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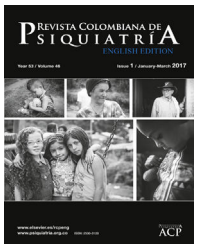

Case Report

Clinical differences between bipolar disorder and borderline personality disorder: a case report

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ABSTRACT

The clinical difference between bipolar disorder and borderline personality disorder has always been a diagnostic challenge, especially with type II bipolar disorder and subthreshold symptoms, opening a diagnostic bias with the consequent repercussions of inappropriate treatment.

Both pathologies are often misdiagnosed initially. The objective of this article is to emphasise the main clinical differences between the two pathologies. We present the case of a patient with a long history of psychiatric symptoms that started in childhood, with considerable functional impairment, who met the criteria for both disorders, pointing to comorbidity. During follow-up, she responded favourably to psychotropic drugs, pushing the diagnosis towards the bipolar spectrum, due to the notable improvement. However, comorbidity should not be neglected due to its high presentation.

Diferencias clínicas del trastorno bipolar y el trastorno límite de la personalidad: a propósito de un caso

Palabras clave:
Trastorno bipolar
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RESUMEN

La diferencia clínica entre el trastorno bipolar y el trastorno límite de la personalidad siempre ha sido un reto diagnóstico, sobre todo con el trastorno bipolar tipo II, y con los cuadros subumbrales, lo cual abre un sesgo diagnóstico con las consiguientes repercusiones de un tratamiento no adecuado. Ambas afecciones reciben en gran proporción un diagnóstico previo equivocado. En este artículo se hace énfasis en las principales diferencias clínicas entre ambas enfermedades. Se presenta el caso de una paciente con una larga historia de síntomas psiquiátricos que se inició en la infancia, con muchas dificultades en su funcionamiento,

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que cumplían criterios de ambos trastornos, lo cual apunta a comorbilidad; en el seguimiento respondió favorablemente a los psicofármacos, y su diagnóstico se inclinó hacia el espectro bipolar, por la notable mejoría. Sin embargo, no debe dejarse de lado la comorbilidad por su alta presentación.

Introduction

Bipolar disorder and borderline personality disorder are serious, chronic psychiatric illnesses. The first is characterised by recurrent episodes of mania, hypomania and depression, or mixed episodes, while the second is characterised by instability and impulsivity in all areas, resulting in a loss of functionality. The prevalence of bipolar disorder is >1% of the world's population,[1] while borderline personality disorder is found in 1.7% of the general population but in 15–28% of patients in psychiatric clinics or hospitals.[2] Both disorders have high comorbidity, such as anxiety disorders, substance use disorders, attention deficit hyperactivity disorder and personality disorders for bipolar disorder,[3] and mood disorders, anxiety disorders, post-traumatic stress disorder, substance use disorders and eating disorders for borderline personality disorder.[4] The risk of suicide is high in both disorders. In bipolar disorder, one-third of patients attempt suicide, with a fatal outcome in 15–20% of cases.[5] Borderline personality disorder is also associated with self-harm and up to 10% of patients commit suicide.[6]

The clinical difference between bipolar disorder and borderline personality disorder has always been a hotly debated diagnostic challenge. Borderline personality disorder has even been considered part of the bipolar spectrum,[7] where diagnoses such as bipolar and related disorders, not otherwise specified of the DSM-5[8] result in bias among clinicians who are not specialised in these illnesses, and bipolar disorder is overdiagnosed.[9] This can be seen in the characteristics of the two disorders, in which symptoms such as impulsivity, affective instability, intense anger, recurrent suicidal behaviour and interpersonal problems often result in diagnostic error. Around 40% of patients with borderline personality disorder have been previously misdiagnosed.[10] To make things even more difficult, comorbidity between the two disorders is high and affects approximately one in every five patients, with even higher rates of comorbidity for bipolar II disorder (affecting up to 37.7% of patients)[11] (Table 1).

Case report

A 25-year-old woman came into the clinic due to affective instability. She reported feelings of anxiety, sadness and irritability, with sadness being the predominant feeling, and dysfunction in all areas. She claimed to have no medical history. With regards to psychiatric history and substance use, she had a major depressive episode at the age of 17, which was treated with paroxetine. She started drinking alcohol at the age of 15 and used to get drunk every weekend, and she used to smoke 3 marihuana joints a month between the ages of 16 and 19. She also said that she had been sexually abused on two occasions at the age of 16 and 20, both times while under the effect of toxic substances. The patient was single, lived with her parents and was a university student.

