Clinical Severity In Bipolar Disorder And Borderline Personality Disorder And Its Comorbidity

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Introduction: *Bipolar disorder and borderline personality disorder are diagnoses that have a wide variety of symptoms. However, it is described that the comorbidity of both intensifies the clinical severity due to the appearance of a greater number of suicide attempts or self-harm. The objective of the study was to determine and compare the sociodemographic characteristics, clinical severity, and symptoms in patients within these 3 groups.* ***Method:*** *the study was descriptive and qualitative, observational and transversal design. A sample of 92 clinical records of patients treated at the National Hospital Víctor Larco Herrera from January 2010 to May 2018 was used. Sociodemographic variables (age, sex, marital status, religion, level of education and occupation) and clinical severity (number of hospitalizations, suicide attempts, refusal of medication, response to treatment, substance abuse, current hospitalization and severity symptoms) using a data collection form.* ***Results:*** *The sociodemographic variables with statistical significance and higher frequency were female sex (p = 0.049), single marital status (p=0.003), catholic religion (p = 0.009), as well as the variables of clinical severity with statistical significance were the number of hospitalizations (p = 0.015), psychotic symptoms (p = 0.009), irritability (p = 0.038), impairment (p = 0.000) and number of symptoms of severity (p = 0.030) in TB, BPD and their comorbidity.* ***Conclusions:*** *The clinical severity is associated with the number of hospitalizations, the presence of psychotic symptoms, irritability, dysfunctionality and the number of severe symptoms in patients with only TB diagnosis, BPD and their comorbidity.*

Keywords: *bipolar disorder, borderline personality disorder, comorbidity, severity (source: MeSH)*

Introduction

Bipolar disorder (BPAD) is a pathology characterized by mood instability, in which periods of exaltation and depression of varied intensity coexist. Traditionally, it was grouped under the heading of "manic-depressive psychosis". There have been several theories related to its nosology, and, eventually, it came to be defined as a mood (or bipolar) spectrum with a strong biological susceptibility which manifests itself with specific clinical presentations in its dimensional evolution.(1-3) Its prevalence is between 0.2% and 1.2% of the general population. It has been claimed that, on average, its lifetime prevalence is around 1% of the general population and that its 6-month prevalence is approximately 0.5% of population. The onset

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age would be around 20 to 25 years, and in 25% of cases it is diagnosed before age 17.[4-6]
Borderline personality disorder (BPD) is possibly the most feared of all psychiatric conditions, since its symptomatology alternates between histrionic, obsessive, antisocial, and psychotic manifestations at a speed in which treatments are inoperative. It is believed to be present in approximately 1% to 2% of the population, and it is twice as common in women than men. Young people of less than 20 years of age, mostly women, that sometimes present either absurd behaviors of the antisocial or psychotic kind, shocking histrionic mechanisms, dysphoric incomprehensible states, obsessive looking inflexibility of thought, or suicide attempts. They do not tolerate loneliness, are hypersensitive to rejection, and lack the personal resources that would allow them to live with themselves without anguish.[7-9]
Comorbidity of BPAD and BPD is a condition which threatens life. Both disorders are associated with elevated suicide rates, self-harm, and other severe aspects, such as: longer hospital stay, higher rates of abandonment, and greater use of medication.[10-18] Around 20% of patients diagnosed with BPAD or BPD are diagnosed with the other. The prevalence of BPAD in subjects with BPD varies from 5.1% to 78.9%, which is higher compared to bipolar I disorder and bipolar II disorder.[19-23]
Studies such as Apfelbaum et al. (2013) found that patients with comorbid BPAD and cluster B personality disorders showed earlier manifestations and more severe symptoms, suicide attempts, hospitalizations, and self-harm in comparison with the BPAD and major depression comorbidity.[24] Likewise, Gunderson et al. (2006) found that patients with BPD, in comparison to other personality disorders, had a high and significant co-occurrence of BPAD of 19.4%. Furthermore, they found that this does not seem to affect the subsequent course of BPD. They concluded that there is a moderate association that involves a risky clinical course.[25]

This research objective was to determine and compare sociodemographic characteristics, specifically, of clinical severity and severe symptoms in patients with BPAD, BPD and their comorbidity.
In mental health, particularly within psychiatry, mood disorders are a field of high prevalence which have not been greatly studied nor understood. For this reason, it is our concern to contribute to the study of factors that could allow us to prevent and estimate the clinical severity. This is of utmost importance during the evolution and treatment of the illness in diagnoses that, historically, have tended to be confused in clinical practice and whose co-occurrence could worsen their course.

