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Differences between patients with borderline personality disorder who do and do not have a family history of bipolar disorder

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Abstract

Diagnostic confusion sometimes exists between bipolar disorder and borderline personality disorder (BPD). To improve the recognition of bipolar disorder researchers have identified nondiagnostic factors that point toward bipolar disorder. One such factor is the presence of a family history of bipolar disorder. In the current report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project, we compared the demographic, clinical, and psychosocial characteristics of patients with BPD who did and did not have a family history of bipolar disorder. A large sample of psychiatric outpatients were interviewed with semi-structured interviews. Three hundred seventeen patients without bipolar disorder were diagnosed with DSM-IV borderline personality disorder. Slightly less than 10% of the 317 patients with BPD (9.5%, $n = 30$) reported a family history of bipolar disorder in their first-degree relatives. There were no differences between groups in any specific Axis I or Axis II disorder. The patients with a positive family history were significantly less likely to report excessive or inappropriate anger, but there was no difference in the frequency of other criteria for BPD such as affective instability, impulsivity, or suicidal behavior. The patients with a positive family history reported a significantly higher rate of increased appetite and fatigue. There was no difference in overall severity of depression, scores on the Global Assessment of Functioning, history of psychiatric hospitalizations, suicide attempts, time unemployed due to psychiatric reasons during the 5 years before the evaluation, and ratings of current and adolescent social functioning. There was no difference on any of the 5 subscales of the childhood trauma questionnaire. Overall, we found few differences between BPD patients with and without a family history of bipolar disorder thereby suggesting that a positive family history of bipolar disorder was not a useful marker for occult bipolar disorder in these patients.

1. Introduction

The goal of the present investigation is to determine whether patients with borderline personality disorder (BPD) with a first-degree relative with bipolar disorder differ from BPD patients without a first-degree relative with bipolar disorder. If so, this might suggest occult bipolar disorder in the patients with a positive family history.

The underrecognition and underdiagnosis of bipolar disorder is a significant clinical problem [1–4]. For patients diagnosed with bipolar disorder, the lag between initial treatment seeking and the correct diagnosis is often more than 10 years [5]. The potential clinical implications of underdiagnosing bipolar disorder in depressed patients include the underprescription of mood stabilizing medications, an increased risk of rapid cycling, and increased costs of care [2,6,7]. Experts have called for improved recognition of bipolar disorder because of these individual and public health consequences [1,3].

The relationship between bipolar disorder and BPD has been the subject of some controversy. The relatively high frequency of diagnostic co-occurrence and resemblance of some phenomenological features has led some authors to suggest that BPD is part of the bipolar spectrum [8,9]. In fact, in a recent large-scale international study, BPD comorbidity was considered as one of the variables validating the distinction between bipolar and nonbipolar disorder [4]. Several review articles have summarized the evidence in support of and opposition to the hypothesis that BPD belongs to the bipolar spectrum [10–13].

Diagnostic confusion sometimes exists between the two disorders [11,12,14]. Given the superficial resemblance of some of the clinical characteristics of bipolar disorder and

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BPD, it is not surprising that the two disorders frequently co-occur. Paris et al., [11] comprehensively reviewed studies reporting the rates of comorbidity between bipolar disorder and BPD. In 12 studies of the frequency of bipolar disorder in patients with BPD, they found that approximately 10% of the patients with BPD were diagnosed with bipolar I disorder and approximately 10% were diagnosed with bipolar II disorder. In 16 studies of BPD disorder co-occurrence in patients with bipolar disorder, approximately 10% of the patients with bipolar I disorder and 16% of patients with bipolar II disorder were diagnosed with BPD.

To improve the recognition of bipolar disorder researchers have identified nondiagnostic factors that point toward bipolar disorder. One such factor is the presence of a family history of bipolar disorder. That is, clinicians are encouraged to consider that a patient has occult bipolar disorder if there is a family history of bipolar disorder. In fact, Young and Klerman [15] considered individuals with a family history of bipolar disorder to have a variant of the disorder (bipolar type 5), and Ghaemi et al. [16] list a positive family history of bipolar disorder as one of their criteria for bipolar spectrum disorder.

