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Brief report

Borderline personality disorder among primary care depressive patients: A five-year study

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ABSTRACT

Background: Studies of depressive disorders with concurrent borderline personality disorder (BPD) in primary health care are scarce and methodologically weak. Limited epidemiological evidence suggests BPD may be common among users of primary care services. Prevalence, characteristics and outcome of primary care depressive patients with co-morbid BPD are unknown.

Methods: The Vantaa Primary Care Depression Study is a prospective five-year cohort study. A stratified random sample of 1119 patients aged 20 to 69 years was screened for depression using the Prime-MD. SCID-I/P and SCID-II interviews were used to diagnose depressive all co-morbid axis I and II disorders. Of the 137 depressive patients at baseline, 82% completed the five-year follow-up. Characteristics and outcome of patients with or without concurrent BPD were compared.

Results: BPD cases accounted for 26% at baseline and 19% at follow-up. At baseline, BPD patients had a two-fold prevalence of anxiety and previous depressive episodes; a three-fold prevalence of substance use disorders, suicidal ideation and severe economic difficulties, and a four-fold prevalence of preceding suicide attempts or unemployment compared to those without BPD. By follow-up, patients with BPD had spent more time depressed, achieved full remission slower and a higher proportion were chronically depressed.

Limitations: Diagnostic reliability of depressive disorders was excellent, but of BPD not tested. Generalizability to other primary care settings remains unknown.

Conclusions: Concurrent BPD may be relatively common among depressed primary care patients. These patients have specific, adverse characteristics and poor long-term outcome, which should be considered when developing treatments for depression in primary care.

1. Introduction

Major depressive disorder (MDD) is one of the most important public health problems (Kessler, 2012; Murray et al., 2012; Wittchen et al., 2011). Borderline personality disorder (BPD) is another severe and chronic psychiatric disorder with marked co-morbidity with mood, anxiety and substance use disorders; a propensity to self-destructive behaviour, functional impairment and remarkably increased health care costs (Gunderson, 2011; Leichsenring et al., 2011). Both disorders are frequently encountered in primary health care (Gross et al., 2002). However, very little is known about clinical epidemiology of BPD among depressed patients in primary care settings. As depression alone still often remains unrecognized, there is a greater likelihood that depressions with more complex diagnostic presentations remain particularly poorly evaluated by primary care physicians (Vuorilehto et al., 2005). BPD is known to complicate the treatment and outcome of depression (Newton-Howes et al., 2006). According to a questionnaire-based PC study, BPD features may associate with a greater risk for and earlier onset of depression, disability and alcohol abuse (Hueston et al., 1999). Among MDD patients in psychiatric care, BPD predicts co-morbid disorders, suicide attempts, disability and poor recovery (Gunderson et al., 2011); findings of the epidemiological NESARC study were similar (Skodol et al., 2011). Investigating epidemiological overlap of depression and BPD in primary care is relevant for planning health services and treatment guidelines.

In a previous cross-sectional study, we found that every fourth depressive patient suffered from BPD (Vuorilehto et al., 2005). Here we investigated differences in characteristics and outcome between primary care depressive patients with or without BPD in a five-year prospective study.

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2. Methods

The Vantaa Primary Care Depression Study (PC-VDS) was approved by the pertinent Ethics Committee in 2001. Based on stratified sampling within the city of Vantaa, Finland, 373 of 1119 general practitioners' patients aged 20–69 years were screened using Primary Care Evaluation of Mental Disorders (PRIME-MD) and found positive for depression (Vuorilehto et al., 2005). The presence of at least one core symptom of MDD according to the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID I/P) was confirmed by telephone. Patients with psychoses other than depressive, bipolar or organic mood disorders, alcohol use problems severe enough to prevent two weeks abstinence were excluded, in addition to those currently receiving treatment in psychiatric care. All of the 175 eligible patients were interviewed face-to-face (by MV) using the SCID-I/P with psychotic screen. Inclusion criteria were current (1) MDD, (2) dysthymia, (3) subsyndromal MDD with two to four current depressive symptoms (minimum one core symptom) and lifetime MDD and (4) minor depression similar to subsyndromal MDD, but without MDD history. Patients who refused to participate (15%) did not differ significantly in age or gender from those who consented. The diagnostic reliability for current DD diagnoses was excellent (kappa=1.0). The final cohort comprised 137 patients. Current and lifetime psychiatric disorders were assessed using SCID-I/P and SCID-II interviews. In addition to the face-to-face interviews, observed and self-report scales along with all medical and psychiatric records were used to assess retrospective and prospective course of depression, co-morbid disorders, and psychosocial and socioeconomic factors (Vuorilehto et al., 2005).

