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Recent advances in understanding physical health problems in personality disorders

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Personality disorders are associated with a range of adverse health outcomes, contributing to the high healthcare utilization seen in patients with these disorders. A growing literature supports a robust association of personality disorders and health problems. The primary aim of this article is to summarize the most recent research documenting the associations between personality disorders and health conditions. Extending past reviews, we discuss the association of personality disorders with chronic physical illnesses, sleep disturbances, pain conditions, and obesity. We provide recommendations for future research in this area.

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Introduction

Personality disorders (PDs) involve longstanding maladaptive patterns of cognition, affect, and behaviors that lead to substantial distress and impairment [1]. According to the fifth revision of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), PDs can be classified as 10 distinct conditions, organized within three clusters [1]. Cluster A includes schizoid, paranoid, and schizotypal PDs, characterized by odd or eccentric features. Cluster B includes antisocial, borderline, narcissistic, and histrionic PDs, characterized by dramatic and impulsive patterns of behavior. Finally, Cluster C includes avoidant, dependent, and obsessive–compulsive PDs, characterized by anxious or fearful patterns of behavior. The DSM-5 also includes an alternative model that maps PDs onto existing models of personality, viewing PDs as maladaptive variants of normative personality dimensions.

Although PDs affect approximately 9% (ranging from 4.4% to 14.8%) of the population [2••], they are associated with a disproportionately high treatment utilization [2••], and reduced life expectancies [3]. Given that physical illnesses predict mortality among mental health patients [4], the elevated rates of physical health problems observed in PD samples (see [2••,5•]) may contribute to these shortened lifespans. Beyond the direct effect of physical illness on mortality, both physical illness and psychiatric disorders predict death by suicide [6]. As such, attention is urgently needed to understand and ameliorate the physical health concerns associated with PDs. The present review extends past reviews on PDs and health concerns (e.g. [5•]), focusing on recent advances in this area.

Chronic physical illnesses

Recent representative studies document higher rates of numerous physical illnesses among those with PDs. In population-based studies, interviewer-rated PDs were associated with numerous physical health concerns [7••]. Likewise, participants who endorsed PD screening items were more likely to report poor health (41.3%) and to report having multiple illness (19.95%) than participants who screened negative for PDs (15% and 9%, respectively) [8]. In particular, those who screened positive for PDs reported higher rates of asthma, rheumatism/arthritis, migraines, and musculoskeletal problems [8].

There is evidence of elevated levels of health concerns among those with Cluster B disorders specifically. In a population-based study, Cluster B PDs were linked with higher odds of syncope, seizures, and arthritis [7••]. In addition, results from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) found that respondents with versus without antisocial PD reported the most past-year provider-diagnosed medical conditions, as well as the highest prevalence of coronary and 'other' cardiovascular, hepatic, gastrointestinal, and arthritic diseases (non-adjusted) [9]. NESARC data also revealed associations between incidence of borderline PD and gastrointestinal, cardiovascular, hepatic, or 'any' other disease, hypertension, and arthritis [10]. Other evidence points to specific concerns in relation to Clusters A and C PDs. Namely, Cluster A PDs were linked to gastroesophageal reflux disease, and Cluster C PDs were associated with higher rates of recurrent headaches [7••]. Of note, these findings remained when controlling for covariates such as physical activity and medication use.

Emerging evidence from a few population-based longitudinal studies highlights the long-term medical risk of PDs (see [2••]). In one such study [11], adolescents with a PD had higher odds of self-reported pain, physical illness, and poor physical health than adolescents without a PD. Of particular concern, participants with PDs showed a 50% faster annual rate of health decline from adolescence through their mid-30s. In another population-based study of 244 adults, only Cluster B PDs and borderline PD traits were associated with greater risk for cardiovascular disease 23 years later, although there was insufficient prevalence of other PDs to adequately examine other associations [12••].

