Bipolar disorders and borderline personality disorders: two sides, one coin

Sandro Elisei, Norma Verdolini, Serena Anastasi
Division of Psychiatry, Clinical Psychology and Rehabilitation
Department of Clinical and Experimental Medicine - University of Perugia
Santa Maria della Misericordia Hospital - Perugia, Italy
School of Specialization in Psychiatry - University of Perugia

Abstract

Because of their pervasiveness and comorbidity, bipolar disorder and borderline personality disorder represent a broad field of interest for scientific research. Several studies have pointed out that there are positive correlations: affective instability and impulsive behaviour could represent shared characteristics. To understand the relationship between the two disorders fully, the authors underline the importance of recovering the concept of affective temperament and the psychodynamic approach. Finally, we consider the effects of early traumatic experience.

Key words: bipolar disorder; borderline personality disorder; continuum; abuse, trauma.

Introduction

There is currently a heated international debate about the relationship between mood disorders, especially bipolar disorder, and borderline personality disorder (1-8). In fact, much clinical evidence shows that often borderline personality disorder may be clinically difficult to distinguish from bipolar disorder and that patients with bipolar disorder are frequently misdiagnosed with borderline personality disorder (9).

Discussion

It is now more than twenty years since Akiskal first suggested that borderline personality disorder could be better understood as an Axis I disorder within a bipolar affective spectrum (10-11). Akiskal used the concept of spectrum to indicate mild, subclinical and atypical bipolar disorders, including forms of depression with hypomanic episodes, both short-term and long-term, temperamental traits of hyperthymia and cyclothymia and subjects with a family history of bipolar disorder. In a schematic revision of the several forms within the bipolar spectrum Akiskal described at least 7 different clinical subtypes, shown in Table 1 on next page (12).

Table 1. Bipolar spectrum (12)

Bipolar I	Depression plus mania
Bipolar I and 1/2	Depression plus prolonged Hypomania
Bipolar II	Depression plus hypomania
Bipolar II and 1/2	Depression plus cyclothymia
Bipolar III	Depression plus hypomania occurring solely in association with antidepressants
Bipolar III and 1/2	Bipolarity associated with stimulants
Bipolar IV	Depression and hyperthymic temperament

The concept of spectrum points out the existence of a quantitative continuum between phenomena which apparently differ in quality, considering a wide range of psychopathological phenomena including typical, atypical and subclinical symptoms as well as groups of symptoms and behavioural disorders related to the core symptoms. These phenomena may either represent prodromes, precursors or residual symptoms of a disorder with complete clinical expression, or they can be present without meeting the criteria for an Axis I disorder, usually interfering with the subject's social-occupational adaptation and quality of life (13).

However, it is worth noting that the definition of "soft" bipolar spectrum also includes temperaments and personality traits, since, according to the concept of spectrum, personality is considered a mosaic of complex dimensions, simpler or elementary, with different psychological and psychopathological features, constantly changing according to the environment (14).

Almost a century before Akiskal, Kraepelin detected the existence of a considerable quantitative and qualitative variability among patients with manic-depressive psychosis and about this issue he wrote: "We include here (in manic-depressive insanity) certain slight and slightest colourings of mood, some of them periodic, some of them continuously morbid, which on the one hand are to be regarded as the rudiment of more severe disorders; on the other hand, pass without sharp boundary into the domain of personal predisposition. In the course of years I have become more and more convinced that all the above mentioned states only represent manifestations of a single morbid process" (15). Several studies have since shown a high frequency of comorbidity between borderline personality disorder and mood disorders (bipolar disorder and major depression) and reported that 12-23% of patients with bipolar II meet criteria for borderline personality disorder as well (16-17,5,18). Table 2 shows the frequency of mood disorders in subjects with borderline personality disorder in a 6-year follow-up period (19).

TAB. 2 Frequency of mood disorders in subjects with borderline personality disorder in a 6-year follow-up period (Modified from (19)).

