

Question

Cite this article: Hickie IB and Chanen A. How are the relationships between childhood temperament, personality development and interpersonal function, and risk to depressive and other mood disorders, best conceptualised? What are the implications for preventive or treatment research? *Research Directions: Depression*. 1, e13, 1–2. <https://doi.org/10.1017/dep.2023.13>

Received: 3 October 2023

Accepted: 3 October 2023

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How are the relationships between childhood temperament, personality development and interpersonal function, and risk to depressive and other mood disorders, best conceptualised? What are the implications for preventive or treatment research?

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Context

One of the long-standing challenges in the field of depressive and other mood disorders is to have a clear conceptualisation of the relationships between childhood temperaments, personality development and adult self and interpersonal function, and depressive and other mood disorders. Some biologically-based dispositional (or temperamental) traits are present from birth and are relatively stable from infancy through to adulthood. These characteristics (e.g., anxious attachment or social inhibition) are commonly seen as ‘at-risk’ traits for later formal diagnoses of anxiety disorders in pre-pubertal children and anxiety and depression in teenagers (Compas et al., 2004; Rothbart, 2007).

These dispositional traits link individual differences in behaviour to developing neurobiological characteristics (Rothbart, 2007; Shiner, 2015) such as arousal or fear sensitivity and might be seen to be caused by a variety of genetic and/or environmental factors that influence the development of key response systems (e.g., hypothalamic–pituitary–adrenal axis, sympathetic nervous system response and immune response), along with their linked behavioural repertoires (fight or flight, flop, retreat and avoid).

Through reciprocal interactive processes in relation to environmental experience, these temperamental traits become known as personality traits (Rothbart, 2007; Shiner, 2015). Certain personality traits have been proposed as ‘at risk’ traits for depression and other mood disorders. Most prominently, ‘neuroticism’, the trait disposition to experience negative affects (anger, anxiety, self-consciousness, irritability, emotional instability, depression) predisposes individuals to respond adversely to environmental (especially interpersonal) stress, such as interpreting ordinary situations as threatening, or experiencing small frustrations to be overwhelming (Boyce et al., 1992; Widiger and Oltmanns, 2017).

When personality traits are associated with other emotional characteristics, such as mood instability and other more enduring patterns of behaviour within interpersonal relationships (i.e., rejection sensitivity), they are also likely to attract a variety of different depressive or mood disorder diagnoses (e.g., dysthymia and bipolar spectrum) or personality disorder diagnoses (e.g., borderline personality disorder). These determinations often have very significant implications for the types of treatments offered, with those labelled ‘personality-determined’ being more likely to attract psychological therapies, while those labelled ‘depressive or mood disorder-determined’ being more likely to attract medical therapies.

Depressive and other mood disorders have as central characteristics key behavioural changes in the interpersonal domain, such as withdrawal from key social relationships, reduced response to key interpersonal cues, avoidance of interpersonal engagement, changes in perception of the value of key interpersonal contacts, and withdrawal from or loss of pleasure associated with physical or sexual intimacy with key others. Consequently, there is often great controversy as to whether these are actually state-based phenomena (i.e., a direct consequence of the mood disorder) or whether they are reflective of enduring personality characteristics (and hence less likely to be greatly affected by the active treatment of the mood disorder).

Much of this area has been complicated by the erroneous conceptualisation of mood disorders as one axis of primary psychiatric disorders within multiaxial diagnostic systems (such as the DSM systems since 1980), while personality and personality disorders have been conceived to be on an entirely separate axis. Within such classificatory systems, treatment of the primary psychiatric disorders is prioritised, while personality characteristics are often simply

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recorded and the assignment of ‘personality disorder’ diagnoses might lead to neglect of the provision of active mood disorder treatments.

So, there is an urgent need to improve our conceptualisation of trajectories of risk, the role(s) of temperament and personality, their active assessment (using standardised measures) in those who present with depression and other mood disorders, and prevention and intervention research focused on delivering optimal outcomes – particularly in the key interpersonal domain.

How to contribute to this Question

If you believe you can contribute to answering this Question with your research outputs, find out how to submit in the Instructions for authors (<https://www.cambridge.org/core/journals/research-directions-depression/information/author-instructions/preparing-your-materials>). This journal publishes Results, Analyses, Impact papers and additional content such as preprints and ‘grey literature’. Questions will be closed when the editors agree that enough has been published to answer the Question so before submitting, check if this is still an active Question. If it is closed, another relevant Question may be currently open, so do review all the open Questions in your field. For any further queries, check the information pages (<https://www.cambridge.org/core/journals/research-directions-depression/information>) or contact this email (depression@cambridge.org).

Competing interests. IBH is the Co-Director, Health and Policy at the Brain and Mind Centre (BMC) University of Sydney, Australia. The BMC operates an early-intervention youth services at Camperdown under contract to headspace. Professor Hickie has previously led community-based and pharmaceutical industry-supported (Wyeth, Eli Lilly, Servier, Pfizer, AstraZeneca, Janssen Cilag) projects focused on the identification and better management of anxiety and depression. He is the Chief Scientific Advisor to, and a 3.2% equity shareholder in, InnoWell Pty Ltd which aims to transform mental health services through the use of innovative technologies.

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