Preface

In the roughly 40 years during which the relationship of borderline personality disorder (BPD) to mood disorders has been the topic of research and debate, there has been significant progress. Still, questions persist. This book will review that progress and will identify those questions. These comments provide an introduction.

In the late 1960s, BPD was introduced primarily as a psychoanalytic construct, which was enthusiastically adopted by the burgeoning psychotherapeutic community. This birthing coincided with the emergence of psychopharmacological treatments for depression, bipolar disorder, and schizophrenia. After becoming official in the DSM-III, BPD was considered a variant of all three. Research easily identified significant descriptive, genetic, and prognostic distinctions of BPD from schizophrenia. The identification of schizotypal personality disorder was a byproduct. No such closure was forthcoming with respect to mood disorders. Based on the results of his research [1, 2], Akiskal portentously announced that “borderline personality disorder was an adjective in search of a noun” [3].

In the 1980s, research about this issue mushroomed. In 1985, a review of the emerging evidence based on the Robbins & Guze criteria for diagnostic validity concluded that this evidence did not confirm either that BPD caused mood disorders or vice versa [4, 5]. Nor did it confirm their independence. The disappointingly complicated conclusion was that neither the mood disorder criteria—both major depressive disorder (MDD) and bipolar disorder—nor the BPD diagnostic criteria were adequately specific and the resulting co-occurrence was due to the heterogeneity within these diagnoses. Thus, more research was needed.

In 1991, 6 years after that initial review, conclusions about this interface were revised [6]. By 1991, bipolar disorder and MDD had established such phenomenological and therapeutic distinctions that research focused on the relationship of BPD to each as separate entities. Particular attention was now being paid to BPD’s interface with MDD due to the high prevalence of both disorders in clinical settings and to the remarkably high rates of their co-occurrence (generally 50% cross successfully and 75% lifetime). New data showed that the high rates of co-occurring MDD in BPD patients and in their relatives was nonspecific, i.e., rates of MDD were just
as high in patients and relatives with other personality disorders [7–9]. New evidence also identified more family dysfunction, conflict, and childhood abuse in the development of BPD than of MDD. Finally, it was now clear that BPD patients were far less responsive to antidepressants (or mood stabilizers) than were mood disorder patients. Thus, the growing evidence showed a weak and nonspecific relationship between these disorders. Though, in retrospect, the quality of the available research in 1991 could be faulted, this conclusion about BPD’s independence from MDD received no serious challenges for the next 20 years. During those 20 years (1990–2010), many hundreds of NIMH- and PHARMA-funded trials were conducted about the efficacy of various antidepressants for MDD. However, these trials rarely examined the effects of co-occurring BPD, and pharmacological research was comparatively absent for BPD. Psychiatry had split the disorders with BPD in the province of psychology and MDD in the province of psychopharmacology.

Those 20 years saw dramatic shifts in psychiatric practices. The generation of psychiatrists trained after 1980 were now oriented toward a biological understanding for psychiatric disorders and had increasingly begun to see their primary clinical role as providers of medications. In this context, the idea of a broad spectrum of bipolar disorder, notably still championed by Akiskal [10–12], that were potentially treatable with mood stabilizers was widely adopted. The empirical support for this expansive claim was modest to say the least [13, 14], but the idea’s appealing conceptual base and clinical implications dramatically increased bipolar diagnoses and mood stabilizer prescriptions [15].

Ironically, even as the bipolar diagnoses and psychopharmacological therapies were both expanding, empirically based psychosocial treatments were showing dramatic success in treating borderline patients. Psychiatrists, however, were no longer being trained to provide such treatments.

This is the background against which this book revisits the question of how BPD relates to MDD and to bipolar disorders. Readers will be surprised, as we have been, by the range and quality of research that newly informs this issue. It will certainly be confirmed that BPD’s relationship to MDD is quite distinct from its relationship to bipolar disorders. While BPD’s independence from bipolar disorders seems surprisingly clear on the basis of family studies and their relatively modest effect on each other’s course, bipolar II might seem to share much with BPD in terms of course, drug response, and developmental adversities. The relationship of BPD to MDD emerges with renewed complexity. There is now much evidence of shared neurobiology, and the negative effects on each other’s course also suggest overlapping psychopathology. And even though BPD’s depression has still not shown much responsiveness to antidepressants, the results from STAR*D show that even most patients with MDD do not benefit from them [16]. This complexity is closer to what was first suggested in the 1985 review than it is to the independence that seemed evident in 1991.

The authors of this book will review the last two decades of progress in scientific inquiry about the relationship between mood and personality disorders and the influence of this empirical data on our ways of conceptualizing and treating them. Paris opens the book with an introduction defining general trends both influencing the expansion of the mood disorder spectrum and undermining clinical recognition and
focus on personality disorders. Goodman and collaborators then review the overlaps and differences between MDD and BPD in phenomenology and biological markers, followed by a review by Choi-Kain and Rodriguez-Villa of the overlaps and distinctions between more atypical mood disorder variants (e.g., atypical depression and cyclothymia) and BPD. Chapters by Zimmerman and Morgan, Ghaemi and Barroilhet, and Reich review the current state of thinking on the distinctions between bipolar disorder and BPD, with attention to problems of misdiagnosis and use of clinical vignettes to illustrate important distinguishing features. Chapters by Lara and collaborators and Yalch, Hopwood, and Zanarini review two models explaining the relationship between mood, temperament, and personality. This is followed by Chanen and Thompson’s review of the literature on risk factors and early signs of BPD and mood disorders in childhood through young adulthood and a review of the longitudinal studies on BPD and mood disorders by Andrew Skodol. The last segment of the book includes three chapters on treatment. Silk summarizes the literature on the psychopharmacological management of depression in BPD. The chapters by Jacob and Rodriguez-Villa as well as Luyten and Fonagy present flexible cognitive behavioral and mentalizing approaches to mood disorders and BPD that might be more well suited to the general mental health practitioner than the highly intensive specialized approaches that are empirically validated for BPD. The book closes with a conclusion with a synthesis of the current status of thinking on the relationship between mood and borderline personality disorder. In summary, all the authors contribute to a sense that the evolving dialogue between the mood and personality disorder realms of psychiatry has moved away from contentious debate and toward the possibility of synthesis, providing increasing clarity on the relationship between mood and personality to inform improvements in the clinical management of the convergence of these psychiatric domains in common practice.

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