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Personality Pathology and Mental Health Treatment Seeking in a Community Sample of Older Adults

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Abstract

Sampling issues are extremely important in studies of psychopathology, especially with regard to the investigation of personality disorders (PDs). Many studies rely on clinical samples while others have focused on representative samples of community residents. Do people who qualify for a PD diagnosis seek and receive mental health services with greater (or possibly reduced) frequency compared to others in the community? Do community-based studies of PDs include people who have been treated? Analyses presented here examine connections between personality pathology and various aspects of treatment seeking in a representative sample of 1,630 middle-aged adults who completed a semi-structured diagnostic interview (SIDP-IV). Results demonstrate a disorder specific effect. Antisocial, borderline, avoidant, and dependent PDs are associated with increased levels of seeking treatment. Four PDs are associated with greater length of treatment. After accounting for lifetime presence of major depression and alcohol dependence, borderline, avoidant, and dependent pathology remained associated with increased treatment seeking. These findings point to several conclusions, including: 1) community samples do include a substantial proportion of people who have received various kinds of mental health services, 2) the association between personality pathology and mental health treatment seeking is not fully explained by comorbid depression and alcohol dependence.

Keywords

personality disorders; epidemiology; treatment; sampling

Most studies in the field of psychopathology have focused on patients who are in treatment. While clinical samples afford a number of advantages (e.g. description of severe cases), they also give rise to some limitations. Arguably the largest disadvantage of a clinical sample is the inability to generalize to the wider population. That is, the representativeness of these types of samples can be questioned. This is particularly problematic with regard to the full characterization of a disorder (including subthreshold levels), likely higher rates of comorbidity, and knowledge of a disorder's prevalence in the community. Comorbidity, both among personality disorders (PDs) and between PDs and other psychopathology, can prove particularly problematic. In these cases, it is unclear whether related social and occupational impairment is caused by one or both disorders, or an interaction of the two.

While the presence of a major mental disorder appears to increase the likelihood of seeking mental health treatment, the majority of individuals, with or without psychopathology, do not utilize these services. Shapiro et al. (1984) reported that only 6% to 7% of their

Epidemiologic Catchment Area (ECA) sample visited a mental health specialist or a general practitioner for mental health reasons in the six months prior to assessment. The National Comorbidity Survey Replication (NCS-R) found that, during the previous 12 months, 18% of their sample sought outpatient help for a mental disorder or substance use problem (Wang et al., 2005). In their representative sample of adults living in the Netherlands, Bijl and Ravelli (2000) found that 15% had received some form of care for psychological or alcohol/drug problems within a twelve month period. The percentage of people seeking mental health treatment was higher among people who met diagnostic criteria for a mental disorder. Seven to 10% of participants in the ECA with past disorders sought treatment, while 16% to 20% of those with recent disorders made a mental health visit. In the NCS-R, Druss et al. (2007) found that 40% of those with a disorder in the past 12 months, 18% qualifying for a disorder prior to the last 12 months, 13% with no disorder but indicated need, and 4% with neither a disorder or indicated need had sought treatment. Bijl and Ravelli (2000) found that 9% of those with no history of psychological disorder had sought care, while 34% of those with one or more disorder had.

Most epidemiological studies concerned with treatment seeking have focused on mood disorders, anxiety disorders, substance use disorders, and psychosis. People who would qualify for a diagnosis of personality disorders – approximately 6–13% of adults living in the community (e.g., Huang et al., 2009; Samuels et al., 2002; Torgerson, 2005; Trull, Jahng, Tomko, Wood, & Sher, 2010) – are largely ignored unless they co-occur with other psychopathology. Even then, their personality pathology is not typically assessed as part of this research. There are many unanswered questions about the use of mental health services among those with personality disorders (PDs).

Do individuals with PD features actually seek treatment at a rate higher than others in the population? How does their rate of treatment seeking compare to rates found for people with other mental disorders? In many ways, one might expect that those with PDs would also seek treatment at increased rates. The ECA study examined antisocial PD and found that the frequency of mental health visits varied greatly by site. Approximately 39% of those who met criteria for antisocial PD in New Haven had made a mental health visit in the six months prior, while only about 7% did so in St. Louis. Additionally, PDs frequently co-occur with other disorders (e.g., schizotypal PD with a variety of anxiety disorders, borderline PD with substance use disorders; Pulay et al., 2009; Skodol, Oldham, & Gallaher, 1999). In these cases, either or both sets of symptoms may cause an individual to seek treatment. Indeed co-occurring pathology seems to increase the rate of help seeking.

