Bipolar or Borderline?

A rampant case of diagnonsense

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As psychiatrists have gone from doing both psychotherapy and prescribing psychiatric drugs to doing basically nothing but writing prescriptions, many of them have fallen into some very bad habits. When all you have is a hammer, everything starts to look like a nail. In this case, when all you have are drugs, everything starts to look like a brain disease.

Personality problems, anxiety, agitation, and reactions to problematic family and other interpersonal interactions have become widely mislabeled as biological/genetic brain diseases. This is quite a change from the time not all that long ago when real brain diseases like autism and schizophrenia were thought to be behavioral ("functional') disorders!

One of the worst trends in this regard is the use by psychiatrists of "symptom checklists" to save time in making a psychiatric diagnosis on their patients. Frankly, the doctor's secretary could make a diagnosis just as easily as the doctor could using this shortcut. Patients are quizzed about specific symptoms without anyone even checking to see if they understand what the symptom must be like in order to be clinically significant.

An adequate evaluation of psychiatric symptoms must take into account their psychosocial context, their pervasiveness, and their time course in order to distinguish them from everyday mood reactivity due to life experiences. Additionally, some symptoms are seen in a wide variety of different psychiatric conditions, and an understanding of these three factors, as well as the taking into account of the presence of other symptoms necessary in order to qualify for a given diagnosis, is essential in differentiating the different disorders.

For example, symptoms seen in a variety of psychiatric disorders as well as in normal people under stress include:

- Impulsivity
- Irritability
- Aggression
- Hostility and Rage
- Moodiness and sudden mood changes
- Agitation
- Poor Concentration
- Disorganization

Irritability can be seen in anxiety, major depressive disorder, dysthymia, mania, personality disorders, and in someone who's just having a bad day.

Nowhere is this problem more problematic than in the differentiation between a major mood disorder called bipolar disorder (which used to be more accurately called manic-depression), and a personality disorder spawned by dysfunctional families called borderline personality disorder (BPD). With BPD, psychiatric drugs only help with anxiety and reactivity - psychotherapy is by far its most important treatment.

The acute manic and depressive episodes of true bipolar disorder, on the other hand, do not really respond to psychotherapy at all, but are treatable with certain medications. Medications are also helpful in the prevention of future episodes (particularly manic episodes), and psychotherapy may also be helpful when patients are in the normal or *euthymic* state and must deal with the sometimes horrific consequences of their behavior when they were manic.

In my 35 years experience of taking complete psychiatric histories, and in my 20 years of experience watching psychiatric residents (trainees) take psychiatric histories, I know that asking patients about prior episodes of mania is one of the more difficult things to do in psychiatry. Almost everybody has been euphoric, partied all night, and felt on top of the world at one time or another. Patients almost invariably answer yes if asked about these symptoms. A patient has to be made to understand that in mania, these symptoms are really extreme, have to last several days in a row without any letup, be relatively unresponsive to anything that is going on in the environment, and be completely different from the patient's normal functioning. It literally has to be a Jeckyl and Hyde situation.

The psychiatrist also has to rule out other potential factors that may account for a patient's "yes" answer. For example, it may seem absurd when you think about it, but many psychiatrists stop asking about sleep after asking a patient about whether they have ever had a period in which they stayed up all night for several days while remaining energetic. They don't ask obvious follow-up questions like, "Did you nap in the daytime?" "Were you using methamphetamines or cocaine at that time?" or even, "How much coffee were you drinking then?"

Furthermore, despite objections from the people who wrote the diagnostic manual in psychiatry, some psychiatrists believe that a "manic" period can last just an hour or two, or even a few minutes. They say that folks who have brief mood swings or go into a rage are "ultra-rapid cyclers" or have "sub-threshold bipolar disorder." There is absolutely not one bit of credible scientific evidence that short-duration "mood swings" are in any way related to bipolar disorder. The docs pushing this idea literally made this up in order to justify selling and prescribing more drugs. They pulled it out of their you-know-whats.

