

# **Bipolar Disorder vs. Borderline Personality Disorder:** *How to Tell the Difference and Why It Matters*

Presented by Andrea Auxier, PhD and Katrin Seifert, PsyD  
Salud Family Health Centers

**Date/Time:**

Tuesday, March 1, 2011

11:30 AM – 1:00 PM Mountain Time

**Target Audience:**

Health Center Providers and  
Support Staff

## ***SUPPLEMENTARY INFORMATION PACKET***

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**LEARNING OBJECTIVES**

Through participation in this webcast, participants will:

1. Understand the commonalities and differences between bipolar disorder and borderline personality disorder.
2. Be prepared to detect and accurately diagnose these conditions.
3. Understand treatment options, particularly in integrated systems.

*This event supports strong program management at Region VIII Community, Migrant, and Homeless Health Centers (CHCs) by **addressing the following HRSA Health Center Program Requirements and Performance Improvement Areas:** Program Requirements: Services – Required & Additional Services and Quality Improvement/Assurance Plan; Performance Improvement: Health Care Plans – Behavioral Health*

**CONTINUING MEDICAL EDUCATION CREDIT**

This activity, Webcast: Bipolar Disorder vs. Borderline Personality Disorder, with a beginning date of March 1, 2011, has been reviewed and is acceptable for up to 1.50 Prescribed credits by the American Academy of Family Physicians.



**Community  
Health  
Association of  
Mountain/  
Plains  
States**

## **SPEAKER BIOGRAPHIES**

**Andrea Auxier, PhD, Director of Integrated Services and Clinical Training, Salud Family Health Centers:** Andrea Auxier is a licensed clinical psychologist and Director of Integrated Services and Clinical Training at Salud Family Health Centers, a migrant/community health center with clinics across north and northeast Colorado. Dr. Auxier holds a BA from Cornell University, an MA from New York University, and an MA and PhD from the University of Massachusetts. She moved to Colorado from Miami, Florida where she completed her postdoctoral fellowship at the University of Miami Miller School of Medicine/Jackson Memorial Hospital, Department of Psychiatry and Behavioral Sciences. As a native Spanish speaker, she has worked primarily with underserved, multicultural populations, with a focus on those affected by posttraumatic stress. She is interested in integrated primary care practice and research, particularly as it applies to immigrant populations with trauma histories. Dr. Auxier's current role involves program development for integrated services models, direct administrative and clinical management of the behavioral health team, and clinical training and supervision of students and postdoctoral fellows. She is a senior clinical instructor at the University of Colorado Denver, Department of Family Medicine and is an associate editor for the Journal of Translational Behavioral Medicine.

**Katrin Seifert, PsyD, Licensed Clinical Psychologist, Salud Family Health Centers:** Katrin Seifert is a licensed clinical psychologist working at Salud Family Health Centers, a migrant/community health center with clinics across north and northeast Colorado. Following undergraduate training at Brandeis University, she worked as a Clinical Research Assistant to a pediatric psychiatrist at McLean Hospital in Belmont, Massachusetts on research projects involving children with Bipolar Disorder, psychotic disorders, and ADHD. Dr. Seifert completed her graduate training at the Graduate School of Professional Psychology at the University of Denver with a focus on high-needs adolescents as well as psychological and neuropsychological assessment. She completed her Predoctoral Internship at Aurora Mental Health Center, which helped foster her new passion for Integrated Primary Care. She recently completed her postdoctoral fellowship at Salud Family Health Centers, where she provided consultation and therapy services to patients of all ages as well as training and supervision to practicum students.

## **DESCRIPTION OF CHAMPS**

CHAMPS, the Community Health Association of Mountain/Plains States, is a non-profit organization dedicated to supporting all Region VIII (CO, MT, ND, SD, UT, and WY) federally-funded Community, Migrant, and Homeless Health Centers (CHCs) so they can better serve their patients. Currently, CHAMPS programs and services focus on education and training, collaboration and networking, workforce development, policy and funding communications, and the collection and dissemination of regional data. For more information about CHAMPS, please visit [www.champsonline.org](http://www.champsonline.org).

