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# Personality traits in the differentiation of major depressive disorder and bipolar disorder during a depressive episode



Jaciana Marlova Gonçalves Araujo\*, Miguel Bezerra dos Passos, Mariane Lopez Molina, Ricardo Azevedo da Silva, Luciano Dias de Mattos Souza

Postgraduate program in Health and Behavior, Catholic University of Pelotas, Pelotas, Rio Grande do Sul, Brazil

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## ABSTRACT

The aim of this study was to determine the differences in personality traits between individuals with Major Depressive Disorder (MDD) and Bipolar Disorder (BD) during a depressive episode, when it can be hard to differentiate them. Data on personality traits (NEO-FFI), mental disorders (Mini International Neuropsychiatric Interview Plus) and socioeconomic variables were collected from 245 respondents who were in a depressive episode. Individuals with MDD (183) and BD (62) diagnosis were compared concerning personality traits, clinical aspects and socioeconomic variables through bivariate analyses (chi-square and ANOVA) and multivariate analysis (logistic regression). There were no differences in the prevalence of the disorders between socioeconomic and clinical variables. As for the personality traits, only the difference in Agreeableness was statistically significant. Considering the control of suicide risk, gender and anxiety comorbidity in the multivariate analysis, the only variable that remained associated was Agreeableness, with an increase in MDD cases. The brief version of the NEO inventories (NEO-FFI) does not allow for the analysis of personality facets. During a depressive episode, high levels of Agreeableness can indicate that MDD is a more likely diagnosis than BD.

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## 1. Introduction

Scales that evaluate the five factors of personality (Agreeableness, Conscientiousness, Extraversion, Neuroticism and Openness to experience) have been utilized in clinical contexts to profile individuals and psychopathological manifestations. Despite not being created for diagnostic purposes, these scales can provide important clinical information (McCrae and Costa, 1987). Some studies have analyzed differences in personality factors between individuals with Major Depressive Disorder (MDD), Bipolar Disorder (BD) and euthymic subjects. MDD and BD are disorders that differ in manifestation, course and treatment. However, particularly during depressive episodes, it can be hard to differentiate them due to patient speech bias and symptoms overlap (American Psychiatric Association, 2013). Therefore, more information is necessary about differential characteristics in these circumstances.

According to Karsten et al. (2012), it is also possible to observe differences during depressive episodes in comparison with euthymia. This is particularly well-established for Neuroticism, with an increase, and extraversion and conscientiousness, with probable decrease. Harkness et al. (2002) found this same pattern in

individuals with BD, all in depressive episodes. Regarding the other traits, there is no consensus in the literature and some studies have found data indicating that Openness and Agreeableness may remain stable (in comparison with normative data) during depressive episodes (Harkness et al., 2002; Karsten et al., 2012).

As can be observed, both disorders share similar personality profiles when compared to euthymic individuals. Nevertheless, when compared amongst themselves, there is no consensus regarding differences in personality traits. Quilty et al. (2013) found that E and A significantly predicted the diagnosis of BD versus MDD at the domain level, although they did not control for current mood state, except for excluding individuals in severe manic episode. Barnett et al. (2011) evaluated a sample of individuals diagnosed with BD and another with MDD, comparing solely subjects in euthymic vs euthymic or depressed vs depressed mood states. The results showed higher levels of O in the sample with a BD diagnosis, without significant differences in the other factors. In another study, however, the only difference between both disorders were higher levels of E in BD, when compared to MDD (Coulston et al., 2013).

It is possible to note a lack of agreement between these findings. At the same time, this demonstrates that differentiating between MDD and BD is, still today, a hard task. The diverse findings in relation to the personality factors may be related not necessarily to an incongruity, but to the different methodologies used in the

\* Corresponding author.

E-mail address: [jacianamga@hotmail.com](mailto:jacianamga@hotmail.com) (J.M.G. Araujo).

studies, which are very different between themselves. Considering sample type, some of these studies compare between depressed patients and population norms (Harkness et al., 2002; Karsten et al., 2012), others compare between both disorders while in euthymia (Coulston et al., 2013). Methodologies also differ by not taking mood state into account (Quilty et al., 2009, 2013), or clinical characteristics, such as comorbidities and suicide risk (Barnett et al., 2011).

These methodological differences can have great influence in the results of the works and their interpretation. Comparison between disorders during symptoms remission presupposes obtaining very diverse data in comparison to population norm, for example. While one aims to differentiate diagnoses independently of symptomatic manifestations, in the second one, the data points to how much the presence of the diagnosis differs the individual's characteristics in relation to the others in a specific population. Nevertheless, despite variations in methodology, personality has been associated with these diagnoses.

One can understand that, despite the similarities between both disorders, especially during depressive episode, personality factors may indicate differences between MDD and BD. The severity of the clinical condition may also play an important role in these differences, something that was not entirely considered in previous studies about the subject. In this sense, the present work has as a strong point of its methodology the fact that the sample is composed only of individuals in current depressive episode. In addition to that, the fact that the evaluations were done by professionals trained for this purpose grants high validity to the diagnostic process. The ample gamma of additional information collected, such as presence of anxiety comorbidities and suicide in addition to sociodemographic data, also corroborates the methodological strength of the study. Due to this excellent availability of data, which was obtained in an ample sample, and the care in the conduction of the study's aims, we believe that this study is qualified to contribute to the current existent scientific findings.

Due to the difficulty in distinguishing MDD from BD during depressive episodes, and aiming to evidence indicators that may help with this distinction, this study aimed to determine the differences in the personality traits of individuals with Major Depressive Disorder and Bipolar Disorder, during a depressive episode, in a clinical sample. We hypothesized that Extraversion, Conscientiousness and Agreeableness would act as differentials, with the former being higher in BD and the latter two being higher in MDD.

