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Borderline Personality in Patients with Poly-Diagnoses Treated for a Bipolar Disorder

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Abstract

Some patients with dysphoria, explosive behaviour, or suicidal ideation, may receive a diagnosis of, and treatment for Bipolar Disorder (BD) and, not infrequently. The coexistence of these two diagnoses has been explained in different ways. Some authors include the BPD in the *bipolar spectrum;* others are sceptical about the existence of real comorbidity, suggesting a misdiagnosis. This study aimed to assess the personality of this group of poly-diagnosed patients (PolyD) and hypothesised they had a pathological borderline organisation. Via the administration of the Schedler Westen Assessment Procedure (SWAP-200), we compared PolyD patients with those suffering from BPD or BD only. We performed two different MANCOVAs to test PolyD, BPD and BD patients' differences in PD-factors, Q-traits and age. The sample comprised 45 patients (Mean age=43.3, SD=15.7; Females 57.7%, N=26). BD patients (N=15) did not present any personality disorder, they had a higher functioning and Obsessive Q-traits, and a lower Histrionic PD-factor than both PolyD (N=20) and BPD (N=10) patients. Compared to PolyD patients, BD had inferior PD-Borderline, PD-Antisocial factor and Dependent-Masochistic Q-traits, but there were no other differences with BPD patients. PolyD did not differ from BPD patients in any of the PD-factors and Q-traits. Our results suggest that PolyD patients are different from BD patients and propose to consider the pathological borderline personality as a central core of their disease.

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1. Introduction

Some patients who access psychiatric services with symptoms such as dysphoria, explosive behaviour, or suicidal ideation, may receive more than one diagnosis over the years. Not infrequently, these patients are diagnosed with Bipolar Disorder (BD), but they receive also other diagnoses (such as Schizoaffective, Bulimia, Anorexia, Substance Abuse) and Borderline

(BPD) or Not Otherwise Specified (PD-NOS) Personality Disorder (American Psychiatric Association, 2002) throughout their clinical history.

A recent meta-analysis showed a range of rates of comorbidity of BPD in BD conditions, between 26.1 and 37.5 (Fornaro et al., 2016), mostly due to the impulsivity traits, considered it an additional detrimental factor for a poorer prognosis (McDermid et al., 2015). It also reported a lower but consistent presence of BD diagnoses in BPD patients, ranging from 18 to 21% (Fornaro et al., 2016). Sometimes this comorbidity leads to focus on the affective disorder as the starting point for the therapeutic management. However, as it does not target the primary therapy on personality disorder, it will only result in weaker long-term outcomes (Paris, 2011; Paris & Black, 2015), or it will focus on symptom-dimensions or part of them (Aguglia, Mineo, Rodolico, Signorelli, & Aguglia, 2018).

According to some authors (Akiskal, 2004; Young et al., 2013), BPD falls within the *bipolar spectrum*, because emotional instability develops through the same mechanisms in both diagnostic categories. However, this spectrum-perspective is not fully sustained (Youngstrom, Van Meter, & Algorta, 2010). Other authors suggest that the BPD can share some aetiological patterns with BD, even genetic (MacKinnon & Pies, 2006), that research needs to investigate further (Paris, Gunderson, & Weinberg, 2007). Although BPD and BD have significant clinical differences, distinctive personal and family histories, and response to treatment, studies on comorbidity have provided inconsistent results (Martinucci, Chiesa, Taponecco, Biagi, & Di Fiorino, 2011; Paris & Black, 2015).

An alternative explanation suggests that BPD and BD could be clinically overlapping, but different pathologies (de la Rosa et al., 2017), thus real comorbidity would not be frequent and often a result of misdiagnosis (di Giacomo et al., 2017), and often a source of disagreement among clinical staff (Saunders, Bilderbeck, Price, & Goodwin, 2015). It also occurs especially because clinical (empirical or impressionistic) criteria are preferred to DSM criteria in diagnostic differentiation (Bayes & Parker, 2017). It was proposed that emotional instability is a non-unique psychopathological pattern, but closely related to environmental and relational stressors in BPD (Martinucci et al., 2011). So that borderline affective instability is more interpersonal than the affective instability of BD, who could additionally experiment some form of *euthymia* when they are stable (Reich, Zanarini, Hopwood, Thomas, & Fitzmaurice, 2014).