## **CHAMPS ARCHIVES**

This event will be archived online and on CD-ROM. The online version will be available within two weeks of the live event, and the CD will be available within two months. CHAMPS will email all identified participants when these resources are ready for distribution. Visit [www.champsonline.org/Events/DistanceLearning.html](http://www.champsonline.org/Events/DistanceLearning.html) for information on all CHAMPS archives.


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## Bipolar Disorder vs. Borderline Personality Disorder: How to Tell the Difference & Why it Matters

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March 1, 2011 - 11:30 a.m. Mountain Time



This live activity, Webcast: Bipolar Disorder vs. Borderline Personality Disorder: How to Tell the Difference & Why it Matters, with a beginning date of March 1, 2011, has been reviewed and is acceptable for up to 1.50 Prescribed credits by the American Academy of Family Physicians. Application for 1.50 Prescribed credits for the archived version will be filed immediately following the live event. Andrea Auxier and Katrin Seifert have indicated that they have no relationships to disclose relating to the subject matter of this presentation.


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## Presentation Outline


- A) Prevalence, epidemiology, and etiology
- B) Bipolar: Defined, Comorbidity, Structural imaging findings
  - A) Treatment: Psychotherapy and Pharmacology
  - B) Special considerations for children and pregnant women
  - C) Diverse populations
- C) Borderline PD: Defined, Theory, Comorbidity, Manifestation, Neurochemistry
  - A) Treatment: Pharmacology and Psychotherapy
  - B) Diverse populations
  - C) How to manage these patients in a medical setting
- D) Common Features
- E) Differential Diagnosis
- F) Integrated Systems approach to treatment



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## Interactive Question #1a


- What percentage of patients do you think have Bipolar Disorder in your setting?
  - a) 0-1%
  - b) 1-2%
  - c) 2-5%
  - d) 5-10%
  - e) > 10%



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## Interactive Question #1b


- What percentage of patients do you think have Borderline Personality Disorder in your setting?
  - a) 0-1%
  - b) 1-2%
  - c) 2-5%
  - d) 5-10%
  - e) > 10%



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## Prevalence- Bipolar

- Bipolar: 1.2% - 1.7%
  - 3.0% among 15-24 year olds (Kozloff, et al., 2010)
  - Age of onset:
    - 66% report sx onset prior to age 18 (Perlis, et al., 2004)
    - 20% have first episode during adolescence (Geller & Luby, 1997)



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## Prevalence - Borderline

- **Borderline: 1.5% - 3%**
  - 1-2% in general population (e.g. Torgersen, et al., 2001)
  - 10-20% in treatment-seeking patients (e.g. Skodol, et al., 2002; Skodol, et al., 1999)



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## Epidemiology

- **Bipolar**
  - Equally common in men & women & across age groups (Diflorio & Jones, 2010)
- **Borderline**
  - 3x more common in women (DSM-IV-TR)
  - Most common in young women



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## Family Hx – 1<sup>st</sup> Degree Relatives

- **Bipolar:**
  - BDI: 4-24%
  - BDII: 1-5%
  - MDD: 4-24%
  - Twin and adoption studies provide support for high heritability index
- **Borderline:**
  - 5x more common in 1<sup>st</sup> degree relatives of people with Borderline PD than in general population



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## Etiology

- **Bipolar:** Strong genetic component
- **Borderline:** A combination of individual vulnerability to environmental stress, neglect or abuse as young children, markedly inconsistent parenting and a series of events that trigger the onset of the disorder as young adults
- Common etiology is suggested because of similar phenomenology and because Borderline PD responds to mood stabilizers (Smith, et al., 2004; Paris, et al., 2007)



