



# The correlates of obsessive–compulsive, schizotypal, and borderline personality disorders in obsessive–compulsive disorder



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## ABSTRACT

We assessed correlates of obsessive–compulsive (OCPD), schizotypal (SPD) and borderline (BPD) personality disorders in 110 obsessive–compulsive disorder (OCD) patients. We found OCD patients with OCPD (20.9%) to exhibit higher rates of hoarding and bipolar disorders, increased severity of hoarding and symmetry, lower prevalence of unacceptable thoughts involving sex and religion and less non-planning impulsivity. Conversely, OCD patients with SPD (13.6%) displayed more frequently bipolar disorder, increased severity of depression and OCD neutralization, greater prevalence of “low-order” behaviors (i.e., touching), lower low-planning impulsivity and greater “behavioral” compulsivity. Finally, in exploratory analyses, OCD patients with BPD (21.8%) exhibited lower education, higher rates of several comorbid psychiatric disorders, greater frequency of compulsions involving interpersonal domains (e.g. reassurance seeking), increased severity of depression, anxiety and OCD dimensions other than symmetry and hoarding, more motor and non-planning impulsivity, and greater “cognitive” compulsivity. These findings highlight the importance of assessing personality disorders in OCD samples.

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## 1. Introduction

The DSM-5 defines personality disorder (PD) as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and lead to distress or impairment” (APA, 2013). Although several studies have shown that patients with obsessive–compulsive disorder (OCD) display an increased prevalence of several PDs in clinical (Baer & Jenike, 1992; Maina, Albert, Salvi, Pessina, & Bogetto, 2008; Pinto, Mancebo, Eisen, Pagano, & Rasmussen, 2006) and epidemiological settings (Torres et al., 2006), it is unclear whether PDs or associated traits predispose to, or are a consequence of OCD. One study found that individuals with mixed avoidant, compulsive and dependent features were more likely to have a longer duration of illness leading authors to suggest that lifestyle changes secondary to OCD might end up misshaping and

disarranging the personality structure of OCD patients who had no premorbid PDs (Baer et al., 1990). The mitigation of PD traits after successful treatment of OCD has been seen as an evidence supporting the later hypothesis (Ricciardi et al., 1992). However, it has also been demonstrated that one specific PD (obsessive–compulsive personality disorder or OCPD) predicted OCD relapse in the long-term (Eisen et al., 2013). Other studies suggest that the rates of specific PDs in OCD do not differ from those seen in other anxiety disorders (Albert, Maina, Forner, & Bogetto, 2004; Pena-Garijo, Edo Villamon, Melia de Alba, & Ruiperez, 2013).

Despite the long-standing discussion on the primary vs. secondary nature of PDs in OCD, very few studies have attempted to clarify or characterize the socio-demographic and clinical correlates of different PDs in OCD. In general, these studies typically focus on a single PD, most frequently obsessive–compulsive (Coles, Pinto, Mancebo, Rasmussen, & Eisen, 2008; Diaferia et al., 1997; Eisen et al., 2006; Garyfallos et al., 2010; Gordon, Salkovskis, Oldfield, & Carter, 2013; Lochner et al., 2011; Starcevic et al., 2013) or schizotypal PDs (Jenike, Baer, Minichiello, Schwartz, & Carey, 1986; Poyurovsky, 2008; Stanley, Turner, & Borden, 1990). This limited focus ignores the fact that in several cases, individuals may fulfill diagnostic criteria for more than one PD at any given time.

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For instance, OCPD, schizotypal personality disorder (SPD), and borderline personality disorder (BPD) tend to increasingly co-occur as the patients' illness progresses (Sanislow et al., 2009). Consequently, it is important to investigate the correlates of these PDs in the same sample. Importantly, despite BPD's substantial prevalence, significant disability, disturbing risk of suicide, increased levels of treatment seeking, and major economic burden (Leichsenring, Leibing, Kruse, New, & Leweke, 2011), we are also not aware of any study to date that has investigated the correlates of BPD in OCD.

In this study, we examined the socio-demographic and clinical correlates of a sample of PDs judged by Skodol and colleagues (Skodol et al., 2011) to be associated with the most extensive empirical evidence of validity and clinical utility, namely SPD, BPD, and antisocial (APD) PDs. Given its importance to the field of obsessive-compulsive and related disorders, OCPD was also included as a variable of interest. The aforementioned PDs are also recognized to be the representatives of each personality cluster, namely SPD (cluster A), AS/BPD (cluster B), and OCPD (cluster C) (APA, 2013). Therefore, the selected PDs represent a series of conditions covering a substantial range of the entities described as PDs in the DSM system.

