

The Relationship of Personality to Eating Disorders

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This paper highlights a variety of personality disorders in individuals with eating disorder and also emphasizes the importance of identifying clinically meaningful eating disorders subtypes based on concurrent personality disorder. The relationship between personality disorders and eating disorders is an important issue as this association has implications for assessment and treatment. Different hypotheses concerning the relationship between personality disorders and eating disorders will be reviewed. The prevalence rates of concomitant personality disorder diagnoses in eating disorder patients is highlighted to illustrate some of the pertinent conceptual issues concerning the meaning of the co-occurrence of separately defined diagnostic entities. The literature review reveals a robust finding that patients with personality pathology have a poorer response to treatment of Axis I disorders than those without such pathology. It is also argued that therapeutic relationship deserves more attention in the assessment and treatment of eating disorder patients with a co morbid personality disorder.

Key Words:

Eating disorder, Personality disorder, Comorbidity

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There is evidence to suggest that many patients presenting for treatment of eating disorders have concurrent personality disorders. The exact nature of this association and the sequence in which these disorders tend to develop, however, remain unclear and controversial.

It has been suggested that anorexia nervosa and bulimia nervosa have different associations with specific personality disorders and distinct personality clusters: histrionic behaviour with the dramatic-erratic Diagnostic and Statistical Manual of Mental Disorders-4th ed.-Text Revised (1) personality clusters, particularly histrionic personality disorder, and anorexia nervosa with anxious-fearful personality cluster, particularly obsessive-compulsive and avoidant personality disorders (2-4). Other studies, however, in no way support these associations (5, 6).

The relationship between personality disorders and eating disorders has both clinical and theoretical importance. Clinically, a clarification of the way in which personality features interrelate with symptoms of eating disorders could, in principle, provide guidelines for more effective psychotherapeutic intervention. Theoretically, an increased understanding of this relationship might clarify some of the sources of heterogeneity in eating disorders and the ways in which personality disorder and eating disorder might bring about changes in one another. Here we will first provide an overview of the various hypotheses concerning the relationship between personality disorders and eating disorders. In doing so, we address the prevalence rate of personality disorders as a

comorbid condition accompanying eating disorders from two perspectives: 1) the frequency with which individuals suffering from eating disorders are also diagnosed as suffering from personality disorders; and 2) the way in which individuals with different subtypes of eating disorders differ in personality disorders.

Poor outcome in different psychiatric conditions has been found to be significantly related to pathology of the personality (7-9). As with other diagnostic groups, eating disorders may have a poor prognosis when accompanied by personality disorders. Given the higher prevalence rate of personality disorders as a comorbid condition accompanying eating disorders, it is also necessary to review the empirical findings related to the impact of any coexisting personality disorder on the course and outcome of eating disorders, and this will be addressed in this paper.

The concluding section summarizes briefly the major findings on the clinical implications of concurrent eating disorders and personality disorders, and recommendations for future study.

The relationship between personality disorders and eating disorders

The nature of the relationship between personality and psychopathological conditions can be conceptualised using several alternative, but not necessarily mutually exclusive, hypothetical approaches.

Predisposition Hypothesis

The predisposition approach considers certain personality characteristics to provide a

characterological psychological predisposition to the development of a psychopathology(10-16). The importance of personality characteristics in the aetiology of eating disorders has been illustrated by early psychoanalytic theorists. For example, an emphasis upon fixation at the oral level of psychosexual development, regression in instinctual drives from the genital level of development, and symptom formation around oral conflicts (17). Anorexia nervosa was thought to be a defence against such fixations such as to manage the guilt of oral impregnation fantasies (18, 19).

Anger manifested against the mother has been conceptualized in showing primitive oral aggression towards the breast (20), and as fear of adolescent change in the body size as a representation of the greed of the oral phase (21).

Avoiding the emphasis on orality, more recently, Bruch has focused on early object relations. She described the premorbid personality as critical etiological factor in the development of anorexia nervosa (22).

Besharat found that personality disturbance may be relevant to the psychopathology of eating disorders by representing an etiological risk factor (23). However, that study suggested that the association between eating disorder and personality disorder had not been shown to be a direct relationship between specific symptoms and specific personality trait/disorders. It appeared to be more likely that personality might act as one of the predisposing factors that influence the individual's eating problem and that sometimes may determine the form of the specific eating disorder.

Pathoplasty Hypothesis

The pathoplasty approach proposes that personality characteristics affect either the symptomatic expression and/or the course of the psychological disorders. This model refrains from etiologic speculations regarding the nature of the relationship between personality and psychopathology.

