Axis I Diagnostic Comorbidity and Borderline Personality Disorder

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Borderline personality disorder (PD) has been the most studied PD. Research has examined the relationship between borderline PD and most axis I diagnostic classes such as eating disorders, mood disorders, and substance use disorders. However, there is little information regarding the relationship of borderline PD and overall comorbidity with all classes of axis I disorders assessed simultaneously. In the present study, 409 patients were evaluated with semistructured diagnostic interviews for axis I and axis II disorders. Patients with a diagnosis of borderline PD versus those who did not receive the diagnosis were assigned significantly more current axis I diagnoses (3.4 v 2.0). Borderline PD patients were twice as likely to receive a diagnosis of three or more current axis I disorders (69.5% v 31.1%) and nearly four times as likely to have a diagnosis of four or more disorders (47.5% v 13.7%). In comparison to nonborderline PD patients, borderline PD patients more frequently received a diagnosis of current major depressive disorder (MDD), bipolar I and II disorder, panic disorder with agoraphobia, social and specific phobia, posttraumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), eating disorder NOS, and any somatoform disorder. Similar results were observed for lifetime diagnoses. Overall, borderline PD patients were more likely to have multiple axis I disorders than nonborderline PD patients, and the differences between the two groups were present across mood, anxiety, substance use, eating, and somatoform disorder categories. These findings highlight the importance of performing thorough evaluations of axis I pathology in patients with borderline PD in order not to overlook syndromes that are potentially treatment-responsive.
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E PIDEMIOLOGICAL and clinical studies have established that comorbidity among the axis I disorders is frequent. There are several reports from the Epidemiological Catchment Area Study examining lifetime comorbidity rates in individuals with a lifetime history of particular disorders. For example, Davidson et al.[1] found that 84.5% of social phobics had a history of another DSM-III disorder, the most frequent being simple phobia (60.8%), agoraphobia (45.0%), generalized anxiety disorder ([GAD] 26.9%), obsessive-compulsive disorder ([OCD] 18.6%), alcohol abuse/dependence (17.2%), and major depressive disorder ([MDD] 14.6%). Weissman et al.[2] reported that 77.1% of individuals with dysthymic disorder had at least one other lifetime disorder, the most frequent being MDD (38.9%) and substance use disorders (29.8%). Likewise, between 66% and 80% of individuals with a lifetime history of other disorders such as MDD, posttraumatic stress disorder (PTSD), and panic disorder had one or more comorbid disorders.[3-5]

High comorbidity rates likewise have been found in the National Comorbidity Study. Kessler et al.[6] indicated that 56% of individuals with a lifetime history of any DSM-III-R disorder had at least two additional lifetime disorders. Fifty-six percent of individuals with MDD at the time of evaluation had at least one additional current disorder.[7] A lifetime history of at least one other disorder was present in 88% and 79% of men and women, respectively, with a lifetime history of PTSD,[8] and 87%, 83%, and 81% of individuals with a lifetime history of agoraphobia, simple phobia, and social phobia, respectively, had a lifetime history of at least one other disorder.[9]

In clinical samples, comorbidity is expected to be even higher because the presence of multiple disorders increases the likelihood of seeking treatment.[10] Using structured interviews, the evidence indicates that 50% to 75% of patients receiving a diagnosis of PTSD, GAD, OCD, social phobia, MDD, dysthymia, specific phobia, or panic disorder with or without agoraphobia meet criteria for at least one additional diagnosis.[11-22]

During the past 10 years, a separate literature has accumulated regarding the comorbidity between axis I disorders and personality disorders (PDs).[23-25] Borderline PD has been the most studied PD. Researchers have examined the relationship between borderline PD and most axis I diagnostic classes such as eating disorders,[26-28] mood disorders,[29-31] and substance use disorders,[32] and a few studies have examined the full range of axis I disorders in patients with borderline PD.[33-35] While there are some studies comparing the rates of specific disorders in patients with and without borderline PD, there is a surprising lack of information on total axis I comorbidity rates in borderline and nonborderline patients. That is, no study has examined whether patients with borderline PD are more likely to have multiple axis I disorders.

In the present report from the Rhode Island Methods to Improve Diagnosis and Services (MIDAS) project, we examined whether the presence of borderline PD is associated with the total number of axis I diagnoses patients receive. In addition, we compared the frequency of specific axis I disorders in patients with and without borderline PD. To our knowledge, this is the first study of the association between borderline PD and specific axis I disorders based on DSM-IV criteria.