Rates of treatment seeking probably vary substantially as a function of the specific PD in question. PDs are often ego-syntonic. Many people who exhibit features of PDs may not seek treatment because they consider their symptoms to be part of their identity. Furthermore, several of the DSM-IV PDs are characterized by discomfort with, or disinterest in, other people. Disorders in Cluster A include criteria such as the belief that personal information will be used maliciously if disclosed (paranoid PD), general anxiety around others (schizotypal PD), and an overall desire to be left alone (schizoid PD). It would not be surprising if these individuals are less likely to seek treatment. Two of the four disorders in Cluster B have shown higher rates of treatment seeking. It seems possible, however, that those with narcissistic PD would not attribute their interpersonal problems to themselves. Cluster C is often referred to as the anxious/fearful cluster; by definition, these disorders involve psychological distress. Nevertheless, fear of negative evaluation by a professional (avoidant PD) may keep some individuals out of treatment.

Tyrer, Mitchard, Methuen, and Ranger (2003) have proposed a distinction between “treatment seeking” and “treatment rejecting” PDs based on the person’s desire to change.

In a sample of inpatients, Cluster A had the greatest proportion of treatment rejecting individuals while Cluster C had the greatest proportion of treatment seekers (contrary to their initial prediction that Cluster B would have the largest proportion of individuals interested in changing their behavior). Despite the fact that an inpatient sample was used, these analyses demonstrate that there continues to be some question about the influence of personality pathology on mental health service utilization.

The role of personality pathology in mental health treatment seeking remains largely unexplored in epidemiological samples. The overall goals of the present study are to examine the prevalence, trajectory, and impact of personality pathology in a large, regionally representative sample of adults living in the St. Louis metropolitan area. The specific analyses reported in this paper were designed to answer the following questions: Is current personality pathology associated with a history of treatment for mental health issues, and if so, what is the nature of that association? Do community-based studies of PDs include people who have been treated?

Method

Participants

The current sample consists of 1,630 participants (55% female, 32% African American). Participants used for the present analyses are part of an ongoing, prospective study of personality disorders in later middle-age. Standard epidemiological recruitment procedures were used to obtain this sample of community-dwelling adults between the ages of 55 and 64. Listed phone numbers were randomly selected after being cross-referenced with census age data. Once a household had been selected, twelve attempts were made to contact households at various times during the day. When a household was contacted, all individuals within our age range were identified and the Kish (1949) method was employed to select the target individual. If this individual was unwilling or unable to participate, no other residents were recruited (sampling without replacement). If the target individual was eligible and able, but did not wish to participate, one final call was made several weeks later in which the target was politely asked to reconsider. Because many people decline participation if initial contact was made at a busy time, these calls are standard in survey research (Fowler, 2002; Oltmanns et al., under review). Hispanic and African American households were oversampled to more accurately represent the demographics of the St. Louis area (Spence & Oltmanns, 2011). Response rate for this sample was 43%, comparable to other longitudinal, in-person studies (e.g., Cacioppo, Hawkley, & Thisted, 2010). The potential for response bias was a matter of interest, as it is likely to be for any epidemiological study. To investigate this potential, we sent the NEO Five Factor Inventory (NEO-FFI; Costa & McCrae, 1992) to the non-responders. Results indicated that the non-responders did not differ significantly from our participants on any domain of the Big 5. For a more thorough discussion of sampling and recruitment procedures, see Oltmanns and Gleason (2011). Participants completed a three-hour, in-person assessment and were paid \$60 for their time.

