Miriam Olivola
Silvia di Volo
Arianna Goracci
Simone Bolognesi
Federico Salvaro
Andrea Fagiolini

University of Siena, Department of Molecular Medicine, Siena, Italy

BIPOLAR DISORDER AND SUBTHRESHOLD SYMPTOMS OF BORDERLINE PERSONALITY DISORDER: IMPACT ON QUALITY OF LIFE

Abstract

Objectives: The nature of the relationship between bipolar disorder (BD) and borderline personality disorder (BPD) has been a field of debate in the last two decades. Literature's data show that as many as 20 % of patients with BPD meet criteria for bipolar I disorder. Furthermore, the presence of BPD has a high impact in the course of BD in terms of prognosis and scores of global functioning. However, a large number of BD patients shows BPD subthreshold symptoms and little is known about their impact in the course of BD. The purpose of the study is to evaluate the impact of BPD subthreshold symptoms in patients with a primary diagnosis of BD in terms of patient's prognosis and quality of life.

Materials and methods: The sample consisted of 29 outpatients (15 males and 14 females), aged between 24 and 66 years old suffering from BD seeking treatment at the Psychiatry Department of Siena Hospital. BD diagnosis was determined following the diagnostic criteria of the DSM IV TR. Patients were assessed with SCID II (Structured Clinical Interview for DSM IV axis II Disorders) and Q-LES (Quality of life enjoyment and satisfaction questionnaire). SCID II was administrated to assess the diagnosis of BPD (5 positive item) or the presence of BPD subthreshold symptoms (3-4 positive item). Additional clinical and prognostical data were also evaluated: age of disorder's onset, working and social condition, self-injury behaviours and suicide attempts, substance abuse, pharmacotherapy's degree of adherence. Patient's sample was divided in three groups with regard to BD diagnosis and SCID II assestment: BD (n = 11), BD and subthreshols symptoms of BPD (n = 8), BD and BPD (n = 10). A medium percentage of QLES-Q scores and of values of the other clinical data was calculated for every group.

Results and conclusions: Patients with DB and BPD showed an earlier age of symptom's onset than patients with a single diagnosis of BD. Moreover, subjects with BD and BPD subthreshold symptoms showed an intermediate age of onset compared with the other subgroups. Overall score results of Q-LES-Q are lower in the BD and subthreshold symptoms of BPD group with the only exception for the social relationships area where lower scores were founded in the group of BD+BPD patients (according to the specific relational instability of patients with BPD). The higher level of relational functioning was found in the BD group since these patients have more likely periods without symptoms of the disease than the other groups. The higher percentage values of abuse and self-injury behaviors was found in the BD+BPD group, confirming the natural history of BPD. With regard to psychopharmacological therapy, besides the use of mood stabilizers due to the comorbidity with BD, results showed a more widespread use of atypical antipsychotics in the BD+SBPD group. This results may be explained with the greater degree of adherence of this group of patients. The limit of the study is the small sample size. Larger controlled, prospective trials are warranted to confirm our preliminary results.

Key words: borderline personality disorder, quality of life enjoyment and satisfaction questionnaire, pharmacotherapy

Correspondence

Miriam Olivola
miriamolivola@icloud.com

Introduction

The nature of the relationship between bipolar disorder (BD) and borderline personality disorder (BPD) has been a field of debate in the last two decades [1].
Literature's data show that as many as 20% of patients with BPD meet criteria for bipolar I disorder [2].
BD can be mistaken for symptoms of BPD masking Axis I disorder [3].
The high prevalence of residual symptoms in patients affected by BD and its unstable course makes difficult to distinguish the two pathological conditions.
However, a large number of BD patients shows BPD subthreshold symptoms (BPDS) and little is know about their impact in the course of BD.
There are several studies that show the use of drug therapy on affective dysregulation symptoms of patients with BPD [4].
Literature's data show that, the presence of BPD has a high impact in BD' s prognosis and scores of global functioning.
Furthermore, some studies show how the comorbidity of BPD affects the severity and the number of hospitalizations of BD and may anticipate episode onset.
Actually no specific pharmacological treatment is approved for BPD.
However, there is evidence that some core symptoms of Borderline Personality Disorder can be successfully treated with antipsychotics and mood stabilizers [5].
The purpose of the study is to evaluate the impact of BPD subthreshold symptoms in patients with a primary diagnosis of BD in terms of patient's prognosis and quality of life.

