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Original Article

Differences in mental health among young adults with borderline personality symptoms of various severities

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Abstract *Purpose:* This study examined the differences in mental health and behavioral problems among young adults with borderline personality symptoms of various severities.

Methods: 500 college students participated in this study. Borderline personality symptoms were evaluated using the Taiwanese version of the Borderline Symptom List (BSL-23). Mental health problems were assessed using the Symptom Checklist-90-Revised Scale. Suicidality and other behavioral problems were assessed using questions from the epidemiological version of the Kiddie Schedule for Affective Disorders and Schizophrenia and BSL-23 Supplement. According to the distribution of BSL-23 scores at the 25th, 50th, and 75th percentiles, the participants were divided into 4 groups: No/Mild, Moderate, Severe, and Profound. Analysis of variance and the chi-square test were used to compare mental health and behavioral problems among the 4 groups.

Results: All mental health problems differed significantly among the 4 groups. The severity of nearly all mental health problems increased with that of borderline personality symptoms. The

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proportions of most behavioral problems differed significantly among the 4 groups. The Pro-found group was more likely to have behavioral problems than the other 3 groups.

Conclusion: Young adults who had more severe borderline personality symptoms had more severe mental health and behavioral problems.

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Introduction

Borderline personality disorder (BPD) is a common and serious mental disorder that is characterized by a pervasive pattern of instability in affect, self-image, and interpersonal relationships as well as marked impulsivity.¹ The prevalence rate of BPD in the general population of the United States ranges from 1% to 3%.^{2–4} A higher percentage of 5.9% was also reported,⁵ probably because a more liberal diagnostic rule, whereby subthreshold patients might also be included, was applied.³ Females exhibit a slightly higher rate of the disorder.³ BPD was observed in 9.3%⁶ and 10%–25%⁷ of psychiatric outpatient and inpatient populations, respectively. BPD is associated with high comorbidity with other mental and personality disorders, a high prevalence of self-harm attempts/suicidal behavior, an increased caregiver burden, severe impairment of occupation and interpersonal relationships, and extensive use of mental health resources.^{8–11}

Assessing and diagnosing BPD is the first step in providing intervention. According to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, personality disorders are still diagnosed using the categorical approach (have/do not have a certain personality disorder).¹ BPD is diagnosed when a person exhibits at least five of the nine criteria in the *DSM-5*.¹ However, a dimensional approach for assessing and diagnosing personality disorders has long been argued. Compared with the categorical approach, the dimensional approach has the advantage of higher reliability and stability of diagnosis and a higher association with psychosocial morbidity.¹² In addition, studies have reported that the psychosocial well-being of people with subthreshold borderline personality symptoms warrants survey with caution. On the basis of the Methods to Improve Diagnostic Assessment and Services (MIDAS) project of Rhode Island, in which psychiatric outpatients were evaluated, Zimmerman et al. reported that compared with patients who did not fulfill any *DMS-IV* criteria for BPD, those who fulfilled only one criterion had significantly more psychosocial morbidities including *DSM-IV* axis I disorders, a history of suicide attempts or ideation, psychiatric hospitalizations, durations of unemployment, and a lower rating on the Global Assessment of Functioning.¹³ Moreover, the MIDAS project revealed that the association between dimensional BPD scores (the sum of BPD criteria count) and psychosocial morbidity was higher for people who did not meet the *DMS-IV* diagnostic criteria for BPD than for those who did.¹⁴ These findings further supported the clinical significance of surveying people with

subthreshold borderline personality symptoms by using the dimensional approach. However, the MIDAS project evaluated clinical samples and assessed BPD severity by summing the *DSM-IV* BPD criteria count. The association between psychosocial morbidity and subthreshold borderline personality symptoms measured using a comprehensive scale in nonclinical populations has not been studied. In addition, whether the association between the severity of borderline personality symptoms and mental health and behavioral problems exhibits a trend requires further study.

The full version of the Borderline Symptoms List (BSL-95) was developed by Bohus et al. to quantify the borderline personality symptomatology.¹⁵ It is a dimensional self-report measure that exhibited good psychometric properties including high internal consistency, favorable convergent validity, and high ability to discriminate patients with BPD from health controls and those with other *DSM-IV* axis I disorders.¹⁵ Its validity has also been confirmed by demonstrating a strong association with borderline personality symptoms assessed on the basis of the Structured Interview for *DSM-IV* Personality Disorders.¹⁶ The BSL-23, a shorter version derived from the BSL-95, was later developed and exhibits similar psychometric properties.¹⁷ The BSL-23 offers a faster but similar comprehensive means for dimensionally assessing borderline personality symptoms.

The present study examined the differences in mental health and behavioral problems among young adults with borderline personality symptoms of various severities measured using the BSL-23. We hypothesized the presence of trend patterns; that is, young adults who had more severe borderline personality symptoms had more severe mental health and behavioral problems.

Methods

Participants

Participants were recruited using an advertisement posted on websites for college students aged 20–30 years. Students willing to join the study could contact with research assistant by telephone, by which research assistant explained the procedures of research and screened the eligibility of volunteers. Eligible volunteers then came to our research room, and were informed about the research procedures by the research assistant again face to face before providing informed consent. A total of 500 students from 67 colleges participated in this study. Of them, 238 participants were men and 262 were women, and their mean age was 22.1

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