Differentiating Bipolar Disorder and Borderline Personality Disorder: Utilizing Effective Clinical Interviewing and the Treatment Environment to Assist with Diagnosis

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Abstract

Adolescent mood swings can create diagnostic confusion for clinicians. Adolescents presenting with mood fluctuations are often diagnosed with Bipolar Disorder. A closer review of the context for mood fluctuations as well as response to medication trials may suggest that mood fluctuations are consistent with a Borderline Personality Disorder diagnosis rather than a Bipolar diagnosis. This paper reviews criteria for these diagnoses as well as clinical indicators, supported by the work of Gunderson, et al. (2006), which can help clinicians make the proper diagnosis. Effective collaboration of an inpatient or residential interdisciplinary treatment team facilitates accurate diagnosis, as the integration of observational data across multiple settings can provide a more accurate analysis of mood variability.

Affective instability or reactivity is the \textit{sine qua non} of borderline personality disorder (Koenigsberg, Harvey, Mitropoulou, Schmeidler, & Goodman, 2002). As clinicians we all know this. Yet this instability, which most of us would say we recognize, contributes to a great deal of difficulty in differentiating borderline personality disorder (BPD) from bipolar disorder (BD). Reactivity of mood leads to the affective instability, which is often equated to the mood swing of bipolar disorder. Reactivity may imply that the patient is unable to use cognitive skills to control or dampen affective response to a particular situation, hence the patient can present with a confusing picture of wildly fluctuating mood states. If the clinician is not careful, these presenting symptoms can easily lead to a diagnosis of BD.

A significant number of admissions to our adolescent inpatient unit come with a diagnosis of Bipolar II Disorder or Bipolar Disorder
NOS; and many leave, not with a diagnosis of BD but with a diagnosis of BPD. Many of these adolescents (initially mostly female, but now including more males) have held a BD diagnosis for at least a year prior to coming. Typically there has been a history of multiple medication trials, as is appropriate for treating bipolar disorder; and the focus of treatment has been medication, visits monthly or less frequently, with supportive therapy from an individual therapist. Sometimes as many as 20 medications have been tried over a two-year period in various combinations to help mood, depression, sleep and anxiety. Unfortunately, none of these clinical efforts have significantly improved the adolescents’ level of functioning or prevented the need for hospitalization.

Bipolar II Disorder

One or more major depressive episodes with hypomanic episodes

- One or more major depressive episodes
- At least one hypomanic episode
- Never manic or mixed
- Not Schizoaffective or Schizophrenic
- Symptoms cause clinically significant distress

A variety of reasons are given for admission such as:
- “the medications are not working”,
- “he or she is still cutting on him/herself”,
- “she can’t make decisions”,
- “she’s still not functioning”,
- “she still tries to kill herself and we never know when it is going to happen”,
- “his moods are all over the place no matter what medicine he’s on”,
- “she’s not improving”, and
- “we just don’t know what else to do”.
The majority of parents want clarity about what is “really” wrong with their youngster, and ask that we “please get the medications right.” Getting the medications correct is an appropriate expectation with a diagnosis of any type of BD and, initially we wonder, along with parents, why the medications have not been more effective (or, in psychiatric jargon, why so many adolescents seem to have ‘treatment resistant’ forms of Bipolar Disorder?).

Most parents give similar versions of the trajectory of their youngster’s illness. The following is a summary of a number of common scenarios, but does not cover all possible presentations:

