Personality Disorders and the Bipolar Spectrum

Recognition and management of personality disorders in a pain clinic setting.

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Patients with moderate-to-severe personality disorders (PD) may wreak havoc on an unsuspecting medical office. It is increasingly important to recognize, limit, and manage those with aggressive types of PD. Likewise, it is crucial to recognize those who fit the bipolar spectrum. In particular, the mild end of the spectrum is often missed. The clinical stakes for missing bipolar are enormous, as these patients tend to bounce from antidepressant to antidepressant, with predictably poor results.

Consider the following scenario: a 28- year-old man, “Bill” presents to the pain clinic with severe low back pain. He seems angry on the first visit, and is very demanding with the front office staff. Bill is mistrustful of physicians and openly states to the doctor, “I will go back to work when you give the right amount of drugs that help.” Bill is upset with his last two health providers.

Over the next few months, the clinic bends over backwards for Bill, even though he can be abusive to the staff. Bill overuses opioids, and is manipulative. He always has a sense of entitlement. When he calls, stating, “I want to talk to Dr. Smith NOW, put me through!” the staff, out of fear, jumps and does as he asks. The physician finds himself in a subservient position, trying to appease the patient and end the confrontations.

Bill laughs at the idea of seeing a psychotherapist but, after nine months of treatment, Bill is suddenly blaming everything on the physician and clinic: his pain, his obesity, his sexual dysfunction. Bill threatens to sue and reports the doctor to the state regulatory office. What happened here?

Bill will be later diagnosed as a paranoid personality disorder. The clinic did not recognize him as such, and failed to set limits on Bill’s behavior. The disruptions in the business of the clinic, the increased stress on the staff, and the monopolization of the doctor’s time cannot be recovered. In the following, we discuss features of personality disorders that should help with identification. Better management of the problem starts with recognition. This paper delves into the recognition and management of patients whose pain treatment is complicated by psychological concerns.

Personality Disorders at a Clinic

Approximately 10-15% of people have features of a personality disorder.[1] There are a number of personality disorders, and some are more dangerous and difficult than others. In general, characteristics of personality disorders include: lack of insight, poor response to psychotherapy or other therapeutic interventions, difficulty with attachments and trust, a sense of entitlement, and the creation of chaos and distress in family, friends, and co-workers. Comorbid substance abuse is common.

Personality disorders range from mild to very severe. Patients with personality disorders may take on different roles: victim, rescuer, or persecutor. When they turn persecutor, they can be dangerous to the person they have set their sights on. Seeing a therapist for a long period of time, perhaps 5-7 years, helps to some degree. However, goals and expectations must be limited. The plasticity of the brain is important, as some people can improve naturally over time. There are a number of other personality disorders which are not as dangerous for the people around them or for health care providers. Even though PD characteristics may seem extreme, they are often overlooked, and health care clinics may react by treating these patients in a dysfunctional manner. The problem begins with not recognizing the personality disorder.

The following section describes some of the more severe personality disorder types including:

- paranoid personality disorder
- antisocial personality disorder
- borderline personality disorder
- narcissistic personality disorder

However, many people do not fit neatly into any of these categories but may have features of two or three personality disorders.

Paranoid Personality Disorder. This type tends to be non-trusting, suspicious, and see the world as dangerous. They may seem secretive and reluctant to confide in others. In relationships, they view themselves as being constantly mistreated. They doubt the loyalty of everybody around them, and believe they are being exploited or harmed. These patients bear severe grudges against others. Often, they become angry easily and have a sense of entitlement. Paranoid personalities can become violent and dangerous, as most spree killers are paranoid personalities. Several notorious world leaders, such as Joseph Stalin and Saddam Hussein, were most likely paranoid personalities.[2]

Antisocial Personality Disorder. These people generally have no regard for the rights of others. In demeanor, they tend to be irritable and impulsive. They are exploitative, see themselves as better or superior, and can be very opportunistic in getting what they want. Antisocials are deceitful, may steal from people around them, and often have trouble with the law. They frequently engage in fraudulent activities and make very good scam artists. For example, one may take on the role of financial savior for a church and end up stealing everything. They generally have no remorse. Conduct disorder in a child often morphs into antisocial personality disorder. Examples include Tony Soprano on the TV show, and, in real life, the mafia's "Dapper Don," John Gotti.[2]

