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Case Report

Telling the Difference between a Histrionic Personality Disorder and the Manic Phase of a Bipolar Disorder in a Pain Clinic, or who is at Risk for Suicide?-A Case Series with Seven Patients

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Introduction

Background: Patients with histrionic personality disorder usually attempt suicide to gain attention, while up a third of bipolar patients end their lives by suicide. Discerning between the two is challenging for physicians outside the field of psychiatry. In the setting of a pain clinic, the differentiation can be very relevant for the treating physician.

Methods: Seven cases are presented, of which only one patient was diagnosed with mania. The aim is to work out the differences between mania and histrionic personality (disorder) for the non-psychiatrist in an understandable way.

Results: Patients with conspicuous and artificial appearances are quickly labelled as suffering from a histrionic personality disorder. This presentation can mask a manifest mental illness in the form of a mania.

The comparison of the manic patient with six patients with an initial diagnosis of a histrionic personality disorder allows the elaboration of differences and characteristics against the background of previous literature.

Conclusion: Mental disease progressions are not always characterized by constant symptoms, but their symptoms and progressions are versatile. This requires attentive following and describing of concise signs in behaviour, facial expressions, gestures, and language. If a mania is diagnosed as a comorbid psychiatric disease of a pain disorder, it must be treated with medication in addition to the somatic comorbidity. The very high risk of suicide that may be present with a mania should be kept in mind.

Keywords: Pain Clinic; Histrionic Personality Disorder; Mania; Bipolar Disorder; Suicidality

Introduction

In Germany, the overall group of dissociative disorders and conversion disorders (ICD-10: F44) is assumed to have a (point) prevalence of 3% in the general population and up to 30% in clinical populations [1]. Personality disorders have a prevalence of 10-15% in the general population [2]. In pain clinics, the prevalence of personality disorders is 41% [3], whereas the subgroup of histrionic disorders is 1.3 to 3% of these. Manic disorders (mostly in the context of bipolar disorders) occur in the course of life (lifetime prevalence) in 1.5 to 5% of the population [4]. They are among the 10 most serious diseases with a high risk of permanent disability [5]. Mania in particular have a very high

suicide risk through bipolar disorders with 19 to 30% suicides and 60% suicide attempts [4]. On the other hand, patients with a diagnosis of "histrionic personality" form a kind of counterpole, since in their case the patient usually only attempt suicide in order to gain attention. In his autobiography, the psychiatrist Bürger-Prinz describes the case of a woman in 1971 [6]: "What she presented were quite clearly hysterical mechanisms, albeit to a degree and with a wealth of fantasy, which surpassed almost everything we had experienced in the clinic in this field so far: screaming cramps, extremely severe anxiety, paralysis, twilight states, and of course the most violent nocturnal unrest." However, a few years later they saw this patient again, this time in a manic phase. How could respected psychiatrists err in their diagnosis? Therefore it is worth comparing the two disorders. However, how can we tell the difference when the patients of both disorders are cheerful, very lively and charming; and are there no other characteristic symptoms in the individual patient for one or the other mental disorder?

Casuistry

Case 1

Female, observation period: since 2012. At admission 59-year-old female patient with pain in the lumbar spine, which extends into both legs, the cervical spine and the right arm. The pain quality is described as stabbing, ranging from three at admission with a maximum of seven to eight and a minimum of three on the NRS scale (0-10). Target is set at three. The pain is multilocular and had previously been treated with Tramadolor and Duloxetine as well as Trazodone in an anxiety outpatient clinic. The social history revealed schooling up to 8th grade, training as a cook, married with four children.

Psychiatric findings on admission: Appearance: pink jacket and sweater, light blond, short (dyed) hair with small corkscrew curls. Strong make-up. Lively facial expressions and gestures. Patient is excited. Fast speech. No signs of depressive moodiness. Flat, not empathetic affectivity when she exclaims: "Dear God, let me die." The patient had attempted suicide three times (1996, 1997, 1999), although a history of depression is unknown at this time, yet has to be suspected. It is only known that in 1993 she was given an antidepressant (Trimipramine) due to anxiety. No affective incontinence, yet irritable. No flight of ideas. Questions are answered verbosely. Her drive is bad. The following diagnoses were initially made (according to ICD.10): hyperthymic temperament, differential diagnoses: beginning mania, personality with histrionic parts; algogenic psychosyndrome.

