), decreased self-esteem (81 %), psychic anxiety (62 %), inappropriate guilt (62 %), decreased interests and productivity (57 %), decreased effectiveness (52 %), pessimism (52 %), and tearfulness (52 %). Their overall conclusion was that cognitive and functional symptoms are the most characteristic signs of dysthymic disorder.

Clinically, dysthymia must be differentiated from major depression.

#### 1.5.2 Dysthymia versus Major Depression

The differentiation between dysthymia and major depression regarding presenting symptomatology has always been problematic. McCullough (1988) feels that major

depression differ from dysthymic disorder in that the symptoms in dysthymia outnumber the signs, whereas in major depression the converse occurs. The depression in dysthymia appears to be more subjective than objective. This implies that marked disturbances in appetite and libido are uncharacteristic and severe psychomotor agitation or retardation are absent. A diagnosis of major depression according to DSM-III-R requires either depressed mood or loss of interest or pleasure. Depressed mood per se is thus not a requirement for the diagnosis of major depression. In contrast, dysthymia always require a depressed mood. Although dysthymia is associated with a constant depressed mood, the mood changes in dysthymia are usually not severe enough to require hospitalization (Ladds, 1988).

Since the refinement of the concept of dysthymia, it has become possible to study the background and epidemiology of the disease.

#### 1.6 EPIDEMIOLOGY OF DYSTHYMIA

The epidemiology of dysthymia in terms of prevalence, social and health variables, incidence in children, ethnicity, hereditary and predisposing factors will now be discussed.



#### 1.6.1 Prevalence

Various studies reported different figures for the prevalence of dysthymic disorder. Results also depend on the classification and definition of dysthymia. A comprehensive study done in the NIMH Epidemiologic Catchment Area and based on the DSM-III diagnostic categories reported the rate of dysthymia to be between 2.1 % and 3.8 % (Escobar, Karno, Burnam, et al., 1988).

Weissman, Leaf, Bruce and Florio (1988) found that dysthymia affected approximately 3 % of the adult population in a survey of five U.S. communities. Prevalences of dysthymia in women ranged from 2.9 % to 5.4 % and were significantly higher than in men (Robins, Helzer, Weissman et al., 1984). An earlier study found the prevalence of chronic depression to be 4.5 % (Weissman and Myers, 1975). Kaplan and Sadock (1988) put the lifetime prevalence at about 45 per 1000, and the incidence in psychiatric outpatients at about 10 %.

#### 1.6.2 Other Epidemiological Issues

In an extensive study by Weissman, Leaf, Bruce and Florio (1988), dysthymia was found to be more common in women under the age of 65. Dysthymia was more prevalent in unmarried persons, young persons with low income and was associated with greater use of general health and

psychiatric services and psychotropic drugs. Dysthymia had a high comorbidity with other psychiatric disorders particularly major depression, with only about 25 - 30 % of cases occurring over a lifetime in the absence of other psychiatric disorders. Further findings in the study suggest that, although the onset and highest risk periods of major depression and bipolar disorder are in young adulthood, a residual state of dysthymia occurs in middle and old age.

In an article by Perez-Stable, Miranda, Munoz and Ying (1990), both major depression and dysthymia are reported to be a common problem in medical outpatients. Yet primary care physicians recognize the disorder in only about half of their depressed patients. Patients misdiagnosed as depressed by physicians were older, less educated, had more outpatient visits, and were prescribed more medications.

#### 1.6.3 Chronicity and Lifetime Prevalence

Chronic depression appears to be extremely common among patients presenting to psychiatric settings for treatment of depression. Kocsis and Frances (1987) reported a chronic condition in 25 % to 35 % of patients presenting for treatment of depression. In a review of the literature of studies of depression which define chronicity in terms of the persistence of symptoms and

follow up of the patients for a period of observation of two or more years or until death, it appears that a chronic course evolves in 12 - 15 % of cases (Scott, 1988 ; see also Moore, 1985).

Bland, Orn and Newman (1988) studied the lifetime prevalence of psychiatric disorders amongst 3258 randomly selected adult households in Edmonton. Overall 33,8 % of the population had one or more psychiatric diagnosis and, excluding substance use disorders, one-fifth of the population had a psychiatric diagnosis. Other results in this study were :

- The lifetime prevalence rates of dysthymia was found to be:

- males 2,2 % ,
- females 5,2 % , and
- both sexes 3,7 %.

- Regarding age groups, the prevalence rates of dysthymia were:

- 18 - 24 years 1,6 % ;
- 25 - 34 years 3,9 % ;
- 35 - 44 years 3,8 % ;
- 45 - 54 years 5,2 % ;
- 55 - 64 years 6,8 % ; and
- 65 + years 3,3 %.

- The last part of the study indicated the prevalence rates of dysthymia to be:

- 4,2 % among married individuals ;
- 6,4 % among widowed, separated or divorced subjects, and
- 1,6 % among people who have never been married.

#### 1.6.4 Social and Health Variables

Kivela and Pahkala (1989) investigated the prevalence of dysthymic disorder and its relationship to social and health variables in a Finnish population aged 60 years and over. The prevalence was lower in men (17,2 per 100) than in women (22,9 per 100). In the total population the occurrence was higher in the widowed (24,9 per 100) than in the married (18,3 per 100). In men, dysthymic disorder was more common in those with a lower educational level (22,6 per 100) than with a higher educational level (15,1 per 100). Dysthymia was also more common in persons receiving long-term institutional care or home nursing or home help (28,7 per 100) than in persons living independently at home (14,6 per 100). The rate was not related to age, marital status or occupation. In woman, the occurrence was not related to age, marital status, education, occupation or form of social and health care. The female rate was higher than the male in the older group (70 years +), in married

persons, in those with a higher educational level and in those living independently at home. The occurrence of dysthymic disorder was related to poor health and poor functional status and to the occurrence of social and health stressors.

#### 1.6.5 Dysthymia in Children

The prevalence of dysthymic disorder in children appears to be high. Kocsis and Frances (1987) found in a study of children referred for treatment of mood disorders, that 43 % of a sample of 65 subjects had a history of dysthymic disorder. They defined dysthymia here as having a duration of at least 1 year in children. Clinically it was found that the children that initially presented with a dysthymic disorder had a slow recovery, and the median duration was 3 1/2 years.

In a large study done by Whitaker, Johnson, Shaffer, et al., (1990) with adolescents the prevalence of dysthymic disorder was found to be 5,3 % amongst girls and 2,3 % amongst boys, with a total prevalence of 4,9 % between both sexes.

#### 1.6.6 Ethnical Influence on Dysthymia

A study done by Escobar, Karno, Burnam, et al., (1988) attempted to establish the distribution and prevalence of major mental disorders amongst ethnical groups.

According to DSM-III the most common operational syndromes elicited were phobic, dysthymic, and substance abuse disorders. When the ethnic background of the respondents in the study was considered, only a few differences emerged. A subgroup of female Mexican Americans over the age of 40 years showed an increased prevalence of phobia, dysthymia as well as higher indexes of somatization than others. This higher rate of psychological distress reported by older Mexican American woman compared to younger ones may be related to psychosocial stressors often reported to affect this group such as financial and domestic strain, social isolation, unemployment and low educational level.

#### 1.6.7 Hereditary Factors

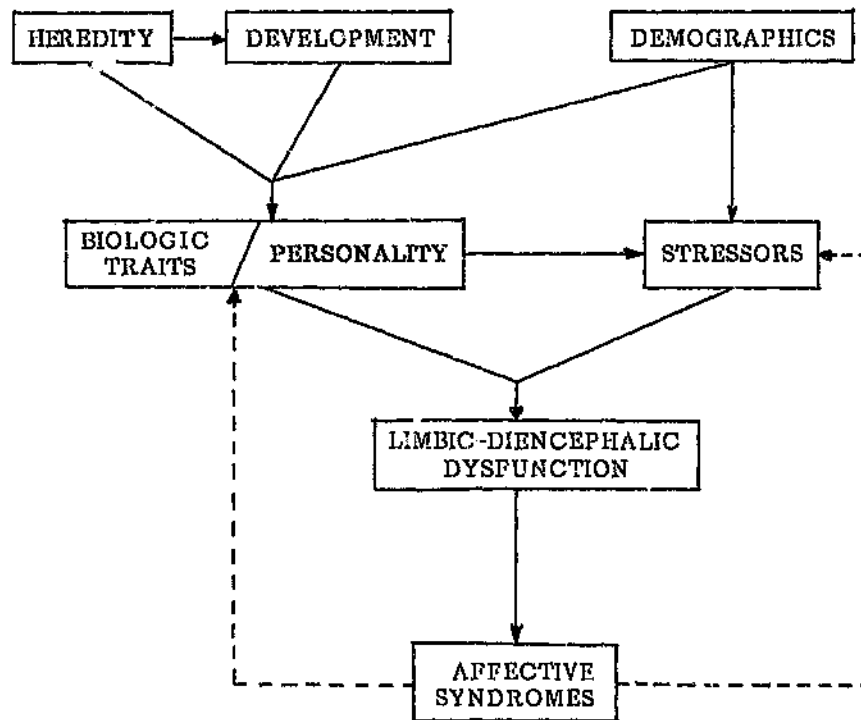
Torgersen (1986 (b)) investigated the contribution of hereditary factors in the development of affective and depressive adjustment disorders. The sample consisted of 151 index twins with moderately severe and mild affective illness, as well as their co-twins. The analysis of concordance rates indicated that except in nonpsychotic, hysterical individuals, hereditary factors may be important in the development of bipolar disorder and in major depression. Finally, they concluded that hereditary factors may not play any role in dysthymic disorder and depressive adjustment disorder.

1.6.8 Predisposing Factors

On scanning the literature, one finds very little to have been written on the predisposing factors leading to dysthymia, besides the possible role played by personality. Akiskal (1986) gives a diagrammatic representation in general of the complex interaction between diverse predisposing factors which he hypothesized lead to the development, during the formative years, of biological and personality attributes that facilitate major affective breakdowns in adult life. Not included, but important, are demographic factors as well as gender and age. (See Figure 3). De Liso, Maremmani, Perugi, et al., (1986) and Perugi, Maremmani, McNair, et al., (1988) also expand on these concepts as they relate to depression.

Cornelis, Ameling and de Jonghe (1989) studied life events and social network in relation to the onset of depression. They hypothesized that there is an obvious relationship between life events, deficient interactions with others and actual depressive feelings. Results showed that the mean number of undesirable events was significantly higher in depressed patients, as well as that these patients had a relatively poor social network. The study concluded that the premorbid lack of a wellfunctioning social network seems to be correlated

FIGURE 3 : DIAGRAMATIC REPRESENTATION OF THE COMPLEX INTERACTION BETWEEN DIVERSE PREDISPOSING FACTORS IN THE DEVELOPMENT OF AFFECTIVE SYNDROMES. ( Akiskal, 1986, p. 579)





with the onset of depression. The general idea that depressive patients have fewer friends seems to be confirmed in the premorbid situation. No deterioration of the network during depression was found in the study.

#### 1.6.9 Conclusion

Recognizing the vast amount of differing and inconclusive findings on the basic epidemiologic and demographic features of dysthymic disorder, Finlayson (1989) lists the most common features as follows :

- A common disorder
- Onset usually by age 21 years
- In adulthood, more common in females
- In childhood, equally common in males and females
- More common among first-degree relatives of persons with major depression than among the general population.

After consideration was given above on the epidemiology of dysthymia, the next section will deal with the course and prognosis of dysthymia.

#### 1.7 COURSE AND PROGNOSIS OF DYSTHYMIA

Interesting studies were done to determine the natural course of dysthymia. The natural course dysthymia followed also gave rise to speculations about different

subtypes of dysthymia. Late-onset characterological dysthymia will specifically be discussed in relation to the course of dysthymia. Attention will lastly be given to the prognosis of dysthymia.

#### 1.7.1 Natural Course

Several studies have been done on the natural course of dysthymia and chronic depression in samples of patients. Akiskal, Rosenthal, Robinson, et al., (1981) reported on 137 patients with chronic depressions. Three groups were identified according to the course of the illness. Those were :

- 28 % of patients developed chronic depression following clear-cut episodes of major depression in middle or late life,
- 36 % developed chronic depressions as complications of other psychiatric or chronic medical illness, and
- 37 % of subjects fell into a group of characterological depressions consisting of patients with intermittent subsyndromal depression with insidious onset in childhood or adolescence. Approximately one-third of this last group had had periods of major depression superimposed on their chronic mild depression.

Kocsis and Frances (1987) embarked on further studies that show 55 % of patients reporting chronic depression before the first episode of major depression, and 41 % reporting onset with a clear-cut episode of major depression. Forty-eight percent of the patients reported onset before the age of 26, and 50 % said they had been depressed for more than 10 years. In another study by the same authors, 97 % of patients reported an insidious or indistinct onset of their depressive symptoms, 65 % reported onset before age 25, and 50 % stated that their depression had been present for more than 10 years.

Conclusions from the above studies suggest three subtypes of chronic depression. These can be identified as follows :

- a subtype which has an early, insidious onset followed by a course that may or may not progress to intermittent or chronic depression of major proportions,
- a subtype of intermittent or chronic depression that may develop after an acute major depression, often at a later stage, and
- a subtype that is associated with either axis I or axis II psychopathology, chronic medical disorder, or chronic stress.

Tuncer and Karamustafalioğlu (1989) classified 40 male and 40 female inpatients according to their clinical picture into the above mentioned categories and obtained the following results. There were 13 inpatients (16,3 %) of subtype 1, eight inpatients (10 %) of subtype 2, and 59 inpatients (73,8 %) of subtype 3. Seven female and two male (15,3 %) of the inpatients in subtype 3 had only somatization disorder and dysthymia.

#### 1.7.2 Late-Onset Characterological Dysthymia

A study by McCullough, Kasnetz, Braith, et al., (1988) represents one of the first psychological investigations that attempts to describe the untreated course of the late onset characterological dysthymias. Their study was a longitudinal, nine-month investigation of 34 predominately late onset adult dysthymics who remained untreated. Twenty-eight subjects (82 %) remained unchanged during this nine-month period, while six subjects (18 %), all women, remitted spontaneously.

Data from this study indicated that the dysthymic subjects that did not remit maintained a depressionogenic attributional style and used ineffectual coping strategies. Their dominant strategies for handling stress continued to be wishing their problems away, blaming themselves and seeking support from others. These subjects also had a notable lack of sociability. A

high incidence of superimposed major depression was found among the nonremitters.

On the other hand, the dysthymic subjects that went into remission appeared to enter the study with some skills that the nonchangers did not have and their experimental participation seemed to provoke a facilitative reactive effect. This was the result of the fact that the study forced them to focus on the reasons for their depression. Self-monitoring appeared to help the remitters mobilize their skills, while a similar effect was absent among the nonchangers. The remitting group was found to be less depressionogenic in their attributions, to use progressively more adaptive coping patterns, to possess a greater degree of sociability, and to achieve greater emotional control as the study unfolded.

#### 1.7.3 Prognosis of Dysthymia

The course and prognosis of dysthymia vary with the specific subtype of the disorder. The prognosis of secondary dysthymia depends on the course of the primary disorder. Early-onset primary dysthymia may be so chronic that the patient accepts the symptoms as part of his very nature. Early-onset primary dysthymia, especially with a positive family history for mood disorder, may eventually evolve into a major mood disorder. In contrast, late-onset, primary dysthymia can have a variable onset,

prognosis and course (Kaplan and Sadock, 1988).

Studies of patients diagnosed as having dysthymia indicate that approximately 20 % develop major depressive disorder, 15 % develop major depressive episodes with hypomanic episodes, the so called bipolar II disorder), and less than 5 % develop bipolar disorder. In addition to a family history of mood disorder, a positive therapeutic response to antidepressants increases the possibility that a major mood disorder will develop in the future (Kaplan and Sadock, 1988).

From the clinical data discussed in the previous sections above, the definitive diagnosis of dysthymia remains a problem. Some attempts have been made to identify neurobiological correlates of dysthymic disorder.

#### 1.8 NEUROBIOLOGICAL FINDINGS IN DYSTHYMIA

Neurobiological data specific to dysthymia, or in relation to the identification or prediction of dysthymia, remain vague and nonspecific. Currently, little evidence exist for biological factors in longterm depression or for the prediction of chronicity in depression. There have been no major studies looking specifically at this issue. Most researchers tend to focus on acute depressives who are more representative of the general clinical population.

Scott (1988) quotes three studies of patients with chronic major depression with a mean length of four years. The study results showed that the patients studied have reductions in REM latencies on their sleep EEG's. These reductions were similar to those of the primary depressive controls used in the study. Two of the studies mentioned by Scott also found similar Dexamethasone Suppression Test (DST) non-suppression rates in chronic and non-chronic depressives. These studies suggest that the findings support the view that chronicity has an affective rather than a characterological basis.

Further biochemical studies between chronic and non-chronic depressives showed no difference in measures of lumbar 5-Hydroxyindoleacetic acid concentration or plasma free tryptophan concentration. However, when compared with normals, chronic depressives showed a significant reduction in whole blood 5-Hydroxytryptamine and an increase in platelet tryptophan. In contrast, it was found that whole blood 5-Hydroxytryptamine was not significantly less in patients with dysthymic disorder than in normals (Scott, 1988). Scott (1988) quoted Akiskal who suggested that a blunted thyrotropin-releasing hormone (TRH) stimulation test response predicts chronicity in primary major depressives. Scott also found that female chronic depressives, independent

of previous drug treatment, had a significantly greater prevalence of thyroid dysfunction than episodic depressives.

Other case reports exist showing chronic depression in patients with copper and zinc deficiency, temporal lobe dysrhythmias, rheumatological diseases, latent herpes simplex virus and undiagnosed carcinoma of the pancreas or abdominal lymphoma, and lastly occult neoplasia (Scott, 1988).

Specific neuroendocrine studies conducted on dysthymic patients tend to be inconclusive. Brambilla, Musetti, Tacchini, et al., (1989) studied 8 children and adolescents with dysthymic disorders. They found that the DST, TRH and Clonidine tests revealed normal responses in each patient. TRH induced abnormal GH rises in five of the eight patients. There were no correlations between neuroendocrine parameters and degree of depression, age, sex or weight of the patients, age of onset, duration and family history of the disease. Roy, Sutton and Pickar (1985) found the same results in their study of 11 early-onset dysthymic disorder patients.

Leake, Griffiths and Ferrier (1989) measured the concentrations of plasma N-terminal pro-opiomelanocortin, adrenocorticotrophic hormone and cortisol in response to a fourteen-hundred-and-thirty-hour human corticotrophin



releasing hormone (hCRH) stimulation test (1 ug/kg), in control, major depression and dysthymic subjects. The increases in all three hormones were similar in the depressed groups when compared to the control values. The elevation in cortisol after hCRH was significantly greater in major depression when compared to the dysthymic subjects.

Neurobiological findings in terms of the above thus remains controversial and of little practical value at this stage in regard to the understanding of dysthymia. Present studies need to be repeated, verified and further expanded upon in order to bring us closer to the biological basis and neurochemical identification of dysthymic disorder.

The treatment of dysthymia will receive attention in the final part of this section.

## 1.9 THE TREATMENT OF DYSTHYMIA

### 1.9.1 Introduction

Due to the conceptual difficulties in diagnosing dysthymia, as well as various other factors such as personality and the environment, the treatment of dysthymia remains complex. Generally, people with dysthymia have experienced a long-term debilitating condition which saps the morale of themselves, their

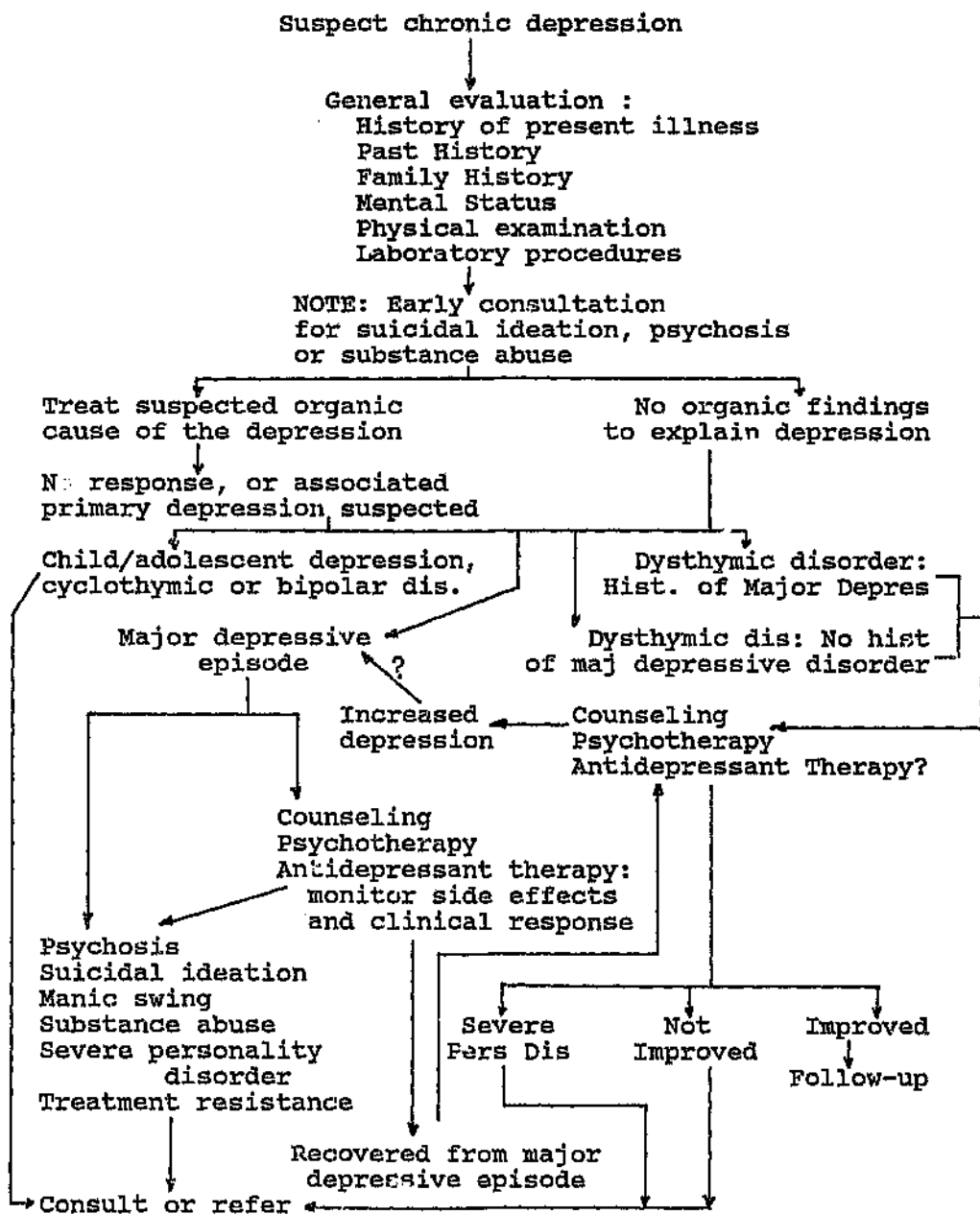
therapist and their environment. Novel treatment approaches, both biological and psychological, are thus required.

Finlayson (1989) suggested an approach to the diagnosis and management of chronic depressive illness (see Figure 4). The successful management of dysthymia depends on recognition of the chronic nature of the disorder and on the setting of realistic goals. The initial goals of management are the gradual stabilization of mood and the prevention of complications. The latter goal includes avoiding excessive medical investigation, preventing drug dependence, reducing psychosocial disruption and preventing suicide. Psychosocial management, including psychotherapy, is the foundation of care for most patients with dysthymia. Pharmacotherapy is reserved for certain circumstances. Each of the afore mentioned approaches needs further special attention.

#### 1.9.2 Pharmacotherapy

Reviewing the treatment of chronic depression with antidepressants, Kocsis and Frances (1987) conclude that patients with chronic depression may be helped by various antidepressant medications. Response to antidepressant medication may be dependent on several factors or subgroups as described in sections 1.2 and 1.3 above. The main factors predicting the outcome of treatment

FIGURE 4 : SUGGESTED APPROACH FOR THE DIAGNOSIS AND MANAGEMENT OF CHRONIC DEPRESSIVE ILLNESS (Finlayson, 1989, p. 233)



depend on the interaction between severity of the dysthymic condition and the course of the illness. The three most important treatment subgroups appear to be chronic minor depression, chronic major depression, and double depression. In double depression an acute major depressive episode is superimposed on a chronic mild depression. Other factors that appear to be involved include : age at and type of onset, presence of either axis I or axis II diagnoses, medical illness, and level of stress.

A systematic approach to the pharmacological treatment of dysthymia is important. Management should start with the removal of contributory pharmacological factors, such as reserpine, benzodiazepines, or alcohol. Most patients with chronic residual depression can be satisfactorily managed by vigorous chemotherapy (Akiskal, 1990). The psychiatrist can begin the treatment regime with one of the classic tricyclic antidepressants in combination with supportive psychotherapy and interpersonal psychotherapy (Dean and MacDonald, 1987).

Non-responsive patients can be given a full trial of a dissimilar tricyclic antidepressant or one of the newer antidepressants such as fluoxetine or ritanserin. Some patients may require electro-convulsive therapy. Underdosage of antidepressants or insufficient duration

of treatment are the most frequent causes of treatment failure (Akiskal, 1991). These considerations pertain primarily to the uncomplicated dysthymics and unipolar depressives. On the other hand, the protracted mixed states of depression require special management. The course of these depressions are complicated by superimposed cyclothymic or hypothyroid temperaments. The different strategies involved include lithium, thyroid hormone, and carbamazepine (Alexander and Cook, 1990).

In an extensive review of the literature on the pharmacotherapy of dysthymia, Howland (1991) disputes the claim that psychotherapy rather than pharmacotherapy is the treatment of choice in dysthymic disorder. The literature Howland reviewed provides substantial evidence for the efficacy of antidepressants in dysthymia, although the treatment response is less than that typically found in major depression. Furthermore, the findings suggest the possibility that monoamine oxidase inhibitors (MAOIs) may be superior to tricyclic antidepressants (TCAs) in the treatment of dysthymia.

The duration of pharmacotherapy in dysthymic disorder is controversial in that the duration of antidepressant therapy is always variable. If a clear-cut depressive event occurred, three to six months of therapy, followed

by drug tapering, would be reasonable. Some dysthymic patients may require long-term therapy, usually at the lowest effective dose and with periodic attempts to discontinue the drug.

Dysfunction of the central serotonergic system has been associated with depression, including dysthymia, and with suicidal and/or impulsive aggressive behaviour (Coccaro, Siever, Klar, et al., 1989; Bekker, 1991). In double-blind placebo-controlled studies the new 5-Hydroxytryptamine-2 receptor antagonist, ritanserin, has been reported to decrease significantly the depressive symptoms of patients with dysthymia (Murphy and Checkley, 1988 ; Bersani, Pozzi, Marini, et al., 1991). A treatment effect was evident in both subgroups of subaffective dysthymic disorder and character spectrum disorder (to Section 1.2 Subtypes of Dysthymia). Bekker (1991) did not, however, find a significant improvement between a group of dysthymic patients treated with ritanserin and a placebo control group.

#### 1.9.3 Psychological Approaches to Treatment

Most literature on the treatment of dysthymic disorder point to a multidimensional assessment and approach to the management of the disease. Personality, concurrent medical problems, social circumstances, including recent stresses and losses, and previous level of function must

be evaluated before rational treatment can be instituted. While treatment plans will often emphasize one of these areas, usually some intervention will be important in all of these presumed etiological factors (Moore, 1985).

In principle, dysthymic persons are chronically dissatisfied, socially isolated, sometimes physically disabled, frequently in the elderly, with long-standing maladaptive styles of interpersonal relationships which can induce reactions of anger and rejection on the part of people in their environment. If a meaningful personal or therapeutic relationship can be developed, the volume of complaints and behavioural difficulties can be diminished. A non-rejecting, stable and patient approach which focuses on acceptance of the symptoms rather than an attempt to cure them is most likely to reduce the symptoms of these patients.

In summary, the physician should try to develop a biopsychosocial understanding of dysthymia as it relates to the patient and to his family. This approach includes counselling, psychotherapy, drug therapy, and social support (Finlayson, 1989 ; Waring, Chamberlaine, McCrank, et al., 1988 ; Perry, 1990). Counselling in this context is basically educational and advice-giving. The counselling should be aimed at the understanding of the chronic nature of the disease, as well as its

psychological and social consequences on the individual and his environment. Recommendations should be made that strengthen the dysthymic patient's base of social support. Finlayson (1989) further writes that psychotherapy seeks to address basic personality factors, with the goal of either strengthening the person's pre-existing healthy defences or bringing about a fundamental change in personality and related behaviours. No one style of psychotherapy is indicated for all patients with dysthymic disorder.

Various psychological treatments of depression were developed over the past years. The most widely adopted, extensively evaluated, and influential of these is the cognitive behavioural approach.

