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Obsessive-compulsive disorders and anxiety disorders: A comparison of personality and emotionality patterns

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ABSTRACT

Even though obsessive-compulsive disorders (OCD) and anxiety disorders (AD) have been separated in the taxonomy adopted by the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, many issues remain concerning the physiopathological similarities and differences between those categories. Our objective was therefore to explore and compare their personality and emotional features, with the assumption that the distinction of two independent spectrums should imply the existence of two partially distinct temperamental profiles. We used the Temperament and Character Inventory (TCI-R) and the Positive and Negative Emotionality (PNE) scale to compare two groups of patients with OCD ($n=227$) or AD ($n=827$). The latter group included patients with social anxiety disorder, panic disorder, agoraphobia, and generalized anxiety disorder. Most temperament, character and emotionality measures showed no significant differences between both groups. In the personality measures results, only the self-directedness score (TCI-R) was significantly lower in OCD patients but this difference was not significant when the comparison was adjusted for the depressive scale score and age. Only lower PNE positive affects scores were obtained in OCD patients in the adjusted comparisons. These findings suggest that OCD and AD are not really distinguishable from the point of view of associated personality traits.

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1. Introduction

An important change in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM5) (American Psychiatric Association, 2013) when compared to previous DSM versions in the domain of affective and neurotic disorders was the creation of the obsessive compulsive and related disorders (OCRD) category which effectively moved obsessive-compulsive disorder (OCD) out of the anxiety disorders category. Various arguments have been given in favor of this evolution and they have been summarized by Stein et al. (2010). The two categories of disorders vary mainly on clinical (different symptoms and comorbidities) and neurobiological (different brain circuits and neuropsychological deficit) elements as well as the types of therapy used to treat them (different pharmacotherapy and psychotherapy methods). However, Stein et al. (2010) also underlined the fact that most of these arguments are mitigated because of partial overlaps and similarities in clinical, epidemiological, neurobiological, neuropsychological, and therapeutic features of OCD and anxiety disorders. An international survey conducted on 187 OCD experts showed that 40% of them did not support moving OCD out of the anxiety disorders section (Mataix-Cols et al., 2007). Therefore, even if the OCRD category has been validated for the DSM5 classification, this discussion is still open in the psychiatric community in particular in the perspective of the future ICD-11 classification.

Personality, temperament and emotionality are very important clinical and psychopathological features that have to be taken into account in the comparison of OCD and anxiety disorders. They are also potent markers of biopsychological vulnerability to psychiatric disorders (Rihmer et al., 2010; Laceulle et al., 2014) and, therefore, useful to progress towards a more scientific and etiological taxonomy (Watson, 2005). Indeed, temperament and emotionality refer to endogenous basic tendencies of thoughts, affects, and behaviors which can be linked to neurotransmitter dysregulation, genetic vulnerabilities, and brain circuit particularities (Whittle et al., 2006). Various observations of differences or similarities, concerning personality and affective traits, have been made in subjects with OCD and anxiety disorders. For example, behavioral inhibition and neuroticism are key antecedents and personality traits associated with anxiety and phobic disorders but are also prevalent in OCD patients (Coles et al., 2006; Lahey, 2009). Perfectionism is associated with OCD and other OCRD such as

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body dysmorphic disorder but may also be seen in other anxious or depressive disorders (Sassaroli et al., 2008).

The psychobiological personality model developed by Cloninger is one of the most used models in psychiatry mainly because of its' originality since it allows the study of seven fundamental dimensions of personality: four reflecting the biological and hereditary traits (temperament) and three representing the cognitive maturity levels acquired through learning (character) (Cloninger et al., 1993). The Temperament and Character Inventory (TCI) allows a precise and reproducible evaluation of these seven dimensions (Cloninger et al., 1994). Many studies have used the TCI or the Tridimensional Personality Questionnaire (created by Cloninger prior to the TCI to evaluate temperament) in order to describe the personality of patients suffering from OCD when compared to controls. These studies show high Harm Avoidance (Pfohl et al., 1990; Bejerot et al., 1998; Kusunoki et al., 2000; Lyoo et al., 2001; Alonso et al., 2008; Kim et al., 2009) as well as low Self-Directedness and Cooperativeness scores in OCD patients (Bejerot et al., 1998; Kusunoki et al., 2000; Lyoo et al., 2001; Alonso et al., 2008; Kim et al., 2009). This profile is also frequently observed in other anxiety and phobic disorders (Pelissolo et al., 2002; Wachleski et al., 2008). Furthermore, some studies have shown low Novelty Seeking (Bejerot et al., 1998; Kusunoki et al., 2000; Lyoo et al., 2001; Alonso et al., 2008) and Reward Dependence scores (Kim et al., 2009) in OCD patients. These profiles are not classically found in patients with anxiety disorders and it is interesting to note that, in Cloningers' model, Novelty Seeking scores are linked to dopaminergic system activation levels. Neurobiological models of OCD are linked to dysfunctional dopaminergic systems (Bloch et al., 2006) which is not the case in most anxiety disorder models. To further our understanding on the temperamental differences between OCD and anxiety disorders, we need comparative studies between TCI profiles of both pathologies. To the best of the authors' knowledge, no studies of this type have been published. Indirect comparisons have been made using mainly the five factors model and a meta-analysis of these studies has shown that anxiety disorders and OCD present a very similar profile marked by high neuroticism and low extraversion traits (Kotov et al., 2010). There is, however, no head to head comparison and, although some dimensions are shared by both models (De Fruyt et al., 2006), most of the Cloninger model dimensions do not exist in the five factor model. For example, correlations between novelty seeking and extraversion are low at 0.36 for a non-clinical sample and 0.46 for a clinical sample (Cloninger et al., 1994).