Sleep disturbances

Past work has documented an association of PDs and sleep disturbance (see [5•]). For instance, patients with sleep disturbance screened positive for Cluster C PDs at high rates (50%) [13]. In addition, forensic patients with (versus without) antisocial PD reported higher sleep dissatisfaction [14]. An epidemiological study focused on borderline PD found that PD symptoms were associated with poorer subjective sleep quality [15], comparable to that of individuals with other mental health problems. Likewise, patients with borderline PD reported worse sleep quality than healthy controls [16].

In contrast, several studies have not demonstrated unique associations between PDs and sleep disturbances. For instance, participants who endorsed having trouble sleeping (versus those without sleep difficulties) reported more anxiety and depression, but not significantly more antisocial or borderline PD symptoms [17]. In addition, those with borderline PD exhibited better sleep quality on objective measures (latency, efficiency) than patients with depression [18] and comparable sleep quality to those with insomnia [19]. Thus, although people with PDs (especially Clusters B or C) often report sleep-related difficulties, they do not exhibit greater sleep problems than individuals with mood or anxiety disorders.

Pain-related conditions

A broad foundation of research points to higher rates of pain disorders among patients with PDs, although most of this work has focused on Cluster B disorders. For instance, epidemiological research shows that individuals with chronic pain generally were more likely to screen positive for antisocial and borderline PD traits [20]. Similarly, disproportionately high rates of borderline PD (19%) have been found in chronic pain patients [21]; see [22]. In particular, patients who screened positive for borderline PD report more chronic back/neck problems, headache, fibromyalgia, visceral pain, and pain severity and interference [21].

Obesity

Research has documented a robust relationship between PDs and obesity (see [5•]). Not only have PDs consistently shown positive associations with concurrent body mass index (BMI) [9,23], but also high rates of interviewer-rated PDs (26%) were seen among obese patients referred for bariatric surgery [24]. Although people with psychiatric disorders generally had greater odds of being overweight, those with PDs were more likely to be obese [25].

Evidence is mixed, however, on whether specific types of PDs are linked to obesity. Whereas several studies identified Cluster C as the most common PDs in obese bariatric surgery patients [24], other studies found that Cluster A disorders were the most prevalent [26]. Results revealed that both Cluster A and B disorders were linked with greater odds of obesity [23]. Furthermore, antisocial, avoidant, obsessive compulsive, paranoid, and schizoid (but not depressive or histrionic) PDs were associated with obesity [27]. Although borderline PD was not assessed in this sample [27], interviewer-rated borderline PD severity was associated with high BMI in a community sample [28].

Longitudinal studies reveal that PDs also predict later obesity. In the McLean Study of Adult Development, of the 264 patients with borderline PD, 17% were obese at baseline, and 28% were obese at the 6-year follow-up assessment [29], although it is unclear how these compare to rates seen in the general population. Among a subset of these patients, BMI was associated with poorer psychosocial outcomes at a 10-year follow-up [30]. In a community sample, adolescents with any diagnosed PD were 1.84 times more likely to be obese 17 years later, even after adjusting for demographic characteristics [31].

Dimensional measures of personality

The emergence of the alternative models of PDs raises the question of how personality traits, such as negative affectivity, may relate to disease [1]. Although there is scant evidence on the relation of physical health with pathological PD traits of *negative affectivity*, *disinhibition*, *antagonism*, *detachment*, and *psychoticism*, there is some research on their normative counterparts (i.e. *neuroticism*, *conscientiousness*, *agreeableness*, *extraversion*, and *openness*).

Broadly, conscientiousness, agreeableness, extraversion, openness, and low neuroticism are linked with better health outcomes. The shared variance among agreeableness, conscientiousness, and the inverse of neuroticism were associated with decreased risk for cardiometabolic disease [32••]. Likewise, extraversion, openness, and low neuroticism were associated with better physical health among cardiovascular disease patients [33]. In addition, conscientiousness is generally associated with positive health outcomes and longevity [34]. Conscientiousness may spark more healthy behaviors, stabilize relationships, and boost socioeconomic status (see [35•]). Some traits, such as neuroticism, may not be linearly related to health