

AFFECTIVE TEMPERAMENTS TODAY (II)

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Abstract:

Starting from Kraepelin's concept of "fundamental states", but employing the classical term of temperament, the authors focus on "affective temperament" as a specific constitutional disposition, a dimensional construct; only the extremes can be considered abnormal in statistical and perhaps in a clinical sense; he proposed some criteria for a better and shared definition of the affective temperaments in accord with Akiskal views. In modern classifications the term "Major Depression" replaced the terms of melancholia and endogenous (the reference to the endogenous has been abandoned because its theoretical implications). Melancholia has been considered "a term of the past", used, in this manual, to indicate a typically severe form of depression that is particularly responsive to somatic therapy; the criteria of DSM are conceived in order to define a sub-classification (Major Depressive Episode with Melancholia). According the authors, the temperament still has an important role in determining the clinical picture of the affective episodes and the longitudinal course of the illness.

Key Words: temperament, historical perspective, contemporary psychiatry

Introduction

In DSM III (APA, 1980), the term Major Depression replaced the terms of melancholia and endogenous. The reference to the endogenous has been abandoned because its theoretical implications.

Melancholia has been considered, in DSM-III, "a term of the past", used, in this manual, to indicate a typically severe form of depression that is particularly responsive to somatic therapy (Nelson et Al., 1981).

The criteria of DSM-III are conceived in order to define a sub-classification (Major Depressive Episode with Melancholia).

In the DSM-III, have been added three anamnestic criteria (lack of personality disorders, previous remission of major depressive episodes, and favourable response to antidepressants).

In DSM-IV (1994), the specifier "With Melancholic Features" can be applied to the diagnosis of a Major Depressive Episode in Major Depressive Disorder and in Bipolar I or II Disorder (only if it is the most recent type of mood episodes). It has been reintroduced the "distinct quality of depressed mood" and excessive or inappropriate guilt, while it has been excluded the natural course and the response to antidepressant medication, criteria already included in the definition itself.

Mania seems to maintain a greater terminological stability where the adjective "maniacal" goes to identify, in the DSM-IV, the episode with the typical characteristics of the phase of excitement. It is likely that to a higher terminological stability will correspond precise and constant phenomenal and phenomenology of mania symptoms, while, in the event of depression, we assist both

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to a elevated variety of syndromes aggregations and to a more significant clinical evolution and transfiguration happening in the course of time: much more infrequent is the observation of the catatonic and nihilistic types and much more frequent are the masked types or the atypical characteristics one.

In a historical excursus from antique books to modern classifications, what it emerges is for sure the strait relationship between depression (melanconia) and mania: as classic Authors report to frequent passage from one to the other types of disease, today's conception of mania is not thinkable as something separated from the one of depression; similarly, depression is viewed more and more as a manifestation of the bipolar spectrum, yet position of dichotomic type prevailed (unipolar-bipolar) (Cassano, 2002).

According to Cassano et al. (1999), there are several reasons for the lower rate of recognition of subthreshold manic symptoms, when compared to the analogous pure depressive ones. This contributes to the frequent under-diagnosis of bipolar disorder. Attention should also be devoted to mild symptomatic manifestations of a manic diathesis. These symptoms are not referred as such manifestations may sometimes enhance the quality of life. The term *spectrum* is used to refer to the broad range of such manifestations of a disorder from core symptoms to temperamental traits.

Spectrum manifestations may be present during, between, or even in the absence of, an episode of full-blown.

Figueira (2002) has pointed that accepting the model of spectrum in affective disorders could modify our clinic attitude. There is the need to a systematic reevaluation of the changes of the clinical syndrome. Clinical evidences impose a cautious clinical judgement.

Temperament took a large part in the classic conceptions and in the ethiopatogenetic theories from authors such as Ippocrate to our days, but it seems now to dissolve itself and to lose connotation within the present classification systems, phagocytized by the great nosography groups of Axis I and II. In the recent versions of the DSM, there are no traces of "irritable temperament" as well as does not appear the "hyperthymic temperament": even hypomania, showing among its symptoms various characteristics which evoke an excessive of a few aspects of the hyperthymia, is delineated like an attenuated type of mania, a phase of mood alteration well distinguished from the typical *modus vivendi* of the individual, an episode of illness that stands out from the usual way of being of that patient.