Treatment: In addition to an opioid (initially Tramadolor, then morphine sulphate), she received Carbamazepine as a mood stabilizer and valproic acid against irritability.

Further course: The paramount aspects over time were the irritability or affectability, the garish appearance and the fast way of speaking. The initial flat affectivity resided and gave way to impressive and therefore credible descriptions of her symptoms. We then interpreted this as a sign for high psychotic energy, and after three years she suddenly reported of hearing voices, ("My brain communicates loudly with me."). This happens especially when her brain is heavily strained. In addition, she now complained about free-floating fears. Therefore, Carbamazepine was exchanged for Ziprasidone. Under Ziprasidone, the thought process disappeared and the anxiety level decreased. When she reported of a past panic attack, Paroxetine was also added at 20mg/d. From this time onwards, the patient has been stating that she has neither pain nor anxiety.

Final diagnosis: Mania with acoustic hallucinations (thoughts becoming loud), therefor overboiling mania (bipolar psychosis within a schizoaffective disorder).

Case 2

Female, observational period: since 2008. At admission 48-year-old female patient who complained of pain in the lumbar spine, extending into both legs, the cervical spine and the right arm. The pain quality is described as burning, stinging, itchy, tingling, and dull; intensity on at admission 8, maximum 9, minimum 7, target 5. Multilocular pain.

Previous medication: oxycodone, trip tan, amitriptyline in the evening 100mg.

Social history: 10th grade, geriatric caregiver, divorced, 2 children.

Psychiatric findings on admission: Mostly smiling patient (at NRS 8), interrupted either by "kidding/goofing around" with the doctor or by sobbing attacks. Fear of death, tachycardia. Then her head becomes empty, and she falls into darkness. Last suicidal ideas one year ago. Exaggerated, shallow, paramimic affectivity, which the examiner cannot empathize with, even when the patient cries. Anamnestically, she reacts constantly with fear, not only of dying, but also of new drugs, with anxiety symptoms such as tachycardia, difficulty swallowing, and shortness of breath, sensation of suffocation, nausea, and nightmares. She avoids thinking about the future; on some days, she just wants to stay in bed. For 6 years now under psychotherapy (behavioural therapy). Three-fold surgery of the spine due to persistent pain, always unsuccessful. In addition to an opioid (hydromorphone), she had received various psychotropic drugs, to which she always reacted with the same anxiety symptoms (Mirtazapine, Venlafaxine, Duloxetine, Carbamazepine, Pregabaline, Lamotrigine, Ziprasidone and Quetiapine). Doxepin was the only medication she tolerated so far.

Diagnosis on admission: Personality with histrionic parts.

We further present brief descriptions of cases that were diagnosed with "histrionic personality disorder" on admission.

Case 3

Female, duration of observation: 3 years. A 70-year-old female patient admitted with pain in the lumbar spine extending to the foot of the left leg. She cannot describe the quality of the pain (e.g. dull or burning); instead, she uses psychological adjectives ("terrible").

Pain intensity: at admission 8, maximum 9, minimum 5, target 3-4. Multilocular pain. Previous medication: Pregabaline 100mg 3x1 per day, Tramadolor.

Social history: schooling up to 8th grade, trained podiatrist, married since 2008 in 2nd marriage. 1 child

Psychiatric findings on admission:

Paramimic: smiles at pain intensity 8. Motor restlessness, knibbles constantly with a finger on the thumb of the left hand. Affect-labile, cries when questioned on suicidal tendencies, denies acute suicidality. Still affect-labile with high doses of Pregabaline. Anamnestically anxious personality according to referring doctor's letter, but the patient knows nothing about it.

Case 4

Female, duration of observation: 2 years. At admission 58-year-old woman with pain of the lateral left thigh, as well as lower back pain. Pain quality: burning, stabbing like with a knife, tingling. Pain intensity at admission 3, maximum 10, minimum 3, target 3. Only 1 type of pain.

Social: high school diploma (Abitur), Teacher, not married.

