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Comorbid atypical depression in borderline personality disorder is common and correlated with anxiety-related psychopathology

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Abstract

Background: The core features of borderline personality disorder (BPD) are affective instability, unstable relationships and identity disturbance. Axis I comorbidities are frequent, in particular affective disorders. The concept of atypical depression is complex and often underestimated. The purpose of the study was to investigate the comorbidity of atypical depression in borderline patients regarding anxiety-related psychopathology and interpersonal problems.

Methods: Sixty patients with BPD were assessed with the Structured Clinical Interviews for DSM-IV Axis I and II Disorders (SCID I, SCID II) as well as the Atypical Depression Diagnostic Scale (ADDS). Additionally, patients completed a questionnaire (SCL-90-R, BDI, STAI, STAXI, IIP-C).

Results: Forty-five BPD patients (81.8%) had a comorbid affective disorder of which 15 (27.3%) were diagnosed with an atypical depression.

In comparison to patients with major depressive disorder or no comorbid depression, patients with atypical depression showed significant higher scores in psychopathological symptoms regarding anxiety and global severity as well as interpersonal problems.

Conclusions: The presence of atypical depression in borderline patients is correlated with psychopathology, anxiety, and interpersonal problems and seems to be of clinical importance for personalized treatment decisions.

1. Introduction

Borderline is one of the most common personality disorders that affects about 1% to 2% of the general population, around 10% psychiatric outpatients and 20% psychiatric inpatients. The diagnosis is more common in women (75%) than in men [1,2].

BPD was included in 1980 in the DSM-III classification [3]. The main characteristics include affective instability, unstable relationship patterns, disturbed identity and impulsivity. DSM-IV-TR defines affective instability as intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days, due to a marked reactivity of mood [4].

BPD is considered both psychologically [5] and biologically [6] as a heterogeneous disorder and is associated with high comorbidity [7]. Biological vulnerability and developmental insults combined determine the presentation of BPD. The diagnostic criteria of BPD can be organized into four sectors of psychopathology: affective, cognitive, behavioural and interpersonal criteria [8]. Patients vary widely in their severity of manifestation of these factors and even do not need to be impaired in all four factors. There are 126 different possibilities (clusters) to fulfil the diagnostic criteria for BPD (at least 5 of 9 different criteria) [9]. These dissimilarities can lead to alternate courses of the disorder [10] as well as different treatment responses.

The disorder of affectivity in borderline disorder is conceptualized in different ways. Psychiatrists emphasize either the disorder of affect regulation with difficulty of personality-conditioned affect control [11,12], or the emotional dysregulation due to elevated biological vulnerability [13].

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Gunderson and Phillips [14] point out that depressive disorder in borderline disorders shows a qualitatively different characteristic than in major depression being more developmentally and interpersonally based.

Comorbidities are very common in patients with BPD and seem to predict the characteristic as well as the course of the disorder. Several studies have found that borderline patients are often diagnosed with an Axis I disorder (e.g. anxiety disorders and substance abuse) [8,15]. However the most frequent comorbidities are affective disorders, especially major depression, which occurs in 70% to 90% of all borderline patients [16,17]. Zanarini et al. [17] reported that 80% had experienced a major depression episode at some point in their medical history. It seems that a specific depressive subtype is often connected with BPD; Posternak and Zimmermann [18] found that 27% of their borderline patients had a comorbid atypical depression (AD). The international BRIDGE study [19] examined 2658 patients with an MDD regarding BPD and bipolar disorder. A bipolar diagnosis was more frequent in the non-borderline group whereas borderline patients reported significantly more atypical features.

Atypical depression (AD) was introduced to specify major depressive episodes in DSM-IV following a series of antidepressant trials showing that such patients responded preferentially to monoamine oxidase inhibitors (MAOIs) [20]. This depressive form is characterized by depressive mood, emotional reactivity, increased sleep, eating disorders and somatic impairment and affects about 30% of unipolar depressive patients, mostly women. Biological studies [21] as well as statistical classifications [22] support the hypothesis of a distinct depressive subtype. Compared to melancholia and other depression, atypical depression shows an earlier age of onset and a more chronic course of illness [23]. The quality of the depressive experience in borderline personality disorder has always been perceived to be different from the depression experienced in major depression (MDD) [24].

Perugi and colleagues [25] compared patients who met the DSM-IV criteria for major depressive episode with atypical features in terms of a comorbid BPD. The group with a comorbid borderline disorder had significant higher lifetime comorbidity for bulimia nervosa, cyclothymia and Axis II disorders of the anxious and dramatic cluster (narcissistic, dependent and avoidant). This group also scored higher on multiple Atypical Depression Diagnostic Scale items (mood reactivity, interpersonal sensitivity, functional impairment, avoidance of relationships and other rejection avoidance). Most interestingly, heightened rejection sensitivity seems to be a feature in both AD and BPD [26].

Deliberate self-harm is correlated with heightened sensitivity to interpersonal rejection [27]. High rejection sensitivity is also associated with increased borderline personality features among people low in self-reported executive control and among those high in self-reported executive control, the relationship between rejection sensitivity and borderline personality features is attenuated [28]. Patients with BPD may be more sensitive to rejection, and these fears of rejection may result in increased emotion dysregulation and subsequent behavioral problems [29] or rage [30].

Anxiety disorders seem to be rather common in borderline personality disorder [31,32]. Silverman et al. [33] studied the comorbidity of patients with an Axis II disorder and found rates of 89% anxiety disorders in BPD patients. A national epidemiologic survey with over 34,000 adults [34] also showed a high co-occurrence of anxiety disorder with BPD.

However, AD is also reported to be connected to anxiety disorders. Gili and colleagues [35] compared AD, melancholic and non-melancholic depression in non-borderline patients and found that AD patients had higher rates of comorbid anxiety disorders. More specific studies showed a correlation of AD with social phobia and panic disorder [36–38].

Given that anxiety and rejection sensitivity are common in both AD and BPD the question arises how the co-occurrence of the both disorders is affecting the patient? From our point of view until now there has not been a study investigating BPD and comorbid AD in reference to anxiety.

2. Aims of the study

Since BPD and depression are rather common in co-occurrence the aim of our study was to more closely examine a specific group of depression—atypical depression—in association with BPD. We expected patients with comorbid AD to show a more severe psychopathology compared to other BPD patients with either a different type of depression or no depression at all.

Another hypothesis was whether this co-occurrence of AD leads to more interpersonal problems in BPD patients.

3. Methods

3.1. Study design and participants

All patients were inpatients at the Psychiatric Hospital of the University of Basel and were diagnosed with a borderline personality disorder (BPD) according the DSM-IV-TR criteria. Patients participated in a matched-controlled inpatient study for BPD patients (Basel Borderline Inpatient Study [BABIS]). The aims of this study were to compare the effects of transference focused psychotherapy (TFP)-based disorder-specific inpatient treatment versus treatment as usual and to identify the possible influence of subgroups within the heterogeneous group of BPD patients. Detailed descriptions of the aims, methods and sample characteristics of the Basel Borderline Inpatient Study (BABIS) supported by a research grant from the Swiss National Science Foundation have been reported separately [39].