Bipolar disorder or borderline personality disorder?

Understanding the clinical, psychopathological, and sociodemographic correlates is critical

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Although evidence suggests that bipolar disorder (BD) and borderline personality disorder (BPD) are distinct entities, their differential diagnosis is often challenging as a result of considerable overlap of phenotypical features. Moreover, BD and BPD frequently co-occur, which makes it even more difficult to differentiate these 2 conditions. Strategies for improving diagnostic accuracy are critical to optimizing patients' clinical outcomes and long-term prognosis. Misdiagnosing these 2 conditions can be particularly deleterious, and failure to recognize their co-occurrence can result in additional burden to typically complex and severe clinical presentations.

This article describes key aspects of the differential diagnosis between BD and BPD, emphasizing core features and major dissimilarities between these 2 conditions, and discusses the implications of misdiagnosis. The goal is to highlight the clinical and psychopathological aspects of BD and BPD to help clinicians properly distinguish these 2 disorders.

Psychopathological and sociodemographic correlates

Bipolar disorder is a chronic and severe mental illness that is classified based on clusters of symptoms—manic, hypomanic, and depressive.[1] It is among the 10 leading causes of disability worldwide, with significant morbidity arising from acute affective episodes and subacute states.[2] Data suggest the lifetime prevalence of BPD is 2.1%, and subthreshold forms may affect an additional 2.4% of the US population.[3] The onset of symptoms typically occurs during late adolescence or early adulthood, and mood lability and cyclothymic temperament are the most common prodromal features.[4]

continued

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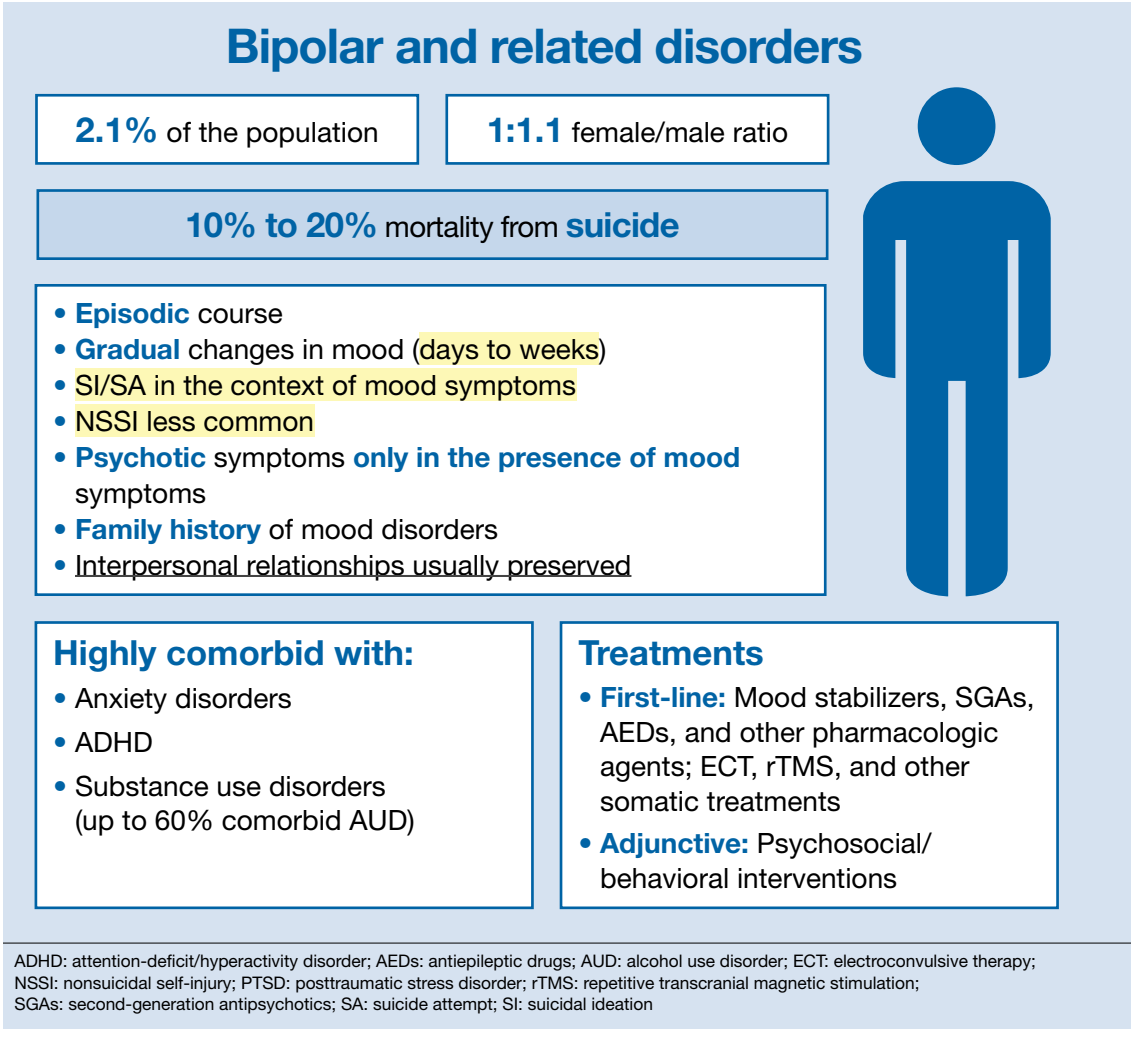
Bipolar disorder or BPD?