The Cyclothymic Temperament can be partly assimilated to the present "Cyclothymic Disorder", the last one consisting of a chronicle mood fluctuation including numerous periods with hypomanic symptoms and numerous periods with depressive symptoms. Typically, onset of the disorder is during the adolescence or in the first adult age and it is also absorbed to a temperamental type model, determining itself as a clinical representation fading its origins in the personality and in the characteristic nature of the individual. This temperament can also be observed between the lines of some Personality Disorders, characterized by an extreme mood fluctuation, such as the Borderline Disorders, in which, however, it is possible to find a variety of other psychopathological dimensions that render Cyclothymia only one of the several aspects delineating such a disturbance.

Depressive temperament is less traceable, except for the "Dysthymic Disorder with premature onset", where a chronically depressed mood is present, as well as reduced energy or fatigue, low self-esteem and facility to self-criticism: however, DSM views it as "unipolar mood disorder", a clinical entity well distinguished from what is considered the personological attitude of the individual.

There is also a syndromic group that DSM-IV defines "Depressive Personality Disorder", characterized by depressive and pervasive beliefs and behaviours; the onset is during the first adult age and it manifests itself with a propensity to being serious and gloomy, feeling of restlessness, lack of joy, a negative way to look at the future, pessimism, lack of self-esteem and a tendency to feel guilty. Perhaps, among all those in the handbook, "Depressive Personality Disorder" is the one that better seems to recall the characteristics of the Depressive Temperament, even if it concerns a diagnostic entity numbered among new proposed categories, not sufficiently verified and validated yet.

As a result, we have pointed out to the loss of one integral and unitary classification of the Affective Temperaments as classically understood in the contemporary psychiatry; however, from another point of view, we would emphasize that the validity of meanings, that are at the bottom of the definitions of temperaments is not lost, but is quite variously identified, classified and defined in

their nuclear elements, meaning that the classic conceptions are neither faded nor exceeded, but re-elaborated and re-shaped like malleable, plastic material always well amalgamated, variously mouldable by different authors and different cultural and epistemological influences.

A return to Kraepelin Schema

Akiskal takes from Kraepelin the concept of “fundamental states”, but employing the classical term of temperament. The affective temperament is a specific constitutional disposition, a dimensional construct; only the extremes can be considered abnormal in statistical and, perhaps, in a clinical sense; he proposed some criteria for a better and shared definition of the affective temperaments (Akiskal et Al. 1979). We cite the criteria for the definition of the cyclothymic temperament as an example (table 9-1).

Table 1. Criteria for the definition of the Cyclothymic Temperament

The Cyclothymic Temperament
Biphasic mood swings-abrupt from one phase to the other, each phase lasting for a few days at a time with infrequent interphase euthymia.
At least four of the following features constitute the habitual long-term baseline of the subject: 1. Lethargy alternating with eutonia 2. Shaky self esteem alternating between low self-confidence and overconfidence 3. Decreased verbal output alternating with talkiveness 4. Mental confusion alternating with sharpened and creative thinking 5. Unexplained tearfulness alternating with excessive punning and jocularity 6. Introverted self-adsorption alternating with uninhibited people-seeking.

According to Akiskal the temperament has an important role in determining the clinical picture of the affective episodes and the longitudinal course of the illness. Unlike Kraepelin, he attributes to temperamental dispositions an important role in the pathogenesis of mixed states (Akiskal et al. 1998) (Table 9-2).

Table 2. The mixed states according to Kraepelin and Akiskal

The mixed states	
Kraepelin (1904)	Akiskal (1998)
Unsynchronized transition between the two phases; the patient is “trapped in the switch process”.	Intrusion of an affective episode into an opposite affective temperament or one with a high degree of chronic instability, such as in the cyclothymic temperament.

To acknowledge temperamental dispositions could be very important also in order to make the patients with such features more accessible to the effective therapies in the connected treatment.

Temperamental dimensions include relatively stable aspects of individual differences, thought constitutionally based (Buss, 1991). Personality: as temperament upon which are overlaid cognitive structures, motivational and behavioural patterns, that incorporate these basic styles or inclinations in a more or less well socialized manner, and emotional expression (Buss and Plomin, 1975).

From a biological point of view, the proposal of Robert Cloninger obtained a great success: he tried to correlate character with specific neurotransmitters and elaborated an instrument called “The Temperament and Character Inventory (TCI)” for the assessment of the personality dimensions linked to the different biological pathway (table 9-3, figure 9-1) (Cloninger et Al., 1993; 1994).

