Personality and Mood Disorders

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Chapter 1

Introduction to Personality Disorders

Personality disorders, formerly referred to as **character disorders**, are a class of personality types and behaviors that the American Psychiatric Association (APA) defines as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the culture of the individual who exhibits it". Personality disorders are noted on *Axis II of the Diagnostic and Statistical Manual of Mental Disorders* or *DSM-IV-TR* (fourth edition, text revision) of the American Psychiatric Association.

Personality disorders are also defined by the International Statistical Classification of Diseases and Related Health Problems (ICD-10), which is published by the World Health Organization. Personality disorders are categorized in ICD-10 Chapter V: Mental and behavioural disorders, specifically under Mental and behavioral disorders: 28F60-F69.29 Disorders of adult personality and behavior.

These behavioral patterns in personality disorders are typically associated with severe disturbances in the behavioral tendencies of an individual, usually involving several areas of the personality, and are nearly always associated with considerable personal and social disruption. Additionally, personality disorders are inflexible and pervasive across many situations, due in large part to the fact that such behavior is ego-syntonic (i.e. the patterns are consistent with the ego integrity of the individual) and are, therefore, perceived to be appropriate by that individual. This behavior can result in the client adopting maladaptive coping skills, which may lead to personal problems that induce extreme anxiety, distress and depression in clients.

The onset of these patterns of behavior can typically be traced back to late adolescence and the beginning of adulthood and, in rarer instances, childhood. It is therefore unlikely that a diagnosis of personality disorder will be appropriate before the age of 16 or 17 years. General diagnostic guidelines applying to all personality disorders are presented below; supplementary descriptions are provided with each of the subtypes.

Diagnosis of personality disorders can be very subjective; however, inflexible and pervasive behavioral patterns often cause serious personal and social difficulties, as well as a general functional impairment. Rigid and ongoing patterns of feeling, thinking and behavior are said to be caused by underlying belief systems and these systems are referred to as fixed fantasies or "dysfunctional schemata" *(Cognitive modules)*.

Classification

World Health Organization

- (F60.) Specific personality disorders
  - (F60.0) Paranoid personality disorder
  - (F60.1) Schizoid personality disorder
  - (F60.2) Antisocial personality disorder
  - (F60.3) Borderline personality disorder
  - (F60.4) Histrionic personality disorder
  - (F60.5) Anankastic personality disorder
  - (F60.6) Anxious (avoidant) personality disorder
  - (F60.7) Dependent personality disorder
  - (F60.8) Other specific personality disorders
    - Narcissistic personality disorder
    - Passive-aggressive personality disorder
  - (F60.9) Personality disorder, unspecified
- (F61.) Mixed and other personality disorders

The DSM-IV lists ten personality disorders, grouped into three clusters in Axis II. The DSM also contains a category for behavioral patterns that do not match these ten disorders, but nevertheless exhibit characteristics of a personality disorder. This category is labeled Personality disorder not otherwise specified.

Cluster A (odd or eccentric disorders)

- **Paranoid personality disorder (DSM-IV code 301.0):** characterized by irrational suspicions and mistrust of others.
- **Schizoid personality disorder (DSM-IV code 301.20):** lack of interest in social relationships, seeing no point in sharing time with others, anhedonia, introspection.
- **Schizotypal personality disorder (DSM-IV code 301.22):** characterized by odd behavior or thinking.

Cluster B (dramatic, emotional or erratic disorders)

- **Antisocial personality disorder (DSM-IV code 301.7):** a pervasive disregard for the law and the rights of others.
- **Borderline personality disorder (DSM-IV code 301.83):** extreme "black and white" thinking, instability in relationships, self-image, identity and behavior. Borderline personality disorder occurs in 3 times as many females than males
- **Histrionic personality disorder (DSM-IV code 301.50):** pervasive attention-seeking behavior including inappropriate sexual seductiveness and shallow or exaggerated emotions.
- **Narcissistic personality disorder (DSM-IV code 301.81):** a pervasive pattern of grandiosity, need for admiration, and a lack of empathy.

Cluster C (anxious or fearful disorders)

- **Avoidant personality disorder (DSM-IV code 301.82):** social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation and avoidance of social interaction.
- **Dependent personality disorder (DSM-IV code 301.6):** pervasive psychological dependence on other people.
- **Obsessive-compulsive personality disorder (not the same as obsessive-compulsive disorder) (DSM-IV code 301.4):** characterized by rigid conformity to rules, moral codes and excessive orderliness.

Appendix B: Criteria Sets and Axes Provided for Further Study

Appendix B contains the following disorders. They are still widely considered amongst psychiatrists as being valid disorders, for example by Theodore Millon.

