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Clinical Differences Between Borderline Personality Disorder and Schizophrenia: A Case Report in Switzerland

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Abstract

It is possible to identify the clinical difference between schizophrenia and borderline personality disorder without difficulty, but when BPD is in comorbidity with an addictive disorder, there is a risk of misdiagnosis, leading to inappropriate treatment and consequent implications. The aim of this article is to highlight the main clinical differences between the two disorders, presenting the case of a patient with a long history of psychiatric symptoms that began in adolescence, with functional impairment and an initial diagnosis of schizophrenia. During the last hospitalization and territorial follow-up, the patient responded positively to psychotherapy and psychotropic drugs, pushing the diagnosis toward borderline personality disorder in comorbidity with an addictive disorder that was also the cause of acute psychotic episodes.

Keywords: Case report, Borderline Personality Disorder, Addiction Disorder, Substance use Disorder, Dual Diagnosis, Schizophrenia, Differential Diagnosis

Introduction

Borderline Personality Disorder (BPD) is characterized by a pervasive pattern of instability in controlling impulses, regulating emotions, managing interpersonal relationships and forming a stable self-image. People with BPD are inherently vulnerable to heightened emotional states and to stressful social and interpersonal interactions.

Besides making frequent use of healthcare services, clinically they may engage in self-destructive and/or high-risk sexual behaviors, are prone to aggressive outbursts, report physical complaints and often have substance misuse problems. Individuals with BPD commonly experience additional psychiatric disorders, including mood disorders, substance use disorders (SUDs), eating disorders, post-traumatic stress disorder, ADHD and other personality disorders.

Patients with both BPD and a substance-related disorder tend to be more impulsive and clinically less stable than those with BPD only. While differentiating the hyperemotional pattern of BPD from schizophrenia, characterized by delusions and emotional unresponsiveness, is typically straightforward, challenges arise when BPD patients exhibit micro-psychotic symptoms or brief psychotic episodes, which are not uncommon. These features, particularly auditory hallucinations, are more prevalent in BPD than commonly recognized, and may be attributed to the use of psychoactive substances.

Psychotherapy stands as the preferred treatment for BPD, with various approaches available, although no single method has demonstrated clear superiority. Evidence supporting the efficacy of pharmacological treatment for the core features of BPD remains limited. Nevertheless, early diagnosis and intervention may help to significantly relieve patient suffering and reduce societal costs.

Case Report

This is a clinical observation involving one subject, a 46-year-old woman who came to our attention at the psychiatric hospital upon referral from her treating psychiatrist. The request was for a voluntary protective admission due to a resumption of cannabinoid, cocaine and alcohol use. Upon admission, the patient was taking Haloperidol 10 mg per day, Topiramate 200 mg per day, Clonazepam 2 mg per day, and Zolpidem 12.5 mg per day. The referring psychiatrist requested a review of the pharmacological therapy, but strongly recommended not discontinuing Haloperidol 10 mg per day, considering it an extremely effective medication. The patient was admitted to the hospital department dedicated to the treatment of substance use disorders.

At the time of admission, the patient's medical history was collected from both the patient and her accompanying mother. It emerged that at the age of 17 the patient had undergone her first admission to a psychiatric clinic for substance use and a probable drug-induced psychosis, but was discharged with a diagnosis of schizophrenia.

During that turbulent period, the patient used various psychoactive substances, including LSD and cocaine, extensively. Unfortunately, during that time her social circle was closely tied to substance use, and for an extended period she had relationships with men facing multiple substance use issues, like herself. The first admission was initiated by the patient's family, after she experienced a psychotic decompensation. For several years, she was treated with low doses of Olanzapine, with reported benefits according to her mother.

Despite these challenges, the patient completed university, worked as a journalist and maintained a certain psychological balance, avoiding psychiatric hospitalizations and sustaining employment and positive social relationships. Subsequently, she underwent 3-month compulsory hospitalization in 2007 at the age of 30.

During the admission interview, she presented as extremely eccentric, initially uncooperative and inadequate. After several minutes, she managed to relax minimally, accepting pharmacological therapy. She appeared well-groomed but poorly oriented in various domains. There were marked alterations in thought form and content, with circumstantial responses and flight of ideas. The mood was extremely dysphoric, with continuous shifts between laughter and tears, displaying incongruent affectivity. Suicidal ideation was present.