Table 3. The dimensions of temperament and character according to Cloninger

Temperamental traits	Biological correlation
Harm avoidance (HA)	Serotonergic system
Novelty seeking (NS)	Dopaminergic system
Reward dependence (RD)	Noradrenergic system
Persistence (P)	
Characterial traits	
Self-directedness (SD)	
Cooperativeness (C)	
Self-transcendence (ST)	

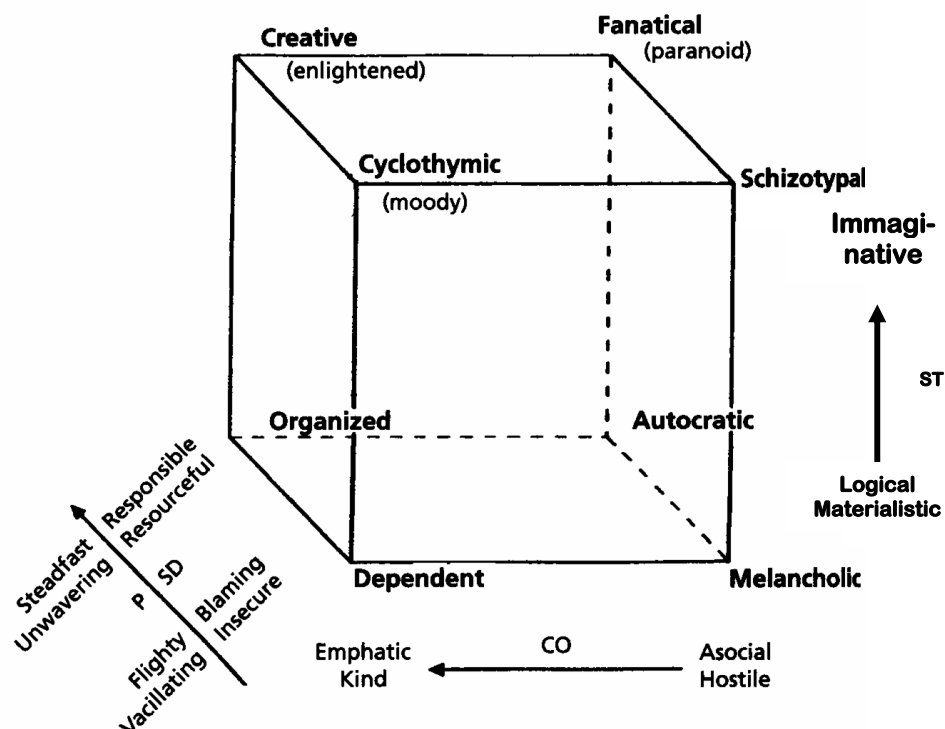


Fig. 1. The character cube: eight possible configurations of high or low scores on three TCI character dimensions (from Cloninger, 1999, modified)

Recent theories (e. g. those of Cloninger or Akiskal) combine different aspects. After reviewing the historical temperament concepts we present underlying factors which are linked to affective disorders (such as emotional reactivity, cyclicity or trait affectivity). Ehrt et al. (2003) illustrate the importance of temperament concepts for research in affective disorders.

The relationship between personality / temperament and illness

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 Leonhard⁵ (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)⁶.

Olothymic conception could represent a very simplified conceptualization of 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 polarity⁷.

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 *Schlüsserlebnis*), occurred in a specific (like a key in a lock) personality at a particular time of person's life⁸.

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)⁹. 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.

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⁵ Leonhard (1957) proposing the separation into unipolar and bipolar types, considered personality patterns as subclinical, "diluted" forms of manic depressive 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 Anxiety, Depressive, Bipolar, Attention Deficit / Hyperactivity, Alcohol, Substance Use and their Impulse-Control, as well as Cluster B and C Personality Disorders.

⁶ 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.

⁷ Kraepelin (1913) described cases of chronic depressions. The continuity and the chronicity seem important features in mood disorders.

⁸ Kretschmer (1918) describes this mechanism in *Der sensitive Beziehungswahn*, a type of paranoia, developed in sensitive personalities with a good prognosis.

⁹ This appears particularly evident in the patterns of Cloninger with risk seeking and novelty seeking.

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