Blurring Boundaries: Differentiating Borderline Personality Disorder and Bipolar Disorder to Guide Treatment-A Case Report

Izzati Mohd Bashir[1,2*], Nurul Syuhaida Binti Azazian[3,4], Siti Aminah Omar[1,2], Nur Ilyana Nasrin binti Abdul Fattah[5,6]

[1]Department of Psychiatry, Faculty of Medicine, Universiti Teknologi MARA Sg Buloh, Malaysia

[2]Jabatan Psikiatri, Hospital Al Sultan Abdullah, Universiti Teknologi MARA (UiTM), 42300 Bandar Puncak Alam, Selangor.

[3]Pusat Pakar Psikologi Jiwadamai,

[4]Faculty of Health Science National University of Malaysia

[5]Autism Gym Centre

[6]Faculty of Social Science and Humanities National University of Malaysia.

***Corresponding Author**

DOI: https://doi.org/10.47772/IJRISS.2026.100601231

Received: 24 June 2026; Accepted: 29 June 2026; Published: 15 July 2026

ABSTRACT

A case of a 22-year-old female with mood instability, impulsivity, recurrent self-harm, and impaired interpersonal functioning is presented. This case demonstrates the diagnostic challenges and case management due to overlapping features of Borderline Personality Disorder and Bipolar II Disorder. Impulsivity and mood instability are considered gray areas for these two conditions because of their shared symptoms and high comorbidity. The patient completed ten sessions of individual Dialectical Behavior Therapy (DBT) alongside ongoing psychiatric care. The frequency of self-injurious behaviour decreased, and improvements were observed in emotional regulation and interpersonal functioning. This case demonstrates the need for careful differential diagnosis in managing the complex affective and personality presentations.

Keywords: Borderline Personality Disorder, Bipolar Disorder, Differential diagnosis, Diagnostic challenges, Treatment implications

INTRODUCTION

Borderline Personality Disorder (BPD) and Bipolar Disorder has been consistently demonstrating shared overlapping clinical features. Across studies, approximately 10% of patients with BPD had bipolar I disorder and another 10% had bipolar II disorder. Likewise, approximately 20% of bipolar II patients were diagnosed with BPD, though only 10% of bipolar I patients were diagnosed with BPD (1). Clinical features like mood reactivity and impulsivity are the core symptoms that contributes to the diagnostic uncertainty. This uncertainties can mislead therapists to misdiagnose or missed diagnosis. Therapists may diagnose one as a personality disorder and the other as a mood disorder. In the past 20 years, there are increasing investigations which led to suggestions that Borderline Personality Disorder (BPD) should be conceptualized as part of the spectrum of Bipolar Disorder (BD) (1,2).

Despite the overlapping, important distinctions between Borderline Personality Disorder (BPD) and Bipolar Disorder have been identified. Bipolar Disorder is characterised by person's mood shifts between periods of feeling very low (depressed) and periods of feeling unusually high, energetic, or irritable (mania or hypomania),

often in clear episodes (2). Borderline Personality Disorder (BPD) is a pervasive pattern of emotional, interpersonal, cognitive, and behavioral dysregulation, marked by instability in relationships, self-image, and affect that persists across contexts. If this distinction is not identified, diagnostic decisions may become unclear and treatment planning becomes less effective as both diagnosis have different key treatment (2,3).

Diagnostic formulation plays a significant role in choosing the appropriate treatment. Current Clinical Practice Guidelines recommend Dialectical Behaviour Therapy (DBT) as a first-line psychological intervention for patients with BPD (4). In contrast, the management of Bipolar Disorder primarily focuses on mood stabilisation, relapse prevention, and long-term monitoring. The pharmacological treatment is a central component of care (5) for Bipolar Disorder. Accurate differentiation is important as BD is dependent on pharmacological stabilization while BPD is dependent on psychotherapy.

This case report highlights the challenges arising from overlapping features of BPD and Bipolar II Disorder. Accurate identification of diagnosis and understanding the possibilities of comorbidity of BPD and Bipolar II Disorder is critical for effective treatment planning.

Case Report

A.D. is a 22-year-old Malay undergraduate female students who is referred for psychotherapy due to recurrent self-harm, marked mood instability, and interpersonal conflicts. She had been under psychiatric follow-up with provisional diagnoses of Bipolar II Disorder and Borderline Personality Disorder. The symptoms begin in mid-adolescence. At age 15, she engaged in non-suicidal self-injury, primarily wrist cutting due to intense emotional distress and perceived rejection by her friends. At age 19, following breakup of a romantic relationship, she attempted suicide attempt by ingesting medications and household substances. This resulted acute kidney failure and prolonged hospitalisation. She later described the attempt as impulsive behaviour and driven by emotional exhaustion, fear of abandonment, and feelings of being unloved. Limited family visit during her hospitalisation made experienced sense of rejection and loneliness heightened. At age 21, she presented with depressive symptoms, including low mood, reduced pleasure in previously enjoyed activities, hopelessness, insomnia, and recurrent suicidal ideation, leading to a diagnosis of Major Depressive Disorder. Pharmacological treatment resulted in partial improvement in which it is hard to help her improve her low mood.