METHOD

Five hundred patients were evaluated with semistructured diagnostic interviews in the Rhode Island Hospital Department of Psychiatry outpatient practice. This private-practice group predominantly treats individuals with medical insurance (including Medicare but not Medicaid) on a fee-for-service basis, and it is distinct from the hospital's outpatient residency training clinic that predominantly serves lower-income, uninsured, and medical-assistance patients.

The patients were interviewed by a diagnostic rater who administered the Structured Clinical Interview for DSM-IV Axis I Disorders—Patient Edition (SCID)[36] and the borderline PD section of the Structured Interview for DSM-IV Personality Disorders (SIDP-IV).[37] The Rhode Island Hospital institutional review committee approved the research protocol, and all patients provided informed written consent.

Six diagnostic raters were used to administer the SCID. The

raters included the authors of this report, each of whom has extensive experience administering research diagnostic interviews. The other four raters were research assistants with college degrees in the social or biological sciences. One of the raters had more than 6 years' experience administering the SCID and had previously trained other research assistants in its use. The remaining three diagnostic raters received 3 months of training during which they observed at least 20 interviews, and they were observed and supervised in their administration of more than 20 evaluations. At the end of the training period, these three raters were required to demonstrate exact or near-exact agreement with a senior diagnostician on five consecutive evaluations. During the course of the study, information on joint-interview diagnostic reliability was collected on 17 patients. For disorders diagnosed at least two times, the kappa coefficients were as follows: MDD, $\kappa = 1.0$; dysthymic disorder, $\kappa = 1.0$; bipolar disorder, $\kappa = 1.0$; depressive disorder NOS, $\kappa = .45$; adjustment disorder, $\kappa = .45$; panic disorder, $\kappa = 1.0$; social phobia, $\kappa = .87$; OCD, $\kappa = 1.0$; specific phobia, $\kappa = 1.0$; GAD, $\kappa = .64$; PTSD, $\kappa = 1.0$; anxiety disorder NOS, $\kappa = .19$; and borderline PD, $\kappa = 1.0$.

Throughout the MIDAS project, ongoing supervision of the raters consisted of weekly diagnostic case conferences involving all members of the team. In addition, every case was presented to the senior author on the day of the evaluation. Diagnostic uncertainties usually were clarified the same day, and if necessary, patients were telephoned to obtain additional information needed to render a definitive diagnosis.

The January 1995 version of the SCID was supplemented with the borderline PD section of the SIDP-IV. The SIDP-IV borderline section was added to the SCID after 91 patients had already participated in the project; thus, only 409 patients were interviewed with both measures. The axis I version of the SCID covers seven DSM-IV sections: mood disorders (MDD, bipolar disorder, dysthymia, depressive disorder NOS, mood disorder due to a general medical condition, and substance-induced mood disorder), psychotic disorders (schizophrenia, schizophreniform disorder, delusional disorder, schizoaffective disorder, brief psychotic disorder, and psychotic disorder NOS), substance use disorders (abuse of and dependence on alcohol, sedatives-hypnotics, cannabis, stimulants, opioids, cocaine, hallucinogens, inhalants, and phenylcyclidine, and polydrug abuse), anxiety disorders (panic disorder with and without agoraphobia, agoraphobia without history of panic disorder, social phobia, specific phobia, OCD, PTSD, acute stress disorder, GAD, and anxiety disorder NOS), somatoform disorders (somatization disorder, pain disorder, undifferentiated somatoform disorder, hypochondriasis, and body dysmorphic disorder), adjustment disorders, and eating disorders (anorexia nervosa, bulimia nervosa, and binge-eating disorder). The SCID does not evaluate childhood, cognitive, factitious, dissociative, sexual- and gender-identity, sleep, and impulse-control disorders or other conditions that may be the focus of clinical attention. However, information from the overview at the beginning of the interview could be used to diagnose these other disorders. The SIDP-IV borderline PD section was administered to the patients only; supplemental information from informants was not obtained.

The prevalence of some axis I disorders may have been influenced by modifications of the SCID. First, modules were added for the impulse-control disorders (intermittent explosive disorder, kleptomania, pathological gambling, trichotillomania,