Finally, patients who receive several different diagnoses, beside a BPD or a PD-NOS, could be included in a group that some authors (Martinucci et al., 2011; Paris & Black, 2015) describe as *borderline organisasion* (Kernberg, 1975). That would be able to explain the stable configuration of impulsivity, dysphoria and affective instability which may develop in a number of different other

symptoms. For example, Meissner (Meissner, 1984) described as part of the borderline organisation different cases on a continuum, between the hysterical and the schizoid poles.

This study aimed to assess pathological personality traits in people diagnosed with different diagnoses over their lifetime or in comorbidity, along with BPD or a PD-NOS at some point in their life [polydiagnosed patients (PolyD)], by comparing them with a group of people diagnosed with Borderline Personality Disorder (BPD) or Bipolar Disorder (BD) only.

We hypothesised a highly pathological borderline organisation that may represent the central psychopathological nucleus of the PolyD group.

2. Methods

2.1 Subjects

Patients referred to the Psychiatric Unit of Policlinico general Hospital "Paolo Giaccone" of Palermo between January 2015 and December 2016, who presented 1) a BPD (ICD-10: F60.3; DSM-IV-TR: 301.83); 2) a diagnosis of BD (ICD 10: F30-F31, F34.0; DSM-IV-TR: 296.0-296.4, 296.89); 3) poly-diagnoses (PolyD) constituted by a BD, coupled with at least a second diagnosis such as BPD or an Unspecified (ICD-10: F60.9) or NOS (DSM-IV-TR: 301.9) personality disorder (World Health Organization, 1992). All patients signed the informed consent included in their clinical records, including a section regarding the use of instruments such as personality tests. Data collected were treated anonymously by the researchers.

2.2 Instruments

All patients were administered with the Italian version of the *Shedler-Westen Assessment Procedure* (SWAP-200) (Shedler, Westen, Lingiardi, & Gazzillo, 2014) by a qualified psychiatrist in training. The clinical interviews were also corroborated by other sources of information such as clinical records and the reports from patients' clinicians and family members.

The evaluation method of the SWAP-200 is based on the Q-sort procedure (Stephenson, 1953). It consists of a 200 statements' set that describes different psychological functioning aspects that might be characteristic of a person in a clinical contest. The clinician orders the cards in a predetermined number of categories, each category allows to retain a pre-fixed number of cards only. The first category (marked by number 0) includes any description that does not reflect the characteristics of the subject examined. It continues in a progressive mode until the last category, which includes the items that best describe the person, awarding the maximum score of 7. The scales are written not to be theoretically oriented, and therefore understandable to all clinicians. Once all the items are distributed within each category, the software compares the subject's

characteristics with that of the prototype healthy personality and with the ten personality disorders of DSM-IV-TR and DSM-5, by a correlation coefficient called PD-factor.

The correlation coefficients are then transformed into T scores, with an average of 50 and a standard deviation of 10. A T score equal or up to 60 indicates the appropriate cut off to make a categorical diagnosis of personality disorder. The instrument also identifies the absence of disturbance (<=49.99) and the presence of few (50-54.99) or many (55-59.99) disorder features, below the cut-off point. A patient presenting a >60 score at High Functioning scale does not present any personality disorder.