#### 1.9.3.1 Cognitive Behaviour Therapy of Depression

Cognitive behaviour therapy for depression was developed by Beck and his colleagues in Philadelphia (Beck, Rush, Shaw, et al., 1979). Cognitive therapy is a short-term structured therapy that uses active collaboration between the patient and the therapist to achieve the therapeutic goals. It is orientated towards current problems and their resolution. Cognitive therapy is thus an active, directive, time-limited, structured approach, based on an underlying theoretical rationale that an individual's affect and behaviour are largely determined by the way in

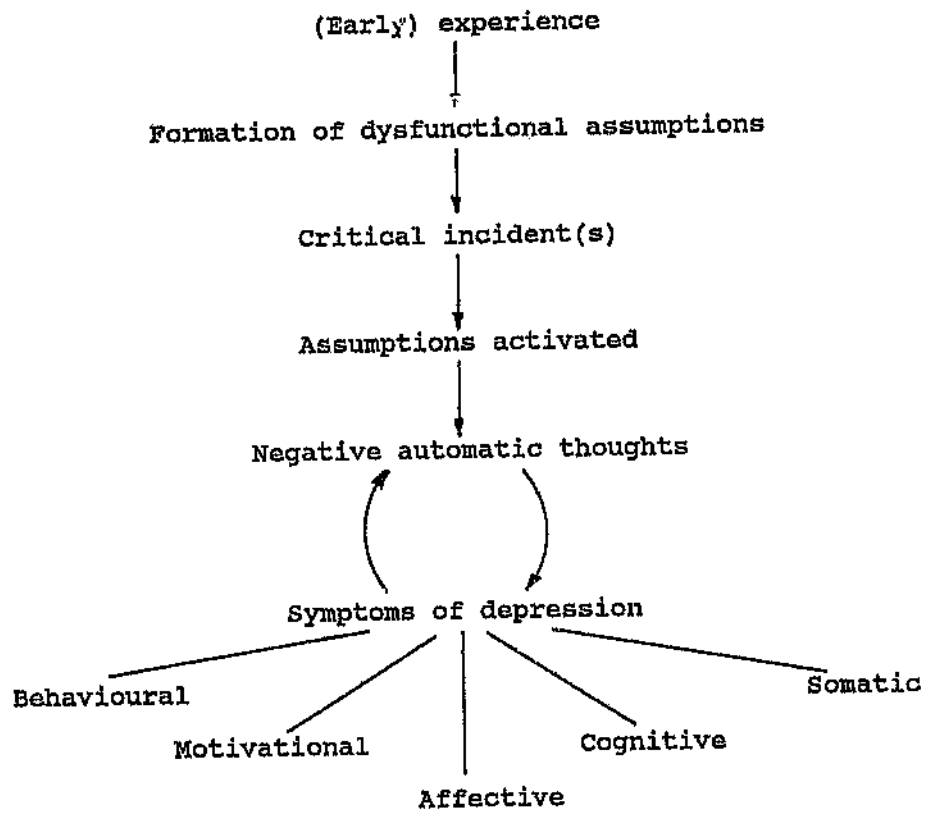


which he structures the world (Hawton, Salkovskis, Kirk, et al., 1991).

Beck's cognitive model of depression is illustrated schematically in Figure 5 (Hawton, Salkovskis, Kirk, et al., 1991). It suggests that experience leads people to form assumptions or schemata about themselves and the world which are subsequently used to organize perception and to govern and evaluate behaviour. The ability to predict and to make sense of one's experiences is helpful, and indeed necessary, to achieve normal functioning. Some assumptions, however, are rigid, extreme, resistant to change, and hence dysfunctional or counterproductive. Dysfunctional assumptions alone do not account for the development of clinical depression. Problems arise when critical incidents occur which mesh with the person's own system of beliefs.

Once activated, dysfunctional assumptions produce an upsurge of negative automatic thoughts. These thoughts are negative in that they are associated with unpleasant emotions, and automatic in that they pop into people's heads rather than being the product of any deliberate reasoning process. These negative automatic thoughts in turn lead on to other symptoms of depression. The following symptoms can be prominent :

FIGURE 5 : THE COGNITIVE MODEL OF DEPRESSION  
(Hawton, Salkovskis, Kirk, et al., 1991, p. 171)



- behavioural symptoms (lowered activity levels, withdrawal) ;
- motivational symptoms (loss of interest, inertia) ;
- emotional symptoms (anxiety, guilt) ;
- cognitive symptoms (poor concentration, indecisiveness) ; and
- physical symptoms (loss of appetite, loss of sleep).

As depression develops, negative automatic thoughts become more and more frequent and intense, and more rational thoughts are gradually crowded out. This process is helped on its way by the development of increasingly pervasive depressed mood. In this way a vicious cycle is formed : the more depressed a person becomes, the more depressing his thoughts and the more he believes them ; the more depressing his thoughts and the more he believes them, the more depressed he becomes.

The cognitive therapist interrupts this vicious cycle by helping patients to question negative automatic thoughts and then to challenge the assumptions on which these are based.

#### 1.9.3.2 A Specific Cognitive Behaviour Therapy Programme for Dysthymia

McCullough (1984) developed according to his understanding of dysthymia a specific programme to be

used in the treatment of these patients. In contrast to many contemporary theories of psychotherapy where the intrapersonal symptoms of depression are emphasized, this therapy focus the client's attention on interactional problems.

McCullough conceptualizes dysthymic disorder as a clinical syndrome meaning that a cluster of intrapersonal and interactional symptom characteristics are usually present. With intrapersonal is meant the person and with interactional is meant the environment. Intrapersonal, affective, cognitive, behavioural and somatic symptoms frequently exist concomitantly in the dysthymic individual. The most common symptom is usually a long-standing self-reported disturbance of mood, lasting for a minimum of two years, which the client cannot account for.

Interactionally, the patient frequently reports a perplexing and repetitious history of disappointments in relating to others whose closeness to the patient varies from passing acquaintances to highly valued significant friends. Dysthymia thus denotes a lifestyle in which habitual cognitive and behavioural response patterns combine with the environment's generally negative reaction toward the client to produce an entrenched intrapersonal and interactional predicament. When the

dysthymic person finally seeks therapeutic assistance, the intrapersonal symptom picture of dejection and reported helplessness is often so intense and compelling that many clinicians tend to overlook the interactional components of the disorder.

In summary: from an interactional perspective the aetiological causes of dysthymic disorder can originate either in the actual environment or in the way the individual behaves within the environment. The causal sources usually lie in both domains. The problem as well as the cure lie in the client's present interactions with the environment. Treatment must be focused on current performance and, using performance feedback, demonstrate to the client that the depressive predicament is self instigated. Psychotherapy must thus show that the patient is producing the negativistic environmental misfortunes they correctly report and focus upon in therapy.

Thus, McCullough (1984) specifically developed the 'Cognitive-Behavioural Analysis System of Psychotherapy' (C-BASP) for the treatment of dysthymic disorder. McCullough describes the following six procedural steps in the analysis :

- 1) The identification and description of a stressful situational event that has occurred recently.

Sequences of behaviour between patients and others are reported so that the therapist knows what happened first, then second, e'c.

- 2) To elicit the cognitive attributions(s) the patient is asked 'What did the situation mean to you?'. Situational attributions should function as a sort of behavioural director guiding the person toward a desired outcome.
- 3) Pinpointing the affective responses the client experienced in the target situation.
- 4) Discussion of the verbal and non-verbal behavioural responses the client made in the situation.
- 5) The client is asked to describe the situational outcome by answering the question, 'How did the event come out for you? This is labeled the actual outcome (AO) in C-BASP.
- 6) With the last and crucial step the client is asked 'How did you want the situation to come out?' This is desired outcome (DO) in C-BASP.

Usually there is a clear discrepancy between the actual outcome (AO) and the desired outcome (DO) - meaning that frequently the client does not get what he wants. Pinpointing the discrepant outcome variables produces a

discomforting state of cognitive dissonance in the client. The therapist has now created a negative reinforcement condition in which the dissonance in the client can be reduced by more adaptive strategies. The client is next assisted to go back through the analysis procedure to see where his situational performance derailed.

Four specific benefits result from using the analysis procedure :

- 1) The client is taught to think functionally about his relationship with the environment.
- 2) The therapy assists the therapist in pinpointing cognitive and behavioural problems that interfere with effective situational management.
- 3) The analysis methodology benefits the therapist by providing him or her with powerful psychological change techniques.
- 4) Analysis training gives the client a self-evaluative structure to use beyond therapy to assess situational performance.

1.10 SUMMARY

The current complex, and often the most confusing view of dysthymia can be summarized as follows :

1. Since dysthymia was described in the last century, its understanding has undergone various changes. Dysthymia was initially viewed as part of a character neurosis, but in the DSM-III-R was relabeled as part of the chronic depressions and reclassified in the affective disorder section. Conceptually, personality disorder is currently considered to be present concurrently with dysthymia. This means that the affective features of dysthymia are viewed as secondary to an underlying personality disorder.
2. Although DSM-III-R made an attempt to divide dysthymia into various types such as primary or secondary, and early or late-onset, these distinctions need further exploration. The majority of recent research focuses on the subclassification of early-onset dysthymia, also called the characterological depressions. Early-onset dysthymia is further subdivided into two groups those that do not respond to medication called the character-spectrum disorders and those who are responsive to medication, called the subaffective dysthymic disorder group.



3. The relationship between dysthymia and depression remains an area of debate. The term chronic depression has often been used synonymously with characteriological depression and dysthymia. Double depression describe the condition of patients that have acute major depressive episodes superimposed on an underlying chronic minor disorder . Various studies have not produced any significant results in establishing differences in characteristics between unipolar, bipolar and dysthymic conditions.
4. The comorbidity of dysthymia with other disorders is also an area of continual research. Significant areas of comorbidity couple anxiety and somatization disorder. Isolated findings link dysthymia with various other psychiatric and physical disorders.
5. Literally, dysthymia means ill humoured. The core clinical manifestations of dysthymia centre around the mood, vegetative, cognitive and psychomotor areas. The clinical distinction between dysthymia and major depression remains problematical.
6. Due to variations in the definition of dysthymia, results in epidemiological studies on dysthymia change from time to time. The prevalence of dysthymia is reported to be between 2,1 % and 3,8 % of the population. In general the prevalence was lower in

men than in women. One study reported the prevalence of dysthymia in children to be high. Predisposing, hereditary and ethnic factors in dysthymia remain unclear.

7. Studies show that the course and prognosis of dysthymia varies with the specific subtype of the disorder. Due to variations in subtyping dysthymia, no conclusive facts can be given on the course and prognosis of dysthymia.
8. Similarly to the above, neurobiological data specific to dysthymia remain vague and non-specific.
9. As with most other psychiatric disorders, the approach to the treatment of dysthymia must be on both pharmacological and psychological levels. The pharmacological approach involves the basic principles as applied to the treatment of depression. No pharmacological agent has yet been proven specific to or superior in the treatment of dysthymia. A large body of dysthymics do not respond to antidepressant medication, and in such cases psychotherapy appears to be more appropriate choice of treatment. The best response to psychotherapy has been with cognitive-behavioural techniques.

CHAPTER 2

CONCEPTS IN PERSONALITY

2.1 INTRODUCTION

Each of the various mental processes such as speaking, feeling, perceiving, learning, thinking, remembering, forgetting and solving problems, reflect one particular aspect of mental functioning. Each of these tools is in the service of the individual as a whole - an individual who has needs, drives and goals. Unique combinations of these give each individual a personality that is shaped by interactions with other persons and finds expression in such relationships throughout life. Such relationships in turn give each individual a sense of meaning. Nash, Stoch and Harper (1984, p. 216) write that to understand an individual we need to become aware of that person's :

- relationship with him or herself ;
- relationships with others ;
- relationships with the environment, with possessions, ideas and ideals.

The study of personality attempts to meet this need.

A 'persona' was a theatrical mask used in Greek drama and adopted before Christ by Roman players. Persona was thus

the face that was presented to the audience, and was later used to describe the specific role portrayed by the actor. Personality now has dozens of different meanings : legal, grammatical, ethical, religious, economic, and psychological. The psychological definitions vary from those that regard personality as a stimulus, to those that define it as a response or as an intervening variable. Obviously, the definition of personality is moulded to fit the purpose at hand. As psychologists have different purposes so they have somewhat different definitions of personality (Smith, 1968).

## 2.2 DEFINITION AND THEORIES OF PERSONALITY

There are various approaches to the description of personality and the detection of individual differences in personality. Physical constitution presents a simple basis of differentiation, one that has appealed since the early Greeks. One modern effort to find types of physique is that of Kretschmer. He described asthenic, athletic, pyknic, and dysplastic types. Another, that of Sheldon, is based on relative degrees of endomorphy, mesomorphy, and ectomorphy. Both systems attempt to go further and to relate type of physical constitution to behavioural phenomena (Geldard, 1963).

The simplest and most used definition of personality is that of Gordon Allport (Nash, Stoch and Harper, 1984, p.

216 ; Smith, 1968, p. 41) :

'Personality is the dynamic organization within the individual of those psychophysical systems which determine his (or her) unique adjustments to his/her environment'.

This definition stresses what a person is, not what others see him to be. It includes such units of personality as dynamic, suggesting development and change; psychophysical, emphasizing the unity of body and mind; determine, indicating that active part the individual can play through interacting with others and the world about him or her.

Numerous theories and approaches have been formulated to understand personality. Looking at an overview of theories, Nash, Stoch and Harper (1984, p. 218) write that these can be grouped under four basic headings :

- 1) The Trait Approach : This approach involves a description of personality types. The most significant contributors to this theory were the Swiss psychiatrist Carl Jung and the British psychologist Hans Eysenck who divided all personalities into introverts and extraverts. The concept of types can be seen as a condensation of a number of dimensions of the personality called

traits. These are characteristics in which one individual differs from another in a relatively permanent or consistent way.

- 2) The Humanistic Actualization Approach : The main exponents of this approach are Abe Maslow with his theory of motivation and Carl Rogers who developed client centered therapy.
- 3) The Psychoanalytic Approach : Depressive neurosis was hypothesized by psychoanalytic theory to be the result of an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession. The basic concepts of Freud's theory of unconscious processes and the way these shape the individual, especially as it relates to depression and dysthymia, will be discussed later in this chapter.
- 4) The Social-learning Theory Approach : The originator of this theory was Albert Bandura who claimed that individual differences in behaviour result from variations in the conditions of learning which the person encounters in the course of growing up. In essence, we watch others and copy them. Moreover, we behave in ways likely to produce rewards. The emphasis is not on what people are like, but on what they do in relation to the situation they are in.

Thus social-learning theory, as its name implies, looks at human actions as responses to specific situations instead of as the product of unconscious internal forces. The way a person perceives a situation is the most important factor in determining behaviour. This situation has a particular and specific meaning for him.

Rather than being overinclusive and making an attempt to describe all theories of personality, this study will focus on the two most used approaches to personality. From an historical point of view, attention will be given to the psychodynamic approach to personality and dysthymia. After this, some aspects of the development of human behaviour will be dealt with, and then lastly the biosocial-learning theory as described by Millon (1981) will be discussed. The understanding and measurement of personality in this study will be based on these concepts of Millon.

### 2.3 THE PSYCHODYNAMIC APPROACH TO DYSTHYMIA

In short, the psychodynamic approach is concerned with the ideas, impulses, emotions, and defense mechanisms that explain how the mind works and adapts. Nash, Stoch and Harper (1984) write that Freud saw the personality as composed of three major systems : the id, the ego and the

superego which interact to govern behaviour. The id is the original source of personality and provides the energy source, or as he has labelled it the libido, for the operation of all three systems. The ego develops out of the id because of the necessity for dealing with the real world; it serves to restrain the impulsive demands of the id, and also through its central executive function, to modify the requirements of the superego. The superego, arising from the internalized values and morals of society, includes the punishing conscience and the ego-ideal that sets the required standards.

In the normal individual, the three aspects of personality work together. Conflicts may arise between the sexual and aggressive instincts of the id and the restraining ego and superego. Such conflicts induce a state of tension termed anxiety. Individuals relieve anxiety either by giving way to instinctual impulses through acting-out, or using one or more of the ego-defence mechanisms.

Kaplan and Sadock (1988) write that modern advances in psychoanalysis have focused on the increased understanding of the ego's functions (ego psychology), the role of early relationships (object relations), and the relationship between the analyst and the patient. Cameron and Rychlak (1985, pp. 316 - 318) made an attempt



to describe the development of dysthymia from a psychodynamic perspective.

According to Cameron and Rychlak, the onset of dysthymic disorder can be gradual or sudden. Using the example of some loss in life, these authors write that the sudden decompensation of a tenuously balanced personality can be dramatic. For some time following the loss, the person seems to be in a state of shock. Together with this, the person eventually and in a relatively gradual manner begins to slip into a depressed state. Associated with this process, somatic complaints often develop including headaches, backaches, inability to sleep, and chronic fatigue. Eventually life begins to lose its pleasurable aspects altogether. A patient now may begin to withdraw, become irritable, and complain of always feeling lonely. Soon the patient is unable to concentrate or to remember things. These symptoms in terms of analytic theory suggest that a regression toward infantile dependency is under way.

A preoccupation with bodily illness may now enter the picture. The process is further characterized by feelings of unreality which appear to approximate symptoms of a dissociative disorder. It is however self-depreciation that is the neurotically depressed (dysthymic) person's most striking symptom as well as

being, in terms of dynamic theory, the most important. There is a heavy component of unconscious guilt in the self-deprecatory statements made by this person who actually hates himself or herself but does not know this consciously. In dynamic terms, the archaic superego is rejecting, castigating, and despising the infantile, regressed ego. The dysthymic patient gradually loses the capacity to love others as was possible previously. It is not unusual for the dysthymic person to treat loved ones in a cruel manner. This trace of sadism isolates the patient from precisely those people who might aid recovery.

Cameron and Rychlak (1985) further write that dysthymia forms a natural bridge to the psychotic depression, stopping short of the greater involvement thanks to a less severe regression. As with the obsessive-compulsive disorder, the dysthymic disorder is a form of guilt neurosis with superego involvements prominent in both the former and the latter. It has the distinct clinical picture of an oral fixation in dysthymic disorder, whereas the obsessive-compulsive patient shows us more of an anal fixation. In the main, the fantasies and acting out which take place in dysthymic disorders are expressive of oral dependency. We find the dynamic of reverting from object-choice to narcissism in the

dysthymic disorder, but to a somewhat lesser extent than in the psychotic depression. The three most important dynamics in dysthymia are defective repression, projection, and the use of complaint to extort narcissistic supplies from others.

Chodoff (1972) agrees with the abovementioned two authors and write that the repression in dysthymic disorders is unsuccessfully aimed in two directions. Firstly, it is aimed at the control of id impulses, in whose derivatives there are oral dependent longings for love mingled with hostile resentment because these longings are not fulfilled. Secondly, repression is aimed at the control of attacks by the archaic superego which germinate feelings of unconscious guilt. The complaints of the dysthymic patient actually help to maintain contact with reality. Hence good object relationships occur, at least early in the disorder. Reassurances from others about personal worth act as narcissistic supplies which in time can germinate further regression to a stage where object choices are no longer retained and the person slips into narcissism. Projection enters the dynamics of this disorder when the patient begins to assign his or her superego recriminations to other people.

Finally, Cameron and Rychlak (1985) write that it is through this last mentioned projection, as well as the

inability of others to satisfy the narcissism and resultant continual frustration, that the dysthymic person begins to discharge aggressive impulses from both the id and the ego portions of the personality. The dysthymic person begins to level threats at loved ones, mistreat them, and imply that if a suicide results it will be their fault. When this phase is reached in dysthymia, the regression appears to be complete. Reality contact also appears to be better in dysthymia than in psychotic depression. With this regression in dysthymia, hostility that the patient engenders in others through such regression acts as a motive to project unconscious superego condemnations on to others. The now more realistic bad treatment received from others can provide opportunity for discharge of further ego and id aggression on to others, rather than turning it inward in an act of suicide.

The other main theory that needs attention is the theory derived from behavioural concepts.

#### 2.4 BEHAVIOURAL CONCEPTS IN PERSONALITY DEVELOPMENT

For centuries society and researchers have asked, debated and theorized about the nature and understanding of human behaviour. Many fundamental questions to why people behave the way they do remain unanswered. The understanding of personality and its disorders offers a

wealth of relevant insight into human behaviour (Smith, 1968 ; Sjobring, 1973).

From a basic behavioural developmental viewpoint, Moller (1987) writes that children in the first years of life engage in a wide variety of behaviour responses. Although children will display what appear to be constitutional characteristics at birth, it seems that these behaviour responses serve only as an exploratory function. Thus through a process of trial and error learning, the child learns which behaviour responses are effective and which are not. In short, from a learning perspective, the child discovers which behaviour responses are pleasurable and lead to reinforcement, and which responses are unpleasurable and are ineffective or punishing.

Continuing from this basic principle of pleasurable and unpleasurable experiences, the child develops and matures, and through this a shaping process takes place. In total the child develops a repertoire of what are now empirically tested behaviours designed to achieve reinforcement and avoid punishment. In time, those observing the child may note that the child fairly consistently practises specific behaviour responses in a variety of different situations. At this point, the child may be said to be demonstrating a habit. As the

child continues to mature, he begins to exhibit a repetitive clustering or grouping of habits. This collection of habits may be referred to as a trait.

Concluding this process of development, Moller (1987) writes that the child's behaviour becomes crystallized into preferred patterns of behaving. Not only do these patterns become resistant to extinction, but the very fact that they have been successful in the past makes them a high-priority response pattern. Thus, given a continuity in basic biological development and a range of experiences for selecting and adopting behaviour responses, the child can be seen to develop a distinctive pattern of environmental and intrapersonal interaction that is deeply embedded and not easily eradicated. In short, these characteristics are the essence and sum of the child's personality.

Supporting this theory of behavioural personality development, Millon and Everly (1985, p 5) define personality as 'representing a pattern of deeply embedded and broadly exhibited cognitive, affective, and overt behavioural traits that persist over extended periods of time'. These traits emerge from a complicated matrix of biological dispositions and experiential learning. Lying at the core of personality are two processes : (1) how the individual interacts with the demands of the

environment and (2) how the individual relates to self. According to Millon and Everly, the term pattern is used when referring to personality for two reasons : first, to focus on the fact that these behaviours and attitudes arise from a complex interaction of both biological dispositions and learned experience; second, to denote the fact that these personality characteristics are not just a scattered aggregation of random tendencies but a learned and predictable structure of overt and covert behaviours.

According to Widiger, Frances, Spitzer and Williams (1988) this learning behavioural concept of personality as proposed by Millon and Everly is now central to the DSM - III and DSM-III-R classification systems. This conceptualization breaks the long-entrenched tradition of theoretically viewing syndromes of psychopathology as pathological, alien entities or lesions that insidiously or abruptly overwhelm the individual so as to prohibit normal functioning.

One of the most common problems facing mental health professionals involves the determination and differentiation of normal and abnormal behaviour. Despite many quantitative and qualitative definitions of normality, Millon and Everly (1985, p. 7) write that an individual may be said to possess a normal and healthy

personality when :

- he displays an ability to cope with the environment in a flexible and adaptive manner,
- the individual's characteristic perceptions of self and environment are fundamentally constructive,
- the individual's consistent overt behaviour patterns can be considered health promoting.

Conversely, an individual may be said to possess an abnormal and unhealthy personality pattern when :

- the person attempts to cope with average responsibilities and everyday relationships with inflexibility and maladaptive behaviour,
- his characteristic perceptions of self and environment are fundamentally self-defeating,
- the individual's overt behaviour patterns can be shown to be health eroding.

Kisker (1972) questions the concept of normality. He explains various theoretical models of normality. These theoretical models serve as standards against which we measure the behaviour of people we know or hear about. Descriptive models emphasize the criteria used in determining whether or not behaviour is abnormal;



explanatory models are based upon the assumed processes underlying abnormal behaviour. One such explanatory model is the biosocial-learning theory as proposed by Millon (1975 and 1981). This thesis will be based largely on Millon's theoretical assumptions.

Theorizing on the nature of normality, Millon and Everly (1985) write that abnormal personality patterns may be differentiated from normal personality patterns by their adaptive inflexibility, their tendency to foster vicious cycles, and their tenuous stability, all of which inhibit effective coping, are essentially self-defeating, and may be viewed from a broader perspective as health eroding. They extend on the above three criteria that point to the abnormal personality pattern as follows :

1. Adaptive inflexibility : The term adaptive inflexibility refers to the consistent tendency of the individual to relate to self and cope with the environment through inappropriately rigid and uniformly applied strategies. Such rigidity furthermore inhibits the development of a broad repertoire of coping skills. Not only is the individual unable to adapt to events, but this person also seeks to change the conditions of the environment so that they do not call for behaviours beyond his limited behaviour repertoire.

2. A tendency to foster vicious cycles : Of course all individuals tend to attempt to manipulate their environment to receive reinforcement and to avoid punishment. What distinguishes abnormal from normal personality patterns is not only inappropriate rigidity and uniformity in coping strategies, but also a tendency of those strategies to provoke or set into motion further self-defeating coping behaviours. Thus abnormal personality patterns are, in and of themselves, pathogenic in intensifying pre-existing difficulties.
  
3. Tenuous stability : Abnormal personality patterns are characteristically fragile and lack resilience under conditions of environmental pressure. This notion is sometimes referred to as weak ego strength. Faced with a recurrent series of ineffective attempts at coping, unresolved conflicts tend to re-emerge. When this occurs, the individual is likely to revert to pathological ways of coping, to less adequate control over his emotions, and ultimately to subjective and distorted perceptions of reality.

## 2.5 THE BIOSOCIAL-LEARNING THEORY

### 2.5.1 Principles of the Biosocial-Learning Theory

The biosocial-learning theory grew out of the

formulations of Millon (1975 and 1981) and attempts to generate the established and recognized personality categories through formal deduction and to show their covariation with other mental disorders. Looking at the theories of personality in the literature, one cannot but notice the number and diversity of concepts and types. To repair this confusion Millon proposed a threefold group of dimensions that were used time and again as the raw materials for personality construction. These were the active-passive, subject-object and pleasure-pain dimensions.

Millon (1981) explains these three dimensions as :

- 1) The active-passive dimension which usually implies that the vast range of behaviours engaged in by a person may be fundamentally grouped in terms of whether the individual takes the initiative in shaping surrounding events or whether behaviour is largely reactive to those events.
- 2) The distinction of pleasure-pain recognizes that motivations are ultimately aimed in one of two directions. On the one hand towards events which are attractive or positively reinforcing and on the other hand away from those which are aversive or negatively reinforcing.

3) Lastly, the distinction of subject-object, or self-other, recognizes that among all objects and things in our environment there are two that stand out above all others in their power to affect us : our own selves and others.

Using this threefold framework as a foundation, Millon (1981) derived personality coping patterns that correspond in close detail to each of the official personality disorders in the DSM-III.

Millon (1981) describes these learned coping patterns as complex forms of instrumental behaviour. This instrumental behaviour aims at achieving positive reinforcements and avoiding negative reinforcements. These strategies reflect what kinds of reinforcements individuals have learned to seek or avoid (pleasure-pain), where individuals look to obtain them (self-others), and how individuals have learned to behave in order to elicit or escape them (active-passive). Eight basic coping patterns and three severe variants (see later in this section) were derived by combining the nature (positive or pleasure versus negative or pain), the source (self versus others), and the instrumental behaviours (active versus passive) engaged in to achieve various reinforcements. Describing pathological strategies of behaviour in reinforcement terms merely

casts them in a somewhat different language than those utilized in the past.

In more practical terms, Millon (1987) writes that personality styles reflect deeply etched and pervasive characteristics of patient functioning. These characteristics tend to perpetuate themselves and aggravate everyday difficulties, but they are so embedded and automatic a way of life that the patient often is unaware of their nature and their self-destructive consequences. Under conditions of persistent adversity, the patient's maladaptive style of functioning may begin to decompensate, acquiring features that justify the designation of moderate or marked severity. These advanced stages of personality pathology reflect an insidious and slow deterioration of the personality structure, and usually accentuate the patient's lifelong style of functioning. Despite evident changes in psychic cohesion, social competence and emotional control, the patient continues to display the major personality characteristics that were previously evident.

#### 2.5.2 Dependent and Independent Coping Patterns

From the above theoretical model, Millon (1981) claims that people can be differentiated in terms of whether their primary source of reinforcement is within themselves or within others. This distinction

corresponds to the dependent and independent patterns. Dependent personalities have learned that feeling good, secure, and confident are those feelings associated with pleasure or the avoidance of pain, and that they are best provided by others. On a behavioural level, these personalities display a strong need for external support and attention. Should these people be deprived of affection and nurturance they will experience marked discomfort, if not sadness and anxiety.

In contrast to the dependent personality, independent personality patterns are characterized by a reliance on the self. These individuals have learned that they obtain maximum pleasure and minimum pain if they depend on themselves rather than others. In both dependent and independent patterns, individuals demonstrate a distinct preference as to whether to turn to others or to themselves to gain security and comfort.

### 2.5.3 Ambivalent Coping Pattern

Clear-cut distinctions between dependent and independent as above are not made by all personalities. Some individuals remain unsure as to which way to turn and are termed ambivalent by Millon. Ambivalent personalities are in conflict regarding whether to depend on themselves for reinforcement or on others. Some of these ambivalent patients vacillate between sometimes turning to others in

an agreeable conformity, and sometimes turning to themselves in efforts at independence. Other ambivalent personalities display overt dependence and compliance. Beneath these outwardly conforming behaviours, however, are strong desires to assert independent and often hostile feelings and impulses.

