# Borderline not Bipolar!

Fiore Lalla, MDCM, FRCP

# Today.....

***as a result of attending this session, participants will be able to:***

One. Detect borderline pathology as a cause of resistant psychiatric illness.

Two. Properly refer affected individuals to resources in the public and private sector.

Three. Educate patients about the disorder and give them some optimistic hope.

# Conflicts…

- Speaker receiving honoraria from:
  - Lundbeck, Sunovion, Otsuka, Takeda, Janssen, HLS
  - No “specific” pharmacological treatments are mentioned or endorsed in this presentation
  - I like tuna steak, warm cornbread, and sunny afternoons

# Riddle me this….

- Rapid cycling bipolar disorder is a stable subtype of the illness: T/F
- 15 years into borderline history, a patient has what probability of remission:20, 40, 65, 75%?
- Up to how many adhd patients are borderline: 15,30,35 %
- What is the most frequent presentation of a borderline in family practice: suicidality, depression, somatization, or anxiety?
- Which class of drugs appears to cover the most symptom types in borderline? Antidepessants, mood stabilizers, or antipsychotics?
- *In the community,* what is the F:M ratio of borderlines: 5:1, 3:1, 1:1?

**TABLE 1.** Diagnostic criteria for borderline personality disorder

| A pervasive pattern of instability of interpersonal relationships, self image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following: |
|---|
| 1. Frantic efforts to avoid real or imagined abandonment.<br>Note: Do not include suicidal or self-mutilating behavior covered in criterion 5. |
| 2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation |
| 3. Identity disturbance: markedly and persistently unstable self image or sense of self |
| 4. Impulsivity in at least two areas that are potentially self damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).<br>Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5. |
| 5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior |
| 6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days) |
| 7. Chronic feelings of emptiness |
| 8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights) |
| 9. Transient, stress-related paranoid ideation or severe dissociative symptoms |

American Psychiatric Association, *DSM-IV-TR*: 710[2]

## Borderline personality disorder: Commonly reported features

| |
|---|
| Impulsivity |
| Unstable relationships |
| Unstable self-image |
| Affective instability |
| Fear of abandonment |
| Recurrent self-injurious or suicidal behavior |
| Feelings of emptiness |
| Intense anger or hostility |
| Transient paranoia or dissociative symptoms |

## Clinician biases that may favor a bipolar disorder diagnosis, rather than BPD

| |
|---|
| Bipolar disorder is supported by decades of research |
| Patients with bipolar disorder are often considered more “likeable” than those with BPD |
| Bipolar disorder is more treatable and has a better long-term outcome than BPD (although BPD is generally characterized by clinical improvement, whereas bipolar disorder is more stable with perhaps some increase in depressive symptom burden) |
| Widely thought to have a biologic basis, the bipolar diagnosis conveys less stigma than BPD, which often is less empathically attributed to the patient’s own failings |
| A bipolar diagnosis is easier to explain to patients than BPD; many psychiatrists have difficulty explaining personality disorders in terms patients understand |

BPD: borderline personality disorder

# EPIDEMIOLOGY

- The point prevalence of BPD is 1.4 percent and the **lifetime prevalence is 5.9 percent**. (vs 1-2.5% Bipolar I and ll)
- Studies in clinical settings found BPD was present in **6.4 percent of urban primary care patients**, 9.3 percent of psychiatric outpatients, and approximately 20 percent of psychiatric inpatients
- The ratio of females to males with the disorder is greater in clinical populations than it is in the general population. **The ratio is 3:1 in clinical settings**.
- Multiple epidemiologic surveys of the United States general population have found the lifetime prevalence of BPD **does not differ significantly between men and women.**
- This discrepancy suggests that **women with BPD** are more likely to seek treatment than men.
- In a study of patients with BPD, men and women were found to have **similar rates of childhood-trauma** history and levels of current psychosocial functioning.

# Borderline Personality in the Medical Setting

*Randy A. Sansone, MD, and Lori A. Sansone, MD*

- Patients with borderline personality disorder tend to present with different symptoms **as a function of treatment setting.**

- **Mental health settings: present with relationship difficulties, mood lability/dysphoria, and graphic self-harm behavior**.