Measures

Personality pathology was assessed using the Structured Interview for DSM-IV Personality (SIDP; Pfohl, Blum, & Zimmerman, 1997). Questions in this semi-structured interview are non-pejorative, lay translations based on each criterion of the ten DSM-IV PDs. Interviewees are instructed to report on their thoughts and behaviors within the last five years. Interviewers code responses on a scale from 0 (not present) to 3 (strongly present). This allows researchers to maintain a more dimensional measure of personality pathology. When creating categorical diagnoses, a score of 0 or 1 indicates not present/subthreshold

and a score of 2 or 3 indicates that the criterion is present at a threshold/pathological level. The following analyses use both dimensional and categorical scores.

Treatment seeking was assessed using a series of questions developed by the study team. Participants were asked to indicate whether they have ever “received treatment for a mental disorder or advice from a mental health professional on problems in life.” Type of treatment was recorded, as was total duration for each type. Participants were also asked whether they have ever received any professional help with their relationships (e.g., marital counseling). All treatment seeking items were assessed for the participant’s lifetime. Depressive symptoms were assessed using the Computerized Diagnostic Interview Schedule (Robins, Helzer, Croughan, & Ratcliff, 1981) and DSM-IV substance abuse and dependence criteria (for both alcohol and drugs) were measured with the Mini International Neuropsychiatric Inventory (Sheehan et al., 1999).

Results

We began our analyses by examining the prevalence of personality pathology and major depressive disorder (MDD) in our sample. Of the 1,630 participants, 8.2% met criteria for at least one personality disorder, while 1.1% met criteria for more than one, and 1.8% met criteria for PD not otherwise specified (defined as the presence of 10 or more miscellaneous PD features without meeting the diagnostic threshold for at least one DSM-IV PD). Table 1 outlines the prevalence of individual disorders within our sample, as well as the percentage of the sample falling one criterion short of any given diagnosis (i.e., subthreshold). Additionally, 26.8% of our sample met criteria for a lifetime diagnosis of MDD. Of those who meet criteria for a PD, 33.3% also met criteria for MDD. The correlations between personality pathology, measured dimensionally, and lifetime diagnoses of MDD and Alcohol Dependence (AD) are shown in Table 2.

We continued our analyses by investigating the relation between personality pathology and treatment seeking. Forty-four percent of our sample reported having received some form of individual mental health treatment: 29% psychotherapy, 13% medication, 10% therapy in conjunction with medication, and 4% other (e.g., inpatient, electroconvulsive therapy, hypnosis). Independent of individual treatment, 36% of our sample reported receiving marital counseling or other professional help with their relationships, and 9% reported belonging to a self-help group (such as Alcoholics Anonymous). Taking into account that participants may have sought multiple forms of treatment, 61% of our sample has had at least one individual, marriage, or group treatment session (60% among those who do not meet PD criteria, and 71% among those who do; $t = -2.56, p = .01$). While these percentages are considerably higher than those found in the ECA and NCS, the current study asked about lifetime visits, versus the six and twelve month time periods covered by the other studies, respectively. Among those participants who have had any kind of individual treatment, the median time spent in treatment was 12 months.

We then conducted binomial logistic regressions predicting mental health care utilization, seen in Table 3. Socioeconomic status, as approximated by education and income, and gender were entered in the first block of the analyses. Covarying race/ethnicity did not substantially change results, so it was dropped from analyses. Personality pathology scores were entered in the second step of the model to determine whether personality pathology uniquely predicted having sought treatment. Results revealed that antisocial, borderline, avoidant, and dependent PDs significantly predicted treatment seeking above and beyond demographic characteristics. Features of borderline ($p < .001$), avoidant ($p = .01$), and dependent ($p = .04$) PDs, as well as paranoid traits ($p = .03$), also significantly predicted duration of longest treatment (in months) after controlling demographic variables. It is

interesting to note that both antisocial and paranoid features were positively associated with treatment seeking and length of treatment, respectively.

The next set of analyses looked at the relation between antisocial, borderline, avoidant, and dependent pathology and treatment seeking after statistically controlling for presence of lifetime MDD and AD. Results of these analyses are also shown in Table 3. This was done to examine the unique contribution of personality pathology, as mood and substance use disorders are known correlates of several PDs (Skodol, Oldham, et al., 1999; Skodol, Stout, et al., 1999) and consistently associated with increased rates of treatment seeking (e.g., Wang et al., 2005). Borderline, avoidant, and dependent features remained uniquely predictive of treatment seeking after accounting for MDD and AD, despite the fact that MDD in particular was highly predictive of treatment seeking (*ORs* ranged from 5.61 for borderline to 6.17 for avoidant PD). Features of borderline ($p < .001$) and avoidant ($p = .03$) PD remained significant when predicting length of treatment, as well.

