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Depression and Quality of Life in Elderly Patients with Cluster C Personality Disorder

Echim Iulia[1], Nireștean A.[1,2], Toma Mirela[1], Roșu Codruța[1]

[1] Psychiatric Clinic No II, Târgu Mureș
[2] University of Medicine and Pharmacy, Târgu Mureș

PhD advising
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Introduction: Health-related quality of life (HRQoL) is an accepted outcome measure in patients with depression.
Aim: Our study aimed at assessing QoL in depressed elderly patients with cluster C PDs, admitted to Psychiatric Clinic No II Targu Mures. Cluster C PDs is the most frequent diagnosis on axis II for depression.
Material and method: A sample of thirty elderly in-patients with cluster C PDs and depression was studied. Mental disorders were assessed based on DSM IV criteria, Hamilton scale of depression and SCID II (structured clinical interview for DSM). QoL was assessed with the aid of the World Health Organization Quality of Life instrument (WHOQoL-Bref), and the Global Assessment of Functioning scale (GAF).
Results: We formed high co-morbidity among depression and cluster C PD, especially dependent PD, which was associated with poor QoL. The WHOQoL physical health and social functioning were significantly associated with GAF. Conclusion and
Discussion: PD symptoms in elderly patients appear to operate as co-factor that amplify or exacerbate the impact of depression on long-term functioning and QoL. We conclude that if co-morbid personality disorder is not treated, patients will respond less well to treatment for depression than do those without PD.

Keywords: depression, cluster C personality disorder, quality of life

Introduction

With life expectancy generally increasing, growing clinical attention and research has focused on mental health in late life. Often depression, one of the major causes of decline in the health-related QoL (HRQoL) of elderly persons, and its risks, like suicide, are central concerns in late life, particularly with estimates of prevalence of major depression ranging from 3% among community samples up to as high as 25% among nursing home residents [1].

On an intuitive level, QoL and depression can appear as opposing phenomena – crudely representing all the positive and negative aspects of well-being. Poor QoL is sometimes seen as a consequence of depression. On the other hand, poor QoL may also be a precursor to depression. In other formulations, depression can be seen as a component of QoL. Whatever the interrelationships, there has been little theoretical attention or research to understand the relationship between depression and QoL [2].

There is mounting evidence that PD are no less prevalent in late life than in adulthood and that the presence of PD is associated with poor treatment outcomes and disability [3].

A personality disorder (PD), by DSM IV definition, is an enduring pattern of inner experience and behavior that differs markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. Personality disorders are a long-standing and maladaptive pattern of perceiving and responding to other people and to stressful circumstances [4].

Cluster C PD represents the so-called anxious or fearful group, which includes the avoidant, dependent and obsessive-compulsive PDs. There are studies that suggest that the prevalence of cluster C PD is 10.2% in the general population [1].

Material and method

Patients

The study included elderly patients (over 60 years old) with cluster C PDs, from Psychiatric Clinic No II Targu Mures, recruited from January 1, 2009.

Diagnosis of mental disorder was assessed based on DSM IV criteria, Hamilton scale of depression and SCID II.

Exclusion criteria were: mental retardation, lifetime psychosis and bipolar disorder, organic mental disorder, current intense suicidal ideation.

Eligible patients were those aged over 60 years old and diagnosed with cluster C PDs. They received oral and written information about the study from their therapists.

Measures

Professional-rated: The Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II) is a clinician-administered semi structured interview designated to diagnose the Axis II personality disorders of the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev.), plus the Appendix category self-defeating personality disorder. The SCID-II is unique as it was designed with the primary goal of providing a rapid clinical assessment of personality disorders without sacrificing reliability or validity. It can be used in conjunction with a self-report personality questionnaire, which allows the interview to focus only on items corresponding to positively endorsed questions in

Table I. Demographical and psychopathological features in elderly patients

Variables	Obsessive compulsive	Avoidant	Dependent
Age (mean)	64.3	67.8	69.3
Gender (n, %)			
Male	4	2	6
Female	2	7	9
Marital status			
Married	5	2	6
Widowed	0	4	9
Divorced	1	2	0
Not married	0	1	0
GAF (mean)	57.5	52	41.5
WHOQoL (mean)			
Domain 1	56.3	52.9	48
Domain 2	50	43.8	47.4
Domain 3	54.3	58.6	57.5
Domain 4	58.6	56.4	54.1