- ***In primary care settings, patients with this disorder tend to present with pain sensitivity and somatic preoccupation***.

- The characteristic symptoms observed in patients with borderline personality in primary care settings (ie, pain sensitivity/syndromes, somatic preoccupation) have been described in the literature by a number of clinicians and verified by a number of investigators, including the authors.

# Physician's reactions to the borderline

- Does the patient…
  - Try to make you feel especially good or deficient?
  - Switch opinion of you radically?
  - Give you a strong sense of wanting to reject them?
  - Divide other treators into good or bad categories?
  - Spark disagreements amongst staff?

# Distinguishing bipolar, borderline (BPD), and adhd

- Probably the most important distinguishing characteristic is that the borderline displays symptoms and behaviors in response to a perceived environment that is rejecting or invalidating.
- The other patient types display their symptoms across environments, often without provocation and independent of stimulus or stress.
- Overlap of borderline and bipolar diagnoses not frequent (less than 10% in each).
- The borderline wants a bipolar diagnosis

# Key distinguishing features

Quality of mood episodes

Types of impulsivity

Longitudinal course

# Mood differences

- In BPD, mood swings, usually of negative affect, are triggered by interpersonal stressors or perceived stressors, are transient, last from minutes to hours, and are highly dependent on the environment.
- In bipolar disorder, mood swings are more spontaneous and of longer duration (weeks/months not hours/days), especially for bipolar I disorder, and there are *extended periods of elation.*
- In addition, in bipolar disorder, acute episodes and symptom-free intervals occur, while in BPD, the affective instability is part of a characteristic pattern of emotional responding
- Rapid cycling mood states are rarer and ***transitory***

REVIEW ARTICLE

# Rapid Cycling in Bipolar Disorder: A Systematic Review

*André F. Carvalho, MD, PhD; Dimos Dimellis, MD, PhD; Xenia Gonda, MA, PharmD, PhD; Eduard Vieta, MD, PhD; Roger S. McIntyre, MD, FRCPC; and Konstantinos N. Fountoulakis, MD, PhD*

The only confirmed close relationship of rapid cycling is that to female gender, while connections to specific bipolar subtype, depressive predominant polarity, treatment with antidepressants, and several biological factors are not universally accepted or documented beyond doubt.

# Impulsivity

- Clinically, impulsivity is believed to be more episodic in bipolar disorder than in BPD, although inter-episode impulsivity is seen in bipolar disorder when comorbid substance abuse complicates the clinical picture.
- Impulsive acts such as suicidal behavior occur in both disorders, but in bipolar disorder these are predominantly found in the *depressive phase and they are related to hopelessness while in BPD, they are often a function of the inability to tolerate acute distress and made out of anger*

# Course

- Many cases of bipolar disorder assume a chronic depressive course, with long-term morbidity and substantial inter-episode symptomatology, whereas multiyear follow-up studies of patients with BPD have found that most people eventually stop meeting threshold criteria for the disorder

# Diagnosing borderline personality disorder

Robert S. Biskin MD, Joel Paris MD

Retrospective studies have shown that symptoms resolve over time, with 75% of patients at 15-year follow-up and 92% of patients at 27-year follow-up no longer having the disorder.[8,9] One large, well-conducted 10-year prospective study found that 93% of those with borderline personality disorder had at least a 2-year period of remission, but only 50% also attained good psychosocial functioning.[10]

# McLean Screening Instrument for Borderline Personality Disorder

| | |
|---|---|
| 1. Have any of your closest relationships been troubled by a lot of arguments or repeated breakups? | 1 = yes 0 = no |
| 2. Have you deliberately hurt yourself physically (e.g., (punched yourself, cut yourself, burned yourself)? How about made a suicide attempt? | 1 = yes 0 = no |
| 3. Have you had at least two other problems with impulsivity (e.g., eating binges and spending sprees, drinking too much and verbal outbursts)? | 1 = yes 0 = no |
| 4. Have you been extremely moody? | 1 = yes 0 = no |
| 5. Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner? | 1 = yes 0 = no |
| 6. Have you often been distrustful of other people? | 1 = yes 0 = no |
| 7. Have you frequently felt unreal or as if things around you were unreal? | 1 = yes 0 = no |
| 8. Have you chronically felt empty? | 1 = yes 0 = no |
| 9. Have you often felt that you had no idea of who you are or that you have no identity? | 1 = yes 0 = no |
| 10. Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g., repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, clung to them physically)? | 1 = yes 0 = no |

# Zanarini BPD screening instrument: Francais

1) Est-ce qu'il vous est déjà arrivé que vos relations les plus proches aient été perturbées par beaucoup d'arguments ou des ruptures répétées ?