#### 2.5.4 Detached Coping Pattern

A further group of patients are characterized by their diminished ability to experience both pain and pleasure. They have neither a normal need for pleasure nor a normal need to avoid punishment. A second group of patients in this category are further distinguished by diminished ability to feel pleasurable reinforcers. This second group are notably sensitive to pain and life is experienced as possessing few gratifications but much anguish. Both groups share a deficit capacity to sense pleasurable reinforcers, although one is hyperreactive to pain.

Millon (1981) describes both of these groups as having detached patterns. They are unable to experience rewards from themselves or from others, and they drift increasingly into socially isolated and self-alienated behaviours.

#### 2.5.5 Active and Passive Personality Patterns

Another theory-derived distinction reflects the fact that patients instrumentally elicit the reinforcements they seek in essentially one of two ways : actively or passively. Descriptively, those who are typically active tend to be characterized by their alertness, vigilance, persistence, decisiveness, and ambitiousness in their goal-directed behaviour. Active oriented personalities plan strategies, scan alternatives, manipulate events, and circumvent obstacles, all to the end of eliciting pleasures and rewards, or avoiding the distress of punishment, rejection, and anxiety. Although their goals may differ from time to time, they initiate events and are enterprising and energetically intent on controlling the circumstances of their environment.

On the other hand, Millon (1981) describes passive personalities as people who engage in few overly manipulative strategies to gain their ends. They often display a seeming inertness, a lack of ambition and persistence, an acquiescence, and a resigned attitude in which they initiate little to shape events and wait for the circumstances of their environment to take their course.

The dimensions discussed above represent coping pattern styles which will now be put together in order to derive



the personality disorder scales.

2.5.6 Personality Disorder Scales Based on the Coping Pattern Styles According to Millon

Using the above classical polarities as a basis, Millon derived a classification that combined in a four-by-two matrix. The matrix includes dependent, independent, ambivalent, and detached styles combined with the activity-passivity dimension. This combination produced eight basic types. To this eight types three severe disorders were added. A total of 11 theory-derived personality patterns crystallized out of this combination. Enumerated below are the eight well-compensated or mildly pathological patterns. These patterns are followed by the three more severe or borderline variants of behaviour that characterize a specific personality pattern (Millon, 1981, pp. 60 - 62 ; and Strack, Lorr and Campbell, 1990) :

1. The passive-dependent pattern (Millon Submissive personality; DSM-III Dependent disorder)
2. The active-dependent pattern (Millon Gregarious personality; DSM-III Histrionic disorder)
3. The passive-independent pattern (Millon Narcissistic personality; DSM-III Narcissistic disorder)

4. The active-independent pattern (Millon Aggressive personality; DSM-III Antisocial disorder)
5. The passive-ambivalent pattern (Millon Conforming personality; DSM-III Compulsive disorder)
6. The active-ambivalent pattern (Millon Negativistic personality; DSM-III Passive-aggressive disorder)
7. The passive-detached pattern (Millon Asocial personality; DSM-III Schizoid disorder)
8. The active-detached pattern (Millon Avoidant personality; DSM-III Avoidant disorder)
9. The cycloid personality corresponds to the DSM-III category of borderline personality disorder and represents a moderately dysfunctional dependent or ambivalent orientation.
10. The paranoid personality is described with similar features in both Millon and the DSM-III. The paranoid personality matches aspects of three of the theory's types most clearly, primarily the independent orientation, but also, to a somewhat lesser extent, the discordants and ambivalents.
11. The DSM-III schizotypal disorder and Millon's schizoid personality both display a constellation of behaviours that reflect a poorly integrated or

dysfunctional detached personality pattern.

Table 1 provides an overall picture of the theoretical framework for the above personality patterns (Millon, 1987). Appendix 3 summarizes the behavioural characteristics of the above eleven personality types. The features for each personality type are discussed in terms of the typical behavioural pattern, interpersonal conduct and cognitive style of the specific personality. These personality features as described by Millon, together with the DSM-III-R criteria for each personality disorder, served as the basis for the construction of the Millon Clinical Multiaxial Inventory - II (MCMI - II). This personality test will be described in Chapter 4 of this thesis and will form the basis of personality measurement in this study.

#### 2.5.7 The Clinical Syndrome Scales

According to Millon (1987) the personality disorders as described by the DSM-III-R, Axis II and the MCMI-II Scales, are in contrast with the clinical syndrome disorders comprising Axis I. The Axis I disorders are best seen as extensions or distortions of a patient's basic personality pattern. These Axis I syndromes tend to be relatively distinct or transient states, waxing and waning over time depending on the impact of stressful

TABLE I : THEORY-BASED FRAMEWORK FOR PERSONALITY PATHOLOGY (Millon, 1987, p. 19)

Pathology domain	Self-Other			Pain-Pleasure	
	Other + Self -	Self + Other -	Self ↔ Other	Pain ↔ Pleasure	Pleasure- Pain +/-
Reinforcement source	Other + Self -	Self + Other -	Self ↔ Other	Pain ↔ Pleasure	Pleasure- Pain +/-
Instrumental coping style/Interpersonal pattern	Dependent	Independent	Ambivalent	Discordant	Detached
Passive variant	Dependent	Narcissistic	Compulsive	Self-defeating (masochistic)	Schizoid
Active variant	Histrionic	Antisocial	Passive-Aggressive	Aggressive (sadistic)	Avoidant
Dysfunctional variant	Borderline	Paranoid	Borderline or Paranoid		Schizotypal

situations. Most typically, they caricature or accentuate the basic personality style. Regardless of how distinctive they appear to be, however, they take on meaning and significance only in the context of the patient's personality and should be appraised with reference to that pattern. Despite the observation that certain of the disorders arise most frequently in conjunction with particular personality styles, each of these symptom states will occur in several patterns. For example, Millon (1987) feels that neurotic depression or dysthymia (Scale D - MCMI-II ; see Chapter 4), occurs most frequently among avoidant, dependent, and self-defeating personalities.

Millon (1987) further writes that several covariations are possible between Axis I syndromes and Axis II personality styles on the DSM-III-R. For this reason, Millon included the following disorders of moderate severity in the construction of the Millon Clinical Multiaxial Inventory - II : Anxiety, Somatoform, Bipolar : Manic, Dysthymia, Alcohol Dependence and Drug Dependence. Millon also included the following disorders of marked severity : Thought Disorder, Major Depression and Delusional Disorder (see Appendix 3 and Chapter 4).

Lastly Millon (1987) writes that, although clinical syndromes and personalities are assessed independently on

the MCMI-II, each syndrome should be coordinated with the specific personality pattern with which it is related. Most of the Axis I clinical syndromes described above are of the reactive kind that are of substantially briefer duration than the personality disorders. They usually represent states in which an active pathological process is clearly manifested. Many of these symptoms are precipitated by external events. Most typically, they appear in somewhat striking or dramatic form, often accentuating or intensifying the more prosaic features of the premorbid or basic personality style. During periods of active pathology it is not uncommon for several symptoms to covary at any one time and to change over time in their degrees of prominence.

#### 2.6 THE DSM-III-R. AXIS II - PERSONALITY DISORDERS

The personality typology of Millon as described above has played a large role in forming the theoretical basis for the classification schema for personality disorders employed in DSM-III and DSM-III-R, Axis II (Millon and Everly, 1985). Millon (1984) was instrumental in developing the original DSM-III categories and criteria for Axis II.

The DSM-III-R (1987) groups the personality disorders into three clusters :

- The first cluster (A) includes the paranoid, schizoid, and schizotypal personality disorders. Persons with these disorders often appear odd and eccentric.
- The second cluster (B) includes the histrionic, narcissistic, antisocial, and borderline personality disorders. Persons with these disorders often appear dramatic, emotional, and erratic. The second cluster, with the possible exception of the borderline, captures the concept of extroversion.
- The third cluster (C) includes the avoidant, dependent, obsessive-compulsive, and passive-aggressive personality disorders. Persons with these disorders often appear anxious or fearful. The third cluster captures the dimension of introversion (Lorr and Strack, 1990).

According to DSM-III-R, many people exhibit traits that are not limited to a single personality disorder and, if a patient meets the criteria for more than one disorder, each one should be diagnosed. Personality disorders are coded on Axis II of DSM-III-R (Kaplan and Sadock, 1988 ; American Psychiatric Association, 1987).

In their critique on the DSM-III-R personality disorders Widiger, Frances, Spitzer and Williams (1988) acknowledge that, despite the many changes that have been made,

inconsistencies in the diagnosis of personality disorders remain. They agree that there is variation in the breadth of coverage, evident in part by the variation across criteria sets in the cutoff points, number of items, and behavioural specificity. Secondly they write that there is a lack of consistency in the emphasis on cognitive, affective, behavioural, and interpersonal features. Some of the criteria sets emphasize affective features (eg. borderline), while others emphasize cognitive (eg. paranoid), behavioural (eg. antisocial), or interpersonal (eg. dependent) features. They conclude that in future systems it may be preferable for each disorder to include systematically each area of personality functioning (also see Millon above, and Appendix 3).

#### 2.7 THE TREATMENT OF PERSONALITY DISORDERS

Psychotherapy outcome studies have focused on axis I conditions, and there is no body of systematic research available on the optimal treatment of personality disorders. It is well experienced that chronic and pervasive maladaptive personality traits will certainly have an effect on any attempt to treat an axis I syndrome or, for that matter, any medical condition.

It is widely recognized and accepted that the mainstay of treatment of personality disorders remain psychotherapy.



Widiger and Frances (1985) write that various theoretical frameworks have been proposed for the management of personality pathology, of which the psychodynamic and psychoanalytic approach must be the most influential. Other psychotherapeutic modalities used for the treatment of personality disorders include behaviour therapy, familial and interpersonal therapies. Millon (1988) in his article on personologic psychotherapy gives a good integrative eclectic outline of psychotherapy with personality disorders. Recently, Soloff (1990) focused some attention on the pharmacological treatment of personality disorders.

Soloff (1990) writes that psychopharmacology can be helpful when it is used to focus on particular target symptoms that are commonly seen in certain of the personality disorders. Neurochemical models of behaviour and empirical pharmacotherapy trials have brought into focus the role of biologic trait vulnerabilities in the formation and expression of personality disorders. Reports indicate that medications clearly relieve symptom distress and may address neurotransmitter pathologies that define trait vulnerabilities to loss of control of affect, anxiety, cognition, and impulse. Characterologic behaviours once deemed unaccessable may become amenable to psychotherapy when uncoupled from their biologic generators. On the negative side, the treatment of

biologic trait vulnerabilities may require chronic maintenance of medications in selected cases, with known long-term adverse consequences. The effects of currently available medications appear modest at best. As the neurochemical basis of trait vulnerabilities is better defined, more specific pharmacologic agents will be needed for effective intervention. Medication does not cure character but may modify its biologic basis in the long-term pursuit of change.

#### 2.8 SUMMARY

The important aspects of personality theory discussed above can be summarized as follows :

1. The definition and description of personality remains difficult and controversial. Numerous personality theories exist. However, these can be classified broadly into four categories : the trait approach, the humanistic actualization approach, the psychoanalytic approach and the social-learning theory approach.
2. From a historical perspective, a brief outline of the psychodynamic approach to dysthymia was given. Depressive neurosis was hypothesized by psychoanalytic theory to be the result of an excessive reaction of depression due to an internal

conflict or to an identifiable event such as the loss of a love object or cherished possession.

3. For the purpose of this study, behavioural concepts in personality development were discussed. From this behavioural view grew the biosocial-learning theory of Millon. Through research and formal deduction, Millon made an attempt to generate the established and recognized personality categories as adopted in the DSM-III and DSM-III-R, Axis II.
4. By using the following three dimensions : active-passive, subject-object, and pleasure-pain in a matrix with various coping patterns which included : dependent and independent, ambivalent, and detached, Millon derived eleven personality patterns which also correspond to the DSM-III and DSM-III-R personality classification systems.
5. This chapter is concluded with a brief outline of the treatment of personality disorders. To date the mainstay of treatment remains interpersonal psychotherapy. The use of some psychopharmacological agents as a adjunct to psychotherapy is discussed.

CHAPTER 3

THE RELATIONSHIP BETWEEN DYSTHYMIA  
AND PERSONALITY DISORDERS

3.1 INTRODUCTION

After reviewing dysthymia in the first chapter of this thesis and in the second chapter, discussing various concepts of personality focusing mainly on the biosocial-learning theory of Millon, it is now necessary to review the relationship between dysthymia and personality. Considering the history of the understanding and classification of chronic depression and dysthym disorder emphasis has shifted from views of inherited temperaments to acquired character tendencies. Later views saw dysthymia as attenuated variants of classical manic-depressive disorders or complications of other mental disorders, physical illnesses, or environmental stressors. The relationship between chronic depression, dysthymia, character pathology and personality disorders remains questionable. Because personality disorders and dysthymic disorders often have a similar course and share common symptoms or traits, it is intuitively reasonable to study the association between these two types of disorder.

Empirical studies on the relationship between personality

and dysthymia have been few and also complicated by methodological problems. Studies have failed to take into account that depressed mood itself may confound evaluations of personality. Several studies have attempted to overcome this problem, for instance by asking patients to rate their personality as they would have done prior to the onset of the illness, but few of these studies produced significant results (Scott, 1988).

Hirschfeld (1990) writes that the relationship between personality and dysthymia can be conceptualized in the following four ways :

- (a) personality features may predispose to dysthymia,
- (b) the expression of certain personality features and dysthymia may lie on the same genetic spectrum,
- (c) dysthymia may best be conceived of as a personality disorder and its expression involves abnormal personality, and
- (d) personality features can be changed as a result of the experience of living with dysthymia which further complicates the disorder. For example, any character abnormalities found in chronic depressives represent a deterioration in the personality as a secondary consequence of a prolonged illness.

Scott (1988), looking at clinical records of patients, observed that -while many chronic depressives were

categorised as having personality disorder during the course of the chronic depressive illness -the diagnosis of dysthymia was rarely recorded in their case-notes.

In order to understand the relationship between depression and personality, it is necessary firstly to distinguish the relationship between depression and personality and secondly between the classification categories of depressive personality type. In order to do so, the following six aspects as described by Phillips, Gunderson, Hirschfeld and Smith (1990, pp. 830 and 831) are important in reviewing the relationship between depression and personality :

1. Premorbid personality traits. This refers to normal personality traits such as introversion and dependency that exist before -, and may predispose an individual to - the development of a subsequent depressive episode.
2. Postdepressive (postmorbid) personality traits. In contrast to premorbid personality traits, postmorbid personality features are considered sequelae of depressive illness. Examples of these personality features can be resignation and insecurity.
3. Personality disorders coexisting with depression. According to Phillips, Gunderson, Hirschfeld, et al.,

(1990) literature has documented the existence of personality disorders among depressed populations, but without explaining the development of this comorbidity. For example whether the personality disorders predispose an individual to or result from depression.

4. Personality traits coexisting with depression. Personality traits as opposed to disorders are observed to be associated with depression. Reports about such traits, for example social withdrawal and self-centeredness, are also generally descriptive without implying causality.
5. Personality as a modifier of depressive episodes (pathoplasty view). According to this view, personality is considered a premorbid factor that modifies the symptomatic expression of depressive episodes. The example is used of an obsessional person with depression who may be more morbidly preoccupied than, say, a person with an hysterical personality. Similarly, personality traits like neuroticism or ego resilience are posited to affect the clinical course and long-term outcome of depressive episodes. The personality traits, however, neither predispose an individual to nor result from the depression.

6. Normal depressive traits. Enduring personality traits conveying depressive mood are considered variants of normal rather than attenuated forms of affective illness or personality disorder. Traits like being self-critical or persistently gloomy may or may not predispose an individual to depression.

A second aspect of the relationship between personality and depression needs attention. In contrast to the above six points, if a specific depressive personality type exists, it must be considered an enduring type of character or temperament. Together with this it should also have the characteristics that define other personality disorders. These characteristics include early onset, associated dysfunction or subjective distress, and traits that are fairly stable across many situations and over long periods of time, regardless of symptomatic state.

Finally, the conceptualization of the depressive personality as a disorder touches on another larger topic : the nosology of the affective and personality disorders. In essence this concerns the relationship of a depressive personality disorder to existing axis I and axis II disorders. This relationship should be examined and will be part of this study.



### 3.2 PERSONALITY CHARACTERISTICS AND DYSTHYMIC DISORDER

Until very recently, due perhaps to changing terminology, few empirical studies exist exploring the personality characteristics of patients suffering from dysthymia. Older studies made an attempt to identify personality variables in chronic depressives. At present some authors are speculating about the interactive nature of personality and dysthymic disorder.

Akiskal, King, Rosenthal, et al., ( ), in their study of the clinical and familial characteristics of chronic depressives, found that 44 % of chronic depressives as opposed to 28 % of non-chronic depressives they researched fulfilled the criteria for depressive personality. Nystrom (1979), in his 10 year follow-up study of factors related to prognosis in depression, suggested that depressives with hysteroid, aesthenic, syntonio or sensitive personality traits had a poor outcome to treatment. Hirschfeld Klerman, Andreasen, et al., (1986) found in their study that chronic depressives showed more emotional instability, less objectivity and a greater tendency to break under stress. Depressive patients also demonstrated more neuroticism, introversion, and obsessionality than manic patients or normal individuals (Hirschfeld and Klerman, 1979). In a further study by Hirschfeld, Klerman, Clayton and Keller

(1983) a group of recovered depressives were compared with the normal population and were found to be introverted, submissive, and passive, with increased interpersonal dependency but normal emotional strength.

Furthermore, the course of primary late onset depressive illness in patients older than forty years of age can be quite protracted (Akiskal, 1990). Although the pre-morbid psychiatric history may be free of depressive manifestations, residual depressive symptoms are common, and chronicity may develop after one or several depressive episodes that fail to remit fully. This residual phase after a depressive episode may linger on for months or even years. During this residual phase, personality characteristics such as a sense of resignation, inhibited communication, rigidity, irritability or emotional lability may dominate the patients' clinical picture. The lives of these patients are often characterized by overdedication to work and inability to enjoy leisure activities. Marital conflict is often in a state of chronic deadlock, with patients neither seeming able to divorce nor to achieve reconciliation. In other patients, the residual state is dominated by somatic manifestations involving vegetative or autonomic nervous system irregularities.

In a recent study, Roy, Sutton and Pickar (1985) used

several personality questionnaires specifically to identify personality variables in dysthymic disorder patients. They found that dysthymic disorder patients were significantly more neurotic, extrapunitive, and intrapunitive and had significantly lower self-esteem than the control subjects (also see Vaz Serra and Pollitt, 1975 ; Boyce, Parker, Barnett, Cooney and Smith, 1991). Patients with dysthymic or cyclothymic disorder alone, or in combination with major depression, showed more self-doubt, insecurity, sensitivity, compliance, rigidity and emotional instability (Alnaes and Torgersen, 1989 (b)).

In a collaborative research project between five major university hospitals in the United States (Hirschfeld, 1990) 955 dysthymic disorder patients, and 2284 first-degree relatives of these patients were evaluated. Results showed that relatives who had recovered from dysthymia and double-depressed patients still suffering from dysthymia scored significantly higher on the neuroticism scale as measured on the Maudsley Personality Inventory. On the extraversion scale the recovered dysthymic relatives and currently dysthymic patients were significantly more introverted than all other groups. Overall results from this study indicate that individuals suffering from dysthymia have decidedly abnormal personalities. They have extremely low levels of

emotional strength and are likely to break down under stress. They are likely to be moody and fearful. They are very introverted and shy, avoiding social interactions. Their personalities are significantly more disturbed than those of individuals who have suffered only from major depression. This study also strongly suggests that the abnormal personality features are independent factors continuing to exist even after recovery from dysthymia (also compare Boyce, Parker, Hickie, et al., 1990).

### 3.3 DYSTHYMIA AND SPECIFIC PERSONALITY DISORDERS

In contrast to the above section where researchers made an attempt to identify specific personality characteristics of dysthymic patients, a few studies were carried out to explore the relationship between dysthymia and known personality disorders. In 1980 the DSM-III already suggested that dysthymic disorder may be particularly associated with certain personality disorders, especially with the borderline, histrionic, and dependent types of personality.

Akiskal, Rosenthal, Haykal, et al., (1980) reported an excess of unstable personality traits in characterological depressions unresponsive to antidepressant medication. These traits include passive-dependent, histrionic, antisocial, or borderline

personality characteristics (also see Akiskal, 1981 ; Ionescu and Popescu, 1989).

A further study by Roy, Sutton and Pickar (1985) found that 9 of the 11 dysthymic patients in their study were clinically assessed as having an associated personality disorder that met DSM-III criteria - 4 patients were borderline, 2 were schizoid, 1 was histrionic, 1 was compulsive, and the last one dependent (also Charney, Nelson and Quinlan, 1981 ; and Prasad, Val, Lahmeyer, et al., 1990).

The study by Alnaes and Torgersen (1988) of 18 dysthymic patients found schizotypal and avoidant personality disorders to be the most frequent. In a subsequent study (Alnaes and Torgersen, 1989 (b)) dysthymic patients were found to be more schizoid, schizotypal, borderline and avoidant according to the Millon Clinical Multiaxial Inventorium - I (MCMI-I). Dysthymic patients also had a higher prevalence of DSM-III Axis II diagnosis, and had more borderline, avoidant, and passive-aggressive personality disorders as measured by the Structured Interview for DSM-III Personality Disorders (SIDP).

In their most recent study, Alnaes and Torgersen (1991) compared personality and personality disorders among patients with various affective disorders. Patients in the dysthymic group of affective disorders more often had

schizoid, schizotypal, borderline, avoidant, and passive-aggressive personality disorder characteristics than patients in the other psychiatric disorder groups. When dysthymic patients were compared with the bipolar group, dysthmics more often showed avoidant personality disorder characteristics than patients in the bipolar group. If compared with the major depression group, dysthmics showed a higher incidence of schizotypal personality disorder characteristics.

Using the Millon Clinical Multiaxial Inventory - I, Joffe and Regan (1988) evaluated the effect of depressed mood on personality. Their results show that both level of personality traits as well as the frequency and type of diagnoses of personality disorder change in depressed patients with complete remission of their depressive disorder. With regard to personality trait levels, there were significant changes in mean scores between the depressed and remitted phase on ten out of the eleven personality scales on the MCMI-I. These personality trait levels were the schizoid, avoidant, dependent, histrionic, narcissistic, antisocial, compulsive, passive-aggressive, schizotypal and borderline, with the paranoid scale being unchanged. Furthermore, there were significant decreases in the prevalence of personality disorder diagnoses in depressed patients in remission in six of the eleven personality scales (i.e. schizoid,

avoidant, dependent, passive-aggressive, schizotypal and borderline). These findings are consistent with several studies quoted in the study of Joffe and Regan (1988) which have shown that elevated personality trait scores on a variety of measures may be either a function of the depressive state or due to distorted recall of previous behaviour as a result of being depressed. On the other hand, Joffe and Regan (1988) found that there were significant increases in personality trait scores on the histrionic, narcissistic, antisocial and compulsive personality scales. Similar results were found by Libb, Stankovic, Freeman, Sokol, Switzer and Houck (1990).

Personality pathology appears to be a major factor in recurrent depression. Personality assessments in a study of 119 treatment-responsive patients with recurrent unipolar depression revealed that nearly half of the patients (48 %) showed some personality disturbance. The most common personality features were avoidant (30,4 %), compulsive (18,6 %), and dependent (15,7 %) (Pilkonis and Frank, 1988).

Kocsis and Frances (1987) conducted a similar study to determine the prevalence of personality disorder in depression. In their study they evaluated 54 outpatients with chronic depression, most of them fulfilling the criteria for both dysthymic disorder and major

depression. Clinically 41 % were found to have an axis II disorder, mostly dependent (13 %) and atypical, mixed (11 %). An earlier study by Koenigsberg, Kaplan, Gilmore, et al., (1987) reported similar data with a 34 % rate of axis II diagnosis in a sample of 68 patients with dysthymic disorder. They found specifically that the most common personality types were atypical mixed (16 %) and dependent (8 %).

A recent paper by Tyrer, Seivewright, Ferguson, et al., (1990) studied the personality status of 65 patients with dysthymic disorder and found that 31 of the patients (51 %) had a personality disorder according to DSM-III criteria. These patients were included in a clinical trial in which diazepam, dothiopin or placebo tablets, cognitive and behaviour therapy, or a self-help package were given over ten weeks, and they were found to respond poorly to all these treatment modalities.

Various specific associations have been described between DSM-III-R, Axis II disorders and dysthymic affective disorder. These can be summarized as follows :

### 3.3.1 The Narcissistic Personality Disorder

Millon and Everly (1985) write that dysthymia occurs when narcissistic persons are confronted with their inability to live up to their inflated self-image. They then tend



to revert to feelings of self-doubt, uncertainty, and a general dissatisfaction with themselves. They exhibit a process of self-disillusionment that leads to a depressed state. Prolonged severe major depression is, however, seldom encountered in narcissistic persons. They are usually successful at using rationalization as a defense mechanism to reduce the significance of their past failures. At times, however, a major decompensation process may result in a severe depressive episode.

### 3.3.2 The Histrionic Personality Disorder

Millon and Everly (1985) claim that dysthymic disorder is the most common affective disorder experienced by histrionic personalities. These relatively mild episodes of depression tend to be manifest through typical histrionic behaviours, for example, dramatic and eye-catching displays. This exhibitionistic display is a natural manifestation of the histrionic's basic style of actively seeking attention and approval. In these individuals, dysthymic disorders most often arise when they are anticipating or actually feeling being isolated, abandoned, or stranded. It is not uncommon for histrionics to philosophize about their existential anxiety or the alienation that we all share in this age of anxiety or this impersonal society. Thus, they tend to engage in pseudosophisticated discussions, career

counseling, or other activities in an attempt to rationalize their own lack of identity or lack of personal or professional direction. Their interpersonal and work histories usually reflect a series of short-lived relationships and occupations. They purport to be in search of meaningful relationships, careers, and self-identity. Should histrionic individuals fail to establish the support they need, they may decompensate into other Axis I affective disorders, such as major depression, hypomanic symptoms or bipolar episodes.

#### 3.3.3 The Dependent Personality Disorder

Millon and Everly (1985) explain dependent personalities, like the histrionic personalities described above, as especially susceptible to separation anxiety and feelings of helplessness and abandonment. The actual loss of a supportive person or relationship may promote dysthymic reactions, major depressive episodes, or even bipolar disorders.

#### 3.3.4 The Passive-Aggressive Personality Disorder

Millon and Everly (1985) write that affective disorders such as dysthymic reactions and cyclothymic disorders are quite common among passive-aggressive personalities. Passive-aggressive individuals characteristically vacillate between anxious futility, despair and self-

deprecation, on the one hand, to bitter discontent and demanding irritability on the other hand. A generalized pessimism often engulfs them and those around them. As these feelings persist, a host of affective disorders may be seen to arise.

According to Hirschfeld (1991), it is however necessary to keep in mind the following differences between passive-aggressive and depressed patients. The negativism of passive-aggressive persons is directed toward people who have some authority or influence over them and not towards people in general. The negativism is related to their subordinate role. This issue is irrelevant to persons with a depressive personality disorder. Their negativism is more generally directed and does not necessarily increase in the presence of people who make demands on them. Nor are depressed individuals necessarily obstructive toward other people. Another key difference between passive-aggressive persons and depressed persons is that the former do not have a persistent tendency to feel dysphoria and gloominess and certainly do not see themselves as inadequate or worthless. If anything, people with a passive-aggressive personality disorder tend to have a consciously inflated opinion of themselves in contrast to the depressed individual's self-concept of inadequacy.

### 3.3.5 The Compulsive Personality Disorder

According to Millon and Everly (1985), whereas compulsive personalities have been described in the literature as having a tendency to suffer from psychotic episodes, in the clinical experience of the authors they tend more often to experience non-psychotic affective disorders. The most prevalent affective reaction by the compulsive personality disorder appears to be dysthymia. This reaction occurs when the compulsive personalities come to the realization that they lead empty, excessively conforming lives. Millon further writes that compulsive personalities will exhibit classic forms of agitated depression characterized by diffuse apprehension, marked feelings of guilt, and a tendency to complain about personal sin and unworthiness. Finally, compulsive personalities are likely to turn the angry and resentful components of their ambivalence inward and against themselves, claiming that they truly deserve punishment and the misery they now suffer.

Hirschfeld (1991) writes on the difference between obsessive-compulsive and depressive personality disorders. The essential features of obsessive-compulsive personality disorder are that the person is withholding and controlling. In contrast, the depressive personality disorder patients tend to be unhappy, negativistic, and

critical by nature. Whereas persons with an obsessive-compulsive disorder because of their constricted affect, rarely enjoy themselves. In the absence of enjoyment they are accordingly gloomy like depressed individuals. Obsessive-compulsive individuals do not feel good, but they do not feel bad either, nor do they complain of unhappiness. Depressed persons, in contrast, often feel bad and reflect this negative state in their interactions.

#### 3.3.6 The Depressive Personality Disorder

The concept of a depressive personality disorder as a distinct entity remains controversial. Very recently Hirschfeld (1991) discussed the concept of the depressive personality disorder. He wrote that the clinical core of this disorder is an excessively negative pessimistic belief about oneself and other people. It is characterized by feelings of dysphoria, dejection, gloominess, and pessimism. These patients perceive themselves as inadequate and worthless. Their low level of self-esteem renders them critical, blaming, derogatory, and punitive towards themselves. They are prone to worry and to feel guilty, as well as negativistic, critical, and judgmental towards others.