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# Bipolar Disorder



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## Manic Episode

- At least 1 week of elevated, expansive, or irritable mood with 3+ of following (4+ if mood only irritable):
  - Inflated self-esteem/grandiosity
  - Decreased need for sleep
  - More talkative, pressured speech
  - Racing thoughts/flight of ideas
  - Distractibility
  - Increase in goal-directed activity
  - Excessive involvement in risky activities
- Marked impairment in functioning, hospitalization necessary, or psychotic features (DSM-IV-TR)



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## Hypomanic and Mixed Episodes

- Hypomanic episode
  - Same as Manic episode except
    - Only 4 days
    - Not severe enough to cause marked impairment in functioning or to necessitate hospitalization, no psychotic features
- Mixed episode
  - Criteria met for both Manic Episode and Major Depressive Episode for at least 1 week



(DSM-IV-TR)

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## Bipolar Types

- Bipolar I (Manic episode)
- Bipolar II (Hypomanic episode plus major depressive episode)
- Bipolar NOS
- Cyclothymic Disorder (mild depression alternating with hypomania for at least 2 years)
- Do not diagnose Bipolar Disorder solely based on manic-like episodes in reaction to antidepressant medication (p. 362, 368)



(DSM-IV-TR)

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## Bipolar Comorbidity

- Comorbidity is common (Kozloff, et al., 2010)
- Common comorbidities:
  - Substance abuse (Bizzarri, et al., 2007)
  - Anxiety disorders (Mueser, et al., 1998; Strakowski, et al., 1998; Krishnan, 2005)
  - Increased risk for thyroid issues, migraines, heart disease, diabetes, obesity, etc (Krishnan, 2005; Kupfer, 2005)



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## Bipolar Brain Structure: MRI

- Whole brain reduction (Arnone, et al., 2009)
- Prefrontal lobe reduction (Arnone, et al., 2009)
- Increased volume of globus pallidus (Arnone, et al., 2009)
- Increased volume of lateral ventricles (Arnone, et al., 2009; Kempton, et al., 2008)
- Reduced corpus callosal areas (Arnone, et al., 2008)
- Increased deep white matter hyperintensities (Beyer, et al., 2009; Kempton, et al., 2008)
- Increased subcortical gray matter hyperintensities (Beyer, et al., 2009)
- Findings different for first episode Bipolar, suggesting different patterns of changes in brain morphology over course of disorder (Vita, et al., 2009)



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## Interactive Question #2

- For Bipolar Disorder, which of the following is typically your first treatment recommendation?
  - a) Mood Stabilizer (Lithium, Depakote)
  - b) Antidepressant (Paxil, Zoloft, Celexa, Wellbutrin, Effexor, etc)
  - c) Atypical Antipsychotic (Seroquel, Zyprexa, Risperdal, Abilify, etc.)
  - d) Anticonvulsant (Tegretol, Lamictal, etc.)
  - e) Psychotherapy
  - f) Medication AND Psychotherapy



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## Bipolar Tx: Psychotherapy

- Interpersonal and social rhythm therapy (IPSRT)
  - Theory: Relationships (when exciting or stressful) and biorhythm contribute to sx's of Bipolar:
    - Disruptions in daily routine and pxs in relationships can cause recurrence of manic and depressive episodes
  - Treatment: Stabilize circadian and social rhythms



(Frank, 2005)

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### Bipolar Tx: Psychotherapy Research

- Therapy designed specifically for Bipolar is effective in preventing or delaying relapses (Lam, et al., 2009)
- NIMH study (STEP-BD)
  - Those who received 30 sessions of therapy over 9 months (CBT, IPSRT, Family-focused) did better than those who received 3 psychoed sessions over 6 weeks
    - Fewer relapses
    - Lower hospitalization rates
    - Better able to adhere to treatment plan
    - More likely to get well faster and stay well longer (Miklowitz, et al., 2007)



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### Bipolar Tx: Pharmacology Research

