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The Case: The case of physician do not heal thyself

The Question: Does the patient have a complex mood disorder, a personality disorder or both?

The Dilemma: How do you treat a complex and long-term unstable disorder of mood in a difficult patient?

Pretest Self Assessment Question (answer at the end of the case)

Frequent mood swings are more a sign or symptom of a mood disorder than they are of a personality disorder

A. True
B. False

Patient Intake

- 60-year-old man
- Chief complaint is "being unstable"
- Patient estimates that he has spent about two thirds of the time over the past year being in a mixed dysphoric state and about one third as depressed, but waxing and waning every few days, or even every few hours

Psychiatric History: Childhood and Adolescence

- As a young child, had symptoms of generalized anxiety and separation anxiety
- Also, as a child, remembers "emotional trauma" from mother, herself with recurrent episodes of either unipolar or bipolar depression who was often physically unavailable because of hospitalizations, or emotionally distant when depressed at home
- Has had a lifetime of multiple turbulent interpersonal relationships since childhood, with family members, with friends and especially with women
- As an older child and adolescent, continued to have not only subsyndromal generalized anxiety but developed at least subsyndromal levels of OCD with ruminations, checking and rigidity
- He was told these were good traits and would make him a good student, which he was, with good grades through high school and college, gaining admission to medical school

Psychiatric History: Adulthood

- Diagnosed as major depression for the first time at age 23, early in medical school
  - Was his worst depression so far, as other depressions previously

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characterized as unhappiness and transient depressed moods of a few days duration and with more anxiety than depression, improving without treatment
  - Actively suicidal and overdosed on his medications at this time but recovered
  - In retrospect, patient believes that he has long experienced rejection sensititivity with up to 2 depressive episodes per year since age 16 up to the present
- No clear history of any full syndromal manic or hypomanic episodes
- Since age 23, however, has had many episodes lasting a week or more of irritability, inflated self esteem, increased goal-directed work activity, decreased need for sleep, overtalkativeness, racing thoughts, psychomotor agitation and risky behavior; could also experience euphoria or expansiveness to a significant degree but only for 2 or 3 days at most and usually shorter
- He interpreted these as good traits, indicative of creative persons, and were the reason he was productive as well as creative
- In getting his history, it is not clear whether he has had an irritable dysphoric temperament since childhood, a superimposed episodic subsyndromal dysphoric mixed hypomania, or both
- First marriage ages 32–33
  - Depressive episode and overdosed again when first marriage broke up
- Second marriage between 35 and 36
  - Another depressive episode after breakup of this marriage
- Third marriage ages 46 to 58
  - Another depressive episode after breakup of this marriage

Medication History

- Starting with his first diagnosed episode of depression in medical school, treated off and on with TCAs and benzodiazepines, starting and stopping them over many years in relationship to his symptoms
- First received lithium at age 43, 17 years ago
- Unclear whether this was an augmentation strategy for resistant depression or for bipolar spectrum symptoms
- Was not that helpful according to the patient
- States he has had many, many medication trials since then
- Valproate (Depakote) not tolerated
- Clonazapam (Klonopin) helped sleep
- Oxcarbazapine (Trileptal) caused dysphoria and agitation
- Verapamil caused/worsened depression
- Risperidone (Risperdal) caused depression
- Fluoxetine (Prozac) caused rapid fleeting relief of depression, but also insomnia and headache

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- Other SSRIs caused activation and were not tolerated and discontinued after a few doses
- Presents now only taking methylphenidate (Ritalin), which he prescribes for himself as he does not think his physicians know as much about his case, or what he needs, as he does and they will not prescribe it for him

Social and Personal History

- Married and divorced 3 times, currently single
- No children
- Non smoker
- No drug abuse, rarely drinks
- Physician and successful businessman

Medical History

- Crohn's disease

Family History

- Father: sleep disorder
- Mother: either bipolar or unipolar depression, unsure, but successfully treated with ECT
- Maternal uncle: depression
- Maternal aunt: depression
- Maternal grandmother: hospitalized for "manic depressive disorder"

Current Medications

- Azothiaprine and Remicaid for Crohn's
- Methylphenidate

Based on just what you have been told so far about this patient's history what do you think is his diagnosis?

