Original article / *Araştırma*

Effects of comorbid personality disorders in bipolar type I disorder patients to disease course

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ABSTRACT

Objective: It was planned to compare bipolar I patients (BP-I) with personality disorder (PD) and without any personality disorder in terms of variables such as disease characteristics, disease course, suicide risk, alcohol and substance use. **Methods:** This cross-sectional study 99 patients with BP-0I according to DSM-IV TR and gave to informed consent were included. Sociodemographic Data Form, Hamilton Depression Scale, Young Mania Scale, and DSM-IV-TR-SCID-II were administered to participants. **Results:** At least one PD was detected in 38 (38.4%) patients with BP-I. Histrionic type (18%) PD was the most common in patients. Two types of PD were found in 21.2% and three types of PD were found in 6.1% of the participants. In patients without personality disorder, the mean number of hospitalizations and the total number of manic episodes were high while the total number of depressive episodes was low. The incidence of atypical depression, attempted suicide, and alcohol-substance abuse were statistically higher in patients with multiple PD than non-PD group. **Conclusion:** BP-I patients with multiple PD have more depressive episodes than non-PD patients; this group of patients should be considered as a special subgroup that should be followed carefully because of the atypical nature of these attacks, more suicide rates and the use of more alcohol and substance. In addition, these patients lower hospitalization times may need to be interpreted in favor of not being able to complete the treatment. For this reason, it may be important to monitor these patients outpatiently. *(Anatolian Journal of Psychiatry 2019; 20(3):237-244)*

Keywords: bipolar disorder, personality disorder, comorbidity

Bipolar tip I bozukluk hastalarında kişilik bozukluğu eş tanısının hastalığın gidişine etkileri

ÖZ

Amaç: Bir kişilik bozukluğu (KB) olan ve herhangi bir KB olmayan bipolar tip I bozukluğu (BP-I) hastalarının hastalık özellikleri, hastalığın gidişi, intihar riski, alkol ve madde kullanımı gibi değişkenler açısından karşılaştırılması planlanmıştır. **Yöntem:** Kesitsel desendeki bu çalışmaya, DSM-IV-TR'e göre BP-I tanısıyla izlenen ve gönüllü onamı alınan 99 hasta alınmıştır. Katılımcılara Sosyodemografik Veri Formu, Hamilton Depresyon Ölçeği, Young Mani Ölçeği ve DSM-IV-TR-SCID-II yönergesi uygulandı. **Bulgular:** BP-I bozukluk hastalarının 38'inde (%38.4) en az bir KB saptandı. Hastalarda en fazla histriyonik KB (%18) bulundu. Katılımcıların %21.2'sinde iki çeşit KB, %6.1'inde üç çeşit KB saptandı. Birden fazla KB olan ve KB olmayan BP-I hastalar klinik özellikler açısından karşılaştırıldığında, KB olmayan hastalarda ortalama yatış süresi ve toplam manik atak sayısı yüksekken, toplam depresif atak sayısı düşük bulundu. Birden fazla KB olan hastalarda atipik depresyon görülme, intihar girişiminde bulunma ve alkol-madde kullanma oranları, KB olmayan gruptan istatistiksel olarak yüksek bulundu. **Tartışma:** Birden fazla KB olan BP-I hastaları KB olmayanlara göre daha fazla depresif atak geçirmeleri, ayrıca bu atakların atipik özellikli olması,

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daha çok alkol/madde kullanmaları ve daha çok intihar etme oranları göz önünde bulundurularak dikkatle izlenmesi gereken özel bir alt grup olarak ele alınmalıdır. Ayrıca bu hastaların daha düşük oranda hastanede kalma süreleri de tedaviyi tamamlayamama lehine yorumlanarak izlemelerinde ayaktan tedavinin daha ön planda olmasına özen gösterilmesi gerekebilir. **(Anadolu Psikiyatri Derg 2019; 20(3):237-244)**