2) Est-ce que vous vous êtes déjà automutilé(e)s (ex. en vous coupant, en vous brûlant, en vous donnant des coups) ? Avez-vous déjà fait une tentative de suicide ?

3) Avez-vous déjà eu au moins 2 autres problèmes d'impulsivité ? (ex. surconsommation de nourriture, d'argent ou d'alcool, des emportements ou des crises verbales, etc.)

4) Avez-vous déjà été d'humeur changeante ?

5) Est-ce que vous avez déjà ressenti beaucoup de colère et ce de façon fréquente ? Avez-vous déjà souvent réagi de façon sarcastique ou colérique ?

6) Est-ce que vous vous êtes déjà méfié(e)s d'autres personnes et ce de façon fréquente ?

7) Est-ce que vous vous êtes déjà senti(e)s surréel(le) ou comme si tout ce qui vous entourait était surréel ?

8) Est-ce que vous vous êtes déjà senti(e)s chroniquement vide ?

9) Est-ce que vous avez déjà senti que vous ne vous connaissiez pas ou que vous n'aviez pas d'identité ?

10) Avez vous déjà fait des efforts désespérés pour éviter de vous sentir abandonné(e) et/ou pour éviter d'être abandonné (ex. appeler quelqu'un de façon répétitive pour vous assurer que vous êtes importants pour eux, leur prier de rester avec vous, leur tenir physiquement)?

# Screening for Bipolar Disorder and Finding Borderline Personality Disorder

Mark Zimmerman, MD; Janine N. Galione, BS; Camilo J. Ruggero, PhD; Iwona Chelminski, PhD; Diane Young, PhD; Kristy Dalrymple, PhD; and Joseph B. McGlinchey, PhD

***Conclusions:*** Positive results on the MDQ were as likely to indicate that a patient has borderline personality disorder as bipolar disorder. The clinical utility of the MDQ in routine clinical practice is uncertain.

# QUESTIONNAIRE SUR LA SANTÉ DU PATIENT – 9 (PHQ-9)

| **Au cours des 2 dernières semaines, selon quelle fréquence avez-vous été gêné(e) par les problèmes suivants ?** *(Veuillez cocher (✔) votre réponse)* | **Jamais** | **Plusieurs jours** | **Plus de la moitié du temps** | **Presque tous les jours** |
|---|---|---|---|---|
| **1.** Peu d'intérêt ou de plaisir à faire les choses | 0 | 1 | 2 | 3 |
| **2.** Être triste, déprimé(e) ou désespéré(e) | 0 | 1 | 2 | 3 |
| **3.** Difficultés à s'endormir ou à rester endormi(e), ou dormir trop | 0 | 1 | 2 | 3 |
| **4.** Se sentir fatigué(e) ou manquer d'énergie | 0 | 1 | 2 | 3 |
| **5.** Avoir peu d'appétit ou manger trop | 0 | 1 | 2 | 3 |
| **6.** Avoir une mauvaise opinion de soi-même, ou avoir le sentiment d'être nul(le), ou d'avoir déçu sa famille ou s'être déçu(e) soi-même | 0 | 1 | 2 | 3 |
| **7.** Avoir du mal à se concentrer, par exemple, pour lire le journal ou regarder la télévision | 0 | 1 | 2 | 3 |
| **8.** Bouger ou parler si lentement que les autres auraient pu le remarquer. Ou au contraire, être si agité(e) que vous avez eu du mal à tenir en place par rapport à d'habitude | 0 | 1 | 2 | 3 |
| **9.** Penser qu'il vaudrait mieux mourir ou envisager de vous faire du mal d'une manière ou d'une autre | 0 | 1 | 2 | 3 |

