Detection of comorbidity with Borderline Personality Disorder in patients with Bipolar Disorders

Riconoscimento della comorbidità con il disturbo borderline di personalità nei pazienti affetti da disturbo bipolar

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Summary

Background
Difficulties are frequently encountered in distinguishing between Bipolar Disorder and Borderline Personality Disorder, with differential diagnosis being complicated by the presence of comorbidity. The present study aims to evaluate the utility of the Millon Clinical Multiaxial Inventory-III (MCMI-III) in discriminating patients affected by “pure” Bipolar Disorder from those affected by Bipolar Disorder with Borderline Personality or Other Personality Disorder.

Methods
57 patients (M = 20, F = 37; mean age 47.9 ± 10.8 yrs) affected by BD (BD-I 51%; BD-II 49%) in clinically stable remission were recruited; 28 patients were affected by BD (49.1%), 18 by BD and BPD (31.6%), 11 by BD plus Other Personality Disorders (OPD) (19.3%). Subjects were submitted to SCID-I and SCID-II and rated by the CGI-severity and GAF scales, and MCMI-III.

Results
MCMI-III scales focusing on “clinical syndromes” and “severe clinical syndromes” revealed significantly higher mean scores for comorbid patients on all scales, with the exception of somatization and posttraumatic stress scales. In particular, BD + BPD scored highest on Anxiety, Bipolar-manic, Alcohol dependence, Drug dependence and Thought Disorder scales, while BD + OPD scored highest only on the Dysthymia scale. With regard to “clinical personality patterns”, highly significant increases in mean scores were obtained for depressive, narcissistic, antisocial, sadistic-aggressive, passive-aggressive scales among BD + BPD patients, who conversely displayed the lowest scores on the obsessive-compulsive scale. Moreover, the highest scores on Avoidant, Dependent and Self-Defeating Scales were obtained by BD + OPD patients, who likewise scored lowest on the Histrionic Scales; no inter-group differences emerged with regard to the Paranoid scale. Cluster B and C scales discriminated respectively between BD + BPD and BD + OPD patients (Table II).

Conclusions
MCMI-III may prove to be useful in identifying Bipolar patients with comorbid BPD in routine clinical practice.

Key words
Bipolar Disorder • Personality disorder • Comorbidity • Personality dimensions • Millon Clinical Multiaxial Inventory-III

Riassunto

Background
La distinzione fra disturbo borderline di personalità e disturbo bipolare dell’umore comporta frequenti difficoltà, tenendo conto del fatto che la diagnosi differenziale è non raramente complicata dalla presenza di una comorbidità. Il presente studio ha l’obiettivo di valutare l’utilità del MCMI-III nel discriminare pazienti affetti da un disturbo bipolare “puro” rispetto a pazienti affetti da disturbo bipolare in comorbidità con disturbo borderline o con altri disturbi di personalità.

Metodi
Sono stati reclutati 57 pazienti (M = 20, F = 37, età media 47,9 ± 10,8 anni) affetti da disturbo bipolare (BD-I 51%; BD-II 49%) in condizioni di stabilizzazione clinico-sintomatologica; 28 pazienti erano affetti da solo disturbo bipolare (BD) (49,1%), 18 da disturbo bipolare e disturbo borderline di personalità (BD + BPD) (31,6%), 11 (19,3%) da disturbo bipolare e altri disturbi di personalità (BD + OPD). Tutti i soggetti sono stati sottoposti alla SCID-I e alla SCID-II e ad una valutazione mediante le scale CGI-gravità, GAF ed il Millon Clinical Multiaxial Inventory (MCMI-III).