The method allows forming both categorical diagnoses, following DSM-IV-TR nosography and dimensional diagnosis, based on the empirically-derived classification proposed by Shedler and Westen in terms of Q-scores (Shedler & Westen, 2004a, 2004b). They are based on the empirical description of patients that are similar for some characteristics, and they are pathological if high functionality score is under 60. Otherwise, they only describe the personality style. The borderline personality organisation is missing because of the intrinsic Q-description, which considers a *borderline organisation* typical of multiple personality style and based on a dysphoric personality style with affective dysregulation. Dysphoric traits are Avoidant, Depressive High Functioning, Affective Dysregulation, Dependent-Masochistic and Hostile. Other Q-traits are Antisocial-Psychopath, Schizoid, Paranoid, Obsessive, Histrionic and Narcissistic. The test is useful to identify pathological and functional areas of those patients who do not reach criteria for any personality diagnosis, despite having a pathological personality organisation (Westen & Arkowitz-Westen, 1998). The interviews, spanning from three to five meetings, assess the individual's functioning on multiple levels: cognitive, affective, motivational and behavioural, and how it can change based on external circumstances. It also discriminates between pathological and functional areas.

2.3 Statistics

To compare the three groups (BD, BPD and PolyD) for age and sex differences, we used the ANOVA and chi-square test, respectively. We performed two different MANCOVAs to establish differences between groups, in both SWAP-200 PD-factors and Q-traits, by selecting those resulting in a score ≥50 as the outcomes. To see how they were related to different diagnostic groups we used the variable "group" as a fixed factor, alongside with sex; age was used as the covariate. Results were presented as their main effects. MANCOVA allowed us to take into account the correlation among SWAP-200 factors. Box's M test was used to test the homogeneity of the covariance matrix. Bootstrap 95% confidence intervals (C.I.) were calculated as inferential tests using 1000 samples, bias-corrected and accelerated (BCa).

Wilks'Lambda was used to test significance. We applied Bonferroni multiplicity correction for multiple comparisons. All statistical analyses were conducted using SPSS 25.

3. Results

The sample included 45 patients (Mean age=43.3, SD=15.7): 26 females (Mean age: 45.12, SD=14.5) and 19 males (Mean age: 40.84, SD=17.4), comparable in terms of mean age [t (43)=-0.894, p=0.376]. Patients were divided into three groups, according to the diagnosis given by their clinicians: 1) 15 patients constituted the BD group; 2) 10 patients represented the BPD group; 3) 20 patients constituted the PolyD group. Patients in the three groups did not differ in terms of sex distribution ($\chi^2(2)=0.797$, p=0.671), but BD patients were very much holder than BPD [Mean difference (M^{diff})= 25.8, 95% C.I. =(16.6, 33.9)] and PolyD patients [M^{diff}=24.2, 95% C.I. =(15.7, 30.7)] (Table 1).

Table 1. Comparisons by age and sex between groups of patients

	BD (N=15)	**BPD** (N=10)	**PolyD** (N=20)	**Test**[a]	***p-value***
Sex, N (%)				$\chi^2(2)=0.797$	0.671
Male	5 (33.3)	5 (50)	9 (45)		
Female	10 (66.7)	5 (50)	11 (55)		
Age, mean (SD)	59.8 (2.7)	34 (3.3)	35.6 (2.4)	F (2, 42)=26.5	<0.001

[a]*omnibus test*

Table 2 shows mean scores at SWAP-200 obtained from each group, from the most to the less representative, both PD-factors and Q-traits scores. The BD group did not present any personality disorder, they had a good Functionality ($mean_{PD}$=56.6; SD=3.8) and a high Depressive High Functioning trait ($mean_{Q}$=57.7; SD=4.1), but only slightly Borderline ($mean_{PD}$=50.6; SD=7.6), Histrionic ($mean_{Q}$=54.4; SD=7.7), Obsessive ($mean_{Q}$=52.6; SD=5.2) and Paranoid traits ($mean_{Q}$=51.2; SD=5.9), beside some Affective Dysregulation ($mean_{Q}$=51; SD=7.1).

