

PSYCHOSOCIAL FUNCTIONING IN PATIENTS WITH PERSONALITY DISORDERS: A REVIEW OF THE EVIDENCE-BASED RESEARCH STUDIES LITERATURE

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SUMMARY

Evidence based practice is a complex aim to achieve in the area of Psychiatry, and even more complex, when aspiring to explain personality disorders, theoretical constructs that in themselves are fully vague, and that have always been a source of confusion and debate between mental health professionals. This confusion, as much as anything, justifies the need to empirically back the areas of treatment that can be supported by evidence, without disregarding the unique elements of clinical practice such as the professional's own experience, and the patient's preferences and values.

The authors offer a brief revision of the most relevant literature regarding psychosocial dysfunction on PD's. Empirically investigations remain scarce, but the existing findings seem to support that impaired functioning, especially social functioning, is an enduring component of PD's.

KEY WORDS

psychosocial dysfunction. Borderline Personality disorder

In the last years there has been an increased push for an *evidence-based practice*, which started in the area of general medicine, and progressively extended to the area of Psychiatry. The movement is as much a regulative idea as a research method. It intends to demonstrate aspects of treatment that can indeed be supported by evidence, and those

that must be supported by other valid factors, such as clinical experience, the unique aspects of clinical situations and patients' preferences and values. This attempt to become more discriminate, acquires a higher degree of complexity within the area of mental health, where it is sometimes difficult to find common ground of validity between the different ethical and theoretical positions inherent in clinical and research practice.

Proof of this complexity can be found when reviewing the evidence based literature on the psychosocial functioning in patients with Personality Disorders (PDs). Empirically based research is scarce, and the need for further well designed clinical studies is recognized. The present paper seeks to offer a brief review on the current existing evidence based studies in psychosocial functioning in PDs. To this purpose we will examine the more prominent variables involved in psychosocial functioning, the validity of certain measurement tools and the evidence that supports the various results obtained from the different studies.

1. SOME VARIABLES INVOLVED PSYCHOSOCIAL DYSFUNCTIONING

For some authors, such as Skodol et al. (1), a defining feature of the PD is an enduring pattern of inner experience and behaviour that is stable over time. However, different follow-up and follow-along studies have shown a considerable diagnostic instability in PDs, even over short intervals. Thus, it appears that what remains a constant over time *is* the continued pattern of instability. In this way, the authors propose that impairment in psychosocial functioning is a main stable trait in these patients and a fundamental aspect in PDs that serves to distinguish it from normal personality. It follows, that the comparative abilities of competing skills to predict psychosocial impairment, offer a way to examine their merits.

Currently, different empirical studies have analyzed various variables involved in psychosocial functioning. There exists abundant literature linking a damaging psychosocial environment in childhood to an emerging PD in later years. Such is the case of Jovev et al. (3). These authors have documented poor functioning and higher rates of negative life events in association with PDs, in particular with borderline personality disorder (BPD). However, a research from Ullrich (6) qualifies that although most PDs are associated with impaired psychosocial functioning and life-failure, some PD traits, (even when considered pathological), can contribute positively to one important aspect of life-success: status and wealth. Pagano et al. make an important point (4) on this subject. The authors indicate that although much attention has been given to the effects of adverse childhood experiences on the development of PDs, we still know far less about how recent life events influence the ongoing course of functioning. This would allow to re-evaluate how important early experience is in PDs, in contrast to later life experiences.

In the clinical presentation of PDs differences in the psychosocial adaptation features between male and female patients have been observed. Some studies report that men with BPD are more likely to be diagnosed with substance use disorders, as well as paranoid, passive-aggressive, narcissistic, sadistic, and antisocial personality disorders.

On their side, women with BPD appear to be more likely to report histories of adult physical and sexual abuse and to meet diagnostic criteria for post-traumatic stress disorder (PTSD) and eating disorders. However, we must take in consideration the findings of Johnson et al. (5). These authors outline that a majority of the literature on BPD focuses on its occurrence in women or does not specifically assess for gender differences in clinical presentations.

On a more general level, symptom alleviation and improved social functioning have always been considered to be related. Zanello et al. (2) comment that since the fifties, social functioning is considered as an important dimension to take into account for treatment planning and outcome measuring. They contend that, for many years, symptoms scales have been considered as sufficient outcome measures, and social functioning improvement has been expected on the basis of symptom alleviation. As symptoms and social adjustment sometimes appear relatively independent, no accurate conclusion concerning the patient's social functioning can so be driven on the basis of his/her clinical symptoms.