The self-defeating personality disorder can be confused with the depressive personality disorder. Hirschfeld

(1991) writes that, in contrast to the depressive personality disorder features above, a person with a self-defeating personality disorder has a tendency towards victimization and suffering. In the self-defeating personality disorder the individual plays an active role in producing and maintaining the suffering. The individual with a depressive personality disorder experiences unhappiness and dissatisfaction but does not seek situations to reinforce this perception. Dysphoria and unhappiness are less tied to specific situations.

In his critical review of the depressive personality, Chodoff (1973) writes that many psychiatrists believe that individuals prone to develop clinical depressive illness display certain distinctive personality features which distinguish them from individuals not so predisposed. Writing specifically on neurotic depression, Chodoff claims that reactive depression is associated with a poorly adjusted premorbid personality. A depressive personality disorder occurs in those patients prone to neurotic depression and characterized by chronic pessimism, loneliness, dissatisfaction, unhappiness, guilt or feelings of inadequacy.

### 3.3.7 The Self-Defeating Personality Disorder

Turning more specifically to the person with a self-defeating personality disorder, Hirschfeld (1991) writes

that the person with a self-defeating personality disorder actively chooses people and situations that lead to disappointment, failure, or mistreatment even when better options are clearly available. In contrast to these self-defeating characteristics, the person with a depressive personality disorder is dysphoric and gloomy. In general, the depressed individual is not affected one way or the other by positive personal events. Such events make no difference in the person's self-concept of inadequacy, worthlessness, and low self-esteem. On the other hand, the person with a self-defeating personality disorder has an active negative reaction following positive events. Whereas the person with a self-defeating personality disorder actively rejects opportunities for pleasure, the individual with a depressive personality disorder is not even capable of experiencing pleasure.

#### 3.3.8 The Borderline Personality Disorder

Borderline personality disorder and depressive personality disorder overlap in the area of dysphoria and negative feelings toward other people (Hirschfeld, 1991). The borderline mood is characterized by its instability so that the patient tends to be dysphoric as well as irritable or anxious, whereas the depressive mood is characterized by fairly persistent dysphoria. The

difference is in the instability and brevity of affect shifts, and in the multiple kinds of affect states that the borderline person experiences, such shifts not being characteristic of the depressed individual. Similarly, borderline individuals tend to alternate between negative feelings, especially devaluation, and positive feelings, such as idealization. Depressed individuals however tend to be persistently critical, blaming, and derogatory. In terms of self-concept, the person with a borderline personality disorder feels emptiness and boredom. The person with depressive personality disorder experiences chronic low self-esteem and feelings of inadequacy and worthlessness. Thus borderline individuals struggle with the absence of a clear sense of self, which is not the case for depressed individuals.

#### 3.4 THE MEASUREMENT OF PERSONALITY AND DYSTHYMIA

According to Anastasi (1968) an important area of psychological testing is concerned with the affective or nonintellectual aspects of behaviour. Tests designed for this purpose are commonly known as personality tests. Although some personality assessments include intelligence tests, personality tests most often refer to measures of such characteristics as emotional adjustment, interpersonal relations, motivation, interests, and attitudes.



The earliest personality tests utilized the technique of free association, and the work of Kraepelin, Galton, Pearson, and Cattell should be mentioned (Anastasi, 1968). Their work concerned the development of standardized questionnaires and rating-scale techniques. The prototype of the personality questionnaire, or self-report inventory, is the Personal Data Sheet developed by Woodworth during World War 1. This test was designed as a rough screening device for identifying seriously neurotic men who would be unfit for military service. Subsequent questionnaires made an attempt to subdivide emotional adjustment into more specific forms, such as home adjustment, school adjustment and vocational adjustment.

A further approach to the measurement of personality discussed by Anastasi (1968) is through the application of performance or situational tests. The purpose in such a test is generally disguised. Most of these tests simulate everyday-life situations quite closely.

Projective techniques represent a third approach to the study of personality and one that has shown phenomenal growth, especially among clinicians. In such tests the subject is given a relatively unstructured task that permits wide latitude in its solution. The assumption underlying such methods is that the individual will

project his characteristic modes of response into such a task (Rabin, 1968).

In the literature, the objective measurement of depression remains a problem. Rapaport, Gill and Schafer (1976) discuss indicators of depression on psychological tests which include the Wechsler-Bellevue and Wechsler Adult Intelligence Scales, Story Recall Test, Sorting Test, Word Association Test, Rorschach and the Thematic Apperception Test. The most widely used objective clinical scale for the measurement of depression today is the Hamilton Depression Scale (Hamilton, 1960). As far as the literature is concerned, no scale exists for the specific measurement of dysthymia (Kaplan and Sadock, 1988). In a recent development, the Millon Clinical Multiaxial Inventory (MCMI) based on the DSM-III-R symptom criteria for psychopathology, was constructed by Millon (1987) and includes a scale for dysthymia. The MCMI will be used in this study, and will be discussed in more detail in the next chapter.

### 3.5 SUMMARY

1. In contrast to the first two chapters in this study which dealt separately with the entity of dysthymia and concepts of personality this chapter made an attempt to give an overview of the relationship between dysthymia and personality disorder.

2. Empirical studies on the relationship between personality and dysthymia have been few and have been complicated by methodological problems. Basic principles about this relationship for future consideration and research include :

- personality features may predispose to dysthymia,
- the expression of certain personality features and dysthymia may lie on the same genetic spectrum,
- dysthymia may best be conceived of as a personality disorder and its expression involves abnormal personality, and
- personality features can be changed by the experience of living with dysthymia, the changed features complicating the diagnosis of the disorder.

3. Several studies made an attempt to identify some personality characteristics of chronic depressives and dysthymia. These characteristics include greater measure of neuroticism and emotional instability, and less objectivity. Recovered depressives were found to be introverted, submissive, and passive with increased interpersonal dependency. On personality questionnaires, dysthymic disorder patients were significantly more neurotic, extrapunitive and

intrapunitive, and had a significantly lower self-esteem.

4. Dysthymic disorder has also been associated with certain personality disorders, especially with the borderline, histrionic, and dependent types of personality. Further associations have been made with the narcissistic, passive-aggressive, compulsive, self-defeating and depressive personality disorders.
5. This chapter is concluded with a brief discussion of the psychological measurement of personality and dysthymia. The objective measurement of depression and dysthymia remains a problem. The only test that measures personality traits and disorders, and which has a subscale for dysthymia, is the Millon Clinical Multiaxial Inventory (MCMI). This test will be discussed in the next chapter.

CHAPTER 4

THE MILLON CLINICAL MULTIAXIAL INVENTORY

4.1 BACKGROUND TO THE DEVELOPMENT OF THE MCMI-I

In a review of the MCMI, Wetzler (1990) comes to the conclusion that the MCMI is a significant step forward in psychological assessment. The reason for this assumption was that the MCMI, in contrast to other psychological tests, was designed to discriminate and identify different psychiatric syndromes. Most other psychological tests were designed to identify psychiatric patients from a normal population or to describe normal personality features in healthy subjects. Wetzler thus concludes that consequently most other psychological tests have limited usefulness in psychiatric populations.

In the development of the first version of the MCMI, Millon used a rational/procedural approach to test construction. Grounded in the biosocial-learning theory (see Chapter 2.5), the MCMI defines meaningful dimensions of psychopathology. This empirical theoretical structure represents its greatest strength. Other important advances of the MCMI on other psychological tests are the use of Base Rate (BR) scores tied to the true prevalence of various psychiatric syndromes. Further advances are the attempted separation of transient clinical syndromes

from longstanding personality characteristics and the attempt to link the MCMI to DSM nosology (Wetzler, 1990).

The Millon Clinical Multiaxial Inventory (MCMI-I) was developed to operationalize personality disorders as they were conceived by Millon (see chapter 2.5). Because Millon was influenced by DSM-III in the definition of personality disorders, these scales generally paralleled the disorders officially recognized by the American Psychiatric Association. The MCMI scales have been widely used by clinicians and researchers and a considerable body of research has supported their validity (Costa and McCrae, 1990). A few studies investigated the validity of the MCMI-I personality scales by comparing them to the DSM-III Axis II diagnosis obtained by means of a clinical interview and found them variable (Torgersen and Alnaes, 1990).

#### 4.2 THE MCMI-II

In 1987 Millon offered a revision of his theory-based framework for personality pathology (MCMI-II) to account for the addition of two provisional disorders on Axis II of the DSM-III-R (see Chapter 2.6). The revision posits 10 basic styles of personality functioning and 3 severe variants (see Appendix 3). The basic disorders can be formed from a 5 x 2 matrix (see Table 1) consisting of two dimensions : The first refers to the primary sources

of reinforcement - that is, dependent, independent, ambivalent, discordant, or detached - and the second reflects the pattern of coping behaviour - that is, either active or passive. Combining the five sources of primary reinforcement together with the two coping patterns results in 10 basic personality styles. The ten basic personality styles are schizoid, avoidant, dependent, histrionic, narcissistic, antisocial, aggressive-sadistic, compulsive, passive-aggressive and self-defeating.

Three more severe styles are seen as variants of these 10. The three severe personality pathology scales are schizotypal, borderline and paranoid. In addition to the extra scales, a differential weighting scheme for items was added to the MCMI-II (Streiner and Miller, 1989).

#### 4.3 COMPOSITION OF THE MCMI-II

The MCMI-II questionnaire consists of 175 true-false statements designed to quantify psychopathology relevant to DSM-III-R Axis I and Axis II in individuals over 17 years of age. The test contains 22 clinical scales and 3 correction scales which are divided into 5 categories to reflect more accurately the distinction between relatively enduring personality features and acute symptoms. The test also includes a Validity Index that

has been shown to be sensitive to careless, confused or random responses. The scales are :

- Modifier Indices (correction scales) :  
Disclosure, Desirability, Debasement
- Clinical Personality Pattern Scales  
(DSM-III-R / Axis II) : Schizoid, Avoidant, Dependent,  
Histrionic, Narcissistic, Antisocial, Aggressive-  
Sadistic, Compulsive, Passive-Aggressive, Self-  
Defeating
- Severe Personality Pathology Scales :  
Schizotypal, Borderline, Paranoid
- Clinical Syndrome Scales (DSM-III-R / Axis I) :  
Anxiety Disorder, Somatoform Disorder, Bipolar :  
Manic Disorder, Dysthymic Disorder, Alcohol  
Dependence, Drug Dependence
- Severe Clinical Syndrome Scales :  
Thought Disorder, Major Depression,  
Delusional Disorder.

The test produces both raw scores and base rate scores for each subscale. The base rate reflects the severity of pathology as compared to that found in the general population.



#### 4.4 STRUCTURAL PROPERTIES OF THE MCMI-II

The structural properties of the MCMI-II include: item overlap among scales, internal consistency of scales, test-retest reliability, the distinction between personality disorder and clinical syndrome scales, and scale intercorrelation and factor structure (Millon, 1987; Lorr, Strack, Campbell, et al., 1990).

Norms for the MCMI-II are based on a nationally representative sample of 1292 male and female clinical subjects representing a variety of primary DSM-III-R diagnoses. The subjects were in- and outpatients in clinics, hospitals and private practices throughout the United States. Adequate reliability and validity have been demonstrated by Millon as well as by independent researchers.

The test-retest reliabilities on the basic personality disorder scales range from .69 to .85, and the test-retest reliabilities on all 26 scales range from .43 to .91 (Millon, 1987). Multitrait-multimethod procedures and factor analyses were utilized to assess convergent/discriminant validity of the MCMI-II clinical syndrome scales and effects of item overlap on scale performance. Convergent validity was supported, but poor discriminant validity was found for the alcohol dependence (B) scale, drug-dependence (T) scale, and

scale PP. Item overlap did not influence performance for many scales. Results indicate that some scales such as bipolar: manic (N), may perform better in overlapping form. Factor structure was generally stable, regardless of whether overlapping or nonoverlapping scales were utilized (McCann, 1990).

Overholser (1990) reports on two studies in his article which examined the temporal stability of the personality disorder subscales on the MCMI. He reports that the scales demonstrated adequate stability in psychiatric inpatients who were retested with an average of just over one year between testings. Furthermore, a separate sample of depressed inpatients assessed when depressed and 6 weeks later showed that the stability of MCMI personality scales was observed even after patients displayed an initial reduction in depression severity. Although stability is vital to the accurate assessment of personality disorders, both the studies of Overholser found high retest correlations for the MCMI clinical syndrome subscales. In general, these results suggest that patients displayed similar symptom patterns over time, whether construed as personality traits or characteristic patterns of responding when symptomatic.

Very few cross-validation studies between the MCMI-I and MCMI-II and other psychological tests were conducted.

Zarrella, Schuerger and Ritz (1990) used the scores of the Minnesota Multiphasic Personality Inventory (MMPI) to predict MCMI scores in a 100-patient sample. Their results indicated that scores on 19 of the 20 MCMI scales can be successfully predicted by the subscales of the MMPI.

Retzlaff, Sheehan and Lorr (1990) were concerned with the fact that MCMI-II items were weighted in a complicated manner. This weighting necessitates relatively expensive and time consuming computer scoring, which has recently become an issue for practitioners. Proprietary computer scoring also limits the access researchers have to data and consequently reduces the amount of research related to the MCMI. For these reasons, Retzlaff, Sheehan and Lorr (1990) conducted a small study to correlate the weighted and unweighted MCMI-II scales. They found a correlation of high .90's indicating that weighting MCMI-II scales has little effect.

Retzlaff, Sheehan and Fiel (1991) conducted an important study to determine to which extent a person can fake answers on the MCMI-II. In summary, for clinical purposes, they report that elevated profiles with high scales of avoidant, passive-aggressive, self-defeating, borderline, anxiety and dysthymia should be questioned as overreports of symptom level. With regard to the

response indices, high validity scale scores are good indicators of invalid profiles. High disclosure scale scores are also good indicators. Low disclosure scale scores are poor indicators of underreport. Finally, high desirability and high debasement are only fair screens.

#### 4.5 THE MCMI AND AFFECTIVE DISORDERS

Choca, Bresolin, Okonek and Ostrow (1988) conducted a study to investigate the convergent validity of four MCMI-I scales in diagnosing mood disorders. Those selected were the cycloid scale, the dysthymic scale, the hypomania scale, and the psychotic depression scale. Also explored in their study was the issue of whether the four MCMI-I affective scales measure the current mood state of the individual or reflect a history of mood disorders. This question is central to the diagnosis of affective disorders because such diagnosis requires the determination of both current mood dysfunction and the historical presence of such problems.

Significant coefficients were obtained in the intercorrelations between the four affective scales mentioned above. Millon argued that the commonalities between MCMI scales reflect a real-life covariation of clinical symptoms. This indicate that the affective scales of the MCMI should have items in common because patients with different types of affective disorders

share many aspects of their clinical pictures. The study support the premise that the four scales, in particular the dysthymic and hypomanic scales, are an accurate indication of the overall mood state of the patient at the time the inventory is administered. As such, the data confirmed the convergent validity of the scales for assessing current mood state. The dysthymic scale appeared to show an effect for both mood and diagnostic subtype. This scale was also the strongest MCMI scale in terms of its positive predictive power. In the final analysis, findings in this study show that the four scales studied are measuring both the mood state of the patient and a more permanent psychological attribute.

Goldberg, Shaw and Segal (1987) investigated the concurrent validity of the MCMI-I depression scales, and compared the two subscales of dysthymia and major depression with the Beck Depression Inventory and the Hamilton Rating Scale for Depression (HRSD). All measures in the study were significantly intercorrelated.

Piersma (1991) examined the diagnostic efficiency of the MCMI-II major depression (CC) and dysthymia (D) scales for the differential prediction of unipolar depressive disorders. All 109 inpatients in the study had a primary Axis I diagnosis of a depressive disorder given by the attending psychiatrist. When MCMI-II scores were

compared to clinician diagnoses, it was found that both the major depression (CC) and dysthymia (D) scales had a valid prediction for clinical major depression. Overall, the dysthymia scale functioned slightly better as a predictor of major depression than did the major depression scale. This can be explained in that the major depression scale contains very few items assessing vegetative/somatic symptomatology which are critical factors in distinguishing major depression from other unipolar depressive disorders.

Assuming that the MCMI has been developed to identify clinical syndromes and personality traits consonant with the DSM-III, Libb, Stankovic, Sokol, et al., (1990) conducted a study to determine the stability of the MCMI among depressed psychiatric outpatients. The stability of the MCMI-I measures for both the theoretically more stable personality characteristics and the clinical syndromes was investigated using a group of depressed psychiatric outpatients. In the test-retest design with a three month interval between tests, clinical syndrome scales of relevance changed significantly as expected. However, many of the personality scales also changed significantly. Only four of the personality scales met a two-fold test of stability in a sample of depressed outpatients. Those personality scales were dependent, histrionic, antisocial and paranoid. A treatment effect

was demonstrated on the clinical scales. MCMI correlations for the clinical scales of anxiety, dysthymia and psychotic depression did not reach acceptable levels of confidence but showed reduction after treatment.

Finally, it is clear that few studies reviewed the significance of the dysthymia scale on the MCMI-II. However, in their review of the diagnosis of depression by self-report, Wetzler, Kahn, Strauman and Dulcan (1989) write that, as a diagnostic tool, the MCMI-II dysthymia scale was found to be most useful.

#### 4.6 SUMMARY

This chapter describes the Millon Clinical Multiaxial Inventory (MCMI) used in this study. The MCMI is unique in the sense that it was designed to discriminate and identify different psychiatric syndromes. The test is based on the sound theoretical background of the biosocial-learning theory of Millon. The scoring of the MCMI is also based on the true prevalence of the various psychiatric syndromes. A further great advantage of the test is that it is linked to the DSM-III and DSM-III-R nosology. For these reasons, the MCMI-II was a logical choice for use in this study to determine the personality profiles of dysthymic disorder.

Historically, the MCMI-II is a renewed version of the original MCMI. The MCMI-II contains 22 clinical scales and 3 correction scales. The clinical scales are divided in the personality pattern and pathology scales, as well as in the clinical syndrome scales according to the DSM-III-R Axis II and Axis I respectively.

The MCMI-II is a very well researched and constructed instrument. The structural properties include : item overlap among scales, internal consistency of scales, test-retest reliability, the distinction between personality disorder and clinical syndrome scales, scale intercorrelation and factor structure, cross-validation, and weighting of items and scales.

Although the MCMI-II includes scales for the measurement of dysthymia and major depression, more research needs to be done to explore the relationship between the affective disorders and personality traits and personality disorders. A few studies have been reported which made an attempt to address this. Results, however, remain inconclusive. This study will make a further attempt to explore the relationship.



SECTION B

STUDY

CHAPTER 5

PROBLEM FORMULATION AND HYPOTHESES

5.1 PROBLEM FORMULATION

5.1.1 INTRODUCTION

No unitary theory exists that explains the development of an abnormal personality. On the one hand, both Millon and the DSM-III-R accept that personality disorders reflect inflexible, maladaptive exaggerations of normal personality traits (see Chapter 2). This is called the dimensional view where the abnormal personality is just an extension of the person's normal personality. In contrast to this, theorists and researchers argue that the distinctions between normal personality and abnormal personality do not consist of dimensions as proposed by Millon and the DSM-III-R. From this opposing view, the abnormal personality is a distinct phenomena with its own characteristics.

According to the dimensional view of Millon and the DSM-III-R, individuals with personality disorders show variants of familiar personality traits. From this perspective, it is still necessary to ask what makes

these variants pathological. In order to answer this question, additional research is needed to establish whether there is some pattern of personality traits in clinical samples of personality pathology (DSM-III-R, Axis II), as well as in other psychiatric diagnoses (DSM-III-R, Axis I). Theoretical and empirical research is needed to understand the relations between personality disorders, psychiatric diagnoses and personality trait dimensions.

#### 5.1.2 SPECIFIC PROBLEM FORMULATION

From the theoretical background in the previous chapters of this dissertation, it is clear that clinicians have for a long time been interested in the relationship between depression, character traits and personality. More so, with the introduction of the DSM-III and DSM-III-R multiaxial diagnostic classification systems, clinical syndromes were classified on Axis I and personality style and disorders on Axis II. Making this distinction between personality and clinical syndrome raised the question of their possible relationship, and whether this separation was purely artificial. The influence of personality on clinical syndrome, or clinical syndrome on personality was also questioned.

Dysthymia has been used since the 1800's to denote a chronic, low-grade depression. This term was not however

widely used until it was included in the DSM-III in 1980. In the DSM-III dysthymia replaced the concept of depressive neurosis which was used in the DSM-II.

Growing dissatisfaction with the term depressive neurosis made way for the introduction of alternative terms such as depressive personality and depressive character (Phillips, Gunderson and Hirschfeld, 1990). The DSM-II category of depressive neurosis was replaced by the DSM-III classification of dysthymia in the belief that the chronic characterological tendency to dysphoria was the most meaningful dimension of neurotic depression. Furthermore, the goal for DSM-III to define disorders more atheoretically and phenomenologically led to classifying dysthymia under the affective disorders, but with recognition that the affective components of dysthymia may be secondary to underlying personality disorder (Keller and Russell, 1991).

The most influential proponents of the link between personality and dysthymia were Akiskal and workers (Akiskal, Rosenthal, Haykal, et al., 1980). They proposed that dysthymic disorder should be seen as synonymous to early-onset characterological depressions. These early-onset characterological depressions can be divided into subaffective dysthymias, sharing many features of primary affective illness and character

spectrum disorders, representing a heterogeneous mixture of personality disorders such as passive-dependent, histrionic, antisocial, or borderline. Inherent in the concept of characterological depression is an intertwining of depression and character such that depression becomes an integral and prominent part of personality.

The task force for the DSM-IV Mood Disorders Work Group (Keller and Russell, 1991) identified the following two main problem areas for immediate field-trial research :

- To further differentiate the threshold of severity for dysthymia and major depression.
  
- To determine the type of symptoms that should be used for the diagnosis of dysthymia. It is proposed that DSM-IV should include the cognitive and functional symptoms that are most characteristic of dysthymia. Vegetative symptoms should also be included to further clarify dysthymia as an affective disorder and not as a personality disorder.

The views of Akiskal and workers that strongly relate dysthymia to personality structure are in direct contrast to those of the DSM-IV work group that regards dysthymia as a distinct affective disorder with cognitive, functional and vegetative symptoms. In order to explore

this dichotomy further, this study is aimed at establishing a possible link between dysthymic disorder and a characteristic personality style. In order to do this objectively and statistically, a group of dysthymic patients will be compared to a group of mentally healthy subjects. The Millon Clinical Multiaxial Inventory - II which measures personality traits and pathology based on the DSM-III-R will be used.

## 5.2 HYPOTHESES

### 5.2.1 NULL, NONDIRECTIONAL AND DIRECTIONAL HYPOTHESES

The first step in experimental research and in decision-making procedure is to state a hypothesis which must then be tested. Three types of hypotheses exist (Surwillo, 1980 ; Kerlinger, 1975 ; Siegel, 1956) :

- 1) Nondirectional Hypothesis : A nondirectional hypothesis is postulated when specific differences are expected between two groups but the direction of the difference is not known.
- 2) Directional Hypothesis : A directional hypothesis is postulated when specific differences between two groups are expected and the direction of the difference is known.
- 3) Null Hypothesis : A null hypothesis is postulated

when no differences are expected between the two groups.

A central comprehensive hypothesis will initially be formulated in this study. This will be done in order to compare the personality profiles as measured on the Millon Clinical Multiaxial Inventory - II (MCMI-II) of a group of dysthymic patients with a group of mentally healthy subjects. Subsequently, the two groups will be compared on the 25 scales of the MCMI-II.

As different personality traits or disorders and clinical syndromes are measured on the MCMI-II, separate hypotheses are postulated for each scale and the two groups will be compared. These hypotheses are operational hypotheses in the sense that directional hypotheses are postulated when literature indicates that differences are to be expected between the two groups and the null hypothesis is postulated when no differences are expected between the two groups (Grinker, 1988 ; Lombaard, 1984).

#### 5.2.2 OPERATIONAL HYPOTHESES

##### Hypothesis 1

There will not be a statistically significant difference between the personality profiles of a group of patients

suffering from dysthymic disorder compared to a group of mentally healthy subjects as measured on the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Hypothesis 1 deals with a comparison of the overall personality profile of the experimental and control groups.

This hypothesis is the null hypothesis as there is not strong evidence in the literature or current thinking to suggest differences between dysthymic subjects and control subjects regarding personality profiles.

Hypothesis 2

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Disclosure Scale (X-Scale) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

The X-scale according to Millon (1987) signifies problematic response behaviours, notably whether the patient was inclined to be frank and self-revealing or reticent and secretive. A base rate score of less than 35 on scale-X indicates either a general hesitance and reserve or a broad unwillingness to be candid about psychological feelings and problems. Conversely, a base rate score greater than 75 on scale-X suggests an

unusually open and self-revealing attitude, not only while completing the inventory but also when discussing emotional difficulties with others.

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 3

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Desirability Scale (Y-Scale) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

According to Millon (1987) the desirability gauge, referred to as scale-Y, seeks to identify the degree to which the results may have been affected by the patient's inclination to appear socially attractive, morally virtuous, and/or emotionally well composed. Base rate scores over 75 on scale-Y signify the tendency to place oneself in a favourable, if not personally appealing, light. The higher the score, the greater the care that must be given to figuring out what the patient may be concealing about his or her psychological or



interpersonal difficulties.

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 4

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Debasement Scale (Z-Scale) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-Z, the debasement measure, reflects tendencies opposite to those of Scale-Y, although on occasion both indices are high, especially among patients who are usually self-disclosing (Scale-X). In general, base rate scores above 75 on scale-Z suggest inclinations to depreciat. or devalue oneself by presenting more troublesome emotional and personal difficulties than are likely to be uncovered upon objective review. Especially high scores deserve closer examination than usual, not only for purposes of gaining a more accurate assessment of what might prove to be a distorted level of psychological severity, but also to inquire as to whether

they signify a call for help, a drawing of attention by a patient experiencing an especially distressing degree of emotional turmoil (Millon, 1987).

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 5

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Schizoid Scale (Scale-1) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-1 is the schizoid scale. According to Millon (1987) this scale signifies a passive-detached orientation which is akin to the DSM-III-R schizoid personality disorder. These patients are noted by their lack of desire and their incapacity to experience depth in either pleasure or pain. They tend to be apathetic, listless, distant, and asocial. Affectionate needs and emotional feelings are minimal, and the individual functions as a passive observer detached from the rewards and affections of human relationships as well as from

their demands (also see Appendix 3).

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 6

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Avoidant Scale (Scale-2) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-2 is the avoidant scale. According to Millon (1987) this scale signifies an active-detached orientation which is much the same as the DSM-III-R avoidant personality disorder. These patients experience few positive reinforcers from self or others, are vigilant, perpetually on guard, and are ever ready to distance themselves from anxious anticipation of life's painful or negatively reinforcing experiences. Their adaptive strategy reflects a fear and mistrust of others. They maintain a constant vigil lest their impulses and longing for affection result in a repetition of the pain and anguish they had previously experienced with others.

Only by active withdrawal can they protect themselves. Despite desires to relate, they have learned that it is best to deny these feelings and keep a good measure of interpersonal distance (see also Appendix 3).

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

#### Hypothesis 7

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Dependent Scale (Scale-3) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-3 is the dependent scale. According to Millon (1987) this scale signifies a passive-dependent orientation which corresponds to the DSM-III-R dependent personality disorder. These individuals have learned not only to turn to others as their source of nurturance and security, but to wait passively for their leadership in providing them. They are characterized by a search for relationships so they can lean upon others for affection, security, and guidance. The lack of both initiative and

autonomy of these personalities is often a consequence of parental overprotection. As a function of these experiences, they have simply learned the comforts of assuming a passive role in interpersonal relations, accepting what kindness and support they may find, and willingly submitting to the wishes of others in order to maintain their affection (see also Appendix 3).

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 8

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Histrionic Scale (Scale-4) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-4 is the histrionic scale. According to Millon (1987) this scale signifies an active-dependent orientation which matches the DSM-III-R histrionic personality disorder. Although they turn to others no less than do passive-dependents, these individuals appear on the surface to be quite dissimilar from their passive

counterparts. This difference in overt style arises from the active-dependent's facile and enterprising manipulation of events through which they maximize the amount of attention and favours they receive as well as avoid the disinterest and disapproval of others. These patients often show an insatiable, if not indiscriminate, search for stimulation and affection. Their clever and often artful social behaviours give the appearance of an inner confidence and independent self-assurance. Beneath this guise, however, lies a fear of genuine autonomy and a need for repeated signs of acceptance and approval. Tribute and affection must constantly be replenished and are sought from every interpersonal source and in every social context (see also Appendix 3).