We then examined those with three or more features of borderline personality disorder more closely to better characterize these individuals (for a discussion of the clinical relevance of this cutoff, see Clifton & Pilkonis, 2007). This sample contained 27 people who met or exceeded this threshold. Of those 27 participants, 23 (85.2%) had sought treatment, and 4 (14.8%) had not. Among the individuals who had sought treatment, though mean number of months in treatment was substantial ($M = 146.3$), the distribution was highly positively skewed. Among those who had sought treatment, 22.2% ($N = 6$) received treatment for 6 months or less. Given the short duration of treatment, it is improbable these individuals would be identified in clinical samples. Out of 27 individuals, then, at least 10 are unlikely candidates for inclusion in a treatment receiving sample.

We ran similar analyses for subthreshold and threshold cases of the remaining two PDs associated with higher rates of treatment seeking after controlling for MDD and AD. There were 58 individuals with three or more features of avoidant PD, of whom 21 (36.2%) never sought treatment. Among those who did, five (8.5%) received treatment for 6 months or fewer. Of the seven participants with four or more symptoms of dependent PD, one never received treatment, and another had received treatment for less than one month.

Defining treatment more broadly, we also looked at relationship counseling. Borderline ($OR = 1.11, p < .001$), histrionic ($OR = 1.12, p < .001$), narcissistic ($OR = 1.06, p < .001$), and dependent PD ($OR = 1.13, p = .003$) features all predicted having received professional help with a relationship after controlling for gender, education, and income. It is noteworthy that, in this sample, histrionic and narcissistic features are associated with a greater number of marriages ($r = .14$ and $r = .12$, respectively, both $p < .001$). Regression analyses indicate that histrionic features remain significantly predictive of relationship counseling after controlling number of marriages ($OR = 1.07, p = .03$), but narcissistic features do not.

Discussion

The analyses reported in this paper were conducted in order to examine the relationship between personality pathology and treatment seeking in a community sample. This topic has been largely overlooked, with previous treatment seeking research focusing primarily on other forms of psychopathology. The question of what effect personality pathology has on treatment seeking behavior is particularly interesting given the different characteristics of the ten types of PDs.

Our results show that a greater proportion of personality disordered individuals sought treatment than those without. Furthermore, features of the ten PDs demonstrate unique

associations with different aspects of treatment seeking. Traits of four of the ten PDs were related to having sought treatment (antisocial, borderline, avoidant, and dependent PD), four were related to time spent in treatment (paranoid, borderline, avoidant, and dependent PD), and four were related to seeking marital counseling (borderline, histrionic, narcissistic, and dependent PD). Borderline and dependent features appear to be the most problematic in terms of utilizing mental health care services. The answer to the first question addressed by our analyses then appears to be yes, personality pathology is associated with treatment seeking; a disorder-specific set of relationships did emerge between personality pathology and mental health treatment seeking. These results are consistent with previous literature suggesting that number of PD criteria met postdict treatment (Hopwood et al., 2008) and that borderline PD demonstrates a particularly strong relationship with treatment seeking (e.g., Bender et al., 2006).

Further analyses revealed that a majority of our participants have sought some form of treatment. The answer to the second question addressed by the present analyses, then, is also yes. Community-based studies do include individuals who have been in treatment for mental health concerns. However, only 58 (3.6%) had ever been hospitalized and only four of these individuals met criteria for a PD as assessed by the present study. This is relevant to the extent that clinical samples are drawn from inpatient or hospital settings. Additionally six of the ten PDs were unrelated to treatment seeking after controlling demographic characteristics, suggesting that clinical samples may provide an incomplete picture of personality pathology.