Researchers have used a family history of bipolar disorder to validate the concept of the bipolar spectrum [4,17,18]. Although family studies of borderline personality disorder have not found an elevated rate of bipolar disorder in first-degree relatives [19–23], this does not preclude the value of using a family history of bipolar disorder in patients with borderline personality disorder to identify individuals who are on the bipolar spectrum. Accordingly, in the current report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project, we compared the demographic, clinical, and psychosocial characteristics of patients with borderline personality disorder who did and did not have a family history of bipolar disorder.

2. Methods

The Rhode Island MIDAS project represents an integration of research methodology into a community-based outpatient practice affiliated with an academic medical center [24]. A comprehensive diagnostic evaluation is conducted upon presentation for treatment. 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. Data on referral source were recorded for the last 1800 patients enrolled in the study. Patients were most frequently referred from primary care physicians (29.6%), psychotherapists (16.6%), and family members or friends (18.4%). The Rhode Island Hospital institutional review committee approved the research protocol, and all patients provided informed, written consent.

The sample examined in the present report was derived from the 3600 psychiatric outpatients evaluated with semi-structured diagnostic interviews. Patients were interviewed by a diagnostic rater who administered a modified version of the Structured Clinical Interview for DSM-IV (SCID) [25] supplemented with items from the Schedule for Affective Disorders and Schizophrenia (SADS) [26] and the BPD section of the Structured Interview for DSM-IV Personality (SIDP-IV) [27]. During the course of the MIDAS project the assessment battery has been modified at times. The assessment of all DSM-IV personality disorders was not introduced until the study was well underway and the procedural details of incorporating research interviews into our clinical practice had been well established, though we had introduced the assessment of BPD near the beginning of the study. In June, 2008 we stopped administering the full SIDP-IV and continued to only administer the BPD module. The assessment of personality disorders always followed the evaluation of Axis I disorders. In some instances, due to a lack of time, the personality disorder interview was not completed; thus, 3465 patients were assessed for BPD, of whom 375 (10.4%) met DSM-IV criteria for BPD. We excluded the 58 patients diagnosed with both BPD and bipolar disorder because we were interested in whether BPD in the absence of bipolar disorder should be considered as part of the bipolar spectrum. This left a final sample of 317 patients with BPD without bipolar disorder who were included in the analysis. The 317 patients included 89 (28.1%) men and 228 (71.9%) women who ranged in age from 18 to 68 years (mean = 32.1, SD = 10.4). About half of the subjects were single and had never married (46.7%, n = 148); the remainder were married (23.0%, n = 73), divorced (13.9%, n = 44), separated (4.4%, n = 14), widowed (0.6%, n = 2), or living with someone as if in a marital relationship (11.4%, n = 36). Approximately three-quarters of the patients graduated high school (73.2%, n = 232), though only a minority graduated a 4-year college (16.7%, n = 53). The racial composition of the sample was 86.4% (n = 274) white, 6.9% (n = 22) black, 3.8% (n = 12) Hispanic, 1.3% (n = 4) Asian, and 1.6% (n = 5) from another or a combination of the above racial backgrounds.

Following the SCID interview patients completed a booklet of questionnaires that included the Childhood Trauma Questionnaire [28]. We compared the groups on the 5 subscales of the Childhood Trauma Questionnaire—emotional abuse, physical abuse, sexual abuse, physical neglect and emotional neglect.

From the SADS we examined the items assessing psychic and somatic anxiety, anger and irritability, and somatization. The SADS ratings referred to symptom severity during the past week. The interview also included items from the SADS on best level of social functioning during the past five years, social functioning during adolescence, and the amount of time employed during the past five years. The Clinical Global Index (CGI) of depression severity [29] and Global Assessment of Functioning (GAF) were rated on all patients. The SCID/SADS interview included an assessment of lifetime number of psychiatric hospitalizations and suicide attempts.