

# THE CONTINUUM BETWEEN BIPOLAR DISORDER AND BORDERLINE PERSONALITY DISORDER

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## SUMMARY

**Introduction:** Several studies have been carried out regarding the possible overlap between Bipolar Disorder and borderline personality disorder. Up to now, it is not possible to provide a definitive picture. In fact, there is currently significant debate about the relationship between Borderline Personality Disorder and Bipolar Disorder.

**Methods:** MEDLINE searches were performed to identify the latest studies of these disorders, considering psychodynamic aspects.

**Discussion:** Bipolar disorder and borderline personality disorder share common clinical features, namely affective instability and impulsivity which however differ in quality. Consequently, to better understand these aspects, it is necessary to trace the stages of childhood psychological development.

**Conclusions:** It has been claimed that Bipolar Disorder Type 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. However, better diagnostic theories, psychiatrist's empathy and patience remain the essential tool to understand and to face human suffering.

**Key words:** bipolar disorder - borderline personality disorder – spectrum - continuum

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## INTRODUCTION

There is currently significant debate about the relationship between borderline personality disorder (BPD) and bipolar disorder. Bipolar Disorder may be clinically difficult to distinguish from BPD (Bolton 1996) and there is recent evidence that patients with BPD are frequently misdiagnosed to have Bipolar Disorder (Zimmerman 2010).

Evidence of a possible overlap between bipolar disorder and BPD comes from several sources. In this context some investigators have asserted that many cases of BPD are actually part of a bipolar spectrum (Akiskal 2004).

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 aspects 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 (Cassano 2010).

## METHODS

MEDLINE searches were performed to identify potential studies of these disorders.

Data from studies that met inclusion criteria (Bipolar Disorder, borderline personality disorder, Spectrum,

Continuum) were incorporated into our study estimating the overlap between Bipolar Disorder and Borderline personality disorder.

Furthermore, we analyzed the psychodynamic aspects.

## DISCUSSION

It is now more than two decades since Akiskal first suggested that borderline personality disorder could be better understood as an Axis I disorder within a bipolar affective spectrum (Akiskal 1985a, Akiskal 1985b).

Akiskal initially used the concept of spectrum to describe mild, subclinical and atypical bipolar disorders (the so-called bipolar disorder III and IV). However temperaments and personality traits also pertain to this definition since, according to the concept of spectrum, personality is considered a mosaic of complex dimensions, simpler or elementary with psychological and psychopathological different features, constantly changing depending on the environment (Cassano 2010).

This is in line with Krapelin's theories stating that there is a considerable quantitative and qualitative variability among patients with manic-depressive psychosis. Concerning this 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” (Kraepelin 1921).

Psychiatric literature shows how BPD often presents in comorbidity with affective disorders and also shares common symptoms with them, thus resulting into numerous discussions about the relationship between BPD and the disorders of the Bipolar Spectrum, mainly Bipolar Disorder Type II (BDII) (Paris 2007).

In fact, the co-existence of the two disorders as separate diagnoses seems to be rather common. Different studies have reported that 12-23% of patients with BDII meet criteria for BPD as well (Paselow 1995) (Vieta 1999, Benazzi 2000).

Chantal et al. 2010 reported a high frequency of comorbidity between BPD and mood disorders (bipolar disorder and major depression) from 35 to 51.5% (Chantal 2010).

As previously mentioned these disorders are often contemporaneously present, but it is also true that they share common clinical features, namely affective instability and impulsivity which however differ in quality (Agrawal 2004).

It seems that affective instability characterizes both disorders, although there are subtle differences in the way it manifests itself in them.

For instance BPD is characterized by fear of abandonment and dependent relationships (Agrawal 2004, Gunderson 2001, Meyer 2001) as well as anxiety, anger and hostile behaviour (Wilson 2007).

Both BPD and mood disorders share high neuroticism (related to affective instability) and low conscientiousness but BPD is high on harm avoidance whereas Bipolar Disorder is not (Paris 2007).

MacKinnon et al. (2006) suggested that affective instability could be referable to a common genotype showing with different phenotypes depending on the influence of environmental and psycho-social factors (MacKinnon 2006).

In fact, affective instability in BPD is related to stimuli by the environment, which is uncommon in BD (Paris 2007).