A classic example of this hypothesis is presented by Lazare and Klerman who found that a depressed patient with hysterical personality feature appeared quite different from a depressed patient with obsessive-compulsive personality feature(24).

The pathoplastic hypothesis has recently been acknowledged in the eating disorder literature (25-29). Garfinkel and Garner (27), for example, concluded that poorer outcome in anorexia nervosa was associated with (1) unstable and neurotic personality trait, (2) increased somatic and obsessional characterisation, and (3) with bulimic symptoms. Besharat (23) has supported such a position on the basis of data showing bulimic symptoms to be influenced by histrionic characteristics and anorexic symptoms to be influenced by anxious characteristics.

Complication Hypothesis

In contrast to the predisposition and pathoplasty hypotheses, there is an approach that proposes that

personality disorder may be seen as a complication of a psychopathological condition. The nature and severity of personality changes within this approach, and it is thought to depend on the course and chronicity of the psychiatric disturbance. These changes may include changes in personality characteristics such as an individual's attitude toward him- or herself, an individual's style of interaction with others, or an individual's perception of the environment. All these things could be a consequence of the long standing symptomatic state (9, 14).

Fairburn illustrates this position by identifying evidence that suggests depression is improved in bulimia nervosa when the eating symptoms are brought under control (30). The complication hypothesis has been addressed to a limited extent in the eating disorders literature. Longitudinal studies which assess eating disorder patients both at the admission and termination of treatment when the patients have been symptomatic would present a first step in exploring this hypothesis.

Attenuation Hypothesis

This approach proposes that personality disorders are actually the subclinical forms of actual psychiatric disorders on that this presence attenuates the disorder (16). As such, both personality and psychiatric disorders are expressions of the same underlying factors. Within this approach, a trait-state continuum was first postulated between premorbid personality and depressive disorders (31). Schneider's (32) writings on the depressive and hypomanic personality types, and Kretschmer's (33) on the cycloid and schizoid types, extended Kraepelin's model.

Akiskal has stated that schizotypal personality disorder probably represents an attenuated form of schizophrenia (34). As pointed by Swift and Wonderlich, while it is possible to visualize a schizotypal personality disorder as an attenuated variant of a schizophrenic disorder, it is much more difficult to imagine personality characteristics associated with eating disorders as a subclinical form to anorexia nervosa and bulimia nervosa (35). In the former instance, the differences can be concealed as quantitative, but in the latter they seem dramatically qualitative. This position is implied in the International Classification of Disease (36) which has a category of "enduring personality change secondary to chronic disorders."

Orthogonal Hypothesis

This hypothesis postulates that personality disorders and eating disorders are independent entities, which can coexist by chance (37). This position is implicit in the DSM multiaxial classification, where eating disorders are coded on Axis I and personality disorders on Axis II. Such a biaxial classification, however, does not resolve the question of which psychopathology is primary.

Prevalence of Personality Disorders in Eating Disorder Patients

The starting point for understanding the meaning of the co-occurrence of separately defined diagnostic entities is the study of co morbidity (38). Such studies, on the psychiatric comorbidity of eating disorders, are likely to be important both for treatment planning and for prognosis in eating disorders (9, 37, 39). Comorbidity also has a place in determining whether anorexia nervosa and bulimia nervosa are discrete and independent disorders or different phases of the same disorder (23). Research on comorbid prevalence generally indicates that personality disorders are relatively common in eating disorder samples, but the proportion of affected persons has ranged rather widely (5, 23, 28, 37, 39-45).

Studies of personality disorders have generally been of two types: 1) categorical approaches to personality, 2) dimensional approaches. Categorical approaches such as Axis II DSM classifications (1) focus on discrete diagnostic categories. A number of categorical studies have estimated the prevalence of comorbid personality disorder in eating disorder samples. Skodol, Oldman, Hyler, Kellman, Doige & Davies summarised the studies on the co-occurrence of personality disorders with mixed samples of anorexic and bulimic subjects (46). The rate of one or more personality disorders is 59% varying from 27% (43) to 93% (47) for the presence of any personality disorder. Figures for bulimia nervosa have been distributed across ranges of 21%-40% (48), 41%-60% (37, 49) and 61%-85% (5, 50). The reported prevalence for restricting and bulimic anorexics has varied from low estimates of 23% and 35%, respectively (43) to highs of 87% and 97% (4).