Risultati
Le scale MCMI-III riguardanti le “sindromi cliniche” e le “sindromi cliniche severe” hanno posto in luce punteggi significativamente superiori nei pazienti con comorbidità fatta eccezione per quanto riguarda le scale relative alla “somatizzazione” e allo “stress posttraumatico”. In particolare, nei pazienti affetti da...
BD + BPD are more common in the general population compared to BD + OPD, whereas BD + BPD patients tend to have higher scores on the scales of anxiety, depression, and aggression compared to BD + OPD patients. Furthermore, the presence of BPD in BD + BPD patients is associated with a higher rate of comorbid mood disorders, particularly bipolar disorders, compared to BD + OPD patients.

Materials and Methods

Methods

Criteria applied for inclusion in the study were: age 18-65 years; lifetime diagnosis of bipolar I or bipolar II disorder according to DSMIV criteria; absence of current depressive, manic/hypomanic or mixed episode according to DSMIV criteria, together with stable clinical remission over the last month and providing of informed consent to take part in the study. Exclusion criteria were: patients with a past or current schizophrenic, schizoaffective or other psychotic disorder; patients with a past or current mental disorder due to a medical condition; current mental retardation or other significant cognitive disturbances;
current severe physical illness; concurrent alcohol and/or other substance abuse/dependence. All consecutive outpatients attending a university community mental health centre who fulfilled the above mentioned criteria were enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatrist on the basis of a non-structured clinical interview. They were also enrolled in the study. Following routine protocols, patients were diagnosed by a senior psychiatr...
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**Table I.**
Clinical Characteristics of the sample according to diagnosis. Caratteristiche cliniche del campione in funzione della diagnosi.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>BD</th>
<th>BD + BPD</th>
<th>BD + OPD</th>
<th>Total</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age (± sd) at onset of Bipolar Illness</td>
<td>27.79 ± 11.18</td>
<td>26.28 ± 10.87</td>
<td>31.91 ± 17.16</td>
<td>28.11 ± 12.35</td>
<td>F = 0.720</td>
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<td>df = 56</td>
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<td>p = 0.491</td>
</tr>
<tr>
<td>Mean duration (± sd) of illness (yrs)</td>
<td>22.54 ± 10.08</td>
<td>18.17 ± 11.35</td>
<td>14.36 ± 13.14</td>
<td>19.58/-11.37</td>
<td>F = 2.349</td>
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<td>df = 56</td>
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<td></td>
<td>p = 0.105</td>
</tr>
<tr>
<td>Mean number of drugs prescribed</td>
<td>2.38 ± 1.09</td>
<td>2.56 ± 0.96</td>
<td>2.40 ± 1.07</td>
<td>2.44 ± 1.04</td>
<td>F = 0.151</td>
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<td>df = 51</td>
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<td>p = 0.860</td>
</tr>
<tr>
<td>Mean score (± sd) at CGI</td>
<td>3.21 ± 0.68</td>
<td>3.61 ± 0.60</td>
<td>3.82 ± 0.60</td>
<td>3.46 ± 0.68</td>
<td>F = 4.190</td>
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<td>df = 56</td>
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<td>p = 0.02</td>
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<tr>
<td>Mean score (± sd) at GAF</td>
<td>69.64 ± 5.64</td>
<td>65.17 ± 9.18</td>
<td>63.36 ± 3.82</td>
<td>67.02/-7.67</td>
<td>F = 3.744</td>
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<td>df = 2,54</td>
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<td>p = 0.03</td>
</tr>
<tr>
<td>Mean number of attempted suicides</td>
<td>0.54 ± 1.07</td>
<td>1.67 ± 1.68</td>
<td>0.85 ± 0.44</td>
<td>0.85 ± 1.35</td>
<td>F = 5.914</td>
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<td>df = 54</td>
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<td>p = 0.005**</td>
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</tbody>
</table>

BD: Bipolar Disorder; BD + BPD: Bipolar Disorder + Borderline Personality Disorder; BD + OPD: Bipolar Disorder + other Personality Disorder; “post-hoc test = BD > BD + OPD, p = 0.034; “post-hoc test = BD + BPD > BD, p = 0.012; BD + BPD > BD + OPD, p = 0.012.

