Borderline Personality Disorder: Diagnosis and Common Comorbidities

Patients in inpatient and outpatient settings who have a previous diagnosis of anxiety, depression, or bipolar disorder may also have a coexisting diagnosis of borderline personality disorder (BPD). This condition is characterized by mood swings, inappropriate anger, instability in relationships and employment, fear of abandonment, and impulsive decisions.[1,2]

EPIDEMIOLOGY

BPD has a lifetime prevalence in up to 6% in the population, and is apparent in 20% of patients hospitalized due to mental health conditions. Women and men have similar incidence, with women seeking treatment more often than men. The frequency of psychiatric comorbidities with BPD varies between genders (see Table); the incidence of BPD between ethnic groups is inconclusive.[1,2] The onset of BPD occurs in late adolescence or early adulthood with prodromal symptoms often occurring even earlier. A final diagnosis, however, should be delayed until early adulthood.[1,3]

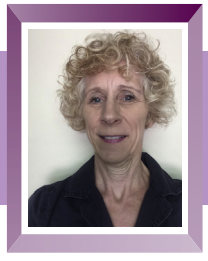
PATHOPHYSIOLOGY

The cause of BPD is not clear, but there is evidence of genetic susceptibility, as well as neurobiologic dysfunction in the frontal lobe, altered neuropeptide function, and neurotransmitter alterations.[1] Studies link dysfunctional environmental influences to the development of BPD, which may explain some of the aforementioned influences. Childhood trauma is associated with the development of BPD, including sexual trauma, severe physical and verbal abuse, witnessing domestic abuse, neglect, and abandonment.[1,2]

DIAGNOSIS: HISTORY AND EXAM

Of those diagnosed with borderline personality disorder, 85% have one or more additional mental health disorders, including substance abuse/addiction, eating disorders, somatoform disorders, anxiety, depression, and bipolar disorder. When patients present with an established mental health disorder, comorbid BPD should be considered.

While assessing the patient's history, the diagnosis may become apparent from 3 primary criteria: (a) a history of failed relationships and a feeling of "emptiness"; (b) affective dysregulation including excessive mood lability and fear of abandonment; and (c) behavioral dysregulation, including impulsivity, suicidality, or other self-injurious behaviors.[1,3] A history of excessive anger, mood lability, and avoidance of abandonment (affective dysregulation) is the most sensitive screening for BPD. Extreme mood swings may occur several times a day over meaningless triggers. Euthymia may instantly change to severe distress leading to outbursts against the patient's closest contacts.[1] Mood instability is associated with feelings of guilt, failure, and self-harm. Because there is often lack of insight, contributions from family members provide essential information to support the diagnosis.



DIAGNOSTIC TIPS

Mellisa A. Hall, DNP, and
Katherine M. Riedford, PhD

Table. Variance Between Genders of Borderline Personality Disorder With Comorbid Mental Health Disorders

Diagnosis	Females	Males
Depression	No variance	No variance
Posttraumatic stress disorder	51%	31%
Eating disorder	42%	19%
Identity disturbance	67%	48%
Substance use disorder	58%	85%
Antisocial personality disorder	10%	30%
Narcissistic personality disorder	5%	22%
Schizotypal personality disorder	10%	25%
Alcohol use disorder	No variance	No variance

Data from Ellison.[1]

The feeling of chronic emptiness has the highest correlation with suicidality.[1,3] Assessment of early personal relationships may help identify a pattern of dysfunctional relationships, including instability in employment. Active listening and keen skin inspection can identify previous nonsuicidal self-injury such as cutting, burning, or injecting with needles. Suicidal risk increases during periods of worsening depression, recent loss, and increased patterns of substance abuse.[1,3]

DIAGNOSIS: *DSM 5* and Screening Tools

The McLean Instrument for Borderline Personality disorder helps with initial diagnostic screening. The instrument has a sensitivity of 0.81 and a specificity of 0.85. Criteria for BPD, as described in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM 5*), include an ongoing pattern of instability in interpersonal relationships, lower self-image, and impulsivity, beginning in early adulthood. Five or more of the following criteria should be met, but patients often have all 9 of the *DSM 5* diagnostic criteria: affective instability (95%); inappropriate anger (87%); impulsivity (81%); unstable relationships (79%); feelings of emptiness (71%); paranoia or dissociation (68%); identity disturbance (61%); abandonment fears (60%); and suicidality or self-injury (60%).[1,3]

BPD shares clinical features with antisocial, histrionic, narcissistic, paranoid, schizotypal, and dependent personality disorders.[3] Because BPD patients may share similar traits with these other personality disorders, a mental health referral is essential in confirming all diagnoses and appropriate treatment recommendations.[4]

CONCLUSION

Timely diagnosis is vital in identifying suicidal thoughts or plans. Approximately 10% of patients with BPD have committed suicide.[1] Referral to a mental health specialist to confirm the diagnosis of BPD is recommended, with follow-up therapy essential to improve symptomatology. JNP

References

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Both authors are affiliated with the University of Southern Indiana. Mellisa A. Hall, DNP, is an associate professor, and Column Editor for Diagnostic Tips. She can be reached at mhall@usi.edu. *Katherine M. Riedford, PhD, is an associate professor of nursing.*

1555-4155/17/$ see front matter

http://dx.doi.org/10.1016/j.nurpra.2017.07.012