	Baseline (N=290)	2 Years (N=275)	4 Years (N=269)	6 Years (N=264)
Axis I Disorder	N %	N %	N %	N %
Mood Disorders	281 96.9	233 84.7	199 74.0	198 75.0
Major Depression	251 86.6	189 68.7	166 61.7	162 61.4
Dysthymia	130 44.8	93 33.8	78 29.0	107 40.5
Bipolar I	0 0.0	2 0.7	4 1.5	3 1.1
Bipolar II	16 5.5	19 6.9	18 6.7	12 4.6

However, in the literature we also found studies coming to different conclusions. For example, Berrocal claimed that the coexistence of the two disorders is quite uncommon (20), while other authors underlined the specific distinction between them (21-22).

Regarding the likely common elements shared by these two complex psychopathological entities, Benazzi highlighted that the Work Group on borderline personality disorder for DSM-IV concluded that the possible overlap between borderline personality disorder and mood disorders was caused by the item "affective instability" and that "impulsivity" could be its "essential feature" (6).

Concerning this, numerous studies agreed that affective instability and impulsivity themselves are the common basic clinical characteristics (18,22,23,24), which, however, can manifest themselves in qualitatively different ways in the two disorders (25,18,8).

With regard to impulsivity, Benazzi detected that the only significant association is between the episodic impulsivity of hypomania and the impulsivity characterizing borderline patients (6); in borderline personality disorder, impulsivity can also be present in the form of lack of concentration, loss of ideas, disorientation, difficulty in organizing and planning actions and considering their consequences (18).

MacKinnon suggested that affective instability could be referable to a common genotype that manifests itself with different phenotypes, depending on the influence of environmental and psycho-social factors, such as, for example, an experience of abuse. This author underlined that affective instability in borderline personality disorder is related to environmental stimuli, contrary to what happens in bipolar patients; he considered the affective instability of borderline personality disorder as a form of prolonged ultra-rapid cycling with extreme rapid mood switching (7), closely resembling the classic description of cyclothymia (10).

Henry showed that affective instability in borderline personality disorder is mainly present as oscillations between anger and euthymia, while in bipolar disorder II it is more often expressed as oscillations between depression and/or elation and euthymia (26).

Other studies detected that borderline patients show greater fluctuations towards anger and anxiety, often as a reaction to stressful environmental stimuli, especially in the field of personal relationships; oscillations between depression and anxiety have been also described in patients without

comorbidity with bipolar disorder II, but without episodes of elation (27,18).

Recently, in line with previous literature, Bradford Reich observed that lability involving anxiety, anger, intense discomfort and irritability is more characteristic of borderline patients (24), as well as being of a more episodic nature (18), whereas lability involving elation is more characteristic of bipolar patients (24).

These authors thus concluded that the recognition of the different characteristics of the oscillations in the item "affective instability" may represent a useful element for differential diagnosis between borderline personality disorder and bipolar disorder.

With reference to lowered mood, borderline personality disorder patients may use the term "depression" to describe chronic feelings of boredom, loneliness and emptiness, without showing the classic signs and symptoms of major depression (28). Authentically depressed patients, in fact, do not feel empty but, on the contrary, feel full of several negative mental states, affective and cognitive, described as sadness, lack of interest in life, feelings of unworthiness and of guilt; in the case of "negative" experiences, such as the loss of interests, there is always a reference to the world of objects: the concept of loss itself implies the fact that once there was something, something that then loses its value. In borderline cases, on the other hand, the void refers to the absence of objecthood and relations (29), probably because such experiences refer more to identity than to tone of mood (30,29). The continuous oscillation of transitory representations, positive and negative, divided, makes borderline subjects incapable of defining themselves in their own real identity, which remains inconsistent, indefinite or empty (29).

MacKinnon agreed with those who consider borderline personality disorder a mood disorder within the bipolar spectrum and thus suggested that the clinician has to decide whether symptoms are best attributed to an acute mood disorder or whether they are merely the latest manifestation of a more chronic and pervasive problem. He also suggested that borderline personality disorder should be transferred to Axis I and be integrated into BP II as one of its clinical subtypes (7).
Concerning this, Benazzi claimed that bipolar disorder II can be divided into two subtypes: one stable and functional between episodes and one unstable between episodes, which is related to borderline personality disorder (5).