**Discussion**

Prior to discussion of the results obtained, several limitations of the present study should be acknowledged. First, the sample examined was made up of patients judged to be in “stable” remission, mainly to avoid the possible influence of a highly symptomatic status on personality assessment. The authors did however include “remitted” patients who no longer met criteria for depressive, manic, mixed or hypomanic episodes according to DSMIVTR in the study, thus not excluding the possibility of persisting subsyndromal status which may have influenced, at least in part, personality evaluation. Secondly, the sample investigated was relatively small and comprised a mixed sample of bipolar patients, thus limiting the possibility of achieving a separate evaluation of the impact of axis II comorbidity on bipolar I and bipolar II patients. Moreover, the overall high level of axis II comorbidity found in the present study is likely to have been influenced by the referral patterns employed in our unit, which often receives secondary and tertiary referrals from other centres, thus resulting in the sample including numerous complex cases. Conversely, the exclusion of patients affected by comorbid alcohol and/or drug abuse/dependence may have reduced the generalizability of findings obtained. A further limitation is represented by the lack of a control group of patients with BPD alone, a difficulty encountered in similar studies, due to the relative scarcity of such individuals, with 80% or more of BPD patients being affected by comorbid mood disorders. Fifty-one percent of bipolar patients observed in the present study were affected by a comorbid personality disorder, a finding exceeding figures obtained in clinical studies reported in literature: a previous study conducted in the same country by Rossi et al. found a 42% prevalence rate of comorbid personality disorder among bipolar patients, while Brieger et al. reporting pooled data from seven studies estimated a comorbidity rate of 45.2%. This finding appears to be of considerable importance, particularly in view of the fact that in routine clinical practice the use of standardized diagnostic techniques is infrequent and detection of comorbidity may be overlooked; indeed,
<table>
<thead>
<tr>
<th>Scales</th>
<th>BD</th>
<th>BD + BPD</th>
<th>BD + OPD</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Personality Patterns</strong></td>
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<tr>
<td>Schizoid</td>
<td>56.43 (22.82)</td>
<td>58.00 (25.70)</td>
<td>73.36 (27.57)</td>
<td>F = 1.964, N.S.</td>
</tr>
</tbody>
</table>
| Avoidant                 | 40.04 (31.61) | 44.61 (27.65) | 78.26 (28.45) | F = 6.670, p = 0.003  
BD + OPD > BD p = 0.002  
BD + OPD > BD + BPD, p = 0.015 |
| Depressive               | 54.00 (32.51) | 83.39 (19.06) | 80.82 (18.88) | F = 8.143, p = 0.001  
BD + OPD > BD, p = 0.002  
BD + OPD > BD, p = 0.02 |
