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Research report

Different impulsivity profiles in borderline personality disorder and bipolar II disorder

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ABSTRACT

Introduction: Borderline personality disorder (BPD) and bipolar II disorder (BP II) share clinical characteristics including impulsivity. Their relationship is disputed. In this study, we investigated self-reported impulsivity in these patient groups and in a healthy control group. Effects of current mood state and of traumatic childhood experiences were explored.

Methods: Twenty-five patients with BPD without comorbid bipolar disorder; 20 patients with BP II without comorbid BPD; and 44 healthy control subjects completed the UPPS questionnaire which yields assessments of four components of impulsivity: Urgency, Lack of Premeditation, Lack of Perseverance, and Sensation Seeking. Current mood state was rated using the Montgomery Asberg Depression Rating Scale (MADRS), and the Young Mania Rating Scale (YMRS). Traumatic childhood experiences were assessed using the Childhood Trauma Questionnaire (CTQ). Group differences in UPPS levels; and effects of mood state and CTQ score on UPPS scores in patients were investigated.

Results: BPD patients showed significantly higher levels of Urgency and Lack of Perseverance than BP II patients and controls, and a significantly higher level of Lack of Premeditation than controls. BP II patients showed higher levels of Urgency and Lack of Perseverance than controls. In BP II, higher MADRS scores were associated with higher impulsivity scores. Also, higher CTQ scores were associated with higher Urgency scores in BP II.

Limitations: Relatively small sample size; cross-sectional assessment of influence of mood state.

Conclusions: BPD patients exhibited markedly elevated UPPS impulsivity scores compared with healthy controls and BP II patients, and the elevations were not related to current mood state. BP II patients showed moderately elevated impulsivity scores which were associated with a depressed mood state and to some extent with a history of childhood trauma. The findings suggest that BPD and BP II have different impulsivity profiles.

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1. Introduction

Borderline personality disorder (BPD) and bipolar disorder have several commonalities. For years, there has been a debate about how the two conditions are related (Zanarini et al., 1998; Ruggero et al., 2010; Paris, 2013; Fletcher et al., 2014; Ghaemi et al., 2014). Some have argued that BPD may represent a subgroup of the bipolar spectrum disorders (Akiskal et al., 1985), or that BPD and

bipolar disorder may share a genetic predisposition to temperamental instability, which may develop into either BPD or bipolar disorder (Mackinnon and Pies, 2006). Others acknowledge that BPD and bipolar disorder have a certain reciprocal comorbidity, but maintain that they represent distinct diagnostic entities (Zimmerman and Morgan, 2013). The manias of bipolar I disorder are qualitatively distinct and easily recognizable; therefore, recent research has focused on the relationship between BPD and bipolar II disorder (BP II) (Perugi et al., 2011).

Present data support that the disorders differ on central aspects such as etiology, course of illness, emotion dysregulation profile, and treatment response (Bayes et al., 2014; Ghaemi et al., 2014; Parker, 2011). However, direct comparisons of BPD and BP II

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patients are few, and there are still unresolved questions regarding their relationship. For example, it is not fully clarified whether and how the disorders are separated on measures of impulsivity (Bayes et al., 2014; Ghaemi et al., 2014).

1.1. Impulsivity in BPD and BP II

Impulsivity is a defining feature of the BPD diagnosis, but has also been shown to be associated with bipolar disorder (Lewis et al., 2009; Swann et al., 2009; Strakowski et al., 2010). To our knowledge, only two studies have compared impulsivity in BPD and BP II. Both studies assessed impulsivity by means of the Barratt Impulsiveness Scale (BIS) (Henry et al., 2001; Wilson et al., 2007). Both studies compared four patient groups classified by different comorbidity combinations, and both found that BPD was associated with higher impulsivity than BP II. However, neither study compared BPD and BP II groups directly, but instead conducted two-way analyses of variance with the presence or absence of BPD and BP II or mood disorder as factor. Nor did any of them include a healthy control group. Those study limitations impeded determinations of whether and how impulsivity might differ between these two diagnostic groups (Zimmerman et al., 2013).

1.2. Self assessment of impulsivity

BIS is probably the most commonly used self-assessment measurement of impulsivity in psychiatry, and elevated BIS scores have been shown repeatedly in BPD (Herpertz et al., 1999; Paris et al., 2004; Domes et al., 2006) and in BP II (Lewis et al., 2009; Swann et al., 2009; Etain et al., 2013). However, a large factor analysis study suggested that BIS and other questionnaires do not capture all facets of impulsivity (Whiteside and Lynam, 2001). Importantly, impulsivity related to negative affect is not well evaluated by the BIS scale, which might limit the assessment of impulsivity related to psychiatric disorders. Therefore, Whiteside and Lynam wanted to create a more comprehensive self assessment scale to measure impulsivity (Whiteside and Lynam, 2001). This new scale, known as UPPS, includes four components and corresponding subscales. The first component, **U**rgency, refers to a tendency to act impulsively under experiences of negative effect. The second component, Lack of **P**remeditation, refers to a difficulty to reflect on the consequences of an act before engaging in it, and corresponds closely with several previous measures of impulsivity including the BIS. The third component, Lack of **P**erseverance, refers to an inability to remain focused on boring or difficult tasks. The fourth component, **S**ensation Seeking, refers to a tendency to engage in exciting, new, and sometimes dangerous activities.