Over the following year, she developed experienced periods of abnormally high energy, happiness, or irritability that differ from her usual self. She had reduced need for sleep, increased goal-directed activity, impulsive spending, pressured speech, distractibility, and inflated self-esteem. These episodes typically lasted three to four days and were followed by depressive crashes marked by hypersomnia and self-critical rumination, prompting a revised diagnosis of Bipolar II Disorder. Concurrently, she also experienced rapid shifting mood and intense anger. Most of the time, the triggers involved interpersonal stressors, particularly perceived rejection or abandonment. She reported chronic feelings of emptiness and unstable self-image alongside recurrent self-injurious behaviours including wrist cutting, head-banging, and self-punching. These behaviours were identified as maladaptive coping mechanisms for her overwhelming emotions. She denied suicidal intent.

Diagnostic assessment included structured clinical interviews and standardised psychometric assessments. A Structured Clinical Interview for DSM-5 (SCID-5) confirmed that diagnostic criteria were met for both Bipolar II Disorder and Borderline Personality Disorder (BPD). The Deliberate Self-Harm Inventory (DSHI) indicated recurrent non-suicidal self-injury in response to emotional distress. Scores on the Beck Depression Inventory-II (BDI-II) reflected moderate depressive symptom severity. The Hypomania Checklist reported the presence of bipolar spectrum features in A.D. The Borderline Symptom List-23 (BSL-23) reported elevated emotional dysregulation and interpersonal dysfunctioning. The patient was referred for individual Dialectical Behavior Therapy (DBT) while receiving pharmacological treatment mainly targeting mood stabilisation.

Ten sessions of Dialectical Behavior Therapy (DBT) were delivered. Sessions mainly focus on: 1)distress tolerance skills to reduce self-harm behaviors 2) mindfulness skills to reduce impulsivity 3) emotion regulation skills to alleviate low mood, and 4) interpersonal effectiveness skills to manage interpersonal dysfunctional patterns. Treatment adherence was high. As therapy progressed, A.D. discontinued wrist cutting and head-

banging behaviors. She demonstrated a reduction in self-punching behaviors, and reported decreased depressive symptoms. The patient also reported improved emotional awareness, greater distress tolerance during crises, and increased use of assertive communication skills during interpersonal conflicts. No adverse events were reported. A summary of the management plan using DBT is provided in Table 1.

Table 1. Summary of DBT Session Plan and Clinical Progress

Phase	Session	Session Focus	Key Clinical Outcomes
Phase 1: Engagement and Mindfulness	1	Pre-treatment assessment (BSL-23: severe; BDI-II: moderate); risk assessment; orientation to DBT; mindfulness ("What" skills, 4-4-4 breathing)	Understood DBT structure and goals; disclosed one episode of wrist-cutting prior to session; passive suicidal ideation without plan; agreed to remove razor from environment; deemed suitable for Stage 1 DBT
	2	Psychoeducation on Biosocial Theory; chain analysis of self-harm	Improved insight into triggers and functions of self-harm; identified prompting events, emotions, and consequences; no new self-harm reported
Phase 2: Emotion Regulation and Distress Tolerance	3	Distress tolerance: introduction of ACCEPTS	Identified preferred coping strategies (e.g. writing poetry, walking away, using ice); no self-harm reported
	4	Mindfulness of emotions; Pros and Cons	Applied ACCEPTS during interpersonal conflict; strong urges reported without self-harm
	5	Emotion regulation: functions of emotions, myths; emotion labelling (Wheel of Emotions)	Improved accuracy in identifying emotions; recognised invalidation history and anger masking vulnerable emotions; no self-harm
Phase 3: Interpersonal Effectiveness and Relapse Prevention	6	Interpersonal effectiveness: introduction of DEAR MAN	Linked self-harm urges to relationship conflict; practised assertive communication; one episode of self-harm (punching thigh with phone) following partner conflict
	7	Review of DEAR MAN; FAST skills	Improved boundary awareness; practised balancing self-respect and relationships; no self-harm reported
	8	Review of FAST; introduction of GIVE; parental psychoeducation	Set limits around waiting for partner's calls; improved distress tolerance; enhanced family communication and validation; no self-harm
	9	Emotion regulation: describing emotions; accumulating positive emotions (short-term)	Increased emotional awareness; planned pleasant activities (e.g. skateboarding, journaling, reading); no self-harm
	10	Consolidation of DBT skills; relapse prevention; crisis survival planning	Demonstrated sustained skill use; increased engagement in valued activities; no self-harm reported; transitioned to continued care

DISCUSSION

This case illustrates the diagnostic and management challenges associated with co-occurring Borderline Personality Disorder and Bipolar II Disorder. Although the term "borderpolar" has been used informally to describe such presentations, it is not a recognised diagnostic entity within classification systems such as the DSM-5-TR. In clinical practice, these presentations are more appropriately conceptualised as either comorbidity or a differential diagnostic challenge due to overlapping features.

