

Distinguishing Between Borderline Personality Disorder and Bipolar Disorder

To the Editor: We read with interest a recent original research article published in JCP by de la Rosa and colleagues.¹ They investigated the question of whether borderline personality and bipolar disorders might be alternative expressions of the same disorder. Using a 3-factor solution composed of 9 borderline personality symptoms, 8 depression symptoms, and 7 mania symptoms, they concluded that “the dimensions underlying bipolar disorder and borderline personality disorder are not separate entities, but rather correlated constructs.”^{1(p e997)} The pattern of correlation among these factors was positive and consistent with the existence of 3 syndromes, 2 of which often co-occur (depression and mania). The authors concluded that the third syndrome, borderline personality disorder, is often comorbid with bipolar disorder and shares important clinical manifestations, but is an independent nosologic entity. Their sample was representative of the US adult population and was assessed by nonclinical interviewers with the Alcohol Use Disorder and Associated Disabilities Interview Schedule–DSM-IV Version.

Our research group investigated the possibility of discriminating between borderline personality and bipolar disorders.² The academic debate regarding the inclusion of borderline personality disorder in the bipolar spectrum versus their discernment as 2 distinct nosologic entities^{3–11} encouraged us to conduct an in-depth analysis based on symptom categorization and essence. Our sample was representative of the psychiatric patient population and larger compared to previous studies. We explicitly selected only patients affected by borderline and bipolar disorders using the Structured Clinical Interview for DSM-IV Axis I Disorders and Axis II Personality Disorders, and we recruited them in 6 psychiatric departments across Italy. Bipolar patients had to satisfy criteria for a manic or mixed state, since most of the reported overlapping symptoms have pertained to emotional instability and impulsivity (although with different connotations), which are more evident during these states of bipolar illness.^{12,13} All of the patients were evaluated by clinicians using the Hamilton Depression and Anxiety Rating Scales, Young Mania Rating Scale (YMRS), Borderline Personality Disorder Severity Index (BPDSI-IV), and a semistructured interview.

We found a real comorbidity of 3.6% between these disorders.² Importantly, though, our study, using common and well-recognized tests focused on symptom frequency and intensity, demonstrated that a precise analysis of symptom presentation permitted accurate discrimination between borderline personality and bipolar disorders. Some key symptoms were essential in differentiating the disorders. A sense of guilt, depersonalization, irritability, lack of insight, and paranoid ideation were able to separate even bipolar patients and borderline personality patients with a comorbid manic episode (YMRS score > 20). All of the borderline personality criteria (BPDSI-IV) differentiated bipolar and borderline personality patients with a comorbid manic episode with the exception of “emptiness,” which might be masked by manic symptoms.²

In conclusion, we believe that in the clinical psychiatric population a real comorbidity between bipolar and borderline

personality disorders is rare, and even in cases in which it does exist, key symptoms still permit a distinction between bipolar patients and borderline patients with a comorbid manic episode. Together with administration of commonly used assessments, which yield immensely different scores between the two disorders, a timely and precise clinical examination focused on the essence, nature, and extent of the symptoms should allow an accurate understanding of the essential characteristics of these disorders.

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Dr Gonzalez-Pinto and Colleagues Reply

To the Editor: In their letter to the editor,¹ Dr di Giacomo and colleagues point out that in their study,² only 3.6% of individuals who were diagnosed with borderline personality disorder met criteria for bipolar II disorder. The difference in results between the di Giacomo et al study and ours³ is most likely due to methodological differences. For example, their study focused on treatment-seeking patients in 6 Italian cities. By contrast, the National Epidemiologic Survey on Alcohol and Related Conditions aimed to be representative of the US adult population, regardless of whether they sought treatment, and assessed comorbidity in all individuals. Further, di Giacomo et al² used a categorical approach to comorbidity, based on diagnoses, and compared dimensional assessments of psychopathology between the 2 categories (113 bipolar I disorder patients in a mixed or manic state without borderline personality disorder versus 95 borderline personality disorder patients, 3 of whom met criteria for bipolar II disorder). Instead, our study³ used a dimensional approach, based on latent factors. Also, the personality disorder evaluation in the di Giacomo study² was conducted when the patients were in a manic or mixed state, with an average Young Mania Rating Scale score of 33. All of these factors in their approach may have influenced the rates of comorbidity found in their sample.

Although as clinicians and researchers we agree that it is sometimes easy to differentiate borderline personality disorder from bipolar disorder, based on the published literature⁴ and our own findings, we believe that in some cases the differential diagnosis is more difficult and in others, the diagnoses co-occur. As our understanding of the phenomenology and neurobiology of psychiatric disorders advances, it will be important to continue to

examine the relationship between borderline personality disorder and bipolar disorder.

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