Materials and methods

The sample consisted of 29 outpatients (15 males and 14 females), aged between 24 and 66 years old suffering from BD seeking treatment at the Psychiatry Department of Siena Hospital.
BD diagnosis was determined following the diagnostic criteria of the DSM IV TR.
Patients were assessed with SCID II (Structured Clinical Interview for DSM IV axis II Disorders) and Q-LES-Q (Quality of life enjoyment and satisfaction questionnaire).
Q-les-Q t is a self-assessment scale developed in order to easily obtain a sensitive measure of the degree of pleasure and satisfaction that subjects with both psychological and somatic disease, experience in the different areas which make up daily life (Endicott et al., 1993).
Q-LES-Q consists of 58 items that explore five different areas: physical health (13 items), subjective feelings (14 items), social relationships (11 items), leisure activities (6 items), employment (14 items).
SCID-II interview was administrated to assess the diagnosis of BPD (5 positive item) or the presence of BPD subthreshold symptoms (3-4 positive item).
Additional clinical and prognostical data were also evaluated: age of disorder's onset, working and social condition, self-injury behaviours and suicide attempts, substance abuse, pharmacotherapy's degree of adherence.
Patient's sample was divided in three groups with regard to BD diagnosis and SCID II assessment BD (n = 11), BD and subthreshols symptoms of BPD (n = 8), BD and BPD (n = 10).
A medium percentage of QLES-Q scores and of values of the other clinical data was calculated for every group.

Results and conclusions

Conclusions are conditioned by the small sample size.
Patients with DB and BPD showed an earlier age of symptom's onset than patients with a single diagnosis of BD. Moreover, subjects with BD and BPD subthreshold symptoms showed an intermediate age of onset compared with the other subgroups.
Overall score results of Q-LES-Q are lower in the BD and subthreshold symptoms of BPD group with the only exception for the social relationships area where lower scores were founded in the group of BD+BPD patients (according to the specific relational instability of patients with BPD).
The higher level of relational functioning was found in the BD group since these patients have more likely periods without symptoms of the disease than the other groups.
The higher percentage values of abuse and self-injury behaviors was found in the BD+BPD group, confirming the natural history of BPD.
With regard to psychopharmacological therapy, besides the use of mood stabilizers due to the comorbidity with BD, results showed a more widespread use of atypical antipsychotics in the BD+BPD subthreshold symptoms group.
This results may be explained with the greater degree of adherence of this group of patients.
The limit of the study is the small sample size. Larger controlled, prospective trials are warranted to confirm our preliminary results.

Table I. Comparison between the three study subgroups.

Diagnosis Number of patients	BD 38% (n = 11/29)	BD+BPD subthreshold 28% (n = 8/29)	BD+BPD 34% (n = 10/29)
Age at first contact with specialist	37 years	30 years	28 years
TS and self-harm	0%	12% (n = 1/8)	33% (n = 3/10)
Behaviour of alcohol abuse or psychoactive substances	18% (n = 2/11)	50% (n = 4/8)	50% (n = 5/10)
Marital status conjugate	72% (n = 8/11)	37 % (n = 3/8)	30% (n = 3/10)
Q-les-Q general (median of scores)	55%	45%	53%
Q-les-Q physical health	69%	62%	65%
Q-les-Q emotions	58%	48%	60%
Q-les-Q social relations	65%	55%	52%
Drug theraphy with antideprassants	55% (n = 6/11)	75% (n = 6/8)	70% (n = 7/10)
Drug theraphy with mood stabilizers	91% (n = 10/11)	87% (n = 7/8)	90% (n = 9/10)
Drug theraphy with antipsychotics	55% (n = 6/11)	75% (n = 6/8)	50% (n = 5/10)

Take home messages for psychiatric care

- There is evidence that some core symptoms of Borderline Personality Disorder can be successfully treated with antipsychotics and mood stabilizers
- The use of mood stabilizers due to the comorbidity with BD, results showed a more widespread use of atypical antipsychotics in the BD+BPD subthreshold symptoms group
- Score results of Q-LES-Q are lower in the BD and subthreshold symptoms of BPD group with the only exception for the social relationships area where lower scores were founded in the group of BD+BPD patients

Future target will expand the sample, analyze other variables such as the number of episodes and the remission time.

References

1 Borda JP. *Self over time: another difference between borderline personality disorder and bipolar disorder.* J Eval Clin Pract 2016 May 3. doi: 10.1111/jep.12550. [Epub ahead of print]

2 Comtois KA, Cowley DS, Dunner DL, et al. *Relationship between borderline personality disorder and Axis I diagnosis in severity of depression and anxiety.* J Clin Psychiatry 1999;60:752-8.

3 Gross R, Olfson M, Gameroff M, et al. *Borderline personality disorder in primary care*. Arch Intern Med 2002;162:53-60.

4 Bellino S, Paradiso E, Boggetto F. *Efficacy and tolerability of pharmacotherapies for borderline personality disorder.* CNS Drugs 2008;22:671-92.

5 Lieb K, Vollm B, Rucker G, et al. *Pharmacotheraphy for borderline personality disorder: cochrane systematic review of randomised trials.* Br J Psychiatry 2010;196.