Anahtar sözcükler: *Bipolar bozukluk, kişilik bozukluğu, eş tanı*

INTRODUCTION

Bipolar disorder (BD) is a psychiatric disorder characterized by heterogeneous nature.[1] This is caused both by the nature of the disease and by other comorbid conditions. Personality disorders (PD) have a significant place among comorbid diseases. As the PD can impair the mental, behavioral and cognitive processes of the individual comorbidity with BD can make diagnosis, handling and management even more difficult. Thus, PD is defined in DSM-5 as a chronic disorder with significant effects on mood, behavior, cognition, and interpersonal relationships.[2,3]

There are many studies on BD comorbid PD in literature. However, few studies on multiple PD have been achieved, and PD comorbidity rates are also very variable (9-89%).[4-7] Obsessive compulsive, borderline and narcissistic PD is the most common personality disorders in BP-I.[4,5]

A meta-analysis study has supported the previous different from aech other results by suggesting the factors such as changes in diagnostic systems (DSM-III-R versus DSM-VI), methodologic differences, and studies with inpatients and outpatients.[8] Herein, possible contributions of the culture must also be considered, which indeed this confounding factor has not been addressed in many studies.[9]

The comorbidity of PD and bipolar type I (BP-I) indicates an increase in disease burden and time lost due to disease. Having a comorbid PD disrupts the outcome or prognosis for several reasons. Firstly, the negative impacts on treatment response could be indirectly leading to increase in psychopathology.[8,10] Secondly, the risk of poor outcome following antidepressant treatment duplicates, which could lead significant impaired psychosocial and vocational functioning.[11] PD comorbidities increase residual symptoms, reduce functioning, cause early onset of the disease, and increase suicidal thoughts and behavior.[12,13] In some publications it was suggested that PD causes patients to be more susceptible to affective disorders.[14,15]

BP-I patients with more than one PD may lead to different outcomes and progression in compared to those with only one type PD.[16] In this study, it was aimed to investigate different clinical course characteristics (such as, age at onset, type and feature of episode, duration of hospitalization and alcohol-drug use) of BP-I patients comorbid multiple PD, thus it was hoped that the points to be considered in the follow-up of this patient group, especially the risk of suicide.

METHODS

Participants

We taken to study consecutively 121 patients, called BP-I disorder according to DSM-IV-TR diagnostic criteria, who followed up by the structured applied form since 2003 in Rasit Tahsin Mood Disorder Center (RTMDC) came to between December 2009 and March 2010. However, it was possible to complete the study with a sample of 99 persons who gave informed consent in accordance with the study criteria.

Inclusion criteria:
1. between the ages of 18-65,
2. do not having mental retardation,
3. having been educated for at least five years,
4. give written consent to agree to participate in the study,
5. not having any neurological disorder chronic or medical condition that is likely to affect a central nervous system functions,
6. clinical remission within the past month.

The remission criteria has been identified seven points for the Hamilton Depression Rating Scale and five points for the Young Mania Rating Scale.[4]

In the patients with BP-I disorder who participated in the study, sociodemographic data form and SCID-II interview schedule, Hamilton Depression Scale and Young Mania Scale were applied.

Sociodemographic Data Form: Semistructural form developed by researcher, includes number, type and duration of episodes and illness, the presence of psychotic symptoms, the presence and/or number of suicide attempts, the number and duration of hospitalizations, substance use, and demographic and clinical variables. Information was obtained from follow up files and inter-

views with patients and at least one patient's relatives.