- Research support for:
  - **Lithium, Depakote, Lamictal** as maintenance therapy for prevention of relapse
  - **Lithium, Zyprexa, Abilify** in preventing manic relapses
  - **Depakote, Lamictal, imipramine** in preventing depressive sx's

(Beynon, 2009)



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### Bipolar Tx: Mood Stabilizer Research

- Research support for **valproate** vs placebo for reducing depressive sx's but not anything else (Bond, 2010; Smith, et al., 2010)
- **Lamotrigine/Lamictal** better than placebo for reducing depression (Geddes, et al., 2009)



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### Bipolar Tx: Antipsychotic Research

- One study showed that **Abilify** was helpful but many discontinue (Tang, et al., 2010)
- Another showed that **Abilify** was not superior to placebo (Cruz, 2010)
- Research support for **Seroquel** with no additional meds (Ketter, et al., 2010)
- **Seroquel** and **Zyprexa** superior to placebo (Cruz, 2010)



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### Bipolar Tx: Antidepressant Research

- Long-term adjunctive antidepressant tx not superior to mood stabilizer alone
- Antidepressant as part of tx:
  - 27% lower risk for new depression but
  - 72% greater risk for new mania

(Ghaemi, et al., 2008)



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### Bipolar Medication Research: Summary


- General support for
  - Lithium
  - Lamictal
  - Depakote
  - Zyprexa
  - Seroquel
- Mixed evidence for Abilify (2 pro, 1 con)
- Risk of adding antidepressant to mood stabilizer may outweigh benefit



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### Bipolar Tx Outcomes

- Therapy + meds better than treatment as usual
  - Addition of therapy had positive impact on sx's, adherence, QOL (although less robust at follow-up) (Gregory, 2010; Szentagotai & David, 2010)
- Medication tx most effective when continuous, not start-stop (NIMH)
- Less likely to recover if have comorbid mental illness (Perlis, et al., 2006)




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### Atypical Antipsychotics and Obesity/Diabetes

- Obtain personal and family hx for diabetes, obesity, dyslipidemia, hypertension, cardiovascular disease
- Get body mass index, waist circumference, BP, fasting glucose, fasting lipid
- Reassess weight at 4, 8, 12 weeks after initiating or changing antipsychotic then every 3 months
- If patient gains more than 5% of initial weight, change medication


(American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, & North American Association for the Study of Obesity, 2004)



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### Bipolar in Children/Adolescents


- Even in children, it is difficult to differentiate between mood swings of Bipolar Disorder and symptoms of personality disorder (Mattes, 2010)
- Often present with mixed or dysphoric picture with frequent short periods of intense mood lability and irritability (Geller, et al., 1995; Wozniak, et al., 1995)
- Bipolar in children:
  - Rapid cycling
  - Mixed episodes
  - Irritability
  - Multiple comorbidities (e.g. disruptive behavior and anxiety disorders) (Geller, et al., 2002; Mick, et al., 2003)



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### Bipolar in Children

- 69% of children with Bipolar also had Conduct Disorder (Kovacs & Pollock, 1995)
- ADHD is most common comorbid dx (Kowatch, 2005)
- Differential between Bipolar and ADHD:
  - For Bipolar must have **elated mood or grandiosity**
  - Other sx's seen more in Bipolar:
    - Hypersexuality
    - Decreased need for sleep
    - Racing thoughts (Geller, et al., 2004)




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### Bipolar in Children

<ul style="list-style-type: none"> <li>■ Medical conditions that can mimic mania                             <ul style="list-style-type: none"> <li>■ Temporal lobe epilepsy</li> <li>■ Hyperthyroidism</li> <li>■ Head injury</li> <li>■ MS</li> <li>■ Systemic lupus erythematosus</li> <li>■ Wilson's disease</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>■ Medications that may increase mood cycling                             <ul style="list-style-type: none"> <li>■ Antidepressants</li> <li>■ Aminophylline</li> <li>■ Corticosteroids</li> <li>■ Sympathomimetic amines</li> <li>■ Antibiotics</li> </ul> </li> </ul>
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(Kowatch, 2005)