Psychiatric findings on admission: Very conspicuous appearance: presents in a long, colourful robe with a crocheted emblem around the neck ("souvenir from a recent trip to Mexico"). Weepy facial expression, but can also laugh, emotionally unstable; trembling; reports death wishes. She reports of a depressive period about 20 years ago, which was treated with an antidepressant. Currently only slight depressive fluctuations. Increased flow of speech. When questioned on future perspectives, she wishes to enjoy her beautiful home.

Case 5

Female, duration of observation: 1 year. 60-year-old patient with pain in the cervical spine (including back of head and forehead), lumbar spine, right thigh and both groins, left knee and left foot. Pain quality is described as stabbing and "like labour pain". Pain intensity at admission 5-6, maximum 8, minimum 4, target: 3-4. Multinlocular pain.

Social: Schooling up to 10th grade, trained stenotypist, unemployed for 5 years before admission. Currently suing for incapacity pension. Married in 3rd marriage. 2 children.

Psychiatric findings on admission: Her greeting is submissive, but firm in tone. Talking past while questioned on pain (question: "where is the pain localized?" Answer: "I have pain all day".) Facial expressions and gestures tense, trembling all over her body, as if she was about to do something unforeseen. When asked about her mood, she answers: "like the weather, I could either cry or dance on the table". Affect-labile: cries when questioned on the topic of suicidality and fears; also describes thoughts of death, as well as a feeling of hopelessness. Claims to have low self-esteem.

Colourful expression: Can hardly describe her pain (which is the initial reason for her referral), although suffering from it for more than 10 years. However, she can describe her previous suffering in detail.

Case 6

Female, duration of observation: 9 years. 54-year-old female patient admitted with pain of the cervical spine, lumbar spine, in the region of the M. Trapezius, both shoulders, ventral right lower leg as well as both wrists and right ankle.

Pain quality: stabbing, tingling, dull, electrifying. Pain intensity at admission: 5-6, maximum 7-8, minimum 3-4, target 3-4. Multilocular pain.

Social: schooling up to 10th grade, primary school teacher, married in 2nd marriage. 2 children

Psychiatric findings on admission: Blond hair with red highlights. Describes a fluctuating mood, and reports of quickly becoming weepy. Logorrheic. Patient was under considerable tension during the interview (suspicious, lurking). Was relieved when confronted with questions, as she could then elaborate on the answers. Shallow affectivity. Patient felt misunderstood, not sufficiently appreciated by her surroundings for her work as a teacher, not taken seriously in the bodily complaints. Suicidal ideas one year ago. When questioned on future perspective, she answers that she wants to accomplish something, but is afraid of failure.

Case 7

Male, observation period: 1 year. 52-year-old patient with cervical and lumbar pain. The former extend from the cervical spine into the left arm, the latter into the right leg dorsally and ventrally down to the foot.

Pain quality: pulling, stabbing. Pain intensity: at admission 6, maximum 9, minimum 5, target 5-6. Multilocular pain/Panalgesia.

Social: Schooling up to 10th grade, mechanical engineer, married, 2 children. Incapacity pension since 5 years.

Psychiatric findings on admission: Carries his crutches on route to the examination. Cannot describe the pain he is experiencing since 2006. Reports of severe, continuous back pain, but also

of riding his bike for 20 km. Presents as more incapacitated as can be found in the physical examination. Considerable tension during the examination. Constantly monitors his impression on his surroundings. Complains about motor- and inner restlessness. Denies suicidal tendencies, yet indicates feelings of hopelessness. Reports phobic aspects (fear of fainting in public), and regularly taking benzodiazepines to calm down. The patient is not empathisable.

Discussion

The risk of a patient committing suicide is not the same for different types of psychiatric disorders. Patients in a manic phase of a bipolar disorder have a high risk of committing suicide, whereas histrionic personalities do not.

Suicidal ideation

In the outpatient pain department of Magdeburg University, 3.4% of patients have a diagnosis from the spectrum of bipolar disorders (hyperthymia, hypomania or mania) whereas 0.9% have the diagnosis of a histrionic personality disorder. Patients with a histrionic personality disorder (HPD) as well as those with bipolar spectrum disorder (BSD) do not consult a pain clinic because of the disorder itself but because of physical complaints such as pain. Patients with HPD and BSD form two poles of suicidal ideation: While patients with HPD usually attempt suicide to gain attention, up to 30% of bipolar patients commit suicide and 60% suicide attempts. Suicidality is often linked to the subjective feeling of depression [7], but can occur in both disorders. Suicidal ideation (including suicide attempts) occurred in all presented patients, although the male patient (case 7) denied this, yet was the only one to take benzodiazepines and paroxetine to calm his fears.