- **Depressive personality disorder** - is a pervasive pattern of depressive cognitions and behaviors beginning by early adulthood.
- **Passive-aggressive personality disorder** (negativististic personality disorder) - is a pattern of negative attitudes and passive resistance in interpersonal situations.

Deleted

The following disorders are still considered to be valid disorders by Millon. They were in DSM-III-R but were deleted from DSM-IV. Both appeared in an appendix entitled "Proposed diagnostic categories needing further study", and so did not have any concrete diagnostic criteria.

- **Sadistic personality disorder** - is a pervasive pattern of cruel, demeaning and aggressive behavior.
- **Self-defeating personality disorder** (masochistic personality disorder) - is characterised by behaviour consequently undermining the person's pleasure and goals.

Cause

A study of almost 600 male college students, averaging almost 30 years of age and who were not drawn from a clinical sample, examined the relationship between childhood experiences of sexual and physical abuse and currently reported personality disorder symptoms. Childhood abuse histories were found to be definitively associated with greater levels of symptomatology. Severity of abuse was found to be statistically significant, but clinically negligible, in symptomatology variance spread over Cluster A, B and C scales

Child abuse and neglect consistently evidence themselves as antecedent risks to the development of personality disorders in adulthood. In the following study, efforts were

taken to match retrospective reports of abuse with a clinical population that had demonstrated psychopathology from childhood to adulthood who were later found to have experienced abuse and neglect. The sexually abused group demonstrated the most consistently elevated patterns of psychopathology. Officially verified physical abuse showed an extremely strong role in the development of antisocial and impulsive behavior. On the other hand, cases of abuse of the neglectful type that created childhood pathology were found to be subject to partial remission in adulthood.

Diagnosis

According to ICD-10, the diagnosis of a personality disorder must satisfy the following general criteria, in addition to the specific criteria listed under the specific personality disorder under consideration:

1. There is evidence that the individual's characteristic and enduring patterns of inner experience and behaviour as a whole deviate markedly from the culturally expected and accepted range (or "norm"). Such deviation must be manifest in more than one of the following areas:
    1. cognition (i.e., ways of perceiving and interpreting things, people, and events; forming attitudes and images of self and others);
    2. affectivity (range, intensity, and appropriateness of emotional arousal and response);
    3. control over impulses and gratification of needs;
    4. manner of relating to others and of handling interpersonal situations.
2. The deviation must manifest itself pervasively as behaviour that is inflexible, maladaptive, or otherwise dysfunctional across a broad range of personal and social situations (i.e., not being limited to one specific "triggering" stimulus or situation).
3. There is personal distress, or adverse impact on the social environment, or both, clearly attributable to the behaviour referred to in criterion 2.
4. There must be evidence that the deviation is stable and of long duration, having its onset in late childhood or adolescence.
5. The deviation cannot be explained as a manifestation or consequence of other adult mental disorders, although episodic or chronic conditions from sections F00-F59 or F70-F79 of this classification may coexist with, or be superimposed upon, the deviation.
6. Organic brain disease, injury, or dysfunction must be excluded as the possible cause of the deviation. (If an organic causation is demonstrable, category F07.- should be used.)

In children and adolescents

Early stages and preliminary forms of personality disorders need a multi-dimensional and early treatment approach. **Personality development disorder** is considered to be a childhood risk factor or early stage of a later personality disorder in adulthood.

In executives

In 2005, psychologists Belinda Board and Katarina Fritzon at the University of Surrey, UK, interviewed and gave personality tests to high-level British executives and compared their profiles with those of criminal psychiatric patients at Broadmoor Hospital in the UK. They found that three out of eleven personality disorders were actually more common in executives than in the disturbed criminals:

- Histrionic personality disorder: including superficial charm, insincerity, egocentricity and manipulation
- Narcissistic personality disorder: including grandiosity, self-focused lack of empathy for others, exploitativeness and independence.
- Obsessive-compulsive personality disorder: including perfectionism, excessive devotion to work, rigidity, stubbornness and dictatorial tendencies.

History

The concept of personality disorders goes back to at least the ancient Greeks.

Chapter 2

Psychopathy

Psychopathy was, until 1980, the term used for a personality disorder characterized by an abnormal lack of empathy combined with strongly amoral conduct but masked by an ability to appear outwardly normal. The publication of DSM-III changed the name of this mental disorder to Antisocial Personality Disorder and also broadened the diagnostic criteria considerably by shifting from clinical inferences to behavioral diagnostic criteria. However, the DSM-V working party is recommending a revision of Antisocial Personality Disorder to "Antisocial/Psychopathic Type", with the diagnostic criteria having a greater emphasis on character than on behavior. The ICD-10 diagnostic criteria of the World Health Organization also lacks psychopathy as a personality disorder, its 1992 manual including Dissocial (Antisocial) Personality Disorder, which encompasses amoral, antisocial, asocial, psychopathic, and sociopathic personalities.