Borderline Personality Disorder (BPD). This type of personality shows instability of mood, poor self-image, and pervasive abandonment fears. There is an identity disturbance and major boundary issues. Borderlines usually demonstrate impulsiveness, and very quick shifts from depression to anxiety to irritability. There are usually chronic feelings of emptiness or severe loneliness, plus anger and temper, and even suicidal behavior. Under stress, they can become somewhat paranoid. Coexisting problems with drug abuse or other addictive behaviors may occur. There are often sleep disorders with severe insomnia. Severe borderlines will react with high drama and create chaos for everybody around them. They tend to have a split view in that they see people as wonderful or terrible, with nothing in between. Examples include Adolph Hitler, Marilyn Monroe, and Glenn Close's character Alex, in the movie, "Fatal Attraction." Borderline personality can vary from mild to severe, and may become better or worse over time. Suicide becomes more likely as patients age into their upper twenties and thirties.3 Suicide is also more common within a week of discharge from a psychiatric unit. .

Narcissistic Personality Disorder. This is less common, and is typified by a personality which sees itself as above others. The personality is grandiose, has a lack of empathy, and feels and acts self-important. There is a deep sense of entitlement. They may be very vain and constantly require admiration. They are envious, arrogant, exploitative, and can be very angry. Examples include General George Patton, Nicole Kidman's character in the movie, "To Die For," Michael Douglas' character, Gordon Gekko, in the movie, "Wall Street."[2]

Comorbidity of Migraine and Personality Disorders

One previous study on borderline personality (BPD) concluded that BPD comorbidity with migraine is associated with increased disability from the headaches.4 In addition, among those with BPD, there was an increase in medication-overuse headache, and headaches were more pervasive. There was a higher

degree of depression among those with BPD, more unscheduled visits for acute headache treatment, and a lesser chance of adequate response of headache medications. Those with BPD were more severely affected by headaches, and more inclined to be refractory to treatment.[4]

Another study indicated that the incidence of BPD was increased in migraineurs.[5] My recent study of 1000 migraineurs indicated that 5.5% of patients had a moderate or severe personality disorder.6 There is ample evidence that transformed migraine is associated with more prevalent psychopathology, including PD, than is episodic migraine. BPD itself is the mental health equivalent of chronic pain. In my experience, the two most important prognostic indicators for those with PD are impulsivity and substance abuse.

Treatment Approaches for PD Patients

Treatment for those with PD necessitates a caring, but stern, approach. Limits must be set on physician contact, including telephone calls. No abuse of staff should be tolerated. Referral to other health care providers, particularly mental health professionals, should be suggested. Psychotherapists and psychiatrists who are experienced with this population are vital if the patient is to be adequately managed. Many of the PD patients do not do well with traditional, insight-oriented therapy treatment, but are better managed long-term with a dialectical behavioral approach. For a therapy to be beneficial, it must be consistent and long-term. A psychoeducational approach may also help. Unfortunately, many PD patients will not continue in therapy, even with encouragement and support. Our therapeutic goals for the PD patient are relatively modest.

It is easy to become drawn into the drama surrounding patients with PDs, particularly those with BPD. The patient with BPD may grant his doctor power, but then subvert the therapy. An example of this would be, “Doctor, you are the greatest, only you can help me. These headaches ruin my life, ….and I know that nothing is going to work!” Some physicians are able to manage these patients without becoming involved in the drama and countertransference, but most do not do well with these patients. If there are signs of a dangerous PD from the first visit or phone call to the clinic—with abuse and anger showing at times—it may be better to refer the patient to a physician or clinic that is better equipped to handle such cases than to become enmeshed in the relationship.