Peter was 15 years old when he was admitted to the hospital. Peter’s parents reported that Peter seemed happy enough in kindergarten and through seventh grade. There were periods of separation anxiety early in kindergarten, but with support from his parents he soon adjusted and did well. He had friends, was invited to parties, and seemed happy enough. When he was nine years old, the family moved to another city for mother’s job. Peter had a hard time adjusting to his new school. He missed his old friends, and didn’t seem to make new friends very easily. He used to play soccer at his old school, but at this school he was convinced the new kids didn’t like him. His parents decided to let him quit the soccer team, and things seemed to settle. He had some periods of sadness and isolation, but in general, things went well. In eighth grade, he seemed to stumble badly. His grades fell markedly to the point where he was failing most of his subjects. He became angry and irritable and often argued with his parents about insignificant matters. He became intensely involved with a girlfriend, herself a depressed and unhappy person. All of his other tenuous friendships dropped away as Peter became convinced that most of his classmates hated him anyway. He was convinced they were talking about him all the time, so much so that he hated walking into class when the others were already seated. The girlfriend became the focus of his life. It seemed, as his parents described it, that the girlfriend took over his life. Many of their arguments centered around Peter’s wanting to be with her when his parents felt he should be home doing homework. Peter felt better around his girlfriend and said she helped him “calm down”; and that when he was with her he didn’t have all the mood “ups and downs” he complained so bitterly about.
at home. He felt “lonely and empty” when he was away from her. At first, his parents did everything to keep them together, because at home Peter’s irritability and moodiness were becoming harder to live with. If the girlfriend made him happy, they reasoned, why not let him spend time with her. However, this strategy soon backfired as Peter exhibited more and more need to be with his girlfriend. Peter’s parents insisted he decrease his contact with her. He began to stay up all night, and his parents could hear him walking through the house. He claimed he couldn’t sleep because he “couldn’t shut his mind down.” In the mornings he was too tired to go to school and slept until mid-afternoon. During a routine pediatrician’s visit they discovered he had been cutting on himself quite regularly. His therapy visits began at that time but didn’t seem to help. His parents felt less and less able to manage Peter, as “everything we say is the wrong thing” and “we never know what’s going to upset him or make him start talking about suicide.” Soon Peter, his moods and his irritability began to dominate the house. The arguments at home continued and became so explosive that the police had to be called. During one argument Peter threatened to kill his father and himself and was hospitalized. The medication trials began. He was diagnosed with Bipolar I Disorder, based on his parents’ descriptions of his moodiness and explosiveness, and his description of not being able to control his moods. He was initially put on Depakote. Since then there have been three more acute hospitalizations, two for suicide attempts which followed arguments with his girlfriend, and one for severe self-harm. His medications have been changed many times: Lithium, Lamictal, Geodon, Risperdal, Zyprexa, and Effexor have all been tried, but side effect problems or lack of efficacy have plagued his medication management. He was admitted to our extended-stay hospital program directly from his third acute inpatient admission on a combination of Lamictal and Tegretol for mood stability, Paxil and Cymbalta for depression, Adderall to help give him energy in the morning, Abilify for reasons which were not clear at admission, Topamax to help counter weight gain caused by previous medication trials and Ambien CR for sleep. Drug screens done at each acute hospitalization were negative. No drug screens were done in outpatient treatment as Peter insisted he was not using.

Peter’s age might have caused some clinicians diagnostic confusion. The diagnostic criteria for BPD (see Table 1 below) state
that symptoms begin in early adulthood, yet that is not the experience of many clinicians who treat adolescents (Bleiberg, 2001). Very often, a 12 or 14-year-old presenting with symptoms of BPD is diagnosed with BD because many clinicians believe BPD cannot be diagnosed under age 18. This unfortunate state of affairs denies adequate treatment for many adolescents. The situation is complicated by the developmental state of the adolescent brain. Recent research (Gogtay, Giedd, & Rappaport, 2002) indicates that the adolescent brain is undergoing intense and important developmental changes. This research further states that during adolescence the brain is developing the connections between the frontal lobes and the limbic system that will eventually enable the adolescent to better use thinking (frontal lobes) to manage emotions (limbic system). This research helps us understand the source of the “normal” irrationality and moodiness of adolescents. In normal development, the ability to manage emotions develops as the brain matures. Some amount of emotional variability is normal in the trajectories of many adolescent lives, but the adolescent’s developmental path should not be stopped or stalled by their emotional variability. There may be more arguments at home, but daily fights are not the norm. Frequent recourse to the police to maintain order should give cause for concern, as should threats of suicide, failing grades, or any combination of behaviors which clearly stops the forward movement of development. In Peter’s case, his developmental trajectory was clearly impacted by his symptoms.

