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Mini Review

Bipolar disorder with personality disorders: A difficult diagnosis

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Abstract

Bipolar disorder poses some diagnostic difficulties because it is colored by the personality of the patients. What complicates the problem are the personality disorders, which make the diagnosis difficult. Comorbid personality disorders are frequent and may complicate the course of bipolar illness. We have much information about treating patients with uncomplicated Bipolar Disorder (BD) but much less knowledge about possibilities for patients with the comorbidity of BD and personality disorder. This review tries to make a point to avoid confusion.

Introduction

Some authors emphasize the difficulty of diagnosing BD in pathological personalities, but the personality disorder is frequently approached from the angle of comorbidity with the idea that two-thirds of affected patients will sooner or later present other problems: some will develop personality disorders, others morbid anxiety and many will abuse alcohol or narcotics [1]. A majority of patients will have eating disorders and many will have difficulty concentrating and hyperactivity.

To find out what the chicken or the egg is, personality or BD, studies have been carried out focusing mainly on pathological personalities. Thus, personality traits or temperaments specific to patients with bipolar disorder have been identified, but few studies have focused on assessing dimensions mental health includes our emotional, psychological, and social well-being [2]. This affects the way we think, feel, and act. It also helps determine how we deal with stress, relate to others, and make choices. Mental health is important at all stages of life, from childhood to adolescence through adulthood.

Bipolar disorder is classified in Axis I of the DSM 5 as a "disorder of mood characterized by the periodicity of depressive and manic disorders or hypomanic [3]. Personality disorders, classified in Axis II of the DSM5, are defined as "characteristic behaviors or traits to both recent behavior and long-term behavior since adulthood", a definition that mixes the notions of personality pre or post morbid [4]. This comorbidity complicates both the clinical picture of bipolarity, the diagnostic identification, and treatment. Different hypotheses are evoked to discuss the pathogenesis, the etiopathogenesis, and the links that unite bipolar disorder and personality [5].

Interactions between BD and personality disorders

About 10 to 15% of people in the general population have characteristic features of a personality disorder [6]. There are many personality disorders, and some are more dangerous and complex than others.

Paranoiac personality disorder: This type tends to be untrusting, distrustful, and see the world as dangerous. They may seem secretive and reluctant to confide in others. In relationships, they consider themselves to be constantly abused. They doubt the loyalty of everyone around them and feel they are being taken advantage of or wronged. These patients have strong grudges against others. They often get angry easily and

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feel like they are in the right place. Paranoid personalities can become violent and dangerous, most non-bandit murderers (who are psychopaths) are paranoid personalities [7].

Antisocial personality disorder: These people generally have no respect for the rights of others. In their behavior, they tend to be irritable and impulsive. They exploit others, consider themselves better or superior, and can be very opportunistic in getting what they want. Antisocial personality people are deceitful, can rob people around them, and often have trouble with the law [8]. They frequently engage in fraudulent activities and make very good scammers. For example, they can take on the role of financial savior for a charity and end up stealing everything. They usually have no remorse. "Conduct" disorder in a child often turns into antisocial personality disorder. "Conduct disorder" refers to a group of repetitive and persistent behavioral and emotional problems in young people. Children and adolescents with this disorder have great difficulty following rules, respecting the rights of others, showing empathy, and behaving in a socially acceptable way. They are often viewed by other children, adults, and social agencies as "bad" or delinquent, rather than mentally ill. Many factors can lead a child to develop conduct disorder, including brain damage, abuse or neglect, genetic vulnerability, academic failure, and traumatic life experiences [9].

⊠Borderline personality disorder: This personality type shows mood swings, poor self-image, and generalized fears of abandonment. There is a disruption of identity and major boundary issues. Borderline patients generally demonstrate impulsivity and very rapid changes from depression to anxiety and irritability. There are usually chronic feelings of emptiness or severe loneliness, as well as anger moodiness, and even suicidal behavior. When stressed, they can become somewhat paranoid [10]. Problems with drug abuse or other addictive behaviors may arise. Often there are sleep disorders with severe insomnia. They tend to be split opinions in that they see people as wonderful or terrible, with nothing in between. Borderline personality can range from mild to severe and can get better or worse over time. Suicide becomes more likely as patients reach their twenties and thirties. There has long been confusion among psychiatrists between borderline subjects and bipolar subjects. It is possible to present both pathologies simultaneously, which is why in front of a "borderline" it is imperative to carefully look for mood disturbances [11].

