“A diagnostic challenge in bipolar disorders”

Belgium Conference February 2010
Bernadette Grosjean. MD. UCLA.
1-Introduction
2-Diagnosis and treatment
  - Borderline Personality Disorder (BPD)
  - Bipolar Disorder (BP)
3-Differential Diagnosis
4-Dual pathology
5-Main Points & Conclusions
1- Introduction: Why this subject?

- Overlap between BPD and BP is controversial
- Complexity of pathology that increase the risk for mortality morbidity and poor social functioning
1- Introduction:
Why this subject?

Subset of population falling through the cracks of mental health net:
the FSP experience.
Harbor Full Service Partnership (FSP) (1-2-2008)
Why is this question important?

For the patient, for the clinician, for the community:

- Diagnosis
- Prevention
- Getting the appropriate treatment and better use of resources
- Long term risk/benefit of pharmacological treatment
- Research / etiopathology
- Save suffering and $$$
Are BPD and bipolar disorders on a same spectrum?
Mood Disorder?

"Borderline: An Adjective in Search of a Noun."
J Clin Psychiatry. 1985

"I don’t have any use for the borderline diagnosis"
American psychiatric association meeting 2006

Hagop Souren Akiskal, M.D.
Professor of Psychiatry and
Director of International Mood Center
UCSD LA Jolla, California
Borderline patients have a higher co-occurrence of bipolar disorder (19.4 percent) than patients with other personality disorders.

80% patients with borderline do not have bipolar disorder.

John Gunderson MD.
Professor of Psychiatry
Director, Psychosocial & Personality Research
McLean Hospital
Harvard Medical School
Importance of correct diagnosis

- Danger of missing bipolar diagnosis when BPD traits are present, especially in adolescent

- Danger of misdiagnosis BPD patients without bipolar disorder
Access to care: “B” aka “she's a borderline” has historically been a reason not to admit people to hospital, or discharge them more quickly than others, for example.

Missing bipolarity because of a diagnosis of "borderline" may lead to an emphasis on using antidepressant medications.

Giving mood stabilizer to patient with BPD “only”
Importance of correct diagnosis

- Anticipation/prognosis
- Therapist readiness and counter transference
- Patient and family education
- Avoid getting too stuck on a diagnostic label.
- Needs a subtle specific blend of different type of therapeutic approaches.
2- Diagnosis and treatments
FEAR
ABANDONMENT
ANGER
DESPAIR
SUICIDAL TENDENCIES
NO REASON
NO REASON
NO REASON

BORDERLINE PERSONALITY DISORDERS
"Borderline individuals are the psychological equivalent of third-degree-burn patients. They simply have, so to speak, no emotional skin. Even the slightest touch or movement can create immense suffering." Marsha Linehan
Prevalence:

10% of psychiatric outpatients
20% of psychiatric inpatients.

1-3% general population
(USA = 5,873,108)

Prevalence 5.9% (=18 millions in US)

There were no differences in the rates of BPD among men and women.

BPD was more prevalent among Native American men, younger and separated/divorced/widowed adults, and those with lower incomes and education.

Less prevalent among Hispanic men and women and Asian women.

Prevalence, Correlates, Disability, and Comorbidity of DSM-IV Borderline Personality Disorder: Results From the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions
Bridget F. Grant, Ph.D., Ph.D.; S. Patricia Chou, Ph.D.et al
The Journal of Clinical psychiatry April 2008
Diagnostic Criteria for BPD (301.83)

- Fears of abandonment
- Unstable intense interpersonal relationships
- Identity disturbances
- Self-damaging impulsivity (e.g., spending, sex)
- Recurrent suicidal or self-mutilating behavior
- Affective instability
- Feelings of emptiness
- Inappropriate intense anger
- Transient paranoia or dissociation
Clinical Features
Phenomenology

- Emotion dysregulation;
- Cognitive dysfunction;
- Dissociative states; perceptual alteration; temporary malfunction of reality testing.

BPD-1- Behavioral Symptoms

- Poor affect regulation.
- Poor impulse control.
- Unstable relationships.
- Risky behaviors.
- Self harm.
- Suicidality.
BPD-2- Cognition

Problems with:

🎉 Attention
🎉 Memory
   🎉 working memory
   🎉 declarative memory
   🎉 procedural (implicit) memory
🎉 Learning processes
🎉 Executive functioning
🎉 Social cognition (emotion recognition, interpretation of emotion, mentalization/Theory of Mind [TOM])

Lapse in reality testing (paranoid experience, hallucination, magical thinking etc).

