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Review article

Comorbidity between bipolar disorder and borderline personality disorder: Prevalence, explanatory theories, and clinical impact

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ABSTRACT

Background: The relationship between bipolar disorder (BD) and borderline personality disorder (BPD) has been controversial and widely debated. Specifically, the comorbidity between both disorders has yielded a plethora of research, but there are no comprehensive reviews on this issue.
Objective: To determine the empirical evidence regarding the comorbidity between BD and BPD based on prevalence data, explanatory theories for their co-occurrence, and clinical impact of one disorder in the other.
Method: A comprehensive search of databases (PubMed and PsycINFO) was performed. Published manuscripts between January 1985 and August 2015 were identified. Overall, 70 studies fulfilled inclusion criteria.
Results: Over a fifth of subjects showed comorbidity between BPD and BD. Empirical evidence from common underlying factors was inconclusive, but BPD appears to be a risk factor for BD. Data also indicated that the negative impact of BPD in BD (e.g., suicidality, worse mood course) was greater than vice verse.
Conclusions: Given the high prevalence of comorbidity between BD and BPD and the negative effects of BPD in subjects with BD, further studies are needed to clarify the factor associated with the comorbidity between these two disorders. This information is important to develop appropriate treatments for subjects with both disorders, improve their clinical course, and prevent the increased risk of suicidality commonly found in these subjects.

Contents

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1. Introduction

The relationship between bipolar disorder (BD) and borderline personality disorder (BPD) has been controversial, specifically whether BPD is an affective disorder or a personality disorder (Galione and Zimmerman, 2010; Parker, 2014). If BPD is considered a separate disorder, the differential diagnosis between these two disorders, specially with BD-II, still remains a matter of debate (Bayes et al., 2014; Ghaemi et al., 2014; Paris, 2004; Paris and Black, 2015; Renaud et al., 2012; Ruggero et al., 2010; Zimmerman et al., 2010; Zimmerman, 2015). In addition, findings regarding the prevalence, explanatory factors for the co-occurrence of both disorders, and clinical impact of the comorbidity between BPD and BD lack a comprehensive review to draw compelling conclusions (Antoniadis et al., 2012; Coulston et al., 2012; Marcinko and Vuksan-Cusa, 2009; Paris et al., 2007; Zimmerman and Morgan, 2013).

The study of this comorbidity is relevant because the co-occurrence of BPD and BD may impact the course, outcome, and well-being of subjects who suffered from both disorders. Besides, the recognition of the factors associated with this comorbidity may inform treatment and the development of preventative strategies. Within this framework, the present comprehensive review focuses on the three following related areas: (i) what is the prevalence of comorbidity between BPD and BD? (ii) what are the potential factors that account for the comorbidity between BPD and BD? , and (iii) what is the clinical impact of having BDP and BD?

2. Method

2.1. Search strategy

A literature search was carried out through PsycINFO and PubMed databases from January 1985 to August 2015. Terms employed included indexing terms (e.g., MeSH) and free texts: [(borderline personality) AND (bipolar disorder OR bipolar I OR bipolar II OR bipolar disorder not otherwise specified) AND (comorbidity)].

2.2. Selection criteria

Inclusion criteria included cross-sectional and longitudinal studies in adult or adolescent samples. Studies were selected if they included subjects with comorbid BPD and BD. In addition, to evaluate whether BPD and BD had common risk factors, studies that compared subjects with only BPD vs BD were also included. Studies used the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R, 1987; DSM-IV, 1994) or the International Classification of Diseases (ICD-10, 1990).

2.3. Study selection

Of 117 manuscripts that included BPD and BD, 70 fulfilled the inclusion criteria. The others were rejected because they only discussed differential diagnosis, included other issues not relevant for this review, or were partial reviews not covering all areas of research (see Fig. 1). The selected manuscripts were reviewed according to each of the areas noted above.

Studies selected were independently classified by A.F. and I.B. according to their methodological rigor. To this end, studies based

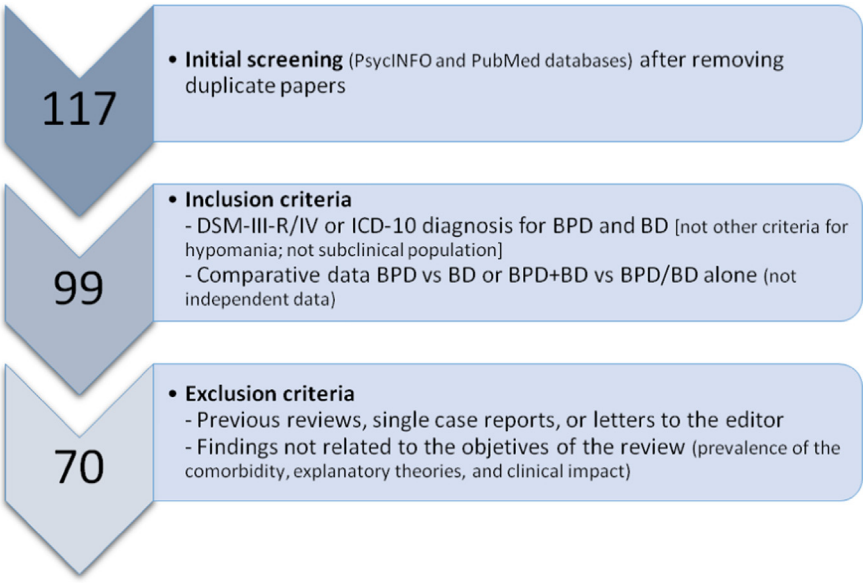

Fig. 1. Flow chart of studyselection.