The shared symptoms namely affective instability, impulsivity and mood reactivity contributes to diagnostic uncertainty. Longitudinal assessment is vital in discriminating episodic mood changes characteristic of bipolar disorder from the more pervasive and context-dependent emotional dysregulation that was observed in borderline personality disorder.

In the present case report, hypomanic symptoms were discrete and time-limited, consistent with Bipolar II Disorder. However, difficulties related to emotional regulation, interpersonal instability, identity disturbance, and recurrent self-harm were persistent across situations and had been present since adolescence. This clinical feature is more aligned with Borderline Personality Disorder (BPD). Chronic affective instability is commonly misinterpreted as bipolar mood disturbance leading to overdiagnosis of bipolar disorder (Zimmerman & Morgan, 2013). Discriminating these features is vital in this case as it informs the next course of management.

Besides that, it is important to carefully explore the risk factors. The patient reported adverse childhood experiences while growing up that aligns with known risk factors of Borderline Personality Disorder (BPD). In contrast, biological and genetic factors are common known risk factors in Bipolar Disorder. Identifying predisposing factor helps in assessing complex presentations.

It is also noted that individuals who have both Borderline Personality Disorder (BPD) and Bipolar Disorder tend to develop symptoms earlier, have more trouble with day-to-day functioning, and are at higher risk of self-harm and suicide than people who have only one of these conditions (Temes et al., 2024). The early onset of symptoms observed in this case are aligned with these findings.

From an intervention standpoint, individual Dialectical Behavior Therapy (DBT) therapy was selected as the primary psychological treatment, given its demonstrated effectiveness in reducing self-harm and improving emotional regulation in Borderline Personality Disorder (BPD). In this case, patient demonstrated reductions in self-injurious behaviour and improvements in crisis management despite ongoing interpersonal stressors. These findings are consistent with previous evidence supporting DBT in similar presentations. Pharmacological treatment for bipolar disorder was continued to address episodic mood symptoms. However, medication alone had not been sufficient in managing the patient's longstanding emotional and interpersonal difficulties.

This case supports an integrated treatment approach that pairs psychological interventions aimed at borderline pathology with pharmacotherapy for mood stabilization. The main limitations of this report include the single-case design which restricts generalisability. Nevertheless, the detailed assessment and thorough identification of symptom patterns enhance the robustness of the clinical interpretation.

CONCLUSION

Overall, this case underlines the value of comprehensive assessment and careful formulation in managing the complexities of Borderline Personality Disorder (BPD) and Bipolar Disorder. Differentiating episodic mood symptoms from chronic, persistent emotional and interpersonal dysregulation supported the identification of BPD as the primary diagnosis. Consequently, DBT was chosen as the main intervention, supplemented by pharmacotherapy in targeting bipolar symptoms. This approach led to clinically meaningful reductions in the frequency of self-harm behaviours and improvements in emotional regulation, distress tolerance skills, and interpersonal effectiveness skills. Taken together, these findings highlight the need for careful identifications in comorbid Borderline Personality Disorder (BPD) and Bipolar Disorder presentations.

REFERENCES

1. Zimmerman M, Morgan TA. The relationship between borderline personality disorder and bipolar disorder. Dialogues Clin Neurosci. 2013;15(2):155–69.
2. Zimmerman M, Morgan TA. Problematic boundaries in the diagnosis of bipolar disorder: the interface with borderline personality disorder. Curr Psychiatry Rep. 2013;15(12):422.
3. Fornaro M, Orsolini L, Marini S, De Berardis D, Perna G, Valchera A, Ganança L, Solmi M, Veronese N, Stubbs B. The prevalence and predictors of bipolar and borderline personality disorders comorbidity: systematic review and meta-analysis. J Affect Disord. 2016;195:105–18.
4. National Institute for Health and Care Excellence (NICE). Borderline personality disorder: recognition and management (CG78). London: NICE; 2009.
5. National Institute for Health and Care Excellence (NICE). Bipolar disorder: assessment and management (CG185). London: NICE; 2014.