After baseline, patients were prospectively investigated at 3, 6, 18 months and 5 years (Riihimaki et al., 2011). The 5-year investigation (by KR) included all the same diagnostic interviews, scales and medical and psychiatric records used at the baseline investigation: psychiatrists carried out evaluations at both compared time-points. Timing and duration of episodes of depression and substance abuse were integrated into a graphic life-chart; 82% participated in the 5-year follow-up. Drop-outs did not differ from participants in age, gender, baseline depression severity or prevalence of BPD (Riihimaki et al., 2011). Logistic and linear regression models were used to analyse differences in characteristics and outcomes between those with and without BPD at baseline. Sensitivity analyses excluding subsyndromal depressive subgroups and post-hoc comparisons of young vs. old BPD patients were conducted. All models were adjusted for age and gender and follow-up time, and socioeconomic variables also for MDE-duration. Patients who had switched into bipolar disorder by follow-up ($n=5$, one with concurrent BPD) were included in the baseline comparisons but censored at the time of first (hypo)mania. Excluding them from all analyses did not influence significance.

3. Results

3.1. Outcome of BPD

At the baseline interview, concurrent BPD was diagnosed in 26% (35/137) of the patients. At five years it was diagnosed in 19% (21/111). Of the 111 who participated in both interviews, 20 patients (19%) were assigned the BPD diagnosis in both interviews, nine (8%) only at baseline, and one (1%) only at follow-up.

3.2. Differences at baseline

BPD patients at baseline had a two-fold prevalence of anxiety and previous depressive episodes; three-fold of substance use disorders, suicidal ideation and severe economic difficulties, and a four-fold prevalence of preceding suicide attempts or unemployment over non-BPD patients (Table 1).

Table 1
Baseline differences between depressed primary care patients ($n=137$) with and without BPD.

Variables	BPD		No BPD		p-Value
	n	%	n	%	
	35		102		
Socio-demographic features					
Male gender	5	14	28	28	0.117
Any professional education	16	46	68	67	0.020
Employed	15	43	55	54	0.143
Unemployed	11	31	16	16	0.044
Social assistance	19	54	19	19	<0.001
Clinical features					
Psychiatric co-morbidity[a]	29	83	67	66	<0.001
Current axis I co-morbidity	27	77	55	54	0.016
Anxiety disorder (any)	22	63	37	36	0.006
Generalized anxiety disorder	7	20	15	15	0.463
Panic disorder	7	20	2	2	<0.001
Current axis II co-morbidity[a]	15	43	36	35	
Cluster B[a]	0	0	4	4	<0.001
Cluster A	4	11	3	3	0.050
Cluster C	13	37	31	30	0.462
Substance use disorder	10	29	10	10	0.011
Alcohol abuse	5	14	7	7	0.182
Treatment of alcohol abuse	8	23	4	4	0.002
Cigarette smoking	20	57	33	34	0.022
Suicide attempts before BL	14	40	9	9	<0.001
Treatment history					
Psychiatric care before BL	24	69	49	39	0.003
Psychiatric hospital before BL	11	31	7	7	<0.001
Socio-demographic features	**Mean**	**SD**	**Mean**	**SD**	
Age (years)	37.3	13.7	48.0	12.7	<0.001
Clinical features					
Age at onset of depression (years)	25.4	12.6	38.6	14.2	<0.001
HAM-D	17.2	5.7	15.8	5.1	0.148
BDI	24.3	11.9	17.5	8.6	<0.001
No of previous depressive episodes	4.37	6.1	2.19	2.6	0.006
BAI	24.1	16.6	14.2	9.8	<0.001
HS	10.5	5.2	8.1	5.1	0.022
SOFAS	50.1	12.1	58.9	10.5	<0.001
SSI	5.80	7.3	1.87	4.5	0.002

Between-group comparisons analysed using the two-sample *t*-test or ANOVA; Mann–Whitney *U*-test or Kruskal–Wallis test, and the Chi-square test.

[a] Other than BPD.

3.3. Differences in outcome

During the follow-up, BPD patients spent more time depressed, achieved full remission slower, and a higher proportion of them remained in MDEs throughout the whole follow-up time (Table 2). The many differences between the BPD- and non-BPD patients at baseline had persisted up to5-year follow-up.

3.4. Outcome differences in BPD age groups

In post-hoc subgroup analyses of the patients with BPD, older patients (35–69 years) had worse outcome than the younger (20–35 years), by having longer duration of depression during follow-up (38 vs. 15 months, $p=0.004$), and if in the labour force at baseline, shorter time able to work during follow-up (22.1 vs. 49.6 months; $p=0.038$).

3.5. Sensitivity analyses with depressive disorders vs. MDD

Statistically significant differences between patients with or without BPD persisted in the sensitivity analyses including only