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Borderline personality disorder and mood spectrum

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Abstract

Several lines of evidence have raised the question of whether Borderline Personality Disorder (BPD) is an independent disease entity or it might be better conceptualized as belonging to the spectrum of mood disorders. This study explores a wide array of lifetime mood features (mood, cognitions, energy, and rhythmicity and vegetative functions) in patients with BP and mood disorders. The sample consisted of 25 BPD patients who did not meet the criteria for bipolar disorders, 16 bipolar disorders patients who did not meet the criteria for BPD, 19 unipolar patients who did not meet the criteria for BPD, and 30 non-clinical subjects. Clinical diagnoses were determined by administering the structured clinical interviews for DSM-IV disorders. The Mood Spectrum Self-Report (MOODS-SR) was used for measuring lifetime mood phenomenology. Clinical subjects displayed higher mean scores than normal subjects in all domains of the MOODS-SR, and BPD patients displayed higher scores than unipolar patients in the Mood and Cognition depressive subdomains. Differences between patients with BP and bipolar disorders on MOODS psychopathology did not attain statistical significance for any (sub)domain considered. The results of this study are consistent with previous findings suggesting the importance of mood dysregulations in patients with BPD.
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1. Introduction

Affective symptomatology is a central feature of borderline personality disorder (BPD). Indeed, the overlap in core symptoms of mood disorder and BPD continues to be one of the main concerns regarding the diagnostic validity of this category (Akiskal et al., 1985; Davis and Akiskal, 1986). Additionally, high rates of comorbidity between BPD and mood disorder have been documented (McGlashan, 1983; Pope et al., 1983; Frances et al., 1984; Perry, 1985; Zanarini et al., 1998). These and other related lines of evidence have raised the question of whether BPD is an independent diagnostic category or might be better conceptualized as belonging to the spectrum of mood disorders (for discussions, see Gunderson and Phillips, 1991; Koenigsberg et al., 1999; White et al., 2003).

In this regard, the research examining the relationship between BPD and depression often has produced conflicting findings. In a review of the literature, Gunderson and Phillips (1991) concluded that even

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though the two disorders frequently co-exist, their relationship is not only "weak" but also non-specific. Findings from previous research in this field are, however, difficult to interpretate since, as other authors have highlighted (Koenigsberg et al., 1999; Riso et al., 2000), they suffer from important methodological shortcomings, including not using structured diagnostic interviews or not accounting for comorbidity between BPD and mood disorders.

Indeed, several family studies suggest that when comorbidity is either statistically or metodologically controlled, the familial aggregation of several psychiatric disorders (including mood disorder and BPD) is generally similar for patients with BPD and mood disorder (Klein et al., 1995; Riso et al., 1996; Riso et al., 2000). In reviewing new findings provided by biological and treatment studies, Koenigsberg et al. (1999) concluded that even though the link between BPD and depression is not a specific one, both disorders display similarities and differences in their underlying biology and treatment response. The precise nature of this relation, however, is still not fully understood or widely agreed upon.

The affective disorder thesis of BPD has also been extended to bipolarity (Akiskal et al., 1977; Levitt et al., 1990; Perugi and Akiskal, 2002), and the landscape here is no less controversial. In this regard, it has been suggested that many patients with BPD represent bipolar variants at the subthreshold level (Pinto and Akiskal, 1998). Consistent with this hypothesis, in a treatment response study, Pinto and Akiskal (1998) found that five of six subjects with BPD required mood stabilizers. On the basis of such findings, the authors argued that a "unipolar" hypothesis of BPD is misleading, and hypothesized that the depressive symptomatology of patients with BPD is related to bipolarity rather than to unipolarity.

In line with Akiskal's view, Deltito et al. (2001) explored several clinical indicators for bipolarity — including history of spontaneous mania and hypomania, bipolar temperaments, typical pharmacological response of patients with bipolar disorder, and positive bipolar family history — in a cohort of patients suffering from BPD. Results indicated that at least 44% of patients with BPD should be allocated to the bipolar spectrum.

Henry et al. (2001), however, reported that even though patients with BPD did not differ from patients with bipolar II disorders on measures of affective lability, participants in the BPD group displayed a more severe pattern of impulsiveness and aggressiveness, suggesting that they may represent distinct disorders. In contrast with these findings, Perugi et al. (2003) reported on a strong association between mood lability, interpersonal sensitivity traits, and cyclothymic features in a sample of patients who met criteria for major depression with atypical features, and who were further evaluated for bipolar spectrum. Thus, the authors suggested that bipolar II, BPD and atypical depressions share a common temperamental diathesis, including cyclothymic mood-reactive instability, anxious-dependent and avoidant attitudes, and impulsive and reactive behavior, which in turn may explain the pattern of anxiety, mood and impulsive symptomatology in these conditions.

Benvenuti et al. (2005) recently compared BPD patients with or without a lifetime history of mood disorders on psychotic and mood measures. BPD patients with mood disorders scored significantly higher on depressive mood and cognition dimensions than BPD patients without mood disorders (with higher scores indicating higher depressive symptomatology). The groups did not differ either in manic or in energy features of depression. It is unknown, however, if these differences are related to either the unipolar or the bipolar component, since the BPD with mood disorders group included both subjects with bipolar and unipolar conditions.

Given the changing complex scenario provided by the research in the field, a better understanding of the components of BPD and its relation with mood disorders is needed. With this aim, the present study explores a wide array of clinically significant dimensions of mood psychopathology (mood, cognitions, energy, and rhythmicity and vegetative functions) in patients with BPD, and in unipolar and bipolar conditions, separately. As several authors have argued (cf. Krueger et al., 2005), adopting a dimensional approach to isolate or capture important components of psychopathology may lead to a better understanding of psychopathology and, most specifically, may help in addressing some common problems associated with categorical classification – including the issue of high rates of comorbidity. Such a dimensional approach may simply involve a description of similarities and distinctions across specific diagnostic groups in empirically supported symptom dimensions.

2. Method

2.1. Participants

The sample consisted of three groups of patients and a group of non-clinical subjects. Participants in the clinical groups were 60 outpatients who met DSM-IV-TR criteria for: a) borderline personality disorder (BPD, $n = 25$), without current or lifetime history of mood

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