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### Medication Tx of Bipolar in Children

- General Guidelines
  - First stabilize mood then treat comorbid disorders
  - Many start with antipsychotic or Lithium
  - Often combine traditional mood stabilizer and atypical antipsychotic

(Kowatch, 2005)



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### Medication Tx of Bipolar in Children

- For comorbid ADHD: After control Bipolar sx's with divalproex, can use low dose Dexedrine/Adderall XR (Scheffer, et al., 2005)
- Antidepressants
  - Can destabilize mood
  - Lamictal good alternative for treating depression (Kowatch, 2005)



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### Resources for Bipolar Disorder in Children/Adolescents

- Kowatch, R.A. & DelBello, M.P. (2005). Pharmacotherapy of children and adolescents with bipolar disorder. *Psychiatric Clinics of North America*, 28(2), 385-397.
- Geller, B. & DelBello, M. (Eds.) (2003). *Bipolar Disorder in Childhood and Early Adolescence*. New York: Guilford Press.



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### Bipolar in Pregnancy

- Balance risks of damage to fetus against risks of not treating Bipolar (Marangell, 2008)
- Lithium is best but can lead to heart problems in fetus (Viguera, et al., 2007; Yonkers, et al., 2004)
- Lamictal during pregnancy better than no treatment for symptom recurrence (Newport, et al., 2008)
- Of women with Bipolar who give birth, 40-67% report postpartum depression or mania (Marangell, 2008)



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### Treating Bipolar in Women

- When treating women with Bipolar Disorder:
  - Check for hypothyroidism (Marangell, 2008)
  - SE of Depakote = increased testosterone
    - This can lead to polycystic ovarian syndrome (Joffe, et al., 2006; O'Donovan, et al., 2002; Vainionpaa, et al., 1999)



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### Diversity Considerations: Bipolar

- No difference in prevalence between ethnic groups in U.S. older adults (Byers, et al., 2010)
- Expression and functional impairments of Bipolar similar across ethnic groups (White, Af Am, Latino) (Perron, et al., 2010)
- Mixed evidence about correlation between SES and Bipolar (Abood, et al., 2002; Tsuchiya, et al., 2004)
- Whites have higher chance of remission when treated with atypical antipsychotic (Dikeos, et al., 2010)
- Higher risk for Af Am and Puerto Rican pts with Bipolar of being misdiagnosed with SCZ (Mukherjee, et al., 1983)



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### Interactive Question #3

- Which of the following have you experienced in your setting (check all that apply)?
  - a) A patient yelling in the waiting area
  - b) Frequent, urgent phone calls from a patient
  - c) A patient who displays intense, easily triggered emotion that seems out of proportion to the event
  - d) A patient alternating between "loving" and "hating" you
  - e) Pitting providers against each other (e.g., "Dr. X said you would increase the dose of my medication")
  - f) A patient who pushes for special treatment (same day appointments, longer appointments, longer intervals between refills, contact outside the medical visit, etc)



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# Borderline Personality Disorder



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## Personality Disorder

- Enduring pattern of inner experience & behavior that deviates markedly from culture's expectations, manifested in at least 2 areas:
  - Cognition
  - Affectivity
  - Interpersonal Functioning
  - Impulse control
- Leads to clinically significant distress or impairment in functioning



(DSM-IV-TR)

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## What is Borderline Personality Disorder?