SCID-II Interview Schedule: It is a chart of validity and reliablity made in 1994 and devoloped for detect to personality disorders. At the end of the interview, there is a summary section evaluating the criteria for personality disorders. This assessment focused on the ten PD categories specified in DSM-IV.[17,18]

Hamilton Depression Rating Scale: The scale was developed to assess the level of depression. Turkish reliability and validity was also published. Fourteen points and and above points to depression. The reliability and validity study for our country was conducted by Akdemir et al.[19, 20]

Young Mania Scale: It is a non-diagnostic scale but reflects to clinical aspect of the patient's; aimed to evaluated by the clinician for the last week.[21] The validity and reliability studies were conducted by Karadağ et al.[22]

Statistical analysis

SPSS 18.0 for Windows program was used for statistical analysis. Student t test was used in evaluating quantitative measurements (average, standard deviation, frequency) and as well as descriptive statistical methods when study data were evaluated. Chi-square test and Fisher's exact test were used to compare qualitative data. The results were evaluated in a confidence interval of 95% and a significance level of $p < 0.05$.

RESULTS

Ninety-nine patients with BP-I diagnosis were included in this study. The mean age of the sample was 33.71. The majority of the group graduated from high school or higher education. Approximately half of the patients were working. (Table 1)

Table 1. General characteristics of the study groups

	No personality disorders Total patient=61		With personality disorders Total patient =38		Test	p
	n	%	n	%		
Age (Mean±SD, years)	33.84±8.47		33.50±9.33		t=0.18	>0.05
Gender					χ^2=0.01	>0.05
Male	28	45.9	17	44.7		
Female	33	54.1	21	55.3		
Education level					χ^2=4.12	>0.05
Primary school	11	18.0	7	18.4		
Middle school	5	8.2	8	21.1		
High school	26	42.6	11	28.9		
University	19	31.1	12	31.6		
Marital status					χ^2=2.03	>0.05
Married	21	34.4	14	36.8		
Job					χ^2=2.62	>0.05
Not working	23	37.7	10	26.3		
Working	38	62.3	28	73.7		

When the sociodemographic data were compared, the education level, occupation and marriage rate were no differences between with PD and non-PD groups.

In 61 (61.6%) of the patients did not have PD and at least one PD was detected in 38 (38.4%) patients. The most common PD was histrionic PD (18%), whereas antisocial PD was not detected at all. (Table 2)

Two types of PD were detected in 21.2%, and three types of PD were detected in 6.1%. The proportion of patients with only one PD was 11.1%. (Table 3)

The mean day of hospitaly stay (t=3.18) and total number of manic episodes (t=2.57) were significantly higher in non-PD patients compared to those with more than one PD, while total depressive episodes (t=2.40) were significantly lower (p<0.05). (Table 4)

Comparison of depressive episodes between the groups revealed the prevalence of atypical depression in 29.6% of patients with more than

Table 2. Personality disorders types

Cluster types	n	%
A Cluster		
Paranoid personality dis.	8	8
Schizoid personality dis.	3	3
Schizotypical personality dis.	2	2
B Cluster		
Antisocial personality dis.	0	0
Borderline personality dis.	16	16
Narcissistic personality dis.	1	1
Histrionic personality dis.	18	18
C Cluster		
Avoidant personality dis.	3	3
Dependent personality dis.	3	3
Obsessive compulsive personality dis.	16	16

Table 3. Co-occurrence rates of personality disorders types

Number of types of personality disorders	n	%
Only one types of personality disorders	11	11.1
Two types of personality disorders	21	21.2
Three types of personality disorders	6	6.1

one PD. The difference between the groups was statistically significant (χ^2=5.48, p<0.05). (Table 5)

The rate of suicide attempt was 29.6% in patients with more than one PD and 9.8% in the other group. The difference between the groups was statistically significant (χ^2=5.48, p<0.05). (Table 5)

Finally, the proportion of patients using alcohol (χ^2=4.56, p<0.05) and substance (χ^2=7.02, p<0.05) was significantly higher in patients with more than one PD compared to the non-PD group. Alcohol and drug dependence rates were 22.2% and 1.1% in more than one PD cases, respectively. The incidence of alcohol use in the non-PD group was 6.6%, while substance abuse was not detected. (Table 5)

DISCUSSION

In this study, PD was determined as 38%, two types of PD as 21.2%, and three types of PD as 6.1% of total sample. These rates and study design are also quite different than local studies.[4,13,14]