Variability is also marked when cluster assignments and specific diagnoses are tabulated. Bulimia nervosa appeared to be associated with personality disorders from cluster B personality disorders (borderline, antisocial, histrionic, and narcissistic personality disorders) typically with borderline personality disorder (BPD) and histrionic personality disorder (4, 5, 43, 46-49, 51). Borderline personality disorder has been identified in 2% to 47% of the bulimics, 0% to 21% of the restricting anorexics, and 15% to 40% of the bulimic anorexics (5, 52-54), depending on the nature of the group studied.

Anorexia nervosa was found to be associated with personality disorders from cluster C personality disorders (avoidant, dependent, obsessive-compulsive, and passive-aggressive personality disorders) most commonly with obsessive-compulsive or avoidant personality disorder (4, 43, 46, 47).

Overall, anorexics tend to receive fewer personality disorder diagnosis compared with the bulimics (23, 46, 55, 56); bulimic anorexics have been reported to have the highest rates of personality disorder (43, 46, 51, 56). Among inpatients, the overall rate is 74%; among outpatients or volunteers, the rate is 54% (46).

In contrast to the many categorical studies of personality in eating disorder patients, fewer studies

have addressed personality disturbances from a dimensional point of view. Three recent studies (23, 52, 57) examined the prevalence of personality disorders among eating disorder patients with the diagnoses made according to interviewer ratings on the Personality Assessment Schedule (58). This measure requires the interviewer to evaluate the extent to which the subject manifests each of the 24 personality variables. Rating of the presence or absence of a personality disorder is made along a 9-point dimensional scale with the scores determined by the extent of social maladjustment produced by each personality trait. Each of these can be rated by interview with the subject and interview with an informant.

Using the PAS in an eating disorder sample, McClelland et al. (52) found personality disorders in 26 patients (52%). In another study, Fahy, Eisler and Russell assessed personality disorders in 39 bulimia nervosa patients evaluated with the PAS. Fourteen (39%) were given a personality disorder diagnosis and 10 (28%) had more than one personality disorder. Histrionic and anxious personality disorders were most common (57). Besharat evaluated the presence of personality disorders in a sample of 58 outpatients who met DSM-IV-TR (1) and ICD-10 (36) criteria for anorexia nervosa or bulimia nervosa. Personality disorder diagnoses were based on information obtained during interviews with the patient or an informant using the PAS. Twenty-seven (46%) met the PAS criteria for at least one personality disorder. The most common diagnoses were histrionic and anxious personality disorders for bulimia and anorexia nervosa, respectively. The bulimia nervosa patients tended to fulfill the criteria more than the anorexia nervosa patients (40% vs. 27.9%). Twenty-seven patients (46.5%) also had more than one personality disturbances. When personality disorders were identified using the four clusters of personality disorders suggested in the PAS, 50% of the bulimics fell within the dependent PAS cluster, whereas 40% of anorexics fell within the inhibited PAS cluster(23).

Treatment Outcome

There is some clinical evidence that personality disorders are negatively associated with the outcome of treatment in different clinical conditions including depression (59-61), anxiety (62-64), neurotic disorders (65), and drinking problems (66). However, it is only recently that controlled studies have been conducted to determine whether the diagnosis of concurrent personality disorder correlates with differential outcome in eating disorder patients (7-9, 37).

Using the PAS, Fahy, Eisler and Russell have shown that personality disorders are associated with a poorer response to cognitive-behavioural treatment for bulimia. Patients with personality disorder did significantly worse than those without personality disorder both on bulimic and binge frequency. When controlled in the statistical analysis for initial severity

and depression, however, the differences in treatment response between patients with and without personality disorders were no longer significant (57). Rossiter et al. found that bulimics with a high cluster B score had a significantly poorer response to treatment consisting of either cognitive-behavioural treatment, drug treatment (desipramine) or the combination of both treatments. High cluster B personality disorder was found to be predictive of poor outcome at 16 weeks and at the end of 1 year of treatment (49). In the more specific area of borderline personality disorder, Johnson, Tobin and Dennis showed that bulimics with this concurrent diagnosis were less likely to benefit from a combination of cognitive-behavioural and psychodynamic therapy than non-borderline patients one year after entry into the treatment. Borderline patients were also more disturbed in terms of bulimic symptoms and emotional distress. This is perhaps unsurprising as, on intake, the borderline group were significantly more emotionally distressed and depressed, and reported poorer social adjustment. It was concluded that non-borderline bulimics require substantially less intervention than do borderline patients (67).