Clinical Point

As a result of the phenotypical resemblance between BD and BPD, the differential diagnosis is often difficult

Figure

Bipolar disorder and borderline personality disorder: Clinical and sociodemographic correlates



ADHD: attention-deficit/hyperactivity disorder; AEDs: antiepileptic drugs; AUD: alcohol use disorder; ECT: electroconvulsive therapy; NSSI: nonsuicidal self-injury; PTSD: posttraumatic stress disorder; rTMS: repetitive transcranial magnetic stimulation; SGAs: second-generation antipsychotics; SA: suicide attempt; SI: suicidal ideation

In contrast, personality disorders, such as BPD, are characteristically pervasive and maladaptive patterns of emotional responses that usually deviate from an individual's stage of development and cultural background.[1] These disorders tend to cause significant impairment, particularly in personal, occupational, and social domains. Environmental factors, such as early childhood trauma, seem to play an important role in the genesis of personality disorders, which may be particularly relevant in BPD, a disorder characterized by marked impulsivity and a pattern of instability in personal relationships, self-image, and affect.[1,5,6] Similarly to BD, BPD is also chronic and highly disabling.

According to the National Survey on Alcohol and Related Conditions (NESARC), approximately 15% of US adults were found to have at least one type of personality disorder, and 6% met criteria for a cluster B personality disorder (antisocial, borderline, narcissistic, and histrionic).[7] The lifetime prevalence of BPD is nearly 2%, with higher estimates observed in psychiatric settings.[7,8]

As a result of the phenotypical resemblance between BD and BPD (***Figure***), the differential diagnosis is often difficult. Recent studies suggest that co-occurrence of BD and BPD is common, with rates of comorbid BPD as high as 29% in BD I and 24% in BD II.[8,9] On the other hand, nearly 20% of individuals with BPD seem to have comorbid BD.[8,9]

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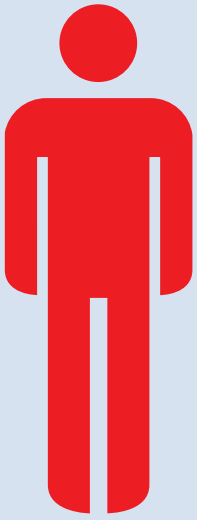
Borderline personality disorder



1% to 2% of the population

2:1 female/male ratio

8% to 10% mortality from **suicide**

- **Pervasive** course
- **Abrupt** changes in mood (hours)
- SI/SA in the context of psychosocial stressors
- **NSSI common**
- **Transient psychotic symptoms**, usually in the context of **stressful situations**
- **Chaotic interpersonal relationships**
- **Significant history of trauma**

Highly comorbid with:

- Mood disorders
- PTSD
- Substance use
- Eating disorders

Treatments

- **First-line:** Psychosocial/behavioral interventions
- **Adjunctive:** Pharmacotherapy

Clinical Point

Evidence suggests that BD and BPD have distinct underlying neurobiological and psychopathological mechanisms

