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Research report

Personality disorders in bipolar and depressive disorders

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Abstract

The association of mood disorders with personality disorders (PDs) is relevant from a clinical, therapeutic and prognostic point of view. To examine this issue, we compared the prevalence of DSM-III-R personality disorders assessed with SCID-II in patients with depressive ($n = 117$) and bipolar ($n = 71$) disorders *both* recovered from a major depressive index episode that needed hospital admission. PDs prevalence and comorbidity with axis I were calculated. Avoidant PD (31.6%) (O.R. = 1.7, C.I. = 1.06–2.9, $P < 0.01$), borderline PD (30.8%) and obsessive–compulsive PD (30.8%) were the most prevalent axis II diagnoses among patients with depressive disorder. In bipolar disorder group, patients showed more frequently obsessive–compulsive PD (32.4%), followed by borderline PD (29.6%) and avoidant PD (19.7%). Avoidant PD showed a trend toward being significantly more prevalent among depressives ($P < 0.07$). A different pattern of PDs emerges between depressive and bipolar patients. © 2001 Elsevier Science B.V. All rights reserved.

Keywords: Mood disorders; Personality disorders; SCID-II; Comorbidity

1. Introduction

The bipolar–unipolar distinction, providing a basis for evaluating genetic, pharmacological, clinical and biological differences between bipolar and unipolar

illness, has represented a major advance in the understanding of affective disorders. However, ambiguity concerning some aspects of them still exists (Goodwin and Jamison, 1990).

Several studies addressed the issue of the differences between bipolar and unipolar disorders either from a clinical (Pfohl et al., 1982; Mitchell et al., 1992; Weissmann et al., 1996) and psychobiological point of view (for a review, see Yatham et al., 1997) leading to contrasting results.

Interestingly, considering the DSM-III (APA,

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1980) formal diagnostic categories for personality disorders (PDs) on a separate diagnostic dimension (axis II), recent research focused on mood disorders comorbidity (Cloninger et al., 1990), ruling out the possibility that personality disorders comorbidity may explain more accurately the heterogeneity of mood disorders and may better predict prognosis and treatment response (Mulder et al., 1994; Corruble et al., 1996).

In order to better investigate the issue of bipolar–unipolar distinction, we assessed the prevalence of each PD among bipolar and depressive disorders by using SCID-II interview and the pattern of their comorbidity with the axis I mood disorders. The study was done in a sample of patients recovered from a major depressive index episode that needed hospital admission.

2. Patients and method

2.1. Patients

The study population comprised 117 depressive and 71 bipolar patients consecutively admitted to a psychiatric research unit, on a voluntary basis, between November 1997 and October 1998, for a major depressive index episode.

Patients with general medical conditions and neurological disorders that could interfere with the assessment were excluded from the study.

Inclusion criteria were the patient's agreement to participate in the study, after the informed consent was obtained; a minimum age of 18 years, according to DSM-III-R criteria not to diagnose PD before that age, and an upper age limit of 65 years to avoid unreliable anamnestic data secondary to memory affects (Loranger et al., 1987; Vaglum et al., 1989).

2.2. Instruments

Axis I diagnoses were established by two senior clinicians (G.B. and L.D.C.) by employing the Structured Clinical Interview for DSM-III-R (SCID-P), Italian version (Spitzer et al., 1993a).

To assess DSM-III-R axis II diagnoses, the Italian version of the Structured Clinical Interview for DSM-III-R personality disorders (SCID-II) (Spitzer

et al., 1993b), a semistructured interview covering the full range of DSM-III-R axis II diagnoses, and SCID-II-PQ were used; SCID-II for DSM-IV is not currently available in the Italian version. The SCID-II-PQ is a 113-item yes/no self-report questionnaire designed to assess for DSM-III-R PDs. Its administered before clinical interview as screening measure, in order to speed personality assessment (Nussbaum and Rogers, 1992). This questionnaire is designed to yield false-positive information, and it requires the SCID-II interview to complete the assessment of personality disorders.

2.3. Design

Since axis I concomitant disorders may influence personality measurement, we decided to limit our sample to patients with recent major depressive episode excluding patients with recent manic or mixed episode. The SCID-II-PQ was given to patients when they were in, at least, moderate remission (i.e., symptom abatement that allows to plan hospital discharge within 1 week) and they showed 17-items Hamilton Rating Scale for Depression (HDRS; Hamilton, 1967) ≤ 10 , and able to fully understand and participate to the interview session according to evaluations by clinicians treating them (Zimmerman, 1994). One to 2 days later the SCID-II interview was performed, to determine Axis II diagnoses. In conformity with the SCID-II instructions, subjects were only asked for the items marked yes on SCID-II-PQ, and they were repeatedly invited to answer according to their most typical personality style, i.e., without taking into account temporary changes occurring in the course of psychiatric illness. Patients were judged to meet specific criteria of the SCID-II if personality dysfunction had been pervasive and persistent for, at least, the last 5 years.