Broadly speaking, we predicted that OCD patients with personality disorders would be characterized by earlier onset, increased severity of symptoms and lower socio-economic status. More specifically, based on the existing literature, we hypothesized that: (i) patients with OCPD will exhibit an earlier OCD onset age (Starcevic & Brakoulias, 2014), higher rates of hoarding and symmetry symptoms (Starcevic & Brakoulias, 2014), decreased impulsivity and increased compulsivity levels (Fineberg, Sharma, Sivakumaran, Sahakian, & Chamberlain, 2007), (ii) OCD patients with SPD will exhibit an earlier age at OCD onset (Brakoulias et al., 2014; Sobin, Blundell, & Karayiorgou, 2000), increased rates of hoarding (McDougle et al., 1995), and other "low-order" OCD symptoms (Anagnostou et al., 2011; McDougle et al., 1995),<sup>1</sup> and greater impulsivity (Chapman et al., 1984) and compulsivity (Yamamoto et al., 2012); (iii) OCD patients with BPD will display an earlier OCD onset age (Fontenelle, Mendlowicz, & Versiani, 2005; Lovato et al., 2012; Matsunaga et al., 2005), greater rates of mood, anxiety, eating, and impulse control disorders (Paris, 2007), increased frequency of OCD symptoms involving some sort of interpersonal interaction (e.g. reassurance seeking) (Storch et al., 2012), and higher impulsivity (Sebastian, Jacob, Lieb, & Tuschler, 2013) and compulsivity levels (Fontenelle, Oostermeijer, Harrison, Pantelis, & Yucel, 2011); and finally (iv) patients with APD will exhibit decreased rates of scrupulous obsessions (e.g. unacceptable religious or sexual thoughts) or compulsions (e.g. need to confess or to be reassured) (O'Neill, Nenzel, & Caldwell, 2009), increased impulsivity levels and, due to its exclusionary criteria (APA, 2013), reduced rates of kleptomania (Grant, 2004), but increased rates of other impulse control disorders (APA, 2013).

## 2. Methods

### 2.1. Participants

One hundred ten OCD patients who sought treatment at a university clinic for anxiety and obsessive-compulsive spectrum disorders were included in this study. Inclusion criteria were a diagnosis of primary OCD according to DSM-IV-TR criteria, age between 18 and 70 years and being able to read and fill out forms. Patients

<sup>1</sup> We used the term "low order" OCD symptoms to describe repetitive behaviors that are more motoric/less cognitively based, such as the need to touch or rub, self-mutilatory symptoms and superstitious behaviors. (Anagnostou et al., 2011).

were considered to have primary OCD if obsessive-compulsive symptoms were the most clinically significant ones as compared to other co-occurring conditions. Whenever this was not the case, patients were not included in the study and were referred for treatment in another specialized clinic (e.g. mood disorders clinic, substance abuse or rehabilitation units, and inpatient facilities). The procedures involved in this research protocol were fully explained to patients, who signed an informed consent before being included in the study. The protocol was approved the local ethics committee.

### 2.2. Measures

Participants were assessed with a specially designed socio-demographic questionnaire, interviews for the diagnosis of PDs (the Structured Interview for DSM-IV Personality) (Pfohl, Blum, & Zimmerman, 1997) and co-occurring psychiatric disorders (the Structured Clinical Interview for DSM Disorders, Del-Ben et al., 2001 and the Structured Interview for Hoarding Disorder, Nordsletten et al., 2013), and self-report instruments to evaluate OCD symptom profiles (Florida Obsessive-Compulsive Inventory, Storch et al., 2007), severity of depression (Beck Depression Inventory, Cunha, 2001), anxiety (Beck Anxiety Inventory, Cunha, 2001), borderline (Borderline Evaluation of Severity Over Time, Pfohl et al., 2009), and obsessive-compulsive symptoms (Yale-Brown Obsessive-Compulsive Scale, Goodman, Price, Rasmussen, Mazure, Delgado et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleischmann et al., 1989) and dimensions (Obsessive-Compulsive Inventory-Revised, Souza, Foa, Meyer, Niederauer, & Cordioli, 2011), and the degree of impulsiveness (Barratt Impulsiveness Scale, Patton, Stanford, & Barratt, 1995), and compulsiveness (Gratatan Compulsivity Scale). One specially trained psychiatrist (IAM) conducted all clinician-administered interviews, including the SIDP, the SCID, and the SIHR. See below a description of each assessment instrument.

#### 2.2.1. The Structured Interview for DSM-IV Personality (Pfohl et al., 1997)

The Structured Interview for DSM-IV Personality (SIDP-IV) is a semi-structured diagnostic instrument that assesses behavior and personality traits from the patient's perspective. It allows interviewers to diagnose the 10 PD listed in DSM-IV. Each criterion is rated on a scale from 0 (absent) to 3 (strongly present). Questions are arranged by topics (e.g. work style, interpersonal relationships, emotions, interests, and activities) rather than by specific PDs. However, for the specific purposes of this study, only the diagnoses of SPD, BPD, ASP and OCPD are reported. As previously suggested (Mataix-Cols et al., 2010), hoarding did not count as a criterion for OCPD. Although one SIDP study (Jane, Pagan, Turkheimer, Fiedler, & Oltmanns, 2006) found moderate inter-rater reliability estimates for BPD (0.60), ASP (0.62), and OCPD (0.55), the figures for SPD were particularly low (0.03). Poor reliability estimates for SPD were ascribed to the fact that this diagnosis is partly based on subjective judgments or observations of symptoms that lack behavioral anchors (such as inappropriate or constricted affect) and that largely overlaps with those of other conditions (including OCPD).

#### 2.2.2. The Structured Clinical Interview for DSM-IV Axis I Disorders (Del-Ben et al., 2001)

The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) is a clinician administered, semi-structured interview developed to provide broad coverage of psychiatric diagnosis according to DSM-IV (First, 2007). The main body of the SCID-I consists of nine diagnostic modules, including mood episodes, psychotic symptoms, psychotic disorders differential, mood disorders differential, substance use, anxiety disorders, somatoform disorders, eating disorders and adjustment disorders. The SCID-I

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