Clinical samples probably disproportionately include those individuals with severe PDs and/or comorbid psychopathology. Naturally, these are important and interesting phenomena to characterize, especially with the high rates of comorbidity seen for many forms of psychopathology, including PDs (e.g., Lenzenweger, Lane, Loranger, & Kessler, 2007). However this suggests an equally important place for community samples. The present results demonstrate that a large percentage of individuals with PD features do not seek treatment and are therefore unlikely to be included in traditional clinical samples. Community samples, particularly those that follow standard epidemiological methods, have the unique and important task of helping to characterize the full spectrum of mental health experience.

After we controlled for lifetime presence of MDD and AD, borderline, avoidant, and dependent features remained significantly predictive of treatment seeking. Research has demonstrated that these specific PDs showed the strongest relationship with depressive disorders (Skodol, Stout, et al., 1999) and depression has consistently been linked to treatment seeking. Controlling for MDD, then, is a strict criterion and suggests that features of these PDs may have a greater presence in clinical settings. Given that MDD showed a strong association with treatment seeking, it is still possible that individuals are more likely to seek treatment when their mood is low, but their mental health care utilization is not fully explained by depression.

It should be noted that the DSM-5 PD workgroup has proposed the removal of a dependent PD type, stating that the literature suggests dependent features (as well as those of other dropped categories) are better characterized as an aspect of personality pathology represented within the trait profile, as opposed to a specific type (APA, 2010). The current analyses – like all DSM-IV-based PD assessments – are also constrained by substantial overlap among PD constructs. Correlations from the current sample indicate that borderline, avoidant, and dependent PD are significantly, but modestly associated (ranging from .24–.42), indicating substantial non-redundancy, as well.

Antisocial features no longer significantly predicted treatment seeking after controlling MDD and AD. Though AD did account for a significant portion of the variance ($OR = 1.95$, $p < .001$), MDD accounted for the majority of the variance ($OR = 6.00$, $p < .001$). This finding was somewhat unexpected, given that antisocial PD is not typically considered to be associated with MDD. The fact that we are using dimensional, largely subthreshold scores may help explain this result.

One limitation of the current study is that of potentially limited generalizability. There are a few ways in which generalizability may be a concern in the present analyses. First, though consistent with previous prevalence estimates, the number of individuals who meet full DSM-IV criteria for some of the PDs is low. This might pose particular problems for those PDs with little variation in our sample. For example, this may account for our failure to replicate research indicating higher rates of treatment seeking among individuals with schizotypal PD (Bender et al., 2001). Using dimensional scores is one way to overcome this limitation; research has demonstrated that fewer criteria than the DSM-IV-designated cutoff are clinically meaningful (e.g., Clifton & Pilkonis, 2007). Still, low rates of individual PDs may limit generalizability. Second is the potential for response bias. Though non-responders did not differ in terms of their “normal” personality, pathological personality assessments were not completed. It is possible that non-responders have higher levels of PD features. Additionally, potential for limited generalizability lies in the fact that our sample is comprised of individuals aged 55 to 64. The question then remains whether these results would hold true for younger (or older) samples. Due to the prospective nature of the study, the current sample does not have comprehensive information regarding past symptomology. So it is unknown, for example, whether individuals currently endorsing borderline features are remitting, worsening, or experiencing new onset compared to their younger adult years. One benefit of a later middle-aged sample, however, is that these participants have had a longer period in which to utilize mental health resources. If a younger sample were used, the conclusion may simply be that they had not sought treatment *yet*. Of course care must be taken when interpreting the present results, as individuals’ reasons for seeking treatment are not clear. We must also use caution when interpreting the relationships among personality pathology, depression, and alcohol use. It is possible that the MDD and AD symptoms are part and parcel of the personality pathology (e.g., as in borderline PD); perhaps individuals become depressed and/or increase their alcohol use when their disordered personality causes them problems. Conversely MDD and AD, or the utilization of mental health care resources more generally, may be incidental to the PD. Perhaps the individual is seeking treatment for unrelated, or only indirectly related, reasons. However, Powers and Oltmanns (in press) found that PDs, particularly borderline features, were significantly related to worse perceived physical health, greater medical care utilization, and increased use of prescription medications, even after accounting for demographic variables, number of chronic illnesses health-related behaviors (i.e., drinking, smoking, exercise), and MDD. These authors’ results suggest that personality pathology substantially influences healthcare utilization independent of objective health predictors. These authors’ results – along with the fact that the relation between borderline, avoidant, and dependent personality pathology remain significant after controlling MDD and AD – provide evidence that the relation between personality pathology and health care utilization is not simply incidental.