Peter’s story demonstrates some important areas of confusion in distinguishing BPD from BD. This is a youngster with wildly swinging erratic moods, intense irritability, irregular sleep, and problems with obsessive thought ideologies. If one pays attention purely to the mood symptom picture and not to the context where the symptoms are occurring, it is possible to misconstrue Peter’s problems as some kind of mood swing disorder such as BD. However, a careful reading of DSM IV criteria will begin to cast doubt on the diagnosis. There is nothing in Peter’s story indicating a manic episode or hypomanic episode as described by the DMS IV criteria. Frequent explosive arguments or temper tantrums are not ‘equivalent’ to manic or hypomanic episodes. The mood swings of mania and hypomania fit a particular descriptive pattern as described in DSM IV.
DSM IV Definition of Manic Episode

1. A distinct period of abnormal and persistently elevated expansive or irritable mood lasting one week (or any duration if inpatient is necessary)
2. During the period of mood disturbance 3 or more of the following symptoms have persisted and have been present to a significant degree
   - Increased self-esteem or grandiosity
   - Decreased need for sleep
   - Talkative or pressure to keep talking
   - Flight of ideas; racing thoughts
   - Distractibility
   - Increased goal directed activity/agitation
   - Excessive involvement in pleasurable activity
3. Symptoms don’t meet criteria for mixed episode
4. Severe enough to cause marked disturbance in occupational functioning/psychotic features/need IP
5. Not due to drug or antidepressants, ECT, light therapy etc

DSM IV Hypomanic Episode

1. Distinct period of persistently elevated expansive or irritable mood for four days
2. During period of mood disturbance, 3 or more of the following are present
   - Increased self esteem or grandiosity
   - Decreased need for sleep
   - Increased talking
   - Flight of ideas/racing thoughts
   - Distractibility
   - Increased goal directed behavior
   - Excessive involvement in pleasurable activity
3. Unequivocal change in functioning
4. Change observable by others
5. Not severe enough to cause marked impairment
6. Not due to medical problems, medications etc.
It does not behoove us as clinicians to label all fluctuations of mood as bipolarity when there is no surrounding history to support this diagnosis. Temper tantrums, rages or arguments are not manic episodes, even if they occur four or five times in a day. Emotional ups and downs related to relationships are not manic episodes or “some kind of bipolar mood swing” as they are sometimes loosely described. Astute clinicians will note that the diagnostic criteria for BPD provide further assistance in distinguishing between the two disorders: recurrent self harm is not a feature of BD, and identity disturbance and chronic feelings of emptiness are not a feature of BD (Gunderson, Weinberg, Daversa, Kueppenbender, & Zanarini, 2006).

While Peter stays awake at night and sleeps during the day, it is not “as if” he has a decreased need for sleep. Sleep shift problems should not be confused with the sleep difficulties of mania or hypomania. The poor sleep of the anxiety-driven patient who has trouble getting to sleep and staying asleep because they “can’t stop thinking” should not be confused with the decreased need for sleep of the manic or hypomanic patient. “Worrying a lot” or “thinking too much,” both very common in patients with anxiety, is not to be thought of as equivalent to the racing thoughts of mania. Many anxious people don’t sleep well because they “can’t shut my brain down.” Peter’s moods shift – but careful questioning of Peter and his parents might elicit the information that his mood shifts seem to be dependent on his environment (i.e., he is intolerable at home; but seems to do better if he is with his girlfriend, as long as that relationship is running smoothly). The intensity of Peter’s relationship with his girlfriend bears noting, and the fluctuations of his relationship seem to parallel the fluctuations in Peter’s moods. The mood fluctuations and irritability of interpersonal relationships are not to be confused with BD. Many patients with BPD have mood fluctuations that are triggered by interpersonal stressors, whereas the mood problems of BD are far less likely to be linked to environmental issues. BD is not situation dependent; the mood swings of BD occur across all domains, regardless of who is or is not present.