BPD group presented high prototypical presentation of Borderline ($mean_{PD}$=59.4; SD=7.9), and Histrionic personality ($mean_{PD}$=59.1; SD=7.8; $mean_{Q}$=56.2; SD=8.8), followed by strong traits from the other two Cluster-B personality disorders: Narcissistic ($mean_{PD}$=56.9; SD=8.7) and Antisocial ($mean_{PD}$=55.7; SD=7.4; $mean_{Q}$=56; SD=6.3), with a slight presence of Paranoid traits ($mean_{PD}$=50; SD=9.5).

BPD group was also represented by high Affective Dysregulation (mean$_{Q}$=56.1; SD=8.1) and little Dependent-Masochistic traits (mean$_{Q}$=53.6; SD=8.4). Very similarly, the PolyD group presented a Borderline (mean$_{PD}$=62; SD=5.6) and Histrionic (mean$_{PD}$=60; SD=4.9; mean$_{Q}$=57.1; SD=6.9) prototypical presentation, strong Antisocial (mean$_{PD}$=56.9, SD=7.9; mean$_{Q}$=55.7; SD=8.3) and Narcissistic traits (mean$_{PD}$=53.8; SD=6.1), Affective Dysregulation (mean$_{Q}$=56.1; SD=6), few Dependent-Masochistic traits (mean$_{Q}$=54.3; SD=5.7), and a slight presence of Paranoid traits (mean$_{PD}$=50.4; SD=6.1) (Table 2).

Table 2. SWAP-200 Mean Scores by Group

PD-factors	Mean	SD	Min	Max	Q-traits	Mean	SD	Min	Max
					BD				
Functionality	56.6**	3.8	50.0	62.5	Depressive High Functioning	57.7**	4.1	50.9	63.0
Borderline	50.6*	7.6	32.3	59.9	Histrionic	54.4*	7.7	40.8	68.5
Histrionic	49.9	6.9	37.2	60.9	Obsessive	52.6*	5.2	45.8	62.0
Narcissistic	47.8	5.9	38.5	61.5	Paranoid	51.2*	5.9	42.8	62.5
Paranoid	47.0	7.4	36.4	64.4	Affective Dysregulation	51.0*	7.1	35.2	60.5
Antisocial	46.9	4.4	40.7	57.8	Narcissistic	47.0	10.6	28.6	67.2
Dependent	46.3	5.1	36.8	56.5	Antisocial-Psychopath	46.4	5.4	38.1	56.5
Obsessive	45.0	7.8	37.8	60.4	Dependent-Masochistic	44.4	6.9	28.1	57.7
Schizotypal	44.6	4.8	36.5	51.1	Hostile	44.4	5.9	36.4	59.4
Avoidant	42.4	4.1	34.0	50.8	Avoidant	43.5	4.2	37.3	53.8
Schizoid	41.7	4.5	33.8	50.0	Schizoid	42.1	4.4	35.5	50.4
					BPD				
Borderline	59.4**	7.9	50.0	70.8	Histrionic	56.2**	8.8	42.2	68.9
Histrionic	59.1**	5.8	52.5	67.7	Affective Dysregulation	56.1**	8.1	42.2	70.5
Narcissistic	56.9**	8.7	43.8	71.2	Antisocial-Psychopath	56.0**	6.3	46.2	69.5
Antisocial	55.7**	7.4	46.5	70.6	Dependent-Masochistic	53.6*	8.4	40.6	65.6
Paranoid	50.0*	9.5	34.0	68.2	Paranoid	49.9	8.5	35.9	66.9
Schizotypal	46.1	6.9	34.7	55.1	Narcissistic	49.6	9.7	35.0	71.2
Functionality	44.9	7.3	33.7	57.6	Depressive high functioning	45.9	6.1	37.5	57.8
Dependent	44.1	6.4	33.0	51.0	Hostile	45.8	8.7	31.6	60.8
Schizoid	41.3	5.4	32.4	47.5	Schizoid	43.7	5.9	32.6	50.5
Avoidant	39.6	5.5	30.4	46.8	Avoidant	39.1	5.8	31.0	49.5
Obsessive	37.5	4.1	32.0	43.6	Obsessive	38.9	7.2	28.4	55.0
					PolyD				
Borderline	62.0***	5.6	54.3	71.2	Histrionic	57.1**	6.9	47.3	73.2
Histrionic	60.3***	4.9	51.2	68.6	Affective Dysregulation	56.1**	6.0	46.5	69.3
Antisocial	56.9**	7.9	42.5	69.1	Antisocial-Psychopath	55.7**	8.3	41.7	69.8
Narcissistic	53.8*	6.1	44.6	67.0	Dependent-Masochistic	54.3*	5.7	40.7	61.9
Paranoid	50.4*	6.1	39.6	63.7	Paranoid	49.9	4.7	39.4	57.0
Schizotypal	48.9	5.8	38.5	58.4	Narcissistic	45.6	8.3	31.4	66.1
Dependent	43.4	7.5	29.7	58.7	Depressive high functioning	45.1	6.2	35.2	58.1
Functionality	42.0	5.2	33.6	55.6	Schizoid	44.0	4.9	37.2	52.5
Schizoid	40.8	4.6	32.7	49.9	Hostile	43.7	7.1	32.2	55.1
Avoidant	37.2	5.1	30.9	47.7	Avoidant	39.3	4.4	32.0	48.0
Obsessive	33.3	4.3	26.8	41.9	Obsessive	37.9	5.1	31.0	51.7