Materials And Methods

The study is descriptive, and its design is qualitative, observational, and cross-sectioned. The sample used was of 92 medical records of patients that were seen at the National Víctor Larco Herrera Hospital of Lima, Peru from January 2010 to May 2018. In the medical records, the sociodemographic variables (age, sex, marital status, religion, level of education, and occupation) and clinical severity variables (number of hospitalizations, suicide attempts, refusal of medication, treatment response, substance abuse, current hospitalization and severe symptoms) were identified. These were collected in a spreadsheet created by the author. The criteria for inclusion was the following: patients who have been diagnosed with bipolar disorder, borderline personality disorder, and comorbidity of both in emergency services, outpatient visits, and adult psychiatric hospitalization of acute cases, who are between 15 and 65 years of age, and whose diagnosis had been registered at least two times in their medical records, including their last visit, according to the ICD-10 criteria. Medical records of patients with medical or severe neurological conditions, with psychiatric comorbidity other than those mentioned, and with illegible handwriting or incomplete information, were excluded. Initially, the preliminary project was presented to the Teaching and Research Office. Authorization was requested to the General Directorate of the institution for its approval. Prior to execution, a pilot test was ran in order to add observations, improve the instrument and verify the statistical analysis viability. Data processing was conducted with the aid of a SPSS 24.0 software, using the statistical chi-squared test for categorical

variables and frequency tests.

Findings

The findings were studied in three groups. One with bipolar disorder (n=57), another one with borderline personality disorder (n=14) and, between the two, another one with comorbidity (n=21).

Regarding the sociodemographic data, the female sex predominated in all groups, with 63.5% of the manic phase, 66.7% of the depressive one, 92.9% of BPD, and 90.5% of comorbidity. In relation to age, the range of 20 to 39 years was the most frequent with 57.7% of the manic phase, 71.4% of BPD, and 52.4% of comorbidity. Regarding marital status, being single was more frequent with 69.2% of the manic phase, 66.7% of the depressive one, 92.9% of BPD, and 52.4% of comorbidity. Catholic religion also dominated with 73.1% of the manic phase, 66.7% of the depressive one, 57.1% of BPD and 66.7% of comorbidity. The higher education level was larger, with 53.8% of manic phase and 66.7% of depressive phase. Furthermore, the secondary education level was 35.7% of BPD and 52.4 % of comorbidity. In relation to occupation, 63.5% in the manic phase were unemployed, 35.7% in the BPD were students, and 57.1% with comorbidity were employed. Of these subvariables, sex turned out to be more significant (p = 0.049). (Table N°1)

Regarding the clinical severity variables, the number of hospitalizations of two or more was dominant in 46.2% of the manic phase. This variable was significant (p = 0.015) in the three groups despite not being frequent in all. Suicidal attempts were not dominant in any group. The rejection of the medication was mostly present in 51.9% of manic phase, in 57.1% of BPD, and in 52.4% of comorbidity. Likewise, the response to treatment was more frequent in all groups. Substance abuse was most frequent in patients with BPD (57.1%). In turn, hospital stays shorter than 45 days were key in 69.2% of bipolar patients with manic phase. (Table N°2)

In relation to severe symptoms, psychomotor agitation was most frequent in 59.6% of manic patients. Insomnia was most frequent in 75% of manic patients, 66.7% of depressive phase patients, and in 57.1% of patients with comorbidity. Anxiety was frequent in the three groups, while sexual disinhibition was not. Psychotic symptoms were more frequent in 57.7% of manic patients, and they were a significant variable (p=0.009). Suicidal tendencies were dominant 66.7% of depressive phase patients. Irritability was dominant in 86.5% of manic patients, 64.3% of BPD and 61.9% of comorbidity in both. Aggressiveness was 77.8% in maniac patients, 64.3% in BPD, and 52.4% in comorbid cases. Dissociative symptoms were not frequent in any group. Dysfunctionality (work, academic, interpersonal) was higher in the 84.6% of maniac patients, obtaining statistical significance (p=0.000). Regarding the number of severe symptoms, from 6 to 10 were more frequent in 55.8% of maniac patients and 50% of BPD, while from 1 to 5 were more frequent in the depressive phase and comorbidity. Finally, this variable also was statistically significant (p = 0.030). (Table N°3)

