

Personality correlates of impulsivity in subjects with generalized anxiety disorders

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Abstract

Background: As yet, the relation between personality traits and impulsiveness has not been investigated in subjects affected by generalized anxiety disorder (GAD).

Method: A sample of 79 subjects with a diagnosis of GAD has been assessed at intake with Clinical Global Impression (CGI), Barratt Impulsiveness Scale (BIS-11), and with Temperament and Character Inventory. Comorbidity with cluster A or B personality disorders was excluded.

Results: A multiple linear regression has identified 3 variables as independent predictors of impulsiveness: novelty seeking (NS) and reward dependence (RD) as for temperament and self-directedness (SD) as for character. Predictor analysis of the 3 subscales of BIS-11 showed that a higher NS is a predictor of all 3 subscales of BIS-11, whereas a higher RD is a protective factor for the attentive impulsiveness, and a low SD is predictive of a greater nonplanned impulsiveness. The CGI severity index is directly related to motor impulsiveness.

Discussion: Preliminary results showed that in subjects with GAD only the motor component of impulsivity seems directly related to clinical severity, whereas impulsiveness is predicted by higher levels of 2 temperamental dimensions that are influenced by dopamine and norepinephrine systems and by weakness of character.

Conclusion: Subjects with GAD showed an interesting variability in NS. Differences in levels of NS and of other temperament (RD) and character (SD) dimensions seem related to different degrees of behavioral inhibition and to a different impact of the cognitive components of impulsiveness. Clinical implications are discussed.

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1. Introduction

Impulsivity is a complex and multidimensional feature that influences pathogenesis, course, and clinical severity of several mental disorders [1]. A pathologic increase of impulsivity is at the core of impulse control disorders, obsessive-compulsive disorders (OCDs), impulsive personality disorders (borderline personality disorder [BPD] and antisocial personality disorder), eating disorders [2], attention-deficit/hyperactivity disorder [3], and addiction disorders [4]. In bipolar disorders [5,6] and unipolar mood disorders [7], impulsivity was also identified as a significant psychopathologic dimension. In generalized anxiety disorders (GADs), though, the role played by

impulsivity seems widely neglected, in spite of a growing body of data confirming the relation between anxiety and impulsivity [6,8].

Impulsivity is a dimension of extreme interest when it is studied as a personality trait [9]; in fact, impulsivity is rarely studied outside the spectrum of a disease-specific symptoms, but genetic [10] and neuroimaging studies [11] have identified impulsivity (especially in a diminished inhibitory control) as a possible endophenotype [12]. Recent evidences have highlighted the relevance of heritability: familial transmission of impulsivity has been demonstrated both within and outside the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) categories of mental disorders [11]. Moreover, data from twin studies specifically support a genetic component of impulsivity [13]. A more recent twin study that assessed impulsivity using the BIS-11 self-report measure reported a heritability estimate of 0.44 [14]. Converging evidence, therefore, suggests that around 45% of the variance in self-reported impulsivity is accounted for

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by nonadditive genetic factors. The genetic contributions to impulsivity are mediated through numerous neurotransmitter systems; among these, the serotonin and dopamine systems seem to play a leading role [15–17]. A recent meta-analysis [18] showed that the functional variants of the dopamine D4 receptor gene may be associated with measures of impulsivity and novelty seeking (as assessed with Temperament and Character Inventory [TCI]).

Psychological research has investigated impulsivity as a unitary psychological construct [11]. Some authors [19] have proposed an interesting conceptualization of impulsivity based on a 3-factor model, according to which impulsivity can be decomposed as a combination of attentional (“getting easily bored”), motor (“going into action”), and cognitive (“inability to plan”) factors. More recent theories [20] have decomposed impulsivity into 4 dimensions: (a) urgency, that is, the feeling of negative affects when resisting an urge; (b) lack of premeditation, that is, the inability to anticipate consequences; (c) lack of perseverance, that is, the inability to stick to one’s task; and (d) sensation-seeking, that is, the experience of positive feelings toward risky actions. According to the 5-factor model of personality by Costa and McCrae [21], these 4 dimensions seem connected to different factors: urgency is related to higher neuroticism, whereas lack of premeditation and perseverance might be related to lower conscientiousness, and sensation-seeking might reflect higher extroversion [21].