Besharat investigated the impact of personality disorders on the effects of different therapeutic approaches in a mixed sample of 58 anorexic and bulimic patients (23). As part of the initial evaluation in controlled treatment trials of eating disorders currently underway at the Maudsley Hospital, the results of this study are of particular interest since the effects of personality disorders were investigated on different treatment modalities: family therapy, individual focal psychotherapy, cognitive analytic therapy, and standard outpatient treatment. Diagnosis of personality disorders was based on structured clinical interview (PAS). Results of this study revealed that personality disorder negatively affected the treatment outcome. Patients with a co morbid personality disorder had poorer response to treatment than those without personality disorder (68). Taking together there are grounds for believing that personality disorder negatively influences the outcome. However, a negative prognostic effect has not been firmly established (48, 58).

Those patients who had more personality disturbances also experienced greater difficulties in establishing a therapeutic relationship, then expressing lower levels of self-disclosure and emotional engagement to the therapist and therapy. Further, Besharat found that the patient's response style to therapist and therapy as early as in the initial assessment is a good predictor of therapeutic outcome. Eating disorder participants without a concurrent personality disorder illustrated more ability and willingness to involve in the process of treatment than did the patients with a co morbid personality disorder. This finding emphasizes the importance of focusing on the therapeutic relationship early in therapy. Personality disorders can be conceptualized as rigid patterns of interpersonal

relationships and it seems unlikely that such habitual patterns of relating would not affect the therapeutic relationships (23).

A number of instruments are available to assess the therapeutic relationship. The Patient Response Style Scale (23, 69) has been used to assess both verbal and nonverbal communicative aspects of the patient's attitudes and behaviours that are expected to facilitate or impede progress in psychotherapy. The PRSS describes the patient's style of involvement in the interaction and predicts the ability to participate in a therapeutic interaction.

Concluding Remarks

We suggest that there are five types of hypotheses elucidating the relationship of personality disorders and eating disorders. These are labelled Predisposition Hypothesis, Pathoplasty Hypothesis, Complication Hypothesis, Attenuation Hypothesis, and Orthogonal Hypothesis. They were selected for this review as they may shed light on the types of theoretical issues and methodological considerations arising when one attempts to postulate and investigate associations between the two conditions.

In summary, the empirical literature on the relationship of personality disorders and eating disorders is in its infancy. The existing evidence is inadequate to clarify the exact nature of the relationship between eating disorders and personality disorders. Each of the proposed hypotheses has received some support and may account for the patterns of the relationship. The eating disorder or the personality disorder may be an early manifestation of the other: a long duration of eating disorder may lead to a personality disorder (Predisposition Hypothesis); personality disorders may predispose an individual to develop an eating disorder (Complication Hypothesis); individual personality attributions may influence the expression of a particular eating pattern (Pathoplasty Hypothesis); personality disorders may represent different subtypes of each of the eating disorders (Attenuation Hypothesis); or they may discrete and separate clinical syndromes (Orthogonal Hypothesis).

The utility of the various hypotheses of the relationship between personality disorders and eating disorders need further clarification. Longitudinal studies would be especially useful in this regard. Future research should also address the relationship between specific personality disorders and eating disorders. To resolve this issue conclusively, prospective studies are necessary to demonstrate whether specific personality disorders, as well as other Axis I disorders actually predispose patients to develop particular eating disorders. It is unclear whether personality disorder places a patient at risk for eating disorders or whether the development of an eating disorder has a particular formative effect on the personality. Answering these research questions is vital to the development of more targeted prevention and treatment strategies. Further, research on the relationship between particular eating

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and personality disorders allows more specific hypotheses about co morbidity to be proposed.

There is increasing recognition that eating disorder is a heterogeneous disorder with considerable and varied co morbidity. The weight of the available literature indicates the frequent occurrence of Axis I disorders, as well as personality disorders within eating disorder population. The observed co morbidity does not appear to be either random or artifactual. Rather, specific patterns of symptoms and syndromes tend to occur together in individuals and families.

It can be suggested that the mean prevalence rates in the studies reviewed in this paper are roughly 50% concurrent personality disorders among eating disorder patients. This certifies the need to consider the potential effects that personality disturbance may have on the assessment of eating disorders, the treatment planning, and the evaluation of treatment outcomes. Conversely, the degree of severity of a personality disturbance could differentially modify the symptoms and expression of an eating disorder, and that such eating disorder features might further vary according to the type of the personality disorder present. Researches on the latter concerns, however, have been scarce.