***overtly present; **many features or traits; *few features or traits.

Comparisons between groups

Looking at pairwise comparisons in PD-factors between diagnostic groups, BD patients had inferior scores in Borderline [M^{diff}=-10.1, 95% C.I.= (-18.5, -1.8)] and Antisocial factor [M^{diff}=-8.5, 95% C.I.= (-16.6, -0.4)] than PolyD group and no differences with BPD for both factors. They had also lower scores in Histrionic factor than both PolyD [M^{diff}=-9.3, 95% C.I.= (-16.1, -2.5)] and BPD group [M^{diff}=-8.2, 95% C.I.= (-15.9, -0.5)]. They had also higher Functionality than both PolyD [M^{diff}=11.4, 95% C.I.= (4.9, 17.8)] and BPD group [M^{diff}=8.3, 95% C.I.= (1.0, 15.7)]. There were no differences among groups in Paranoid and Narcissistic traits. BPD and PolyD patients did not present any difference in none of the factors (Table 3). Age had not effect into the model [Wilk's lambda=0.668, F(11, 30)=1.3, p=0.243]. Antisocial traits were higher in males [M^{diff}=4.2, 95% C.I.= (0.1, 8.3)]. Histrionic [M^{diff}=4.2, 95% C.I.= (0.8, 7.6)] and Dependent [M^{diff}=4.7, 95% C.I.= (0.9, 8.6)] traits were higher in females.

Table 4. Pairwise comparisons between groups on Q-Traits from the MANCOVA

Q-Traits	Group(0) vs Group(1)		M^{diff}	SE	*p-value*	95% C.I. BCa^{diff}	
						Lower bound	Upper Bound
Depressive High Functioning	**BD**	**BPD**	7.92	3.0	**0.038**	0.33	15.52
		PolyD	9.05	2.6	**0.005**	2.35	15.76
	BPD	**PolyD**	1.13	2.1	1.000	-4.20	6.47
Affective Dysregulation	**BD**	**BPD**	-2.86	3.8	1.000	-12.43	6.70
		PolyD	-2.97	3.3	1.000	-11.42	5.47
	BPD	**PolyD**	-0.11	2.6	1.000	-6.83	6.61
Histrionic	**BD**	**BPD**	-1.81	3.8	1.000	-11.53	7.89
		PolyD	-2.52	3.4	1.000	-11.10	6.05
	BPD	**PolyD**	-0.70	2.7	1.000	-7.53	6.12
Dependent-Masochistic	**BD**	**BPD**	-7.86	3.7	0.122	-17.14	1.42
		PolyD	-8.53	3.2	**0.039**	-16.73	-0.33
	BPD	**PolyD**	-0.67	2.6	1.000	-7.20	5.84
Obsessive	**BD**	**BPD**	11.01	3.1	**0.003**	3.15	18.87
		PolyD	12.16	2.7	**0.000**	5.23	19.10
	BPD	**PolyD**	1.15	2.2	1.000	-4.36	6.68
Antisocial-Psychopath	**BD**	**BPD**	-7.09	3.7	0.192	-16.40	2.21
		PolyD	-7.16	3.2	0.106	-15.38	1.05
	BPD	**PolyD**	-0.06	2.6	1.000	-6.61	6.47
Paranoid	**BD**	**BPD**	-1.22	3.4	1.000	-9.71	7.27
		PolyD	-1.01	3.0	1.000	-8.51	6.49
	BPD	**PolyD**	0.20	2.3	1.000	-5.76	6.18