Then there is the whole matter of the alleged disorder, *Bipolar II.* This disorder is characterized by depressive episodes but not full manic episodes. Instead, patients have to have a milder form of mania called "hypomania," which consists of a lot of the ambiguous symptoms listed above for a minimum of four days. (The duration criterion is routinely ignored by practitioners these days).

After having been in practice in two states with a wide variety of clinical populations (private practice, private hospitals, medical school outpatient department including screening potential patients for studies, state hospitals, county hospitals, and a veterans' hospital) since finshing my training in 1977 - I have come to believe that the whole bipolar II disorder is incredibly rare, is probably just a mild form of bipolar I, and for the most part is basically a figment of the imagination of one Hagop Akiskal.

Hagop Akiskal is an academic psychiatrist I used to know. He did some of his early work where I am now on the faculty, at the University of Tennessee (UT) Department of Psychiatry.

I had tentatively formed a rather skeptical opinion of Dr. Akiskal's diagnostic procedures and acumen in mood disorders from listening to a few stray remarks from a couple of people who worked with him when he worked at UT, but I never had a chance to directly observe him in action with patients or research subjects. However, I did hear him speak at a "Grand Rounds" (academic speak for an invited lecture) not too many years ago. He made a couple of what to me were amazing proclamations.

First, he said that if a depressed patient had been given an anti-depressant like Prozac and had became more agitated as a result, he just *knew* that the patient was bipolar. So I guess benzodiazepines like Xanax or Klonopin must be a cure for bipolar disorder, because they make the *side effect* of agitation go away immediately.

Second, he said that if he was referred a depressed patient who immediately displayed an angry, nasty attitude when they first met (I can't recall his exact words, but that was clearly the gist of what he was saying), then he just *knew* the patient was bipolar. Of course, many patients who have borderline personality traits, as well as other personality problems, act like that a lot of the time, so it sounded to me like he might be either unable or unwilling to make the distinction.

He had also told me in private on an earlier occasion that he knew that a lot of his "bipolar" patients had been abused as children - another characteristic of patients who have personality problems but something not unusually common in patients with true bipolar disorder. I have never personally heard of him saying anything about this in public.

In any event, I became concerned that he might be making rather hasty diagnoses before he had even done a complete psychiatric evaluation, and was seeing bipolar disorder where there was no bipolar disorder at all.

But back to bipolar vs. borderline.

Ironically, a patient who is actively manic and one who is acting out from borderline personality disorder look nothing alike if seen when symptoms are present. The difference is not subtle at all! Furthermore, if psychiatrists know the tricks of the trade (and most do not), they can get a patient with BPD to turn many of their symptoms off and on like a faucet. Manic patients stay manic no matter what the doctor does in the short term - short of knocking them out with sedating drugs.

Nonetheless, the purveyors of the overdiagnosis of bipolar disorder tout a screening symptom checklist called the Mood Disorder Questionnaire (MDQ). They claim it is almost as accurate as a full psychiatric interview in diagnosing bipolar disorder. Sure it is - a really, really *bad* psychiatric interview. Actually, patients who score positively on the MDQ are just as likely to have borderline personality disorder as bipolar disorder, according to a study published in the Journal of Clinical Psychiatry by Mark Zimmerman and colleagues. They found that of the 98 patients who screened positive on the MDQ, 23.5% were ultimately diagnosed as having bipolar disorder and 27.6% as having borderline personality disorder.

My colleague in the Association for Research in Personality Disorders, Joel Paris, MD, of McGill University in Montreal agreed with Dr. Zimmerman et.al, saying that the MDQ scale is "completely invalid." As he told Medscape Psychiatry, "The scale lists all the symptoms of bipolar disorder, but it does not attach any time scale."

Another study in the Journal of Clinical Psychiatry by the same group (Reggero, Zimmerman et. Al. V,71:1, January 2010, pp.26-31) showed that 40% of patients in their sample who clearly met DSM criteria for borderline personality and clearly did not meet criteria for bipolar had been misdiagnosed as bipolar by a prior mental health professional, as well as 10% of all of the other patients.

These patients are getting potentially toxic medications while not receiving the psychotherapy they need. IMHO, this situation borders on criminality.