TECHNICAL COMMENTARY

Personality disorders

Introduction

Personality disorders are enduring patterns of behaviours, thoughts and feelings that deviate from social expectations. Many people exhibit these behaviours, thoughts or feelings occasionally, but deviations that persist across situations and cause significant distress and impairment are considered disorders.

There are a number of different personality disorders. These include; antisocial personality disorder (disregard for the rights of others); schizoid personality disorder (detachment of social interactions and limited emotional expression); schizotypal personality disorder (discomfort of close relationships, cognitive distortions and eccentric behaviour); paranoid personality disorder (distrust and suspiciousness of others); borderline personality disorder (self-harming, difficulty relating to others); histrionic personality disorder (patterns of attention-seeking behaviour and emotions); narcissistic personality disorder (disregard of others, inflated self-image); avoidant personality disorder (feelings of inadequacy, social inhibition); dependent personality disorder (extreme psychological dependence on others); obsessive-compulsive personality disorder (excessive control, orderliness); personality disorder not otherwise specified (mixed symptoms).

Method

We have included only systematic reviews (systematic literature search, detailed methodology with inclusion/exclusion criteria) published in full text, in English, from the year 2010 that report results separately for people with bipolar or related disorders. Reviews were identified by searching MEDLINE, EMBASE, and PsycINFO. Hand searching reference lists of identified reviews was also conducted. When multiple copies of review topics were found, only the most recent and/or comprehensive version was included. Reviews with pooled data are given priority for inclusion.

Review reporting assessment was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist that describes a preferred way to present a meta-analysis[1]. Reviews rated as having less than 50% of items checked have been excluded from the library. The PRISMA flow diagram is a suggested way of providing information about studies included and excluded with reasons for exclusion. Where no flow diagram has been presented by individual reviews, but identified studies have been described in the text, reviews have been checked for this item. Note that early reviews may have been guided by less stringent reporting checklists than the PRISMA, and that some reviews may have been limited by journal guidelines.

Evidence was graded using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group approach where high quality evidence such as that gained from randomised controlled trials (RCTs) may be downgraded to moderate or low if review and study quality is limited, if there is inconsistency in results, indirect comparisons, imprecise or sparse data and high probability of reporting bias. It may also be downgraded if risks associated with the intervention or other matter under review are high. Conversely, low quality evidence such as that gained from observational studies may be upgraded if effect sizes are large or if there is a dose dependent response. We have also taken into account sample size and whether results are consistent, precise and direct with low associated risks (see end of table for an explanation of these terms)[2]. The resulting table represents an objective summary of the available evidence, although the conclusions are solely the opinion of staff of NeuRA (Neuroscience Research Australia).

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Results

We found three systematic reviews that met our inclusion criteria[3-5].

- Moderate to high quality evidence suggests around 42% of people with bipolar disorder have a comorbid personality disorder. The most common personality disorders are obsessive-compulsive, borderline, paranoid and histrionic.
- Moderate to high quality evidence suggests a medium-sized increased risk of personality disorders in people with an early age of onset of bipolar disorder (<18yrs) compared to people with a later onset of bipolar disorder.

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Fornaro M, Orsolini L, Marini S, De Berardis D, Perna G, Valchera A, Gananca L, Solmi M, Veronese N, Stubbs B

The prevalence and predictors of bipolar and borderline personality disorders comorbidity: Systematic review and meta-analysis

Journal of Affective Disorders 195: 105-18

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Comparison	**Prevalence of borderline personality disorder in people with bipolar disorder.**
Summary of evidence	**Moderate quality evidence (large sample, inconsistent, imprecise, direct) suggests around 18.6% of people with bipolar disorder also have borderline personality disorder. Rates are highest with bipolar II disorder, in females, and in young people.**
Borderline personality disorder	
28 studies, N = 5,273, prevalence = 18.6%, 95%CI 14.4% to 23.7%, I^2 = 91% Higher rates of borderline personality disorder were found in people with bipolar II disorder vs. bipolar I disorder, in studies with more females, and in studies with younger participants.	
Consistency in results‡	Inconsistent
Precision in results§	Imprecise
Directness of results‖	Direct