Problems

It is already known from older works [8] that there is a gender effect for both hysteria and mania. This is also the case in the present cases with a numerical ratio of 6:1 for women. With such an imbalance, the discussion always arises as to whether the under-representation comes from the fact that men simply suffer less frequently from these two diagnoses or whether the men are defined under other diagnoses (paranoia) or whether they are admitted to hospitals at all for the same behaviour or rather sent to prison [8]. Especially in mania, social class dependency in the sense of an over-representation of mania in people of the lower social strata is discussed, with simultaneous acceptance of hypomania as normality in the upper class [8]. This still has significance for clinical medicine today, because outside psychiatry, the presentation of the complaints by patients are misjudged as to the significance of the disorder [9]. Within psychiatry, the symptoms for the diagnosis are also often misjudged by the physician. Bürger-Prinz for example had to make this experience when he was presented with a patient whom he diagnosed with mania because of his rich gestures, his fast way of speaking and his flight of ideas. He received considerable laughter from the French auditorium because it turned out that he was a healthy, “typical” citizen of Marseille [6]. This shows that mania is at least partly a diagnosis that lies in the eye of the beholder. As a result, the diagnosis “mania” is often not reliable [10]. Intercultural differences have to be considered when looking at sane and manic patients. “Cultural sensitivity” therefore belongs to the instruments of every diagnostician, especially in times of increasing migration.

In the case of histrionic personalities on the other hand, incorrect diagnosis is almost integral part of the diagnosis. Erickson described this effect in 2002: 184 psychologists had to make diagnoses based on case vignettes. If the patient was coined female, histrionic personality disorders were diagnosed more often, whereas male patients were classified as narcissistic [11]. The difficulty is discerning the two disorders via clinical symptoms. According to Huber and Sulz, both disorders can be distinguished by a psychiatrist as listed in Table 1.

Psychopathological item	Mania (Huber, 2005) [12]	Histrionic Personality disorder (Sulz, 2010) [13]
exterior appearance	Appearance younger than their actual age increased libido funny and quick-witted	Extraverted, charming, attractive, to some extent successful and popular
Facial expression, gestures	urge to speak, move and actuate	Theatrical behavior, tendency to dramatize
affectivity	Emotional fluctuations; cheerful-happy, irritable-quarrelsome, excited-raving mad. Affective coloration often stable over long periods.	Affects give the impression, as if the patient is "in character" Affect-incontinent (i.e. emotional fluctuations with outbreaks of laughter or crying)
Behavior/conduct towards others	Disinhibition, allowing disregard for norms/ conventions and laws.	Over-excitability, i.e. pronounced willingness to react excessively to external changes
aggression	Irritated mania as a reaction to the environment to curb the patient's urge to act	Low tolerance of tension and frustration as soon as patient's own efforts in the environment are unsuccessful.
distractibility	Volatile, excited, imaginative thinking with at the same time increased distractibility through external impressions.	Suggestibility, high influenceability by other persons
hallmark	Actions impress like a "wrong program." No awareness of immorality or and no sense of guilt for violating norms and laws. The manic simply takes action.	Psychodynamics: Awareness of one's own inadequacy. Tries to compensated by pretending to be another person. Fear of losing attention, therefore, does everything to be loved.

Table 1: Psychopathology of Mania (BSD) und histrionic Personality disorder (HPD).

Common Traits

We report of seven patients who were primarily diagnosed with a histrionic personality. The diagnosis was made by a psychiatrist according to ICD-10, but above all according to DSM-IV. As a non-psychiatrist, the differentiation between mania and a histrionic personality by official characteristics (Table 1) is, putting it mildly, strenuous. The relationship between HPD and mania has described by Shorter, where the manic mood was always coined as the main symptom. Within the last 20 years, no study on the prevalence of mania or hysteria within the group of patients with chronic pain can be found. Recently, only pain in manic patients has been examined. The manias were defined according to DSM IV [14] or ICD-10 [15]. Often it was impossible to understand how the manias were diagnosed (for example Nicholl [16]). In the setting of a pain clinic, it is important (due to the suicidality) to differentiate the patients with HPD and BSD from the mentally inconspicuous patients. For a non-psychiatrist, it is possible to identify the same seven cases, based on the following distinctive features.