Affective instability seems to be related to a cyclothymic temperament. Another wide field of research is currently dealing with the recovery of the concept of affective temperament, to try to overcome the difficulties deriving from the attempt to link Axis I Bipolar Disorders to Axis II Personality Disorders. In line with this idea, several studies highlighted that bipolar disorder and borderline personality disorder may share a cyclothymic temperament, involving affective reactivity and lability, interpersonal sensitivity, hostility and anxious-avoidant traits (23-24,31-32).

Ehrt described affective temperament as a biological disposition involving different levels of energy and mood quality which determine a particular reactivity to external stimuli (33).

According to Akiskal, temperamental characteristics of the cyclothymic and hyperthymic types may represent the phenotypic expressions of the underlying bipolar genotype and determine the extreme sensitivity to external events; at the same time several features such as stability over time, early onset and long duration make the concept of temperament similar to the concept of personality (3).
Regarding personality, Cloninger's psycho-social theory offers interesting clues: this author considers the concept of personality a complex hierarchic system, expressing itself through the synthesis of two psychobiological dimensions: temperament and character. Character refers to the part of personality, scarcely inheritable, primarily influenced by learning, culture and unique events for every individual; regarding character, he distinguishes 3 different dimensions: self-directedness (SD), cooperativeness, and self-transcendence (34).

In a clinical population survey, in comparison with a population of students, Svrakic observed that subjects with a personality disorder showing low scores on SD (significantly related to borderline

personality disorder), also showed frequent comorbidity with dysthymia and depression (35-36).

In this way it seems that the SD dimension of character may represent a common factor between mood disorder and personality.

Patients with low scores on SD are described as immature, weak and poorly integrated; they seem to be lacking an internal organizing principle and this makes them fragile and influenced by external stimuli and circumstances (37).

To understand the complex relationships between personality, temperament and mood disorders fully, it is also necessary to take a psychodynamic approach (38-40), which has not been adequately considered in recent years, mainly because of the popularity of evidence-based medicine (41). The internal world of subjects and all those deeper aspects of individual personality which concur in determining the pathological impact of biological, environmental and interpersonal factors, are further aspects requiring consideration in this context. (39,42).

Theoretical and clinical investigations of manic-depressive illness have followed each other over the years; the earliest concepts developed by Freud (43-44) were fundamental to the research of many other authors, including Abraham, Klein, Winnicot, Jacobson and Bibring, who further analysed and improved the understanding of the deep dynamics behind the development of manias and melancholia (45).

To understand the profound affinities between bipolar disorder and borderline personality disorder better, it is necessary to trace the stages of child psychological development described by Margaret Mahler (46).

In the separation/individuation process (6-24 months) the infant ceases to be ignorant of the differentiation between itself and the mother, becoming progressively aware that she is a separate person. In this way it begins to explore the surrounding world with a euphoric feeling of greatness and omnipotence, becoming more distant from its mother. In doing this, the infant reaches the awareness that it is separated from its mother and experiences a feeling of vulnerability related to the loss of the loved object which gave it confidence. This is why it now tries to regain it (46).

In this phase, euphoric advancing movements alternate with depressive return, which leads to the achievement and consolidation of the object constancy (interiorisation of a whole and constant image) comforting and supporting it during the separation process (47).

It is possible to consider the sense of inadequacy and the opposite pseudo-omnipotent part of the bipolar subject as the expression of the failed attempt to overcome the separation/individuation phase. In fact the subject gets stuck in the oscillation between the attempts to obtain a grandiose independence and the return to the emptiness, without ever reaching the structural stabilisation of the Self (45).

This kind of developmental failure is the same as can be observed in the Borderline Personality Organisation, where the founding element is the failed achievement of an integrated identity and of object constancy, with the anguished feeling of abandonment which determines the development of primitive defences like splitting, denial and projection (47).

In this phase of psychosexual development the occurrence of traumas and suffering violence, often repeatedly, at an early stage, have been considered for some time factors of recognized importance in the causal chain at the core of borderline pathology (48).