Discussion

In our environment, comorbidity between BPAD and BPD is frequent. Systematic reviews such as that of Fornaro et al. (2016) confirm latent comorbidity in 1 of 5 patients who experience combined symptoms of both diagnoses.[26]

Regarding sociodemographic characteristics, the dominant ones in the studied groups are female, Catholic religion, and single. These findings are consistent with previous works. These aspects do not necessarily play a defining role in the clinical severity due to the sample's heterogeneity, but they give us an overview of the patient in routine psychiatric practice.

Regarding clinical severity characteristics that were significant, such as more than two previous hospitalizations in patients with manic phase bipolar disorder, there is an agreement with the findings of Mazzarini et al. (2018). In these, it is concluded that 2.6 hospitalizations on average had patients that met the criteria of high bipolar symptomatology recurrence in a sample of depressive patients which in time their diagnosis shifted to this one and came to be considered as high risk patients. On the other hand, suicide attempts did not turn out to be a criterion of severity and frequency in our sam-

Table N°1. Sociodemographic data of patients with sole diagnosis and BPAD and BPD comorbidity.

		Sole Diagnosis								Comorbidity			
		Bipolar Disorder (CIE-10)											
Sociodemographic data								BDP (CIE-10)		BPAD+BPD (CIE-10)		X2	p
		Maniac		Depressive		Mixed		(N=14)		(N=21)			
		(N=52)		(N=3)		(N=2)							
		n	%	n	%	n	%	n	%	n	%		
Sex	Male	19	36,5	1	33,3	0	0	1	7,1	2	9,5	9,534	0,049+
	Female	33	63,5	2	66,7	2	100	13	92,9	19	90,5		
Age	0-19	1	1,9	0	0	0	0	3	21,4	1	4,8	15,808	0,2
	20-39	30	57,7	1	33,3	1	50	10	71,4	11	52,4		
	40-59	13	25	1	33,3	0	0	1	7,1	5	23,8		
	60 a más	8	15,4	1	33,3	1	50	0	0	4	19		
Marital Status	Single	36	69,2	2	66,7	0	0	13	92,9	11	52,4	35,782	0,003+
	Married	6	11,5	0	0	1	50	0	0	4	19		
	Cohabiting partner	5	9,6	0	0	0	0	0	0	3	14,3		
	Divorced	5	9,6	0	0	0	0	1	7,1	2	9,5		
	Widow	0	0	1	33,3	1	50	0	0	1	4,8		
Religion	Catholic	38	73,1	2	66,7	0	0	8	57,1	14	66,7	26,459	0,009+
	Evangelic	1	1,9	0	0	0	0	0	0	0	0		
	Others (Jehovah's Witnesses)	12	23,1	1	33,3	1	50	6	42,9	7	33,3		
	Does not mention	1	1,9	0	0	1	50	0	0	0	0		

Table N°1. Sociodemographic data of patients with sole diagnosis and BPAD and BPD comorbidity.

Level of educa-tion	Illiterate										0	12,304	0,422
	Primary	4	7,7	1	33,3	0	0	1	7,1	0	47,6		
	Secondary	20	38,5	0	0	1	50	5	35,7	10	52,4		
	Tertiary	28	53,8	2	66,7	1	50	7	50	11	0		
	Does not mention	0	0	0	0	0	0	1	7,1	0	14,3		
Job	Employed	11	21,2	1	33,3	0	0	3	21,4	3	57,1	22,53	0,127
	Unemplo-yed	33	63,5	1	33,3	2	100	4	28,6	12	9,5		
	Student	3	5,8	0	0	0	0	5	35,7	2	19		
	Home	5	9,6	1	33,3	0	0	1	7,1	4	0		
	Pensioner	0	0	0	0	0	0	1	7,1	0	9,5		

Table N°2. Comparison of clinical severity data of patients with unique diagnosis and BPAD and BPD comorbidity.

