

# Differentiating Bipolar

## and Borderline Personality Disorder

Two disorders with many overlapping symptoms, fundamental differences in what drives them, and very different treatment approaches. Getting the diagnosis right is the first step toward effective care.

Bipolar disorder (BD) and borderline personality disorder (BPD) share a long list of overlapping symptoms. Both involve explosive anger, self-harm, suicidal ideation, impulsivity, and nightmares. Providers who see clients only in brief sessions may struggle to distinguish one disorder from the other.

But beneath the surface, these disorders have fundamentally different causes, different patterns, and require meaningfully different treatments.

Applying the wrong treatment can delay recovery and, in some cases, cause real harm.

**It is not the symptom itself that matters most. It is what is driving it and where it's coming from that matters.**

Neither disorder is better or worse than the other, and each can have a positive prognosis. Finding the accurate diagnosis and accessing the effective treatment for that diagnosis is the priority.

## The Concepts That *Matter Most*

One of the clearest ways to tell these two disorders apart is by the words clinicians use to describe them. Practitioners who specialize in bipolar disorder keep returning to one word: **mood**. Those who specialize in BPD keep returning to another: **emotion**.

Mood is like the climate: a persistent, biological state that shapes everything. Emotion is like the weather: responsive, reactive, and passing.

- In bipolar disorder, the mood state itself is dysregulated.
- In BPD, the emotional response to relational events is dysregulated.

In BPD, behaviors are relational in nature. There is a function to them: to secure connection, to be seen, to avoid abandonment. The relationship is both the trigger and the treatment target.

◆ In bipolar disorder, mood episodes are energy episodes. Low energy brings depression. High energy brings mania. The relationship is not the trigger the way it is in borderline personality disorder.

**Both disorders are manageable when identified accurately and treated appropriately. The path to effective care begins with a thorough differential diagnosis that examines the context, origins, and motivations behind symptomatic behaviors.**



*Can bipolar disorder or borderline be diagnosed in children and adolescents?*

**YES**

Bipolar disorder is highly heritable and occurs in children as often as in adults. Research shows that approximately 3% of the adolescent population has borderline. Early identification leads to earlier, more effective treatment.

*Is trauma the cause of both bipolar disorder and borderline?*

**NO**

Bipolar disorder is a heritable and biologically based illness. Many people with bipolar disorder have never experienced trauma. Borderline involves a genetic emotional sensitivity, but chronic invalidation, not trauma alone, is the environmental factor most associated with its development.

*Can someone have both bipolar and borderline at the same time?*

**YES**

A percentage of individuals do live with both. However, best practice is to stabilize the mood disorder first. If borderline traits persist after mood stability is achieved, then both diagnoses can be confirmed and treated sequentially.

*Can a diagnosis of bipolar disorder switch to borderline, or vice versa, over time?*

**NO**

Bipolar disorder is a lifelong illness. What appears to change over time is not the disorder itself, but the clinician's understanding of it as more information becomes available from the patient. Diagnosis is a process, not a single event.

*Should the mood disorder be treated first when both may be present?*

**YES**

The behavioral interventions used to treat BPD require the patient to be stable enough to engage. During a bipolar disorder mood episode, behavioral work cannot take hold. Mood stabilization comes first, then behavioral and relational treatment can follow.

*Are the treatments for bipolar disorder and BPD the same?*

**NO**

For bipolar disorder, mood stabilizers including lithium are the gold standard. For BPD, dialectical behavior therapy (DBT) is the gold standard, with medication used to manage symptoms so that behavioral treatment can proceed. Applying the wrong treatment causes harm.

## Symptom Differences

Overlapping symptoms shared by both disorders include explosive anger, self-harm, suicidal ideation, impulsivity, and nightmares. But for each symptom, the function, the trigger, and the meaning differ significantly between the two conditions.

### SELF-HARM: DIRECTIONALITY IS A CORE DIFFERENCE

In BPD, self-harm is often outwardly directed. Ex. "look what you did," or "look how much I hurt because of you." In bipolar disorder, self-harm reflects a deep internal pain. Ex. "things are never going to get better," and "this is the only way to change how I'm feeling." The symptom of self-harm is occurring in both. The driver is fundamentally different.

### ON NIGHTMARES

In BPD, nightmares tend to reflect the emotional recipe of the person's waking experience. In bipolar disorder, nightmares are often completely disconnected from experience: vivid, graphic, and horrific scenes involving the person's own death or harm to loved ones. These dreams can cause post-traumatic stress disorder in their own right.

### INTENSE, EXPLOSIVE ANGER

In BPD the irritable display shows emotional dysregulation in an attempt to make everyone around them feel the same way. They hurt so they seek to communicate that hurt with aggression and rage. Afterwards, those with BPD often continue to think of themselves as the victim.

In bipolar disorder there is often not an identifiable external trigger since the episodes are biologically driven. Those with bipolar disorder typically have regret, shame, and remorse after dysregulated episodes.

## How to Tell Them Apart

Both bipolar disorder and borderline personality disorder involve dysregulation, but the type and origin are different. Bipolar disorder involves biological mood states. BPD involves intense emotional sensitivity that is amplified by relational experiences.

### THE GOLD STANDARD FOR DIAGNOSIS

A structured clinical interview lasting one to two hours, conducted over three to four sessions, combined with detailed developmental history, family history, child inventories, and a thorough review of medical and school records. Diagnosis is a process, not a single appointment.

For bipolar disorder in children and teens, two validated at-home assessments exist: the **Child Bipolar Questionnaire** and the **Janie and Jeffrey Illustrated Interview for Children**, both available at [jbrf.org](http://jbrf.org).

### Key diagnostic contrasts at a glance

- **BD Episodes:** Mood episodes are energy episodes. Biological in origin, not triggered by relationships.
- **BPD Episodes:** Emotional episodes are triggered by relational events: perceived rejection, abandonment, or criticism.
- **BD Impulsivity:** Stems from amygdala-driven drives (e.g., hypersexuality, mission mode) during mood states.
- **BPD Impulsivity:** Stems from fear of disconnection or an attempt to maintain relational contact.
- **BD Suicidality:** Is often driven by the belief they have no other way to end the suffering for themselves and those around them.
- **BPD Suicidality:** Is often relational, a desire to be seen, rescued, or to show others the depth of their pain.

**Both forms of suicidality are equally real dangers and all suicidality must be taken with the utmost seriousness.**

## The Right Treatment for the Right Diagnosis

Because these disorders have fundamentally different causes, they require fundamentally different treatments. The behavioral interventions that work for BPD will not stabilize bipolar disorder. Mood disruptions, because they have a biological and chemical underpinning, cannot be treated with behavior modification alone.

### Treatment for bipolar disorder

- **Gold Standard:** Mood stabilizers as the first-line intervention; lithium carbonate, in some cases with an additional mood stabilizer
- Avoid antidepressants and stimulants: they can trigger mania
- Behavioral therapies are useful only after mood stability is achieved
- Therapy begins with building safety and trust, not skill work, especially in children

### Treatment for BPD

- **Gold Standard:** Dialectical behavior therapy (DBT)
- DBT addresses the relational function of behaviors, building new skills and pathways
- Medications supplement behavioral treatment of symptoms, thoughts, and behaviors

**Both disorders are manageable. Both can have severe consequences when untreated. An accurate diagnosis is not a label: it is a path to the right care.**

*Effective treatment involves medication, therapy, and lifestyle interventions. Together they form a safety net carry the person through if one is disrupted.*

**ON COMPREHENSIVE TREATMENT PLANNING**