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 2

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Narcissistic Scale (Scale-5) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-5 is the narcissistic scale. According to Millon (1987) this scale signifies a passive-independent orientation which parallels the DSM-III-R narcissistic personality disorder. These individuals are noted by their egotistic self-involvement, experiencing primary pleasure simply by passively being or focusing on themselves. Early experience has taught them to overvalue their self-worth. This confidence and superiority may be founded on false premises; that is, it may be unsustainable by real or mature achievements. Nevertheless, they blithely assume that others will recognize their specialness. Hence, they maintain an air of arrogant self-assurance and, without much thought or even conscious intent, benignly exploit others to their own advantage. Although the tributes of others are both welcome and encouraged, their air of snobbish and pretentious superiority requires little confirmation either through genuine accomplishment or social approval. Their sublime confidence that things will work out well provides them with little incentive to engage in the reciprocal give-and-take of social life (see also Appendix 3).

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be

utilized to test this hypothesis.

Hypothesis 10

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Antisocial Scale (Scale-6A) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-6A is the antisocial scale. According to Millon (1987) this scale signifies an active-independent orientation which resembles the outlook, temperament, and socially unacceptable behaviours of the DSM-III-R antisocial personality disorder. These individuals act to counter the expectation of pain and depredation at the hands of others. This is done by engaging in duplicitous or illegal behaviours designed to exploit the environment for self-gain. Their orientation towards aggrandizement reflects their scepticism concerning the motives of others, a desire for autonomy, and a wish for revenge and recompense for what they feel to have been past injustices. They are irresponsible and impulsive, qualities they believe are justified because they judge others to be unreliable and disloyal. Insensitivity and ruthlessness are perpetually their only means to head off abuse and victimization (see also Appendix 3).



This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 11

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Aggressive/Sadistic Scale (Scale-6B) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-6B is the aggressive/sadistic scale. According to Millon (1987) this scale signifies an active-discordant orientation which extends the boundaries of the DSM-III-R in a new important direction. One recognizes individuals who are not judged publicly to be antisocial, but whose actions signify personal pleasure and satisfaction in behaviours that humiliate others and violate their rights and feelings. Depending on social class and other moderating factors, they may parallel the clinical features of what is known in the literature as the sadistic character or, on the other hand, display character styles akin to the competitively striving type A personality. Termed aggressive personalities, they are generally hostile, pervasively combative, and appear

indifferent to or pleased by the destructive consequences of their contentious, abusive, and brutal behaviours. Although many cloak their more malicious and power-orientated tendencies in publicly approved roles and vocations, they give themselves away in their dominating, antagonistic, and frequent persecutory actions (also see Appendix 3).

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 12

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Compulsive Scale (Scale-7) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-7 is the compulsive scale. According to Millon (1987) this scale signifies a passive-ambivalent orientation which coincides with the DSM-III-R compulsive personality disorder. These individuals have been intimidated and coerced into accepting the reinforcements imposed on them by others. Their prudent, controlled and

perfectionistic ways derive from a conflict between hostility toward others and a fear of social disapproval. They resolve this ambivalence not only by suppressing resentment, but by overconforming and by placing high demands on themselves and others. Their disciplined self-restraint serves to control intense, though hidden, oppositional feelings resulting in an overt passivity and seeming public compliance. Behind this front of propriety and restraint, however, are intense anger and oppositional feelings that occasionally break through their controls (see also Appendix 3).

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 13

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Passive-Aggressive Scale (Scale-8A) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-8A is the passive-aggressive scale. According to Millon (1987) this scales signifies an active-ambivalent

orientation which approximates the DSM-III-R passive-aggressive personality disorder but is more extensive in the number and diversity of traits it encompasses. These individuals struggle between following the reinforcers offered by others and those desired by themselves. This struggle represents an inability to resolve conflicts similar to those of the passive-ambivalent personality (compulsives). The conflicts however, of actively ambivalent personalities remain close to consciousness and intrude into everyday life. These patients get themselves into endless wrangles and disappointments as they vacillate between deference and obedience on one occasion and defiance and aggressive negativism on the next occasion. Their behaviour displays an erratic pattern of explosive anger or stubbornness intermingled with periods of guilt and shame (see also Appendix 3).

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 14

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Self-

Defeating Scale (Scale-8B) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-8B is the self-defeating scale. According to Millon (1987) this scale signifies a passive-discordant orientation which corresponds to the newly proposed DSM-III-R self-defeating (masochistic) personality disorder, a character well described in the literature. Relating to others in an obsequious and self-sacrificing manner, these persons allow, and perhaps encourage, others to exploit or take advantage of them. Focussing on their very worst features, many assert that they deserve to be shamed and humbled. To compound their pain and anguish, states they experience as comforting and strive to achieve, they actively and repetitively recall their past misfortunes as well as transform otherwise fortunate circumstances into their potentially most problematical outcomes. Typically acting in an unassuming and self-effacing way, they often intensify their deficits and place themselves in an inferior light or abject position (also see Appendix 3).

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 15

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Schizotypal Scale (S-Scale) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-S is the schizotypal scale. According to Millon (1987) the DSM-III-R schizotypal personality disorder represents a cognitively dysfunctional and interpersonally detached orientation. These persons prefer social isolation with minimal personal attachments and obligations. Inclined to be either autistic or cognitively confused, they think tangentially and often appear self-absorbed and ruminative. Behavioural eccentricities are notable, and these individuals are often perceived by others as strange or different. Depending on whether their basic pattern has been active or passive, they display either an anxious wariness and hypersensitivity or an emotional flattening and deficiency of affect (see also Appendix 3).

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 16

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Borderline Scale (C-Scale) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-C is the borderline scale. According to Millon (1987) the DSM-III-R borderline personality disorder often underlies the theory's dependent, discordant, independent, and ambivalent orientations. Each of these borderline personalities have structural defects, experience intense endogenous moods with recurring periods of dejection and apathy, often interspersed with spells of anger, anxiety or euphoria. What distinguishes them most clearly from the two other severe patterns - the schizotypal and the paranoid - is the dysregulation of their affects, seen most clearly in the instability and lability of their moods. Additionally, many reveal recurring self-mutilating and suicidal thoughts, appear overly preoccupied with securing affection, have difficulty maintaining a clear sense of identity, and display a cognitive-affective ambivalence evident in simultaneous feelings of rage, love, and guilt toward others (see also Appendix 3).

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 17

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Paranoid Scale (P-Scale) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-P is the paranoid scale. The DSM-III-R paranoid personality disorder matches aspects of three of Millon's (1987) personality theory types most clearly. Primarily the paranoid personality disorder matches the independent orientation but also, to a somewhat lesser extent, the discordants and ambivalents. These persons display a vigilant mistrust of others and an edgy defensiveness against anticipated criticism and deception. There is an abrasive irritability and a tendency to precipitate exasperation and anger in others. Expressed often is a fear of losing independence, leading this patient to resist vigorously any external influence and control, whereas the other two severe patterns are noted either by the instability of their affect (borderline personality)



or the dysregulation of their cognitions (schizotypal personality). Paranoid personalities are distinctive in the immutability of their feelings and the inflexibility of their thoughts (see also Appendix 3).

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 18

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Anxiety Disorder Scale (A-Scale) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-A is the anxiety scale. Millon (1987) writes that this patient often reports feeling either vaguely apprehensive or specifically phobic, is typically tense, indecisive, and restless, and tends to complain of a variety of physical discomforts such as tightness, excessive perspiration, ill-defined muscular aches, and nausea. A review of the specific items on the scale will aid in determining whether the patient is primarily phobic and, more specifically, of either a simple or social

variety. Most anxious patients however give evidence of a generalized state of tension, manifested by an inability to relax, fidgety movements, and a readiness to react and be easily startled. Somatic discomforts - for example clammy hands or upset stomach - are also characteristic. Also notable are worrisomeness and an apprehensive sense that problems are imminent, a hyperalertness to one's environment, edginess, and generalized touchiness.

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

#### Hypothesis 19

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Somatoform Disorder Scale (H-Scale) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-H is the somatoform disorder scale. Millon (1987) writes that here we see psychological difficulties expressed through somatic channels, persistent periods of fatigue and weakness, and a preoccupation with ill health and a variety of dramatic but largely nonspecific pains

in different and unrelated regions of the body. Some somatoform individuals give evidence of a primary somatization disorder that is manifested by recurrent, multiple somatic complaints, often presented in a dramatic, vague, or exaggerated way. Others have a history that may be best considered hypochondriac, since they interpret minor physical discomforts or sensations as signifying a serious ailment. If real diseases are factually present, they tend to be overinterpreted despite medical reassurance. Typically, somatic complaints are employed to gain attention.

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 20

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Bipolar : Manic Disorder Scale (N-Scale) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-N is the bipolar : manic scale. Millon (1987) writes that these patients evidence periods of

superficial elation, inflated self-esteem, restless overactivity and distractability, pressured speech, and impulsiveness and irritability. Also evident is an unselective enthusiasm; excessive planning for unrealistic goals; an intrusive, if not domineering and demanding quality to interpersonal relations; decreased need for sleep; flights of ideas; and rapid and labile shifts of mood. Very high scores may signify psychotic processes including delusions or hallucinations.

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 21

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Dysthymic Disorder Scale (D-Scale) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-D is the dysthymia scale. Millon (1987) writes that the high-scoring patient remains involved in everyday life but has been preoccupied over a period of two or more years with feelings of discouragement or

guilt, a lack of initiative and behavioural apathy, low self-esteem and frequently voiced futility and self-deprecatory comments. During periods of dejection, there may be tearfulness, suicidal ideation, a pessimistic outlook toward the future, social withdrawal, poor appetite or overeating, chronic fatigue, poor concentration, a marked loss of interest in pleasurable activities and a decreased effectiveness in fulfilling ordinary and routine life tasks. Unless Scale-CC (Major Depression) is also notably elevated, there is little likelihood that psychotic depressive features will be in evidence. Close examination of the specific items comprising the patient's high score should enable the clinician to discern the particular features of the dysthymic mood (for example, low self-esteem or hopelessness).

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

#### Hypothesis 22

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Alcohol

Dependence Scale (B-Scale) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-B is the alcohol dependence scale. Millon (1987) reports that the high-scoring patient probably has a history of alcoholism, has made efforts to overcome the difficulty with minimal success and, as a consequence, experiences considerable discomfort in both family and work settings. The value of this and the subsequent scale (drug dependence) is the opportunity to set the presence of the problem within the context of the patient's overall style of personality functioning and coping.

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 23

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Drug Dependence Scale (T-Scale) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-T is the drug dependence scale. Millon (1987) claims that this individual is likely to have had a recurrent or recent history of drug abuse, tends to have difficulty in restraining impulses or keeping them within conventional social limits and displays an inability to manage the personal consequences of these behaviours. Composed, as is the alcohol dependence scale, of many subtle and indirect items, this scale may be useful in identifying those with problems of drug abuse who are not readily disposed to admit their drug difficulties.

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

Hypothesis 24

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Thought Disorder Scale (SS-Scale) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-SS is the thought disorder scale. Millon (1987) writes that, depending on the length and course of the problem, these patients are usually classified as

schizophrenic, schizophreniform, or as suffering from brief reactive psychosis. They may periodically exhibit incongruous, disorganized or regressive behaviour, often appearing confused and disorientated and occasionally displaying inappropriate affect, scattered hallucinations and unsystematic delusions. Thinking may be fragmented or bizarre. Feelings may be blunted, and there may be a pervasive sense of being isolated and misunderstood by others. Withdrawn and seclusive or secretive behaviour may be notable.

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis. ,

Hypothesis 25

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Major Depression Scale (CC-Scale) of the Millon Clinical Multiaxial Inventory - II (MCMI-II).

Scale-CC is the major depression scale. Millon (1987) writes that these patients are usually incapable of functioning in a normal environment, are severely



depressed, and express a dread of the future, suicidal ideation, and a sense of hopeless resignation. Some exhibit a marked motor retardation, whereas others display an agitated quality, incessantly pacing about and bemoaning their sorry state. Several somatic processes are often disturbed during these periods - notably, a decreased appetite, fatigue, weight loss or gain, insomnia or early rising. Problems of concentration are common, as are feelings of worthlessness or guilt. Repetitive fearfulness and brooding are frequently in evidence. Depending on the underlying personality style, there may be a shy, introverted, and seclusive pattern, characterized by sluggish immobility or an irritable, complaining and whining tone.

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

#### Hypothesis 26

There will not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Delusional Disorder Scale (PP-Scale) of the Millon

Clinical Multiaxial Inventory - II (MCMI-II).

Scale-PP is the delusional disorder scale. Millon (1987) writes that this patient, frequently considered acutely paranoid, may become periodically belligerent, voicing irrational but interconnected sets of delusions of jealous, persecutory, or grandiose nature. Depending on the constellation of other concurrent syndromes, there may be clear-cut signs of disturbed thinking and ideas of reference. Moods are usually hostile and feelings of being 'picked on' and mistreated are expressed. A tense undercurrent of suspiciousness, vigilance, and alertness to possible betrayal are typical concomitants.

This hypothesis is the null hypothesis as there is not strong evidence in the literature to suggest differences between dysthymic subjects and control subjects on this scale. The appropriate statistical tests will be utilized to test this hypothesis.

The experimental research related to the testing of these hypotheses is discussed in the following chapter.

CHAPTER 6

THE EXPERIMENTAL RESEARCH

6.1 INTRODUCTION

This chapter will provide the background and a description of the research methodology employed in this study. Aspects to be dealt with will include a description of the experimental and control groups, the study design and the statistical methodology.

6.2 THE RESEARCH INSTRUMENT

The Millon Clinical Multiaxial Inventory (Second Version) (MCMI-II) was used in this study. This measuring instrument is discussed in detail in Chapter 4 of this study.

The prescribed American norms were used in scoring the test protocols. These were considered valid as the norms were standardized on psychopathologic diagnostic groups and symptoms according to the DSM-III-R classification system. This is in direct contrast to other psychological tests where norms were obtained from a cross-section of the population.

6.3 THE STUDY DESIGN

Two groups of subjects were compared with each other. The experimental group consisted of patients diagnosed

with dysthymic disorder. The subjects in this experimental group were statistically analyzed against a control group of subjects with no history of any mental illness. The experimental group consisted of a total of 43 dysthymic patients, and the control group were made up of 48 individuals.

#### 6.4 THE EXPERIMENTAL GROUP

##### 6.4.1 Selection

Subjects selected in the dysthymia group were randomly selected from adult psychiatric patients examined at the Dysthymia Outpatient Clinic of Tara Hospital, The H. Moross Centre. This is a psychiatric hospital situated in Sandton, but with a wide patient referral area.

##### 6.4.2 Diagnosis

Only subjects determined to have a diagnosis of dysthymic disorder were included in the experimental group. All patients met the DSM-III-R criteria (see Appendix 1) for dysthymic disorder according to the attending psychiatrists in charge of the patient's care. There were two psychiatrists who made the diagnoses on the basis of their admitting evaluation of the patients. Both psychiatrists had at least 4 years registrar's experience and were on the staff of the Department of Psychiatry at the University of the Witwatersrand.

Table 2 represents the diagnostic criteria for dysthymic disorder according to DSM-III-R (see Appendix 1) for the experimental group on entering the study.

TABLE 2 : EXPERIMENTAL GROUP : DSM-III-R DIAGNOSTIC CRITERIA ON ENTERING THE STUDY (See Appendix 1)

DSM-III-R Criteria	Experimental Male	Experimental Female	Group Total
n =	15	23	38
A	15	23	38
B 1	11	18	29
B 2	15	21	36
B 3	15	23	38
B 4	15	23	38
B 5	15	19	34
B 6	15	23	38
C	15	23	38
D	15	23	38
E	15	23	38
F	15	23	38
G	15	23	38
Primary	13	21	34
Secondary	2	2	4
Early Onset	10	13	23
Late Onset	5	10	15

#### 6.4.3 Age and Sex

All subjects selected for the experimental group had to be above the age of 17 years. Male and female subjects were selected on a random basis.

#### 6.4.4 Exclusion Criteria

Persons for whom a consensual diagnosis was not reached

or whose dysthymic disorder was seen as secondary to any other psychiatric diagnosis or problem were excluded from the analysis.

#### 6.4.5 Informed Consent

All subjects had to agree voluntarily to participate in the study. At the start of the study a full explanation was given to each patient about the disorder, the nature of the study, the measuring instrument, and some time was spent answering any questions. Written informed consent was then obtained from each patient (see Table 3).

#### 6.4.6 Biographical Data

Essential background information and biographical details were obtained from the patients and their hospital out-patient files according to a biographical questionnaire (see Appendix 4). This questionnaire was not attached to the test material as to assure confidentiality and reliability.

The biographical data for the experimental group is presented in Table 4. The final sample in the experimental group were 38 patients out of the 43 dysthymic patients tested. Five patients were excluded on the basis of invalid scores on the MCMI-II test. In the experimental group of 38 dysthymic patients, 23 (60,5 %) were females and 15 (39,5 %) were males.

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TABLE 3 : INFORMED CONSENT

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PERSONALITY PROFILES OF DYSTHYMIC DISORDER

BACKGROUND INFORMATION :

You have been attending the Dysthymia Clinic at Tara Hospital for some time now. As a further study, besides your medication, I would like to know more about your background, your disease and your personality. Data gathered in this study will give us more insight into the nature of your disease (Dysthymic Disorder), and the study will also be used for my research project towards the degree M. Med. in Psychiatry.

In order to draw up a collective personality profile for at least 40 of the patients attending the Dysthymia Clinic, you will be required to complete a short psychological questionnaire. The test is called the Millon Clinical Multiaxial Inventory - II, and consists of 175 short questions which you will mark True or False as you feel it applies to you. The test should not take more than about 20 minutes to complete. No other information, further tests or commitment will be required from you.

The study will also consist of a control sample. These people will be selected from the hospital and the community and follow the same procedure as above. Eventually the collective scores of the people with dysthymic disorder will be compared to those of the control sample.

All questionnaires will be anonymous, and your identity will under no circumstances be revealed. Due to its nature the study will involve no risks or any side effects.

CONSENT FORM :

Hereby I \_\_\_\_\_ declare that I have read the above study outline and understand and have had explained the contents thereof. I realize that I do it at my own free will, and has the right to refuse to partake in the study. Should I do so it will not jeopardize me in any way, or my future treatment at the Dysthymia Clinic. The study will be of no direct benefit to me. I thus consent to take part in the study.

SIGNED \_\_\_\_\_  
this \_\_\_\_\_ day of \_\_\_\_\_ 1991.

Doctor's Declaration :

I \_\_\_\_\_ hereby certify that  
I have explained the above study to the above patient.

SIGNED : \_\_\_\_\_  
\_\_\_\_\_

The mean age for females were 42 years (range 21 to 72 years), 42 years (range 20 to 62 years) for males and the total mean age for the study group were 42 years (range 20 to 72 years). Almost ninety five percent (94,8 %) of the patients were Caucasian, 2,6 % were Black, and 2,6 % were Asian. About thirty seven percent (36,8 %) of the patients had a university degree; 42,1 % had a post school qualification (more than 12 year school qualification, eg. technicon or college); 7,9 % had matric, and 13,2 % left school before reaching the matriculation year.

Table 5 represents the different occupations of the experimental group, with table 6 the DSM-III-R criteria according to Appendix 1 of the patients at the time of enrolment in the study. Table 7 shows that about forty percent of the patients (40 % male and 43,5 % female) had one or more previous hospitalizations for dysthymia / depression. The onset of dysthymic symptoms were on



average 11 to 14 years prior to the establishment of a diagnosis of dysthymic disorder. Table 8 shows the medication of the experimental group at the time of MCMI-II testing, whereas table 9 represents all the medication the patients took in the year prior to enrolment in this study.

TABLE 4 : BIOGRAPHICAL DATA : EXPERIMENTAL GROUP

	Experimental Male	Experimental Female	Experimental Total
n =	15	23	38
Mean Age	42 yrs	42 yrs	42 yrs
Age Range	20-62	21-72	20-72
<u>Race</u>			
Caucasian	13	23	36 (94,8%)
Black	1	0	1 (2,6%)
Asian	1	0	1 (2,6%)
Total	15 (39,5%)	23 (60,5%)	38 (100%)
<u>Education</u>			
< 12 years	1	4	5 (13,2%)
12 years	1	2	3 (7,9%)
> 12 years (University)	8	6	14 (36,8%)
> 12 years (Other)	5	11	16 (42,1%)

TABLE 5 : OCCUPATION : EXPERIMENTAL GROUP

	Experimental Male	Experimental Female
Computer Consultant	2	0
Engineer	1	0
Medical Doctor	2	0
Psychologist	1	0
Dentist	1	0
Nursing sister	0	2
Lawyer	1	1
Analytical Chemist	0	1
Church Minister	1	0
Musician	1	0
Librarian	1	0
Journalist	1	1
Teacher	0	2
Univ Student	1	0
Insurance Consultant	0	1
Bank Clerk	1	0
Secretary	0	6
Hotelier	1	0
Labourer	1	0
Housewife	0	9
Jobless	7 (46,7%)	2 (8,7%)

TABLE 6 : DSM-III-R DIAGNOSIS : EXPERIMENTAL GROUP

	Experimental Male	Experimental Female
<u>Axis I</u>		
Dysthymia	15	23
Alcohol Abuse	1	0
Substance Abuse	1	0
Bulimia	0	1
Generalized anxiety disorder	0	1
Compulsive Gambling	0	1
<u>Axis II</u>		
Avoidant	2	2
Dependent	5	4
Histrionic	0	4
Narcissistic	0	1
Schizotypal	1	0
Borderline	1	3
Compulsive	1	0
Passive Aggressive	2	0
Deferred	3	9
<u>Axis III</u>		
Sauerman's	0	1
Migraine	0	2
Epilepsy	1	0
Hernia	2	1
Inguinal Hernia	1	1
Tuberculosis	1	0
Crohn's Disease	1	0
Sarcoidosis	0	2
Duodenal Ulcer	0	2
Multiple somatic complaints	2	3
<u>Axis IV</u>		
Severe	2	2
Moderate	4	12
Mild	8	9
None	1	0
<u>Axis V</u>		
Poor	7	10
Moderate	5	6
Good	3	7

TABLE 7 : PATHOLOGICAL BACKGROUND : EXPERIMENTAL GROUP

Onset of Symptoms (average amount of years)

Experimental Male = For past 19,6 years  
Experimental Female = For past 16,4 years

Date Dysthymia First Diagnosed (average amount of years)

Experimental Male = 5,5 years ago  
Experimental Female = 5,1 years ago

Previous Hospitalizations for Dysthymia

	Experimental Male	Experimental Female
Yes	6 (40%)	10 (43,5%)
No	9 (60%)	13 (56,5%)

6.5 THE CONTROL GROUP

6.5.1 Selection

The control group were randomly selected from the community.

6.5.2 Exclusion Criteria

Exclusion criteria were no past history of any psychiatric illness or treatment, and individuals did not fulfill the DSM-III-R criteria for dysthymic disorder.

Table 10 represents the diagnostic criteria for dysthymic disorder according to DSM-III-R (see Appendix 1) for the control group on entering the study.

TABLE 8 : CURRENT MEDICATION : EXPERIMENTAL GROUP

	Experimental Male	Experimental Female
None	1	1
Ritanserlin	10	15
Fluoxetine	2	2
Sulpiride	1	1
Clomipramine	3	2
Amitriptyline	1	1
Imipramine	0	2
Lithium Ca	1	1
Diazepam	2	1
Oxazepam	1	7
Lorazepam	0	1
Chlordiazepoxide	0	1
Bromazepam	1	1
Alprazolam	1	0
Buspirone	1	0
Flunitrazepam	2	0
Flurazepam	0	1
Zopiclone	1	0
Promethazine	0	2
Clothiapine	0	1
Propranolol	1	1
Methylphenidate	1	0
Enalapril maleate	2	0
Ranitidine	0	1
Mebeverine	0	1
Rifampicin	1	0
Thyroxine	0	2
Premarin	0	1
Femodene	0	1
Vitamins	1	1

TABLE 9 : PREVIOUS MEDICATION : EXPERIMENTAL GROUP

	Experimental Male	Experimental Female
None	4	4
Sulpiride	0	1
Clomipramine	4	5
Imipramine	4	1
Trimipramine	1	0
Dothiepin	3	6
Amitriptyline	2	2
Desipramine	0	1
Ritanserin	2	2
Maprotiline	0	3
Mianserin	0	1
Fluoxetine	5	7
Lofepamine	3	5
Tranlycypromine	2	2
Lithium-Ca	2	4
E.C.T.	0	1
L-Tryptophan	0	1
Methylphenidate	3	0
Diazepam	2	0
Oxazepam	1	3
Bromazepam	0	2
Alprazolam	1	1
Chlordiazepoxide	1	1
Lorazepam	0	1
Flurazepam	0	1
Midazolam	0	1
Clonazepam	1	1
Propranolol	1	2
Promethazine	1	0
Flupenthixol	0	1
Thioridazine	0	1
Carbamazepine	2	1
Sodium Valproate	0	1
Al-hydroxide	0	1
Premarin	0	1

TABLE 10 : CONTROL GROUP : DS  
ENTERING THE STUDY (see Appendix 1)

DSM-III-R Criteria	Control Male	Control Female	Group Total
n =	21	24	45
A	0	0	0
B 1	0	0	0
B 2	0	0	0
B 3	0	0	0
B 4	0	0	0
B 5	0	0	0
B 6	0	0	0
C	0	0	0
D	21	24	45
E	21	24	45
F	21	24	45
G	21	24	45
Primary	0	0	0
Secondary	0	0	0
Early Onset	0	0	0
Late Onset	0	0	0

#### 6.5.3 Age and Sex

All subjects selected for the control group had to be above the age of 17 years. Male and female subjects were selected on a random basis.

#### 6.5.4 Informed Consent

All subjects had to agree voluntarily to participate in the study. Prior to enrolling the control subjects in the study, a full explanation was given to each individual about the nature and aim of the study and the measuring instrument. Some time was spent answering any

questions. Written informed consent was then obtained from each subject (see Table 3).

#### 6.5.5 Biographical Data

Essential background information and biographical details were obtained from the subjects in the control group at the time of the initial interview according to the biographical questionnaire (see Appendix 4). To assure confidentiality and reliability this questionnaire was not attached to the test material.

The biographical data of the control group is presented in Table 11. The final sample in the control group consisted of 45 subjects out of 48. Three of the control subjects were excluded on the basis of invalid scores on the MCMI-III test. Out of the 45 control subjects, 24 (53,3 %) were females and 21 (46,7 %) were males. The mean age for females was 36 years (range 19 to 56 years), for males 32 years (range 22 to 49 years) and the total mean age for the control group was 34 years (range 19 to 56 years). All the subjects in the control group were Caucasian. Just over thirtyfive percent (35,5 %) of the subjects had a university degree; 42,1 % had a post school qualification; 17,8 % had matriculation certificates, and 4,4 % left school before reaching their matriculation year.



Table 12 represents all the occupations of the subjects in the control group. Table 13 confirms that none of the control subjects suffered from dysthymia or had any other mental illness. Only one subject suffered from epilepsy and was being treated with sodium valproate at the time of testing. Logically, none of the control subjects was hospitalized for dysthymic disorder.

TABLE 11 : BIOGRAPHICAL DATA : CONTROL GROUP

	Control Male	Control Female	Control Total
n =	21	24	45
Mean Age	32 yrs	36 yrs	34 yrs
Age Range	22-49	19-56	19-56
<u>Race</u>			
Caucasian	21	24	45
Black	0	0	0
Asian	0	0	0
	(46,7%)	(53,3%)	(100%)
<u>Education</u>			
< 12 years	0	2	2 (4,4%)
12 years	1	7	8 (17,8%)
> 12 years (University)	8	8	16 (35,6%)
> 12 years (Other)	12	7	19 (42,2%)

TABLE 12 : OCCUPATION : CONTROL GROUP

	Control Male	Control Female
Engineer	4	0
Engineering Technician	2	0
Draughtsperson	7	3
Medical Doctor	5	0
Occupational Therapist	0	2
Social Worker	0	1
Nursing Sister	0	12
Laboratory Technician	1	0
Lawyer	0	1
Accountant	0	1
Manager	0	2
Secretary	0	1
Housewife	0	1
Jobless	0	0

TABLE 13 : DSM-III-R DIAGNOSIS : CONTROL GROUP

	Control Male	Control Female
<u>Axis I</u>		
Dysthymia	0	0
No pathology	21	24
<u>Axis II</u>	0	0
<u>Axis III</u>		
Epilepsy	0	1
<u>Axis IV</u>		
None	21	24
<u>Axis V</u>		
Good	21	24

#### 6.6 EXPERIMENTAL PROCEDURE

After biographical data and informed consent had been obtained, each subject completed the Millon Clinical Multiaxial Inventory-II (MCMI-II) which took about 30 minutes.

The dysthymic patients completed the MCMI-II during a follow-up visit. The inventory was completed by the patients only when their manifest symptoms had abated because the study attempted to measure basic premorbid personality traits and/or disorders without being influenced by an active clinical dysthymic condition. At the time of testing, the experimental subjects were spontaneously or on medication in remission. In order to do this, the dysthymic patients were evaluated according to DSM-III-R Dysthymic Disorder criteria (see Appendix 1) at the beginning of the study. Immediately prior to MCMI-II testing each patient was then again evaluated on the criteria.

The MCMI-II was completed by the subjects in the control group after excluding previous psychiatric illness or any DSM-III-R criteria for dysthymic disorder.