Clinical severity		Sole diagnosis: Bipolar Disorder (CIE-10)						Sole diagnosis: BPD (CIE-10)		Comorbidity: BPAD+BPD (CIE-10)		X2	p
		Maniac (N=52)		Depressive (N=3)		Mixed (N=2)		(N=14)		(N=21)			
		n	%	n	%	n	%	n	%	n	%		
Number of hospitalizations	None	9	17,3	2	66,7	1	50	10	71,4	7	33,3		
	One	19	36,5	0	0	0	0	3	21,4	7	33,3	19,02	0,015
	2 or more	24	46,2	1	33,3	1	50	1	7,1	7	33,3		
Previous suicidal attempts	None	35	67,3	2	66,7	1	50	8	57,1	12	57,1	6,507	0,591
	One	9	17,3	0	0	1	50	1	7,1	5	23,8		
	2 or more	8	15,4	1	33,3	0	0	5	35,7	4	19		
Rejection of medication	Yes	27	51,9	0	0	2	100	6	42,9	10	47,6	5,369	0,251
	No	25	48,1	3	100	0	0	8	57,1	11	52,4		
Response to treatment	Yes	13	25	1	33,3	0	0	1	7,1	7	33,3	3,997	0,406
	No	39	75	2	66,7	2	100	13	92,9	14	66,7		
Substance abuse	Yes	22	42,3	0	0	0	0	8	57,1	8	38,1	5,078	0,279
	No	30	57,7	3	100	2	100	6	42,9	13	61,9		
Real Hospitalization	No	14	26,9	2	66,7	0	0	8	57,1	14	66,7	14,457	0,071
	<45 days	36	69,2	1	33,3	2	100	6	42,9	7	33,3		
	>45 days	2	3,8	0	0	0	0	0	0	0	0		

Table N°3. Comparison of severe symptoms of patients with unique diagnosis and BPAD and BPD comorbidity.

Severe symptoms		Sole Diagnosis								Comorbidity		X2	p
		Bipolar Disorder (CIE-10)						BPD (CIE-10) (N=14)		BPAD+BPD (CIE-10) (N=21)			
		Maniac (N=52)		Depressive (N=3)		Mixed (N=2)							
		n	%	n	%	n	%	n	%	n	%		
Psychomotor agitation	Yes	31	59,6	1	33,3	2	100	6	42,9	6	28,6	8,399	0,078
	No	21	40,4	2	66,7	0	0	8	57,1	15	71,4		
Insomnia	Yes	39	75	2	66,7	2	100	6	42,9	12	57,1	7,01	0,135
	No	13	25	1	33,3	0	0	8	57,1	9	42,9		
Anxiety	Yes	41	78,8	3	100	1	50	11	78,6	20	95,2	5,115	0,276
	No	11	21,2	0	0	1	50	3	21,4	1	4,8		
Sexual disinhibition	Yes	25	48,1	0	0	1	50	2	14,3	7	33,3	7,735	0,102
	No	27	51,9	3	100	1	50	12	85,7	14	66,7		
Psychotic symptoms	Yes	30	57,7	1	33,3	2	100	2	14,3	6	28,6	13,638	0,009
	No	22	42,3	2	66,7	0	0	12	85,7	15	71,4		
Suicidal tendencies	Yes	8	15,4	2	66,7	1	50	6	42,9	4	19	9,104	0,059
	No	44	84,6	1	33,3	1	50	8	57,1	17	81		
Irritability	Yes	45	86,5	1	33,3	2	100	9	64,3	13	61,9	10,157	0,038
	No	7	13,5	2	66,7	0	0	5	35,7	8	38,1		
Aggresiveness	Yes	41	78,8	1	33,3	2	100	9	64,3	11	52,4	7,964	0,093
	No	11	21,2	2	66,7	0	0	5	35,7	10	47,6		
Dissociative symptoms	Yes	4	7,7	0	0	0	0	5	35,7	5	23,8	8,94	0,063
	No	48	92,3	3	100	2	100	9	64,3	16	76,2		
Dysfunctionality (work, academic, interpersonal)	Yes	44	84,6	3	100	2	100	7	50	7	33,3	22,806	0
	No	8	15,4	0	0	0	0	7	50	14	66,7		
Number of severe symptoms	1-May	23	44,2	2	66,7	0	0	7	50	17	81	10,728	0,03

ple. This is also reported by Mazzarini, where patients with more than three severe symptomatic bipolar characteristics had fewer suicide attempts. However, this was not significant in our findings.[27]

Most of the rejection of medication was present in patients with bipolar disorder predominantly with manic phase. The lack of response to treatment was most present in patients with bipolar disorder with manic phase and comorbidity with borderline personality.