75% meet criteria for remission after 6y//10y years (Zanarini et al.2003//2007)

60-75% after 20 y F/u no longer meet criteria for BPD, were doing relatively well and able to live independently.

10% completed suicide

36%, among those who met 8 DSM criteria, completed suicide (compared to 7% who met 5-7 criteria).
BPD: Etiopathology/ Risk & Vulnerability

Genetic Disposition? Temperament

Pathology of early attachment (Bandelow et al. 2005).
  - neglect
  - trauma (sexual, physical abuse)
  - chaotic-disorganized

HPA axis hypersensitivity
  (Figueroa & Silk 1997; Rinne et al. 2002).

Neurotransmitter Systems

Serotonin (Coccaro, Siever et al. 1989; Figueroa & Silk 1997).

Dopamine (Friedel 2004).

NMDA receptors dysfunction (Grosjean & Tsai 2007).


FMRI of BPD patients listening to scripts describing abandonment events show dysfunction of medial and dorso-prefrontal cortex. Schmal et al. 2003.

Pain produced neural deactivation in the perigenual anterior cingulate gyrus (ACC) and the amygdala in patients with BPD. Schmahl et al. Arch Gen Psychiatry. 2006

Abnormal insula response compared to healthy participant in task testing interpersonal cooperation skills. King-Casas et al. Science August 2008
BPD Theories & Treatment Today

  - Object relation model

- **Linehan: Dialectic Behavioral Therapy (DBT) (1993)**
  - Deficit in self regulation
  - Invalidating environment

- **Bateman & Fonagy: Mentalization Based Treatment (MBT).2000.**
  - Importance of attachment; mentalization
Dialectical behavioral therapy (DBT)

Standard DBT is mostly outpatient treatment but has been recently adapted for inpatients

- Comprehensive; evidence based treatment
- Blends cognitive-behavioral approaches and acceptance-based practices (Zen)
- Four basic modes
  - Individual psychotherapy - focus on client focus on client’s motivation
  - Skills training group
  - Telephone consultation - ensure generalization
  - Consultation team - enhance therapist capabilities
Pharmacologic Treatment in Borderline Personality Disorder

- SSRI (antidepressant)
- Antipsychotics (low dose)
  - Mood stabilizers
  - Anxiolytics

Polypharmacy is the (bad) rule rather than the exception

American Psychiatric Association. *Practice Guideline for the Treatment of Patients With Borderline Personality Disorder*
Main Points:

*When establishing BPD diagnosis pay attention to:*

- Past and present symptoms in the 3 dimensions: behavioral, affective and cognitive
- History (personal and familial, social and psychiatric)
- Type of relationships established in and out therapy (object relation/transference; counter transference)
- Response to treatments (pharmacological and psychotherapeutic)
Trouble
Bipolaire
(TB)
Bipolar History

While the term *bipolar disorder* was there since 1980, *manic-depression* was the term that was still more commonly used until the mid-1990s.

The **key event** in the mid-1990s that led to that change in perspective was the *marketing of depakote by Abbott as a mood stabilizer*.

*Before that, the concept of mood stabilization didn't exist. It can’t be found in any of the earlier reference books and journals.*
Bipolar History

In the mid-1990s, the category “Bipolar Disorder” was introduced in the DSM IV and half of all mood disorders were redefined as bipolar disorder rather than depression.

Since then, we have sections for mood stabilizers in all the books on psychotropic drugs, and over a hundred articles per year featuring mood stabilization in their titles.  

David Healy Mania 2008.
Key points in bipolar disorder

- Prevalence estimated between 1-3%
- Found across cultures and ethnicities
- Males=females
- Defined by recurrent episodes of mania (or hypomania) and depression
- Strongly heritable
- Often misdiagnosed
The High Rate of Misdiagnosis

2000 National DMDA Bipolar Survey of 600 bipolar patients:

- 69% Initially Misdiagnosed
- Most frequent misdiagnosis: Unipolar depression 60%
- 35% were symptomatic for more than 10 years before correct diagnosis
- 10+ years