Indeed, a trauma generates an extremely intense frustration in fragile Egos that have just overcome, without too many hitches, the first months of life and are continuing on their path towards Oedipus. Such a trauma has to be understood in the affective sense of the term; it corresponds first of all to an intense drive-related anxiety, the occurrence of which has taken place during a scarcely organized and

still too immature stage as far as the instruments, ability to adapt and defences to be able to deal with it in conditions of safety are concerned; attempts at sexual seduction on behalf of an adult, often quite real and not merely illusory, can prevent entrance into the Oedipus (49).

In such patients the trauma seems to be linked to an "original turbulence" (50) and it emerges with a diffusive mode; it tends to flood other constructions (51).

The initial effects of sexual abuse include fear, anxiety, depression, guilt, anger, hostility and inappropriate sexual behaviour. Long-term results are represented by impulsivity, self-guilt, suicidal behaviour, anxiety, isolation, low self-esteem, substance abuse, sexual problems and lack of trust in interpersonal relationships. Abuse trauma can contribute to the borderline patient's difficulties in expressing affection.

The literature suggests that individuals who have undergone traumatic events are unable to develop the ability to deal with emotional arousal, to the point that they respond to it with a severe coercion of affection or in a way inappropriate to the situation, engaging in impulsive behaviours (52). This is even more true if we consider impulsivity as a predisposition implying the tendency of subjects to act quickly, without planning their behaviour, and without the opportunity of elaborating a rational and aware assessment of the consequences (53). As a result, borderline experience consists in an original instability of relations with others and the world, in an "emotional invalidation"; it is as if the borderline subject grew up with no stable indicators, always in an uncertain balance. In this case the traumatic element is not so much an event (or a series of events), but rather an environment as a whole; "an earthquake swarm consisting of small but continuous and unpredictable shocks that develop on an ever vacillating floor surface: in a state of "stable instability" and "alarmed dysphoria" (54). People with borderline personality are characterized by this absolute pervasive precariousness (51). They are constantly oscillating between challenge and dependence, between a desire for trust and deep disillusionment (48). As a result, their only intention is to test the solidity of every possible relationship: with things, with the 'other', with their own bodies (51).

The psychodynamic and phenomenological assessment underlines the common root of the presumed elation/depression antinomy: melancholic suffering and racing thoughts which are opposite on a descriptive point of view then become the result of a "common despair" deriving from an unsuccessful fulfilling of the Ego (55).

Those who support the hypothesis of a common matrix for borderline personality disorder and bipolar disorder consider affective instability the common starting point. The interaction with frustrating environmental factors, mainly early dysfunctional relationships and traumatic experiences which exacerbate the basic affective instability, represent key moments in which the two disorders may diverge and the primary mood disorder may evolve into borderline personality disorder. In the case of subjects with a predisposition to affective instability, who grow up in an adequate and supporting environment, object relations are better and it is thus more likely for such subjects to develop a bipolar disorder rather than a borderline personality disorder (7).

The central thread of this report is the awareness that the clinician always remains the essential tool, thanks to her/his ability to explore different situations in an integrated way and from different points of view. The enhancement of knowledge, empathy and patience give the clinician the possibility to understand psychic suffering in the evolution of human existence (56-57).

GP Comment

What have I learned from this paper?

1. The relationship between bipolar disorder and borderline personality disorder is interesting and remains controversial (although it has been shown in the BRIDGE study: Angst et al. Arch Gen Psychiatry. 2011; 68 (8): 791-799, that Borderline Personality disorder may be a 'specifier' for a Bipolar Diagnosis).

2. Affective instability and childhood developmental issues are important themes

3. GPs should consider a Bipolar Disorder diagnosis in a patient with 'Borderline Personality Disorder' if there are clear features of hypomania/mania and depression. In practice this would warrant referral for expert Psychiatric review

4. From a GP perspective, it remains unclear how we should treat patients with Borderline Personality Disorder, especially as the evidence base for pharmacological treatment is limited and adverse effects may be significant. Psychological approaches may play a key role.

Dr Daniel Dietch, GP, Lonsdale Medical Centre, London.

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Sandro Elisei
Division of Psychiatry, Clinical Psychology and Rehabilitation,
Department of Clinical and Experimental Medicine - University of Perugia
Santa Maria della Misericordia Hospital - Perugia, Italy
sandro.elisei@unipg.it