Adjusted by age and sex; SE= Standard Error. Significant p-values are in bold.

4. Discussion

The main finding of the study is that PolyD patients are indistinguishable from BPD subjects; this is congruent with our hypothesis confirming that PolyD patients in our study have a highly pathological borderline organisation.

From a descriptive point of view, the older age of the BD group was expected because the average age-of-onset of BD is in late adolescence or early adulthood (Distel et al., 2008; González-Pinto et al., 2017) and represents an evident change in the functioning of the person (Möller & Curtis, 2004). On the contrary, there is no well-defined onset in BPD, with negative affectivity that begins early on in life (Lewinsohn, Seeley, & Klein, 2002) and a depressive state that lasts for long periods (World Health Organization, 1992). Paris and colleagues (Paris & Black, 2015) suggest that in case of real comorbidity, the evolution towards bipolarity is very rare in BPD, as it follows a different course, often going to remission towards middle age. Differences in sex distribution are in line with the previous literature, which reports a higher prevalence of Histrionic and Dependent personality disorders in females and of the Antisocial diagnosis in males (American Psychiatric Association, 2014).

BPD and PolyD patients present both prototypical Borderline and Histrionic presentations, and this is not surprising, given the overlap between clinical appearance of these two disorders which let to question the validity of the Histrionic diagnosis (Blagov & Westen, 2008). Indeed, Histrionic personality disorder disappears in the section three of the DSM-5 (alternative criteria for personality disorders) (American Psychiatric Association, 2014). It has been proposed instead as a subtype of Borderline personality disorder, beside Narcissistic and Antisocial features (Smits et al., 2017), which are primarily present in our group of both PolyD and BPD diagnosis. Interestingly, the PolyD group was the only group of patients showing prototypical nosographic Borderline and Histrionic personality disorders presentation (i.e. PD scores higher than 60).

According to Q-classification, our groups of BPD and PolyD patients present strong traits in Affective Dysregulation and Dependent-Masochistic scores. This was expected, as affective dysregulation is well known as a core feature of Borderline personality disorder (Richetin, Preti, Costantini, & De Panfilis, 2017) and has been further highlighted in the DSM-5 BPD description, alongside with dependence traits (American Psychiatric Association, 2014). This result is also in line with the structure of this part of the SWAP-200 itself, which identifies a small but significant number of BPD diagnosed in patients with high Histrionic (see also Amianto et al. 2012) and Dependent-Masochistic Q-traits (Shedler et al., 2014). Finally, BD patients presented a good Depressive high Functioning, and they did not show any prototypical presentation of pathological personality disorders in our study.

In regard to the group comparisons, higher Functioning and Depressive High Functioning traits distinguished BD patients from both BPD and PolyD groups. They often achieve higher results in social and work performance, probably because of greater identity stability and due to broader

cycles of mood oscillations, compared to BPD, that alternates with periods of clinical compensation.