AGE OF SYMPTOM ONSET
NDMDA Survey N=500


Years of age

- <5: 5%
- 5-9: 12%
- 10-14: 14%
- 15-19: 28%
- 20-24: 15%
- 25-29: 9%
- 30+: 16%
Bipolar Spectrum Symptoms

- Dysphoria
- Hyperactivity
- Impulsivity/suicidality
- Irritability/Hostility
- Anxiety
- Cognition
- Psychosis
Psychosocial Deficits

- Recognition and Regulation of Emotion
- Relationships
  - Peers
  - Family members
- Impulse Control
- Social Problem-Solving
- Self-Esteem
Suicidality:
- Prevalence of suicide attempts: 25-40%
- Completed suicide rate 10-15%
- Usually during depressive or mixed episode
- 50% suicidal ideation in mixed mania
Pharmacologic Treatment in Bipolar Disorder

- Antidepressants
- Antipsychotics
- Mood stabilizers
- Anxiolytic

Polypharmacy is the rule rather than the exception

Bauer MS, et al. *Clinical Practice Guidelines for Bipolar Disorder from the Department of Veterans Affairs.*

Non-pharmacologic Treatments

- Psychotherapy
- Psycho-education
- Family Interventions
- Cognitive-Behavioral Therapy
- Electroconvulsive therapy
3- DIFFERENTIAL DIAGNOSIS
Main points

- Trying to distinguish these two conditions is difficult because they share so many characteristics.
- 3 possible diagnosis:
  - Bipolar only
  - Borderline PD only
  - BPD with BP
- The treatments to be considered are at time similar and require a subtle blend of suppleness and firmness.
Common symptoms

- Rapidly changing moods of depression, irritability, grandiosity, pressured speech, racing thoughts, etc.
- Poor relationships
- Difficulties with concentration and focus
- Difficulties with task completion
- Impaired judgment and impulsivity
- Disorganization
- Becoming overwhelmed with stressful situations
- Psychotic Symptoms
Differential diagnosis

- Can only be made over time
- Clinician need to be flexible and avoid to be rigid about the diagnostic label.
**BPD**

- **Family History ?**
- **Cognitive** unstable self
  transient paranoid ideation
  **chronic emptiness**
  abandonment fear
- **Poor impulse control**
  (sex, substances, **self-harm**)
- **Mood**
  affective instability
  reactive mood
  episodic dysphoria
  irritability, intense anger
  anxiety
- **Behavior**
  suicide attempts (~10%)
  self-harm
  Completed suicide (~10%)

**Bipolar**

- **Family History +**
- **Cognitive** unstable self
  psychosis, esp.
  paranoid/grandiose
- **Poor impulse control**
  (spending, sex, substances, risk sports)
- **Mood**
  affective instability
  "rejection hypersensitivity"
  dysphoria
  irritability, intense anger
  anxiety
- **Behavior**
  suicide attempts (~10%)
  self-harm
  Completed suicide (~10%)
How are Bipolar and Borderline Personality Disorder Different?

- In **BPD**, mood changes are often more **short-lived** -- they may last for a few hours at a time.
- In contrast, mood changes in bipolar disorder tend to **last for days** or even weeks.
How are Bipolar and Borderline Personality Disorder are Different?

- Mood shifts in BPD are usually in reaction to an environmental stressor (such as an argument with a loved one), whereas mood shifts in bipolar disorder may occur out-of-the-blue.

- Mood shifts typical of BPD rarely involve elation -- usually the shift is from feeling upset to feeling "OK," not from feeling bad to feeling a high or elevated mood, which is more typical of bipolar disorder.
How are Bipolar and Borderline Personality Disorder are Different?

**In BPD:**
- auditive hallucinations that are intermittent and related to stress are recognized as hallucination.
- no fixed paranoid delusions
- feelings of “being unreal” are often related to stress

**In psychosis (schizophrenia/SAD)**
- hallucinations are not identified as such, presence of fixed delusion, feelings of being “unreal” are infrequent
Bipolar 1 and 2 have **19.4% comorbidity** with BPD and 7.9% for all the other type of personality disorder.