A pharmacological therapy was initiated with Olanzapine and Diazepam, complemented by regular support sessions, occupational therapy and group therapy. After a few days of extreme withdrawal, the patient gradually became more accessible to inner experiences, showing her readiness to accept support and engage in therapeutic relationships, admitting an inability to control the situation and demonstrating a reasonable illness insight. Initially resistant to talking with her family members, she later accepted visits from her mother and sister, with whom therapy sessions were conducted.

During hospitalization, a significant psychological improvement was observed, leading to the acceptance of the proposed therapy and appropriate reactions to various frustrations encountered during the stay. The patient was discharged on Quetiapine 800 mg per day and Risperidone 4 mg per day.

From 2007 to 2022, there were no hospitalizations, only outpatient check-ups. During the last admission in 2022, the patient presented with acute alcohol intoxication. Additionally, she exhibited hypomimia and perplexity, engaged in conversation with a monotone speech and provided poor responses. There was moderate ideational slowing with a tendency toward concrete thinking, although with valid associative links and an absence of clear delusional content or perceptual disturbances. A restricted affect was noted, with partial illness insight. The patient reported substance use characterized by a dependence syndrome, persistent and repetitive use despite harmful consequences, an intense search for substances, priority given to them and withdrawal symptoms during cessation, which were also documented during hospitalization. Urine toxicology screening tests were positive for psychoactive substances. Alterations in persecutory thought content and bizarre behavioural patterns were also observed.

During the first part of hospitalization, there were repeated episodes of leaving the hospital and acute intoxication with alcohol and cocaine, accompanied by hypervigilance, endopsychic tension, dysphoria, incongruous laughter, verbal and physical aggression towards objects, an exacerbation of persecutory delusional thought content and promiscuous sexual behaviors. Additionally, the patient refused the prescribed pharmacological therapy on several occasions or demanded the use of certain psychotropic medications without specific indications. Due to the acute psychopathological state, posing a risk to herself and others, and a lack of illness insight, voluntary hospitalization was transformed into compulsory medical treatment.

Regarding pharmacological treatment, Pregabalin 400 mg per day was introduced for the anxious component, and Trazodone 50 mg per day was prescribed as a sleep aid, while maintaining the remaining therapy. Oral and intramuscular antipsychotics and benzodiazepines were used to control psychomotor agitation. During hospitalization, the patient demonstrated an inability to manage her daily life adequately and attend to her administrative and financial interests independently.

Psychological intervention was initiated to work on recognizing and managing emotions and addressing the relationship with psychoactive substances. Psychodiagnostic tests, including MMPI-2, Rorschach test, and SCID-5-PD, confirmed the diagnosis of borderline personality disorder in comorbidity with a severe substance use disorder and induced acute psychotic episodes.

Considering the patient's evident difficulties in home management, her mother informed the clinicians that she had reported to the relevant authority to initiate social support interventions upon discharge. Toward the end of hospitalization, in the absence of substance use, the patient was able to conduct a clinical interview, engage in conversation, and did not exhibit perceptual distortions or delusional symptoms. However, emotional dysregulation, underlying impulsivity, an inability to recognize her own identity and craving for psychoactive substance use were still evident.

The patient underwent psychological therapy alongside a revision of psychopharmacological therapy. At discharge, the prescribed therapy included Haloperidol 10 mg per day, Pregabalin 400 mg per day, Topiramate 200 mg per day, and Trazodone 50 mg per day. At the end of a 45-day hospital stay, there was a progressive improvement in the clinical picture, and the patient

showed increased cooperation with the treatment plan, although a tendency toward medication-seeking behavior and bizarre behavioral attitudes persisted.

After discharge, the patient continued her treatment through outpatient care, with no further hospitalizations deemed necessary.

Discussion

In the described clinical case, it is evident that the initial diagnosis of schizophrenia has been reconsidered in favor of a diagnosis of borderline personality disorder in comorbidity with multiple substance use and induced acute psychotic episodes (6, 7). Borderline personality disorder (BPD) includes a variety of clinical features and symptoms, which may also be associated with other mental disorders. As different types of disorders respond to distinct treatment interventions, accurate diagnosis is crucial [2].