- Recurrent major depression with an anxious/dysphoric temperament
- Bipolar II depression
- Bipolar II mixed episode
- Bipolar NOS
- Bipolar NOS superimposed upon a personality disorder (narcissistic, borderline, other)
- Primarily a cluster B personality disorder (antisocial/histrionic/narcissistic/borderline)

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Attending Physician's Mental Notes: Initial Psychiatric Evaluation

- Here is a case that could be a complex combination of a mood disorder plus a personality disorder in someone who has never experienced mania and probably has never reached the threshold of experiencing unequivocal hypomania as defined by DSM IV or ICD10
- It is very difficult to separate the mood disorder from the personality disorder in a one hour initial evaluation session, plus looking at the medical records
- A complete diagnosis will have to await spending more time with the patient, and if possible, having access to the input of other observers as well
- However, seems likely that there is more to this case than a mood disorder, and probably cluster B personality traits if not personality disorder is comorbid

How would you treat him?

- Continue his methylphenidate
- Discontinue his methylphenidate
- Start an antidepressant
- Restart lithium
- Start an anticonvulsant mood stabilizer
- Start an atypical antipsychotic
- Make sure he agrees to weekly insight oriented psychotherapy
- Consider psychoanalysis

Attending Physician's Mental Notes: Initial Psychiatric Evaluation, Continued

- Since the patient lives in another city, psychotherapy will have to be an option via another mental health professional, although some supervision of that plus advice on medications can be possible as a consultant
- The patient is open to pursuing psychotherapy as long as he respects the therapist
- Before recommending psychopharmacologic treatment, it would be good to review what we know from the available history about his response to medications already taken
- As shown from the history of this case, it can be impossible to determine with great accuracy the effects of the medications by taking a history. One should be skeptical of the information as it can be unreliably reported in records and by a patient because it is complex and the medication effects can be subtle

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  - How many medications were taken long enough to have had a chance to work?
  - Did some medications provoke mood instability while others stabilized mood?
  - If the person has a mood disorder with an underlying personality disorder, will medications treat only the mood disorder and expose the symptoms of the personality disorder, or
  - Will treating the mood disorder with medications allow the patient to recompensate and thus have improvement not only in mood but in personality disorder symptoms?
  - These questions are better answered if you live the ups and downs along with the patient and experience the signs and symptoms of such a patient in real time
  - However, the real question is what can you do to help such a patient and what are the realistic goals of treatment
  - Finally, is treatment defined as medications, insight oriented psychotherapy, or both?
- About the only thing solid here is that antidepressants seem to be provocative at times in terms of causing activation and thus should be given cautiously and only concomitantly with mood stabilizing medication
- Has taken numerous mood stabilizing medications that he reported cause depression, especially those that are used to treat mania
- He has a demanding job and is not willing to put up with much sedation and will not accept weight gain
- It is possible that he is a bipolar spectrum patient with more depression than mania and with more pure depressive states alternating with mixed states of dysphoria/irritability superimposed upon depression, but not full syndrome mixed bipolar disorder
- Thus he has four needs"
  - Treat from "below" (i.e., antidepressant)
  - Stabilize from "below: (i.e. prevent cycling into depression)
  - Treat from "above" (in his case, not to treat euphoric mania, but to treat irritability)
  - Stabilize from "above" (i.e. prevent cycling into mixed states of dysphoric/irritable depression)
- Highly unlikely that this will be possible with a single agent
- For now, decided to avoid an antidepressant and to stop the methylphenidate which may help depression but at the expense of destabilizing him and causing cycling into irritable mixed states
- For now, a low side effect mood stabilizing agent with antidepressant and maintenance potential (i.e., treating from below and stabilizing from below) such as lamotrigine seems to be a good bet

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- After this is given, might consider adding lithium which he has tolerated in the past although unclear what therapeutic actions it had for him; however, might treat and stabilize him from above in synergy with lamotrigine for a total therapeutic picture

Case Outcome: First Interim Followup, Week 12

- Patient flies back for a followup appointment 3 months later
- Has stopped methylphenidate and his psychiatrist in his home city started lamotrigine by slow upward titration, but a bit faster and to a higher dose than recommended and now taking 400 mg/day
- Mood stabilized but at a level of low grade consistent depression with decreased libido and sexual dysfunction
- Told to reduce lamotrigine to 200 mg and wait another month or two because it can take a while yet for lamotrigine's antidepressant effect to kick in and its mood stabilizing effects may have already started

Case Outcome: Second Interim Followup, Week 16

- Phone consultation
- Learned that the patient decided that lamotrigine was making him depressed and ruining his sex life, so discontinued it and completely relapsed in terms of depression
- Patient agrees to restart lithium after blood and urine tests from his physician

