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Personality disorders and quality of life. A population study

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Abstract

The purpose of the study was to investigate the relationship between specific personality disorders (PDs) and specific aspects of quality of life in the common population. The sample consisted of 2053 individuals between 18 and 65 years old. *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition* (*DSM-III-R*), axis I was studied by means of a structured interview (Composite International Diagnostic Interview) and axis II by means of a Structured Interview for *DSM-III-R* Personality Disorders; sociodemographic variables were taken into account, and broad aspects of quality of life were included.

Personality disorders appeared to be more important statistical predictors of quality of life than sociodemographic variables, somatic health, and axis I disorder. Those with avoidant, schizotypal, paranoid, schizoid, and borderline PDs had the strongest and broadest reduction in quality of life, whereas those with histrionic, obsessive-compulsive, passive-aggressive, and sadistic PDs did not show any reduction. A number of specific relationships occurred. Furthermore, the more PDs that existed and the more personality criteria fulfilled, the poorer the quality of life, pointing to the importance of comorbidity and continuity.
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1. Introduction

A number of studies have examined the quality of life of individuals with anxiety disorders [1,2], affective disorders [3], and schizophrenia [4]. In contrast, only one Australian population study [5] and one Italian study of individuals contacting community mental health services have included personality disorder (PD) in their study of quality of life and mental disorders [6]. However, their assessment of PDs was based on diagnostic rating and brief screening, and they did not distinguish between different PDs.

Subjective report of dysfunction, disability, and impairment are to some extent the reverse of quality of life, because impairment usually encompasses poor qualities in interpersonal relations. Some investigators have studied how PDs are associated with impaired functioning. Andreoli et al [7] found that patients with PDs had poorer work and interpersonal relationships. Levy et al [8] observed that youth in a psychiatric ward with PDs had lower GAF score than other adolescent patients. A number of studies have found that having a PD in addition to a symptom disorder reduces social functioning. Klass et al [9] found a lower GAF among those who had a PD in addition to anxiety disorder. Noyes et al [10] observed that PD in addition to panic disorder reduced work adjustment, social relationships, and family and marriage functioning. Skodol et al [11] found correspondingly that PDs added to drug disorders reduced the Global Assessment of Functioning (GAF) score.

Some studies have investigated specific PDs. van Velzen et al [12] found that those with avoidant PD in addition to social phobia had poorer social and occupational adjustment.

Most studies have investigated borderline PDs. Pope et al [13] found that those with borderline PD had poorer social and occupational adjustment, compared with patients with bipolar and schizoaffective disorders. Tucker et al [14] observed an improvement in friendship and family relations parallel with an improvement in borderline PD features. Daley et al [15] observed that patients with borderline features experienced more stress and conflicts and were less satisfied than other patients over a 4-year period. However, when they included other PDs in the analyses, they found that histrionic and paranoid features were better predictors of conflicts, and schizotypal and narcissistic traits were almost just as good predictors of “romantic” problems as borderline traits.

Shea et al [16] observed that the eccentric and the dramatic, not the fearful, cluster was related to poor social

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adjustment, but not to poor occupational adjustment. Torgersen [17], however, observed that those with borderline and with schizotypal PD had poorer social as well as occupational adjustment.

Two recent studies have investigated a larger number of PDs. Skodol et al [18] found dysfunction in relation to parents, sibs, and friends among patients with schizotypal, borderline, or avoidant PD; occupational dysfunction among those with schizotypal or borderline PD; and dysfunction in relation to more distant family members among those with schizotypal PD. Those with obsessive-compulsive PD were rather well functioning, compared with controls who were depressive patients without PDs. Fossati et al [19] studied aspects of close relationships: confidence, discomfort with closeness, relationships as secondary, need for approval, and preoccupation with relationships among patients with different PDs. Strongest dysfunction was observed among those with avoidant PD, followed by paranoid, depressive, borderline, schizotypal, dependent, and histrionic PDs.