Individuals with BPD often develop substance-related disorders or addiction at some time in their lives. Those with comorbid substance addiction report higher levels of impulsivity and lower clinical stability than BPD patients without substance dependence. They exhibit a higher prevalence of suicidal behavior, experience shorter abstinence periods and they are more likely to discontinue treatment. When borderline personality disorder co-occurs with addiction, a specialized therapeutic approach is required [8].

Borderline personality disorder (BPD) is fundamentally characterized by emotion dysregulation, and it often manifests through maladaptive coping mechanisms such as substance use and efforts to avoid abandonment.

Distinguishing BDP hyperemotional pattern from schizophrenia, characterized by delusions and/or emotional unresponsiveness, is generally not challenging. However, difficulties may arise when BPD patients exhibit brief psychotic episodes or symptoms such as auditory hallucinations, which are more frequent than commonly recognized [1, 2, 10, 11]. The presence of psychotic symptoms in BPD, which can also be severe, is challenging for clinicians making a differential diagnosis between BPD and Psychosis Spectrum Disorders.

Considering the specificity of needs and interventions for each different condition, it would be advisable to use a dimensional approach, rather than a categorical one, along with distinct care pathways and monitoring [10].

The phenomenon of splitting refers to the breakdown of conscious experience. It manifests distinct processes in borderline personality disorder (BPD) and in schizophrenia. In BPD, splitting gives rise to mental instability, whereas in schizophrenia, according to Bleuler's historical notion of splitting, the fragmentation of the mind results in associative splitting, evidenced by reduced scores in verbal fluency [12, 13].

Dissociation may also be an important factor in both schizophrenia and borderline personality disorder (BPD), but only few empirical studies have compared specific manifestations of related symptoms in the two conditions.

BPD and schizophrenia can often co-occur, with BPD negatively affecting the course and outcome of those suffering from schizophrenia. The presence of this type of comorbidity has an impact on diagnostic classification and treatment choices [14].

Delusions and hallucinations are quite common in individuals with BPD and may lead them to distress. Their presence can be intermittent or persistent; persistent hallucinations can disrupt daily life [14].

Psychotic symptoms, including auditory verbal hallucinations (AVH), in BPD are similar to those occurring in psychotic disorders. The presence of both BPD and psychotic symptoms is indicative of psychopathology severity and may lead to poor outcomes, including suicidality [15, 16].

Healthcare professionals should carefully assess the presence of psychotic symptoms, such as auditory hallucinations (AVH) and delusions, in patients with borderline personality disorder (BPD). In fact, AVH in BDP should be regarded as real and genuine as those experienced by patients with another psychotic disorder presented in the DSM-5, and should not be defined as "pseudo-hallucinations", which may contribute to the stigma already experienced by individuals with BPD. Psychotic symptoms in borderline personality disorder should not be evaluated as stress-related and transient delusional ideations; therefore, the diagnostic criteria for BPD should be reassessed in both the ICD and the DSM-5 [6, 7, 14, 15].

It is possible for these patients to have both BPD and psychosis. Furthermore, psychotic symptoms may be related to a more severe disorder. Differently from delusions and hallucinations, commonly experienced by individuals with BPD, the co-occurrence of negative psychotic symptoms and disorganization rarely tends to manifest in BPD and could be signs of a more severe illness. Treatment planning for individuals with BPD and psychotic symptoms should take into consideration that these patients are at higher risk of having various poor outcomes [14-16].

It is crucial to make an early and accurate diagnostic assessment to provide the most appropriate treatment path, improving the quality of life for individuals with BPD. Patients with borderline personality disorder and comorbid addiction should receive early intervention for both conditions.

Conflict of Interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Author Contributions

Daniele Mastromo: Conception and design, drafting the article and revising it critically, final approval of the version to be published, agreement to be accountable for all aspects of the work.

Aldo De Pietra: Conception and design, drafting the article and revising it critically, final approval of the version to be published, agreement to be accountable for all aspects of the work.

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Scope Statement
Starting from a clinical case that occurred at our Psychiatric Clinic, this study aims to investigate borderline personality disorder features and differences from schizophrenia, which the patient involved had been previously diagnosed with.

