Personality Disorders Among Subjects Recovered from Eating Disorders

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Abstract: Objective: Personality disorders are common in symptomatic eating disorders subjects. Because personality symptoms could be exaggerated by malnutrition or Axis I disorders, we studied women who had recovered from eating disorders for at least 1 year to see if personality disorder symptoms persisted in the well state. Method: Personality disorders were evaluated in 10 women recovered from anorexia nervosa (AN), 28 women recovered from bulimia nervosa (BN), and 16 women recovered from AN and BN, using the Structured Clinical Interview for DSM-III-R personality disorders. Results: Fourteen of 54 subjects (26%) met the criteria for at least one personality disorder, such as self-defeating, obsessive-compulsive, or borderline personality disorder. Cluster B personality disorders were closely associated with bulimic subtypes. Conclusions: While a recovery from eating disorders may have an attenuating influence on the symptoms of personality disorders, such personality disorder diagnoses persist after recovery in some recovered subjects. © 2000 by John Wiley & Sons, Inc. Int J Eat Disord 27: 353–357, 2000.

Key words: eating disorder; personality disorder; recovery

INTRODUCTION

Personality disorders (PDs) have been extensively investigated in patients with eating disorders (EDs; Gartner, Marcus, Halmi, & Loranger, 1989; Wonderlich, Swift, Slotnick, & Goodman, 1990; Braun, Sunday, & Halmi, 1994; Kennedy et al., 1995; Matsunaga, Kiriike, Nagata, & Yamagami, 1998). In spite of a close association between PDs and EDs, it has been suggested that as one of the problems inherent to the categorical typology for PDs, the presence of Axis I disorders, such as depression, influences the expression or the measurement of PDs (Shea, Widiger, & Klein, 1992; Zimmerman, 1994; McDavid & Pil-
konis, 1996). Similarly, treatment for Axis I disorders may have an attenuating influence on the course and stability of PD diagnoses (Ricciardi et al., 1992; McDavid & Pilkonis, 1996). Some studies on PD comorbidity among ED patients pointed out the significant effect of the clinical course of EDs on the PD diagnoses, including borderline PD (Ames-Frankel et al., 1992; Steiger, Stotland, & Houle, 1994). In addition, the presence of depression or anxiety in a majority of eating-disordered subjects may confound attempts to assess personality functioning, as the acute disturbance may bias the judgments of both subjects and their evaluators (Vitousek & Manke, 1994). It is thus possible that a variety of clinical features typical of EDs might exert some influence on the assessment of the personality pathology. It is uncertain as to whether the personality characteristics of ED subjects, commonly described in the previous studies, may truly reflect their enduring personality pathology, even under the possible state-biasing effect caused by the presence of EDs. To examine these issues, we assessed PDs among subjects who were recovered for at least 1 year from EDs.

METHOD

The subjects were 10 women recovered from anorexia nervosa (RAN), 16 women recovered from anorexia nervosa and bulimia nervosa (BAN), and 28 women recovered from bulimia nervosa (NWB) diagnosed according to criteria outlined in the 3rd Rev. ed. of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R; American Psychiatric Association, 1987). After receiving a complete description of this study, all subjects gave signed informed consent to participate in the study. All subjects had previously received treatment for EDs at Western Psychiatric Institute and Clinic (WPIC) at the University of Pittsburgh Medical Center Health System. Each subject had maintained a stable normal weight and had not binge eaten, purged, or engaged in restrictive eating patterns for at least 1 year prior to this study. To assess the DSM-III-R PDs, all subjects were directly interviewed face-to-face using the Structured Clinical Interview for DSM-III-R PDs (SCID-II; Spitzer, Williams, & Gibbon, 1987). Interviewers were master’s or doctoral-level psychologists with extensive experience in diagnostic assessment with structured interviews.

Significant mean group differences for parametric variables were evaluated using one-way analysis of variance (ANOVA) followed by the Scheffe test. Nonparametric variables were compared with chi-square tests with 1 df and Yate’s correction for discontinuity. Fisher’s exact tests were also used for factors with expected cell frequencies of less than 5. Significance level was set at $p < .05$.

RESULTS

There were no significant differences in age and length of recovery among the three ED groups. Subjects in the BAN group were significantly younger in age at onset than subjects in the NWB group ($F = 2.54, df = 2.51, p < .05$). Both subjects in the RAN and BAN groups had significantly lower percentage of average body weight (ABW) in their lifetime than subjects in the NWB group ($F = 71.3, df = 2.51, p < .01$). Subjects in the NWB group were significantly more likely than the other groups to have had higher percent ABW in their lifetime ($F = 6.15, df = 2.51$, NWB vs. RAN; $p < .01$, NWB vs. BAN; $p < .05$).

In the assessment of PDs using the SCID-II, 14 (26%) of the subjects, including 2 RAN
subjects (20%), 6 BAN subjects (38%), and 6 NBW (21%), met the threshold diagnoses for at least one PD. When all of the subjects were considered together, self-defeating PD was most commonly found (11%), followed by obsessive-compulsive PD (9%), borderline and dependent PDs (7%, each), histrionic PD (6%), and then avoidant PD (4%). Among three clusters of PDs, the anxious-fearful (cluster C) PDs, such as obsessive-compulsive, dependent, or avoidant PD were most frequently diagnosed, followed by the dramatic-erratic (cluster B) PDs, such as borderline PD. With respect to the odd-eccentric (cluster A) PDs, there were only 2 subjects in the BAN group who met the criteria for either paranoid or schizotypal PD.