When scoring the tests, the appropriate male/female norms were used. The score on the Millon personality scales runs from 0 to 121. Raw scores were transformed into

base rate scores according to the available norms in the manual. The score on each of the test scales represent a measure of the extent to which that particular person exhibits those personality traits. For determining the personality diagnoses the cutoff points 74/75 and 84/85 have been used. For this study scores of 75 or higher (the level designating the total prevalence of each personality type according to Millon) were considered to define a personality disorder. Invalid questionnaires according to the MCMI-II validity scale were excluded from the study.

#### 6.7 STATISTICAL METHODOLOGY

The experimental and control samples were divided into three groups consisting of a experimental male (n = 15), experimental female (n = 23) and the combined total experimental group (n = 38). The control sample consisted of a control male (n = 21), control female (n = 24) and a combined total control group (n = 45). The MCMI-II profiles of the subjects in the experimental group were compared to the MCMI-II profiles in the control group. The 22 variables, namely the mean MCMI-II base rate scores for each group, as well as average scores above 75 for the groups were compared statistically.

Statistical procedures applied to the group results were:

- 1) Means and standard deviations of profile base-rate scores on the MCMI-II for male and female dysthymic and control groups.
- 2) Two-way analysis of variance
  - a) Univariate analysis of variance between study and control groups.
  - b) Univariate analysis of variance between male and female groups.
  - c) Analysis of variance : interaction group by sex.
  - d) Post-hoc analysis : Tukey Studentized Range Method.
- 3) Spearman Correlation Coefficients.
- 4) Frequency of personality disorders according to MCMI-II (cutting point 75) among male and female dysthymic and control group.
- 5) Fisher's 2-Tail Exact Test.
- 6) Stepwise Discriminant Analysis between Groups.

The results are presented in the following chapter

CHAPTER 7

RESULTS

7.1 ANALYSIS OF BASE-RATE SCORES ON THE MCMI-II FOR MALE AND FEMALE DYSTHYMIC AND CONTROL GROUPS

The mean standardized base-rate scores of each scale of the MCMI-II of the Experimental Group and the Control Group were statistically compared. The results of the statistical comparisons between the Experimental Group and the Control Group are presented for each MCMI-II scale in Tables 14 to 38.

Each of Tables 14 to 38 consists of a summary of the mean and standard deviation of the standardized base-rate scores on the MCMI-II for male and female, and total dysthymic and control groups. Subsequent to this, a two-way univariate analysis was done using groups (experimental total group compared with control total group) and sex (experimental and control male groups compared with experimental and control female groups) individually. The data for the effect of sex on the outcome variable will not be discussed further for the purpose of this study. The reason for this is that groups cannot be divided into male and female without taking experimental and control group factors into consideration. Thirdly, the interaction of these factors

(study and control groups, male and female) was considered.

Finally, a Tukey post-hoc analysis was done for all significant groups. These results were then subjected to a non-parametric examination for conformation. The Spearman Correlation Coefficient Test was used as a non-parametric procedure.

#### 7.1.1 Modifier Indices

The modifier indices on the MCMI-II are the Disclosure (X), Desirability (Y), and Debasement (Z) scales.

##### 7.1.1.1 Disclosure Scale (Scale X)

The two-way univariate analysis for the disclosure scale (X variable) demonstrated a significant effect for group ( $f(1) = 16,25$ ;  $p < 0,0001$ ). Post-hoc analyses revealed that the most significant difference was between the study and control male groups ( $p < 0,01$ ) (see Table 14). Between the study and control female groups the difference was less significant ( $p < 0,10$ ). In the mixed comparisons, study male and control female, as well as the study female and control groups, the level of significance was between the above at  $p < 0,05$ .

Non-parametric examination of the data for the X variable confirmed these findings. The Spearman Correlation Coefficient was at the  $p < ,0001$  level.

TABLE 14 : ANALYSIS OF DISCLOSURE SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	42,9	25,8
Experimental Male	15	68,5	26,6
Control Female	24	46,5	20,4
Experimental Female	23	62,4	20,6
Control Total	45	44,8	22,9
Experimental Total	38	64,8	23,0

Two-Way Analysis of Variance : Disclosure Scale

<u>MCMI-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	16,25	0,0001 *
Sex	1	0,06	0,8092
Interaction	1	0,90	0,3456

Tukey Exp. Male x Control Male = 1 % signif.  
 Exp. Female x Control Female = 10 % signif.  
 Exp. Male x Control Female = 5 % signif.  
 Exp. Female x Control Male = 5 % signif.

\* Denotes Significant Level

7.1.1.2 Desirability Scale (Scale Y)

There were no significant results on the desirability scale (Y variable)



TABLE 15 : ANALYSIS OF DESIRABILITY SCALE  
BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	55,2	23,9
Experimental Male	15	49,0	19,8
Control Female	24	62,4	19,6
Experimental Female	23	53,9	19,3
Control Total	45	59,0	21,8
Experimental Total	38	52,0	19,4

Two-Way Analysis of Variance : Desirability Scale

<u>MCMI-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	2,54	0,1153
Sex	1	1,71	0,1951
Interaction	1	0,06	0,7997

7.1.1.3 Debasement Scale (Scale Z)

The two-way univariate analysis for the debasement scale (Z variable) demonstrated a significant effect for group ( $f(1) = 78,42$  ;  $p < 0,0000$ ). Post-hoc analyses revealed that in all cases control groups scored significantly less than the study group ( $p < 0,01$ ) (see table 16).

Non-parametric examination of the data for the Z variable confirmed these findings. The Spearman Correlation Coefficient was at the 0.0001 level.

TABLE 16 : ANALYSIS OF DEBASEMENT SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	34,3	13,8
Experimental Male	15	74,6	22,7
Control Female	24	25,1	19,6
Experimental Female	23	67,9	26,1
Control Total	45	29,4	17,6
Experimental Total	38	70,6	24,7

Two-Way Analysis of Variance : Debasement Scale

<u>MCMII- Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	78,42	0,0000 *
Sex	1	2,86	0,0945
Interaction	1	0,07	0,7895

Tukey Exp. Male x Control Male = 1 % signif.  
 Exp. Female x Control Female = 1 % signif.  
 Exp. Male x Control Female = 1 % signif.  
 Exp. Female x Control Male = 1 % signif.

\* Denotes Significant Level

7.1.2 Clinical Personality Pattern

The clinical personality pattern on the MCMII is made up from 10 factors being the schizoid (1), avoidant (2), dependent (3), histrionic (4), narcissistic (5), antisocial (6A), aggressive / sadistic (6B), compulsive (7), passive-aggressive (8A), and self-defeating (8B) scales.

7.1.2.1 Schizoid Scale (Scale 1)

TABLE 17 : ANALYSIS OF SCHIZOID SCALE BASE-RATE SCORES

---

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	56,4	23,0
Experimental Male	15	82,2	14,6
Control Female	24	55,3	21,0
Experimental Female	23	68,6	26,4
Control Total	45	55,8	21,7
Experimental Total	38	74,0	23,3

Two-Way Analysis of Variance : Schizoid Scale

<u>MCMII-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	15,56	0,0002 *
Sex	1	2,22	0,1405
Interaction	1	1,57	0,2145

Tukey Exp. Male x Control Male = 1 % signif.  
Exp. Male x Control Female = 1 % signif.

\* Denotes Significant Level

---

The two-way univariate analysis for the schizoid scale (variable 1) demonstrated a moderate significance for group ( $f(1) = 15,56$  ;  $p < 0,0002$ ). Post-hoc analysis indicated a limited significance between groups. A significance level of  $p < 0,01$  was found when the experimental male group was compared with the control male and control female groups (see Table 17).

7.1.2.2 Avoidant Scale (Scale 2)

TABLE 18 : ANALYSIS OF AVOIDANT SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	45,4	28,5
Experimental Male	15	88,1	26,6
Control Female	24	42,9	24,5
Experimental Female	23	79,2	34,8
Control Total	45	44,1	26,2
Experimental Total	38	82,7	31,7

Two-Way Analysis of Variance : Avoidant Scale

<u>MCMII-11 Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	37,17	0,0000 *
Sex	1	0,70	0,3806
Interaction	1	0,24	0,6226

Tukey Exp. Male x Control Male = 1 % signif.  
 Exp. Female x Control Female = 1 % signif.  
 Exp. Male x Control Female = 1 % signif.  
 Exp. Female x Control Male = 1 % signif.

\* Denotes Significant Level

The two-away univariate analysis for the avoidant scale (variable 2) demonstrated a significant effect for group ( $f(1) = 37,17 ; p < 0,0000$ ). Post-hoc analysis revealed that in all cases control groups scored significantly less than the study group ( $p < 0,01$ ) (see table 18).

Non-parametric examination of the data for variable 2 confirmed these findings. The Spearman correlation coefficient was at the  $p < 0,0001$  level.

7.1.2.3 Dependent Scale (Scale 3)

TABLE 19 : ANALYSIS OF DEPENDENT SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard aviation</u>
Control Male	21	48,9	32,7
Experimental Male	15	61,7	32,6
Control Female	24	55,6	31,0
Experimental Female	23	71,0	36,5
Control Total	45	52,5	31,6
Experimental Total	38	67,3	34,9

Two-Way Analysis of Variance : Dependent Scale

<u>MCMII- Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	3,59	0,0617
Sex	1	1,15	0,2860
Interaction	1	0,03	0,8646

There were no significant results on the dependent scale (variable 3).

7.1.2.4 Histrionic Scale (Scale 4)

There were no significant results on the histrionic scale (variable 4).

TABLE 20 : ANALYSIS OF HISTRIONIC SCALE BASE-RATE SCORES

---

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	46,8	30,0
Experimental Male	15	40,3	24,5
Control Female	24	64,4	23,5
Experimental Female	23	51,0	28,6
Control Total	45	56,2	27,9
Experimental Total	38	46,8	27,2

Two-Way Analysis of Variance : Histrionic Scale

<u>MCMII-11 Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	2,72	0,1031
Sex	1	5,55	0,0210
Interaction	1	0,33	0,5646

Tukey Exp. Male x Control Female = 5 % signif.

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7.1.2.5 Narcissistic Scale (Scale 5)

There were no significant results on the narcissistic scale (variable 5).

TABLE 21 : ANALYSIS OF NARCISSISTIC SCALE  
BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	59,5	31,7
Experimental Male	15	46,1	31,5
Control Female	24	67,5	26,0
Experimental Female	23	52,7	33,4
Control Total	45	63,8	28,7
Experimental Total	38	50,1	32,4

Two-Way Analysis of Variance : Narcissistic Scale

<u>MCMII-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	4,30	0,0414
Sex	1	1,14	0,2887
Interaction	1	0,01	0,9169

7.1.2.6 Antisocial Scale (Scale 6A)

There were no significant results on the antisocial scale  
(variable 6A).

TABLE 22 : ANALYSIS OF ANTISOCIAL SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	53,3	30,3
Experimental Male	15	58,5	22,3
Control Female	24	52,7	20,2
Experimental Female	23	50,0	24,6
Control Total	45	53,0	25,1
Experimental Total	38	53,4	23,7

Two-Way Analysis of Variance : Antisocial Scale

<u>MMPI-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	0,05	0,8202
Sex	1	0,68	0,4111
Interaction	1	0,50	0,4828

7.1.2.7 Aggressive / Sadistic Scale (Scale 6B)

There were no significant results on the aggressive-sadistic scale (variable 6B).



TABLE 2. . ANALYSIS OF AGGRESSIVE / SADISTIC SCALE  
BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	68,5	28,2
Experimental Male	15	63,9	25,1
Control Female	24	64,0	22,5
Experimental Female	23	55,7	27,6
Control Total	45	66,1	25,1
Experimental Total	38	58,9	26,6

Two-Way Analysis of Variance : Aggressive / Sadistic  
Scale

<u>MCMII-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	1,24	0,2681
Sex	1	1,23	0,2700
Interaction	1	0,10	0,7489

7.1.2.8 Compulsive Scale (Scale 7)

There were no significant results on the compulsive scale  
(variable 7).

TABLE 24 : ANALYSIS OF COMPULSIVE SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	66,4	20,2
Experimental Male	15	63,2	22,9
Control Female	24	71,3	23,9
Experimental Female	23	70,3	23,6
Control Total	45	69,0	22,2
Experimental Total	38	67,5	23,3

Two-Way Analysis of Variance : Compulsive Scale

<u>MCMI-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	0,17	0,6799
Sex	1	1,39	0,2426
Interaction	1	0,04	0,8331

7.1.2.9 Passive-Aggressive Scale (Scale 8A)

The two-way univariate analysis for the passive-aggressive scale (variable 8A) demonstrated a moderate significance for group ( $f(1) = 13,82$  ;  $p < 0,0004$ ). Post-hoc analysis indicated a limited significance between groups. The significance was on the  $p < 0,01$  level when the experimental male groups was compared with the control male group. When the experimental male group was compared with the control female group a significance level of  $p < 0,05$  was found (see Table 25).

TABLE 25 : ANALYSIS OF PASSIVE-AGGRESSIVE SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	45,1	28,9
Experimental Male	15	80,7	29,8
Control Female	24	52,9	26,0
Experimental Female	23	63,5	27,6
Control Total	45	49,2	27,3
Experimental Total	38	70,3	29,4

Two-Way Analysis of Variance : Passive-Aggressive Scale

<u>MCMI-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	13,82	0,0004 *
Sex	1	0,57	0,4512
Interaction	1	4,06	0,0473

Tukey Exp. Male x Control Male = 1 % signif.  
 Exp. Male x Control Female = 5 % signif.

\* Denotes Significant Level

7.1.2.10 Self-Defeating Scale (Scale 8B)

The two-way univariate analysis for the self-defeating scale (variable 8B) demonstrated a significant effect for group ( $f(1) = 31,02$  ;  $p < 0,0000$ ). Post-hoc analyses revealed that in all cases control groups scored significantly less than the study group ( $p < 0,01$ ) (see table 26).

Non-parametric examination of the data for the 8B variable confirmed this finding. The Spearman correlation coefficient was at the  $p < 0,0001$  level.

TABLE 26 : ANALYSIS OF SELF-DEFEATING SCALE  
BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	38,6	25,9
Experimental Male	15	79,0	32,8
Control Female	24	42,5	24,3
Experimental Female	23	75,4	34,8
Control Total	45	40,6	24,8
Experimental Total	38	76,8	33,6

Two-Way Analysis of Variance : Self-Defeating Scale

<u>MCMII-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	31,02	0,0000 *
Sex	1	0,00	0,9865
Interaction	1	0,33	0,5685

Tukey Exp. Male x Control Male = 1 % signif.  
Exp. Female x Control Female = 1 % signif.  
Exp. Male x Control Female = 1 % signif.  
Exp. Female x Control Male = 1 % signif.

\* Denotes Significant Level

7.1.3 Severe Personality Pathology

The severe personality pathology section on the MCMII-II has only three scales : schizotypal (S), borderline (C), and paranoid (P).

7.1.3.1 Schizotypal Scale (Scale S)

TABLE 27 : ANALYSIS OF SCHIZOTYPAL SCALE  
BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	51,0	15,6
Experimental Male	15	74,3	18,9
Control Female	24	43,3	11,5
Experimental Female	23	62,7	30,0
Control Total	45	46,9	14,0
Experimental Total	38	67,3	26,5

Two-Way Analysis of Variance : Schizotypal Scale

<u>MCMII-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	22,06	0,0000 *
Sex	1	4,51	0,0368
Interaction	1	0,19	0,6634

Tukey    Exp. Male x Control Male = 1 % signif.  
          Exp. Female x Control Female = 1 % signif.  
          Exp. Male x Control Female = 1 % signif.

\* Denotes Significant Level

The two-way multivariate analysis for the schizotypal scale (variable S) demonstrated a significant effect for group ( $f(1) = 0,0000$ ). Post-hoc analysis revealed that when experimental male was compared with control male and female groups, and experimental female with control female groups, the significance level was at  $p < 0,01$  for all groups (see Table 27).

Non-parametric examination of the data for the S variable confirmed these findings. The Spearman correlation coefficient was at the  $p < 0,0001$  level.

7.1.3.2 Borderline Scale (Scale C)

TABLE 28 : ANALYSIS OF BORDERLINE SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	36,3	24,7
Experimental Male	15	76,2	30,0
Control Female	24	38,4	19,5
Experimental Female	23	68,8	26,0
Control Total	45	37,4	21,8
Experimental Total	38	71,7	27,4

Two-Way Analysis of Variance : Borderline Scale

<u>MCMI-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	40,4	0,0000 *
Sex	1	0,23	0,6305
Interaction	1	0,74	0,3923

Tukey Exp. Male x Control Male = 1 % signif.  
Exp. Female x Control Female = 1 % signif.  
Exp. Male x Control Female = 1 % signif.  
Exp. Female x Control Male = 1 % signif.

\* Denotes Significant Level

The two-way univariate analysis of variance for the borderline scale (variable C) demonstrated a significant effect for group ( $f(1) = 40,44 ; p < 0,0000$ ). Post-hoc

analyses revealed that in all cases control groups scored significantly less than the study group ( $p < 0,01$ ) (see table 28).

Non-parametric examination of the data for the C variable confirmed these findings. The Spearman correlation coefficient was at the  $p < 0,0001$  level.

#### 7.1.3.3 Paranoid Scale (Scale P)

TABLE 29 : ANALYSIS OF PARANOID SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	55,1	19,4
Experimental Male	15	57,3	19,4
Control Female	24	62,3	17,1
Experimental Female	23	61,0	9,5
Control Total	45	59,0	18,3
Experimental Total	38	59,5	14,1

#### Two-Way Analysis of Variance : Paranoid Scale

<u>MCMI-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	0,01	0,9123
Sex	1	2,16	0,1457
Interaction	1	0,23	0,6292

There were no significant results on the paranoid scale (variable P).

#### 7.1.4 Clinical Syndrome

The clinical syndrome scales on the MCMI-II are represented by the following six variables : anxiety disorder (A), somatoform disorder (H), bipolar manic disorder (N), dysthymic disorder (D), alcohol dependence (B), and drug dependence (T).

7.1.4.1 Anxiety Disorder (Scale A)

TABLE 30 : ANALYSIS OF ANXIETY SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	17,1	24,5
Experimental Male	15	73,5	36,0
Control Female	24	18,6	24,5
Experimental Female	23	69,1	40,9
Control Total	45	17,9	24,2
Experimental Total	38	70,8	38,6

Two-Way Analysis of Variance : Anxiety Scale

<u>MCMI-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	56,06	0,0000 *
Sex	1	0,04	0,8449
Interaction	1	0,17	0,6776

Tukey Exp. Male x Control Male = 1 % signif.  
 Exp. Female x Control Female = 1 % signif.  
 Exp. Male x Control Female = 1 % signif.  
 Exp. Female x Control Male = 1 % signif.

\* Denotes Significant Level

The two-way univariate analysis of anxiety disorder (variable A) demonstrated a significant effect for group



( $f(1) = 56,06$  ;  $p < 0,0000$ ). Post-hoc analyses revealed that in all cases control groups scored significantly less than the study group ( $p < 0,01$ ) (see table 30).

Non-parametric examination of the data for the A variable confirmed these findings. The Spearman correlation coefficient was at the  $p < 0,0001$  level.

7.1.4.2 Somatiform Disorder (Scale H)

TABLE 31 : ANALYSIS OF SOMATIFORM SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	34,0	22,0
Experimental Male	15	56,0	22,6
Control Female	24	41,1	15,1
Experimental Female	23	60,1	17,5
Control Total	45	37,8	18,7
Experimental Total	38	58,5	19,5

Two-Way Analysis of Variance - Somatiform Scale

<u>MCMII-11 Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	23,18	0,0000 *
Sex	1	1,75	0,1901
Interaction	1	0,13	0,7182

Tukey Exp. Male x Control Male = 1 % signif.  
 Exp. Female x Control Female = 1 % signif.  
 Exp. Male x Control Female = 10 % signif.  
 Exp. Female x Control Male = 1 % signif.

\* Denotes Significant Level

The two-way univariate analysis for the somatoform disorder (variable H) demonstrated a significant effect for group ( $f(1) = 23,18$  ;  $p < 0,0000$ ). Post-hoc analyses revealed that in all cases except where the experimental male group is compared with the control female group, the control groups scored significantly less than the study group ( $p < 0,01$ ). In the situation where the experimental male group is compared with the female control group, the significance level was at  $p < 0,10$  (see table 31).

Non-parametric examination of the data for the H variable confirmed these findings. The Spearman correlation coefficient was at the  $p < 0,0001$  level.

#### 7.1.4.3 Bipolar : Manic Disorder (Scale N)

There were no significant results on the bipolar : manic disorder scale (variable N).

TABLE 32 : ANALYSIS OF BIPOLAR : MANIC SCALE  
BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	42,7	28,8
Experimental Male	15	38,9	27,2
Control Female	24	47,5	18,1
Experimental Female	23	42,0	18,1
Control Total	45	45,2	20,3
Experimental Total	38	40,8	21,8

Two-Way Analysis of Variance : Bipolar Manic Scale

<u>MCMII-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u><math>\frac{1}{1}</math> Probability</u>
Group	1	0,95	0,3321
Sex	1	0,70	0,4062
Interaction	1	0,03	0,8524

7.1.4.4 Dysthymic Disorder (Scale D)

The two-way univariate analysis of variance of the dysthymic disorder (variable D) demonstrated a significant effect for group ( $f(1) = 96,90$  ;  $p < 0,0000$ ). Post-hoc analyses revealed that in all cases control groups scored significantly less than the study group ( $p < 0,01$ ) (see table 33).

Non-parametric examination of the data for the D variable confirmed these findings. The Spearman correlation coefficient was at the  $p < 0,0001$  level.

TABLE 33 : ANALYSIS OF DYSTHYMIC SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	18,4	17,1
Experimental Male	15	84,7	30,4
Control Female	24	12,3	19,0
Experimental Female	23	70,1	40,4
Control Total	45	15,2	18,2
Experimental Total	38	75,9	37,1

Two-Way Analysis of Variance : Dysthymic Scale

<u>MCMI-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	96,90	0,0000 *
Sex	1	2,70	0,1046
Interaction	1	0,46	0,5018

Tukey Exp. Male x Control Male = 1 % signif.  
 Exp. Female x Control Female = 1 % signif.  
 Exp. Male x Control Female = 1 % signif.  
 Exp. Female x Control Male = 1 % signif.

\* Denotes Significant Level

7.1.4.5 Alcohol Dependence (Scale B)

The two-way univariate analysis for the alcohol dependence scale (variable B) demonstrated a significant effect for group ( $f(1) = 19,73$  ;  $p < 0,0000$ ). Post-hoc analysis revealed that when the experimental male group is compared with the control male and female groups, the level of significance is  $p < 0,01$ . When the experimental

female group is compared with the control female group the significance is less at only  $p < 0,10$  (see Table 34).

Non-parametric examination of the data for the B variable confirmed these findings. The Spearman correlation coefficient was at the  $p < 0,0001$  level.

TABLE 34 : ANALYSIS OF ALCOHOL DEPENDENCE SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	34,1	24,2
Experimental Male	15	59,6	21,8
Control Female	24	30,6	19,4
Experimental Female	23	45,7	16,8
Control Total	45	32,2	21,6
Experimental Total	38	51,2	19,9

Two-Way Analysis of Variance : Alcohol Dependence Scale

<u>MCMI-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	19,73	0,0000 *
Sex	1	3,60	0,0614
Interaction	1	1,30	0,2576

Tukey Exp. Male x Control Male = 1 % signif.  
 Exp. Female x Control Female = 10 % signif.  
 Exp. Male x Control Female = 1 % signif.

\* Denotes Significant Level

7.1.4.6 Drug Dependence (Scale T)

TABLE 35 : ANALYSIS OF DRUG DEPENDENCE  
SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	40,3	28,5
Experimental Male	15	51,4	23,9
Control Female	24	42,9	21,3
Experimental Female	23	44,7	20,6
Control Total	45	41,7	24,7
Experimental Total	38	47,3	21,9

Two-Way Analysis of Variance : Drug Dependence Scale

<u>MCMII-II Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	1,48	0,2279
Sex	1	0,16	0,6937
Interaction	1	0,78	0,3785

There were no significant results on the drug dependence scale (variable T).

7.1.5 Severe Clinical Syndrome

In the last category of severe syndromes, the MCMII-II measures three pathologies being thought disorder (SS), major depression (CC) and delusional disorder (PP).

7.1.5.1 Thought Disorder (Scale SS)

TABLE 36 : ANALYSIS OF THOUGHT DISORDER  
SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	41,4	23,8
Experimental Male	15	60,3	9,2
Control Female	24	39,9	19,6
Experimental Female	23	47,8	27,9
Control Total	45	40,6	21,4
Experimental Total	38	52,7	23,1

Two-Way Analysis of Variance : Thought Disorder Scale

<u>MCMII- Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	7,40	0,0000 *
Sex	1	2,02	0,1591
Interaction	1	1,26	0,2642

Tukey Exp. Male x Control Male = 10 % signif.  
Exp. Male x Control Female = 5 % signif.

\* Denotes Significant Level

The two-way univariate analysis for the thought disorder scale (variable SS) demonstrated a significant effect for group ( $f(1) = 7,40$  ;  $p < 0,0000$ ). The post-hoc analysis indicated a limited significance between the groups. When experimental male was compared with control male the significance level was  $p < 0,10$ . On the other hand when experimental male was compared with control female the significance level was  $p < 0,05$ .

7.1.5.2 Major Depression (Scale CC)

TABLE 37 : ANALYSIS OF MAJOR DEPRESSION SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	38,9	17,0
Experimental Male	15	71,6	22,5
Control Female	24	21,8	23,7
Experimental Female	23	61,3	30,7
Control Total	45	29,8	22,4
Experimental Total	38	65,4	27,9

Two-Way Analysis of Variance : Major Depression Scale

<u>MCMII-11 Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	44,43	0,0000 *
Sex	1	6,41	0,0133
Interaction	1	0,40	0,5287

Tukey Exp. Male x Control Male = 1 % signif.  
 Exp. Female x Control Female = 1 % signif.  
 Exp. Male x Control Female = 1 % signif.  
 Exp. Female x Control Male = 5 % signif.  
 Control Female x Control Male = 10 % sign.

\* Denotes Significant Level

The two-way univariate analysis of major depression (variable CC) demonstrated a significant effect for group ( $f(1) = 44,43 ; p < 0,0000$ ). Post-hoc analyses revealed that in all cases, except when the study female group was compared with the control male group, the control groups scored significantly less than the study group ( $p < 0,01$ ) (see table 37). When the study female group was compared



with the control male group the significance level was lower at  $p < 0,05$ .

Non-parametric examination of the data for the CC variable confirmed these findings. The Spearman Correlation Coefficient was at the  $p < 0,0001$  level.

7.1.5.3 Delusional Disorder (Scale PP)

TABLE 38 : ANALYSIS OF DELUSIONAL DISORDER SCALE BASE-RATE SCORES

	<u>n</u>	<u>Mean</u>	<u>Standard Deviation</u>
Control Male	21	43,1	21,1
Experimental Male	15	46,3	18,2
Control Female	24	48,8	20,3
Experimental Female	23	51,0	18,6
Control Total	45	46,1	20,6
Experimental Total	38	49,1	18,3

Two-Way Analysis of Variance : Delusional Disorder Scale

<u>MCMII- Variable</u>	<u>Degrees of Freedom</u>	<u>F Value</u>	<u>Tail Probability</u>
Group	1	0,38	0,5387
Sex	1	1,40	0,2405
Interaction	1	0,01	0,9087

There were no significant results on the delusional disorder scale (PP variable).

#### 7.1.6 Stepwise Discriminant Analysis

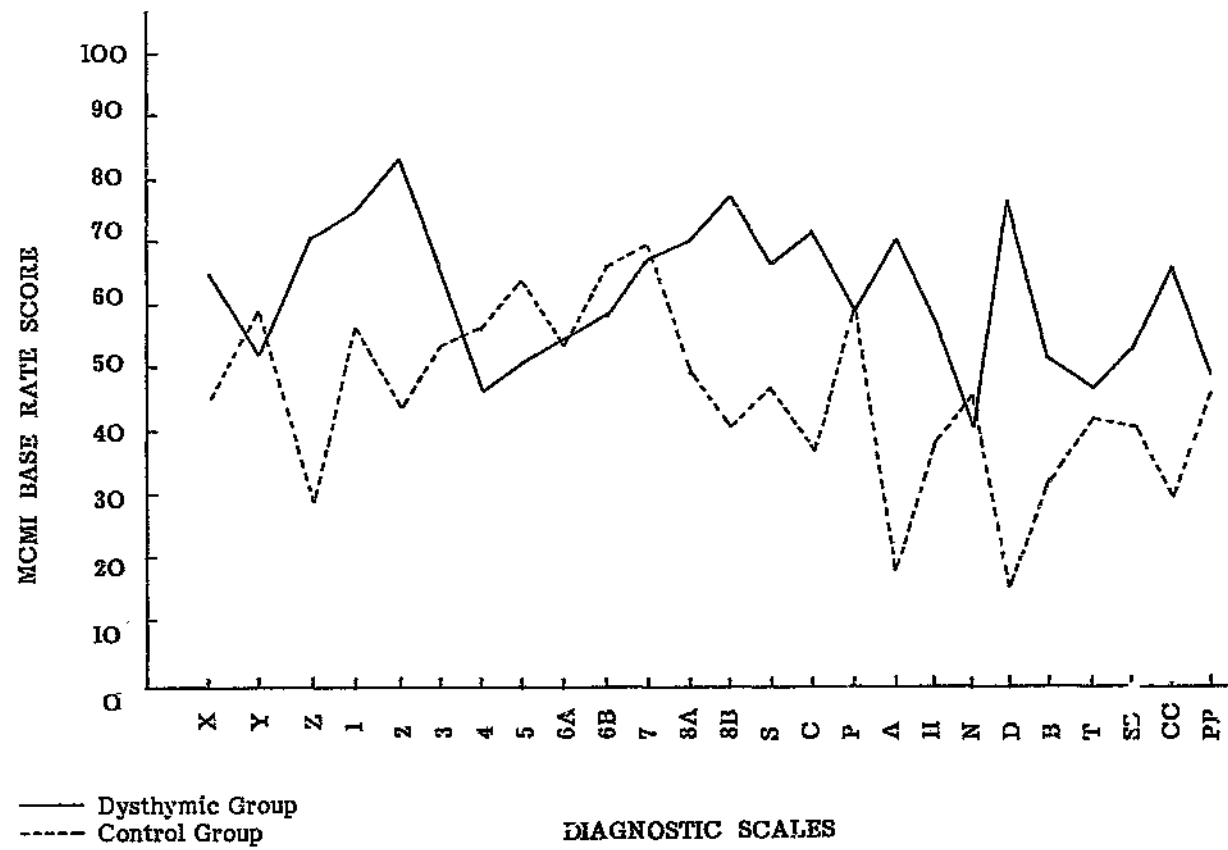
The last part of the statistical analysis involved a stepwise discriminant analysis between the study and control groups. This analysis yielded a figure of 84,3 %. This result implies that should dysthymic and control subjects used in this study be randomized and then reassigned to the dysthymic and control groups, 84,3 % of the subjects will be placed in the correct group in this study. In conclusion this result implies that there is a significant characteristic difference between dysthymic and control subjects.