Her symptoms started during her childhood. She reported having an unstable self-image and impulsiveness and used to constantly compare herself to other children, acting with no thought for the consequences. During her teenage years, she started cutting and binge eating without compensatory behaviours. This went on for a couple of years and, in the patient's own words, was to calm the feeling of emptiness and reduce constant symptoms of anxiety and sadness. At the age of 17, she suffered a major depressive episode with melancholic features, which was treated with paroxetine. The patient declared that she had stopped the drug treatment after 3 months due to feeling a sense of well-being she had never felt before. After a period of apparent improvement, the feeling of emptiness, affective instability, anxiety and irritability returned. She made four low-lethality suicide attempts over the course of a year, all of which were impulsive. She was not admitted as a result of any of the attempts and only received short courses of psychotherapy. The patient reported, more precisely, that from the age of 19 she had episodes when everything seemed to be going well and she had feelings of great inexplicable well-being for several weeks. However, these episodes alternated with periods when everything returned to normal with affective instability, anxiety, irritability, unstable relationships and feelings of worthlessness. When questioned, the patient reported having had a low mood for the last 2 weeks with symptoms of anxiety and irritability, anhedonia, loss of appetite and energy, hypersomnia, thoughts of guilt and worthlessness and occasional reactive thoughts of death. In addition to self-image instability, she had unstable relationships with fear of rejection and chronic difficulty controlling her anger and feelings of emptiness.

Upon psychopathological examination, she was found to be awake, alert and oriented to time, place and person. She was cooperative and her brain age was consistent with her chronological age. She was of average build and her personal appearance was appropriate. She kept adequate eye contact and used normal tone of voice and language. She showed no abnormalities in her way of thinking but had an overvalued thought content of guilt and worthlessness. She had mood swings with anxiety, sadness and irritability, with sadness being the predominant feeling, and appropriate affect. She reported no current suicidal ideation or plans but reported constant thoughts of self-harm, especially dur-

Table 1 – Patient's clinical characteristics.

	Bipolar disorder	Borderline personality disorder
Relatives	• Maternal aunt with bipolar disorder • Family history of depression	• Sister with behavioural problems • Family history of depression
Age of onset	• Childhood onset	• Childhood onset
Clinical course	• It kept getting worse until medicated	• Wait for progression
Depressive symptoms	• She had a melancholic episode at the age of 17	• Multiple reactive symptoms
Suicide and self-harm	• Four suicide attempts and self-harming behaviours	• Four suicide attempts and self-harming behaviours
Symptoms of hypomania	• Inexplicable episodes where everything was going well, with an immense feeling of well-being for several weeks	• Affective instability, devalued self-image and constant anxiety
Context of mood	• Autonomous episodes of hypomania, and one depressive episode at the age of 17; the patient did not report a trigger	• Multiple reactive symptoms
Affective instability	• Episodes of depression and hypomania	• Constant affective instability of high intensity
Impulsivity	• The patient attempted suicide four times, perhaps during a mixed episode	• The patient reports impulsivity since her childhood, with cutting, binge eating and 4 suicide attempts
Psychotic symptoms	• She has not had any psychotic symptoms	• She reports no dissociative symptoms, perhaps transient paranoid ideations
Childhood trauma	• Sexual abuse at the age of 16	• Sexual abuse at the age of 16
Identity	• Improvement in episodes of hypomania	• Unstable self-image since childhood
Interpersonal relationships	• Improvement in episodes of hypomania	• Constant unstable relationships
Temperament	• Cyclothymic and irritable	Cyclothymic and irritable
Comorbidity	• Substance use	• Substance use
Treatment	• Notable improvement with quetiapine	• She did not agree to psychotherapy for her personality disorder

ing times of stress, and occasional thoughts of death. She had sound judgement and reasoning. She showed no psychomotor impairment and reported no sensory or perceptual impairments.

Complementary tests ordered included a full blood count, liver, kidney and thyroid function tests and biochemistry, all of which were normal. Human immunodeficiency virus and hepatitis B and C serology tests were also negative.