Moreover, Bradford Reich et al. (2012) detected that lability involving anxiety, anger, intense discomfort and irritability is more characteristic of borderline patients whereas lability involving elation is more characteristic of bipolar patients (Bradford Reich 2012).

With reference to lowered mood, BPD 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 given that conscious feelings of anger often alternate in patients with Borderline Personality Organization, contrary to what happens in the depressed patient, whether he is bipolar or not.

For this reason mood changes in Bipolar Disorder can be different from those of BPD.

Switch from depression to elation distinguishes bipolar II from BPD as well as a more episodic nature; on the contrary, in BPD mood rarely includes elation and is more likely to shift from euthymia to anger mania as a reaction to environmental events (Paris 2007).

Regarding impulsivity, it prevails in BPD in the form of lack of concentration, loss of ideas, disorientation, difficulty in organizing and planning actions and their consequences (Wilson 2007).

Benazzi et al. (2008) tested the association between hypomania symptoms and BPD traits and detected that the only significant association was between the episodic impulsivity of hypomania and the trait impulsivity of BPD (Benazzi 2008).

Consequently, a clinician has to decide whether symptoms are best attributed to an acute mood disorder or they are just the latest manifestation of a more chronic and pervasive problem. On the other hand it has been suggested that BPD is actually a mood disorder within the bipolar spectrum and should be transferred to Axis I and be integrated into BPDI as one of its clinical subtypes (MacKinnon 2006).

In confirmation of this, the Work Group on BPD for DSM-IV concluded that the overlap between BPD and mood disorders was caused by the item “affective instability” and that “impulsivity” could be its “essential feature” (Benazzi 2008).

Furthermore, it has been claimed that BDII can be divided into two subtypes: one stable and functional between episodes and one unstable between episodes which is related to BPD (Benazzi 2000).

Other authors interpreted the affective instability of BPD as a form of prolonged ultra-rapid cycling with extreme rapid mood switching (MacKinnon et al. 2006), closely resembling the classic description of cyclothymia (Akiskal 1981).

Bradford Reich et al. (2012) proposed that bipolar disorder and BPD may share a cyclothymic temperament involving affective reactivity and interpersonal sensitivity (Bradford Reich et al. 2012).

In fact, mood lability, hostility and anxious-avoidant-sensitive traits seem to be related within a cyclothymic temperament (Perugi et al. 2002, McElroy et al. 2005).

The concept of affective temperament has been recovered to try to overcome the difficulties deriving from the attempt to link Axis I Bipolar Disorders to Axis II Personality Disorders. Affective temperament means in fact a biological disposition involving different levels of energy and mood quality which determine a particular reactivity to external stimuli (Ehr 2003).

Temperamental characteristics of cyclothymic and hyperthymic types may represent the phenotypic expressions of the underlying bipolar genotype and determine the extreme sensitivity to external events (Akiskal 2006).

Moreover some features such as stability over the time, early onset and long duration make the concept of temperament similar to the concept of personality (Akiskal 2006).

However the relationships between personality, temperament and mood disorder are complex and cannot be evaluated only with a descriptive approach. So, to better understand these aspects, it is necessary to trace the stages of child psychological development (Mahler 1975, Benedetti 1978, Sayin 2005).

In the separation/individuation process (6 to 24 months) the infant ceases to be ignorant of the differentiation between him and the mother, becoming progressively aware that she is a separated person. In this way the infant begins to explore the surrounding world with an euphoric feeling of greatness and omnipotence becoming more distant from his mother (Mahler 1975).

Doing this the infant achieves awareness that he is separated from his mother and experiences a feeling of vulnerability related to the loss of the loved object which makes him confident. This is why he now tries to regain it.

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

It is possible to consider the sense of inadequacy and opposite pseudo-omnipotent part of the bipolar subject as the expression of the failed attempt to get over 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 stabilization of the Self. This kind of developmental failure is the same as we can observe in the Borderline Personality Organization where the founding element is the failed achievement of an integrated identity and of the object constancy (Kernberg 1975).

The psychodynamic and phenomenological assessment thus underlines the common root of the presumed antinomy elation/depression.

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 (Quartesan 1996).

## CONCLUSION

In conclusion the central thread of this report is the awareness that the clinician always remains the essential tool thanks to the 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 the psychic suffering in the evolution of the human existence (Elisei 2007).

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