**FOR OFFICE CODING** 0 + _____ + _____ + _____

**=Total Score:** _____

**Si vous avez coché au moins un des problèmes évoqués, à quel point ce(s) problème(s) a-t-il (ont-ils) rendu votre travail, vos tâches à la maison ou votre capacité à vous entendre avec les autres difficile(s) ?**

| **Pas du tout difficile(s)** | **Assez difficile(s)** | **Très difficile(s)** | **Extrêmement difficile(s)** |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

**TABLE 6–1. Current status of pharmacotherapy for borderline personality disorder (BPD)**

- About 30 randomized controlled trials have been conducted (antipsychotics > antidepressants > mood stabilizers > others), usually with small samples (average size about 40), variable outcome measures, and limited duration.
- No medication is uniformly or dramatically helpful.
- No drug has been licensed by the FDA as an effective treatment for BPD.
- Pharmaceutical company–sponsored research has been limited by disproportionate fears of violent or suicidal acts in patients who receive or do not receive medications—both incurring possible liability.
- Polypharmacy is associated with multiple side effects, and the effects of augmentation are unknown.
- The number of medications taken is inversely related to improvement.
- Minimal attention has been given to medication effects on interpersonal relationships.

## How should patients be informed of their diagnosis?

Once a diagnosis of borderline personality disorder has been established, it is important to inform the patient of the diagnosis and discuss the implications for treatment options and outcomes. There is no evidence to indicate that informing patients of the diagnosis causes problems, so it is unfortunate that this important step is often omitted.[56]

When informing a patient about a suspected diagnosis of borderline personality disorder, clinical experience suggests that it is helpful to show the patient the list of diagnostic criteria and explain why the diagnosis is being considered.

# Diagnosing borderline personality disorder

Robert S. Biskin MD, Joel Paris MD

**“Even a single psychoeducation session could help to reduce symptoms, as was found in a randomized trial in which 30 of 50 late adolescent women found to have borderline personality disorder were randomly assigned to attend such a session within a week after being told about their diagnosis. Patients can also be directed to specific resources that can provide more information”**

| Disorder | Borderline | Bipolar | ADHD |
|---|---|---|---|
| Type of illness | Character | Mood | Neurological |
| Baseline state | Unhappy, mood swings | Normal | Disorganized |
| Relationships | Unstable, idealize then denigrate | Normal, unless in a severe episode | Stable |
| Impulsivity | Response to environment, intent to harm, “act out” | Normal, unless in a severe episode | Unpredictable and often independent of triggers |
| Chronic emptiness | Yes | No | No |
| Response of treator | Frustrated, angry, rejected (due to primitive defenses) | Helpless in depression or elated in mania | No particular response, often quite likeable |
| Presence of weeks/months of mania, depression | Chronic downs, no sustained elation | Yes, use these in diagnosis | No, use ASRS scale to initiate assessment |
| Epidemiology | 6%, Onset in early adulthood. | 1-2%, Onset in late teens, early adulthood | 5-8%, Onset in early childhood (before age 7); GENETIC |
| Hierarchy of treatment | Treat first | Treat first | Treat last |

# Summary:

- There is a growing recognition of bipolar and ADHD conditions amongst clients seeking medical or psychological consultation
- Clinicians must resist the urge to give these diagnoses given the prevalence and presentation of the borderline personality
- We now have a better understanding of the presentations of these conditions and better evaluation tools to distinguish them.

**Box 3: Resources for patients and clinicians**

*For patients*

- National Institute of Mental Health: www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml
- Borderline Personality Disorder Resource Center: http://bpdresourcecenter.org/
- National Education Alliance for Borderline Personality Disorder: www.borderlinepersonalitydisorder.com/index.html
- Chapman AL, Gratz KL. *The borderline personality disorder survival guide: everything you need to know about living with BPD*. Oakland (CA): New Harbinger Publications; 2007.

*For clinicians*

- National Education Alliance for Borderline Personality Disorder: www.borderlinepersonalitydisorder.com/index.html
- Behavioural Tech, LLC (for clinicians interested in dialectical behaviour therapy): www.behavioraltech.org/index.cfm
- Paris J. *Treatment of borderline personality disorder: a guide to evidence-based practice*. New York (NY): Guilford Press; 2008.
- Gunderson JG, Links PS. *Borderline personality disorder: a clinical guide*. Washington (DC): American Psychiatric Publishing; 2008.