The diagnosis of a major depressive episode, with a high index of suspicion of bipolar II disorder due to the periods of well-being when everything seemed to be going well, comorbid with borderline personality disorder was determined. It was decided to start extended-release quetiapine and to titrate this to a dose of 300 mg. The patient was also offered transference-focused psychotherapy, which she rejected due to scheduling issues, despite explaining its benefits due to the comorbidity of bipolar disorder and personality disorder. She therefore continued with supportive therapy and drug management.

Discussion

The case of a female patient with a long history of psychiatric symptoms is presented in this paper. A diagnosis of bipolar II disorder comorbid with borderline personality disorder was determined for this patient. She responded well to medication during follow-up. She changed career with a good outcome (she was suspended from her previous employment), became more independent, achieved a stable romantic relationship and her minimal symptoms during times of stress did not limit her. This case leaned towards a disorder on the bipolar spectrum. The main clinical differences between the two disorders are described below.

Heritability of bipolar disorder is estimated at 80%[12] with bipolar or unipolar first-degree relatives.[13] Borderline personality disorder has a large environmental component and runs in families,[14,15] with first-degree relatives with impulse-control disorder or unipolar depression.[16] The most common age of onset of bipolar disorder is between 12 and 30 years.[17] There is no clear age of onset for borderline personality disorder and patients report feeling low and depressed from childhood.[18,19] Bipolar disorder is a chronic illness, does not remit with age and tends to get worse over time.[20] Borderline personality disorder seems to have a more favourable course, with symptoms improving in middle-aged adults.[21,22] Depressive symptoms in bipolar disorder tend to have atypical, melancholic features, with agitation, mixed symptoms, low self-esteem and self-criticism,[23–25] while borderline personality disorder has non-melancholic, reactive depressive episodes, with feelings of emptiness, painful incoherence and a heightened subjective experience.[18,25,26] Suicide and the risk of self-harm are features of both disorders, with arguably slightly higher rates in borderline personality disorder.[5,6,13,27,28] Another feature of bipolar disorder is hypomania with increased self-esteem, energy, creativity and productivity and there may be irritability during the episode.[10,17,29] Borderline personality disorder tends to show patterns of affective instability, with a devalued self-image and marked anxiety.[29,30] Mixed and rapid-cycling episodes may cause the most confusion.[7,31] Bipolar disorder episodes tend to be autonomous and lack an interpersonal context.[30]

In borderline personality disorder, symptoms tend to be reactive to interpersonal problems, such as frustration or a sense of abandonment.[18,29,32] Affective instability in bipolar disorder tends to result in internally-generated episodic shifts between euthymia, euphoria and depression. Borderline personality disorder results in brief, intense, reactive shifts between euthymia, anxiety, anger and depression.[33–35] Impulsivity tends to manifest in both disorders. In bipolar disorder, it appears particularly during episodes of hypomania, while in borderline personality disorder, it tends to be a long-term, diagnostic feature.[2,6,32,36] Psychotic symptoms tend to be a feature of manic episodes and in bipolar disorder, such symptoms have been reported as being mood congruent in up to 45% of patients.[17,37] In borderline personality disorder, transient dissociative symptoms and paranoid ideation tend to be experienced.[38] Childhood trauma is characteristic of both disorders, although more so in borderline personality disorder (60–80%) than in bipolar disorder (50%).[13] The identity of bipolar patients tends to be stable during euthymia and change to devalued or grandiose, depending on the episode.[30] The identity of borderline personality patients tends to suffer a fragmented sense of self, with emotional pain and loss of identity.[13,39] Bipolar patients tend to have stable interpersonal relationships during euthymia, whereas borderline personality patients have serious, ongoing discrepancies when evaluating others, with a tendency towards idealisation, devaluation and fear of rejection.[2,18] Both types of patient have cyclothymic and irritable temperaments.[2,5,40] Both types of patient have high comorbidity, such as anxiety disorders, substance use disorders, attention deficit hyperactivity disorder and personality disorders for bipolar disorder patients,[3] and mood disorders, anxiety disorders, post-traumatic stress disorder, substance use disorders and eating disorders for borderline personality disorder patients.[4] Bipolar disorder has two treatment phases, an acute phase and a maintenance phase. In both phases, mood stabilisers, antipsychotics and sometimes antidepressants are essential.[17] Drugs are only used in borderline personality disorder for short periods of time to relieve symptoms,[41] and some kind of psychotherapy, such as dialectical behaviour therapy, mentalisation-based treatment or transference-focused therapy, is necessary to improve symptoms.[2]

Conclusions

Differentiating bipolar disorder from borderline personality disorder tends to be a difficult task, especially since they share some features, such as temperament, affective instability, impulsivity, suicide and comorbidity. An in-depth comparison of the clinical differences, with a detailed medical history, is usually essential, always with the support of the patient's closest relatives in the absence of diagnostic tests confirming the diagnosis, in order to avoid diagnostic error and repercussions from improper treatment. Possible comorbidity between the two disorders must never be overlooked.