2. MEASUREMENT TOOLS

Recently, (Zanello et al. (2)) attention has been directed toward the development of instruments specifically intended to measure the extent and nature of the social dysfunction observed in most psychiatric syndromes. Many of these instruments are designed to be completed by caregivers or remain time consuming and difficult to use routinely. For this reason, currently in clinical practice, there is a need to rely on simple and brief instruments that consider the patients' perspective on their social adjustment over time.

Different authors have used different tools and instruments to measure psychosocial impairment in PDs. Ullrich et al. (6) used a standardized social interview for the assessment of the dysfunctional adaptation in personality disorders. The study identified indicators of life-success by factor-analysis in two moderately correlated components representing *status and wealth* and *successful intimate relationships*. On their part, Skodol et al. (7) explored the psychosocial impairment through seven domains of functioning as measured by the Longitudinal Interval Follow-up Evaluation (LIFE)¹, while in other researches (1, 8) they used the Social Adjustment Scale, a semi-structured interview assessments and self-report measure.

Psychosocial functioning was also evaluated by Adell et al (9), using well-established semi structured research interviews conducted by trained doctoral-level clinicians. On the other hand Chanen et al. (10) chose to assess psychosocial functioning in adolescents with PDs by means of the Youth Self-Report, the Young Adult Self-Report, the Health of the Nation Outcome Scales for Children and Adolescents, the Social and Occupational Functioning Assessment Scale, and some socio-demographic variables.

¹ They use some questionnaires assessing three-factor and five-factor dimensional models of personality. Personality disorder categories, dimensional representations of the categories based on criteria counts, and three- and five-factor personality dimensions are then compared to patients' social functioning

The *Questionnaire de Fonctionnement Social*, (QFS), developed in Geneva by Zanello et al. (2) deserves a special mention. This new instrument in French was created initially in order to assess both, social functioning and psychometric characteristics, in patients involved in group psychotherapy programs, (within a specialist mental health setting). It was designed to be completed in less than 10 minutes and the questions are phrased in a simple and redundant way, in order to limit problems inherent to illiteracy or language comprehension. The QFS is a 16 items self-report instrument that assesses both the frequency of, (8 items), and the satisfaction with, (8 items), various social behaviours adopted during the 2 weeks period preceding the assessment. It yields three separate indexes of social functioning defined *a priori* and labelled: "frequency", "satisfaction" and "global". The higher scores would be an indicator of greater social functioning. (A Spanish version has been developed in the Department of Psychiatry of the Basque Country by Guimón et al.)

In their studies, Zanello et al. (2) administered the QFS to 457 subjects, aged between 18 and 65, including 176 outpatients (99 with anxious or depressive disorders, 25 with personality disorders and 52 with psychotic disorders) and 281 healthy control subjects². Internal consistency³ ranged from 0.69 to 0.71 (intraclass correlation coefficient). The discriminant validity⁴ showed to be excellent. In healthy controls, the convergent validity⁵ correlation with the SAS-SR was moderate but statistically significant (rS from - 0.21 to - 0.44, p<0.05). When comparing QFS scores with self-rated symptom severity, lower levels of social functioning were significantly associated with more severe symptoms according to the Brief Symptom Inventory (BSI: rS from - 0.38 to - 0.65, p<0.001). The QFS indexes demonstrated sensitivity to change⁶. The factorial validity of the QFS in the first analysis⁷ considered only Frequency items; 7 out of 8 items had loadings above 0.5 on Factor 1 accounting for 30.7%, (unrotated), of the variance. The second analysis considered only Satisfaction items; all items had loadings above 0.6 on Factor 1 explaining 43.4%, (unrotated), of the variance. And finally, in the third factor analysis, all QFS items were included; 15 out of 16 items had loadings above 0.4 on Factor 1 accounting for 30%, (unrotated), of the variance. Concerning the factorial validity of the instrument, these results suggest that all QFS items belong to the same underlying dimension.

² No significant difference was found between patients and controls according to age or gender distribution. Acceptance rate was high (>95%). Moreover, the QFS was generally acceptable to the clinicians who used it.