Several studies suggest that comorbid personality disorders represent a negative prognostic factor in the course of mood disorders, and the presence of BPD in patients with BD seems to be associated with more severe clinical presentations, greater treatment complexity, a higher number of depressive episodes, poor inter-episode functioning, and higher rates of other comorbidities, such as substance use disorders (SUDs).[8-11] The effect of BD on the course of BPD is unclear and fairly unexplored, although it has been suggested that better control of mood symptoms may lead to more stable psychosocial functioning in BPD.[9]

Whether BD and BPD are part of the same spectrum is a matter for debate.[12-14] Multidimensional approaches have been proposed to better characterize these disorders in at-risk populations, based on structured interviews, self-administered and clinician-rated clinical scales (***Table 1***, ***page 35***), neuroimaging studies, biological markers, and machine-learning models.[15,16] Compelling evidence suggests that BD and BPD have distinct underlying neurobiological and psychopathological mechanisms[12,13]; however, the differential diagnosis still relies on phenotypical features, since the search for biological markers has not yet identified specific biomarkers that can be used in clinical practice.

Core features of BPD, such as mood lability, impulsivity, and risk-taking behaviors,

continued on page 35

continued from page 29

Table 1

Clinical scales used in the differential diagnosis of bipolar disorder and borderline personality disorder

Rating scale	Description
Mood Disorder Questionnaire (MDQ)	15 questions The first 13 questions are designed to identify lifetime manic or hypomanic symptoms; the last 2 questions measure severity and level of functional impairment
Hypomania/mania Checklist (HCL-32)	2 introductory questions on current emotional state 32 questions designed to identify manic and hypomanic symptoms
Screening Assessment of Depression-Polarity (SAD-P)	3-item scale: • presence of delusions • number of depressive episodes • family history of major depression or mania
Bipolar Prodrome Symptom Interview and Scale-Prospective (BPSS-P)	Semi-structured interview developed based on DSM-IV criteria for BD and MDD, clusters of symptoms (mania, depression, and general symptom index)
The Personality Inventory for DSM-5	220-item scale assessing 25 personality trait facets, with each trait facet consisting of 4 to 14 items combined in 5 broader domains: • negative affect • detachment • antagonism • disinhibition • psychoticism
Structured Clinical Interview for DSM-5 Personality Disorder (SCID-5-PD)	As an updated version of the SCID-Axis II Personality Disorder Questionnaire from DSM-IV, the SCID-5-PD consists of objective and self-reported components that can be used in research and clinical practice to identify the different PDs across clusters A, B, and C.
Borderline Symptom List 23 (BSL-23)	23-item scale assessing severity of symptoms (from 0 = not at all to 4 = very strong) in the previous week in addition to 10 supplemental items to assess behaviors
McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD)	10-item clinical scale (YES or NO answers) based on DSM-IV criteria for BPD
Borderline Personality Disorder Severity Index-IV	Clinical scale based on DSM-IV criteria for BPD designed to assess the presence and severity of BPD symptoms

BD: bipolar disorder; BPD: borderline personality disorder; MDD: major depressive disorder; PDs: personality disorders

Clinical Point

Comprehensive psychiatric assessments and longitudinal observations are critical to diagnostic accuracy

are also part of the diagnostic criteria for BD (***Table 2, page 36***).[1] Similarly, depressive symptoms prevail in the course of BD.[17,18] This adds complexity to the differential because "depressivity" is also part of the diagnostic criteria for BPD.[1] Therefore, comprehensive psychiatric assessments and longitudinal observations are critical to diagnostic accuracy and treatment planning. Further characterization of symptoms, such as onset patterns, clinical course, phenomenology of symptoms (eg, timing, frequency, duration, triggers), and personality traits, will provide information to properly distinguish these 2 syndromes when, for example, it is unclear if the "mood swings" and impulsivity are part of a mood or a personality disorder (***Table 3, page 37***).

Clinical features: A closer look

Borderline personality disorder. Affect dysregulation, emotional instability, impoverished and unstable self-image, and chronic feelings of emptiness are core features of BPD.[1,5,19] These characteristics, when combined with a fear of abandonment or rejection, a compromised ability to recognize the feelings and needs of others, and extremes of idealization-devaluation, tend to culminate in problematic and chaotic relationships.[6,19] Individuals with BPD may become

Bipolar disorder or BPD?