Clinical samples and community samples have their own advantages and limitations. Both are needed and must be used in a complementary fashion to advance our understanding of personality pathology. Clinical samples are able to describe cases that are associated with the most marked forms of distress and functional impairment, perhaps also the highest rates of comorbidity with problems such as depression and substance use disorders. Community samples provide a more nuanced and variable portrait of these phenomena. They can also be used to estimate prevalence. As Paris (2010) notes, prevalence estimates may be inflated in

community samples if functional impairment is not considered carefully. This is certainly a valid and important point, but it should not be taken to imply that research studies should focus exclusively on clinical samples. Rather, it means that investigators must consider carefully whether symptoms of disorder are associated with meaningful social and occupational dysfunction. Ultimately, the goal is not to champion one sampling method over the other. Investigators following both research strategies must be mindful of how and where their samples are recruited, and they must consider carefully the impact of whichever method they employ. A high priority must be placed on the description of procedures followed to identify participants, regardless of whether the sample is based in a clinical setting or the community.

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Table 1

Diagnostic sample characteristics

	% of sample meeting criteria	% of sample falling one criterion short (subthreshold)
Paranoid	0.8	1.1
Schizoid	0.7	1.2
Schizotypal	0.1	0.1
Antisocial	0.6	0.5
Borderline	0.4	0.2
Histrionic	0.2	0.3
Narcissistic	1.2	0.8
Avoidant	2.5	1.0
Dependent	0.1	0.3
Obsessive-compulsive	2.9	3.7

Note. N = 1042

Subthreshold refers to those who fall one criterion short of diagnosis (i.e., not including those who meet full criteria).

Table 2

Bivariate correlations between dimensional PD scores and lifetime Major Depression, lifetime alcohol dependence.

	Major depression			Alcohol Dependence		
	Males	Females	Total	Males	Females	Total
PND	.07	.07†	.07*	.11*	.08†	.09*
SZD	-.01	.07†	.02	.06	.10	.05†
STPL	.05	.08†	.07*	.07	.08†	.08*
ASP	.05	.10*	.03	.21*	.18*	.22*
BDL	.19*	.27*	.23*	.19*	.20*	.19*
HST	.14*	.08†	.10*	.10*	.08†	.08*
NAR	.02	.07†	.01	.08†	.07†	.11*
AVD	.05	.14*	.11*	.09†	-.01	.03
DEP	.15*	.15*	.15*	.04	.05	.04
OCP	.10*	.07†	.06	-.02	.00	.01

Note. PND = Paranoid; SZD = Schizoid; SZTL = Schizotypal; ASPD = Antisocial Personality; BDL = Borderline; HSTR = Histrionic; NARC = Narcissistic; AVD = Avoidant; DEP = Dependent; OCPD = Obsessive-Compulsive Personality Disorder.

†
p < 0.05.

*
p < 0.01.

Table 3

Binomial logistic regression analyses using dimensional PD interview scores to predict lifetime mental health treatment controlling demographic variables and lifetime presence of MDD

	OR ^a	OR ^b
Paranoid	1.01 (.96–1.07)	
Schizoid	1.03 (.97–1.09)	
Schizotypal	1.08 (1.00–1.17)	
Antisocial	1.14 (1.04–1.24)	1.08 (.98–1.19)
Borderline	1.27 (1.19–1.36)	1.17 (1.08–1.24)
Histrionic	1.05 (.99–1.11)	
Narcissistic	1.03 (.99–1.08)	
Avoidant	1.09 (1.05–1.15)	1.07 (1.02–1.12)
Dependent	1.21 (1.12–1.32)	1.14 (1.05–1.25)
Obsessive-Compulsive	1.02 (.98–1.06)	
Total SIDP	1.02 (.99–1.04)	

Note. OR = Odds ratio.

^a Controlling demographic variables.

^b Controlling demographic variables and lifetime presence of MDD and alcohol dependence. Demographic variables include education, income, and gender.

Bolded values are significant $p < .01$, 95% confidence intervals in parentheses