There also is the “interesting role” of paranoia in this case study. Peter’s thoughts concerning his peers talking about him are often described as “paranoia,” as if it is equivalent to the paranoia of schizophrenics and treated with antipsychotics. Further questioning
of Peter’s parents indicated that Zyprexa was started to treat just this symptom. But careful conversation with Peter will help the clinician to see that his thinking that others are talking about him is a derivative of his poor self esteem and not psychotic pathology. Because he thinks he is ugly, stupid, and not likeable, he thinks others also believe this and projects his insecurity onto those around him. As well as causing the distortions in thinking often referred to as “paranoia,” these self esteem problems often drive the patients’ mood swings. BPD patients may have shifts in mood occurring as rapidly as every hour, based on their constant monitoring of the environment, looking for slights which confirm their belief in their essential worthlessness. The perception that someone dislikes the patient can cause a precipitous drop in mood, while the perception 15 minutes later that someone admires the patient can raise them to giddy heights of pleasure. The BPD patient’s use of cognitive distortions and other rigid thinking styles makes it difficult to exhibit the necessary flexibility in thinking that healthier people use to negotiate the world. Abandonment fears and self-esteem issues are not typically an integral part of BD. If a BD patient has relationship troubles, it is typically not chronic as with BPD, but is more likely to be related to inappropriate behavior that occurs during a manic episode. A great deal of the “acting out” of BPD can be construed as mania or hypomania. However, clinicians need to remind themselves of manic defenses which the BPD patient uses to ward off unwanted affect. Manic defenses should not be confused with episodes of mania.

Careful questioning of patient and parents can usually elicit information that can help distinguish BPD from BD. In Peter’s case well meaning clinicians, with their focus on the symptom picture, did not ask questions about the context of Peter’s life.

- What about his relationships?
- How much time exactly did he spend with his girlfriend?
- What happened inside him when he was not with her?
- What does he think about when he is not with her?
- What events preceded each admission to the hospital?
- What does the patient think of him/herself?
- What does the patient think others think of him/her?
- Can he walk into school without worrying about what others are saying or thinking about him?
These are important questions that can help clarify the diagnosis because they may help treating clinicians begin to see that how the patient sees him/herself in the world may be contributing to his/her emotional difficulties. The questions may not always provide the answers, but they need to be asked in cases that are not responding to adequate treatment as usual for BD. Most adolescents do not think of themselves as responsible for managing either their thinking or their emotions. To the question about what events precede each hospital admission, the answer may well be, “Nothing happened. I just all of a sudden got suicidal.” Yet a careful chronological history of which events happened when will clarify the picture. Today’s adolescents, taught by the culture to focus almost exclusively on their (and others) electronic accoutrements and external appearances, are not at all used to plumbing their inner depths in order to understand themselves. They may genuinely not make a link between an event and their response. More importantly, without careful and thoughtful questions, the therapist or parent may not know that the adolescent is totally different with friends (e.g., happy, laughing, talkative, eating well) as compared to being belligerent and explosive at home. The therapist may not know that the symptoms being treated exist only at home and never show up in a setting where the parents are absent. The

**DSM IV Borderline Personality Disorder**

- 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:
  - Frantic efforts to avoid abandonment
  - Pattern of unstable and intense interpersonal relationships
  - Identity disturbance
  - Impulsivity in at least two areas: sex, spending, substance use etc
  - Recurrent suicidal behavior, gestures, threats, self-mutilation
  - Affective instability due to marked reactivity of mood
  - Chronic feelings of emptiness
  - Inappropriate intense anger
  - Transient stress related paranoid ideation or severe dissociative symptoms
therapist may not know that the parents have learned to manage the adolescent by buying or doing whatever the adolescent wants (e.g., that their fear of ‘causing’ another suicide attempt is so strong they will do anything to avoid it). The therapist may interpret the statement, “I feel better when I’m buying things” as evidence of mania with impulsive shopping, not realizing that the intense activity is simply a method of managing anxiety. Parents having to “walk on eggshells” around the adolescent, not knowing what will “set him/her off”; and if not carefully examined, may be interpreted as signs of the mood instability of bipolar disorder.

In addition to careful questioning of patients and their parents to elicit helpful information in differentiating BPD from BD, observations within the treatment environment are invaluable in making an accurate diagnosis. The treatment environment of an inpatient or residential setting is often referred to as milieu or a therapeutic community. One of the hallmarks of an effective therapeutic community is that it provides life-like situations where difficulties encountered outside the treatment setting are experienced and opportunities present themselves for managing these difficulties in a healthy manner (Kennard, 2004). Therefore, within these settings, clinical symptoms are observed and can be understood within the context of the environment.

Observations within the treatment environment that would support a BD diagnosis include: (a) observable mood shifts unrelated to interpersonal dynamics and (b) random mood shifts and complaints about thinking and cognition. Mood and cognition problems show up in group settings as well as one-on-one interactions; during structured activities as well as during leisure activities. Patients will often report a sense of being out of control or “being changed’ inside.