Conflicts of interest

The authors have no conflicts of interest to declare.

REFERENCES

1. Merikangas KR, Jin R, He JP, et al. Prevalence and correlates of bipolar spectrum disorder in the World Mental Health Survey Initiative. Arch Gen Psychiatry. 2011;68:241–51.
2. Gunderson JG, Herpertz SC, Skodol AE, Torgersen S, Zanarini MC. Borderline personality disorder. Nature Rev Dis Primers. 2018;4:1–21.
3. Merikangas KR, Akiskal HS, Angst J, et al. Lifetime and 12-month prevalence of bipolar spectrum disorder in the national comorbidity survey replication. Arch Gen Psychiatry. 2007;64:543–52.
4. Shah R, Zanarini MC. Comorbidity of borderline personality disorder: current status and future directions. Psychiatr Clin North Am. 2017;41:583–93.
5. Schaffer A, Isometsä ET, Tondo L, et al. International Society for Bipolar Disorders Task Force on Suicide: meta-analyses and meta-regression of correlates of suicide attempts and suicide deaths in bipolar disorder. Bipolar Disord. 2015;17:1–16.
6. Paris J. Suicidality in borderline personality disorder. Medicina (Lithuania). 2019;55.
7. MacKinnon DF, Pies R. Affective instability as rapid cycling: theoretical and clinical implications for borderline personality and bipolar spectrum disorders. Bipolar Disord. 2006;8:1–14.
8. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders: DSM-5. Washington: APA; 2013.
9. Ghouse AA, Sanches M, Zunta-Soares G, Swann AC, Soares JC. Overdiagnosis of bipolar disorder: a critical analysis of the literature. ScientificWorldJournal. 2013;2013:297087.
10. Ruggero CJ, Zimmerman M, Chelminski I, Young D. Borderline personality disorder and the misdiagnosis of bipolar disorder. J Psychiatr Res. 2010;44:405–8.
11. Fornaro M, Orsolini L, Marini S, et al. The prevalence and predictors of bipolar and borderline personality disorders comorbidity: systematic review and meta-analysis. J Affect Disord. 2016;195:105–18.
12. Bienvenu OJ, Davydow DS, Kendler KS. Psychiatric diseases versus behavioral disorders and degree of genetic influence. Psychol Med. 2011;41:33–40.
13. Bassett D. Borderline personality disorder and bipolar affective disorder. Spectra or spectre? A review. Aust N Z J Psychiatry. 2012;46:327–39.
14. Loken EK, Hettema JM, Aggen SH, Kendler KS. The structure of genetic and environmental risk factors for fears and phobias. Psychol Med. 2014;44:2375–84.
15. Distel MA, Trull TJ, Derom CA, et al. Heritability of borderline personality disorder features is similar across three countries. Psychol Med. 2008;38:1219–29.
16. Gunderson JG, Zanarini MC, Choi-Kain LW, Mitchell KS, Jang KL, Hudson JI. Family study of borderline personality disorder and its sectors of psychopathology. Arch Gen Psychiatry. 2011;68:753–62.
17. Bobo WV. The diagnosis and management of bipolar I and II disorders: clinical practice update. Mayo Clin Proc. 2017;92:1532–51.
18. Kernberg OF, Yeomans FE. Borderline personality disorder, bipolar disorder, depression, attention deficit/hyperactivity disorder, and narcissistic personality disorder: practical differential diagnosis. Bull Menninger Clin. 2013;77:1–22.
19. Korner A, Gerull F, Meares R, Stevenson J. The nothing that is something: core dysphoria as the central feature of borderline personality disorder. Implications for treatment. Am J Psychother. 2008;62:377–94.