#### 7.1.7 Summary

A personality profile according to the MCMI-II can now be drawn up comparing the dysthymic and control groups. The mean base-rate score for the twenty five MCMI-II scales as found in tables 14 to 38 were used. This graphic representation is given in Figure 6.

Table 39 summarizes the results of the data found in tables 14 to 38. From this table, as well as from the profile in figure 6, a characteristic profile emerges for dysthymic disorder as compared to the normal population. Dysthymic patients appear to have an avoidant and self-defeating personality pattern. Regarding severe personality pathology, an association was found with the

FIGURE 6 : GROUP PROFILES ON THE MCMI-II



borderline type. Turning to comorbidity with other clinical syndromes, dysthymic pathology was related to anxiety disorder, somatoform disorder and major depression on the MCMI-II.

These findings and their implications are discussed in more detail in the next chapter.

7.2 FREQUENCY OF PERSONALITY DISORDERS ACCORDING TO MCMI-II (MINIMUM SCORE 75) AMONG MALE AND FEMALE DYSTHYMIC AND CONTROL GROUPS

According to the manual for the use of the MCMI-II (Millon, 1987) a base-rate score that exceeds the 75 point mark denotes severe pathology. Scores under the cutoff point of 75, but more prominent than the other scores, can be regarded as indicating a specific personality trait when compared to the rest of the base-rate profile. For this reason, a table was drawn up to compare the frequency of personality disorders according to the MCMI-II (scores above 75) among the male and female dysthymic and control groups. The results of this comparison is given in table 40. Subsequent to this, these results were analyzed according to the Fisher Two-Tail Exact Test which measures the probability between the dysthymic and control groups. The significant differences between the frequency of severe disorders (MCMI-II BR scores above 75) are given in table 41.)

TABLE 39 : SUMMARY OF STATISTICAL SIGNIFICANT FINDINGS  
BETWEEN EXPERIMENTAL (DYSTHYMIC) AND CONTROL  
GROUPS ON THE MCMI-II

MCMI-II Scale	None	Significance Moderate	Significant
X Disclosure	-	-	Yes
Y Desirability	Yes	-	-
Z Debasement	-	-	Yes
1 Schizoid	-	Yes	-
2 Avoidant	-	-	Yes
3 Dependent	Yes	-	-
4 Histrionic	Yes	-	-
5 Narcissistic	Yes	-	-
6A Antisocial	Yes	-	-
6B Aggressive / Sadistic	Yes	-	-
7 Compulsive	Yes	-	-
8A Passive - Aggressive	-	Yes	-
8B Self-Defeating	-	-	Yes
S Schizotypal	-	Yes	-
C Borderline	-	-	Yes
P Paranoid	Yes	-	-
A Anxiety Disorder	-	-	Yes
H Somatoform Disorder	-	-	Yes
N Bipolar : Manic Disorder	Yes	-	-
D Dysthymic Disorder	-	-	Yes
B Alcohol Dependence	-	Yes	-
T Drug Dependence	Yes	-	-
SS Thought Disorder	-	Yes	-
CC Major Depression	-	-	Yes
PP Delusional Disorder	Yes	-	-

TABLE 40 : FREQUENCY OF PERSONALITY DISORDERS ACCORDING TO MCMI-II (CUTOFF POINT 75) AMONG MALE AND FEMALE DYSTHYMIC AND CONTROL GROUPS.

n	Control Male		Exp. Male		Control Female		Exp. Female		Control Total		Exp. Total	
	n	%	n	%	n	%	n	%	n	%	n	%
	21		15		24		23		45		38	
X	1	5	8	53	1	4	6	26	2	4	14	37
Y	7	33	3	20	8	33	4	17	15	33	7	18
Z	-	-	11	73	-	-	11	48	-	-	22	58
1	4	19	10	67	1	4	10	44	5	11	20	53
2	2	10	11	73	2	8	14	61	4	9	25	66
3	5	24	5	33	7	29	13	57	12	27	18	47
4	4	19	-	-	9	38	5	22	13	29	5	13
5	8	38	2	13	11	46	4	17	19	42	6	16
6A	5	24	4	27	1	4	3	13	6	13	7	18
6B	9	43	4	27	8	33	5	22	17	38	9	24
7	6	29	4	27	12	50	12	52	18	40	16	42
8A	4	19	9	60	4	17	8	35	8	18	17	45
8B	1	5	9	60	3	13	14	61	4	9	23	61
S	-	-	5	33	-	-	6	26	-	-	11	29
C	-	-	7	47	-	-	7	30	-	-	14	37
P	1	5	1	7	3	13	-	-	4	9	1	3
A	-	-	11	73	1	4	15	65	1	2	26	68
H	-	-	2	13	-	-	3	13	-	-	5	13
N	-	-	1	7	-	-	-	-	-	-	1	3
D	-	-	12	80	-	-	16	70	-	-	28	74
B	-	-	2	13	-	-	-	-	-	-	2	5
T	1	5	2	13	-	-	-	-	1	2	2	5
SS	-	-	-	-	-	-	3	13	-	-	3	8
CC	-	-	5	33	-	-	8	35	-	-	13	34
PP	-	-	-	-	1	4	1	4	1	2	1	3

TABLE 41 : FISHER'S TWO-TAIL EXACT TEST MEASURING  
PROBABILITY BETWEEN THE DYSTHYMIC AND  
CONTROL GROUPS.

MCMII-II VARIABLE	PROBABILITY LEVEL
X Disclosure	0,0002 *
Y Desirability	0,1521
Z Debasement	0,0000 *
1 Schizoid	0,0003 *
2 Avoidant	0,0000 *
3 Dependent	0,0673
4 Histrionic	0,1950
5 Narcissistic	0,0040
6A Antisocial	0,5586
6B Aggressive / Sadistic	0,1491
7 Compulsive	0,6518
8A Passive-Aggressive	0,0092
8B Self-Defeating	0,0000 *
S Schizotypal	0,0001 *
C Borderline	0,0000 *
P Paranoid	0,3688
A Anxiety Disorder	0,0000 *
H Somatoform Disorder	0,0402
N Bipolar Manic Disorder	0,4578
D Dysthymic Disorder	0,0000 *
B Alcohol Dependence	0,2066
T Drug Dependence	0,5906
SS Thought Disorder	0,0918
CC Major Depression	0,0000 *
PP Delusional Disorder	0,4578

\* Denotes Significant Level

Results from table 40 and table 41 can be summarized as follows :

1. When subjects on the disclosure scale (X variable) were divided in above or below a base-rate score of 75, it was found that 2 out of the 45 controls scored above the base-rate of 75. On the other hand, 14 out of the 38 experimental subjects scored above 75 (see Table 40). This difference was statistically significant as calculated by the Fisher's Two-Tailed Exact Test with  $p < 0,0002$  (see Table 41).
2. When subjects on the debasement scale (Z variable) were divided in above or below a base-rate score of 75, it was found that none of the 45 controls scored above the base-rate of 75. On the other hand, 22 out of the 38 experimental subjects scored above 75 (see Table 40). This difference was statistically significant as calculated by the Fisher's Two-Tailed Exact Test with  $p < 0,0000$  (see Table 41).
3. When subjects on the schizoid scale (variable 1) were divided in above or below a base-rate score of 75, it was found that 5 out of the 45 controls scored above the base-rate of 75. On the other hand, 20 out of the 38 experimental subjects scored above 75 (see Table 40). This difference was statistically significant as calculated by the Fisher's Two-



Tailed Exact Test with  $p < 0,0003$  (see Table 41).

4. When subjects on the avoidant scale (variable 2) were divided in above or below a base-rate score of 75, it was found that 4 out of the 45 controls scored above the base-rate of 75. On the other hand, 25 out of the 38 experimental subjects scored above 75 (see Table 40). This difference was statistically significant as calculated by the Fisher's Two-Tailed Exact Test with  $p < 0,0000$  (see Table 41).
5. When subjects on the self-defeating scale (variable 8B) were divided in above or below a base-rate score of 75, it was found that 4 out of the 45 controls scored above the base-rate of 75. On the other hand, 23 out of the 38 experimental subjects scored above 75 (see Table 40). This difference was statistically significant as calculated by the Fisher's Two-Tailed Exact Test with  $p < 0,0000$  (see Table 41).
6. When subjects on the schizotypal scale (S variable) were divided in above or below a base-rate score of 75, it was found that none of the 45 controls scored above the base-rate of 75. On the other hand, 11 out of the 38 experimental subjects scored above 75 (see Table 40). This difference was statistically significant as calculated by the Fisher's Two-Tailed Exact Test with  $p < 0,0001$  (see Table 41).

7. When subjects on the borderline scale (C variable) were divided in above or below a base-rate score of 75, it was found that none of the 45 controls scored above the base-rate of 75. On the other hand, 14 out of the 38 experimental subjects scored above 75 (see Table 40). This difference was statistically significant as calculated by the Fisher's Two-Tailed Exact Test with  $p < 0,0000$  (see Table 41).
8. When subjects on the anxiety disorder scale (A variable) were divided in above or below a base-rate score of 75, it was found that one of the 45 controls scored above the base-rate of 75. On the other hand, 26 out of the 38 experimental subjects scored above 75 (see Table 40). This difference was statistically significant as calculated by the Fisher's Two-Tailed Exact Test with  $p < 0,0000$  (see Table 41).
9. When subjects on the dysthymic disorder scale (D variable) were divided in above or below a base-rate score of 75, it was found that none of the 45 controls scored above the base-rate of 75. On the other hand, 28 out of the 38 experimental subjects scored above 75 (see Table 40). This difference was statistically significant as calculated by the Fisher's Two-Tailed Exact Test with  $p < 0,0000$  (see

Table 41).

10. When subjects on the major depression scale (CC variable) were divided in above or below a base-rate score of 75, it was found that none of the 45 controls scored above the base-rate of 75. On the other hand, 13 out of the 38 experimental subjects scored above 75 (see Table 40). This difference was statistically significant as calculated by the Fisher's Two-Tailed Exact Test with  $p < 0,0000$  (see Table 41).

The results above mirror the results found in the previous section of this study (see Section 7.1.7). These findings, together with the findings in Section 7.1 are discussed in more detail in the next chapter.

### 7.3 HYPOTHESES TESTED

From the results presented in tables 14 through to table 41, the following conclusions may be drawn in relation to the thirteen hypotheses postulated in Chapter 5 :

#### Hypothesis 1

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the personality profiles of a group of patients suffering from dysthymic disorder compared to a group of

mentally healthy subjects as measured on the Millon Clinical Multiaxial Inventory -II (MCMI-II).

This hypothesis was not accepted.

Hypothesis 2

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Disclosure Scale (X-Scale) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was not accepted.

Hypothesis 3

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Desirability Scale (Y-Scale) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was accepted.

Hypothesis 4

This hypothesis was a null hypothesis and postulated that

there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Debatement Scale (Z-Scale) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was not accepted.

Hypothesis 5

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Schizoid Scale (Scale-1) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was accepted.

Hypothesis 6

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Avoidant Scale (Scale-2) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was not accepted.

Hypothesis 7

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Dependent Scale (Scale-3) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was accepted.

Hypothesis 8

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Histrionic Scale (Scale-4) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was accepted.

Hypothesis 9

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Narcissistic Scale (Scale-5) of the Millon Clinical

Multiaxial Inventory-II (MCMII-II).

This hypothesis was accepted.

Hypothesis 10

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Antisocial Scale (Scale-6A) of the Millon Clinical Multiaxial Inventory-II (MCMII-II).

This hypothesis was accepted.

Hypothesis 11

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Aggressive/Sadistic Scale (Scale 6B) of the Millon Clinical Multiaxial Inventory-II (MCMII-II).

This hypothesis was accepted.

Hypothesis 12

This hypothesis was a null hypothesis and postulated that

there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Compulsive Scale (Scale-7) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was accepted.

Hypothesis 13

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Passive-Aggressive Scale (Scale-8A) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was accepted.

Hypothesis 14

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Self-Defeating Scale (Scale-8B) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was not accepted.



Hypothesis 15

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Schizotypal Scale (Scale-S) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was accepted.

Hypothesis 16

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Borderline Scale (Scale-C) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was not accepted.

Hypothesis 17

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Paranoid Scale (Scale-P) of the Millon Clinical Multiaxial

Inventory-II (MCMII-II).

This hypothesis was accepted.

Hypothesis 18

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Anxiety Scale (Scale-A) of the Millon Clinical Multiaxial Inventory-II (MCMII-II).

This hypothesis was not accepted.

Hypothesis 19

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Somatoform Scale (Scale-H) of the Millon Clinical Multiaxial Inventory-II (MCMII-II).

This hypothesis was not accepted.

Hypothesis 20

This hypothesis was a null hypothesis and postulated that

there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Bipolar : Manic Disorder Scale (Scale-N) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was accepted.

Hypothesis 21

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Dysthymic Disorder Scale (Scale-D) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was not accepted.

Hypothesis 22

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Alcohol Dependence Scale (Scale-B) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was accepted.

Hypothesis 23

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Drug Dependence Scale (Scale-T) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was accepted.

Hypothesis 24

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Thought Disorder Scale (Scale-SS) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was accepted.

Hypothesis 25

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Major Depression Scale (Scale-CC) of the Millon Clinical

Multiaxial Inventory-II (MCMI-II).

This hypothesis was not accepted.

Hypothesis 26

This hypothesis was a null hypothesis and postulated that there would not be a statistically significant difference between the mean base rate scores (BR) of the experimental group and the control group on the Delusional Disorder Scale (Scale-PP) of the Millon Clinical Multiaxial Inventory-II (MCMI-II).

This hypothesis was accepted.

In summary, of the 26 hypotheses postulated in Chapter 7, sixteen hypotheses were accepted and ten hypotheses (hypotheses 1, 2, 4, 6, 14, 16, 18, 19, 21, and 25) were not accepted.

These findings and their implications are discussed in the following chapter.

CHAPTER 8

DISCUSSION

8.1 INTRODUCTION

The relationship between dysthymia, character traits and dysthymia has been an area of concern to many clinicians over the years. On the one hand some authors claim a definite association between dysthymia and personality. On the other hand, however, some clinicians classify dysthymia as a clear-cut affective disorder with few if any pathological personality attributes. The task force for the DSM-IV Mood Disorders also propose this last view (Keller and Russell, 1991). To determine greater understanding of the complex nature between dysthymia and personality these dichotomous views necessitate further research.

The purpose of this study was thus to explore the relationship between personality and dysthymic disorder by means of objective psychometric testing. The Millon Clinical Multiaxial Inventory -II (MCMI-II) was used in this study to explore the relationship. Twenty six hypotheses, each corresponding to a scale on the MCMI-II, were proposed and then in turn tested (see Chapters 5 and 7). The findings that emerged from this process are discussed below.

The discussion will include the biographical and clinical data relating to the present study. The hypotheses tested will then be reviewed, after which an attempt will be made to describe the personality characteristics of the dysthymic patient. The comorbidity of dysthymia with other clinical syndromes will be reviewed. Finally, some critique on the study and concluding remarks will be given.

## 8.2 DISCUSSION OF THE BIOGRAPHICAL AND CLINICAL DATA IN THIS STUDY

Data found in the biographical questionnaire (see Appendix 4) were divided into biographical and clinical aspects for discussion (see Chapter 6).

### 8.2.1 BIOGRAPHICAL DATA

Biographical data regarding dysthymic subjects used in this study is found in Table 4. In the random sample used in the present study, more females (60,5%) were entered into the experimental sample than males (39,5%). These prevalence rates where dysthymia affect more females than males correspond with the results of Robins, Heler, Weissman, et al., (1984); Weissman, Leaf, Bruce and Florio (1988), and Kivela and Pakkala (1989). The subjects diagnosed and included in the present study present a broad age range from 20 to 72 years. The study

of Bland, Orn and Newman (1988) on the lifetime prevalence of dysthymia also confirm that dysthymia occurs over a wide age range in the general population.

Virtually no studies could be found in the literature regarding the ethnic influence on dysthymia (Escobar, Karno, Burnam, et al., 1988). The majority of dysthymic subjects used in this study were from the Caucasian group (see Table 4). The Caucasian preponderance in this study can be explained in that the sources for referral to the dysthymia clinic where the study was conducted came from mainly white middle-class areas. The actual manifest symptoms might also be different in Asian or Black people. The result might be that dysthymic disorder is not easily diagnosed in other ethnic groups. This area needs further exploration in future research.

In direct contrast to the findings of Kivela and Pakkala (1989), dysthymic disorder in this study was more common in those subjects with a higher educational level (see Table 4). A wide range of occupations was found in dysthymia patients participating in this study which corresponds to the findings of Kivela and Pakkala (1989) that dysthymic disorder was not related to occupation (see Table 5).

#### 8.2.2 CLINICAL DATA



8.2.2.1 The Diagnosis of Dysthymia

The task force for the DSM-IV Mood Disorders Work Group (Keller and Russell, 1991) identified two main problem areas for field-trial research. The one area concerned the differentiation of symptoms as well as their thresholds and severity for dysthymia and major depression. These aspects received attention in both the DSM-III (1980) and the DSM-III-R (1987) when the criteria for dysthymic disorder was radically modified (Akiskal, 1991 and Murphy, 1991). The 38 dysthymic subjects used in this study had virtually all the DSM-III-R symptoms for the diagnosis of dysthymic disorder while in their acute phase (see Table 2). The dysthymic subjects displayed some symptoms deviating slightly from the DSM-III-R criteria, for instance decreased appetite or overeating, sleep disturbance and problems with concentration and difficulty in making decisions (see Appendix 1).

Although the criteria for dysthymic disorder according to DSM-III-R were strictly adhered to in the selection of patients for the present study, the identification of symptoms remained a problem. With the decrease in the number of criteria from DSM-III to DSM-III-R for dysthymic disorder (Kocsis and Frances, 1987 and Frances, Kocsis, Martin, et al., 1989) the diagnosis of dysthymia

has become less specific. As seen above, most dysthymic patients in this study suffered from all the criteria needed for the diagnosis. On clinical examination it was felt that in DSM-IV more discriminating criteria should be added. Neglected areas in DSM-III-R are that of functional and cognitive symptoms. The findings in this study correspond with that of Akiskal (1990), Kocsis and Francis (1987), and McCullough (1988). Clinically, the differentiation between dysthymia and a chronic low grade depression following a major depressive episode, or a chronic low grade depression with intermittent depressive episodes, remained a problem. Most of the patients excluded from this study had some history of a major depressive episode in the last two years. This same problem is highlighted by Keller and Russell (1991).

The majority of dysthymic subjects in the experimental group were of the primary type, implying no associated psychopathology (see Table 2). A wide variety of diagnoses were made on all the axes of the DSM-III-R classification system (see Table 6). This wide variety of diagnoses highlight the complex nature of dysthymia and the comorbidity of dysthymia with other diagnoses on the DSM-III-R classification system.

Most clinical associations with dysthymic disorder on Axis I in this study appear to be with Axis II.

Dependent personality disorder was the most prevalent. Most of the other personality disorders seem, however, to be related to dysthymia on a clinical level to some lesser degree. Psychosocial stressors were mild to moderate (Axis IV), and the dysthymics functioned on a moderate to poor level (Axis V). The controversy highlighted here of the association between dysthymia and personality is the aim of this study. Clinically, most dysthymics appear to have been given a personality disorder diagnosis (Axis II) as well. The nature of this association will be discussed in more detail in the rest of this chapter.

#### 8.2.2.2 Age of Onset

The age of onset of the disorder was less clear cut. In 23 (60,5%) of the subjects the onset of the dysthymia was before the age of 21 years, while in the other 15 (39,5%) of the subjects the onset was after the age of 21 years (see Table 2). Table 7 shows that, on average, dysthymic males had experienced symptoms for the past 19,6 years while the diagnosis of dysthymia was made only 5,5 years ago. Forty percent of the dysthymic males had been hospitalized for their dysthymia. The female dysthymics on the other hand had experienced symptoms symptoms for the past 16,4 years, while the diagnosis of dysthymia was made only 5,1 years ago (Table 7).

Slightly more females (43,5 %) had been hospitalized for dysthymia. The late diagnosis for dysthymia can be attributed to the fact that the concept of dysthymia was relatively obscure and only reached prominence in the DSM-III which was published in 1980. Prior to this, the patients in this sample were treated for 'neurotic depression' or 'chronic depression'. The early onset of the dysthymia is in keeping with the recent view of Akiskal (1990). However, both Akiskal (1990) and Ladds (1988) feel that social functioning should be more stable, and patients should not have been hospitalized as much as in the sample used in this study.

#### 8.2.2.3 Medication Used and Hospitalization

On entering the dysthymia clinic and the study, a list was made of the medication used by the patients during the last year (see Table 9). A wide variety of medication was used and often in multiple combinations. Virtually all approaches to the treatment of depression were used - including first and second generation antidepressants, lithium, L-Tryptophan and electroconvulsive therapy. Benzodiazepines were frequently used concurrently with the antidepressants. Most of the patients reported little benefit from this treatment. This wide spectrum of medication used for the treatment of dysthymia confirms the poor response of

dysthymics to current antidepressant medication. These findings might also support the classification of dysthymics into a group which respond to medication, and a second group with no response to medication. These findings necessitate a specialized approach to the management of dysthymia.

At the dysthymia clinic an attempt was made to rationalize the medication taken by the dysthymics (see Table 8). The attending psychiatrists discouraged polypharmacy and most patients responded reasonably well to Ritanserin and one benzodiazepine (Murphy and Checkley, 1988; Bersani, Pozzi, Martin, et al., 1991). The study by Bekker (1991) at the same dysthymia clinic did not show any significant improvement by the dysthymics on Ritanserin.

### 8.3 RESULTS OBTAINED FROM THE MCMI-II

The results found in chapter 7 of the present study will be discussed according to the hypotheses accepted, and the hypotheses rejected. The implications of the relationship between dysthymia, personality and other clinical syndromes will be reviewed.

#### 8.3.1 Validity of the MCMI-II in the Present Study

The modifier indices on the MCMI-II deal with the

possible random completion of the test by the testee. It identifies the personal thoughts and feelings of the individual completing the questionnaire (Millon, 1987). No significant difference was found between the dysthymic and the control group on the disclosure (Y) scale of the MCMI-II (see Section 7.1.1.2). This result signifies that all the subjects that took part in this study made an attempt to answer the questions in the test realistically without making an attempt to deny unattractive or problematic characteristics.

Both the disclosure (X) (see Section 7.1.1.1) and debasement (Z) (see Section 7.1.1.3) scales differed significantly between the experimental and control groups in favour of the dysthymic patients. These results indicate that dysthymics had an open and self-revealing approach to the test situation. In comparison to the control sample used in the present study, the dysthymics might be inclined to depreciate or devalue themselves by presenting more troublesome emotional and personal difficulties.

The modifier indices on the MCMI-II indicate that the measures obtained in the present study is representative of the dysthymic group. Although dysthymic patients tend to be open about their symptomatology, they might overemphasize their pathology. This overemphasis can

result in a process where dysthymics develop a poor self-image and subsequent deficient interpersonal relationships.

8.3.2 MCMI-II Scales for which Null Hypotheses were Postulated and Accepted

No statistical difference was found on six of the clinical personality scales of the MCMI-II. These were the dependent (3) (see Section 7.1.2.3), histrionic (4) (see Section 7.1.2.4), narcissistic (5) (see Section 7.1.2.5), antisocial (6A) (see Section 7.1.2.6), aggressive/sadistic (6B) (see Section 7.1.2.7), and the compulsive (7) (see Section 7.1.2.8) scales.

The present study disagree with studies in the literature that found dysthymic patients to be dependent (Akiskal, Rosenthal, Haykal, et al., 1980; Akiskal, 1983; Hirschfeld, 1991; Koenigsberg, Kaplan, Gilmore, et al., 1985; Roy, Sutton and Pickar, 1985; Mezzich, Fabrega and Coffman, 1987; Kocsis and Frances, 1987; Pilkonis and Frank, 1988; Joffe and Regan, 1988; Millon and Everly, 1985).

Dysthymic patients are not histrionic, compulsive or narcissistic. Once again these findings are in conflict with present belief in the literature (Histrionic : Akiskal, Rosenthal, Haykal, et al., 1983; Hirschfeld,

1991; Roy, Sutton and Pickar, 1985; Joffe and Regan, 1988; Libb, Stankovic, Freeman, et al., 1990; Millon and Everly, 1985) (Compulsive : Roy, Sutton and Pickar, 1985; Joffe and Regan, 1988; Libb, Stankovic, Freeman, et al., 1990; Pilkonis and Frank, 1988; Millon and Everly, 1985; Hirschfeld, 1991) (Narcissistic : Joffe and Regan, 1988; Libb, Stankovic, Freeman, et al., 1990; Millon and Everly, 1985).

The personality pattern of dysthymic patients are not aggressive, sadistic or antisocial according to the findings of the present study. Some authors, however, found increased antisocial traits amongst depressed patients (Akiskal, Rosenthal, Haykal, et al., 1980; Akiskal, 1983; Hirschfeld, 1991; Joffe and Regan, 1988; Libb, Stankovic, Freeman, et al., 1990).

Some statistical difference was found on two of the clinical personality pattern scales of the MCMI-II. The two scales are the schizoid (1) (see Section 7.1.2.1), and the passive-aggressive (8A) (see Section 7.1.2.9) scales. Dysthymic patients can thus show traits of schizoid and passive-aggressive personality patterns. In contrast to the findings in this study, the literature support a relationship between dysthymia and schizoid features (Roy, Sutton and Pickar, 1985; Joffe and Regan, 1988; Alnaes and Torgersen, 1989 (b); Alnaes and



Torgersen, 1991), as well as a relationship between dysthymia and passive-aggressive personality patterns (Millon and Everly, 1985; Alnaes and Torgersen, 1989 (b); Alnaes and Torgersen, 1991; Joffe and Regan, 1988).

According to these findings, dysthymic patients find it difficult to form meaningful relationships. They are distant, and are unable to experience depth in emotional relationships. Dysthymics are unable to resolve interpersonal or intrapsychic conflicts, and tend to be ambivalent and erratic in their everyday behaviour (see also Appendix 3).

Regarding severe personality pathology, no relationship was found between dysthymia and a paranoid personality (P) (see Section 7.1.3.3). This result is in agreement with a similar study done by Joffe and Regan (1988). A slight relationship was found between dysthymia and schizotypal personality disorder (S) (see Section 7.1.3.1). This finding is in contrast to several other studies (Alnaes and Torgersen, 1988, 1989 (b) and 1991; Joffe and Regan, 1988). Dysthymics may thus prefer social isolation with minimal personal attachments and obligations (see also Appendix 3).

The clinical scales on the MCMI-II measure the comorbidity of personality disorders (Axis II) with clinical syndromes (Axis I). No comorbidity was found

between dysthymia and bipolar: manic disorder (N) (see Section 7.1.4.3), alcohol dependence (B) (see Section 7.1.4.5), drug dependence (T) (see Section 7.1.4.6), thought disorder (SS) (see Section 7.1.5.1), or delusional disorder (PP) (see Section 7.1.5.3).

A study by Troisi, Pasini, Bersani, et al., (1990), as with the present study, did not find any relationship between dysthymia and bipolar disorder. No association was found between dysthymia and substance abuse (Mezzich, Fabrega and Coffman, 1987). Akiskal (1983) and Hirschfeld (1991), similarly, could not establish a direct link between dysthymia and alcohol abuse. A strong family history of alcoholism, however, was found in dysthymic patients.