Clinical Point

Fluctuations in mood in patients with BD tend to last days to weeks, in contrast to the transient mood shifts of patients with BPD

Table 2

Core features of bipolar disorder vs borderline personality disorder

Bipolar disorder	Borderline personality disorder
Depressive symptoms • depressed mood • feeling sad, empty, or hopeless • diminished interest or pleasure in activities • significant weight loss or gain • insomnia or hypersomnia • psychomotor agitation or retardation • feelings of worthlessness or excessive guilt • indecisiveness or poor concentration • recurrent thoughts of death or suicide • suicidal ideations, plans, or intent	**Impairment in personality functioning** • impoverished or unstable self-image • excessive self-criticism • chronic feelings of emptiness • dissociative states under stress • compromised ability to recognize the feelings and needs of others • perceptions of others selectively biased • intense, unstable and conflicted relationships • extremes of idealization-devaluation
Manic/hypomanic symptoms • elevated, expansive, or irritable mood • increased goal-directed activity • high risk-taking behaviors • grandiosity or inflated self-esteem • decreased need for sleep • increased energy • distractibility • impulsivity • psychomotor agitation • pressured speech • flight of ideas	**Pathological personality traits** • emotional lability and anxiousness • feelings of falling apart or losing control • fear of abandonment/rejection • depressivity: feelings of being down, hopeless, or miserable • pessimism, pervasive shame, and inferior self-worth • thoughts of suicide, suicidal gestures, and NSSI behaviors • impulsivity and disinhibition • high risk-taking behaviors • hostility and antagonism

NSSI: nonsuicidal self-injury

suspicious or paranoid under stressful situations. Under these circumstances, individuals with BPD may also experience depersonalization and other dissociative symptoms.[6,20] The mood lability and emotional instability observed in patients with BPD usually are in response to environmental factors, and although generally intense and out of proportion, they tend to be ephemeral and short-lived, typically lasting a few hours.[1,5] The anxiety and depressive symptoms reported by patients with BPD frequently are associated with feelings of "falling apart" or "losing control," pessimism, shame, and low self-esteem. Coping strategies tend to be poorly developed and/or maladaptive, and individuals with BPD usually display a hostile and antagonistic demeanor and engage in suicidal or nonsuicidal self-injury (NSSI) behaviors as means to alleviate overwhelming emotional distress. Impulsivity, disinhibition, poor tolerance to frustration, and risk-taking behaviors are also characteristic of BPD.[1,5] As a result, BPD is usually associated with significant impairment in functioning, multiple hospitalizations, and high rates of comorbid mood disorders, posttraumatic stress disorder (PTSD), SUDs, and death by suicide.

Bipolar disorder. Conversely, the fluctuations in mood and affect observed in patients with BD are usually episodic rather than pervasive, and tend to last longer (typically days to weeks) compared with the transient mood shifts observed in patients with BPD.[4,17,18] The impulsivity, psychomotor agitation, and increased goal-directed activity reported by patients with BD are usually seen in the context of an acute affective episode, and are far less common during periods of stability or euthymic affect.[4,17,18] Grandiosity and inflated self-esteem—hallmarks of a manic or hypomanic state—seem to oppose the unstable self-image observed in BPD, although indecisiveness and low self-worth may be observed in individuals with BD during depressive episodes. Antidepressant-induced mania or hypomania, atypical depressive episodes, and disruptions in sleep and circadian rhythms may be predictors of BD.[4,21] Furthermore,

although psychosocial stressors may be associated with acute affective episodes in early stages of bipolar illness, over time minimal stressors are necessary to ignite new affective episodes.[22,23] Although BD is associated with high rates of suicide, suicide attempts are usually seen in the context of an acute depressive episode, and NSSI behaviors are less common among patients with BD.[24]

Lastly, other biographical data, such as a history of early life trauma, comorbidity, and a family history of psychiatric illnesses, can be particularly helpful in establishing the differential diagnosis between BD and BPD.[25] For instance, evidence suggests that the heritability of BD may be as high as 70%, which usually translates into an extensive family history of bipolar and related disorders.[26] In addition, studies suggest a high co-occurrence of anxiety disorders, attention-deficit/hyperactivity disorder, and SUDs in patients with BD, whereas PTSD, SUDs, and eating disorders tend to be highly comorbid with BPD.[27] Childhood adversity (ie, a history of physical, sexual, or emotional abuse, or neglect) seems to be pivotal in the genesis of BPD and may predispose these individuals to psychotic and dissociative symptoms, particularly those with a history of sexual abuse, while playing a more secondary role in BD.[28-31]

