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BORDERLINE PERSONALITY DISORDER AND BIPOLAR DISORDER COMORBIDITY IN SUICIDAL PATIENTS: DIAGNOSTIC AND THERAPEUTIC CHALLENGES

Darko Marčinko & Bjanka Vuksan-Ćusa

Department of Psychiatry, Clinical Hospital Center Zagreb, Croatia

SUMMARY

Suicidality is one of the great challenges in contemporary psychiatry. Suicidal patients are often misdiagnosed in clinical practice. It is very important to evaluate possible comorbidity in diagnostic assessment of suicidal patients. The high prevalence of comorbid bipolar (BD) and borderline personality disorders (BPD) presents both a diagnostic and a therapeutic challenge. Although the primary treatment for patients with BPD is psychotherapy, pharmacotherapy is a core component for the treatment of comorbid conditions such as bipolar disorder. Because of heterogeneity of the BPD, pharmacologic treatment has evolved to some particular dimensions of BPD rather than the disorder in its entirety. The dimensions include affective instability, impulsive aggression and identity disturbance. Effective medication management reduces the overall suffering of the patient and enables to make greater use of psychotherapeutic interventions which is very important for BPD patients with BD comorbidity.

Key words: *personality disorder - bipolar disorder - suicidal patient*

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SUICIDALITY AND BORDERLINE-BIPOLAR COMORBIDITY

Suicidality is one of the great challenges in contemporary psychiatry. Suicidal patients are often misdiagnosed in clinical practice. It is very important to evaluate possible comorbidity in diagnostic assessment of suicidal patients. Several studies suggest that comorbidity is associated with worse clinical status in bipolar disorder (BD). Comorbidity of dual diagnosis, borderline personality disorder (BPD) and bipolar disorder, indicates a higher suicidal risk than for the single diagnosis. Characteristics like affective instability, impulsivity, disinhibition on antidepressants and genetic basis with bipolarity are shared by the two disorders (Akiskal et al. 1985). Comorbidity of personality disorders in patients with mood disorder has been reported at varying rates. Some of the differences in reports of comorbidity may be due to the varying methodologies used for assessment of personality disorders. Although lower rates of comorbidity (4% to 12%) between bipolar and personality disorders were reported in the early 1980s, 5-7 higher rates (50% to 58%) have been found in later studies (Ucok et al., 1998). Solomon et al. (1996) also reported that patients with bipolar I disorder in remission have personality traits that differ from those of normal controls. The fact that only certain disorders or combinations of disorders contribute to heightened risk should help us to begin to formulate what sort of complex affective states and associated clinical features form the basis for a suicidal state. Our team previously reported few papers regarding suicidality in different diagnostic entities (Marčinko et al. 2003, 2004, 2005, 2006, 2007, 2008a) and concerning that suicidal behavior should be assessed only in broader bio-psycho-social integrative context. This paper will review critically the current status of BPD and BD comorbidity, attempting to clarify how a better assessment of this comorbidity may improve our understanding and lead to more focused and effective treatment management.

BORDERLINE PERSONALITY DISORDER

BPD is serious and disabling mental disorder. Despite recent advances in the treatment of BPD, it remains difficult to treat effectively. Many patients

responding poorly to the most widely accepted treatment strategies. The borderline construct has undergone several major shifts since the 1960s. It was first a personality organization and then a syndrome; it is now a disorder (Gunderson 1994). The borderline diagnosis shifted from intrapsychic organization to descriptive syndrome. The importance of the syndromal concept was that it incited researchers to establish the syndrome's meaning through studies of the syndrome's course, genetics, comorbidity, development, and treatment response and, of course, by documenting its discrimination from other disorders in all these areas. Since DSM-III, BPD have been the subject of an enormous amount of research and these studies have found that BPD has a high level of comorbidity with Axis I disorders (including bipolar disorder) and other personality disorders. The DSM-IV (American Psychiatric Association 1994) criteria set for BPD changed only modestly from the original in DSM-III. One of the diagnostic criteria for borderline personality disorder is affective instability. This criterion includes the high intensity, volatility, and range of the borderline patient's affects. It is interesting that basic psychopathology of borderline individuals involved the same problems of affective regularity found in people with bipolar II disorder. Such theories have encouraged widespread use of mood-stabilizing medications. DSM-IV revisions of this criterion (since DSM-III) have tried to distinguish the affect shifts of borderline patients as being more reactive (read "less autonomous") and less enduring than those in mood disorders.