20. Goodwin FK, Jamieson KR. Manic-depressive illness bipolar, disorders and recurrent depression. 2nd ed. New York: Oxford University Press; 2007.
21. Zanarini MC, Frankenburg FR, Hennen J, Silk KR. The longitudinal course of borderline psychopathology: 6-year prospective follow-up of the phenomenology of borderline personality disorder. Am J Psychiatry. 2003;160: 274–83.
22. Paris J, Zweig-Frank H. A 27-year follow-up of patients with borderline personality disorder. Compr Psychiatry. 2001;42:482–7.
23. Parker GB, Fletcher K. Is bipolar II depression phenotypically distinctive? Acta Psychiatr Scand. 2009;120:446–55.
24. Benazzi F. Agitated depression in bipolar II disorder. World J Biol Psychiatry. 2005;6:198–205.
25. Perugi G, Fornaro M, Akiskal HS. Are atypical depression, borderline personality disorder and bipolar II disorder overlapping manifestations of a common cyclothymic diathesis? World Psychiatry. 2011;10:45–51.
26. Wilson ST, Stanley B, Oquendo MA, Goldberg P, Zalsman G, Mann JJ. Comparing impulsiveness, hostility, and depression in borderline personality disorder and bipolar II disorder. J Clin Psychiatry. 2007;68:1533–9.
27. Joyce PR, Light KJ, Rowe SL, Cloninger CR, Kennedy MA. Self-mutilation and suicide attempts: Relationships to bipolar disorder, borderline personality disorder, temperament and character. Aust N Z J Psychiatry. 2010;44:250–7.
28. Bayes AJ, Mcclure G, Fletcher K, et al. Differentiating the bipolar disorders from borderline personality disorder. Acta Psychiatr Scand. 2016;133:187–95.
29. Parker G. Clinical differentiation of bipolar II disorder from personality-based “emotional dysregulation” conditions. J Affect Disord. 2011;133:16–21.
30. Renaud S, Corbalan F, Beaulieu S. Differential diagnosis of bipolar affective disorder type II and borderline personality disorder: analysis of the affective dimension. Comprehens Psychiatry. 2012;53:952–61.
31. Suppes T, Mintz J, McElroy SL, et al. Mixed hypomania in 908 patients with bipolar disorder evaluated prospectively in the Stanley Foundation Bipolar Treatment Network: a sex-specific phenomenon. Arch Gen Psychiatry. 2005;62:1089–96.
32. Paris J, Gunderson J, Weinberg I. The interface between borderline personality disorder and bipolar spectrum disorders. Comprehens Psychiatry. 2007;48:145–54.
33. Henry C, Mitropoulou V, New AS, Koenigsberg HW, Silverman J, Siever LJ. Affective instability and impulsivity in borderline personality and bipolar II disorders: similarities and differences. J Psychiatr Res. 2001;35:307–12.
34. Reich DB, Zanarini MC, Fitzmaurice G. Affective lability in bipolar disorder and borderline personality disorder. Comprehens Psychiatry. 2012;53:230–7.
35. Koenigsberg HW. Affective instability: toward an integration of neuroscience and psychological perspectives. J Personality Disord. 2010;24:60–82.
36. Moeller FG, Barratt ES, Dougherty DM, Schmitz JM, Swann AC. Psychiatric aspects of impulsivity. Am J Psychiatry. 2001;158:1783–93.
37. Mazzarini L, Colom F, Pacchiarotti I, et al. Psychotic versus non-psychotic bipolar II disorder. J Affect Disord. 2010;126:55–60.
38. Skodol AE, Gunderson JG, Pfohl B, Widiger TA, Livesley WJ, Siever LJ. The borderline diagnosis I: psychopathology, comorbidity, and personaltity structure. Biol Psychiatry. 2002;51:936–50.
39. Meares R, Gerull F, Stevenson J, Korner A. Is self disturbance the core of borderline personality disorder? An outcome study of borderline personality factors. Aust N Z J Psychiatry. 2011;45:214–22.
40. Fletcher K, Parker G, Barrett M, Synnott H, McCraw S. Temperament and personality in bipolar II disorder. J Affect Disord. 2012;136:304–9.
41. Starcevic V, Janca A. Pharmacotherapy of borderline personality disorder: Replacing confusion with prudent pragmatism. Curr Opin Psychiatry. 2018;31:69–73.