- Considered a "Cluster B" disorder = "Dramatic-erratic"
  - Other Cluster B are Antisocial, Histrionic, & Narcissistic
- **Pervasive** (*non-episodic*) pattern of instability in 4 domains:
  - Interpersonal relationships
  - Self-image
  - Affects
  - Marked impulsivity
- Beginning by early adulthood & present in a variety of contexts



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## Borderline PD: Theory

- Biological predisposition and response to an invalidating environment that results in:
  - Emotional sensitivity
  - Extreme emotions
  - Slow return to emotional baseline
- Behavioral problems result as an escape from uncomfortable emotions



(Linehan, 1993a)

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## Understanding Borderline PD

- Intense emotion often triggered by feeling:
  - Rejected
  - Alone
  - A failure

(Stiglmayer, et al., 2003)



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## Childhood Abuse History in Borderline PD

- 40-76% report sexual abuse (Battle, et al., 2004)
- 25-73% report physical abuse
- 90% report some form of maltreatment (Zanarini, et al., 1997)



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### Borderline PD Comorbidity

- Substance use disorders (up to 57%) (Trull, et al., 2000)
- Eating Disorder NOS (Marino & Zanarini, 2001)
- Suicide Attempt (75%) (Skodol, et al., 2002)
- Death by suicide (5-7%) (Duberstein & Conwell, 1997)



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### Borderline PD: Manifestation

- Personal History
  - Trouble giving coherent, chronological life history
  - Recurrent job losses, broken marriages, interrupted education, geographical mobility



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### Borderline PD: Manifestation

- Behaviorally
  - Often seen with a transitional object (pet, stuffed animal)
  - Pattern of undermining self when goal is about to be realized
  - Prone to regressive behavior when a milestone is reached
  - Action-prone; impulsive; self-destructive



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### Borderline PD: Manifestation

- Cognitively:
  - Black and white thought patterns
  - Drawn to extreme, all or nothing belief systems
  - Trouble holding positive and negative aspects of people and situations in mind at the same time



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### Borderline PD: Manifestation

- Affectively:
  - Fluctuate between murderous rage and suicidal despair
  - Crisis-driven



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### Borderline PD: Manifestation


- Self-concept:
  - Damaged, rotten, evil, bad – but have a core of omnipotence, conceit, and self-righteousness
  - Tend to identify with admired others to exaggerated degree
  - Tend to confuse own thoughts, feelings, personality with those of others
  - Often act in such a way as to elicit own feelings in other people (e.g., Provoking anger when angry)



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### Borderline PD: Push-Pull Behavior


- Simultaneously needy & rejecting
- Craves intimacy & caring but dismisses when offered
- Infuriating for providers!



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### Myth #1

- People do not recover from Borderline Personality Disorder




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### Fact

- Of patients with Borderline PD who had been hospitalized for psychiatric reasons, full remission from the BPD dx was achieved by:
  - 35% after 2 years
  - 49% after 4 years
  - 69% after 6 years
  - 74% at some point


(Zanarini, et al., 2003)



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### Borderline: Neurochemistry


- **5HT**
  - Impulsivity & aggression
  - Mood
- **NE**
  - Fight or flight
  - Orienting, attention, vigilance
  - Enhanced emotional memories of traumatic events
- **GABA**
  - Major inhibitory neurotransmitter
  - Can stabilize mood
- **Ach**
  - Movement & memory
- **Glutamate**



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### Borderline PD: Neurofunction


- Chronic stress > **NMDA receptor** down-regulation & reduced binding affinity
  - Results in excessive release of Glutamate and ACh, both excitatory neurotransmitters
- Enhanced **amygdala** activation in response to even low-level stressors
  - Slow return to baseline
- Activation of **prefrontal cortical areas**
  - Attempts to control intense emotions during recall of traumatic memories
- GABA dysfunction may make suppression of negative emotion difficult



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### Pharmacology for anger/aggression


- Meta-analysis of 29 RCTs of antidepressants, mood stabilizers, and antipsychotics to date
  - **Mood stabilizers** gave largest reduction in anger/aggression compared to other drug types
  - Limited to lamotrigine, topiramate, and carbamazepine and to short-term use, 6-10 weeks



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### Antidepressants and anger/aggression