### 8.3.3 MCMI-II Scales for which Null Hypotheses were Postulated and Not Accepted

#### 8.3.3.1 Personality Scales

The present study indicated a significant statistical difference between the dysthymic and control groups on two of the clinical personality scales and one severe personality scale. A relationship is thus found between dysthymia and avoidant personality (2) (see Section 7.1.2.2), and self-defeating personality (8B) (see Section 7.1.2.10). On the severe personality scales,

dysthymia formed a relationship with the borderline personality (C) (see Section 7.1.3.2).

Previous studies on personality and dysthymia found a relationship between dysthymic disorder and an avoidant personality (Alnaes and Torgersen, 1988, 1989 (b) and 1991; Joffe and Regan, 1988; Pilkonis and Frank, 1988). No studies were however done on the association between dysthymia and the self-defeating personality. As with the present study, a positive relationship was established between dysthymia and the borderline personality in the literature (Akiskal, Rosenthal, Haykal, et al., 1980; Akiskal, 1983; Hirschfeld, 1991; Roy, Sutton and Pickar, 1985; Charney, Nelson and Quinlan, 1981; Prasad, Val, Lahmeyer, et al., 1990; Alnaes and Torgersen, 1989 (b) and 1991; Joffe and Regan, 1988).

The positive relationship between avoidant, self-defeating and borderline personality patterns and dysthymia can now be explored according to the personality constructs as proposed by Millon (1987) (see also Appendix 3). The dysthymic personality can utilize various ways of handling interpersonal contact. These patterns can be aversive (avoidant personality), deferential (self-defeating personality), and paradoxical (borderline personality).

Interpersonal conduct that is aversive implies that such a person reports an extensive history of social pan-anxiety and distrust. He seeks acceptance, but maintains distance and privacy to avoid anticipated humiliation and derogation. Together with this avoidant pattern, the dysthymic may relate to others in a self-sacrificing, servile, and obsequious manner, allowing, if not encouraging others to exploit or take advantage of them. They are self-abasing and solicits condemnation by accepting undeserved blame and courting unjust criticism (deferential interpersonal conduct pattern).

In contrast to these avoidant and self-defeating patterns of behaviour, the dysthymic realizes that he needs attention and affection. On the other hand, however, the dysthymic appears to be manipulative, volatile, is predictably contrary. This behaviour often elicit rejection rather than support. They further react to fears of separation and isolation in angry, mercurial, and often self-damaging ways (paradoxical interpersonal conduct pattern).

The self-image of the dysthymic personality is generally negative. Through their avoidant interpersonal style, they experience themselves as alienated. They see themselves as a person who is socially isolated and rejected by others. They devalue self-achievements and

may report feelings of aloneness and emptiness, if not depersonalization. Adding to this, they feel undeserving through their self-defeating attitude. They focus on the very worst features of self, asserting thereby that one is worthy of being shamed, humbled, and debased. Dysthymics may feel that one has failed to live up to the expectations of others and, hence, deserves to suffer painful consequences.

Being confronted with these negative features, the self-image of the dysthymic may become uncertain (borderline personality). They experience the confusions of an immature, nebulous, or wavering sense of identity. They seek to redeem precipitate actions and changing self-presentations with expressions of contrition and self-punitive behaviours.

(See also Millon, 1987 and 1988; Appendix 3 and Chapter 5).

#### 8.3.3.2 Clinical Syndrome Scales

According to the present study, comorbidity exists between dysthymia and anxiety disorder (A) (see Section 7.1.4.1), somatoform disorder (H) (see Section 7.1.4.2), and major depression (CC) (see Section 7.1.5.2). The association between dysthymia and these three clinical syndromes will now be discussed.

The most frequent nondepressive symptoms reported by patients with depressive and dysthymic disorders are those typically associated with anxiety (Sanderson, Beck and Beck, 1990; Sanderson, DiNardo, Rapee and Barlow, 1990; Liebowitz, Hollander, Schneier, et al., 1990; Klass, DiNardo and Barlow, 1989; Mezzich, Fabrega and Coffman, 1987). The association of dysthymia with anxiety is borne out by this study. It would be interesting however, to identify and link the subtypes of anxiety disorders (for instance generalized anxiety disorder or specific phobias) to dysthymia. Further research is needed to explore the nature of the relationship between dysthymia and anxiety.

The role of anxiety in personality also remains controversial and unknown. An increase in anxiety has often been reported in the disordered personality. According to Kisker (1972) anxiety plays two major roles in the dynamics of personality organization and disorganization. First, it serves as a signal; second, it is a symptom. Anxiety as a signal alerts the individual to impending danger. It enables the individual to set into motion the defensive and adjustive processes which will serve to protect him against the inner threats. Anxiety as a symptom is an expression of the breakdown of the defensive operations in the personality. In this role, anxiety becomes the basic

symptom of a number of personality disturbances. This major link between dysthymia and anxiety thus further alert the clinician to the problematic personality of the dysthymic patient.

Somatic complaints is often the result of increased or abnormal anxiety. In conjunction with this, the association between dysthymia and somatoform disorder was confirmed by this study. Swartz, Blazer, George, et al., (1986) also reported that 65% of the subjects in their study who had somatization disorder also met the criteria for dysthymic disorder.

The association between dysthymic disorder and major depression remains problematic. For this reason, the DSM-IV Mood Disorders Work Group (Keller and Russel, 1991) has proposed that this association should be studied as a priority through future field-trial research to clarify the distinction between dysthymia and major depression. The study by Klein, Taylor, Dickstein and Harding (1988 (b)) found 59% of dysthymics to be in a current major depressive episode, and 97% of the dysthymics to have had a history of major depression. Kocsis and Frances (1987) showed similar results. Torgersen (1989 (a)) found that 30% of patients with a diagnosis of major depression had a concomitant diagnosis of dysthymic disorder.

Scott (1988) (see Figure 2) made an attempt to demonstrate the relationship between different subtypes of chronic depression. He proposes that dysthymic disorder is a chronic minor depressive illness which can also be described as a characterological depression. A definite association exists between chronic depression and major depressive disorders. The concept of double depression describes a major depressive episode superimposed on a chronic minor depressive disorder such as dysthymia. These concepts were also described by Keller, Lavori and Endicott (1983) and Keller and Lavori (1984). In essence, future research is needed to clarify the subtypes of depression, as well as their relationships with each other.

Finally, it was interesting to note that in the present study the dysthymic patients scored significantly above the control group on the dysthymic scale (see Section 7.1.4.4). This is in contrast to the design of this study where the dysthymic patients were tested on the MCMI-II only when they were symptom free on DSM-III-R evaluation. This finding might be related to the chronicity of the dysthymic disorder, as well as the permanent effect of the disorder on personality. Although dysthymic patients might improve clinically in the short-term, the long-term sequelae of the disease on personality remains unanswered.



#### 8.4 FINAL CRITIQUE

Although clear positive findings emerged from this study, several problems were encountered. Some critique and comments can be leveled against the study design and the research instrument.

##### 8.4.1 Study Design

The study was intended to be a prospective study and was designed and executed as such. Dysthymic patients were initially diagnosed as dysthymic strictly according to the DSM-III-R criteria for dysthymic disorder. Patients in the experimental dysthymic group were tested on the MCMI-II only once they were in remission clinically and according to DSM-III-R criteria. Although this procedure was followed, results on the MCMI-II showed that dysthymics still scored significantly high on the dysthymia scale of the MCMI-II. This contradiction forces one to look critically at the clinical diagnosis of dythymia, as well as at the concept of dythymia in the DSM-III-R. In the light of this contradiction, one should question to what extent this study reflected the premorbid personality of dysthymics as was intended.

A sample size of 38 dysthymic patients was eventually used. Although this can be seen as an adequate sample, especially if compared to similar studies, a larger

sample would have served the purpose of differentiating the dysthymia group into subgroups. In doing this, aspects such as primary / secondary dysthymia and early / late onset dysthymia could have been considered. Subgrouping according to biographical data would also have been made possible.

#### 8.4.2 The Research Instrument

A major issue in conducting research with psychological measuring instruments is that of cross-cultural validity regarding the content of the instrument, as well as the validity of the norms with another culture. The MCMI was chosen for this study for various reasons. The MCMI was constructed with normative data based on psychiatric rather than general populations, thereby improving the discrimination efficiency of scales and diagnostic accuracy. Base-rate, rather than normalized standard score transformations, were moreover used in order to allow for a frequency of personality disorder diagnoses which are roughly equivalent to representative clinical rates.

The MCMI was also chosen because it is reliable and well validated. The test is further based on Millon's taxonomy of personality which formed one of the major conceptual bases for the DSM-III-R classification of personality disorder.

#### 8.5 CONCLUSION

Motivation for undertaking this study stems from the confusion that reigns in the literature regarding the relationship between personality disorder, personality traits and dysthymic disorder. A large body of theorists and researchers still claim a definite association between dysthymia and personality. Their views result to some extent from the concept of dysthymia as it developed through the past few decades. Dysthymia grew out of the concept of depressive neurosis which had a stronger basis in personality pathology. Other terms like neurotic depression and depressive reaction preceded depressive neurosis.

With the advent of DSM-III and DSM-III-R, dysthymia was moved from the neuroses to the mood disorders category. The DSM-IV Mood Disorders Work Group has been reinforcing the classification of dysthymia with the mood disorders. The Work Group has embarked on research to determine the symptomatology that should be used for the diagnosis of dysthymia. It is proposed that cognitive, functional and vegetative symptoms be included in DSM-IV to further entrench dysthymia as an affective disorder and extricate it from the personality disorders.

With this persistent dichotomy in the conceptualization of dysthymia, this study was undertaken to explore the

relationship between dysthymia and personality. In order to do this a group of 38 dysthymic patients in remission was compared to a group of 45 mentally healthy individuals. The Millon Clinical Multiaxial Inventory - II was used to establish a possible characteristic premorbid personality pattern for dysthymics.

Patients that took part in the study were strictly selected according to the DSM-III-R criteria for dysthymic disorder. In terms of the MCMI-II, the dysthymic and control groups were compared on the 3 correction and 22 clinical scales of the test. As a result of these scales, 26 hypotheses were formulated and tested according to a statistical analysis.

The final result showed statistically significant results between the personality pattern and clinical scales when the dysthymia group was compared with the control group. Dysthymic patients have an avoidant and self-defeating personality pattern and are linked to borderline personality disorder. Comorbidity on the clinical scales exists between anxiety and somatoform disorder and dysthymia. Finally, a strong association was found between major depression and dysthymia.

These results are significant when seen against the literature and present concepts of dysthymia. On psychometric testing, a definite association was found

between dysthymia and personality traits. Furthermore, psychometric testing also indicated a pattern of personality functioning specific to the dysthymic patient. This finding holds important implications for the etiology, diagnosis, classification, therapeutic management, and prognosis of patients suffering from dysthymic disorder. This association between dysthymia and personality should also be considered in future attempts to delineate the symptomatology and to draw up classificatory systems for dysthymia.

The present study also emphasizes the importance of a multifactorial and holistic approach to the management of dysthymia. Both psychopharmacological and psychotherapeutic approaches should be utilized if the condition of the dysthymic patient is to be improved. The importance of the relationship between personality and dysthymia and ultimately the affective disorders was stressed in this study. It is only through the understanding of this complex relationship that patients can benefit on both theoretical and clinical level.

APPENDIX I

DSM-III-R CRITERIA FOR DYSTHYMIA  
American Psychiatric Association, 1987

- A. Depressed mood (or can be irritable mood in children and adolescents) for most of the day, more days than not, as indicated by subjective account or observation by others, for at least two years (one year for children and adolescents).
- B. Presence, while depressed, of at least two of the following :
- (1) poor appetite or overeating
  - (2) insomnia or hypersomnia
  - (3) low energy or fatigue
  - (4) low self-esteem
  - (5) poor concentration or difficulty making decisions
  - (6) feelings of hopelessness.
- C. During a two-year period (one-year for children and adolescents) of the disturbance, never without the symptoms in A for more than two months at a time.
- D. No clear evidence of a Major Depressive Episode during the first two years (one year for children and adolescents) of the disturbance.  
Note : There may have been previous Major Depressive Episode, provided there was a full remission (no significant signs or symptoms for six months) before development of the Dysthymia. In addition, after these two years (one year in children or adolescents) of Dysthymia, there may be superimposed episodes of Major Depression, in which case both diagnoses are given.
- E. Has never had a Manic Episode ... or an unequivocal Hypomanic Episode.
- F. Not superimposed on a chronic psychotic disorder, such as Schizophrenia or Delusional Disorder.
- G. It cannot be established that an organic factor initiated and maintained the disturbance, e.g., prolonged administration of an antihypertensive medication.

Specify primary or secondary type :

Primary type : the mood disturbance is not related to a pre-existing, chronic, nonmood Axis I or Axis III disorder, e.g., Anorexia Nervosa, Somatization Disorder, a Psychoactive Substance Dependence Disorder, and Anxiety Disorder, or rheumatoid arthritis.

Secondary type : the mood disturbance is apparently related to a pre-existing, chronic, nonmood Axis I or Axis III disorder.

Specify early onset or late onset :

Early onset : onset of disturbance before age 21.

Late onset : onset of disturbance at age 21 or later.

APPENDIX 2

I.C.D.-10 CRITERIA FOR DYSTHYMIA  
World Health Organization, 1990

F34 PERSISTENT MOOD (AFFECTIVE DISORDERS)

These are persistent and usually fluctuating disorders of mood in which individual episodes are rarely if ever sufficiently severe to warrant being described as hypomanic or even mild depressive episodes. Because they last for years on end, and sometimes for the greater part of the subject's adult life, they involve considerable subjective distress and disability. In some instances, however, recurrent or single episodes of manic disorder, or mild or severe depressive disorder, may become superimposed on a persistent affective disorder. The persistent affective disorders are classified here rather than with the personality disorders because of evidence from family studies that they are genetically related to the mood disorders, and because they are sometimes amenable to the same treatments as mood disorders. Both early and late onset varieties of cyclothymia and dysthymia have been described, and should be specified as such if required.

F34.0 Cyclothymia

F34.1 Dysthymia

A chronic depression of mood which does not fulfill the description and guidelines of recurrent depressive disorder, mild or moderate severity (F33.0 or F33.1), in terms of either severity, or of duration of individual episodes (although the description and guidelines for mild depressive episode may have been fulfilled in the past, particularly at the onset of the disorder). The balance between individual phases of mild depression and intervening periods of comparative normality is very variable. Subjects usually have periods of days or weeks at a time when they describe themselves as well, but most of the time (often for months on end) they feel tired and depressed; everything is an effort and nothing is enjoyed. They brood and complain, sleep badly and feel inadequate, but are usually able to cope with the basic demands of everyday life. Dysthymia therefore has much in common with the concepts of depressive neurosis and neurotic depression. If required, specify whether onset is early (in late teenage or the twenties) or late.



Diagnostic Guidelines

The essential feature is a very longstanding suppression of mood which is never, or only very rarely, severe enough to fulfill the descriptions and guidelines for recurrent depressive disorder, mild or moderate severity (F33.0 or F33.1). It usually begins early in adult life and lasts at least for several years, sometimes indefinitely. When the onset occurs later in life it is often the aftermath of a discrete depressive episode (F32) and associated with bereavement or other obvious stress.

Includes: anxiety depression (persistent); depressive neurosis; depressive personality (disorder); neurotic depression (with more than two years duration).

Excludes: anxiety depression, not persistent (F41.2); bereavement reaction, lasting less than two years (F43.21, prolonged depressive reaction); residual schizophrenia (F20.5).

F34.8 Other persistent mood (affective) disorders

A residual category for persistent affective disorders which are not sufficiently severe or long lasting to meet criteria for cyclothymia (F34.0) or dysthymia (F34.1) but which nevertheless are clinically significant. Some types of depression previously called 'neurotic' are included here, provided they do not meet the criteria for either cyclothymia (F34.0) or dysthymia (F34.1) or for depressive episode of mild (F32.0) or moderate (F32.1) severity.

F34.9 Persistent mood (affective) disorder, unspecified

APPENDIX 3

MAJOR CLINICAL ATTRIBUTES FOR PERSONALITY PATTERNS  
ACCORDING TO MILLON  
Millon, 1987, pp. 21 - 27

1 - SCHIZOID PERSONALITY

Functional Processes

- a) Behaviourally Lethargic
- b) Interpersonally Aloof
- c) Cognitively Impoverished
- d) Intellectualization Mechanism

Structural Attributes

- e) Flat Mood
- f) Complacent Self-Image
- g) Meager Internalizations
- h) Undifferentiated Intrapsychic Organization

2 - AVOIDANT PERSONALITY

Functional Processes

- a) Behaviourally Guarded
- b) Interpersonally Aversive
- c) Cognitively Distracted
- d) Fantasy Mechanism

Structural Attributes

- e) Anguished Mood
- f) Alienated Self-Image
- g) Vexatious Internalizations
- h) Fragile Intrapsychic Organization

3 - DEPENDENT PERSONALITY

Functional Processes

- a) Behaviourally Incompetent
- b) Interpersonally Submissive
- c) Cognitively Naive
- d) Introjection Mechanism

Structural Attributes

- e) Pacific Mood
- f) Inept Self-Image
- g) Immature Internalizations
- h) Inchoate Intrapsychic Organization

4 - HISTRIONIC PERSONALITY

Functional Processes

- a) Behaviourally Affected
- b) Interpersonally Flirtatious
- c) Cognitively Flighty
- d) Dissociation Mechanism

Structural Attributes

- e) Fickle Mood
- f) Sociable Self-Image
- g) Shallow Internalizations
- h) Disjointed Intrapsychic Organization

5 - NARCISSISTIC PERSONALITY

Functional Processes

- a) Behaviourally Arrogant
- b) Interpersonally Exploitive
- c) Cognitively Expansive
- d) Rationalization Mechanism

Structural Attributes

- e) Insouciant Mood
- f) Admirable Self-Image
- g) Contrived Internalizations
- h) Spurious Intrapsychic Organization

6A - ANTISOCIAL PERSONALITY

Functional Processes

- a) Behaviourally Impulsive
- b) Interpersonally Irresponsible
- c) Cognitively Deviant
- d) Acting-Out Mechanism

Structural Attributes

- e) Callous Mood
- f) Autonomous Self-Image
- g) Rebellious Internalizations
- h) Unbounded Intrapsychic Organization

6B - AGGRESSIVE/SADISTIC PERSONALITY

Functional Processes

- a) Behaviourally Fearless
- b) Interpersonally Intimidating
- c) Cognitively Dogmatic
- d) Isolation Mechanism

Structural Attributes

- e) Hostile Mood
- f) Competitive Self-Image
- g) Pernicious Internalization
- h) Eruptive Intrapsychic Organization

7 - COMPULSIVE PERSONALITY

Functional Processes

- a) Behaviourally Disciplined
- b) Interpersonally Respectful
- c) Cognitively Constricted
- d) Reaction Formation Mechanism

Structural Attributes

- e) Solemn Mood
- f) Conscientious Self-Image
- g) Concealed Internalizations
- h) Compartmentalized Intrapsychic Organization

8A - PASSIVE-AGGRESSIVE PERSONALITY

Functional Processes

- a) Behaviourally Stubborn
- b) Interpersonally Contrary
- c) Cognitively Negativistic
- d) Displacement Mechanism

Structural Attributes

- e) Irritable Mood
- f) Discontented Self-Image
- g) Oppositional Internalizations
- h) Divergent Intrapsychic Organization

SB - SELF-DEFEATING (MASOCHISTIC) PERSONALITY

Functional Processes

- a) Behaviourally Abstinent
- b) Interpersonally Deferential
- c) Cognitively Inconsistent
- d) Devaluation Mechanism

Structural Attributes

- e) Doleful Mood
- f) Undeserving Self-Image
- g) Debased Internalizations
- h) Inverted Intrapsychic Organization

S - SCHIZOTYPAL PERSONALITY

Functional Processes

- a) Behaviourally Aberrant
- b) Interpersonally Secretive
- c) Cognitively Autistic
- d) Undoing Mechanism

Structural Attributes

- e) Distraught or Insentient Mood
- f) Estranged Self-Image
- g) Chaotic Internalizations
- h) Fragmented Intrapsychic Organization

C - BORDERLINE PERSONALITY

Functional Processes

- a) Behaviourally Precipitate
- b) Interpersonally Paradoxical
- c) Cognitively Capricious
- d) Regression Mechanism

Structural Attributes

- e) Labile Mood
- f) Uncertain Self-Image
- g) Incompatible Internalizations
- h) Diffused Intrapsychic Organization

P - PARANOID PERSONALITY

Functional Processes

- a) Behaviourally Defensive
- b) Interpersonally Provocative
- c) Cognitively Suspicious
- d) Projection Mechanism

Structural Attributes

- e) Irrascible Mood
- f) Inviolable Self-Image
- g) Unalterable Internalizations
- h) Inelastic Intrapsychic Organizations

APPENDIX 4

BIOGRAPHICAL QUESTIONNAIRE  
PERSONALITY PROFILES AND DYSTHYMIA

Name : \_\_\_\_\_ Trial \ Control

Hosp \ OPD Number : \_\_\_\_\_ Sex : M \ F

Date of Birth : \_\_\_\_\_ Age : \_\_\_\_\_

Address : \_\_\_\_\_

Tel Number : (H) \_\_\_\_\_ (W) \_\_\_\_\_

Diagnosis : I \_\_\_\_\_  
DSM III R

II \_\_\_\_\_

III \_\_\_\_\_

IV \_\_\_\_\_

V \_\_\_\_\_

Date onset of first symptoms : \_\_\_\_\_

Date dysthymia first diagnosed : \_\_\_\_\_

Euthymic : Yes \ No

Highest educational level : \_\_\_\_\_

Occupation : \_\_\_\_\_

Current Medication : \_\_\_\_\_

Previous Medication : \_\_\_\_\_

Previous hospitalization : Yes \ No

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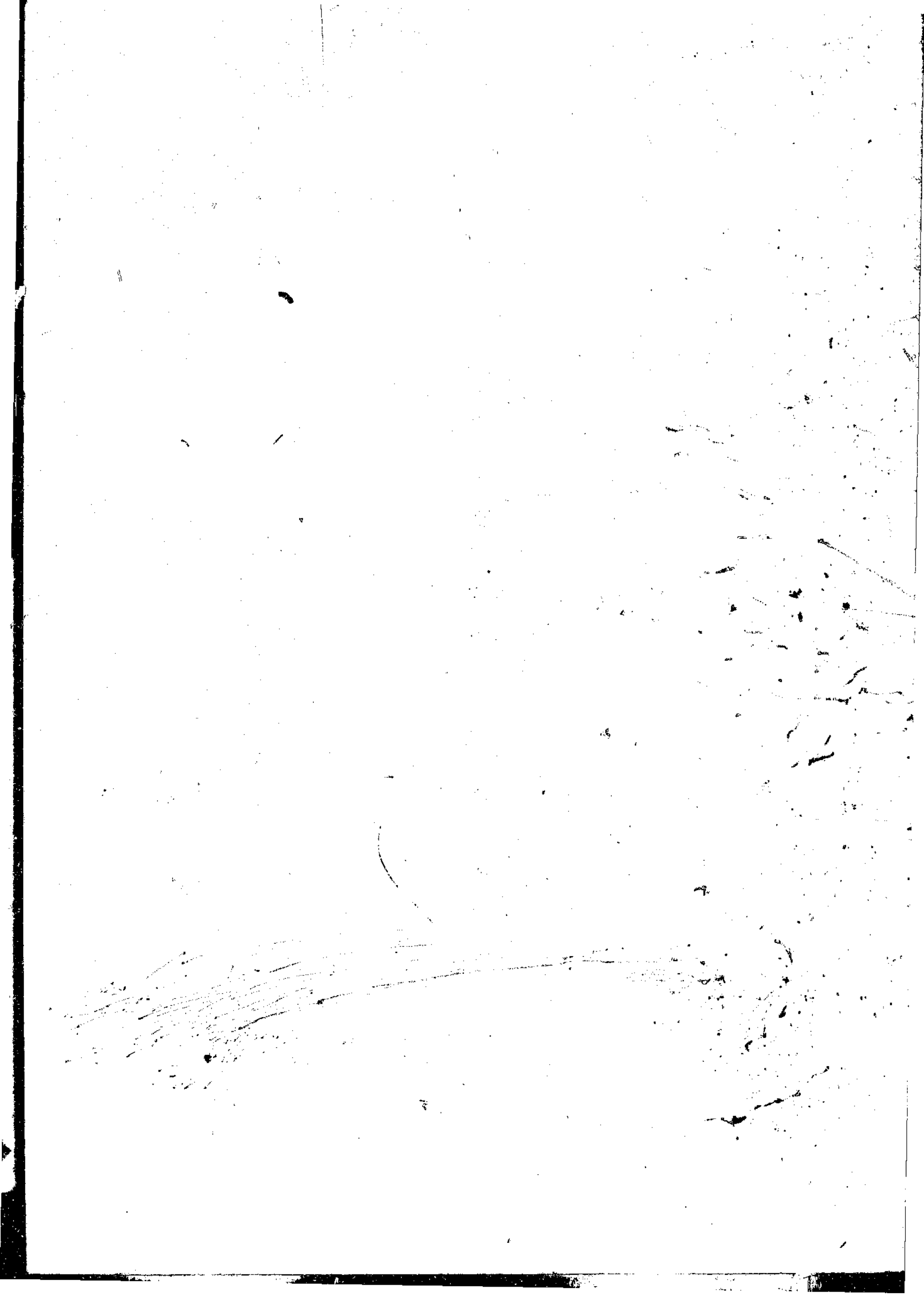
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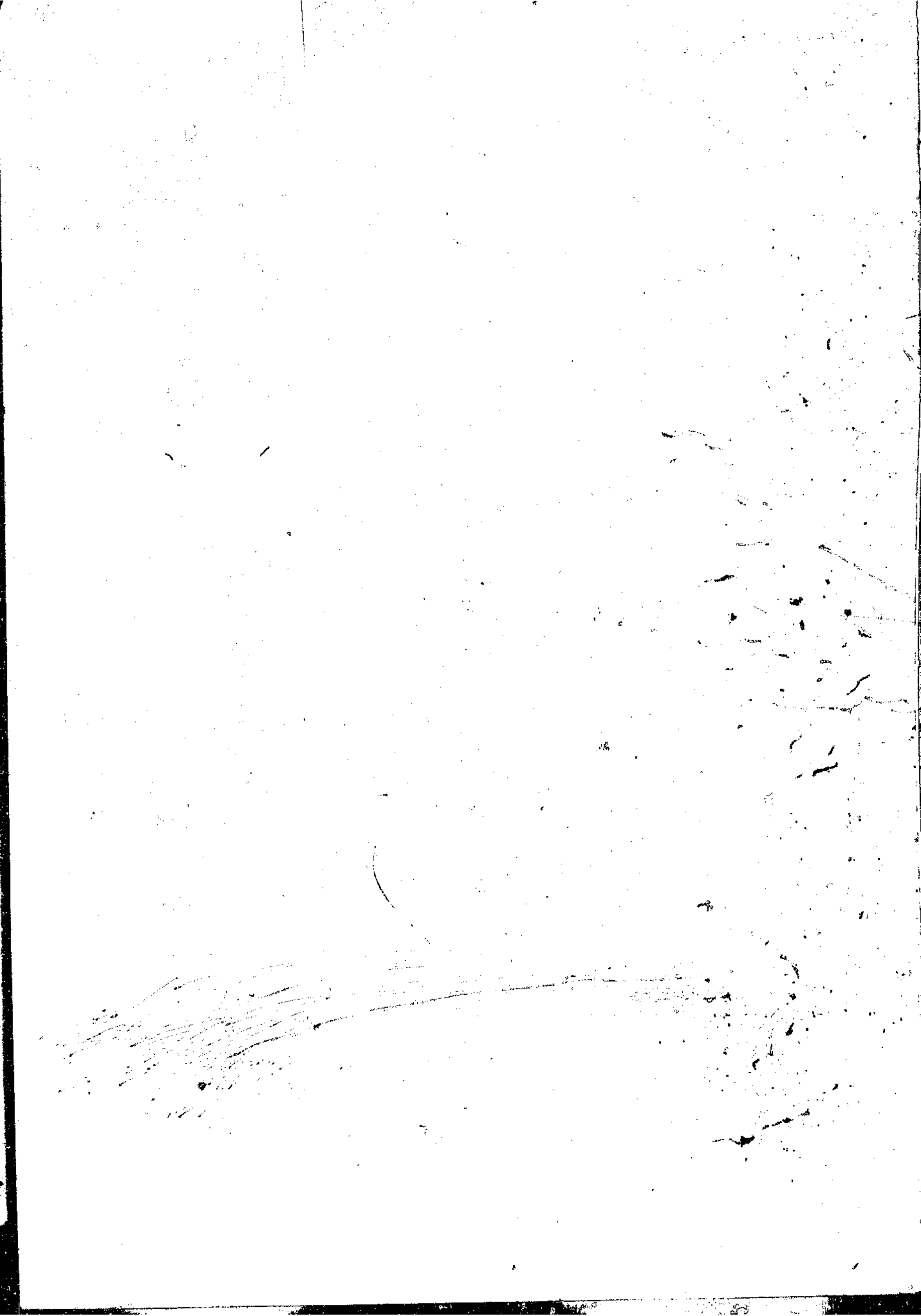
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