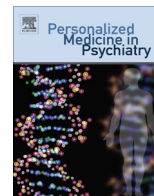




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The structure of personality disorders within a depressed sample: Implications for personalizing treatment

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ABSTRACT

Background: Personality disorders (PDs) and major depressive disorder (MDD) are both significant public health burdens. They are frequently comorbid, and this comorbidity predicts poorer treatment outcomes and lower maintenance of treatment effects. Although there is growing consensus on the structure of personality pathology in non-depressed individuals, there is limited research on the structure of personality pathology in individuals experiencing MDD.

Method: As part of the Predictors of Remission in Depression to Individual and Combined Treatment (PReDICT) randomized controlled trial, 192 treatment-naïve subjects meeting DSM-IV-TR criteria for MDD completed the International Personality Disorder Examination (IPDE). Using this sample, a principal components analysis explored the factor structure of the IPDE.

Results: A three-factor model comprised three factors labeled “NADA” (Negative Affectivity, Disinhibition, and Antagonism), “Social Anxiety,” and “Antisociality.” Factor intercorrelations were small-to-moderate, and the sum score of the three factors was highly correlated ($r = 0.94$) with the total IPDE score.

Limitations: Personality pathology was assessed with one instrument, and sample size was smaller than ideal for factor analytic research.

Conclusions: Consistent with prior factor-analytic findings, a three-factor solution provided the most clinically and theoretically useful model. This finding lends support for the personality disorders retained in DSM-5 and some support for a model of personality pathology aligned with the personality traits found in the leading nonclinical models of personality. The obtained factors are potential moderators of clinical interventions and may serve as an avenue to personalizing treatments.

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Introduction

Major depressive disorder (MDD) carries one of the greatest disease burdens worldwide [1] and affects nearly 7% of adults in the United States each year [2]. In many cases, MDD co-occurs with one or more additional psychiatric disorders, and frequently these comorbidities predict poorer long-term outcomes. Notably, and of particular relevance to this study, rates of MDD are also drastically higher among individuals with personality disorders (PDs) than for the general population [3]. The converse is also true: i.e., there are significantly higher rates of PDs among individuals with MDD than

among the general population [4]. These co-morbidities consistently predict worse acute and maintenance treatment outcomes for MDD across treatment modalities including medications, a range of psychotherapeutic approaches, and combinations of somatic treatments with psychotherapy [4–6].

Due to their high comorbidity rates and the effects of MDD and PD diagnoses on the treatment of each other, it is reasonable to expect there may be a transactional relationship between symptoms of mood disorders and symptoms of PDs. In other words, over the developmental course of these disorders, each class of symptoms may influence the other, exacerbating the overall impairment experienced by an individual over time [7,8].

Despite the attention given to personality traits and PDs in the context of depression, there has been little research on the factor structure of PD traits within a depressed sample. Because some

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personality traits may interact with depressive symptoms over time, it may be the case that the structure of maladaptive personality traits in individuals with depression is distinct from the structure of these traits in a non-depressed sample. This study aimed to investigate the preceding issue by employing a factor analysis of a personality disorder assessment interview within a depressed sample, thereby providing results relevant to both depression and personality disorder research. Particularly, understanding the factor structure of personality disorders and that a depressed individual's score can vary on a particular factor or pattern of factors may play a substantial role in the process of personalizing a depressed individual's specific treatment (e.g., see [9]).

Factor structure of personality disorders

Despite its long lifespan, the current DSM model of PD diagnoses (i.e., Clusters A, B, and C) has been repeatedly criticized since its inception (e.g. [10–12]). Specifically, there is a lack of empirical support for the three-cluster system, and the categorical nature of the model has demonstrated poor ecological validity. In response to these issues, and based on decades of research supporting the structural patterns of nonclinical personality traits (e.g. [13–15]), the DSM-5 work group proposed a novel approach to the classification and diagnosis of personality disorders. The proposed model was relegated to Section III of DSM-5 until sufficient evidence is gathered to support or discount it. Section III maintains and describes six PDs: Antisocial, Avoidant, Borderline, Narcissistic, Obsessive-Compulsive, and Schizotypal. It further categorizes disorders based on patterns and levels of elevation across five broad personality trait domains (i.e., Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism). These domains, considered to be “maladaptive variants of ... the ‘Big Five,’ or Five-Factor Model of personality (FFM)” ([16], p. 773), suggest that PDs are not entirely distinct from broad personality traits; therefore, existing research on personality traits may be extended to PDs through a more dimensional model. Within the alternative model, a number of more specific behaviors and constructs of PDs are arranged as facets of each of the five major personality domains.