| Dependent                | 50.43 (30.34) | 62.33 (25.46) | 76.73 (18.09) | F = 3.997, p = 0.025  
BD + OPD > BD, p = 0.025 |
| Histrionic               | 59.96 (17.89) | 56.39 (16.04) | 41.18 (21.09) | F = 4.258, p = 0.019  
BD > OPD + BD, p = 0.016 |
| Narcissistic             | 62.96 (18.43) | 70.78 (17.97) | 48.36 (24.10) | F = 4.530, p = 0.015  
BD + BPD > BD, p = 0.012 |
| Antisocial               | 43.00 (22.58) | 69.94 (14.05) | 58.64 (24.58) | F = 9.540, p = 0.000  
BD + BPD > BD, p = 0.000 |
| Aggressive               | 51.64 (24.13) | 69.17 (11.90) | 61.73 (20.93) | F = 4.393, p = 0.017  
BD + BPD > BD, p = 0.015 |
| Compulsive               | 60.61 (12.76) | 39.06 (15.07) | 50.09 (12.73) | F = 14.01, p = 0.000  
BD > BPD + BPD, p = 0.000 |
| Passive-Aggressive       | 62.50 (29.90) | 83.78 (18.65) | 76.36 (26.69) | F = 3.800, p = 0.029  
BD + BPD > BD, p = 0.029 |
| Self-defeating           | 47.43 (33.21) | 66.22 (24.16) | 76.55 (24.36) | F = 4.821, p = 0.012  
BD + OPD > BD, p = 0.02 |
| **Severe Personality Pathology** |          |           |           |                                                 |
| Schizotypal              | 29.36 (31.96) | 60.22 (23.67) | 66.36 (23.89) | F = 10.060, p = 0.000  
BD + BPD > BD, p = 0.002  
BD + OPD > BD, p = 0.002 |
| Borderline               | 44.32 (30.35) | 82.22 (18.51) | 67.55 (22.11) | F = 12.189, p = 0.000  
BD + BPD > BD, p = 0.000  
BD + OPD > BD, p = 0.044 |
| Paranoid                 | 54.07 (23.62) | 65.56 (26.00) | 57.55 (36.58) | F = 0.983, NS |
| **Clinical Syndromes**    |          |           |           |                                                 |
| Anxiety                  | 56.71 (28.89) | 75.39 (24.11) | 71.82 (22.08) | F = 3.156, p = 0.051 |
| Somatoform               | 41.71 (24.59) | 57.83 (30.15) | 50.82 (24.19) | F = 2.092, NS |
| Bipolar-manic            | 53.14 (26.40) | 73.39 (12.71) | 60.91 (22.85) | F = 5.883, p = 0.005  
BD + BPD > BD, p = 0.012 |
| Dysthymia                | 46.07 (28.05) | 67.89 (18.58) | 69.27 (23.62) | F = 4.526, p = 0.015  
BD + BPD > BD, p = 0.015  
BD + OPD > BD, p = 0.032 |
| Alcohol-dependence       | 45.36 (26.37) | 61.89 (14.18) | 59.64 (15.57) | F = 3.877, p = 0.027  
BD + BPD > BD, p = 0.040 |
| Drug dependence          | 45.21 (22.99) | 62.06 (15.36) | 51.18 (22.55) | F = 3.539, p = 0.034  
BD + BPD > BD, p = 0.029 |
| Post-traumatic           | 44.80 (21.90) | 47.88 (19.87) | 50.88 (18.90) | F = 0.37 NS |
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the risk of self-harm in bipolar patients. The finding is consistent with results reported by Moran et al. 43 and Ucok et al. 44 who showed a significant major risk of attempted or complete suicide among psychotic patients with comorbid PDs compared to patients lacking comorbidity. Results are also in line with those obtained by Garno et al. 45, demonstrating how lifetime suicide attempts in bipolars are significantly associated with cluster B comorbidity.