1) Exaggerated expression of feelings

In all cases, emotional lability was observed.

2) the inappropriate appearance

Case 1: 59 years old, pink jacket & sweater, dyed, blond hair with corkscrew curls.

Case 4: Heavy make-up, colourful robe

Case 6: 54-year-old with dyed blond hair and red highlights (at NRS 8).

3) The inappropriate behaviour with high pain intensity (because they are the focus of attention)

Case 2: Mostly smiling patient, "Kidding/goofing around" with the doctor (at NRS 8),

Case 3: Paramimic, smiles at pain intensity 8 (to 9)

Case 7: at NRS between 6 to 9, carries his crutches on route to the examination.

4) Dramatization or extensive presentation of symptoms

Case 5: Can hardly describe her current pain, yet can describe her previous suffering in great detail.

Case 7: Cannot describe the pain he is experiencing since 2006 and presents as more incapacitated as can be found in the physical examination.

Differences between mania/bipolar disorders and histrionic personality

After having picked out the patients according to the above mentions criteria, one can differentiate between mania and histrionic personalities according to psychiatric criteria. Patients with mania talk fast and have flight of ideas (the first more, the second less a typical symptom of mania [17]) while the patients with histrionic personality show a more normal pace of conversation. The mania presented here (case 1) was later accompanied by hallucinations, therefore leading to an over boiling mania, a subgroup of schizoaffective disorders [12]. However, some psychiatrists do not automatically assign hallucinations in manias to the schizophrenic spectrum [18]. Patients with personality disorders (HPD) by definition cannot hallucinate, as hallucinations are by definition linked to psychotic disorders. Another feasible diagnostic criterion to us seems to be the patient's type of presence or countertransference, meaning the examiner's emotional reaction to the patient. As an example for presence, the manic patient exerted more pressure on the examiner through her loud, urgent way of pronunciation and description of her problems. The examiner had no choice in these situations but to believe the patient's presentation. This feature was constant over the years of treatment and, in retrospect, has to be deemed as an external sign of how much psychotic energy a manic psychosis can release. Bürger-Prinz also described this as follows: "Shouldn't we have asked ourselves much earlier... how is it possible for a young person to maintain such blatant hysterical mechanisms for almost two years? Can an external situation keep a human being imprisoned for such a long time in such a terrible state of energy waste?" [6]. In observing the countertransference of a histrionic personality, one had the feeling that the patient, except by his external appearance and the exaggerated way of presenting symptoms, does not behave obtrusively toward the examiner, but lets him take the initiative and thus acts manipulatively. Patients appear polite during treatment but allow the physician's efforts to go to waste.

Summary

The common denominator for the presented patients was the subject of suicidal tendencies and the fears that could be repeatedly identified, with different contents for the individual patients. Because of the conspicuous appearance, we initially classified all the patients as histrionic, and missed the manic. The classical criteria for mania and HPD were not feasible for non-psychiatrists. In retrospect, the most helpful criterion was the countertransference. In contrast to mistrusting the suffering of the histrionic patients due to their flat affectivity, it was almost impossible to not believe the extent of the manic patient's symptoms.

Importance for everyday life

As manic patients have a high risk for suicide, it is of considerable importance to detect these patients in a pain clinic. Hysterical personalities pretend to have a condition, but are manipulative enough to fool the doctor into thinking he is doing something good for the patient (e.g., surgery). Manics initially create considerable psychological pressure by presenting their pain to the physician, but then present themselves under pain therapy in such a good mood that the physician believes he has helped them quickly with pain therapy. In both cases, the physician is prevented from helping the patient with the underlying problem. In a pain clinic, recognizing a mania according to official criteria is not reasonable for a non-psychiatrist. We believe, countertransference can be utilized as a guidance through treatment.

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