Table 1 compares the prevalence of three clusters of PDs, and borderline, obsessive-compulsive, avoidant, and self-defeating PDs among the three groups. In the comparison of the threshold diagnoses of each cluster or PD, no significant differences were detected among the three groups. However, after including the subthreshold diagnoses of each PD in this comparison, both subjects in the BAN and NWB groups were significantly more likely than subjects in the RAN group to have cluster B PDs (Fisher’s exact test, \( p < .05 \)). They also showed a trend toward a higher prevalence of borderline PD compared with the subjects in the RAN group.

**DISCUSSION**

A considerable proportion (26%) of the subjects recovered from EDs met threshold criteria for DSM-III-R PD diagnoses. This is lower than the rate of PD found in subjects

<table>
<thead>
<tr>
<th>Cluster A</th>
<th>RAN (N = 10)</th>
<th>BAN (N = 16)</th>
<th>NWB (N = 28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thr</td>
<td>0</td>
<td>2 (13)</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1 (10)</td>
<td>3 (19)</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Cluster B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thr</td>
<td>0</td>
<td>4 (25)</td>
<td>4 (14)</td>
</tr>
<tr>
<td>Borderline</td>
<td>0</td>
<td>7 (44)*</td>
<td>11 (39)*</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>2 (13)</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Cluster C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thr</td>
<td>1 (10)</td>
<td>7 (44)</td>
<td>3 (11)</td>
</tr>
<tr>
<td>Obsessive-compulsive</td>
<td>1 (10)</td>
<td>3 (19)</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Avoidant</td>
<td>3 (30)</td>
<td>6 (38)</td>
<td>8 (29)</td>
</tr>
<tr>
<td>Self-defeating</td>
<td>0</td>
<td>1 (6)</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Total</td>
<td>2 (20)</td>
<td>3 (19)</td>
<td>3 (11)</td>
</tr>
</tbody>
</table>

Note: Values are expressed as numbers (%). Thr = threshold diagnoses; Total = total numbers of threshold and subthreshold diagnoses. RAN = recovered from anorexia nervosa; BAN = recovered from anorexia and bulimia nervosa; NWB = recovered from bulimia nervosa.

*\( p < .05 \) compared to the anorexia nervosa group. Comparisons are made using chi-square tests with 1 df and Yates’s correction for discontinuity. Fisher’s exact tests were also used for factors with expected cell frequencies of less than 5.
with active EDs (51–74%; Gartner et al., 1989; Wonderlich et al., 1990; Braun et al., 1994; Kennedy et al., 1995; Matsunaga et al., 1998). There may be several reasons for this difference. First, the rate of PDs, which may predict poor ED outcome, may be higher in a chronically ill sample (Wonderlich, Fullerton, Swift, & Klein, 1994; Steiger & Stotland, 1996). Second, malnutrition or an Axis I disorder may exaggerate behaviors such as unstable mood which may inflate the rate of PD-like behaviors (Zimmerman, 1994; McDavid & Pilkonis, 1996; Ames-Frankel et al., 1992).

Because we studied subjects after recovery, the number of subjects studied was small. Thus, we collapsed PDs in the three main subdivisions. The clearest finding in this study was the higher rate of cluster B PDs in recovered bulimic subtypes and the absence of this diagnosis in recovered RAN. Such a close association has been found in studies of symptomatic ED subjects (Wonderlich et al., 1990; Herzog, Keller, Lavori, Kenny, & Sacks, 1992; Rossiter, Agras, Telch, & Schneider, 1993; Braun et al., 1994; Vitousek & Manke, 1994; Matsunaga et al., 1998). In addition, compared to recovered RAN, these bulimic people also showed a trend for a higher prevalence of borderline PD as found by others (Wonderlich et al., 1990; Herzog et al., 1992; Braun et al., 1994; Vitousek & Manke, 1994; Matsunaga et al., 1998).

Similarly, as reported in patients with active EDs (Gartner et al., 1989; Braun et al., 1994; Matsunaga et al., 1998), cluster C PDs tended to be more common compared to cluster A or B PDs. In the studies of active EDs, avoidant PD was identified to be the most common cluster C PD, whereas in this study obsessive-compulsive PD was most commonly found in all ED subtypes. Cluster C PDs, especially avoidant PD, have been characterized as being most susceptible to state effects of Axis I disorders among DSM-III-R PDs (Loranger et al., 1991; Ricciardi et al., 1992). On the other hand, compulsivity and perfectionism, which are major factors for obsessive-compulsive PD, have been considered to exert significant effects on the emergence and maintenance of ED symptoms in anorexics (Strober, 1980; Kaye, 1997; Pollice, Kaye, Greeno, & Weltzin, 1997) and bulims (Johnson & Holloway, 1988; Tobin, Johnson, Steinberg, Staats, & Dennis, 1991). The persistence of elevated perfectionism was also reported in recovered ED subjects (Strober, 1980; Srinivasagam et al., 1995). Thus, it can be hypothesized that the close linkage between cluster C PDs and EDs may be attributed not only to the inherent susceptibility of these PDs to the state effects of Axis I disorders, but to the underlying trait closely related to the essential basis for EDs.

In conclusion, a considerable proportion (26%) of the subjects recovered from EDs showed significant severity in personality pathology, enough to qualify for PD diagnoses, such as self-defeating, obsessive-compulsive, or borderline PD. The inclusion of sub-threshold diagnoses of each PD to this study led us to find some similar relationships between PDs and EDs to those reported in active ED subjects, such as a specific linkage with cluster B PDs, especially borderline PD in bulims. These findings suggest that although treatment for EDs may have an attenuating influence on the assessment of PDs, there may be an essential linkage between EDs and PDs. The cross-sectional design of this study prevented us, however, from exploring how the state artifact caused by the presence of EDs effects the assessment of PDs.

REFERENCES

Personality Disorders