Friborg O, Martinsen EW, Martinussen M, Kaiser S, Overgard KT, Rosenvinge JH

Comorbidity of personality disorders in mood disorders: a meta-analytic review of 122 studies from 1988 to 2010

Journal of Affective Disorders 2014; 152-154: 1-11

View review abstract online

Comparison	**Prevalence of any personality disorder in people with bipolar disorder vs. major depression or dysthymic disorder.**

Summary of evidence	**Moderate to high quality evidence (large samples, inconsistent, appears precise, direct) suggests around 42% of people with bipolar disorder have a comorbid personality disorder. The most common personality disorders are obsessive-compulsive, borderline, paranoid and histrionic.**
Personality disorders	
The rates of any personality disorder were highest with dysthymic disorder; Bipolar disorder: 13 studies, N = 1,101, prevalence = 42%, 95%CI 30% to 54% Major depression: 83 studies, N = 17,265, prevalence = 45%, 95%CI 39% to 50% Dysthymic disorder: 21 studies, N = 11,941, prevalence = 60%, 95%CI 52% to 67% *The personality disorders more commonly found with bipolar disorder than major depression/dysthymia were;* Obsessive-compulsive: prevalence = 18% vs. 9%/12% Borderline: prevalence = 16% vs.14%/13% Paranoid: prevalence = 11% vs. 7%/5% Histrionic: prevalence = 10% vs. 6%/6% Rates of personality disorders were higher when diagnoses were based on questionnaires vs. clinical interviews, with DSM-III-R vs. DSM-IV, in studies with more women, and in studies of people with a long duration of bipolar disorder.	
Consistency in results	Authors report results are inconsistent.
Precision in results	Appears precise.
Directness of results	Direct

Joslyn C, Hawes DJ, Hunt C, Mitchell PB

Is age of onset associated with severity, prognosis, and clinical features in bipolar disorder? A meta-analytic review

Bipolar Disorders 2016; 18: 389-403

View review abstract online

Comparison	**Association between comorbid personality disorders and early age of onset of bipolar disorder (<18yrs).**

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Personality disorders

Summary of evidence	**Moderate to high quality evidence (large sample, consistent, imprecise, direct) suggests a medium-sized increased risk of personality disorders in people with an early age of onset of bipolar disorder.**
Symptom severity, prognosis and clinical features	
Significant, medium-sized effect of increased risk of personality disorders with an early age of onset of bipolar disorder; 4 studies, N = 1,746, OR = 2.34, 95%CI 1.85 to 2.95, $p < 0.001$, $I^2 = 0\%$	
Consistency in results	Consistent
Precision in results	Imprecise
Directness of results	Direct

Explanation of acronyms

CI = Confidence Interval, I^2 = measure of heterogeneity in study results, N = number of participants, OR = odds ratio, p = statistical probability of obtaining that result ($p < 0.05$ generally regarded as significant)

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Explanation of technical terms

* Bias has the potential to affect reviews of both RCT and observational studies. Forms of bias include; reporting bias – selective reporting of results; publication bias - trials that are not formally published tend to show less effect than published trials, further if there are statistically significant differences between groups in a trial, these trial results tend to get published before those of trials without significant differences; language bias – only including English language reports; funding bias - source of funding for the primary research with selective reporting of results within primary studies; outcome variable selection bias; database bias - including reports from some databases and not others; citation bias - preferential citation of authors. Trials can also be subject to bias when evaluators are not blind to treatment condition and selection bias of participants if trial samples are small[6].

† Different effect measures are reported by different reviews.

