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THE RELATIONSHIP BETWEEN PERSONALITY / TEMPERAMENT AND ILLNESS

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ABSTRACT:

Background: Temperament refers to trait expressions, resulting from a genetic-constitutional background that sustain energy levels and mood state and represent a main variable accounting for the reactivity in facing an external trigger.

The different models of the relationships and interactions between personality/temperament and illness in affective disorders are discussed. The role of affective temperaments in psycho(pato)logy is double, both representing the earliest subclinical phenotypes in continuum with and preliminary for developing mood disorders, and a fundamental state for the expression of personality.

Keywords: temperaments, personality, affective fundamental states, mood disorders

REZUMAT:

Context: Temperamentul se referă la expresiile caracteristice care rezultă dintr-un fond genetic-constituțional și care susțin nivelul de energie și starea de spirit și reprezintă principala variabilă ce modulează reactivitatea în fața unui trigger.

Diferitele modele ale relațiilor și interacțiunilor dintre personalitate/temperament și tulburările afective sunt discutate. Rolul temperamentelor afective în psiho(pato)logie este dublu, reprezentând

atât cele mai vechi fenotipuri subclinice *in continuum* și cu preliminară pentru dezvoltarea tulburărilor afective, cât și o stare fundamentală de exprimare a personalității.

Cuvinte-cheie: *temperamente, personalitate, stări afective fundamentale, tulburări de dispoziție*

INTRODUCTION

The different relationships and interactions between personality / temperament and illness in affective disorders have been classified according to the following models (Klerman, 1973; Akiskal et al., 1983; Ehrt et al., 2003):

1. Personality predisposes a person to develop an affective disorder. Already, Tellenbach had underscored these aspects in depression; Beck has radicalized this position, isolating the cognitive aspects from the mood.

2. Temperament (which has a more constitutional, biological basis than personality) represents the core characteristic of the illness (model of the dilution of full-blown affective disorders). Kretschmer has made clear the Kraepelinian view. Substantially, it is the point of view of Leonhard¹ (1957) and Akiskal (1979).

3. The premorbid personality can modify the clinical presentation of affective disorders, the interpersonal relationship and the compliance to treatment (Klerman, 1973).

4. Depression induces changes in personality: depressive defect (Helmschen, 1974), residual syndromes (Glatzel, 1973; Janzarik, 1968), residual states (Marneros & Deister, 1990)².

Olothymic conception could represent a very simplified conceptualization of the 2nd type; it puts in brackets the temperament; deflection and expansion of mood modify convictions until delusion.

Emphasis of post-depressive remainder (the conceptualization of 4th type) is in opposition to the Kraepelinian paradigm, which was founded on the criterion of the course in order to distinguish maniac-depressive illness from schizophrenia: in the latter, we find the defect, whereas in maniac-depressive illness there are interval phases between the episodes of opposite polarity³.

In this sub-categorization, founded on the interections between temperament and illness, we can introduce also the role carried out by the life events:

- a) An accentuation of traits of personality without an influx of the events according to the concept of development of Karl Jaspers (1959).

- b) Key Experience (or Event), when a precipitating event (Key Experience, in German *Schlüsselerlebnis*), occurred in a specific (like a key in a lock) personality at a particular time of person's life⁴.

- c) The events are not always casual, but they are looked for by the typus: "It is the man who looks for the circumstances that disconcert him" (José Ortega y Gasset, 1930)⁵. These dynamics are illustrated in the constellations of Including and Remaining of the *Typus melancholicus* by Tellenbach, where there is a "sliding" into the illness.

Lara et al. (2006) build a spectrum model that integrates the advantages of Cloninger's and Akiskal's approaches to personality and temperament, underlining their relationship with affective disorders. They specifically propose that "fear" and "anger" traits – used in a broader connotation than in the conventional literature – provide an optimum basis for understanding how the spectra of

¹ Leonhard (1957) proposing the separation into unipolar and bipolar types, considered personality patterns as subclinical, "diluted" forms of manic depressive illness.

² Marneros and Rohde (1997) found persistent alterations (defined as the persistence of deficits, impairments and alterations in the domains of psychopathology, and psychological and social functions for more than 3 years) in 35,8 % in affective disorders.

³ Kraepelin (1913) described cases of chronic depressions. The continuity and the chronicity seem important features in mood disorders

⁴ Kretschmer (1918) describes this mechanism in *Der sensitive Beziehungswahn*, a type of paranoia, developed in sensitive personalities with a good prognosis.

⁵ This appears particularly evident in the patterns of Cloninger with risk seeking and novelty seeking.