Gunderson (2006)
Dual Diagnosis and outcome

- Adolescent bipolar *without PD* have better response to lithium Kutcher et al (1990).
- No difference in responsiveness to lithium but more severe suicide attempt when Axis 2 comorbidity. Ucok et al (1998)
- Bipolar 1 with Personality disorder have significantly more lifetime day hospitalized and more severe symptomatology than those without PD, and more likely to report that their medication were “unhelpful” Barbato and Hafner (1998).
Dual Diagnosis and outcome

- Patient with multiple episode are more likely to have Personality Disorder than first episode patient, one year later, less likely to show symptoms recovery and less functional recovery (Duynarich et al 1996, 2000).
- Bipolar II plus PD have earlier age of onset of bipolar and more severe suicidal ideations (Vieta et al 1999).
- Bipolar with personality disorder comorbid have worse outcome (Kay et al 2002; Bieling et al 2003): lower rate of employment, more complex medication regimen and greater likelihood of substance abuse.
Therapeutic approaches & Conclusions

Oh what to to, what to dooo?
Main points

• Flexible and open regarding diagnosis
• Great caution in diagnosing BPD during an active affective disorder
• Once diagnosis established be constantly aware of which pathology is “taking over” and where the priorities are
• Long term perspective (e.g. importance of the choice of medication and of type of intervention/ non intervention from the team members)
Main points

In general psychosis has to be addressed first; medication is needed and hospitalization may be required.
However at time, we need to be able to address simultaneously, and appropriately the axis II in order to have the patient working with us in addressing the axis I problem.
Main points

- Do not be blind sight by some aspect of the borderline symptoms that could easily pass for “manic” or depressives” with the risk of “mis-treating” them pharmacologically only and neglecting the psychotherapeutic part.

- Ideally DBT treatment should be available in order to teach patients basics skills such as emotion regulation, interpersonal skills etc.
Main points

Team work is ESSENTIAL
Team work & therapeutic alliance

• Patient-therapeutic team (as an entity and with each individual)

• Within the therapeutic team! (“treatment team like” meeting even if we are not in a strict D BT model can help to prevent burnout and “splitting”)

• Education/support of patient, family, team, other providers
The strength of the working alliance has been the most studied process variable, and it has been shown to correlate positively with psychotherapeutic outcome (Krupnick et al. 1996; Wampold 2001).

In fact, the working alliance—“the collaborative and affective bond between therapist and patient”—may be considered the therapeutic “quintessential integrative variable” (Wolfe and Goldfried 1988).
Last words...

- Intimacy difficulties with closeness pertaining to both pathology in different fashions
- The "trust challenge"
- The counter transference "double challenge"
- The long long sinuous path to recovery
- Do not give up!

The patient does not have that choice!
Thank you!
bernaharbor@yahoo.com
Bibliography:

- Mania: David Healy, 2008
First published in 1952, the DSM has its origins in a book used by the US military to determine if recruits were mentally fit for combat.

The manual was 130 pages long and listed 106 mental disorders.

The difficulty of separating mental disorders from normal variation in behavior made it controversial from the start. Over the years, the book's influence has grown, and today it is used by doctors across the globe.
About the DSM

- Regularly referred to as the profession's bible, the DSM is in the midst of a major rewrite, and feelings are running high.

- In July 2009, two eminent retired psychiatrists (Dr Robert Spitzer and Dr Allen France) are warning that the revision process is fatally flawed. They say the new manual, to be known as DSM-V, will extend definitions of mental illnesses so broadly that tens of millions of people may be given unnecessary and risky drugs.
In separate letters to the APA they accuse the new revision of the DSM of planning unworkable changes and making grandiose claims. In a separate editorial in the Psychiatric Times, Frances complained that most of the authors are university based researchers who are cuts from typical doctors and patients.

Psychiatry Civil war The New Scientist Dec 2009
Some of the most recent and acrimonious arguments stem from worries about the pharmaceutical industry's influence over psychiatry. This has led to the spotlight being turned on the financial ties of those in charge of revising the manual, and has made any diagnostic changes that could expand the use of drugs especially controversial.

“The result would be a wholesale... medicalization of normality that will lead to a deluge of unneeded medication” Frances said in his editorial.
Elly Lilly campagne systématique de désinformation

- Au même moment, la compagnie déclare dans un document interne que « cela ne doit en rien affecter la sauvegarde » du médicament sur le marché américain.
- Deux mois plus tard, Lilly débute une gigantesque campagne de marketing auprès des médecins généralistes américains.
Interview with Dr. John Nash at the 1st Meeting of Laureates in Economic Sciences in Lindau 2004. Around min 21, he answers question about his schizophrenia and how he has been following medications since the 70ies...