Accordingly, the UPPS might have the potential to capture a broad range of aspects involved in impulsivity. The clinical usefulness of the questionnaire has been demonstrated in a variety of samples (Smith et al., 2007; Verdejo-Garcia et al., 2007; Tragesser and Robinson, 2009; Jacob et al., 2010; Miller et al., 2010; Mobbs et al., 2010; Claes and Muehlenkamp, 2013). Notably, UPPS has also proven useful to differentiate between disorders and traits; for example between variants of ADHD (Miller et al., 2010) and between borderline and antisocial traits (DeShong and Kurtz, 2013).

1.3. Aims and hypotheses

The present study aimed to compare UPPS impulsivity among BPD, BP II, and healthy control groups. Our main hypothesis was that BPD and BP II represent distinct diagnostic categories, and thus would display different UPPS profiles. Based on a previous study that used UPPS in the assessment of impulsivity in BPD (Jacob et al., 2010), we expected that patients with BPD would exhibit higher levels of impulsivity compared to healthy controls

on all UPPS subscales, except for the Sensation Seeking scale. Based on studies of bipolar disorder that used the BIS scale, we expected that BP II patients, compared to healthy controls, would exhibit elevations on the UPPS subscales that correspond most closely to BIS; i.e., Lack of Premeditation and to a certain extent Urgency (Whiteside and Lynam, 2001). Furthermore, based on studies that used the Zuckerman Sensation Seeking scale (Fornaro et al., 2013), we expected patients with BP II to exhibit elevated UPPS Sensation Seeking compared to controls. We hypothesized that patients with BP II would not differ significantly from healthy controls on the UPPS Lack of Perseverance scale.

In the direct comparison between BPD and BP II, we hypothesized that the BPD group would exhibit higher impulsivity scores than the BP II group on all subscales, except for Sensation Seeking, where the BP II group was expected to exhibit the highest scores. To highlight differences between the diagnostic categories, we focused on including patients without reciprocal comorbidity (i.e. BPD patients without BP II; BP II patients without BPD). In addition, comorbid ADHD (Attention Deficit Hyperactivity Disorder) was an exclusion criterion, due to the potential confounding role of this disorder in a study of impulsivity (Miller et al., 2010).

Mood state has in some studies been shown to influence BIS impulsivity in bipolar disorder, but those results have been equivocal (Lewis et al., 2009; Strakowski et al., 2010). In exploratory analyses in each patient group, we aimed to investigate the relationship between UPPS impulsivity and depressive state, measured with the Montgomery–Åsberg Depression Rating Scale (MADRS), and the relationship between UPPS impulsivity and the degree of hypomania, measured with the Young Mania Rating Scale (YMRS).

Childhood traumatic experiences are frequent among BPD patients (Battle et al., 2004). Also, such experiences have been shown to increase impulsivity in adult bipolar patients (Leverich et al., 2002). Thus, we also wanted to explore the association between self-reported childhood trauma, assessed by of the Childhood Trauma Questionnaire (CTQ), and UPPS impulsivity in the patient groups.

2. Methods

2.1. Subjects

The Regional Ethics Committee of Southeastern Norway (REK Sør-Øst) approved the study (REK no 6.2008.158). After the subjects were informed about the study, written informed consent was obtained. Twenty-five patients meeting the DSM-IV criteria for BPD were recruited from the Department for Personality Psychiatry at Oslo University Hospital. Twenty patients meeting the DSM-IV criteria for BP II were recruited from outpatient psychiatric clinics in the greater Oslo area and from the Department of Psychosomatic medicine at Oslo University Hospital. Forty-four healthy control subjects were recruited through local advertising. Patients with BPD were excluded if they met the criteria for bipolar I or II disorder. To avoid including BPD patients with subthreshold bipolarity, we excluded patients with a history of hypomanic symptoms that lasted more than 24 h. BPD patients were also excluded if they had a schizotypal or schizoid personality disorder. Patients with BP II were excluded if they met the criteria for any cluster A or B personality disorder. Patients in both diagnostic categories were excluded if they had a lifetime psychotic disorder, or ADHD. Healthy control subjects were excluded if they had any previous or present psychiatric disorder. All participants were excluded if they were under age 18 or above age 50; if they had a history of a neurological or other severe chronic

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