Substance abuse was not a dominant pattern in the patient sample, both with single BPAD diagnosis and with comorbidity. However, it was evident in those with a BPD diagnosis in little more than half of the sample within this category. This contradicts McDermid et al. findings (2015), whose highly representative sample, with significant results for BPAD I and II comorbid with BPD, had a history of substance use, including alcohol abuse.[28]

Current hospitalization as an item of severity occurs in the majority of unique cases of manic phase BPAD within 45 days from the time of data collection. This finding does not occur in most patients with comorbidity and single diagnosis of BPD. This could be explained by the usual confusion in the diagnosis criteria of considering a diagnosis as single or comorbid, which affects their actual prevalence. Another hypothesis lies in the brief nature of BPD crises. They even dominate in emergency situations in comorbid cases. In bipolar disorders, mood dominates the general symptomatology. The latter becomes more florid and thus requiring faster intervention.

Regarding severe symptoms, we found that impulsivity can be objectively manifested through deliberate behaviors such as suicidality and aggressiveness. However, contrary to previous studies, suicidal behavior was not a significant characteristic in relation to frequency nor for the three groups of patients. Aggressiveness, though, despite being present in them, did not have statistical significance. These data are comparable to those of Di Giacomo et al. (2017) who found, in their sample of patients with BPAD, a predominance of aggressiveness and irritability. Furthermore, in their sample of patients with BPD the parasuicidal behavior was significant.[28] Similarly, Bayes et al. (2016) determined that suicidal behavior and aggressiveness are representative symptoms in groups of patients with BPAD and BPD comorbidity. In the latter, self-harm behaviors and suicidality were found to be a clinical severity predictor.[29] Moor et al (2012) also concluded that suicidal behaviors dominate as a synergism when there is comorbidity.[30]

Psychotic symptoms occur more frequently in patients with manic phase bipolar disorder. This could be due the fact that most of the sample was collected in the Acute Care Hospitalization Services, which is already a criterion of severity in this type of patients.

These symptoms are not frequently included in studies evaluating BPAD and BPD comorbidity. However, Mazzarini (2018) found in a sample of BPAD that psychotic symptoms occur mainly in depressive phases. In this same study, psychomotor agitation was not significant in BPAD, which agrees with our findings.

Anxiety and insomnia were manifested with increased frequency in the three groups of patients, without being significant. Shen (2018) also evidenced these findings in a group of patients with BPAD and BPD that had a greater co-occurrence of sleep and anxiety disorders compared to patients with depressive disorder and comorbid BPD with the same characteristics.[31]

Apparently, dissociative symptoms such as depersonalization and derealization, as well as disinhibition and insomnia, are characteristics which are only evaluated in individuals within a BPD sample in routine studies. Current findings show that these first two are not common in the three groups of patients, contrary to insomnia which was found mainly in BPAD. None of these symptoms were significant. DiGiacomo et al. (2017) reported that dissociative symptoms were more frequent in BPD patients. Furthermore, they reported that the highest sexual desire and insomnia were in those with BPAD.

Dysfunctionality was a clinical variant found more frequently in patients with BPAD. It was found in half BPD patients, and with no effect in the comorbidity group. Despite the results, it was a significant variable. This concurred with the conclusions of Zheng (2015) and Goodman (2012), which understood the findings of increased suicide attempts and impulsivity in

comorbid patients because of high interpersonal dysfunctionality and poor social support.[32, 33] Likewise, Zimmerman (2015) found comparative differences in patients with BPAD and BPD as the sole diagnosis, determined by greater actual dysfunctionality in the first group.[34] Frías, Baltasar and Birmaher (2016) concluded that the impact on the negative affect of BPD on BPAD in comorbidity implies the worsening of functionality.[35]

Conclusion

• Frequent characteristics in patients with a sole diagnosis of BPAD and BPD and their comorbidity are: female, single, and catholic.