Implications of misdiagnosis

In the view of the limitations of the existing models, multidimensional approaches are necessary to improve diagnostic accuracy. Presently, the differential diagnosis of BD and BPD continues to rely on clinical findings and syndromic classifications. Misdiagnosing BD and BPD has adverse therapeutic and prognostic implications.[32] For instance, while psychotropic medications and neuromodulatory therapies (eg, electroconvulsive therapy, repetitive transcranial magnetic stimulation) are considered first-line treatments for patients with BD, psychosocial interventions tend to be adjunctive treatments in BD.[33] Conversely, although pharmacotherapy might be helpful for patients with BPD, psychosocial and behavioral interventions are the mainstay treatment for this disorder, with the strongest evidence supporting cognitive-behavioral therapy, dialectical behavioral therapy, mentalization-based therapy, and transference-focused therapy.[34-36] Thus, misdiagnosing BD as BPD with comorbid depression may result in the use of antidepressants, which can be detrimental in BD. Antidepressant treatment of BD, particularly as monotherapy, has been associated with manic or hypomanic switch, mixed states, and frequent cycling.[21] Moreover, delays in diagnosis and proper treatment of BD may result in protracted mood symptoms, prolonged affective episodes, higher rates of disability, functional impairment, and overall worse clinical outcomes.[24] In addition, because behavioral and psychosocial interventions are usually adjunctive therapies rather than first-line interventions for patients with BD, misdiagnosing BPD as BD may ultimately prevent these individuals from receiving proper treatment, likely resulting in more severe functional impairment, multiple hospitalizations, self-inflicted injuries, and suicide attempts, since psychotropic medications are not particularly effective for improving self-efficacy and coping strategies, nor for correcting cognitive distortions, particularly in self-image, and pathological personality traits, all of which are critical aspects of BPD treatment.

Table 3
History-taking: Specific clinical and psychopathological features

Clinical and psychopathological features
Phenomenology of symptoms: • onset patterns • timing/duration • frequency • triggers
Longitudinal course: episodic vs pervasive
Comorbidity
History of childhood adversity
Early life trauma
Nonsuicidal self-injury behaviors
Pathological personality traits
Interpersonal relationship patterns
Family history of psychiatric disorders

continued

Clinical Point

Nonsuicidal self-injury behaviors are common in patients with BPD but less so in those with BD

Bipolar disorder or BPD?

Several factors might make clinicians reluctant to diagnose BPD, or bias them to diagnose BD more frequently. These include a lack of familiarity with the diagnostic criteria for BPD, the phenotypical resemblance between BP and BPD, or even concerns about the stigma and negative implications that are associated with a BPD diagnosis.[32,37,38]

Whereas BD is currently perceived as a condition with a strong biological basis, there are considerable misconceptions regarding BPD and its nature.[4-6,22,26] As a consequence, individuals with BPD tend to be perceived as "difficult-to-treat," "uncooperative," or "attention-seeking." These misconceptions may result in poor clinician-patient relationships, unmet clinical and psychiatric needs, and frustration for both clinicians and patients.[37]

Through advances in biological psychiatry, precision medicine may someday be a part of psychiatric practice. Biological "signatures" may eventually help clinicians in diagnosing and treating psychiatric disorders. Presently, however, rigorous history-taking and comprehensive clinical assessments are still the most powerful tools a clinician can use to accomplish these goals. Finally, destigmatizing psychiatric disorders and educating patients and clinicians are also critical to improving clinical outcomes and promoting mental health in a compassionate and empathetic fashion.

Clinical Point

Misdiagnosing BD as BPD with comorbid depression may result in the use of antidepressants, which can be detrimental in BD

Related Resources

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Bottom Line

Despite the phenotypical resemblance between bipolar disorder (BP) and borderline personality disorder (BPD), the 2 are independent conditions with distinct neurobiological and psychopathological underpinnings. Clinicians can use a rigorous assessment of pathological personality traits and characterization of symptoms, such as onset patterns, clinical course, and phenomenology, to properly distinguish between BP and BPD.

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Clinical Point

Destigmatizing psychiatric disorders and educating patients and clinicians are key to improving clinical outcomes