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Personality disorders evident by early adulthood and risk for anxiety disorders 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 development of anxiety disorders by middle adulthood. Individuals without a history of anxiety disorders who met diagnostic criteria for $\geq$1 PD by early adulthood were at markedly elevated risk for agoraphobia, generalized anxiety disorder, obsessive-compulsive disorder, and panic disorder by middle adulthood. Antisocial, avoidant, borderline, dependent, depressive, histrionic, obsessive-compulsive, passive-aggressive, and schizotypal PD traits, evident by early adulthood, were associated with elevated risk for $\geq$1 anxiety disorder during middle adulthood. These associations remained significant after a history of anxiety disorder and co-occurring Axis I psychiatric disorder was controlled statistically. Findings of this study suggest that some types of PD traits that become evident by early adulthood may contribute to increased risk for the development of anxiety disorders by middle adulthood.

Keywords: Personality disorder; Anxiety disorder

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1. Introduction

The association of personality disorder (PD) with risk for anxiety disorders 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 has been advanced regarding the associations of specific types of PDs with anxiety disorders and other Axis I disorders (e.g., Lyons, Tyrer, Gunderson, & Tohen, 1997). Some PDs may contribute to increased vulnerability for anxiety disorders (Faravelli et al., 2000). Common etiological factors, such as parental over-protection, have been hypothesized to underlie the development of certain types of PDs and anxiety disorders (Latas, Starcevic, Trajkovic, & Bogojevic, 2000). Another hypothesis is that some PDs and anxiety disorders (e.g., avoidant PD and social anxiety disorder; obsessive-compulsive PD and obsessive-compulsive disorder) may occupy different points along a common spectrum (Bejerot, Ekselius, & von Knorring, 1998; Dyck et al., 2001; Tillfors, Furmark, Ekselius, & Fredrikson, 2001). Some associations between PDs and Axis I disorders may also be attributable, in part, to overlapping diagnostic criteria (Widiger & Shea, 1991).

Although research has demonstrated that PDs often co-occur with anxiety disorders and other Axis I disorders (e.g., Dyck et al., 2001; McGlashan et al., 2000; Oldham et al., 1995), there are significant gaps in the scientific literature. Much of the information that is currently available on the association between PD and anxiety disorders has been obtained from cross-sectional studies of Axis I–Axis II comorbidity. These studies have yielded findings suggesting that some types of PDs may be particularly associated with specific anxiety disorders (e.g., Bejerot et al., 1998; Comtois, Cowley, Dunner, & Roy-Byrne, 1999; Dyck et al., 2001; Hoffart, Thornes, & Hedley, 1995; Noyes, Woodman, Holt, Reich, & Zimmerman, 1995; Skodol et al., 1995; Zanarini et al., 1998; Zimmerman & Mattia, 1999). However, it is not yet clear whether the associations between various types of PDs and anxiety disorders are characterized by high, low, or moderate specificity. Another concern has been that cross-sectional data do not permit inferences regarding the directionality of the associations between PDs and anxiety disorders.

Studies conducted with samples of patients with anxiety disorders have investigated PD sequelae, such as the association of PD with treatment outcomes. These investigations have indicated that patients who have anxiety disorders and PDs tend to have poor outcomes (Nurnberg et al., 1989; Perry, 1993; Reich & Green, 1991; Steketee, Eisen, Dyck, Warshaw, & Rasmussen, 1999; Turner, 1987; Yonkers, Dyck, Warshaw, & Keller, 2000). However, most of these studies have used a sample of modest size, a relatively brief follow-up interval (typically one year or less), or have focused on a limited range of PDs. Moreover, 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