Conflict of Interest Statement
The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Credit Author Statement
Daniele Mastromo: Conception and design, drafting the article and revising it critically, final approval of the version to be published, agreement to be accountable for all aspects of the work.

Aldo De Pietra: Conception and design, drafting the article and revising it critically, final approval of the version to be published, agreement to be accountable for all aspects of the work.

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Ethics Statements
No animal studies are presented in this manuscript. Ethical approval was not required for the studies involving humans because the treatment was performed in accordance with the regulations for research as stated in the Declaration of Helsinki. The study was conducted in accordance with the local legislation and institutional requirements.

Data Availability Statement
The original contributions presented in the study are included in the case report, further inquires can be directed to the corresponding author

References

1. Leichsenring F, Fonagy P, Heim N, Kernberg O F, Leweke F, et al. (2024) Borderline personality disorder: a comprehensive review of diagnosis and clinical presentation, etiology, treatment, and current controversies. Official Journal of World Psychiatric Association (WPA) 23: 4-25.
2. Mendez-Miller M, Naccarato J, Radico J A (2022) Borderline Personality Disorder. Am Fam Physician 105: 156-161.
3. Paris J (2018) Differential Diagnosis of Borderline Personality Disorder. Psychiatric Clinics of North America 41: 575-582. doi: 10.1016/j.psc.2018.07.001
4. Stone M H (2022) borderline personality disorder: Clinical Guidelines for Treatment. Psychodyn Psychiatry 50: 45-63. doi: 10.1521/pdps.2022.50.1.45
5. Falk Leichsenring, Nikolas Heim, Frank Leweke, Carsten Spitzer, Christiane Steinert, et al. (2023) borderline personality disorder: A Review. JAMA 329: 670-679. doi: 10.1001/jama.2023.0589.
6. Michael B First (2013) American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association 201: 727-729.
7. World Health Organization (1992) International Statistical Classification of Diseases and Related Health Problems. 10th Revision. Geneva. World Health Organization (1992).
8. Kienast T, Stoffers J, Bermpohl F, Lieb K (2014) Borderline personality disorder and comorbid addiction: epidemiology and treatment. Dtsch Arztebl Int 16: 280-286. doi: 10.3238/arztebl.2014.0280.
9. Miranda Bethanie Snow, Caroline Balling, Mark Zimmerman (2020) Re-examining borderline personality disorder and substance use disorder: The role of emotion dysregulation. Ann Clin Psychiatry 3: 170-175.
10. Arianna Biancalani, Lorenzo Pelizza, Marco Menchetti (2023) Borderline personality disorder and early psychosis: a narrative review. Ann Gen Psychiatry 22: 44. doi: 10.1186/s12991-023-00475-w.
11. Bahorik A L, Eack S M (2010) Examining the course and outcome of individuals diagnosed with schizophrenia and comorbid borderline personality disorder. Schizophrenia Research 124: 29-35. doi.org/10.1016/j.schres.2010.09.005.
12. Pec O, Bob P, Raboch J (2014) Splitting in Schizophrenia and Borderline Personality Disorder. PLoS One 9: e91228. doi: 10.1371/journal.pone.0091228
13. Pec O, Bob P, Raboch J (2014) Dissociation in schizophrenia and borderline personality disorder. Neuropsychiatr Dis Treat 10: 487-491. doi: 10.2147/NDT.S57627.
14. Maria B A Niemantsverdriet, Rosemarij J B van Veen, Christina W Slotema, Ingmar H A Franken, Marc J P M Verbraak, et al. (2022) Characteristics and stability of hallucinations and delusions in patients with borderline personality disorder. Comprehensive Psychiatry 113: 152290 doi.org/10.1016/j.comppsych.2021.152290.
15. Marialuisa Cavelti, Katherine Thompson, Andrew M Chanen, Michael Kaess (2021) Psychotic symptoms in borderline personality disorder: developmental aspects. Current Opinion in Psychology 37: 26-31. doi.org/10.1016/j.copsyc.2020.07.003.
16. Slotema C W, Blom J D, Niemantsverdriet M B A, Deen M, Sommer I E C (2018) Comorbid Diagnosis of Psychotic Disorders in Borderline Personality Disorder: Prevalence and Influence on Outcome. Front. Psychiatry 9: 84. doi.org/10.3389/fpsyt.2018.00084.