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Original article

Distinguishing bipolar disorder from borderline personality disorder: A study of current clinical practice

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ABSTRACT

Background: Diagnosing mental illness is a central role for psychiatrists. Correct diagnosis informs both treatment and prognosis, and facilitates accurate communication. We sought to explore how psychiatrists distinguished two common psychiatric diagnoses: bipolar disorder (BD) and borderline personality disorder (BPD).
Methods: We conducted a qualitative study of psychiatrists to explore their practical experience. We then sought to validate these results by conducting a questionnaire study testing the theoretical knowledge and practical experience of a large number of UK psychiatrists. Finally we studied the assessment process in NHS psychiatric teams by analysing GP letters, assessments by psychiatrists, and assessment letters.
Results: There was broad agreement in both the qualitative and questionnaire studies that the two diagnoses can be difficult to distinguish. The majority of psychiatrists demonstrated in survey responses a comprehensive understanding DSM-IV-TR criteria although many felt that these criteria did not necessarily assist diagnostic differentiation. This scepticism about diagnostic criteria appeared to strongly influence clinical practice in the sample of clinicians we observed. In only a minority of assessments were symptoms of mania or BPD sufficiently assessed to establish the presence or absence of each diagnosis.
Conclusion: Clinical diagnostic practice was not adequate to differentiate reliably BD and BPD. The absence of reliable diagnostic practice has widespread implications for patient care, service provision and the reliability of clinical case registries.

1. Introduction

Both borderline personality disorder and broadly defined bipolar disorder are common psychiatric diagnoses in the adult population with similar prevalences of 1–6% [4,13,17,21,23]. The two are commonly comorbid [9,11,19] with comorbidity as high as 50.1% of those with bipolar-1 [17], indicating an association well beyond chance. However, patients with BPD are deemed to require psychological treatments where medication plays a minor role [25], whereas those with BD generally require complex medication and didactic help with self-management [26]. Prognosis is also very different: 73% of BPD may have remitted in 6 years [45] whilst BD is usually a life-long relapsing condition [3].

Therefore, psychiatric diagnosis matters as a pragmatic tool for informing treatment, communicating about patterns in psychiatric illness, development of appropriate services, and allocation of resources. Its strength lies in its reliability, which can be estimated by looking at inter-rater agreement in clinical samples. This can achieve high values (conventionally described with the Kappa statistic) when structured interviews are employed; over 0.9 for bipolar diagnoses [36] and over 0.75 for borderline diagnoses [43].

The similarities and the differences between the disorders and their co-occurrence are a source of considerable confusion. The rates of misdiagnosis in BD and BPD in clinical practice are largely unknown as few studies have sought to explore this systematically. Patients with BPD have significantly greater odds of being diagnosed with BD compared with psychiatric outpatients who do not have BPD [34,46]. In psychiatric outpatients who had previously been incorrectly diagnosed with BD, 25% were found to have BPD when subjected to formal diagnostic assessment using the SCID-1 and -2 [47] whilst evidence of bipolarity (defined as bipolar-1 or -2) has been found in 44% of patients who had previously been diagnosed with BPD [14]. In another study, over half of supposed BPD participants who had received diagnoses based on clinical assessment did not meet criteria for BPD when subjected to a SCID-2 interview [5]. Finally, temporal stability of

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clinical diagnoses is generally poor: in outpatient settings prospective consistency has been found to be 50.6% for BD but just 35.6% for personality disorder [7].

We know little about how a diagnosis is made in current psychiatric practice or why the BD/BPD distinction appears problematic. There is an overlap of symptoms like impulsivity, recurrent suicidal behaviour, 'affective instability', intense anger, and transient paranoid ideation. While these are diagnostic features of BPD, they also occur in BD patients during mood episodes. Discrimination requires detailed exploration at interview of how such symptoms arise and whether more pervasive symptoms of BPD like fear of abandonment, unstable personal relationships, identity disturbance and chronic emptiness are also present. This requires psychiatrists to collect a substantial history and enquire systematically about these symptoms. However, much of the previous research on the diagnostic process has focussed exclusively on validating clinical diagnoses against different structured or semi-structured interviews [5,24,35,47]. The recent 'fieldwork trials' for DSM-5 are a rare recent example looking at categorical diagnoses in sequentially recruited rather than highly selected patient samples and *without* structured clinical interviews. BD-I and BPD diagnosis showed very good reliability (Kappa : 0.75) in some centres, but not in others [30]. Thus, even when diagnosis is under explicit scrutiny, it cannot be assumed that diagnostic agreement is high.