In the 3-factor model by Cloninger et al [22], impulsivity as a temperament trait results from a combination of low harm avoidance (HA) and high novelty seeking (NS)—a high risk-seeking predisposition (NS) in subjects with a low level of temperamental inhibition (low HA) leads to an impulsive temperament (which is a highly heritable personality trait). Moreover, whenever subjects with low HA and high NS present a personality weakness (low self-directedness [SD]), the likelihood of impulsive personality disorders (cluster B of DSM-IV) increases [23]. Recent studies [24] on a sample of Italian subjects have showed that the character dimensions of SD and cooperativeness [C] were negatively related with impulsivity and anger, whereas NS was directly associated with impulsivity.

Measures of impulsivity seem therefore strictly related to measures of temperament; a combined approach to this issue could lead to the definition of an endophenotype of extreme clinical interest, identified through the assessment of impulsivity (motor and cognitive) and NS [25]. The endophenotype approach could contribute to the identification of diagnostic markers, help to create more homogenous diagnostic categories (or subtypes), and aid the identification of at-risk individuals for specific symptoms, behaviors, or treatment responses [11].

The aim of this study was to investigate the impulsivity dimension in subjects with GAD and the relation between temperament and character traits assessed with TCI and impulsivity. To the best of our knowledge, no data on the role of TCI-evaluated personality dimensions in relation to

impulsivity in subjects with GAD are currently available in literature.

According to the TCI, subjects with GAD are characterized by high HA and low SD [23] and share this quality with patients affected by panic disorder [26]. Our a priori hypothesis postulated the existence of a subgroup of subjects with GAD showing a high level of NS and a greater impulsivity risk. Because both personality dimensions and impulsivity could be related to the state psychopathology, such relation has been controlled not only for personality features but also for symptoms of anxiety and clinical severity at intake.

2. Materials and methods

2.1. Subjects

Seventy-nine subjects with GAD were recruited among all outpatients with GAD referred to the Mental Health Center of Chivasso (Turin, Italy) between September 1, 2007, and June 1, 2009.

Inclusion criteria were (1) a full diagnosis of GAD according to criteria of DSM-IV-TR [27], (2) age range between 18 and 55 years, (3) absence of acute full-syndrome Axis I disorders requiring inpatient treatment, (4) absence of actual addiction disorder [27], (5) absence of mental retardation, (6) absence of a cluster A or B personality disorder in Axis II [27], (7) absence of a bipolar disorder [27], and (8) willingness to give informed consent to participate in the study.

Diagnostic assessment for Axis I and Axis II disorders had been carried out at intake by 2 trained psychiatrists, with the support of the Structured Clinical Interview for DSM-IV (SCID-OP I, and SCID II) [28–29].

Twenty-eight patients with GAD were excluded from the sample for the following reasons: (1) age out of the established range ($n = 3$); (2) comorbidity of an acute Axis I disorder ($n = 12$) requiring inpatient treatment, including mood disorders ($n = 9$), psychotic disorders ($n = 2$), eating disorder ($n = 1$); (3) comorbidity with mental retardation ($n = 1$); (4) presence of acute substance abuse disorder ($n = 6$); (5) presence of a bipolar disorder ($n = 3$); and (5) patients who met the inclusion criteria but refused to participate in the study or to sign an informed consent ($n = 3$).

Subjects were assessed before the onset of outpatient treatment through the Clinical Global Impression (CGI) rating scale, and 2 self-administered questionnaires such as Barratt Impulsiveness Scale (BIS) and TCI.

Two psychiatrists adequately trained in the use of the CGI and SCID-I and SCID-II rated all the subjects included in this study. All the procedures have been approved by a review committee.

2.2. Assessment instruments

2.2.1. Clinical Global Impression

This is a well-known assessment tool [30], administered by clinicians to evaluate the severity of an illness (item 1),

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