BORDERLINE PERSONALITY DISORDER AND SUICIDALITY

Suicidal behavior is a diagnostic criterion in only two disorders: major depression and BPD (DSM-IV). For a diagnosis of BPD, the patient must meet five of nine criteria, one of which includes recurrent suicidal behavior, gestures, threats, attempts, or self-mutilation. Through a review of published studies, Duberstein and Conwell (1997) estimated that 30-40% of individuals who commit suicide have an Axis-II disorder. One of the most frequent personality disorders associated with suicidal behavior is borderline personality disorder. Suicidal thoughts are nearly universal in these patients and, for many of them suicidal behavior has become a lifestyle (Kernberg 1984). At least 50% of chronically suicidal patients with four or more visits in a year to a psychiatric emergency department are patients with BPD (Bongar et al. 1998). Such patients accounted for more than 12% of all psychiatric emergency department visits during the year studied. Depending on the study, the lifetime risk of suicide among patients with BPD is between 3% and 10% (Frances et al. 1986, Paris & Zweig-Frank 2001). Stone (1987) has published that this rate is doubled for BPD patients who display parasuicidal behavior. Suicidality in the context of BPD is often dismissed as non-serious. Family members, friends, even the individuals with BPD themselves, tend to diminish the risk of suicide because the behavior is viewed as manipulative and attention-seeking; the real true is that these behaviors could trigger serious suicidality. Risk factors within the diagnosis of BPD include impulsivity and a history of childhood abuse, something that has been correlated positively with number of suicide attempts (Brodsky et al. 1997). Soloff, Lis, Kell & Cornelius (1994) found that a high degree of medical lethality was predicted by the number of lifetime suicide attempts, older age, and dysphoria, while low lethality attempts were associated with high degrees of anger. Psycho-therapeutic treatment of individuals with BPD is one of the most difficult challenges that clinicians encounter. Treatment is further complicated when individuals with BPD become suicidal. Among psychotherapies, numerous evidence confirmed efficacy of psychoanalytic psychotherapy, menta-lization-based therapy and dialectical-behavioral therapy (Kernberg 2001). In our earlier paper, we have emphasized the role of countertransference in the therapy of suicidal patients (Marčinko et al. 2008b) as an important part of integrative treatment in psychiatry (Jakovljević 2008).

BIPOLAR DISORDER

BD is a complex illness with characteristics and a course that varies from patient to patient, its treatment remains a challenge. The clinical course of bipolar disorder can display forms from a mild depression and a brief hypomania to severe psychotic mania or depression. It is widely accepted that bipolar disorder is frequently misdiagnosed. Comorbidity in bipolar disorder is the rule rather than the exception – more than 60% of bipolar patients have a comorbid diagnosis.

Comorbidity is associated with a mixed affective or dysphoric state rather than with pure mania (McElroy et al. 1995); higher rates of suicidality (Chen & Dilsaver 1996); less favorable response to lithium (Young et al. 1993) and poorer overall outcome. Individuals with BD have a 20- to 30-fold increase in suicide mortality over others of the same age and sex (Angst et al. 2002). Risk of suicide was highest in hospitalized patients with BD compared to unipolar patients and the risk was significantly higher for BD II (24%) compared to BD I (17%) (Kalin 1996, Rihmer & Pestality 1999). Severe suicidal behavior appears to be associated with combined depression and activation, so mixed states may be especially risky (Maser et al. 2002). Most suicidal behavior occurs during or directly after depressive or mixed states and psychiatric and medical comorbidity increases the risk.

BIPOLAR DISORDER TYPE II, BORDERLINE PERSONALITY DISORDER AND SUICIDALITY

Many recent reports and reviews have opposite or different conclusions about the BPD and BP-II relationship. The core feature of BP-II ("recurrent major depressive episodes with hypomanic episodes") is hypomania (American Psychiatric Association 2000) and if BP-II and BPD were related there should be a close relationship between hypomania and BPD traits. From the bipolar spectrum view, there is an overlap of symptoms between BP-II and BPD, and it is related to several BPD "affective" traits. An overlap of symptoms between BPD and BP-II is common in the depressive and hypomanic mixed states (defined by opposite polarity symptoms concurrently present in the same episode), which are a common feature of BP-II (reviewed by Goodwin and Jamison (2007). A remitting course in BPD could shift it into the bipolar spectrum, because it has several "affective" symptoms/traits (Akiskal 2004). Similarity between bipolar disorder and BPD is young age at onset (Benazzi & Akiskal 2008, American Psychiatric Association 2000). The high frequency of inter-episode residual symptoms in bipolar disorders (Judd et al. 2003, Paykel et al. 2006) increases the similarities between BPD and bipolar II disorders. Because of unstable and partly remitting course of BPD, it is hard to distinguish BPD from BP-II.