A review of existing factor analytic work on PDs in the context of the DSM classification system [17] suggested strong evidence for either a three- or four-factor solution. However, there was meaningful variability across the reviewed studies in the criteria and disorders comprising each of the possible factor solutions. Additionally, results from an analysis of previously published data [18] indicated both three- and four-component solutions to the organization of PDs. These structures generally resembled the FFM [19]; the final four-factor solution included a neuroticism component, a low-agreeableness component, an extraversion (vs. introversion) component, and a conscientiousness component, which correspond fairly well to the Section III retained PDs of Borderline, Narcissistic, Antisocial, Avoidant, and Obsessive Compulsive PDs. The three-factor solution was highly similar to the first three components in the four-factor solution; however, adding the fourth factor allowed for inclusion of obsessive-compulsive PD in the final factor structure.

Aims and hypotheses

The primary aim of the current study, therefore, was to examine the factor structure of PD traits in the context of a depressed sample. Based on prior factor analyses of personality disorder traits, it was hypothesized there would be three to five factors bearing strong similarities to major models of personality (e.g. [13,20,15]) and to the DSM-5 Section III PD trait domains.

Method

Participants

Participants were drawn from the Predictors of Remission in Depression to Individual and Combined Treatments (PREdict) project, a randomized controlled trial (RCT) for the treatment of depression (described in [21]). This sample comprises those participants ($n = 192$) who completed the International Personality Disorder Examination (IPDE) [22] at or very close in time to the baseline assessment.

Participants met DSM-IV-TR [23] criteria for major depressive disorder and had a Hamilton Depression Rating Scale (HDRS) [24] score of ≥ 18 at screening and ≥ 15 at their baseline visit. All participants were treatment naïve, defined as having never received treatment for a mood disorder with either: (i) an antidepressant medication at a minimum effective dose for 4 or more consecutive weeks; or (ii) 4 or more sessions of an evidence-based and structured psychotherapy (CBT, IPT, or behavioral marital therapy). All participants were assessed and treated either under the umbrella of a clinic at a university-affiliated hospital outpatient setting or at a Spanish-speaking outpatient setting at a large public hospital [25].

Key exclusion criteria included prior treatment of a mood disorder; lifetime history of dementia, a primary psychotic disorder, or bipolar disorder; or diagnosis of obsessive-compulsive disorder, an eating disorder, or a dissociative disorder within the past year. Participants were also excluded if they met criteria for substance abuse in the past 3 months, or for substance dependence in the 12 months prior to their first treatment visit.

Participants in the present analyses had a mean age of 38.8 ($SD = 11.4$); 58.9% were female. The participants' reported race was 38.5% Caucasian, 16.1% African American, and 45.3% other. Reported ethnicity was 39.1% Hispanic and 60.9% Non-Hispanic.

Procedure

Participants recruited to the PREdict study [21] were screened by telephone and those who qualified were scheduled for an in-office visit. During this visit participants completed the Structured Clinical Interview for DSM Disorders (SCID) [26], were rated on the HDRS, and completed a clinical interview with a study psychiatrist. Participants subsequently completed baseline assessments, including the video recorded IPDE, either before or within two weeks of treatment randomization. Trained clinicians and raters completed all screening interviews and assessments; data were gathered from participants during 2007–2013.

Measures

International Personality Disorder Examination. The International Personality Disorder Examination [24] is a semi-structured 99-item clinical interview developed by the World Health Organization and National Institute of Health. The interview produces both dimensional and categorical scores for the 10 DSM-IV-TR personality disorders. Each item represents a personality trait or behavior and is scored by a clinician on a 3-point scale (0–2); items 1–92 are considered diagnostic items and were included in the present factor analyses, whereas items 93–99 are considered “informational” items and were not included. The IPDE has adequate inter-rater reliability (intra-class correlation coefficients [ICCs] of 0.79–0.95) [22,27] and temporal stability (ICCs of 0.68–0.92) [22] comparable to other widely used clinical measures.

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