The SCID-II interviewers were two residents in psychiatry (M.G.M. and A.S.) who were trained in the use of this instrument through live and videotaped interviews. After training, the two interviewers demonstrated near perfect diagnostic concordance when simultaneously diagnosing 10 patients interviewed by one of them (κ values were above 0.83). The SCID-II interviewers were blind to axis I diagnoses.

According to DSM-III-R system, multiple axis II

diagnoses were allowed. The categories of self-defeating PD and personality disorders not otherwise specified were not used.

2.4. Statistical analysis

To determine significant comorbidity between axis I and axis II disorders, odds ratios with 95% confidence intervals were calculated. Odds ratios were computed for the odds of each pair of disorders occurring together compared with the odds for the occurrence of each disorder alone. Student's *t*-test was used for dimensional variables. Categorical variables were compared with the χ^2 -test. Statistical analysis was made using the SPSS package (Norusis, 1992).

3. Results

Clinical sample involved 117 patients (33 males and 84 females) with an axis I diagnosis of major depression and 71 patients (38 males and 33 females) with an axis I diagnosis of bipolar disorder. This population were sampled from a group of 250 consecutively admitted patients; among them 62 were unable or refused to participate in the study (mean age 37.5 ± 10.2 ; males 24, females 38). Demographic features of the patients who refused or were unable to participate to the study did not statistically differ from those of patients who agreed to be admitted in the study.

Table 1 summarises demographic and clinical features of the patients for age, educational level, age at first episode, 17-item HRSD scores, and percentage of patients with at least one PD, mean of PDs per patients. No statistically significant differences were found.

There was no difference for sex distribution between groups.

Among patients with depressive disorder the most prevalent axis II diagnoses were avoidant PD (31.6%), borderline PD (30.8%) and obsessive–compulsive PD (30.8%). We also found a significant association ($P < 0.01$) between depressive disorder and avoidant PD (O.R. = 1.7, C.I. = 1.06–2.9). Among bipolar disorder group, patients showed more frequently obsessive–compulsive PD (32.4%), fol-

Table 1
Demographic and clinical characteristics for the recovered bipolar and depressive patients

	Bipolar (<i>n</i> = 71)		Unipolar (<i>n</i> = 117)		<i>P</i>
	Mean	S.D.	Mean	S.D.	
Age (years)	36.1	9.9	38.5	12.1	NS
Years of education	11.1	3.7	11.9	3.2	NS
Age at first episode (years)	24.8	7.9	26.4	10.05	NS
HDRS (17-item)	6.3	3.6	7.6	3.9	NS
% of patients with at least one PD	41.9 ^a		63.2 ^a		NS
Mean of no. of PDs for each patient	2.6	1.9	2.9	1.85	NS

^a The findings are expressed as percentage.

lowed by borderline PD (29.6%) and avoidant PD (19.7%) (Table 2).

Chi-square analyses of PDs frequency between the two groups did not show any statistically significant differences. Avoidant PD showed a trend toward a significantly higher frequency among depressive disorders ($\chi^2 = 3.2$, $P < 0.07$).

No statistically significant gender differences in PD distribution were observed by χ^2 analysis in both groups.

4. Discussion

The present study describes DSM-III-R personality disorders of patients with bipolar and depressive disorder, examining different patterns of comorbidity among them.

We report that there were no differences in PD prevalence for each disorder between the two groups, but a trend toward higher prevalence of avoidant PD among depressive disorders. Furthermore avoidant PD showed a statistically significant association with depressive disorders.

Our results of significant association between avoidant PD and depressive disorders, but not bipolar disorders, agree partially with the study of Battaglia et al. (1996), who reported that high harm avoidance (HA) characterised all cluster C PD and patients with mood disorders. These authors observed avoidant and dependent PDs to have the

Table 2

Odds ratios and 95% confidence intervals for comorbidity of a current depressive episode and axis II personality disorders in patients with depressive and bipolar disorders