## 2. Method

### 2.1. Design

This was a cross-sectional study nested within a larger study that aimed to evaluate the mental health profile of patients that sought care in the Clinic of Research and Extension in Mental Health (CREMH) of the Universidade Católica de Pelotas (UCPEL).

### 2.2. Sample

Individuals aged 18–60 years were invited to participate in the study. The service (CREMH) contacted public health facilities in the urban area of Pelotas, from July 2012 to August 2014, including Primary Care Units, Psychosocial Care Centers and other health care services, in order to promote the research. The patients were invited to take part in a research composed of an evaluation that was comprised of several health and behavior aspects as well as a psychological evaluation. This psychological evaluation aimed to verify if the patient met criteria for one of the diagnoses (Major Depressive Disorder, Bipolar Disorder, Obsessive-compulsive Disorder and Post-traumatic Stress Disorder), for which the service offered treatment through clinical trials. The recruitment also included articles published in a local newspaper, and referrals from ongoing researches at the university. In conclusion, this was a convenience sample with patients that sought the study's

outpatient service themselves and/or had been referred from basic health units and mental health facilities in the city. Inability to understand the instruments and presence of severe psychotic symptoms were all considered as exclusion criteria. 500 people were evaluated, but, considering the aims of the current study, only the data of the ones in current depressive episode ( $n=245$ ) were analyzed, in other words, the rest of the sample was excluded from the present study because they did not fulfill this criterion. Patients received no direct compensation, such as payment or something equivalent. Nevertheless, in cases in which the patient was included in the treatments offered by the clinical trials (previously cited), this treatment can be understood as compensation for their participation in the initial evaluation.

### 2.3. Variables

The evaluation instrument was composed of a questionnaire that was responded directly into tablets through the Open Data Kit program (Hartung et al., 2010), containing the following variables: gender, age, marital status, education, work. The economic status of the participants was verified through a scale developed by the Brazilian Association of Research Companies (ABEP) (ABEP-Associação Brasileira de Empresas de Pesquisa, 2003). This scale is based on the accumulation of material goods and the education level of the family chief, categorizing people among the socioeconomic classes A, B, C, D and E. Due to the fact that none of the respondents belonged to class E and that there were few individuals in classes A (1.2%) and D (5.7%), these were added to the others so that this variable could be interpreted between higher classes (A+B) and lower classes (C+D).

The evaluation of Axis I disorders was conducted through the structured clinical interview for the DSM-IV – Mini International Neuropsychiatric Interview Plus version (MINI Plus) (Sheehan et al., 1997). This is an interview adapted for the clinical setting and represents an adequate alternative for patient evaluation, according to international criteria, in both clinical and epidemiological studies (Amorim, 2000). The investigated diagnoses were the following: major depressive disorder; bipolar disorder; dysthymia; suicide risk; panic disorder; generalized social phobia; obsessive-compulsive disorder; post-traumatic stress disorder and generalized anxiety disorder. Anxiety disorders were computed into a single variable according to the presence of one of the assessed anxiety disorders<sup>1</sup>. Suicide risk was also considered as a dichotomous variable and both anxiety disorders and suicide risk were considered as comorbidities. The comparisons were made between groups of individuals with MDD and BD. Regarding MDD, in some cases this was the first episode and in others they were recurring. In order to consider that the patient had BD, previous occurrences of one or more manic or hypomanic episodes (in addition to being in current depressive episode) were investigated.

The diagnostic interviews were conducted by post-graduate psychology students trained for the use of the MINI, which is the instrument used in this stage of the evaluation in order to standardize it. Weekly supervisions with the participation of the raters and two teachers with a large experience in diagnosing mental disorders were realized. In addition to that, in cases in which it was difficult for the first rater to establish the diagnosis with certainty, a second rater (these being psychiatrists who were also post-graduate students) would realize a clinical diagnostic interview with the patients and then the raters would discuss the case among themselves and the supervisors to reach a consensus. No reliability tests between raters were realized, given that two professionals would only evaluate the same patient in cases of uncertainty.

The evaluation of personality traits done through the Revised NEO Five-Factor Inventory (NEO-FFI-R) (Costa and McCrae, 2007). This instrument is a brief version of the NEO-PI-R: an instrument based on the Big Five model proposed by Paul Costa and Robert McCrae (McCrae and Costa, 1987). The version used is constituted of 60 items, which provide a brief and comprehensive measure of the five domains of personality. The test is composed of affirmatives sentences that are answered with one of five alternatives in a Likert scale.

### 2.4. Statistical analysis

The SPSS 21 program was used for the statistical processing of the data. Univariate analysis was performed using simple frequencies. The chi-square and ANOVA statistical tests were used in the bivariate analyses, in which results with a  $p < 0.05$  were considered significant. Effect size for difference in personality factors between diagnoses was estimated through Cohen's  $d$  formula and interpreted considering Cohen (1992). The multivariate analysis included only variables with a  $p \leq 0.20$  in the bivariate analyses (Victoria et al., 1997). Logistic regression was used for the multivariate analysis.

<sup>1</sup> This was done because low prevalence of each disorder was observed. Also, it was not this study's goal to investigate if a specific anxiety disorder was more prevalent in MDD than in BD, but to investigate if the presence of comorbidities would be a differential between these conditions. Therefore, while anxiety disorders are very different between each other, as we used an interview (MINI Plus) based on the DSM-IV-TR classification, they were summed into a single variable and analyzed solely as present or absent.

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