Anxiety, Depressive, Bipolar, Attention Deficit/Hyperactivity, Alcohol, Substance Use and the Impulse-Control, as well as Cluster B and C Personality Disorders arise and relate to one another⁶.

SOME CONCLUSIONS

It seemed useful to us claiming the colleagues to the reflections of our predecessors on a theme so full of echoes.

Today, the dimensional approach, the sub-threshold and the *spectra* run the risk of overlooking classic conceptions of temperaments, which have been confirmed during centuries and have had numerous applications in clinical practice⁷.

Since the classic Greece, it has been understood the biological humoral aetiology of temperament and the relation with the melancholy and the mania.

The historical excursus shows that there is not only a continuity in the use of the terms, but also continuous references – as to the temperaments and the melancholy – to the classic conceptions of Greek and Latin medicine. There is a long duration through the centuries. When today we talk about temperaments, melancholy and mania, echoes still remain of the supernatural interpretations, of the theological conceptions of the capital vices, of the influence of alchemy and of esotericism.

The knowledge of the variegated heritage of classical tradition, rich of suggestions, which have enriched the theories of temperaments, can help our understanding of the successes, but also of the cultural obstacles⁸, after when the temperament has strongly reappeared on the scene of contemporary psychiatry.

Instead, it's lost the concept of an ordering entity, *temperantia* (temperance), in a pedagogical perspective, in the reflection that goes from Aristotle to Saint Thomas, with also a role of discipline and modulation, not only of temperament inhibition.

The reading of the classical texts, full of esoteric references, of theories that sometimes are more kindred to philosophy than clinic, of mechanistic simplifications, can help to understand the bases of conception that are still now deep-rooted in the popular culture (suffice it to think at the spread of the popular astrologic credence and of the relating belief about the influence of the stars on inner experience and behaviour) and that are looked over with irony and scepticism in the scientific contexts.

The conceptions that have been detached from the tradition, as the distinction between monopolar and bipolar (Leonhard, 1957; Angst, 1966; Perris, 1966) show now evident limits. As wrote Hoffman, summoning Aretheus, instability is innate in excitement and depression.

Aretheus (Lib. 3, cap. 5) wrote that melancholy makes up for the beginning and the origin of mania, and by increasing more than by any other cause, the latter is drawn to fury. This connection is confirmed by a daily and very careful observation, when the melancholic ones, above all when the illness is deep seated very easily incur in mania, and when this is ceased, melancholy appears again.

⁶ By erecting a bidimensional approach, Lara et al. (2006) attempt to resolve the paradox that apparently polar conditions (e.g. depression and mania) can coexist without cancelling one another. The combination of excessive or deficient fear and anger traits produces 4 main quadrants corresponding to the main temperament types of hyperthymic, depressive, cyclothymic and labile individuals, which roughly correspond to bipolar I, unipolar depression, bipolar II and ADHD, respectively. Other affective temperaments resulting from excess or deficiency of only fear or anger include irritable, anxious, apathetic and hyperactive. This model does not consider schizophrenia. "Healthy" or euthymic individuals may have average or moderate fear and anger traits. Family history, course and comorbidity patterns can also be understood based on fear and anger traits.

⁷ According to Janowsky (1998), studies on the spectra can improved if they'll comprise personality assessment, meaning with this not as much as "Personality Disorders" rather "base personalities": in this way, the Author approaches himself to the Affective Temperament.

⁸ Here we can catch several differences between European and American point of view. Probably, German culture of constitutions pay off discussed outcomes in which psychiatry has been committed with an eugenetical drift. The American dream of the self made man, craftsman of his own fortune, feels itself too much constraint into the conception of a "temperamental", biological limit.

In the same way, Alexander of Tralles connected mania to melancholy, interpreting it as an accentuation of the disorder, as an advanced stage of melancholy. Manic depressive illness is a cyclic illness: it is not only the course, probably it is the main characteristic.

Our tracking shot of interpretative patterns, of figures, show the complexity of the models until the current ones, which more and more advance toward a spectrum, a continuum where all the components are important and present with quantitative and role-related differences according to a temporal function.

The different interpretative models have an impact on the therapeutic choices. It is evident that the emphasis on the responsibility to change (i.e. to the abandonment of “cognitive schemes”) above all in a melancholic phase is seen with worry as a premise to the accentuation of topics of guilt.

The history of melancholy can be useful also for the clinician as can help us in reflecting about philosophical arguments, as the limits of the freedom of choice that remain when mood may causality explain attitudes and behaviours of the sick man.

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The authors declare that they have no potential conflicts of interest to disclose.

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