³ calculated for each index ranged from 0.65 to 0.83 (Cronbach alpha). Test-retest reliability, calculated within a 15 days time interval on a sample of 49 healthy controls,

⁴ It was calculated on healthy controls and patients divided into sub-groups according to their diagnosis, showing significantly higher scores in control subjects than in psychiatric patients and significant differences across diagnostic categories (Kruskal-Wallis ANOVA with post-hoc tests, all p<0.05).

⁵ The QFS was compared with other measures of social functioning was calculated, using the Social Adaptation Self-Evaluation Scale (SASS) and the Social Adjustment Scale Self-Report (SAS-SR). With the SASS, the convergent validity was higher among patients (Spearman rS 0.71 to 0.92, p<0.01) than controls (rS from 0.49 to 0.66, p<0.001)

⁶ The Wilcoxon showed all p<0.05 on a sample of 27 out-patients suffering from anxious-depressive disorders questioned before and after 4 months of cognitive behavioural group therapy running on a weekly basis during 16 sessions of 2 hours each.

⁷ It was measured through 3 separate factor analysis conducted using the data of 457 subjects.

Zanello et al. provide provisional norms for the QFS for healthy controls, in order to characterize individual patients or patient subgroups. The authors contend that the need for assessment in clinical routine, in order to estimate different aspects of the patients' conditions, as well as the quality of the treatment provided, has contributed to the development of a large variety of instruments measuring several domains. Concerning the level of social functioning, many instruments fail to meet chief criterion of feasibility, remaining often too complex or time consuming. Moreover, only few of them are available in French. Zanello et al. conclude that the QFS is a brief, simple and easy to administer self-rating scale that displays satisfactory psychometric properties. It seems to be a valuable instrument for the monitoring of social functioning in psychiatric patients which, from a therapeutic point of view, may have a clear impact. This instrument sets up an expectation for change and allows both, to reality test patients and therapists beliefs about the presence of progress (or not), and to identify if therapy is working in this specific outcome domain. Nonetheless, to date, the administration of the QFS to other populations and treatment modalities requires further investigation.

3. RESULTS

Related to the different psychosocial variables and to the different implemented measurement tools described previously, the various authors mentioned above have reached a series of empirical conclusions which we will proceed to describe briefly.

Ullrich et al (6) found that the avoidant, obsessive compulsive and narcissistic dimensional scores of their patients were associated with *status and wealth*. Inverse relationships were found between dependent, schizotypal, schizoid, and adult antisocial personality disorder dimensions and this domain of life-success. In addition, avoidant, schizoid, and BPD dimensions were negatively associated with *successful intimate relationships*.

Skodol et al (7, 8)⁸ find that patients with schizotypal personality disorder and BPD have significantly more impairment at work, in their social relationships and at leisure than patients with obsessive-compulsive personality disorder or major depressive disorder; patients with avoidant personality disorder were intermediate. These differences were found across assessment modalities and remained significant after co-varying for demographic differences and comorbid axis I psychopathology. The three and five factor models were compared to three-dimensional representations of DSM-IV PDs and standard categories regarding their associations with psychosocial functioning. Both the categorical and dimensional representations of DSM-IV personality disorders showed stronger relationships to impairment in functioning in the domains of employment, social relationships with parents and friends, global social adjustment and DSM-IV axis V ratings than the three- and five-factor models. The DSM-IV dimensions

⁸ They studied six hundred sixty-eight patients with semistructured interview diagnoses of schizotypal, borderline, avoidant, or obsessive-compulsive personality disorders or with major depressive disorder and no personality disorder.

were the ones that best predicted functional impairment of the four approaches. And, although the Five-Factor personality traits captured variance in functional impairment not predicted by DSM-IV PD dimensions, the DSM-IV dimensions accounted for significantly more variance than the measures of personality. They concluded that scores on dimensions of general personality functioning do not appear to be as strongly associated with functional impairment as the psychopathology of DSM personality disorder. PDs are a significant source of psychiatric morbidity, accounting for more impairment in functioning than major depressive disorder alone. These conclusions suggest that that personality disorders may not represent distinct diagnostic entities and that their categorical classification is not optimal.

In another article, Skodol et al (1)⁹ discuss the stability of impairment in psychosocial functioning in patients with four different PDs. They find that a significant improvement in psychosocial functioning occurred in only three of seven domains of functioning and was largely due to improvements in the MDD and no PD group. Patients with BPD or OCPD showed no improvement in their overall functioning, but patients with BPD who experienced change in personality psychopathology did show some improvement in functioning. (The impairment in social relationships appeared most stable in patients with PDs). They conclude that impaired functioning, especially social functioning, may be an enduring component PDs.

