

## Parental representations, object relations and their relationship to Depressive Personality Disorder and Dysthymia

Steven K. Huprich <sup>a,\*</sup>, John H. Porcerelli <sup>b</sup>, Juliann Binienda <sup>b</sup>,  
Dunia Karana <sup>c</sup>, Ray Kamoo <sup>d</sup>

<sup>a</sup> *Department of Psychology, Eastern Michigan University, 501 Mark Jefferson Building, Ypsilanti, MI 48197, United States*

<sup>b</sup> *Wayne State University, School of Medicine, United States*

<sup>c</sup> *University of Detroit Mercy, United States*

<sup>d</sup> *Private Practice, Birmingham, MI, United States*

Received 6 February 2007; received in revised form 18 June 2007; accepted 28 June 2007

Available online 13 August 2007

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### Abstract

The purpose of this study was to investigate the extent to which DPD is associated with poorer quality of parental representations and object relations in patients meeting criteria for either Depressive Personality Disorder (DPD) or Dysthymia. One-hundred ten, primary care, African–American women completed measures of DPD, Dysthymia, parental descriptions of their mother and father (Blatt, Chevron, Quinlan, Schaffer, & Wein, 1992), and provided stories to two pictures that were scored with the Social Cognition and Object Relations Scale (Westen, 1993, 1995). Results indicated that Dysthymia could be predicted by all object relations dimensions except Aggression. DPD was uniquely associated with problems of managing aggression, maternal punitiveness, and low paternal benevolence. Ongoing investigation into the biogenetic underpinnings of these disorders appears warranted, as is examination of the differences between them.

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\* Corresponding author. Tel.: +1 734 487 2037; fax: +1 734 487 6553.  
E-mail address: [shuprich@emich.edu](mailto:shuprich@emich.edu) (S.K. Huprich).

*Keywords:* Depressive Personality; Dysthymia; SCORS; Object relations; Parental representations

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## 1. Introduction

As the empirical study of psychopathology develops, increasing attention has been devoted to delineating ways in which disorders that are similar may share common, biological or temperamental underpinnings (Clark, 2005; Kreuger, 2005). For instance, it is commonly thought that schizophrenia, schizoaffective disorder, and schizotypal personality disorder are part of a “schizophrenia spectrum” of mental illness (Torgersen et al., 2002; Venables, 1995; Waldeck & Miller, 2000). This spectrum, or dimensional, approach to psychopathology also has been directed to the study of affective illness (Akiskal & Cassano, 1997; Kocsis & Klein, 1995; Ryder, Bagby, & Schuller, 2002). This particularly is important to the proposed diagnostic category of Depressive Personality Disorder (DPD) that was described in DSM-IV (American Psychiatric Association [APA], 1994) and its revision (APA, 2001), as it has been empirically demonstrated that there is a high degree of co-occurrence of mood disorders in first degree relatives of patients with either disorder, as well as diagnostic overlap averaging approximately 50% (Bagby & Ryder, 1999; Huprich, 2001a, 2004; Klein, 1999; Klein & Shih, 1998).

While efforts to identify common underpinnings to similar disorders have potential to improve the diagnostic discriminability and differentiation of psychological disorders, such as DPD and Dysthymia, only a few studies have demonstrated that there are clinically notable differences between individuals with DPD and Dysthymia. McDermut, Zimmerman, and Chelminski (2003) found that those diagnosed with Dysthymia, individuals with DPD were more likely to have a current diagnosis of major depression and higher lifetime rates of social phobia, a specific phobia, obsessive-compulsive disorder, and generalized anxiety disorder than Dysthymics. They also were twice as likely to be diagnosed with another Axis II disorder, were more suicidal at the time of their assessment, and more likely to have had a previous suicide attempt.

Huprich (2000) found that those classified as DPD had significantly higher scores on the NEO-PI-R's (Costa & McCrae, 1992) Self-Conscious, Angry Hostility, and Depression facets than Dysthymics. The DPD group had significantly lower scores on the Extraversion, Openness, and Agreeableness factors, and the Gregariousness and Positive Emotions facets, suggesting a greater degree of interpersonal withdrawal and discomfort than those who were Dysthymic.

Huprich, Porcerelli, Keaschuk, Binienda, and Engle (in press) reported that DPD, Dysthymia, and depressive symptoms were positively correlated with three dimensions of perfectionism – Concern over Mistakes, Doubts about Actions, and Parental Criticism. Variance in measures of DPD was predicted by the Concern over Mistakes and Doubts about Actions subscales of the Frost Multidimensional Scale (Frost, Martin, Lahart, & Rosenblate, 1990) after controlling for depression and Dysthymia symptoms. This relationship with perfectionism did not occur when Dysthymia or depressive symptoms were predicted.

Besides dimensional approaches to assessing personality disorders, Shedler and Westen (2004) suggested that understanding the psychological processes within patients' internal psychic life bears light on how personality disorders diagnoses are assessed and understood. For instance,

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