- Small effect on anger
- Moderate effect when include pts selected for high levels of impulsive aggression  
*(4 positive studies of SSRIs; 2 positive studies of MAOI's)*
- Lone study of amitriptyline had a negative effect
- Studies limited to 13 weeks – cannot draw conclusions about long-term gains



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### Antipsychotics and anger/aggression

- Medium effect on anger  
*(3 studies of Zyprexa, 1 study of Abilify, 3 studies of typical antipsychotics)*
- Note: **Abilify** had the largest effect size of the antipsychotics
- 18-month controlled follow-up trial showed that the effect of Abilify was maintained



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### Psychotherapies for BPD


- Dialectical Behavior Therapy (DBT)  
*(Linehan, 1993a, 1993b)*
  - Mindfulness
  - Emotion Regulation
  - Acceptance
  - Interpersonal Effectiveness
- Meta-analysis of 16 studies found Moderate Effect Size for DBT (only Small Effect Size when compared with other treatments specifically for BPD)  
*(Kliem, et al., 2010)*



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### Psychotherapy for BPD continued


- Schema Focused
  - Maladaptive cognitive schemas resulting from negative interactions with caregivers; Reparenting of client *(Young, 1994)*
- Transference-Focused Psychotherapy
  - Identity diffusion causes inaccurate representations of self and other (all good/all bad), maintained through self-destructive behaviors *(Clarkin, et al., 2006)*
- Mentalization Model of Mentalization-Based Psychotherapy for BPD
  - Hyper-responsiveness of the attachment system renders the capacity to make sense of ourselves and others unstable during emotional arousal *(Fonagy & Bateman, 2008)*



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### Diversity Considerations: Borderline PD


- PD diagnosis lower among Af Am compared to whites *(McGilloway, et al., 2010)*
- Consideration for likelihood of different presentation depending on ethnic group *(Selby & Joiner, 2008)*
- Borderline higher in Hispanic vs. White and Af Am *(Chavira, et al., 2003)*
- Increased incidence of PD in lower SES *(Cohen, et al., 2008)*



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### Common Provider Reactions to Borderline Patients

- Fear
- Confusion
- Helplessness
- Boredom
- Strong desire to cure or save
- Hostility



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### Things that Backfire with Borderline Patients

- Authoritarian approach
- Hiding behind the “white coat” – VERY sensitive to power differentials
- Defensiveness
- Evasiveness
- Insincerity/lack of genuineness
- Lack of/inconsistent boundaries



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### Things that Work with Borderline Patients

- Attention to the quality of the provider-patient relationship
- Honesty & sincerity
- A judicious amount of self disclosure
- Humor, especially irreverent humor
- Clear, consistent boundaries / conditions of treatment



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### Messages you want to convey to Borderline patients

- You are an adult & can tolerate frustration
- I (the provider) refuse to be exploited or abused
- You do not feel good about yourself when you exploit or abuse others



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## Commonalities and Differential



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### Common Features between Bipolar and Borderline PD

- Mood swings
- Violent outbursts
- Depression/Anxiety
- Identity Diffusion
- Fickle – goals change frequently
- Problems with task-completion
- Impulsiveness
- Risky behavior
- Feelings of worthlessness, feeling misunderstood



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### Bipolar and Borderline PD

- Bipolar and Borderline co-occur to larger extent than other diagnoses  
(Gunderson, et al., 2006; Magill, 2004), but relationship is not consistent or specific
- Phenomenology, family patterns, and medication response support notion that they are separate constructs  
(Paris, et al., 2007)



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### Hospitalizations for Mental Illness

- Bipolar accounts for: 50%
- Borderline accounts for: 20%
- Better preventive care may decrease ER visits and hospitalizations



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### Differential Diagnosis

- Majority of people with Bipolar return to full functioning between episodes
- Borderline is NOT episodic in nature
- Key to diagnosis – Look at longitudinal course (Magill, 2004)