Several studies conducted previously applied the Millon Clinical Multiaxial Inventory in the psychological assessment of patients affected by bipolar mood disorder: Choca et al. 46 used MCMI-I to evaluate patients with major affective disorders, Wetzler et al. 47 compared unipolar and bipolar patients by means of MCMI-II and Turley et al. 48 used MCMI-II in recent onset bipolar disorder. However, the present study was the first to apply MCMI-III in the comparison of bipolar patients with and without comorbid personality disorder. Results obtained at “clinical syndromes” and “severe clinical syndromes” scales of MCMI-III revealed significantly higher mean scores for comorbid patients at all scales, excluding somatization and posttraumatic stress scales; in particular BD + BPD achieved the highest scores in several scales such as Anxiety, Bipolar-manic, Alcohol dependence and Drug dependence and Thought Disorder scales, whilst BD + OPD showed the highest scores only at Dysthymia scale. However, the most significant increase in rating from a clinical point of view (BR scores ≥ 74) was detected in BD + BPD for anxiety, bipolar-manic scales. These results suggested a more pronounced presence of anxiety and mood-related symptoms in BD patients with comorbid BPD, even when judged in clinical remission, a finding which may be interpreted as expression of the intrinsic affective component of BPDs.

Table II (continues).

<table>
<thead>
<tr>
<th>Scales</th>
<th>BD</th>
<th>BD + BPD</th>
<th>BD + OPD</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Clinical Syndromes</td>
<td></td>
<td></td>
<td></td>
<td>F = 6.866, p = 0.002</td>
</tr>
<tr>
<td>Thought disorder</td>
<td>42.79 (27.83)</td>
<td>66.22 (16.44)</td>
<td>63.55 (16.83)</td>
<td>BD + BPD &gt; BD, p = 0.004</td>
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<td></td>
<td>BD + OPD &gt; BD, p = 0.041</td>
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<tr>
<td>Major depression</td>
<td>44.43 (29.68)</td>
<td>62.56 (31.72)</td>
<td>63.91 (34.25)</td>
<td>F = 2.546, NS</td>
</tr>
<tr>
<td>Delusional disorder</td>
<td>40.68 (27.44)</td>
<td>60.28 (26.73)</td>
<td>52.64 (33.55)</td>
<td>F = 2.689, NS</td>
</tr>
<tr>
<td>Clusters</td>
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<tr>
<td>Cluster A</td>
<td>43.36 (21.84)</td>
<td>60.72 (19.68)</td>
<td>65.18 (24.42)</td>
<td>F = 4.043, p = 0.023</td>
</tr>
<tr>
<td>Cluster B</td>
<td>52.46 (12.75)</td>
<td>69.50 (11.62)</td>
<td>53.45 (13.29)</td>
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</tr>
<tr>
<td>Cluster C</td>
<td>53.04 (19.66)</td>
<td>57.00 (14.86)</td>
<td>70.00 (15.67)</td>
<td>F = 3.699, p = 0.031</td>
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<td></td>
<td>BD + OPD &gt; BD, p = 0.027</td>
</tr>
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examination of clinical records of cases included in this study revealed how an axis II diagnosis was present only in a minority of cases (7/29, 24.1%). With regard to the main sociodemographic and clinical characteristics of the samples, “pure” bipolar patients do not differ significantly from patients with borderline or other comorbid personality disorders. However, mean scores obtained at CGI-s were significantly higher in comorbid cases than in “pure” bipolars, although in both sub-samples the degree of severity was low (mean scores of approx. 3.7 in the presence of comorbidity and 3.2 in non-comorbid patients), indicating the presence of residual symptoms, as expected in patients in stable remission. The presence of less pronounced mean GAF scores in comorbid patients (approx. 65 compared to approx. 70 non-comorbid patients) demonstrated a poor functional status in these subjects. Taken together, these results are largely convergent with findings emerging from other clinical studies. 17 36 37. In particular, in line with the findings of the present study, George et al. 17 reported more severe symptoms and psychosocial adjustment in comorbid subjects than in bipolar patients in remission. In the present study the rate of attempted suicides was approx. three times higher in bipolar patients with comorbid BPD respect to “pure” BP and 7.6 times higher than in bipolar patients with other comorbid personality disorders, a difference that may not be linked to significant differences in duration or severity of illness, type of treatments or sociodemographic variables of subsamples examined. As shown in literature, suicidality characterizes both bipolar disorders 38 39 and personality disorders 40, particularly cluster B personality disorders 41, more specifically borderline personality disorder 42. The findings of this study, therefore, indicate that comorbidity with BPD considerably increases the risk of self-harm in bipolar patients. The finding is consistent with results reported by Moran et al. 43 and Ucok et al. 44 who showed a significant major risk of attempted or complete suicide among psychotic patients with comorbid PDs compared to patients lacking comorbidity. Results are also in line with those obtained by Garno et al. 45, demonstrating how lifetime suicide attempts in bipolars are significantly associated with cluster B comorbidity.

