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Personality disorder traits associated with risk for unipolar depression during middle adulthood

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Abstract

Data from the Children in the Community Study, a prospective longitudinal investigation, were used to investigate the association of personality disorder (PD) traits, evident by early adulthood, with risk for the development of unipolar depressive disorders by middle adulthood. Antisocial, borderline, dependent, depressive, histrionic, and schizotypal PD traits, identified between ages 14 and 22, were significantly associated with risk for dysthymic disorder (DD) or major depressive disorder (MDD) by a mean age of 33 after a history of unipolar depression and other psychiatric disorder was controlled statistically. Individuals without a history of unipolar depression who met diagnostic criteria for ≥ 1 PD by a mean age of 22 were at elevated risk for DD or MDD by a mean age of 33 years. Individuals identified as having a DSM-IV Cluster A (paranoid, schizoid, or schizotypal) or Cluster C (avoidant, dependent, obsessive–compulsive) PD by a mean age of 22 years were at elevated risk for recurrent or chronic unipolar depression. The findings of this study suggest that some types of PD traits that become evident by early adulthood may contribute to an increased risk for the development or recurrence of unipolar depressive disorders by middle adulthood.

Keywords: Personality disorder; Dysthymic disorder; Major depressive disorder

1. Introduction

The association of personality disorder (PD) with risk for unipolar depression is of considerable interest to researchers, and it has important clinical and theoretical implications. Clinicians are interested in this association because they recognize the importance of being well informed about the outcomes that may be associated with PD and other mental disorders. A variety of conceptual and theoretical models have been advanced regarding the associations of specific types of PDs with depressive and other Axis I disorders (e.g., Klein et al., 1993; Lyons et al., 1997).

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Some PDs may contribute to increased vulnerability for depressive disorders and other Axis I disorders (Gunderson and Phillips, 1991). Common etiological factors have been hypothesized to underlie the development of certain PDs and depressive disorders (Daley et al., 1999). Another hypothesis is that some PDs and mood disorders (e.g., borderline PD and mood disorders; depressive PD and unipolar depression) may occupy different points along a common affective or depressive spectrum (Siever and Davis, 1991; Klein and Shih, 1998). Some associations between PDs and Axis I disorders could also be attributable, in part, to overlapping diagnostic criteria (Widiger and Shea, 1991).

Although research has demonstrated that PDs often co-occur with depressive disorders and other Axis I disorders (e.g., Zanarini et al., 1998; McGlashan et al., 2000; Dyck et al., 2001), there are significant gaps in the scientific literature. Much of the information that is currently available regarding the association between PD and depressive disorders has been obtained from cross-sectional studies of Axis I–Axis II comorbidity (e.g., Zimmerman and Coryell, 1989; Nestadt et al., 1992; Oldham et al., 1995). These studies have not been able to investigate hypotheses about the direction of the associations between PDs and depressive disorders.

A number of studies, conducted with samples of depressed patients, have investigated PD sequelae, such as the association of PD with treatment outcomes. These investigations have established that depressed patients with PDs tend to have poor outcomes, including dysthymic disorder (DD), recurrent major depressive disorder (MDD), and suicidal behavior (Pilkonis and Frank, 1988; Raczek et al., 1989; Reich, 1990; Shea et al., 1990, 1992; Perry et al., 1992; Ilardi and Craighead, 1995; Klein, 2003). However, most of these studies had samples of modest size, had relatively brief follow-up intervals (typically 1 year or less), or focused on a limited range of PDs. While many studies have investigated outcomes associated with antisocial and borderline PDs, few have investigated other PDs in a systematic way. Moreover, the findings of studies that have investigated the sequelae of PDs among patients in clinical settings may not apply to the general population. Patients with PDs differ from individuals with PDs in the remainder of the population, insofar as their symptoms tend to be more severe, and treatment may tend to have a systematic and indeterminate impact on the course and outcomes of the disorder. For these reasons, it is important for researchers to obtain data from prospective longitudinal studies of representative, community-based samples.

To date, however, few community-based studies have investigated the long-term mental health consequences of PDs. The studies that have investigated the associations of PD with subsequent depressive symptoms have focused on overall PD symptoms (Johnson and Bornstein, 1991; Johnson et al., 1996), PD clusters (Daley et al., 1999), a limited range of PDs (e.g., Kwon et al., 2000), or included bipolar disorder (Johnson et al., 1999). In all but one of these studies (Johnson et al., 1996), PDs were assessed among adolescents or college students. There have not yet been any comprehensive population-based investigations of specific types of PD symptoms, evident by early adulthood, and risk for subsequent unipolar depressive disorders. It is important to fill this gap in the scientific literature by investigating the long-term sequelae of PDs, which may not become evident until early adulthood, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000). We report findings from the Children in the Community Study, a community-based prospective longitudinal study, regarding the association of PD by early adulthood with risk for unipolar depression by middle adulthood.

2. Methods

2.1. Participants and procedures

The present findings are based on data from 658 individuals who completed comprehensive psychosocial and psychiatric interviews in 2001–2004 (mean age 33.1, SD=2.8), and in a series of previous interviews conducted during adolescence and early adulthood. The respondents and their mothers were interviewed by extensively trained and supervised lay interviewers in 1983 (N=778; mean age=13.7, SD=2.8), 1985–1986 (N=776; mean age=16.3; SD=2.8), and 1991–1993 (N=749; mean age=22.1; SD=2.7). Maternal interviews had been conducted, in 1975, regarding parental, offspring, and neighborhood