BD patients also had higher Obsessive traits compared to BPD and PolyD patients, as suggested from some studies that report higher rates of obsessive-compulsive disorder in bipolar patients (9–35%) than in general population (1.5–2.3%) (Brieger, Ehrt, & Marneros, 2003; Rossi et al., 2001).

BD had lower Borderline and Antisocial prototypical presentation than BPD and PolyD patients, but this difference was significant by comparing BD with the PolyD group only. This could be obviously due to little numbers in our study. This was also true for the Dependent-Masochistic trait, which not surprisingly reached a significant difference with the PolyD group only, as this trait has been found to be more related to *egodystonic* symptoms in patients with a borderline organisation (Shedler et al., 2014), as was true for the PolyD group. For example, some of them also had a schizoaffective diagnosis in their lifespan. Moreover, the lower affective dysregulation of BD patients did not reach statistical significance compared to both BPD and PolyD patients. These results could be due to our limited sample size, coupled with the broad variance of scores at these subscales within each group. Affective instability has been indicated as the most useful pattern to screen for BPD in patients with BD and Major Depressive Diagnosis (MDD) (Zimmerman, Balling, Dalrymple, & Chelminski, 2019). We cannot exclude that a number of our patients diagnosed with BD and high affective dysregulation (5 patients in total had Affective Dysregulation scores≥55) could present a non-diagnosed borderline personality disorder, in line with other studies (Zimmerman, Chelminski, Dalrymple, & Rosenstein, 2017). On the other hand, the accuracy in differentiating the two disorders (BPD vs BD) has not been fully replicated (Fowler, Madan, Allen, Oldham, & Frueh, 2019) and a previous study using SWAP-200 has found a good predictive value of Borderline and Affective Dysregulation subscales in predicting depressive symptomatology in unipolar patients (MDD) (Straccamore, 2017).

This issue frames into the general and long-lasting debate about the categorical classification of diseases in DSM. The manual increased the diagnostic reliability and comprehension of psychiatric disorders, but epidemiological studies underlined the inadequacy of DSM's criteria in truthfully differentiating between syndromes, especially in community samples, where comorbidities and "not otherwise specified" category has mainly been used (Kupfer & Regier, 2011). DSM 5 has proposed an alternative model of personality disorders in section III, which defines the construct of personality functioning as a dimensional factor, spanning in a continuum from the normality to the most compromised organisation. Some authors claim that

this dimensional approach can better differentiate personality disorders from other mental disorders (Hopwood et al., 2011) and low self-functioning (criterion A) has been recently indicated as a good predictor of patients' dropping-out from therapy (Busmann et al., 2019).

Starting from these results, we could hypothesise to offer our PolyD patients effective and early targeted psychotherapies in association with pharmacotherapy.

Dialectal Behavioural Therapy (DBT) and psychodynamic approaches appeared effective with BPD patients (Cristea et al., 2017). DBT has been shown to be particularly useful to attenuate BPD traits and prevent dropout, frequencies of hospitalisation rates (Linehan et al., 2015), as well as suicidal behaviours (Linehan et al., 2006), and improve social adjustment (Koons et al., 2001). However, if the affective instability of this group of poly-diagnosed patients will be classified, such as a form of bipolarity, the clinicians will be less likely to offer the most effective psychotherapies.

4.1 Limitations

This study was designed to guide clinicians in the diagnosis of this specific group of patients; therefore, caution must be taken with the generalisation of the results. However, there is scope to expand the study with an increased sample size collected in more than one hospital, which would then allow the applications of the observations to a broader context. Another limitation was the absence of a blinded design which may have biased estimates. Nonetheless, the forced item-distribution procedure of the SWAP-200 is designed to prevent the researcher bias. Additionally, it could be useful to add another test to evaluate psychopathology and affective dysregulation.

5. Conclusions

Our results suggest that PolyD patients are different from BD patients and suggest to consider the pathological borderline personality organisation as a central core of their disease. If their affective instability is correctly classified, they could benefit from early and tailored psychotherapeutic treatments, besides the psychopharmacological strategy.

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