In contrast, observations supporting a BPD diagnosis are significantly related to interpersonal difficulties. These adolescents engage in many more discussions about relationships (e.g., who does or does not like them). Program staff find themselves implementing interventions to manage interpersonal problems for these patients. Mood shifts are apparent, but are presented as clearly linked to interpersonal events or to the patient’s interpretation of the event. Incidents of self harm are common as are concerns with body image. Exacerbation of
anxiety is typically present and can be understood as related to patients becoming overwhelmed by interpersonal difficulties.

It is therefore critical that the treatment team work collaboratively in gathering observational data and clarifying diagnoses. Using data from effective clinical interviewing and behavioral observation, the team can come to a more accurate understanding of patients’ difficulties. Our experience has been that once diagnosis has been clarified and shared with patients and parents (providing examples of observations within the treatment setting which support the diagnosis), they report a sense of relief in finally ‘understanding’ what really is going on and can engage in an effective treatment course.

The clinician should always consider co-morbid diagnoses. ADHD, anxiety disorders, Major Depressive Disorder (MAD), PTSD and Substance Use Disorder (SUD) all may co-occur with BPD. In Peter’s case random urine drug screens would have been helpful. He had been using both marijuana and cocaine with his girlfriend, and even more intensely when he was away from her. He said the drugs helped him feel less lonely and empty. BPD and BD do co-occur, but co-occurrence of BPD with SUD, PTSD, and MAD are much more common. Rapid cycling BD is often a common diagnosis given to BPD patients, and can be seen as an attempt to quantify the rapid shifts in mood of the BPD patient. Rapid cycling BD, ultra rapid cycling BD, and ultra-ultra rapid cycling BD occur, but are not common enough to justify the frequency with which they seem to appear as diagnoses. If BD and BPD co-occur, treating the BD does not alter the course of BPD and does not change the need to use therapy models for treatment of BPD. In other words, while there is significant evidence for the efficacy of mood stabilizers in treating BD, there is much less evidence for the efficacy of mood stabilizers in BPD. One should also remember that in the attempt to use medications for BPD, suicide attempts of BPD patients are most often due to affective instability and not to depressions; hence the failure of antidepressants in preventing the troubling and dangerous swings into suicidal behaviors. A final point about trauma and BPD is that while there is an association between BPD and trauma, clinicians should not assume that there has to be trauma for BPD to be diagnosed. In our setting, a lack of parental fit is often seen as a common precursor. For example, a very emotionally
intense, anxious child born to very pragmatic parents may live in what has been referred to as a non-validating environment. Because the child’s anxious responses would not make sense to these pragmatic parents, they may unwittingly say or do things that invalidate the child’s experience of the world.

There has been a regrettable tendency in the field to broaden and stretch criteria to make them as inclusive as possible. Some of this may be due to insurance pressures. It has been reported that between 1990 and 2000 the proportion of discharges with a principal diagnosis of BD increased from 2.9% to 15.1% (Case & Olfson, 2007). As well as reflecting a greater awareness of BD in the adolescent population, a significant portion of the increase may reflect the greater willingness of third party payers to reimburse for a diagnosis of BD, but not for a diagnosis of BPD (which is not viewed as being a ‘biological illness’ and not amenable to treatment with medications). Peter’s story also exemplified why it is important to distinguish BPD from BD – the treatment modalities are different. BPD treatment relies on DBT, mentalizing therapies, transference-based therapies, and supportive psychotherapy; with medications possibly having a supportive role. The treatment of BD is primarily medication based with psychotherapy having a supportive role.

An accurate diagnosis is crucial to directing appropriate and effective treatment. To prescribe medications when they are not indicated is as troubling as withholding medications when they are indicated. The effective use of psychosocial interventions (such as CBT and DBT) can be invaluable to patients troubled by BPD. The authors hope that the contents of this paper will assist readers in making clinical decisions which truly help patients improve their lives.
### Points in Differential Diagnosis

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<td>1. Mood changes are autonomous</td>
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<td>2. Self injuring behavior is common</td>
<td>2. Self injuring behavior is rare</td>
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<td>4. Use of defensive splitting interferes with interpersonal relationships</td>
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*Adapted from G Gabbard (personal communication, October 2006)*

### References