In general, characteristics of personality disorders include lack of insight, poor response to psychotherapy or other therapeutic interventions, difficulties with different attachments and trust, a sense of entitlement, and the creation of chaos and distress in family, friends, and colleagues. Substance abuse is common in these patients [12].

Personality disorders range from mild to very severe. Patients with personality disorders can assume different roles: victim, rescuer, or persecutor. When they become bullies, they can be dangerous to the person they turn on [13]. Seeing a psychotherapist for a long time, maybe 5 - 7 years, helps to some extent. However, goals and expectations should be limited. Brain plasticity is important because some people can improve naturally over time. Several other personality disorders are not as dangerous for those around them or for medical or paramedical personnel. Although personality disorder features may seem extreme, they are often overlooked and hospital or non-hospital care may treat these patients inadequately. The problem starts with not recognizing the personality disorder. The notions of premorbid personality are discussed (for example: antisocial with dysphoric tendency, cyclothymia, or personality disorders limit that Akiskal classifies elsewhere in the spectrum of mood disorders) and postmorbid personality [14].

Discussion

- The literature distinguishes three types of post-morbid personality changes: Changes during the affective episode itself such as emotional lability, anxious tension, and self-confidence [15];
- Short-term changes (< 1 year) with frequent poor personal adjustment and marital relational difficulties [16];
- Long-term changes (> 2 years) such as loss of self-confidence, personal dependence, and feelings of insecurity (but these symptoms are not specific and are found in other chronic pathologies) [17].

It is well known clinically that personality characteristics influence the course of mood disorders, care as well as the psychosocial consequences of two disorders (emotional, financial, and social problems). This clinical approach raises different open questions: Are personality characteristics sequelae of bipolar disorder? Do they predispose to disorders of the mood? Do they influence its evolutionary course? Are they an attenuated form of bipolarity (for example: cyclothymia)? [18]. Clinic of bipolarity shows that the look changes both in child psychiatry and in psychiatry on the question of personality with the emergence of a more psychodynamic conception of the approach to personality disorders. We emphasize the difficulty of care around psychopathologies frequently experienced as a border with psychiatry such as disorders of the personality, addictions, and behavioral disorders [19].

There are inherent risks in caring for people with certain personality disorders. Compared to the general population, people with borderline personality disorder are at an increased risk of suicide, especially as they progress towards middle age [20]. Identifiable risk factors for suicide in borderline patients include repeated hospitalizations (five or more), recent psychiatric hospitalization, and in adolescents, birth trauma. Some types of personality disorders (paranoid narcissistic, antisocial, and borderline) are more likely to become angry and seek revenge, resorting to legal action [21]. Violence can also be a threat. A patient with a personality disorder often presents as a victim, and then quickly turns into a persecutor [22]. Patients with BD showed differences in several personality traits compared to healthy controls. We need more research to provide the basis for future research with a focus on personality and psychopathology in patients with BD. Identifying the

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interaction between expressions of personality traits and BD might provide novel approaches in prevention and therapy [23].

Conclusion

Interactions between personality disorders and bipolar affective disorders are common and complex. This complexity can be broken down into four modalities that are not mutually exclusive viz., personality predisposes to affective disorders: this perspective, the foundation of psychoanalytic theory, is also mentioned in cognitive-behavioral literature; personality is an expression of affective disorder: personality disorders are then considered as "below threshold" manifestations of mood disorders; personality modifies the expression of the affective disorder: it acts like a distorting mirror, modifying the clinical presentation of patients, particularly in those who present hysterical, dependent, or obsessive personality traits. To the extent that personality is a very important determinant in relational aspects, we are witnessing the appearance of a vicious circle where personality disorders promote isolation and relational difficulties which are factors in relapse and the personality is altered by the affective disorder: confronting frequent relapses induces modifications in the various cognitive processes, self-esteem, and social interactions, with the consequences of increasingly marked difficulties in emotional and professional life.

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