We know of no previous qualitative research that explores how clinicians approach the differential diagnosis of BD or BPD. Furthermore, we know of no previous research which directly examines the diagnostic assessment process, including recordings of assessment interviews, to determine whether clinicians explore and have available information about diagnostic criteria when making diagnostic decisions. Here, we report three linked studies, which aim to understand diagnostic practice for patients presenting with mood instability. The first was a qualitative study of psychiatrists and nurses, aiming to understand their experience of distinguishing BD and BPD and the factors that influence their diagnostic decision-making. A qualitative approach was employed because it is flexible, grounded in individual experiences, and because we know so little about how diagnoses are actually made. Using the understanding generated in this study, we developed a questionnaire used in the second study, an electronic survey of UK psychiatrists. Finally, the third study comprised a detailed observational study of the diagnostic assessment process in ordinary practice. Ethical approval for the study was obtained from Oxfordshire REC A (11/H0604/8) and practice was informed by the principles enshrined in the Declaration of Helsinki.

2. Qualitative study of clinician diagnostic assessments

2.1. Method

2.1.1. Participants

Participants were 32 psychiatrists and nurses recruited from secondary mental health services, which included 7 community mental health teams (CMHTs), a specialist mood disorders clinic, and a therapeutic community. Purposive sampling was used [8] to ensure a range of ages, professional backgrounds and geographical locations.

Inclusion criteria included being fully qualified in their discipline. Written informed consent was obtained from all participants (both clinicians and patients).

2.1.2. Data gathering

Demographic data were gathered from all participants, including age, gender, qualifications and any specialist experience or training in BD/BPD. The largest proportion of participants were working in community mental teams (Table 1). In the majority of cases ($n = 24$), assessments with patients referred for the assessment of mood instability were observed and/or audio-recorded.

Table 1
Clinician characteristics of 32 clinicians who participated in qualitative interviews.

	Male	Female	Total
n	16	16	32
Average age (years)	39.1	39.4	39.3
Medical qualification	16	10	26 (81%)
MRCPsych	15	8	23 (72%)
CMHT	13	7	20 (63%)
Specialist mood disorders clinic	2	3	5 (16%)
Self-harm team	0	2	2 (6%)
Psychotherapy/therapeutic community	1	4	5 (16%)
Specialist training			
Bipolar	1	1	2 (6%)
Borderline	1	3	4 (13%)
Both	0	3	3 (9%)

2.1.3. Interviews

Clinician interviews were conducted using a topic schedule and were audio-recorded (for full topic schedule and more information about qualitative interviews see Supplementary material). Interviews varied in length from 20 to 100 minutes. Some clinicians completed multiple interviews when patients had multiple assessments or when clinicians assessed more than one patient meeting the inclusion criteria, resulting in a total of 38 clinician interviews of 32 unique clinicians who had assessed 32 patients.

2.1.4. Data analysis

Quantitative data were summarized using standard statistical approaches; qualitative data coding, management and analysis were conducted using NVivo software [29]. Semi-structured interviews were conducted as part of an on-going and iterative process of data collection and analysis. Audiotaped interviews were transcribed, reviewed, and uploaded to NVivo. Qualitative analysis used a framework technique [32]. Data gathering ceased when understanding of the experience of clinicians in assessing and diagnosing in patients with mood instability was no longer being advanced. To reduce researcher bias, we discussed and maintained an awareness of preconceptions (facilitated by interviewer note-keeping and memos) and constantly linked the emerging thematic framework to clinician-derived data.

2.2. Results

2.2.1. Clinician perception of the problem

Most clinicians agreed that distinguishing between the two diagnoses could be challenging (Box 1). Overlap in diagnostic criteria between BD and BPD was raised by many clinicians particularly in regard to mood instability. The need to rely in many cases on self-reported mood symptoms, the context in which these symptoms were reported, and inaccurate retrospective recall were highlighted by most as particularly challenging. Chaotic lifestyles, including the use of illicit drugs, were reported as additional challenges, as were the difficulties of conducting diagnostic assessments in crisis situations.

2.2.2. Utility of distinguishing the diagnoses

Many clinicians questioned the validity of the BPD diagnosis and felt that determining the presence or absence of an axis 1 disorder was more important because this was their primary