

Complex personality disorder in bulimia nervosa

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Abstract

Objective: Recent research has suggested a move toward a dimensional system for the classification of personality disorders (PDs). Tyrer's dimensional model using severity as a form of categorizing PDs was used to compare eating disorder outcome in women with bulimia nervosa (BN) over 3 years.

Method: One hundred thirty-four women with BN were divided into 4 groups based on PD severity: no PD (n = 32), personality difficulty (n = 27), simple PD (n = 29), and complex PD (n = 46). Eating disorder symptoms and attitudes, general psychosocial functioning, and depressive symptoms were examined at pretreatment and at 1-year and 3-year follow-up (posttreatment).

Results: The complex PD group had greater Axis I comorbidity and psychopathology than the remaining 3 groups at pretreatment. At 1-year and 3-year follow-up, there were no differences in eating disorder outcome, general psychosocial functioning, and depressive symptoms across the 4 groups.

Conclusion: These results suggest that having an increased number of PDs comorbid with BN does not influence eating disorder outcome up to 3 years after treatment.

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1. Introduction

The categorical classification of personality disorders (PDs) has been the subject of considerable debate for some years [1–3]. Limitations of the categorical model have been widely noted, and a number of authors have advocated dimensional models for the classification of PDs [4–6]. One dimensional approach proposed by Tyrer and colleagues [7,8] uses severity as a means of categorizing PDs. In an attempt to reconcile the frequently overlapping PD diagnoses, this approach divides groups into a 4-point severity scale: no PD (does not meet criteria for actual or subthreshold PD), personality difficulty (meets subthreshold criteria for 1 or several PDs), simple PD (meets criteria for 1 or more PDs within the same PD cluster), and complex PD (meets criteria for 2 or more PDs across different clusters) [8]. This model of PD severity has been used to examine the impact on mental disability and outcome in substance use, mood, anxiety, and psychotic disorders [9,10]. However, to

our knowledge, Tyrer's dimensional classification of PD severity has not previously been used to assess the impact on outcome in an eating-disordered group.

The prevalence of PDs in bulimia nervosa (BN) is reported to range from 21% to 67% [11–13]. The comorbidity of BN and PDs has been found to negatively impact clinical symptoms such as general psychiatric functioning, interpersonal skills, and social functioning [14,15]. In recent years, research has attempted to address the complexities of treating comorbid eating disorders and PDs by adapting psychotherapies such as dialectical behavior therapy [16], cognitive behavioral therapy [17], and interpersonal psychotherapy [18] to attend to the combination of eating disorder symptoms and personality pathology [15]. Mixed findings exist on the impact of personality pathology on eating disorder treatment outcome, with some studies reporting greater binge eating severity [19] and more disturbed psychiatric symptoms posttreatment in those with personality pathology [14,20]. In contrast, other studies report that the presence of a PD did not predict outcome [21–23].

The use of Tyrer's dimensional personality classification attempts to address the issue of multiple personality

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diagnoses by considering severity in terms of both extent and breadth of personality dysfunction across personality clusters. The present study aims to evaluate the ability of Tyrer's dimensional approach to predict pathology and outcome in a sample of women with BN participating in a randomized controlled trial of cognitive behavior therapy [24]. This will be achieved by (1) comparing the pretreatment characteristics of women with BN among the dimensional personality groups and (2) examining the impact of PD severity on BN outcome at 1 and 3 years posttreatment.

2. Materials and methods

2.1. Overview

Women with BN were recruited for a randomized clinical trial with long-term follow-up. The trial evaluated the additive efficacy of exposure-based vs non-exposure-based behavioral treatments to a core of cognitive behavior therapy.

All participants received 8 sessions of cognitive therapy before being randomized to a further 8 sessions of 1 of 3 forms of behavioral therapy: (a) exposure to prebinge cues with binge eating prevented, (b) exposure to prepurge cues with purging prevented, or (c) relaxation training. Further details of the study design and outcome, and 3-year follow-up data have been presented elsewhere [24,25].

2.2. Participants

Participants were 134 women, aged 17 to 45 years, with a current *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition* diagnosis of BN. Of the 135 participants entering the study, one was excluded from the analyses because Axis II data were missing. Exclusion criteria were current anorexia nervosa, current obesity (body mass index >30), current severe major depression, current psychoactive substance use disorder, bipolar I disorder, schizophrenia, current severe medical illness or severe medical complications of BN, and current use of psychoactive medications.

2.3. Procedure

This study received ethical approval from the Southern Regional Health Authority (Canterbury) and the University of Canterbury Ethics Committee. Participants provided written informed consent.

2.4. Pretreatment assessment

Current and lifetime psychiatric disorders and PDs were assessed using the Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition* Patient Version and Personality Disorders Version [26]. These assessments were completed by nontreating psychiatrists and psychologists. Eating disorder symptoms such as binge eating and purging frequency were assessed using the Comprehensive Bulimia Severity Index

(CBSI) [27]. The CBSI is a clinician-rated instrument that used questions reflecting concepts from the Eating Disorders Examination [28] and was designed to measure the frequency and intensity of bulimic symptoms (including food restriction and body dissatisfaction) and general functioning (mood, anxiety, substance use, and social and occupational functioning). The treating clinician completed the 17-item Hamilton Depression Rating Scale (HDRS) [29] and the Global Assessment of Functioning Scale (GAF; APA, 1987). The GAF is a measure of general psychosocial functioning over the past week. Participants completed self-report questionnaires including the Eating Disorder Inventory (EDI) [30].

2.5. Follow-up assessment

Participants were reassessed at 1 and 3 years after the end of treatment. Follow-up assessment consisted of reevaluating eating disorder diagnosis and readministering CBSI, HDRS, GAF, and EDI measures.

2.6. Statistical analyses

The Statistical Package for the Social Sciences (SPSS, Version 12; SPSS Inc, Chicago, IL) was used to analyze data. Participants were divided into 4 groups: (1) no PD (absent or minimal symptoms), (2) personality difficulty (subthreshold symptoms, ie, 1 symptom short of diagnosis), (3) simple PD (1 or more PDs met within the same PD cluster), and (4) complex PD (2 or more PDs from different clusters). The PD clusters were cluster A (paranoid, schizoid, schizotypal PDs), cluster B (antisocial, borderline, histrionic, narcissistic PDs), and cluster C (avoidant, dependent, obsessive-compulsive PDs). χ^2 tests were conducted on dichotomous variables. Fisher exact and χ^2 tests were used for post hoc pairwise testing. One-way analyses of variance (ANOVAs) were conducted to examine the impact of personality pathology on binge and purge frequency, eating attitudes (EDI drive for thinness, bulimia, and body dissatisfaction), depressive symptoms (HDRS), and psychosocial functioning (GAF). Repeated-measures ANOVA was used to assess differences among the 4 groups over 3 time points. To reduce the risk of type I error, we have opted for a more stringent statistical significance level of $P < .01$ for all statistical testing. In the few instances where follow-up data were missing, no attempt was made to estimate or impute these values.

3. Results

3.1. Characteristics of personality groups at pretreatment

The mean age of the sample was 26.1 years (SD = 6.1), and 91% were New Zealand European. The remaining ethnicities were as follows: 4.4% Maori/European, 1.5% Maori, 1.5% Pacific Island/European, 0.7% Asian, and 0.7% "other." There were no significant differences among the groups in

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