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Review Article

Personality Disorder Patients in A Pain Clinic

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ABSTRACT

Approximately 9.6% of Americans have a personality disorder. (1,2) These are common conditions, and all medical professionals encounter these patients in their practice. Early identification of these patients is ideal. In the following we discuss how patients with these psychiatric conditions may present to an outpatient pain clinic, and we provide suggestions for management.

1 INTRODUCTION TO PERSONALITY DISORDERS IN A PAIN CLINIC

Personality disorders (PD) are characterized by abnormal behavior and experience that affects a person's functioning. The DSM-5 defines 10 personality disorders separated by shared traits into three clusters: cluster A (characterized by odd, eccentric behaviors), cluster B (characterized by dramatic, erratic behaviors), and cluster C (characterized by anxiety and/or fear).(3) Like many other psychiatric conditions, personality disorders exist on a spectrum, with some patients coping with more mild forms, and others suffering more severe diagnoses that wreak havoc on their lives and relationships.

Cluster A: paranoid, schizoid, schizotypal

Cluster B: antisocial, borderline, histrionic, narcissistic

Cluster C: avoidant, dependent, obsessive-compulsive

These names of various personality disorders make little sense, and should be revised. Not every presentation fits neatly into one diagnosis, and PD patients often show features of different personality disorders. Some personality disorders are inherently more difficult to manage than others. The more challenging PD features include lack of insight, distrust of providers/therapy, disregard of social norms, sense of entitlement, manipulation, emotional outbursts, impulsivity, violent behavior, splitting, and exploitation. Comorbid substance abuse is common and compounds the dysfunction.(4)

While most patients with these conditions are not overly aggressive, there are some situations that can quickly deteriorate. Early detection of personality disorder pathology helps the patient and family, and also may protect the provider. These early signs vary depending on the type of personality disorder. The more severe PDs include **antisocial, borderline, narcissistic,** and **paranoid**.

Feeling uncomfortable or threatened while seeing a patient may be a clue that we may be dealing with a personality disorder. Providers who encounter these patients commonly describe feeling the presence of a personality disorder during the encounter; in troubling cases, the hostility, agitation, manipulation, and egocentrism are usually evident in the patients' dialogue. Additional supportive evidence of a severe personality disorder include constantly changing providers (due to mistrust or dissatisfaction), excessive demands, splitting, medication misuse, and threatening

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behavior (including baseless lawsuits). If the provider feels angry, manipulated, or "set-up" after the encounter, those are clues that we may be dealing with a PD.

Many of the more severe personality disorder patients flip between victim hood, persecutor, and savior. When they turn the severe anger on someone (persecutor) it often does not end well.

Personality disorder characteristics may have an evolutionary advantage in procreating genes. Evolution does not care if we live long, or how happy we are. Evolution is mainly concerned with passing on our genes. The aggressive type A "alpha" male, who may also be charming, mates more often, fulfilling the goal of evolution. These personality characteristics are found in borderline, narcissistic, and antisocial personalities.

The more severe personality disorder types are as follows:

1.1 *Paranoid Personality Disorder (PPD)*

PPD patients are characterized by pervasive suspicion and mistrust of people and the world around them. Frequently, they appear secretive and are reluctant to confide in others, including physicians. In relationships, PPD patients may view themselves as being mistreated, exploited, or harmed, and often doubt the loyalty of even those closest to them. They tend to be ultra frugal. When their interpersonal suspicions cross over into the patient-provider relationship, it may lead to poor compliance and follow up of PPD patients. PPD patients are further complicated if they have a history of hostile outbursts or violent behavior in response to their paranoid perception of the world. Many of the spree killers have PPD.

1.2 *Antisocial Personality Disorder (APD)*

APD patients have little regard for the rights of others and engage in irresponsible or criminal behaviors. The pediatric equivalent is conduct disorder, which may morph into APD once the child reaches adulthood. These patients are irritable and impulsive in demeanor, and generally take part in exploitation, violence, or fraudulent activity. Patients with antisocial personality disorder are at greater risk of alcohol use disorder due to their impulsive nature, and co-occurrence complicates management. [4]

1.3 *Borderline Personality Disorder (BPD)*

BPD is characterized by emotional instability, poor self-image, and pervasive abandonment fears. Like APD, these patients typically demonstrate impulsiveness and coexisting problems with drug abuse, and other addictive behaviors may occur. [4] There are usually longstanding feelings of emptiness or severe loneliness, extreme mood fluctuations, and chronic suicidal ideation. The suicidal feelings increase in the late twenties and thirties, when family and friends have drifted away. If a person with BPD is hospitalized, they often have increased suicidal thoughts upon leaving the hospital. When under stress, these patients can become paranoid. Characteristically, BPD patients demonstrate splitting, a defense mechanism in which people are seen in either an all negative or all positive light. There is no "grey" or middle ground. Borderline patients often produce chaos and drama for no reason. There is a sense of entitlement, with little empathy for others. Most (but not all) people with BPD lack insight. In a medical office they may present as a victim, but there are times the person with BPD will become angry with the staff and provider.