Case Outcome: Third, Fourth, and Fifth Interim Followup Visits, Weeks 20, 24 and 28

- Phone consultations
- Patient has normal labs and starts lithium at week 20 only has a blood level of 0.4, so told to increase dose
- At week 24 calls and states that higher doses give him unacceptable diarrhea and exacerbates his Crohn's disease symptoms, so he is back down to the low dose of lithium
- Also, restarted methylphenidate as needed for dysphoric mood and low energy
- Told to increase his lithium again, more slowly and not to 1800 mg/day which caused diarrhea but only to 1500 mg a day or 1500 mg alternating with 1800 mg/day on alternate days and to stop his methylphenidate
- Also told to restart lamotrigine titrating up to only half his previous dose, namely 200 mg/day with the strategy that both drugs together would allow him to take each in lower tolerable doses for him, yet working together to add their therapeutic effects

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Case Outcome: Sixth and Seventh Interim Followup Visits, Weeks 32 and 36

- Brief phone consults with the patient and his psychiatrist on the phone together
- Getting regular psychotherapy "whatever"
- Monitored by his local psychiatrist monthly face to face appointments
- Lithium level 0.7, occasional tremor and diarrhea but mostly tolerable
- Mood is stable and overall "feels much better"

Case Outcome: Eighth Interim Followup, Week 40

- Emergency phone call
- Can't get a hold of his psychiatrist where he lives
- Patient calls from a football stadium where his alma mater is playing in a big football game
- "I'm in trouble"
- Patient states he has been much troubled recently about always feeling somewhat dysphoric, not really worse recently, but just tired of never being "well"
- Denies psychosocial stressors but feels desperate and suicidal
- Now at the football game, his thoughts are entirely about suicide, making his will, shooting others at the game, and killing himself
- Fortunately, he states he neither has a gun with him nor does he own one
- Has weird reaction to the football game, because when his team scores, he is not euphoric but bursts into tears
- "help me"

What would you do now?

- Tell him to call his local psychiatrist
- Tell him to go to the emergency room
- Tell him to call the suicide hot line
- Tell him to settle down and that you will either call in a prescription for an antipsychotic or coordinate it with his local psychiatrist
- Tell the patient to find another consultant

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Case Outcome: Eighth Interim Followup, Week 40, Continued

- Told the patient to settle down and you would call his psychiatrist to meet him at his local emergency room which he agrees to do after the game ends
- Also patient states he feels much better now that he has spoken on the phone, and also now that his team is now winning
- Local psychiatrist sees him in the emergency room and starts him on aripiprazole 2.5 mg increasing if tolerated and not effective to 5.0 mg 1 to 3 days later, increasing to 7.5 mg if tolerated and not effective 1 to 3 days later

Case Outcome: Ninth Interim Followup, Week 41

- One week later, phone consult with his psychiatrist on the line
- Patient states he contacted his local psychiatrist the same day as his phone call from the football stadium, and saw him a week later (which was yesterday)
- Got the prescription for aripiprazole and the next day following the phone call from the football stadium, left on a business trip from California to New York
- In New York, the aripiprazole was not effective at 2.5 mg, so the next day he became desperate and took 20 mg (not an overdose attempt, just to hurry up the therapeutic response)
- Also increased his lamotrigine on his own to 400 mg/day
- Lowered his lithium dose
- Flew back to California
- Had gait disturbance, tremor, word-finding problems, memory loss, yet still verbally provocative, desperate with recurring suicidal and homicidal ideation
- "I want to hang myself"

What would you do now?

- Start another antipsychotic
- Reinstate the original doses of lamotrigine and lithium
- Tell the patient and his local psychiatrist to find another consultant

Case Outcome: Ninth Interim Followup, Week 41, Continued

- Actually, this time, felt as though the patient was manipulating and scolded him with his psychiatrist on the line
- Told him that his psychiatrist is the treating physician, not the consultant, and the consultant's advice is to see his psychiatrist and to have future contacts with the consultant either by phone with his psychiatrist on the line, or face to face with his psychiatrist on the line

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- Told to decrease lamotrigine, increase lithium back to previous levels and to discontinuie aripiprazole
- Also advised starting ziprasidone 40 mg at night with food

Case Outcome: Tenth Interim Followup, Week 42

- Phone call with local treating psychiatrist and the patient one week later
- Patient was compliant with instructions
- Now states the ziprasidone "turned a switch"
- By this he means that suicidal ideation abated immediately, depression no longer dysphoric but only low grade at worst
- Some fatigue/inertia
- Some tongue chewing suggesting a mild ziprasidone induced EPS
- Dramatically better and very pleased
- Suggest to them that the consultant will now resign from the case
- Did he live happily every after?