• Clinical severity is associated with the number of hospitalizations, the presence of psychotic symptoms, irritability, dysfunctionality, and the number of severe symptoms in patients with a sole diagnosis of BPAD, BPD and their comorbidity.

Limitations

This study has several limitations. Its main weakness is the retrospective and descriptive nature, despite its comparative analysis. Other limitations were sample heterogeneity (since patients were from different psychiatric services), the sample size, and the fact that data was taken by reviewing medical records. It is important to highlight the latter, since, by doing so, there is a loss of objectivity in the diagnoses that different doctors give without the application of psychometric scales and guided only by ICD10 diagnostic criteria.

Bibliography

1. Sadock B, Sadock V, Ruiz P. Kaplan and Sadock's Synopsis of Psychiatry. 11ª edición. Wolters Kluvers (2014).

2. Belloch A, Sandín B, Ramos F. Manual de Psicopatología. Edición Revisada. Mc Graw-Hill Interamericana (2009).

3. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Washington, DC: American Psychiatric Association, 2014.

4. Bolton S, Gunderson JG. Distinguishing borderline personality disorder from bipolar disorder: differential diagnosis and implications. American Journal of Psychiatry. 1996; 153(9):1202-7.

5. Akiskal H. The Emergence of the Bipolar Spectrum: Validation along clinical-epidemiologic and familial-genetic lines. Psychopharmacology Bulletin. 2008; 40(4):99-115.

6. Zimmerman M, Galione JN, Ruggero CJ, Chelminski I, Young D, Dalrymple K, et al. Screening for bipolar disorder and finding borderline personality disorder. Journal of Clinical Psychiatry. 2010;71(9):1212-7.

7. Stone M. Relationship of Borderline Personality Disorder and Bipolar Disorder. The American Journal of Psychiatry. 2006;163(7):1126-8.

8. Eftekhar M, Shabani A. Borderline personality disorder is not a subtype of bipolar disorder. Iranian Journal of Psychiatry and Clinical Psychology. 2009;15(2):147-58.

9. Skodol AE, Gunderson JG, Shea MT, McGlashan TH, Morey LC, Sanislow CA, et al. The Collaborative Longitudinal Personality Disorders Study (CLPS): overview and implications. Journal of Personality Disorders. 2005; 19(5): 487-504.

10. Galione J, Zimmerman M. A comparison of depressed patients with and without borderline personality disorder: Implications for interpreting studies of the validity of the bipolar spectrum. Journal of Personality Disorders. 2010; 24(6): 763-72.

11. American Psychiatric Association. DSM-5 Development. Personality and Personality Disorders. American Psychiatric Association. Versión actualizada del 21 de junio de 2011.

12. Deltito J, Martin L, Riefkohl J, Austria B, Kissilenko A. Do patients with borderline personality disorder belong to the bipolar spectrum? Journal of Affective Disorders. 2001; 67(1-3): 221-8.

13. Berrocal C, Ruiz Moreno MA, Rando MA, Benvenuti A, Cassano GB. Borderline personality disorder and mood spectrum. Psychiatry Research. 2008; 159(3): 300-7.

14. Benazzi F. Borderline personality--bipolar spectrum relationship. Progress in Neuro-Psychopharmacology & Biological Psychiatry. 2006; 30(1): 68-74.

15. Paris J, Gunderson J, Weinberg, I. The interface between borderline personality disorder and bipolar spectrum disorders. Comprehensive Psychiatry. 2007; 48: 145-54.

16. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association, 2000.

17. Vohringer et al. The International Mood Network (IMN) Nosology Project: differentiating borderline personality from bipolar illness. Acta Psychiatr Scand 2016: 1–7.

18. Ghaemi SN, Sachs GS, Chiou AM, Pandurangi AK, Goodwin K. Is bipolar disorder still underdiagnosed? Are antidepressants overutilized? Journal of Affective Disorders. 1999; 52(1-3): 135- 44.

19. Strejilevich S, Retamal-Carrasco P. Perception of the impact of Bipolar Disorder and its diagnosis in health centers in Argentine and Chile. Vertex 2003; 14(54): 245-52.

20. Baldessarini RJ, Tondo L, Hennen J. Treatment-latency and previous episodes: relationships to pretreatment morbidity and response to maintenance treatment in bipolar I and II disorders. Bipolar Disorders. 2003; 5(3): 169-79.