Table II. Psychiatric co-morbidities

	None	Anxiety Disorders	Depressive Disorders	Other mental disorders	Total
Obsessive-compulsive	7	2	3	0	12
Anxious-avoidant	0	3	2	1	6
Dependent	3	2	7	0	12
Total (n,%)	10 (33,33%)	7 (23.33%)	12 (40%)	1 (3.33%)	30 (100%)

Table III. WHOQoL scores for PD patients with and without depression

WHOQoL Bref domains	Cluster C PD pure	Cluster C PD and depression
Domain 1	58	50.5
Domain 2	54.6	51.3
Domain 3	63	61.8
Domain 4	56	58.8

the questionnaire, thus shortening the administration time of the interview.

The Global Assessment of Functioning (GAF), defined as Axis V of the DSM-IV, is a rating scale for the current evaluation of the overall functioning of a subject on a continuum from severe mental disorder to complete mental health. The scale values range from 1 (sickest individual) to 100 (the healthiest person). The scale is divided in ten equal intervals from 1–10 to 91–100. The GAF is a reliable instrument, and the cut-off score for 'minimal impairment' has been set at 70 points or higher and for 'serious mental disorder' at lower than 60.

Patient-rated: The WHOQoL-Bref is an abbreviated version of the WHOQoL-100 quality of life assessment. It produces scores for four domains related to QoL: physical health, psychological, social relationships and environment. It also includes one facet on overall QoL and general health. It contains 26 items, and the scores of the four domains have a range of 1-100. The WHOQoL-Bref has demonstrated sensitivity to change, and scores changes can be interpreted as change in the health-related QoL of the patient.

Results

Our sample was formed out of 30 elderly patients (over 60 years old) with cluster C PDs: 20% obsessive-compulsive, 30% avoidant, and 50% dependent. The demographic features are stated in Table I. Psychiatric co-morbidities found in our sample (Table II). The WHOQoL Bref scores for non depressed PD patients and elderly PD patients with mood disorders. (Table III).

Discussions

"and anxiety" in Source

Our results confirm the well-known association between mood disorders and HRQoL [5].

The most frequent association of depression was with the dependent PD [6], while the obsessive-compulsive PD was in most cases found alone, without depression.

The WHOQoL scores for elderly PD patients with depression were lower than those for patients with pure cluster C PD, confirming the specialty literature data [7].

The presence of co-morbid depression explains a significant part of those scores, especially the psychological and physical health. This is in accordance with the findings of other clinical studies on patients with anxiety disorders, depression, and substance dependence [7], and also with the findings of an Australian study [8].

PD symptoms in elderly patients appear to operate as co-factor that amplify or exacerbate the impact of depression on long-term functioning and QoL [9].

PDs have been also associated with poor treatment outcomes in late life depression and with persistent functional impairment after recovery from an episode of depression [10].

Cluster C PD, through its inflexible mechanisms of coping, pathologic need for perfection, inability to relax, anxiety is considered to be the most vulnerable to depression, and with time, as the idealistic aspirations of youth are dissipated by the natural course of time, the frequency of depressive episodes increases [11].

Conclusion

Elderly people with a PD were more vulnerable to late-life distress. Symptoms of PD in elderly patients may be associated with disability and impaired social and interpersonal functioning after an acute depressive episode.

A low HRQoL of patients with mood or anxiety disorders is not only determined by disease or current health status but is also shaped by personality traits that are relatively stable throughout an individual's life time.

The results are clear: the co-occurrence of depression in a person with PD is about twice as likely to be associated with a poor response as in an individual without depression.

We conclude that if co-morbid personality disorder is not treated, patients will respond less well to treatment for depression than do those with no PD.

These findings suggest that screening for PD may be important for clinicians treating late-life depression and that the combination of Cluster C PDs and residual depressive symptoms may predict functional declines even after recovery from the index episode of depression.

Psychiatric interventions, targeting the patients considered to be the risk group, social programs (governmental or not), meant to improve the patients' quality of life and to reduce their disability, might be useful.

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