We were able to reach only one publication studying the multiple comorbid PD and BP-I in Turkey.[12] This study based on the diagnosis criteria of DSM-IV found PD as 57%, two types of PD as 20%, and three types of PD as 3% likewise the results of our study. In other studies organized according to DSM-III, PD ratio was determined as 47%[9] and 62%[14]. Although the diagnostic systems are different, this situation alone is not considered to be explanatory for the differences between the determined rates.[5,9,23] The most common PD in our study was rate with 18% histrionic PD. Obsessive-compulsive PD and borderline PD rate were 16%. Within the binary PD, the dominant group were B and C combination. Additionally a recent meta-analytic review of 122 publications supports our results too, emphasizing that B and C cluster PD are seen more often while obsessive-compulsive

Table 4. Comparison of disease course among groups

	No PD n=61 Median±SD	More than one PD n=27 Median±SD	t	p
Age at onset of illness	23.02±7.13	21.96±5.72	0.85	>0.05
Age of first treatment	24.02±7.60	23.07±5.82	0.57	>0.05
Total number of hospitalization	2.38±2.11	1.67±2.23	1.43	>0.05
Mean hospitalization stay	20.25±11.05	11.44±13.84	3.18	<0.05
Total attack number	7.59±4.75	8.70±5.24	0.98	>0.05
Average number attac year	0.92±0.90	0.88±0.40	0.21	>0.05
Number manic attack	2.92±2.17	1.89±1.50	2.57	<0.05
Number mixed attack	0.49±0.84	1.00±2.00	1.27	>0.05
Number hypomanic attack	1.79±1.63	2.22±2.15	1.04	>0.05
Number depressive attack	2.31±2.02	3.56±2.66	2.40	<0.05
Number psychotic attack	1.26±1.49	0.96±1.37	0.89	>0.05
Number drugs used	2.13±0.84	2.15±0.81	0.09	>0.05

Table 5. Comparison of disease course among groups

	No PD (n=61)		More than one PD (n=27)		χ^2	p
	n	%	n	%		
Melancholia	6	9.8	3	11.1	0.03	>0.05
Atypical depression	6	9.8	8	29.6	5.48	<0.05
Suicide in the past	6	9.8	8	29.6	5.48	<0.05
Alcohol use	4	6.6	6	22.2	4.56	<0.05
Substance use*	0	0	3	11.1	7.02	<0.05

*: Fisher's exact test

and borderline-type PD are seen more frequently.[8]

Recently, borderline PD is believed to be intertwined with BP I and many publications claim that it can take place in the same spectrum.[24-26] Additionally, phenomenology, etiology, family history, biological studies, going and ending of the disorder, response to drug treatment could be used to distinguish these two clinical forms.[3] In our sample, in accordance with the recent studies, the narcissistic PD was found as 1% whereas the antisocial PD was not found, paranoid PD 8%, schizoid KB 3%, schizotypical PD 2%, dependent PD 3%, avoidant PD 3%. These ratios are consistent with the literature in foreign countries.[4,13,27,28]

On the other hand, it is difficult to explain the literature, when examining the rates of PD in epidemiological studies on this issue.[4,13,,23,29] Therefore, the different results of this study should be discussed in this context.

The presence of PD is a significant clinical entity for bipolar disorder, as it requires separate approaches in terms of the course, outcome and treatment approaches.[8,11,16] In this context it would be an heavier clinical picture to anticipate and manage the multiple PD. In this study, multiple PD is stated as a factor that determines the course of the disorder.

There was not a significant difference among first attack type, age at onset of the disorder, rapid cycling, manic shift, and chronic course. Another study in Turkey has found that the presence of comorbid PD was related to the early age at onset of the disorder.[4] However, there was not a significant difference related to age of onset in this study.