Case Outcome: Eleventh Interim Followup, Week 54

- About 3 months later, that is, 1 year after the initial psychiatric evaluation, got phone call from a new psychiatrist in the patient's home city where the patient had transferred his care
- States that the patient decided to add fluoxetine 10 mg, stopped lamotrigine, tried 160 mg of ziprasidone, now back to 40 mg
- The story goes on. . . .

Case Debrief

- This intelligent and manipulative patient with a genuine mood disorder and a personality disorder is decidedly unstable, but able to function as a physician even though not able to maintain long-term interpersonal relationships
- Is not very compliant, often making therapeutic decisions on his own about how to treat his own case, especially when things are not going well
- It is difficult to determine whether his periods of mood stability are related to drug treatment or to the lack of psychosocial stressors, but there is the sense that medications are somewhat helpful for the worst of his mood swings even though the medications are not helpful for his responses to psychosocial stressors

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Take-Home Points

- Difficult patients are difficult
- To paraphrase Tolstoy in Anna Karenina
  - "Happy families are all alike; every unhappy family is unhappy in its own way"
  - One could say in cases like this one, "Stable patients are all alike; every unstable patient is unstable in his own way"
- Temperament and personality are factors in bipolar disorder and might even be part of bipolar disorder and are certainly part of the barriers to treatment effectiveness and to treatment compliance/adherence
- A realistic goal in a case like this may be less of a roller coaster, but not full stabilization or true remission, yet well enough to stay employed, have relationships and not be desperate, suicidal or homicidal
- Patients tend to hate depressed states more than mixed states whereas those around patients tend to hate the patient's mixed irritable states more than their depressed states

Performance in Practice: Confessions of a Psychopharmacologist

- What could have been done better here?
  - Should the consultant have stayed engaged after the intial consultation?
  - The involvement of two psychiatrists allowed the patient the opportunity for splitting and chaos
  - Should psychotherapy have played a more prominent role here?
- Possible action item for improvement in practice
  - Make a more concerted effort to define the role of a consultant versus a primary psychiatrist, who is the quarterback of the team, allowing the consultant to play a secondary role, and perhaps in cases like this, try and ensure no direct contact with the consultant without the primary psychiatrist also being present
  - Set realistic goals for a patient like this and realize long term stability may not be attainable

Tips and Pearls

- Lamotrigine, lithium and an atypical antipsychotic can be a useful triple combination for unstable cases of mood and personality disorder and combinations and doses can be found that are relatively tolerable
- Stimulants have no role in a case like this
- Antidepressants can be destabilizing in a case like this
- Physicians can be especially difficult to treat when they are patients as they tend to interfere with their own treatments

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Two-Minute Tute: A brief lesson and psychopharmacology tutorial (tute) with relevant background material for this case – Distinguishing personality disorders from mood disorders

Table 1: General symptoms of a personality disorder overlap with general symptoms of a mood disorder, particularly a bipolar spectrum mood disorder

- Frequent mood swings
- Anger outbusts
- Stormy professional and personal relationships
- Social isolation
- Suspicion and mistrust of others
- Difficulty making friends
- Need for instant gratification
- Poor impulse control
- Frequent drug or alcohol abuse

Table 2: Personality disorders vs mood disorders

- Cluster A disorders (paranoid, schizoid personality disorders or schizotypal personality disorder)
  - Tend to overlap with psychotic mood disorders
- Cluster B disorders (antisocial, borderline, histrionic and narcissistic personality disorders)
  - Can be easily confused for a bipolar spectrum disorder
  - Especially if no overt manic episode or any unequivocal hypomanic episode
  - Nevertheless, symptoms can empirically improve when treated with agents for bipolar disorder
  - A very confusing and chaotic condition can be the combination of a bipolar disorder with a cluster B personality disorder
- Cluster C disorders (avoidant, dependent and obsessive compulsive personality disorders)
  - Can be confused with anxiety disorders
  - Often predate the emergence of a mood disorder and can reappear when mood disorder symptoms under control

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Posttest Self Assessment Question: Answer

Frequent mood swings are more a sign or symptom of a mood disorder than they are of a personality disorder

A. True

B. False

Answer: False

Mood swings are prominent signs of both mood disorders and personality disorders; not all mood swings are mood disorders

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