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### Differential: Symptoms

- **Depression** is common in both Bipolar and Borderline but qualitatively different:
  - Borderline:
    - Less guilt, appetite loss, lethargy, & sleep disturbance
    - More loneliness, emptiness & boredom



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	Bipolar	Borderline
<b>Reality Testing</b>	Grandiosity; paranoid psychosis	Transient paranoia; dissociation
<b>Mood swings</b>	Weeks/months	Hours/days
<b>Impulsivity</b>	Sex, substances, gambling, risky sports	Sex, substances, reckless driving, self-harm
<b>Completed Suicide</b>	10-20%	3-9.5%
<b>Parasuicidal Gestures</b>	?	Common
<b>Central Affects</b>	Variable	Chronic emptiness Rage Episodic dysphoria Anxiety
<b>Central Fears</b>	Variable	<b>ABANDONMENT</b>
<b>Perceptions of others</b>	Variable	Extreme rejection sensitivity; confused by others' actions & reactions
<b>Descriptions of others</b>	Unremarkable	Vague, lacking in richness

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### Myth #2

- Borderline Personality is a less severe form of Bipolar Disorder & might, in time, develop into bipolar disorder



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### Fact

- Any co-occurrence of Bipolar in Borderline PD does not appear to affect the subsequent course of Borderline PD

(Gunderson, et al., 2006)



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### Myth #3

- It is preferable to diagnose a patient with Bipolar than with Borderline PD



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### Fact

- Not considering the personality disorder has 2 damaging effects:
  - The bipolar diagnosis breeds unrealistic expectations about what medications can do
  - Therapeutic efforts are diverted away from psychosocial interventions that can often make a remarkable difference



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### Interactive Question #4

- Which of the following would you say is your biggest challenge with Bipolar/Borderline patients?
  - a) Detection/diagnosis
  - b) Providing on-site treatment
  - c) Referral to treatment



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## An Integrated Primary Care Approach to Treatment



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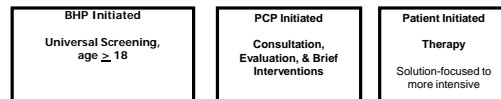
### Behavioral Health at Salud

- Represented in 7/9 sites + Mobile Unit
- Approx 15 FTE (Salud staff + staff from outside agencies)
- Various disciplines: Psychology, psychiatry, social work, counseling
- Psychology clinical training program
  - 2 licensed psychologists
  - 6 postdoctoral fellows
  - Several practicum students



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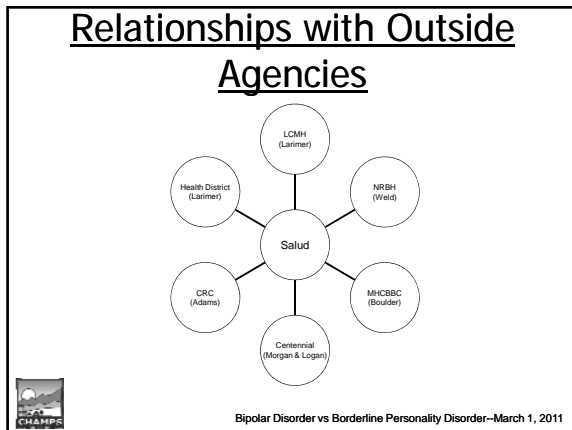
### Service-Delivery Model



A completely integrated primary care system  
that provides quality population-based care  
through improved access



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- ### What's Insufficient
- A straight consultative model = lost opportunity for patient contact
  - Integration does not equal referral
  - Can't reach entire population in 50-minute visits
  - There is no break in quality at 50 minutes
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- ### The Cost of Integration
- Integration reduces costs - to a point
  - Higher levels of integration cost more
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- ### Funding Integrated Care
- Fee for service reimbursement is not favorable to integrated systems
  - Meeting current carve-out requirements would radically alter the way we practice = fewer patients seen; little integration
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## Questions?

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