In contrast to the few studies of PDs, a number of studies have demonstrated the relationship between personality traits and dimensions, and subjective well-being [20]. Subjective well-being correlated negatively with the so-called Big Five factor neuroticism and positively with the factors extraversion, agreeableness, conscientiousness, and openness to experience in descending magnitude in 2 American studies [21,22].

Based on Saulsman and Page [23], metaanalysis of Big Five and PDs, those with avoidant PD will then be expected to have most strongly deficiency in quality of life, followed by borderline, schizotypal, dependent, paranoid, schizoid, and antisocial PD. Those with obsessive-compulsive PD should not have a poor quality of life, and those with histrionic and narcissistic PD a good quality of life.

However, subjective well-being is not the only important aspect of quality of life. Also, a number of subjective relational aspects of life are important, as well as broad aspects of the good life [24-26]. Consequently, in the present study, we have included in the concept of quality of life also relation to friends, family and neighbors, self-realization, social support, and absence of negative life events.

The aim of the present study was to investigate whether PDs are related to broad aspects of quality of life, whether our prediction from the studies of personality dimensions are confirmed, and what specific relationships exist between specific PDs and specific aspects of quality of life. To our knowledge, this is the first study of quality of life and specific PDs.

2. Method

2.1. Subjects

The study was approved by the Regional Ethical Committee. Written informed consent was obtained after the study had been fully explained. The sample is described more in detail in previous articles [27,28]. Briefly, the basis was 3590 individuals between 18 and 65 years old registered in the National Population Register in Oslo in 1994. All known individuals supposed to live in Oslo are included in the Register. The 3590 individuals were drawn by chance. It turned out that only 2693 actually lived in Oslo and were possible to trace. The others had either moved out of the city or moved to an unknown address in Oslo. Four were deceased. One hundred seventy-seven was too ill, in prison, or a refugee reception center, or they could only speak a foreign language, which made it impossible for us to interview them. Of the remaining 2516 persons, 415 (16.5%) refused to be interviewed and 35 (1.4%) postponed the interview beyond the study period. Thus, 2066 subjects of the original random sample were interviewed, with 2053 adequate PD interviews.

2.2. Research instruments

The Structured Interview for *DSM-III-R* Personality Disorders (SIDP-R) [29] was applied to assess PDs in the subjects. The interviewers, mainly experienced nurses but also medical students and experienced interviewers, were trained using live patient interviews and videos of patient interviews over a period of several weeks. All interviews were conducted face-to-face, mostly at home, but some were also done at the psychiatric clinic. SIDP-R consists of 160 questions that are grouped under 16 thematic sections, such as "relationships," "emotions," "reactions to stressful situations," and so on. At the end of each section is a listing of relevant *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition* (*DSM-III-R*), criteria that are rated from 0 to 2, with brief descriptions guiding the ratings. Level 0 corresponds to "not present," and levels 1 and 2 correspond to "present to a moderate degree" and "present to a severe degree." A rating of 1 or 2 indicates criterion fulfilled.

The instructions for the SIDP-R specify a "5-year rule," which means that behavior typical of the past 5 years is the basis for the ratings. If an individual's personality changed dramatically during the past few years, the personality that dominated most of the time during the last 5 years is considered typical. The PD diagnoses were made without reference to the exclusion criteria, for example, schizophrenia for schizotypal.

The reliability was assessed by means of a rater listening to 40 audiotaped interviews. The κ for any PD was 0.84. The number of persons with a specific PD was too small for making any κ calculation. Instead, intraclass correlations for the scaled PDs were calculated. The intraclass correlation for schizoid PD was 0.78, 0.71 for paranoid, 0.92 for schizotypal, 0.78 for obsessive-compulsive, 0.78 for histrionic, 0.82 for dependent, 0.95 for antisocial, 0.83 for avoidant, 0.89 for borderline, 0.95 for passive-aggressive, 0.87 for sadistic, and 0.85 for self-defeating PD. The median intraclass correlation was thus 0.83.

Demographic variables such as age, marital status or living together, or alone, and sociodemographic variables

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