To test the construct validity of the taxonomy chosen for the DSM5, our study aims at comparing the personality profiles, based on the Cloninger model, of OCD and anxiety disorder patients. The hypothesis was that the main personality features will be significantly different since both disorders belong to two distinct spectrum. For example, we could predict differences in Novelty Seeking scores due to neurobiological hypotheses on OCD. Conversely, a lack of difference in the personality profiles of OCD and AD patients should be an argument against the complete distinction of both disorders. As a secondary objective, but for the same reasons, we also have studied emotionality measures that constitute an important temperamental expression as it reflects a state instead of a trait (Watson et al., 1988; Watson, 2000), especially in the context of affective disorders.

2. Materials and methods

2.1. Subjects

1054 new consecutive outpatients seeking treatment at an anxiety clinic in a university hospital department of psychiatry in Paris, France, were enrolled in this study, between December 2009 and February 2013. Eligible patients were older than 18 years of age and had confirmed OCD ($n=227$) or one of the three main anxiety disorders (social anxiety disorder, panic disorder with or without agoraphobia, or generalized anxiety disorder) diagnosis ($n=827$) according to the DSM-IV. OCD or anxiety disorders had to be the primary complaints and diagnoses of these patients. Patients with comorbid (current or lifetime) OCD and anxiety disorders were excluded and it was the case of 171 of the approached subjects. Past or current drug medications or therapy were authorized and information on these treatments was not recorded. After providing written informed consent, participants were evaluated by trained psychiatrists with the Mini International Neuropsychiatric Interview (MINI), a semi-structured interview for the DSM-IV (Sheehan et al., 1998). Exclusion criteria were refusal to participate, schizophrenia or other psychotic disorders, delirium or dementia, linguistic difficulties or a double diagnosis of OCD and anxiety disorders according to DSM-IV criteria. Thirty-nine patients were excluded for these reasons from the consecutive population. In the studied sample, 853 (81%) were referred by a psychiatrist or another physician, while 201 (19%) patients were self-referred.

2.2. Instruments

Diagnosis of DSM-IV OCD, anxiety disorders, and lifetime major depressive disorder were done using an adapted version of the MINI 5.0.0 (Sheehan et al., 1998).

For the main goal of this study, all the patients responded to the Temperament and Character Inventory-Revised (TCI-R), exploring Cloninger's psychobiological model of personality (Cloninger et al., 1993; Pelissolo et al., 2005). This model relies on the definition of four temperament traits that are supposed to be biologically determined heritable and stable dimensions, and three character traits which reflect individual differences in levels of maturity influenced by social learning and life experience. The temperament traits are the following:

1. Novelty seeking (NS), defined as a hereditary tendency to respond actively to novel stimuli with frequent exploratory activity in response to novelty or impulsive decision making.
2. Harm avoidance (HA), viewed as a heritable bias in the inhibition of behaviors, such as pessimistic worry, passive dependent behaviors or rapid fatigability.
3. Reward dependence (RD), a heritable bias in the maintaining or continuation of ongoing behaviors, which is manifested as sentimentality and social attachment or dependence.
4. Persistence (P), defined as a hereditary tendency to perseverance despite frustration and fatigue.

The character traits are:

1. Self-directedness (SD), referring to self-determination or "willpower", to self-esteem and to the ability of an individual to control, regulate and adapt his behavior in concordance with personal goals and values.
2. Cooperativeness (C), reflecting individual differences in identification with and acceptance of other people (agreeability, compassion, empathy, etc.).
3. Self-transcendence (ST), referring to spiritual maturity, transpersonal identification and self-forgetfulness.

The TCI-R is a 240-item self-administered questionnaire with a 1–5 Likert response scale. Its results include the seven temperament and character main scores, and 29 subscales representing

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