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Antisocial and borderline personality disorders revisited

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Abstract

Antisocial personality disorder (ASPD) and borderline personality disorder (BPD) have an overlap in both symptoms and risk factors, suggesting that they might reflect the same form of psychopathology, shaped by gender. However other lines of evidence point to the presence of partly unique, albeit overlapping, trait dimensions, specifically affective instability which differentiates BPD from ASPD. Our conclusion is that ASPD and BPD are separate disorders.

1. Defining disorders

Fifteen years ago, our research group [1] suggested that ASPD and BPD could have a common base in personality traits, and that their behavioral differences could be largely attributable to gender. This review aims to update research on these relationships, and to reconsider earlier conclusions.

To examine this question, we conducted a literature search. Using the keyword "antisocial personality disorder and borderline personality disorder", we found 331 articles published since 1950, but of these, only 31 were relevant to the issue of differential diagnosis. The selection was augmented by including papers that examine theoretical issues related to our question.

ASPD has a very large empirical literature. First described in the early nineteenth century, terms such as psychopathy, sociopathy, or dyssocial personality have also been used to describe this clinical picture [2]. While dissocial personality is the preferred term in the International Classification of Diseases [3], psychopathy describes a more specific syndrome emphasizing abnormal personality traits rather than criminal and irresponsible patterns of behavior [4], and some of these traits can be identified early in development [5].

In DSM-5 [6], patients must meet overall criteria for a personality disorder: impairments in self and interpersonal relationships, associated with pathological personality traits. DSM-5 requires general overall criteria for a personality disorder, with a characteristic trait profile marked by antagonism (manipulativeness, deceitfulness, callousness, and hostility) and disinhibition (irresponsibility, impulsivity, and risk-taking). The requirement in DSM-IV [7] that conduct disorder beginning before the age of 15 must be present has been removed, but predisposing traits are assumed to be stable from childhood to adulthood. Callousness, the hallmark of psychopathy [5], defined as the absence of concern or guilt over painful experiences felt or induced in others, is listed as a modifier in children with conduct disorder. As before, a diagnosis of ASPD can only be made in patients aged 18 or over.

BPD, which also has a large empirical literature, is defined in DSM-5 by a personality trait profile consisting of negative affectivity (emotional lability, anxiousness, separation insecurity, depressiveness) disinhibition (impulsivity and risk-taking), and antagonism (hostility). Thus the last two domains overlap both disorders, while negative affectivity, particularly affective instability (also called emotional lability or emotional dyresgulation), is more unique to BPD. One does not usually see this feature in ASPD, in which comorbidity for anxiety and depression may be present, but emotions tend to be shallow [2]. In research, these symptoms are often understood as reflecting affective instability [8], also called emotional dysregulation [9], and have been considered to be a core feature of BPD. Moreover, antagonism takes a different form in BPD: instead of the manipulativeness, deceitfulness, and callousness that characterize ASPD, one sees persistent anger in response to slights. Finally, while disinhibition is common to both disorders, it also presents differently: ASPD patients take advantage of others, and are irresponsible, impulsive, and risk-taking, but BPD patients, due to their interpersonal

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difficulties, often find themselves in abusive or violent relationships, leading to higher rates of victimization [10]. There is no age requirement for BPD, and the definition gives little weight to cognitive symptoms, chronic depersonalization, subdelusional paranoid trends, and auditory hallucinations that have been shown to differentiate patients with BPD from those with other forms of personality disorder [11]. However, similar phenomena, transient and stress-related, can be seen in ASPD [2]. In summary, while there remains an overlap, the trait profiles described in DSM-5, particularly the predominance of affective instability in BPD, point to major differences between these disorders.

2. Epidemiological and clinical surveys

ASPD was the first personality disorder for which epidemiological surveys measured community prevalence [12,13]. However, prevalence has ranged greatly in different studies [14–18]. If the higher numbers, approaching 4%, are correct, then ASPD would be one of the more common mental disorders. While it presents less often in clinical settings [19], it may be present as a comorbid diagnosis when other complaints are prominent. In all studies, ASPD is about five times as common in men as in women. Most epidemiological studies of BPD [10–14] have found BPD to be less common than ASPD, with a prevalence of less than 1%, or no higher than 2% [20]. While one study [21] found a much higher prevalence for BPD (over 6%), this probably reflects an error in methodology, and re-analysis of the data using more stringent criteria [20] produced a rate consistent with other research.

The effects of gender are crucial for whether or not ASPD and BPD are separate or similar disorders. While clinical populations of BPD are largely female [10], community studies, with one exception [17], have found an equal prevalence of men and women [14]. This surprising finding could be explained if men with BPD are less help-seeking than women, and/or if they tend to have more "subsyndromal" features of the disorder [22]. It is also possible that a failure to observe gender differences reflects a loose definition of BPD. There are problems with the polythetic DSM-IV criteria, in that many different combinations of symptoms can produce the same diagnosis [23]. For this reason, some researchers have developed a semi-structured interview to identify a narrower range of patients with more severe symptoms and problems in multiple domains [24]. Finally, in clinical samples of men with BPD, comorbidity between ASPD and BPD is rare [25].

Both ASPD and BPD seem to have increased in prevalence since the Second World War. There is good support for cohort effects in ASPD, but the evidence for increases in BPD is indirect [26], based on increases in accompanying symptoms (parasuicide, youth suicide, and substance abuse). Research shows cross-cultural differences in the prevalence of ASPD: for example, Taiwan [27] and Japan [28] have low rates, while Korea has a higher prevalence [29]. Unfortunately, there have been no systematic cross-cultural studies of that kind on BPD. It has been hypothesized that this disorder is uncommon in traditional societies, but is increasing in urban areas around the world [26,30].

3. Risk factors

Like other mental disorders, ASPD and BPD can be understood in a biopsychosocial model [31]. Genetic factors account for approximately 40% of the variance in both personality dimensions [32] and disorders [33]. Although twin studies have not been conducted on ASPD, heritability has been established for criminality [34], and for behavioral patterns and traits related to the disorder [35]. In BPD, twin studies find that genetic factors account for nearly half the variance [33]. However, the nature of the vulnerabilities to both disorders is unknown: while a relationship between impulsive and affective trait dimensions with central serotonergic activity has been suggested in BPD [36], no specific genetic polymorphisms or biomarkers have been identified.

The psychosocial risk factors for ASPD and BPD clearly overlap. In ASPD, paternal antisocial features, associated with family dysfunction and parental inconsistency, are long established risks [37]. Studies of psychological factors in BPD strongly implicate parental psychopathology family dysfunction, and psychological trauma, with similar risks in males and females [38]. However, since these risk factors are not specific to any mental disorder, their presence in both ASPD and BPD cannot determine whether they should be considered separate.

4. Outcome and treatment

A comprehensive study of ASPD outcome [39] found that by late middle age, most patients no longer meet criteria, but that many continue to suffer from severe interpersonal problems and poor work histories. In general, impulsivity is a trait that tends to "burn out" as people grow older [40]. Studies of the long-term outcome of BPD, both retrospective [41], and prospective [42,43], paint a similar picture. Most patients are no longer diagnosable by middle age, largely due to reduced impulsivity, while many achieve stable employment, and about half eventually find a stable partner. While both disorders have suicide rates ranging from 5% to 10% [44], the overall prognosis of BPD is somewhat more favorable, while that of ASPD is largely unfavorable. There is also evidence for increased mortality in ASPD, associated with risk-taking behaviors and the possibility of becoming a victim of homicide [2]. These findings point to an essential distinction between the two disorders.