Bipolar disorder or borderline personality disorder?

Understanding the clinical, psychopathological, and sociodemographic correlates is critical

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lthough 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.\(^4\)
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. 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. 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). The lifetime prevalence of BPD is nearly 2%, with higher estimates observed in psychiatric settings.

As a result of the phenotypical resemblance between BD and BPD, 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. On the other hand, nearly 20% of individuals with BPD seem to have comorbid BD.

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

Whether BD and BPD are part of the same spectrum is a matter for debate. 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. Compelling evidence suggests that BD and BPD have distinct underlying neurobiological and psychopathological mechanisms; 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,
are also part of the diagnostic criteria for BD (Table 2, page 36). Similarly, depressive symptoms prevail in the course of BD. This adds complexity to the differential because “depressivity” is also part of the diagnostic criteria for BPD. 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 (e.g., 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. 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. Individuals with BPD may become
suspicious or paranoid under stressful situations. Under these circumstances, individuals with BPD may also experience depersonalization and other dissociative symptoms. 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. 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. 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. 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. 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. 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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{32} For instance, while psychotropic medications and neumodulatory 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.\textsuperscript{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.\textsuperscript{24-36} 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.\textsuperscript{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.\textsuperscript{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.

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**Table 3**

**History-taking: Specific clinical and psychopathological features**

<table>
<thead>
<tr>
<th>Phenomenology of symptoms:</th>
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<tbody>
<tr>
<td>- onset patterns</td>
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<tr>
<td>- timing/duration</td>
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<tr>
<td>- frequency</td>
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<tr>
<td>- triggers</td>
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| Longitudinal course: episodic vs pervasive |

<table>
<thead>
<tr>
<th>Comorbidity</th>
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<tr>
<td>History of childhood adversity</td>
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<tr>
<td>Early life trauma</td>
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| Nonsuicidal self-injury behaviors |

| Pathological personality traits |
| Interpersonal relationship patterns |

| Family history of psychiatric disorders |

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**Clinical Point**

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

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*continued*
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.4,6,22,26

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.

Related Resources

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.