Medications, though limited, may be beneficial for the impulsivity, aggression, self-mutilation, anxiety and depression components of PD.[7] While there are no specific medications indicated for those with PD, the Axis I symptoms are more amenable to pharmacotherapy. Antidepressants, mood stabilizers, and antipsychotics may ameliorate symptoms. Some of these medications may also lessen headache pain as well. PD patients with severe, chronic pain present additional challenges for treatment. It is important to limit and closely monitor addicting medications. Particularly with BPD, opioids and benzodiazepines are best avoided. The diagnosis of a moderate or severe personality disorder alters both our goal and approach.

Risk Factors

There are risks inherent in caring for those with certain personality disorders. As compared to the general population, those with BPD are at increased risk for suicide, particularly as they progress into middle age. Identifiable risk factors for suicide among BPD patients include repeated hospitalizations (five or more), a recent psychiatric hospitalization, and among adolescents, birth trauma.[3] Certain types of PD (paranoid, narcissistic, antisocial and borderline) are more likely to become angry and vengeful with their health care providers, resorting to lawsuits or letters to the departments of regulation. Violence may also be a threat. A PD patient often enters as a victim, then rapidly flips into the role of persecutor. Their anger becomes intently focused, creating a stressful environment for healthcare workers. Setting limits and keeping careful documentation are important in these situations.

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It does take a village to help a patient with a personality disorder, just as it does to adequately treat those with severe pain. It is important to recruit others, such as mental health providers, physical therapists, biofeedback therapists, etc., to aid in the treatment.

Bipolar Disorder

The clinical spectrum of bipolar disorder is an evolving concept. The DSM has historically-inherent biases against independently diagnosing bipolarity, and bipolar II is defined very conservatively in DSM-IV. For example, in DSM-IV, the important hypomanic reaction to an antidepressant is not included in helping to determine bipolarity.[8] Some authors feel DSM-IV has an inherent bias toward diagnosing personality disorders, rather than bipolar disorders. These biases lead to bipolar disorders being missed or underdiagnosed. The name, "bipolar," is unfair and misleading; the stigma inhibits the diagnosis. We need books and materials aimed at patients with symptoms at the milder end. When we label people with the term "bipolar," (or worse, "manic-depressive") and then prescribe "antipsychotic" drugs, it's no wonder patients resist the diagnosis.

Mania is better recognized than is hypomania (with milder bipolar features.) Symptoms of mania include: euphoric mood, distractibility, flight of ideas, grandiosity, thoughtlessness or risk-taking, and excessive involvement in pleasurable activities (i.e., sex, spending, gambling). Also, pressured speech, an increase in activities, excited (or irritable) energetic mood, and insomnia are indicators.[9] It is the milder end of the bipolar spectrum that tends to be missed. Look for those with persistently agitated personalities, with frequent depression or excessive energy, and those with a strong bipolar or depressive family history. They may not remember a clear hypomanic or manic episode. To aid the diagnosis, it is vital to speak with a close family member; some 40% of hypomanias are missed if one simply talks to the patient. Mild bipolar signs include: early depression (as early as the teens), severe bouts of depression, quick onset depression, bipolar reactions to certain meds (complaints of being up all night, mind racing, etc.), agitation and anger, very high anxiety, poor response to medication, and moody personality. Sleep disorders are com-monly seen. Cycles of brooding, irritable pessimism may be a manifestation of hypomania. Cyclical depression, for no clear reason, is common for bipolar depression, and may be accompanied by high anxiety. Depression is the primary problem with bipolar; it is much more pervasive than are the highs of hypomania. Left untreated, patients with bipolar often self-medicate.

As an example, consider "Jane," a 44 year-old woman with a history of depression since age 16. Her mom was depressed and an alcoholic; Jane's uncle committed suicide. In addition to the depression, Jane suffers from fibromyalgia. She tends to be irritable and angry, and self-medicates with prescription opioids and alcohol. Jane saw her family physician, who prescribed fluoxetine for her symptoms. After the first dose she was, "up all night and felt crazy, like my mind was going 95 miles an hour." So, instead of fluoxetine, sertraline was prescribed, and the same response occurred. Jane also had similar hypomania from pseudephedrine and corticosteroids. She finally was diagnosed as bipolar II, and was placed on lamotrigine, but then developed a rash. Quetiapine was tried, but Jane seemed overly sedated. Eventually, small doses of lithium improved Jane's moodiness by 50%, without the extreme side effects.