Personality disorders	Depressive disorders (pz.117)			Bipolar disorders (pz.71)		
	n (%)	Odds ratio	Confidence interval (95%)	n (%)	Odds ratio	Confidence interval (95%)
Paranoid	20 (17.1)	0.9	0.5–1.7	13 (18.3)	1.1	0.5–2.1
Schizoid	2 (1.7)	0.3	0.06–1.3	4 (5.6)	1.4	0.4–4.4
Schizotypal	5 (4.3)	0.8	0.3–2.3	4 (5.6)	1.2	0.4–3.7
Antisocial	6 (5.1)	0.4	0.2–1	4 (5.6)	0.5	0.2–1.5
Borderline	36 (30.8)	1.2	0.7–1.9	21 (29.6)	1.1	0.6–1.9
Histrionic	11 (9.4)	0.8	0.4–1.7	9 (12.7)	1.2	0.6–2.8
Narcissistic	18 (15.5)	0.9	0.5–1.7	8 (11.3)	0.6	0.3–1.3
Avoidant	37 (31.6)	1.7	1.06–2.9 ^a	14 (19.7)	0.7	0.4–1.4
Dependent	23 (19.6)	1.4	0.8–2.5	10 (14.1)	0.8	0.4–1.7
Obsessive–compulsive	36 (30.8)	1.1	0.7–1.75	23 (32.4)	1.2	0.7–2.05
Passive–aggressive	15 (12.8)	0.8	0.4–1.5	11 (15.5)	1.05	0.5–2.2

^a Confidence interval does not include 1.0: $P < 0.05$.

highest correlation with HA. Unfortunately they did not discriminate between depressives and bipolars. Oldham et al. (1995) in a group of 91 patients with mood disorders, including only 16 bipolar disorder and one cyclothymia, found a statistically significant association with avoidant and dependent PDs. Goodwin and Jamison (1990), reviewing bipolar–unipolar differences in phenomenology of depression, reported unipolar subjects to reveal more introversion which could resemble DSM-III-R avoidant construct. Akiskal et al. (1995), in an 11-year prospective study involving 559 patients with major depressive disorder at their entry into the study, reported that patients with shy-sensitive traits, similar to avoidant personality, had lower switch process. Hecht et al. (1997) reported that ‘typus melancholicus’ predicted a predominant depressive course of an affective disorder. All these studies support the view of personality trait differences between bipolar and non bipolar patients, with more avoidant traits among the latter group.

Our findings are difficult to translate into clinical practice. Since, by definition, a personality disorder requires an onset no later than early adulthood (APA, 1987) and likely before an overt onset of a mood disorder, the avoidant traits could be predictive of depressive disorders, while the presence of obsessoid and/or borderline traits suggests to look at past unnoticed signs of bipolarity (Savino et al., 1993; Akiskal et al., 1995). Interestingly, Ucock et al.

(1998) reported a prevalence rate of 47.7% of at least one PD in a population of DSM-III-R bipolar patients, where obsessive–compulsive PD was the most frequent.

This statement could be also analysed in a different perspective: even though the same three disorders avoidant (Av) PD, borderline (Bd) PD and obsessive–compulsive (OC) PD are the most prevalent in both groups, they show a different profile of comorbidity in the two groups.

Interestingly, in a family study of DSM-III-R PDs of relatives of probands with non-psychotic unipolar major depression, Maier et al. (1992) found that OC-PD, Av-PD, and Bd-PD were the most frequent PDs both in relatives of depressed patients and in relatives of controls, suggesting that this association is mainly due to non-familial factors. In this case one may argue that these traits could represent a predispositional condition within the affective spectrum with different degrees of unipolar–bipolar connections.

We are aware of possible limitations in considering personality disorders, in the way they are operationally defined by the DSM-III-R, as a ‘robust’ trait measure; the intermorbid and premorbid personality functioning might affect these measurements (Akiskal, 1992) or, alternatively, SCID II could have measured just these intermorbid traits; however, in the same way in the two groups of patients. Nevertheless, SCID II showed high reliability, so that its

use in clinical research seems justified (Skodol et al., 1988).

A yet unresolved question is whether a PD diagnosis could be made during, at the end or long after the recovery of a depressive episode (Hirschfeld et al., 1983; Stuart et al., 1992). However, in our case this issue should equally affect the two groups.

The overall level of comorbidity and the frequencies of multiple Axis II disorder diagnoses found in the current study are likely to be affected by the referral pattern for the unit, that often receives secondary and tertiary referral from other centres so that our patients can be considered severe cases (Flick et al., 1993). Furthermore, the use of standardized instruments demonstrates that in most studies more than half of the patients showed two or more coexisting PDs, meaning that on Axis II, disorders overlap extensively and multiple PD is the rule rather than the exception (Okasha et al., 1996).

Another limitation is that patients in the two groups could have not reached the same levels of recovery and this could have affected the PDs evaluation in both groups, even though the HDRS scores did not differ. Furthermore our approach is naturalistic and we do not assess the impact of other variables such as different treatments or previous episodes on PDs comorbidity.

The validity of an axis of personality conditions has been covered by Goodwin and Jamison (1990), who summarised personality as a predispositional condition to illness, personality as an expression of illness, personality as a modifier of the illness and personality as altered by illness. Unfortunately, findings derived from our approach leave these questions open but underline the need of further research in this area especially in the follow-up of first episode mood disorder.

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