CASE REPORT

Misdiagnosis or Comorbidity: Borderline Personality Disorder in a Patient Diagnosed With Bipolar Disorder

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The current and central biosocial theory of borderline personality disorder as defined by Dr. Marsha Linehan (1) focuses on impairment in the domains of affective, behavioral, and interpersonal functioning. Impulsivity, aggression, and affective instability, key behaviors in borderline personality disorder, are connected to a dysfunction of serotonin (2). A polymorphism within a specific serotonin transporter gene has been associated with suicide, impulsivity, addiction, and emotional lability (3). A confluence of biological predisposition and environmental effects produces a borderline personality disorder phenotype (2).

Borderline personality disorder can commonly be confused with or misdiagnosed as bipolar disorder, largely because of the overlapping symptoms relating to affective instability (4). Some believe that bipolar disorder and borderline personality disorder are separate entities that, in some cases, can coexist (5), while others see them on a spectrum together (6). In the present case report, the patient was formerly diagnosed with bipolar disorder but later given the diagnosis of borderline personality disorder.

CASE

"Mrs. W" is a 29-year-old woman who presented to the inpatient psychiatric hospital via the police after she texted a male friend repeatedly, following consumption of five alcoholic beverages, stating that she wanted to kill herself. Upon interview the following day, she appeared calm and cooperative and had little memory of sending the text messages. She held a previous diagnosis of bipolar disorder and endorsed past symptoms consistent with past manic episodes, such as elevated and irritable mood, hyperactivity, racing thoughts, hypersexuality, reduced need for sleep, pressured speech, and grandiosity. She also displayed poor impulse control and emotional dysregulation. She admitted to problems with affect (specifically anger and loneliness), impulsive action patterns (suicidal gestures, sexual deviance, and substance abuse), and interpersonal relationships (abandonment issues, dependency, and entitlement).

The patient endorsed stressors such as tension with her mother and marital discord. She is married with three children and stated that her husband "would never leave her," regardless of her infidelity during periods of mania. She had never been diagnosed with borderline personality disorder, but she did report a history of self-mutilating behavior, anorexia for 3 years in high school, and two suicide attempts via overdosing on medication at ages 15 and 21, respectively.

After the initial interview with the patient, our team identified this admission as a depressive episode of her preexisting bipolar disorder and therefore restarted her on quetiapine, to which she had reported a good response in the past, as well as lithium. As her 4-day inpatient hospitalization continued, she was compliant with her new medication regimen, and the diagnosis of borderline personality disorder was more thoroughly discussed with her.

DISCUSSION

Borderline personality disorder is seen in approximately 1%–6% of the general population (6). Borderline personality disorder can commonly be confused with bipolar disorder, largely because of the overlapping symptoms of impulsivity, mood instability, inappropriate anger, and suicidal threats (4). The above patient is a good example of a case in which an individual formerly diagnosed with bipolar disorder is also given the diagnosis of borderline personality disorder later. Her history of manic episodes met DSM-5 criteria, as they lasted for longer than a week and included elevated and irritable mood, hyperactivity, racing thoughts, hypersexuality, reduced need for sleep, pressured speech, increased distractibility, flight of ideas, grandiosity, and reckless behavior, and they caused an impairment in self-functioning. Her manic episodes appeared to be in remission when she presented to the inpatient psychiatric hospital, during which time she met DSM-5 criteria for borderline personality disorder. Her behavior was not solely attributed to alcohol intoxication because her history showed an enduring pattern of thinking, acting, and relating characteristic of borderline personality disorder that occurred outside her episodes of alcohol use.

While some believe that bipolar disorder and borderline personality disorder are separate diagnoses that can occur together, others consider them to be related. Borderline personality disorder and bipolar disorder co-occur more often than would be expected by chance alone, given that borderline personality disorder occurs in less than 1% of the population and bipolar disorder in greater than 2%. It is reported that up to 20% of people with borderline personality disorder have comorbid bipolar disorder, and about 15% of people with bipolar disorder have comorbid borderline personality disorder (this difference could be due to overestimating the former or underestimating the latter) (6). Those in favor of two separate disorders conclude that while the comorbid-

KEY POINTS/CLINICAL PEARLS

- Both borderline personality disorder and bipolar disorder may present with a core feature of affective instability.
- Misdiagnosis of borderline personality disorder as bipolar disorder and vice versa is common but avoidable.
- Borderline personality disorder and bipolar disorder necessitate very different treatments; if borderline personality disorder is suspected, antidepressants and mood stabilizers should be used in conjunction with psychosocial interventions such as dialectical-behavioral therapy.

ity rates are substantial, more often than not the two occur independently (5), suggesting two distinct disorders.

Fiedorowicz and Black summarized theories that support the diagnoses being related (6). The first theory posits that they are indeed two distinct conditions that happen to share a few overlapping criteria. The second suggests that bipolar disorder and borderline personality disorder are actually on a spectrum, with bipolar II disorder in the middle, representing the transitioning portion of the spectrum. Fiedorowicz and Black also raise the idea of one as a risk factor for the other, and vice versa, while their final theory identifies a set of shared risk factors that influence both, potentially explaining the link between the two disorders. The true reason for the diagnostic overlap may likely be a combination of different theories.

The above case is a prime example of a case in which a former diagnosis of bipolar disorder should be questioned when reconceptualizing the patient as having borderline personality disorder. This approach to diagnosis presents many advantages for care. Gunderson et al. identified two significant negative effects that can come from omitting a borderline personality disorder diagnosis in the face of a bipolar diagnosis (7). It can leave patients and their families with an unrealistic expectation of what medications can do, as well as a feeling of despair when medications are not very effective. It can also deprive the patient of helpful psychosocial interventions, such as dialectical-behavioral therapy (7). A borderline personality disorder diagnosis will emphasize the importance of outpatient skills-based psychotherapy and highlight that recurrent suicidal ideation may be part of the expected course but does not necessarily require hospitalization. Actually, Dr. Linehan views hospitalization as interfering with treatment for borderline personality disorder patients and recommends a short one-night stay rather than prolonged hospitalization when possible (8). Effective strategies for management in such cases include pharmacologic treatment with lithium to mitigate suicidal ideation and self-injury (9), quetiapine for depression and mood stabilization (10), and quickly discharging the patient to reduce dependence on the hospital while directing the patient toward appropriate outpatient psychotherapy, which clinical trials have supported for borderline personality disorder patients in crisis (11). All of these strategies have the potential to decrease burden of disease and improve quality of life.

CONCLUSIONS

Affective instability is a core feature of both bipolar disorder and borderline personality disorder. Some believe that the two diagnoses are separate entities that can coexist (5), while others see them on a spectrum together (6). Their similarities can cause misdiagnosis, but care should be taken to diagnose as accurately as possible, even if it means changing an existing diagnosis. This allows the patient realistic expectations and access to effective treatment.

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