There was a significant decrease in average length of hospitalization in BP I patients with more than one PD than those without PD. This kind of result has yet to be discussed in literature. Besides a study in Turkey stated that bipolar patients had similar durations of manic and depressive episodes.[30] In a study conducted in Korea last year, bipolar patients with short term hospitalization were found to have higher rates of marriage and work,[31] except that the rates of more than one comorbid PD was significantly lower in this sample. But in our sample, there is no difference between the two groups in terms of marriage and study, and the multiple PD ratio is higher. So it can be said that early discharge of our patients is related to adjustment problems rather than social adaptation purposes. Yet it must be hold in mind that although this condition statistically shortens the hospitalization period it should not be interpreted as a good prognostic trait. It should be kept in mind that it can be considered as a factor that makes treatment difficult and even a factor that could lead to incomplete treatment regardless of the type of attack.

There are multiple studies indicating that the gender (specifically males) and hyperthymic temperament have a role predicting the increase of manic attacks.[32-34] There are fewer male participants than females in our study (54 females, 45 males). This difference may have affected the results in this contex. In our study, the total numbers of manic attacks were significantly higher in the group with no PD thanthose with more than one PD. Latest studies showed that women who have bipolar disorder are expected to have dominant depressive polarity. More importantly, those studies highlighted that two variables are responsible for most clinical variation related to gender: dominant polarity type, common in women and in depressive period; cocain abuse, common in men.[35] These results explain the dominant depressive attack in women side. The sensitivity

to be neglected and frustrated commonly seen in persons with some personality disorders, such as borderline or histrionic personality disorder, higher in this group, and the tendency to easily get inside of dysphoric or depressed situations may cause the depressive episode. Tendency to and relationship with depression in PD are partially unique. Therefore, depression may appear differently in different types of PDs.[36] It can be interpreted that these results explain the higher rates of depressive attacks in those with PD in a way.

In addition, these results are parallel to the results of another study stating that individuals who have atypical depression tend to have higher rates of PD.[37] Multiple PDs cause at least two different personality traits in person. This result can be responsible for the atypical clinical picture by changing the clinical picture mostly known.[38] Summary, these findings indicate that bipolar patients with PD, especially the depressive episodes, should be evaluated more carefully.

25-50% of patients who have bipolar disorder tend to commit suicide at least one time throughout the life.[39] Among risk factors there are age at onset of disorder, suicide history, familial suicide history, borderline PD, substance-use disorders, and hopelessness.[20,29] Supportively there are numerous publications identifying that bipolar disorder with comorbit PD increases the risk of suicide in patients.[12,19,27,39] In this study it is found that multiple PDs tend to have significantly higher rates of suicide history (29%) when compared to the bipolar patients with no PDs. Beside the fact that studies have confirmed that Cluster B, especially with presence of borderline

PD, is a risk factor for patients to commit suicide,[40] traits related to the process of disorder become more important. It is crucial that patients with multiple PDs should be observed carefully in terms of suicide risk because of hopelessness due to increased rates of depressive attacks and of increased substance use.

Finally, patients with multiple PDs had higher rates in alcohol and substance use in our study, 22.2% and 1.1% respectively. These rates are significantly higher than those of patients with no PDs. BP-I patients with comorbid PD are prone to use alcohol and substance. This is a factor that increases the severity of disorder and affects the process negatively by increasing depressive attacks and suicidal behavior.[27,32,38] Besides, BD I patients with alcohol use are suggested to treat as a special subgroup due to increased risk of early onset and increased suicidal behavior.[40] Therefore patients with multiple PDs should be also considered as another special subgroup in terms of the course caharacteristics of disorder.

Under these results, this study is the first publication accessible in local literature describing the differences between course characteristics of patients with multiple PDs. In addition, the results reveals the dramatic increase in suicidal behavior, alcohol and substance use, depressive attacks, and atypical characteristics. However, these results need to be further results with broader samples, future-focused, and longitudinal. We hope to bring new points in literature for the treatment process especially for the culture-based cases.

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