Prevalence refers to how many existing cases there are at a particular point in time. Incidence refers to how many new cases there are per population in a specified time period. Incidence is usually reported as the number of new cases per 100,000 people per year. Alternatively some studies present the number of new cases that have accumulated over several years against a person-years denominator. This denominator is the sum of individual units of time that the persons in the population are at risk of becoming a case. It takes into account the size of the underlying population sample and its age structure over the duration of observation.

Reliability and validity refers to how accurate the instrument is. Sensitivity is the proportion of actual positives that are correctly identified (100% sensitivity = correct identification of all actual positives) and specificity is the proportion of negatives that are correctly identified (100% specificity = not identifying anyone as positive if they are truly not).

Weighted mean difference scores refer to mean differences between treatment and comparison groups after treatment (or occasionally pre to post treatment) and in a randomised trial there is an assumption that both groups are comparable on this measure prior to treatment. Standardised mean differences are divided by the pooled standard deviation (or the standard deviation of one group when groups are homogenous) that allows results from different scales to be combined and compared. Each study's mean difference is then given a weighting depending on the size of the sample and the variability in the data. Less than 0.4 represents a small effect, around 0.5 a medium effect, and over 0.8 represents a large effect[6].

Odds ratio (OR) or relative risk (RR) refers to the probability of a reduction (< 1) or an increase (> 1) in a particular outcome in a treatment group, or a group exposed to a risk factor, relative to the comparison group. For example, a RR of 0.75 translates to a reduction in risk of an outcome of 25% relative to those not receiving the treatment or not exposed to the risk factor. Conversely, a RR of 1.25 translates to an increased risk of 25% relative to those not receiving treatment or not having been exposed to a risk factor. A RR or OR of 1.00 means there is no difference between groups. A medium effect is considered if RR > 2 or < 0.5 and a large effect if RR > 5 or < 0.2[7]. lnOR stands for logarithmic OR where a lnOR of 0 shows no difference between groups. Hazard ratios measure the effect of an explanatory variable on the hazard or risk of an event.

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Correlation coefficients (eg, r) indicate the strength of association or relationship between variables. They can provide an indirect indication of prediction, but do not confirm causality due to possible and often unforseen confounding variables. An r of 0.10 represents a weak association, 0.25 a medium association and 0.40 and over represents a strong association. Unstandardised (*b*) regression coefficients indicate the average change in the dependent variable associated with a 1 unit change in the independent variable, statistically controlling for the other independent variables. Standardised regression coefficients represent the change being in units of standard deviations to allow comparison across different scales.

‡ Inconsistency refers to differing estimates of effect across studies (i.e. heterogeneity or variability in results) that is not explained by subgroup analyses and therefore reduces confidence in the effect estimate. I^2 is the percentage of the variability in effect estimates that is due to heterogeneity rather than sampling error (chance) - 0% to 40%: heterogeneity might not be important, 30% to 60%: may represent moderate heterogeneity, 50% to 90%: may represent considerable heterogeneity and over this is considerable heterogeneity. I^2 can be calculated from Q (chi-square) for the test of heterogeneity with the following formula[6];

$$I^2 = \left(\frac{Q - df}{Q}\right) \times 100\%$$

§ Imprecision refers to wide confidence intervals indicating a lack of confidence in the effect estimate. Based on GRADE recommendations, a result for continuous data (standardised mean differences, not weighted mean differences) is considered imprecise if the upper or lower confidence limit crosses an effect size of 0.5 in either direction, and for binary and correlation data, an effect size of 0.25. GRADE also recommends downgrading the evidence when sample size is smaller than 300 (for binary data) and 400 (for continuous data), although for some topics, these criteria should be relaxed[8].

‖ Indirectness of comparison occurs when a comparison of intervention A versus B is not available but A was compared with C and B was compared with C that allows indirect comparisons of the magnitude of effect of A versus B. Indirectness of population, comparator and/or outcome can also occur when the available evidence regarding a particular population, intervention, comparator, or outcome is not available and is therefore inferred from available evidence. These inferred treatment effect sizes are of lower quality than those gained from head-to-head comparisons of A and B.

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