The therapeutic implications for not recognizing bipolarity are substantial. Patients such as Jane, when undiagnosed, are often given a number of antidepressants, with predictable hypomanic results. The tricyclic antidepressants appear to have the highest propensity towards triggering mania, followed by the selective serotonin reuptake inhibitors (SSRIs). Any antidepressant can provoke hypomania (or full mania) in someone who is bipolar. The best results seem to come from a combination of mood stabilizers with antidepressants, although the role of antidepressants remains controversial. The

diagnosis is a crucial step, but treatment for the bipolar patient is not always easy or successful. While psychotherapy usually is helpful, many patients are reluctant to go for therapy, often due to time or money constraints.

Comorbidity of Migraines and Bipolar Disorder

Comorbidity of migraine with anxiety and depression is well established—both in clinically based studies and in epidemiologic samples from community populations.[10] The physiologic overlap between migraine and depression is considerable. Antidepressants or mood stabilizers help both conditions. In the vast majority of migraine patients who suffer from depression, anxiety is a complicating factor. The anxiety disorder often precedes the age of onset of migraine, with depression following afterward. It is possible that poorly controlled migraines may fuel the onset of depression, or that depression may, at times, increase headache. However, it is more likely that shared environmental and genetic factors link migraine and depression.

The relationship between bipolar illness and migraine has not been as well studied as depression and migraine. However, in several studies, bipolar I and bipolar II were found to be increased in migraineurs.[11] For a recent article, I assessed 1000 consecutive migraineurs. The results were as follows:

- Bipolar I: 2.1%
- Bipolar II: 2.4%
- Cyclothymic Disorder: 1.3%
- Bipolar Disorder Not Otherwise Specified: 2.8%,
- Total Bipolar Spectrum: 8.6%[12]

Other recent studies have confirmed that at least 7% of headache patients fit into the bipolar spectrum, and 30-50% of bipolar patients have migraines.[13,14]

Medications for Bipolar Disorders

Once the bipolar diagnosis is established or suspected, mood stabilizers often are very helpful for both moods and headaches. Divalproex sodium is effective for mania, hypomania, depression associated with bipolar disorder, and for headache prevention. It has been extremely well studied for these conditions and has become one of the primary migraine and chronic daily headache preventives. Lithium carbonate is underutilized; it should be used more often. One or more of the newer antiepileptics may prove to be helpful for bipolar disorders and migraine. Carbamazepine has some utility as a mood stabilizer, but not for migraine prophylaxis. Oxcarbazepine is a milder form of carbamazepine, and may be useful.

Lamotrigine is becoming one of the most commonly used mood stabilizers. It is one of the few effective medications for bipolar depression.[15] Doses must be slowly titrated due to the 1 out of 2,000-5,000 occurrences of toxic epidermal necrolysis, or Stevens Johnson Syndrome.

The atypical antipsychotics are also used for bipolar symptoms.[16] When a mood stabilizer is effective, the underlying agitation, anger, or depression improves. Quetiapine has reasonable efficacy data. As a class, the atypicals do carry the risk of metabolic syndrome.

Unfortunately, the medications dis-cussed are more effective for the manic and hypomanic symptoms. The accompanying depression often goes untreated. Bipolar patients spend the majority of their time in depression, and we need better medications for their benefit. Many patients need two to four different medications; an effective combination might be lamotrigine, lithium, and an antidepressant. Rational polypharmacy is an improvement over monotherapy in treating the various bipolar symptoms.

Conclusion

For patient care, it has become increasingly important to recognize those patients whose psychiatric problems complicate their treatment in a pain clinic. Patients with a personality disorder are more likely to abuse drugs, file lawsuits, or abuse the staff. With personality disorders, setting limits is vital.

For those patients with bipolar symptoms, missing the diagnosis leads to poor outcomes with medication. Antidepressants tend to be wrongly utilized instead of the required mood stabilizers—usually with discouraging results for the patient.

Treating patients with chronic pain is chal-lenging enough; for those pain patients who also have psychological comorbidities, it is vital that the psychopathology be attended to, as well as the pain.
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