COMORBIDITY OF DUAL DIAGNOSIS AND INCREASED RISK FOR SUICIDAL BEHAVIOR

Numerous data emphasized that comorbidity in psychiatry is a contributor to heightened risk for aggressive and suicidal behavior. Comorbidity among BPD patients is the rule rather than the exception. The underlying biological vulnerability of BPD patients predisposes them toward mood and anxiety disorders. If we use the term comorbidity in the sense that Moscicki (1995) has (i.e., to mean comorbid psychiatric diagnoses or a primary psychiatric diagnosis plus high levels of other psychiatric symptoms), then comorbidity is an additional significant risk factor with each of the high-risk diagnoses such as BPD and BD. The determination of particular risk factors includes a careful elucidation of numerous factors on biological, psychological and social level. It is obvious that patients diagnosed with borderline personality disorder carry an elevated risk of suicide. Previous attempts, level of anger, childhood abuse, impulsivity, and inability to solve interpersonal conflicts all have been found to be important predictive factors. Furthermore, there is relevant evidence to suggest that the comorbidity of bipolar disorder heightens risk. As noted earlier, comorbidity suggests an additive or interactive effect of two or more pathological processes. However, it is unknown if the suicidal behavior in BPD occurs most often in the context of a current affective episode (most often major depressive episode) or simply that individuals with a vulnerability for affective illness are also at increased risk for suicidal behavior. This distinction is very important because of therapeutic implications. It is often presumed that diagnosis and treatment of depression would prevent most suicides in patients with BPD but little empirical data exists in psychiatric literature. In the context of bipolar-borderline comorbidity, the important fact is that after correct diagnostic procedure the clinician should keep in mind integrative therapeutic modalities based on adequate psychopharmacology and psychotherapy.

THE ROLE OF PSYCHOPHARMACOTHERAPY

Patients suffering from both bipolar disorder and borderline personality disorder pose great treatment challenges. Although the primary

treatment for patients with BPD is psychotherapy, pharmacotherapy is a core component for the treatment of comorbid conditions such as bipolar disorder. Compliance with drug therapy poses some problems for BPD patients. BPD patients tend to self-medicate with alcohol and other illegal substances. They are often hypersensitive to medication effects despite their high pain tolerance to acts of self-mutilation and autoaggressive behavior. Because of heterogeneity of the disorder and that the diagnosis of BPD requires only 5 of 9 DSM-IV criteria, pharmacologic treatment has evolved to some particular dimensions of BPD rather than the disorder in its entirety. The dimensions include affective instability, impulsive aggression and identity disturbance. For affective instability, treatments of choice are SSRI (selective serotonin reuptake inhibitors) and mood stabilizers. SSRI are also used for treating impulsive aggression. Many trials have documented the benefits of SSRI in different forms of clinical indications, it has been difficult to document the relatively rare but very serious risk of suicidal behavior related to SSRI (Marčinko 2007). Dissociation and identity problems should be medicated by low-dose of new antipsychotics. A review of pharmacologic studies suggests that anticonvulsants may have similar stabilizing effects in both borderline personality disorder and bipolar disorder. Careful assessment of coexisting Axis I disorders in BPD patients is essential, because they represent the clinical picture, and determine treatment response and outcome. Axis I conditions suggest which type of psychopharmacotherapy will be used. Effective medication management reduces the overall suffering of the patient and enables her or him to make greater use of psychotherapeutic interventions which is very important for BPD patients.

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Correspondence:

Darko Marčinko, MD, PhD
Department of Psychiatry, Clinical Hospital Center Zagreb
Kišpatićeva 12, 10000 Zagreb, Croatia
E-mail: darko.marcinko@zg.t-com.hr