Ansell et al. (9) compared psychosocial functioning and treatment utilization in 130 participants who were diagnosed with BPD, non-BPD personality disorder (OPD), mood and/or anxiety disorder (MAD), or those with no current psychiatric diagnosis that served as a healthy comparison group. The analysis of variance revealed that the most severe deficits in functioning lay within the BPD group across areas of global functioning with more moderate impairments in functioning occurring in OPD and MAD groups. The BPD group was characterized by significantly greater psychiatric and non-psychiatric treatment utilization than the other groups. These findings indicate that BPD, as well as other personality disorders, is a source of considerable psychological distress and functional impairment equivalent to, and at times exceeding, the distress found in mood and anxiety disorders.

Chanen et al.(10) examined adaptive functioning and psychopathology in adolescents with DSM-IV BPD¹⁰. The borderline personality disorder group (N = 46) had the most severe psychiatric symptoms and functional impairment across a broad range of domains, followed by other personality disorders (N = 88) and no personality disorder group (N = 43), respectively. BPD was a significant predictor, over and above Axis I disorders and other PD diagnoses for psychopathology, general functioning, peer relationships, self-care, and family and relationship functioning. The authors conclude that the borderline personality disorder diagnosis should not be ignored or substituted by Axis I diagnoses in adolescent clinical practice, and early intervention strategies need to be developed for this disorder.

⁹ They compared the findings with those of patients with major depressive disorder (MDD) and no PD, prospectively over a 2-year period. Skodolm e al RESULTS:

¹⁰ The study included 177 psychiatric outpatients (derived from 2 samples collected between March 1998 and July 1999 and between November 2000 and September 2002) aged 15 to 18 years

Jovev et al. (3) investigated the impact of recent life events, daily hassles and uplifts on psychosocial functioning in patients with PDs, while extending previous research by examining the role of perceived coping effectiveness and perceived stress of recent life events¹¹. Results indicated that the BPD group reported the poorest levels of functioning, especially in what related to interpersonal functioning. The BPD group also reported more negative life events, particularly in the interpersonal relationships, personal health, crime, and financial domains. This group also reported to experience less uplifts, more hassles and found employment circumstances particularly stressful and difficult to cope with. Intensity of hassles was a predictor of functioning independent of a BPD diagnosis. A greater frequency of life events was closely associated with a non-BPD diagnosis in predicting a decrease in psychosocial functioning.

Pagano et al.(4) examined the extent to which PD subjects differ in rates of life events and the extent to which life events impact psychosocial functioning¹². Borderline personality disorder subjects reported significantly more total negative life events than other PDs or subjects with Major Depressive Disorder. Negative events, especially interpersonal events, predicted decreased psychosocial functioning over time. The authors conclude that higher rates of negative events in subjects with more severe PDs and suggest that negative life events adversely impact multiple areas of psychosocial functioning.

And lastly, as mentioned initially when describing some psychosocial variables, Johnson et al. (5) examined gender differences in BPD¹³. Men with BPD were more likely to present with substance use disorders, and with schizotypal, narcissistic, and antisocial PDs, while women with BPD were more likely to present with PTSD, eating disorders, and the BPD criterion of identity disturbance. Generally speaking, women and men with BPD displayed more similarities than differences in clinical presentations. The differences that did emerge are consistent with those found in epidemiological studies of psychopathology and therefore do not appear unique to BPD. Additionally, many gender differences traditionally found in epidemiological samples did not emerge in BPD subjects. For example, no difference was found in rates of major depressive disorder, a condition that is more prevalent in females.

¹¹ There were ninety-seven participants (Axis I group, N = 30; BPD group, N = 23; Other PD group, N = 44

¹² They studied a total of 633 subjects were drawn from the Collaborative Longitudinal Personality Disorders Study (CLPS), a multi-site study of four personality disorders--schizotypal (STPD), borderline (BPD), avoidant (AVPD), obsessive-compulsive (OCPD)--and a comparison group of major depressive disorders (MDD) without PD.

¹³ They used baseline data from the Collaborative Longitudinal Personality Disorders Study (CLPS), men and women who met criteria for BPD were compared on current axis I and II disorders, BPD diagnostic criteria, childhood trauma histories, psychosocial functioning, temperament, and personality traits

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