1.4 *Narcissistic Personality Disorder (NPD)*

NPD is one of the less common personality disorders and is typified by a someone which sees itself as better than others. The patient is grandiose and exhibits a lack of empathy. The person carries an inflated sense of self-importance. Many of these features overlap with BPD. There is a deep sense of entitlement, and they constantly require admiration and special treatment. As with most PDs, patients with NPD have demonstrated a limited response to psychiatric therapy. There is usually a resistance and hostility towards intervention, and patients prematurely terminate the therapeutic relationship. [5]

Physicians have a right to discontinue treatment when the patient is beyond their scope of practice, is disrespectful, or is threatening. Providers who encounter severe PD patients should evaluate whether their practice can safely manage that type of person. The staff does not deserve to put up with a dangerous, abusive, or hazardous work environment. A physician, or a clinic staff, only has so many "emotional marbles" for the day. One difficult PD patient can sap all of the staff's emotional marbles. Most practices should severely limit how many moderate or severe PD patients they treat.

Below is a discussion of the four more troubling personality disorders (paranoid, antisocial, borderline, and narcissistic) in the context of chronic pain, treatment, and associated risks to the clinic. There are other personality disorders that are essentially harmless, such as those with an avoidant personality. These patients are far less concerning for an outpatient pain clinic, and thus will not be discussed in this paper.

1.5 *Comorbidity of Chronic Pain and Personality Disorders*

Personality disorder patients with comorbid chronic pain present additional challenges. Personality traits color one's perception of self and relationships. Maladaptive personality traits may affect how pain is perceived. Some studies have reported that up to 60% of patients with chronic pain meet criteria for comorbid personality disorder and an estimated 30% of chronic pain patients may have borderline personality disorder. [6–8] These prevalence rates support

theories of predisposition of patients with personality disorders to developing chronic pain syndromes.[8] Patients who are being treated for their personality disorder use less medication for pain relief than those who go untreated.[6]

1.6 Comorbidity of Migraine and Personality Disorders

A study analyzing the inpatient treatment of refractory chronic daily headaches found that 26% of hospitalized migraineurs also had a personality disorder, particularly cluster B or cluster C.[9] The presence of a personality disorder was identified as a negative prognostic indicator, with these patients less likely to see moderate improvement upon discharge compared to non-PD patients.[9] Cluster B personality disorder comorbidity with migraine is associated with a more severe course of headaches, often with increased use of medications and poor treatment response.[9–11] Over 62% of hospitalized migraineurs with a personality disorder were found to be opioid dependent, compared to 37% of those without PD.[9]

Coexisting BPD with migraine is associated with higher rates of medication-overuse headache and increased frequency of unscheduled visits for acute migraine treatment.[11] The treatment-resistant nature of migraines in BPD patients is likely driven by dysregulation of both affective and nociceptive systems. This population exhibits poor tolerance of internal pain. BPD patients exhibit decreased control over their emotions, which may magnify the pain-related functional distress.[10] From a provider perspective, migraines in patients with BPD are often difficult to manage. Patients fare better when their personality disorder is being addressed by mental health professionals.[6]

1.7 Treatment Approaches for PD Patients

Treatment for those with personality disorders is difficult. PD patients often do not respect boundaries. If a physician chooses to treat a PD patient, limits must be set on physician contact – including telephone calls. It should also be made clear that abuse of staff is not tolerated. Referral to other health care providers, particularly mental health professionals, should be suggested in these patients.

Psychotherapists and psychiatrists who are experienced with treating personality disorders are one key to successful treatment. A collaborative approach also helps to protect the pain physician. Many PD patients do not do well with traditional, insight-oriented therapy treatment. They are better managed with a dialectical behavioral approach. For a therapy to be beneficial, it must be consistent and long-term. Depending on the level of insight the patient possesses, psycho education may also help.

Many physicians struggle to manage their counter transference in personality disorder cases. They often also become caught up in the anger, sadness, paranoia, or frustration exhibited by PD patients. These PD patients frequently present themselves in crisis with chaos and drama. It is important for the provider to not be caught up in the chaos and drama. At times there are signs of a severe PD from the first visit or phone call to the clinic—with abuse, anger, major sense of entitlement, etc. If the clinic is overrun by PD patients, or does not feel comfortable handling them, it may be best to refer and not become enmeshed in the relationship.