21. Smith DJ, Ghaemi NS. Hypomania in clinical practice. Advances in Psychiatric Treatment 2006; 12:110–20.

22.Perugi G, Akiskal HS. The soft bipolar spectrum redefined: focus on the cyclothymic, anxious-sensitive, impulse-dyscontrol, and binge-eating connection in bipolar II and related conditions. Psychiatric Clinics of North America. 2002; 25(4): 713-37.

23. Paris J. Borderline or Bipolar? Distinguishing Borderline Personality Disorder from Bipolar Spectrum Disorders. Harvard Review of Psychiatry 2004;12(3):140-5.

24. Apfelbaum S, Regalado P. La comorbilidad del trastorno bipolar con trastornos de la personalidad tipo B como indicador de severidad clínica y desregulación afectiva. Actas Esp Psiquiatr 2013;41(5):269-78

25. Gunderson JG, Weinberg I, Daversa MT, Kueppenbender KD, Zanarini MC, Shea MT, et al. Descriptive and longitudinal observations on the relationship of borderline personality disorder and bipolar disorder. American Journal of Psychiatry. 2006;163(7):1173-8.

26. Fornaro M, Orsolini L, Marini S, De Berardis D, Perna G, Valchera A et al. The prevalence and predictors of bipolar and borderline personality disorders comorbidity: Systematic review and meta-analysis. J Affect Disord. 2016 May; 195:105-18. DOI: http://dx.doi.org/10.1016/j.jad.2016.01.040

27. Mazzarini L, Kotzalidis GD, Piacentino D, Rizzato S, Angstc J, Azorin JM et al. Is recurrence in major depressive disorder related to bipolarity and mixed features?: Results from the BRIDGE-II-Mix study. J Affect Disord. 2018 Mar 15; 229:164-170. DOI: 10.1016/j.jad.2017.12.062

28. di Giacomo E, Aspesi F, Fotiadou M, Arntz A, Aguglia E, Barone L et al. Unblending Borderline Personality and Bipolar Disorders. J Psychiatr Res. 2017 Aug; 91:90-97. DOI: 10.1016/j.jpsychires.2017.03.006.

29. Bayes AJ, Parker GB. Clinical vs. DSM

diagnosis of bipolar disorder, borderline personality disorder and their co-occurrence. Acta Psychiatr Scand 2016: 1–7. DOI: 10.1111/acps.12678

30. Moor S, Crowe M, Luty S, Carter J, Joyce PR. Effects of comorbidity and early age of onset in young people with Bipolar Disorder on self-harming behaviour and suicide attempts. J Affect Disord. 2012 Feb;136(3):1212-5. DOI: 10.1016/j.jad.2011.10.018.

31. Cheng-Che Shen, Li-Yu Hu, Ya-Han Hu. Comorbidity study of borderline personality disorder: applying association rule mining to the Taiwan national health insurance research database. BMC Medical Informatics and Decision Making. 2017; 17:8. DOI 10.1186/s12911-016-0405-1

32. Zeng R, Cohen L, Tanis T, Qizilbash A, Lopatyuk Y, Yaseen Z et al. Assessing the contribution of borderline personality disorder and features to suicide risk in psychiatric inpatients with bipolar disorder, major depression and schizoaffective disorder. Psychiatry Research. 2015; 226:361–367

33. Goodman M, Roiff T, Oakes AH, Paris J. 2012.Suicidal risk and management in borderline personality disorder. Curr Psychiatry Rep. 2012 Feb; 14(1), 79–85. DOI: 10.1007/s11920-011-0249-4.

34. Zimmerman M, Ellison W, Morgan T, Young D, Chelminski I, Dalrymple K. Psychosocial morbidity associated with bipolar disorder and borderline personality disorder in psychiatric out-patients: comparative study. The British Journal of Psychiatry. 2015; 206, 1–5. DOI: 10.1192/bjp.bp.114.153569

35. Frías A, Baltasar I, Birmaher B. Comorbidity between bipolar disorder and borderline personality disorder: Prevalence, explanatory theories, and clinical impact. J Affect Disord. 2016; 202, 210-219. DOI: https://doi.org/10.1016/j.jad.2016.05.048

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