Current research findings have begun to suggest that subgroups might be delineated on the basis of patterns of co morbidity, with anorexia nervosa patients more likely to have a personality disorder from the anxious-fearful cluster and bulimia nervosa patients more likely to have a personality disorder from the dramatic-erratic cluster.

One can conclude that eating disordered patients with a concurrent personality disorder are characterized by various clinical features different from those of eating disordered patients without personality disorders. Generally, presence of a personality disorder tends to complicate the eating disorder, as evident by more severe psychopathology, more conflictual family relationships, less ability or willingness to involve in therapeutic relationship, poorer treatment response, and greater risk for dropping out of treatment.

Subgroups of eating disorder patients with co morbid personality disorder may have different risk factors, clinical courses, and response to treatment. So their proper identification may lead to refinements in prevention and treatment strategies. Rather, further examination of the patterns and structure of the observed co morbidity could help to revise and improve the existing methods of classification.

The impact of concomitant personality disorders on treatment outcome for eating disorder patients was reviewed in the light of the empirical findings. The coexistence of eating disorders and personality disorders is important as patients with the both disorders do worse in treatment than those without these disorders. The overall findings confirm that the presence of a personality disorder leads to poorer prognosis in patients with eating disorder. Further work will need to be done to determine specific personality disorders that are especially important in prognosis and

to try to untangle the relationship among personality disorders, psychotherapeutic relationships, and outcome in patients with eating disorder. Longitudinal assessment is required in order to clarify whether personality disorders have predictive value regarding the long-term course and outcome of eating disorders.

Some evidence suggests that treatment of eating disorders in the context of personality disorder requires some change in attitude (23). There is an impression that eating disorder patients with different types of personality disorder would probably respond better to different kinds of intervention. However, it remains an issue whether treatments for eating problems in patients with concurrent personality disorders should differ from those offered to patients without the disorder. Although much further work is needed to delineate patterns of treatment response associated with specific Axis II disorders, as well as to establish links between the presence of co morbid Axis II conditions and differential response to psychological treatments, it seems clear that future outcome research in this area will have to contend increasingly with the complications presented by the co morbidity of these and other disorders in people with eating disorders.

The negative influence of personality disorder on the quality of therapeutic relationship at intake has been shown in different kinds of psychotherapy (7-9, 23). However, relatively little work has been done on therapeutic relationship in the last stages of treatment. Part of the reason for this may be the lack of interest in predictor variables near termination. Nonetheless, it seems quite possible that the quality of the relationship at this point may have important implications for the long-term effectiveness of the therapy. Moreover, the identification of similarities between the patient's response style and specific therapy results, are potentially important areas of research. In future work, it will be feasible to measure specific components of the psychotherapeutic relationship in therapy sessions before and after therapy, and correlate these measures with changes in both patient's symptomatology and personality features.

Since some evidence is found that eating disorder patients with a personality disorder tend to drop out of treatment (23), research should not only focus on the treatment outcome but also on factors that influence the drop outs, like additional Axis I disorders and the therapeutic relationship. There are some clues that the latter might be influenced by the interpersonal style of the patient (23, 69). Because a large part of the personality disorder patients' problems is of an interpersonal nature (1), the latter variable may be of great importance and would be a fruitful area of future study.

There are methodological problems including small sample size, selected populations (i.e., inpatients, outpatients, female subjects), use of different measures and approaches, and examination of only one personality disorder which limit comparisons across studies and generalizability of the findings. Our

understanding of the relationship between personality and eating disorders has been hampered by these methodological limitations. Assessments have generally been made after the onset of the illness, thereby, confounding effects of illness on personality and posing the most serious methodological problems in this area. It is very difficult to separate the psychopathological characteristics that are the possible precursors of the disorder from those that are the by-products of a serious illness or are secondary to starvation. Over-diagnosis of personality disorders using different diagnostic schemes could occur as well, owing to the presence of an Axis I disorders. Therefore, rates of clinical symptoms and syndromes in the subject groups should always be measured. Important details regarding the clinical samples should be included since different results are obtained with different patient groups. Researcher biases always exist and are hard to assess. The use of psychiatric and non-psychiatric control groups is important in trying to clarify this issue.

Because recent research suggests that there are important differences in the pattern, course, and treatment outcomes across the range of personality disorders, future studies should refrain from combining all persons with a personality disorder and then comparing them with eating disorder controls. Available research also suggests systemic differences between inpatient and outpatient eating disorder individuals with a concurrent personality disorder. Consequently, researchers should incorporate both inpatient and outpatient samples into their studies and analyze data separately from these groups.

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