Medications can improve the aggression, impulsivity, self-mutilation, anxiety and depression components of personality disorders. While there are no specific medications indicated for those with PD, antidepressants, mood stabilizers, and antipsychotics show promise in relieving the severity of these symptoms. Additionally, these medications may also improve headache severity. Personality disorder patients with severe, chronic pain present additional challenges for treatment. Due to the high rates of refractory chronic pain, medication dependence, and overuse headaches in this group of patients, it is important to limit and closely monitor addicting medications such as benzodiazepines and opioids for signs of misuse.

It often takes several specialists 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.

1.8 Personality Disorder Risk Factors

There are risks inherent in caring for those with these personality disorders. Borderline personality disorder is known to be strongly associated with an increased risk of self-harm and suicide, and associations with suicide have also been found for patients with antisocial personality disorder.[12] Suicide in those with BPD is increased as patients progress into their late 20's and 30's. by that time, family and friends have often abandoned the person, and the "malignant loneliness" is worsened. Patients with impulsive, insensitive personalities are more likely to carry out vindictive or even violent actions. This places physicians in an uncomfortable and dangerous position.[13]

BPD patients average three lifetime suicide attempts, and up to 10% of BPD patients will die by suicide.[13] Impulsivity and unstable mood puts many BPD patients in a chronic state of suicidality, characterized by frequent, non-fatal suicide attempts following stressful life events.[13] The suicidality leads to frequent emergency room visits and hospital admissions by this group of patients.[13] Despite the overwhelming frequency of non-fatal attempts, there remains a high risk of completed suicide in this population. Unfortunately, risk algorithms are not accurate at predicting which BPD patients will die by suicide.[13] General considerations associated with completed suicide include treatment nonadherence and/or poor response to psychiatric therapy. APD patients are also at a higher risk for

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suicide.[12] Narcissistic personality disorder may generally be moderately protective against suicidality, but due to the hardheaded nature of NPD, the few that are suicidal may be more likely to succeed.[14] NPD patients are at an additional risk of completed suicide when they also exhibit comorbid aggression, hostility, or substance abuse.[14,15]

Certain types of personality disorder patients (paranoid, antisocial, borderline, and narcissistic) are more likely to resort to frivolous lawsuits and partake in litigious behavior. This tendency also manifests in other areas of a PD patient's life, including their employment and personal relationships.[16,17] Choosing to treat an extreme personality disorder patient opens doors to potential legal action. Providers must proceed with caution when opting to manage these cases. A PD patient may initially present themselves as a victim before rapidly taking on the role of persecutor. Many PD patients flip between the triad of victim, persecutor, and savior.

Careful documentation is important. The setting of boundaries is essential. Suicide in BPD is unpredictable and difficult to prevent.[13] Despite what is commonly practiced, repetitively admitting BPD patients to the hospital after each suicide threat or attempt may actually lead to an increase in completed suicide. This happens within the first few days upon leaving the hospital. Most PD patients should be referred to psychiatry and psychotherapy.[13]

1.9 Suggestions for Management of Patients with a Personality Disorder

1. Maintaining strict boundaries is crucial.
2. Do not become caught up in the chaos and drama.
3. Limit the number of moderate or severe personality disorder patients within your practice.
4. Refer to others for concurrent care, particularly mental health professionals.
5. Be very careful, and greatly limit, controlled substances.
6. Check the PMP for each visit.
7. Do not tolerate any staff or provider abuse.
8. If a patient "splits" on the provider, or levels severe anger, the approach of "killing them with kindness", or reasoning and bargaining with the person, usually does not work. Do not hesitate to call the police in difficult situations.
9. Be very conservative when recommending invasive procedures.
10. Document everything.
11. Consider taking a "dialectical" approach.
12. Dismiss out of your practice PD patients who cross lines or create havoc, or are dangerous to you or the staff. You do have to dismiss by following accepted guidelines, particularly being careful not to abandon the patient.
13. Place limits on the patient calling you after hours.
14. Place limits on emails and calls to your clinic.
15. Remember, these patients create more of an emotional burden on a staff and provider. We only have only so many "emotional marbles" for our day or week. One difficult encounter may sap all of our marbles.

2 CONCLUSION

It is crucial to recognize those patients with borderline, narcissistic, antisocial, or paranoid personality disorder. Patients with these types of personality disorders often suffer a poor outcome. They require a multidisciplinary approach. Boundaries and limits must be enforced. It is important not to become caught up in the "chaos and drama" of the patient. Without recognition and adequate management, these patients place the pain provider at risk.

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