Several studies conducted previously applied the Millon Clinical Multiaxial Inventory in the psychological assessment of patients affected by bipolar mood disorder: Choca et al. 46 used MCMI-I to evaluate patients with major affective disorders, Wetzler et al. 47 compared unipolar and bipolar patients by means of MCMI-II and Turley et al. 48 used MCMI-II in recent onset bipolar disorder. However, the present study was the first to apply MCMI-III in the comparison of bipolar patients with and without comorbid personality disorder. Results obtained at “clinical syndromes” and “severe clinical syndromes” scales of MCMI-III revealed significantly higher mean scores for comorbid patients at all scales, excluding somatization and posttraumatic stress scales; in particular BD + BPD achieved the highest scores in several scales such as Anxiety, Bipolar-manic, Alcohol dependence and Drug dependence and Thought Disorder scales, whilst BD + OPD showed the highest scores only at Dysthymia scale. However, the most significant increase in rating from a clinical point of view (BR scores ≥ 74) was detected in BD + BPD for anxiety, bipolar-manic scales. These results suggested a more pronounced presence of anxiety and mood-related symptoms in BD patients with comorbid BPD, even when judged in clinical remission, a finding which may be interpreted as expression of the intrinsic affective component of BPDs.
As expected, comorbid bipolar patients rated statistically significant different scores for all “personality patterns” scales (with the sole exception of the schizoid scale) and “severe pathology of personality” scales (excluding the “paranoid” scale). BD + BDP displayed the highest scores in the majority of scales including depressive, narcissistic, antisocial, sadistic-aggressive, passive-aggressive and Borderline scales and the lowest for obsessive-compulsive scales while BD + OPD rated higher scores at Avoidant, Dependent, Self-Defeating and Schizotypal scales; on taking into account only clinically relevant scores (≥ 74) BD + BPD achieved exceedingly high scores at “depressive”, “self-defeating” and “borderline” scales of personality patterns while BD + OPD showed very high scores at “Avoidant” scale. With regard to the BD + BPD sample the results obtained seem to reflect the intrinsic clinical characteristics of borderline personality disorders, whilst for BD + OPD they likely reflect the composition of this subsample, mainly constituted by cluster C disorders (approx. 70% pts of this group). The latter hypothesis seems to be confirmed by the higher scores obtained at “cluster B” scales and “cluster C” scales respectively by BD + BPD and by BD + OPD. Interestingly, the very low scores achieved by BP + BDP patients at obsessive-compulsive scale may be interpreted as a confirmation of the hypothesis that obsessive-compulsive disorder should no longer be considered a trait of the anxiety domain but rather as an extreme of a personality trait ranging from excessive self-control to impulsivity, as indicated by studies showing an inverse correlation between impulsivity measures and obsessive-compulsive disorders. 49 50. As a consequence, the finding in bipolar patients deemed in clinical remission of higher than expected scores at clinical scales regarding mood and anxiety dimensions, of exceedingly high scores at scales intrinsically linked to BPD (borderline) or evaluating affective dimensions of personality (depressive, self-defeating), and very low scores at obsessive-compulsive scale possibly indicating marked impulsivity traits, may orient the clinician to suspect a comorbidity with borderline personality disorder, which might have been missed on the basis of clinical evaluation alone. Thus, in the light of the importance of this comorbidity in terms of course, outcome and therapeutic management of bipolar patients, the possibility of improving diagnostic accuracy by means of a user-friendly self-evaluation instrument such as MCMI-III may be of particular relevance in routine clinical practice.

To conclude, the results obtained in the present study underline the general utility of MCMI-III in distinguishing between patients affected by “pure” bipolar disorder and bipolar patients with comorbid personality disorders; in particular, the tool clearly differentiates bipolar patients with comorbid borderline personality disorder from patients with other personality disorders

References

18. Rossi A, Marinangeli MG, Butti G, et al. Personality dis-