Despite being currently unused in diagnostic manuals, psychopathy and related terms such as psychopath are still widely used by mental health professionals and laymen alike. In particular, NATO has funded a series of Advanced Study Institutes on psychopathy both prior to DSM-III and since. Researcher Robert Hare has been a particular champion of the term and his Hare Psychopathy Checklist is the standard tool for differentiating between those with Antisocial Personality Disorder (APD) and the subset who are

psychopaths. According to this scale, the prevalence of APD is two to three times that of psychopathy.

According to Christopher J. Patrick in his 'Handbook of Psychopathy' clinicians generally believe that there is neither a cure nor any effective treatment for psychopathy; there are no medications that can instill empathy, while psychopaths who undergo traditional talk therapy only become more adept at manipulating others. However, other researchers suggest that psychopaths may benefit as much as others from psychological treatment, at least in terms of effect on behavior. According to Hare, the consensus among researchers in this area is that psychopathy stems from a specific neurological disorder which is biological in origin and present from birth although this was not what was reported by a 2008 review which instead indicated multiple causes and variation between individuals. Hare estimates that about one percent of the population are psychopaths.

Classification

The classification of mental disorders, also known as psychiatric nosology or taxonomy, is a key aspect of psychiatry and other mental health professions and an important issue for consumers and providers of mental health services. There are currently two widely established systems for classifying mental disorders—Chapter V of the International Classification of Diseases (ICD-10) produced by the World Health Organization (WHO) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) produced by the American Psychiatric Association (APA). Both list categories of disorders thought to be distinct types, and have deliberately converged their codes in recent revisions so that the manuals are often broadly comparable, although significant differences remain. Other classification schemes may be in use more locally, for example the Chinese Classification of Mental Disorders. Other manuals have some limited used by those of alternative theoretical persuasions, such as the Psychodynamic Diagnostic Manual.

Characteristics

The prototypical psychopath has deficits or devianes in several areas: interpersonal relationships, emotion, and self-control. Psychopaths gain satisfaction through antisocial behavior, and do not experience shame, guilt, or remorse for their actions. Psychopaths lack a sense of guilt or remorse for any harm they may have caused others, instead rationalizing the behavior, blaming someone else, or denying it outright. Psychopaths also lack empathy towards others in general, resulting in tactlessness, insensitivity, and contemptuousness. All of this belies their tendency to make a good, likable first impression. Psychopaths have a superficial charm about them, enabled by a willingness to say anything without concern for accuracy or truth. Shallow affect also describes the psychopath's tendency for genuine emotion to be short lived and egocentric with an overall cold demeanor. Their behavior is impulsive and irresponsible, often failing to keep a job or defaulting on debts. Psychopaths also have a markedly distorted sense of the potential consequences of their actions, not only for others, but also for themselves. They do not deeply recognize the risk of being caught, disbelieved or injured as a result of their behaviour.

Researcher Robert Hare, whose Hare Psychopathy Checklist is widely used, describes psychopaths as "intraspecies predators". Also R.I. Simon uses the word predator to describe psychopaths. Elsewhere Hare and others write that psychopaths "use charisma, manipulation, intimidation, sexual intercourse and violence" to control others and to satisfy their own needs. Hare states that: "Lacking in conscience and empathy, they take what they want and do as they please, violating social norms and expectations without guilt or remorse". He previously stated that: "What is missing, in other words, are the very qualities that allow a human being to live in social harmony".

According to Hare, many psychopaths are superficially charming, and can excellently mimic normal human emotion; some psychopaths can blend in, undetected, in a variety of surroundings, including corporate environments.

Perceptual/emotional recognition deficits

Facial affect recognition

In a 2002 study, David Kosson and Yana Suchy, *et al.* asked psychopathic inmates to name the emotion expressed on each of 30 faces; compared to the control group, psychopaths had a significantly lower rate of accuracy in recognizing disgusted facial affect but a higher rate of accuracy in recognizing anger. Additionally, when "conditions designed to minimize the involvement of left-hemispheric mechanisms" (i.e. sadness) were used, psychopaths had more difficulty accurately identifying emotions. This study did not replicate Blaire, *et al.* (1997)'s findings that psychopaths are specifically less sensitive to nonverbal cues of fear or distress.

Vocal affect recognition

In a 2002 experiment, Blair, Mitchell, *et al.* used the Vocal Affect Recognition Test to measure psychopaths' recognition of the emotional intonation given to connotatively neutral words. Psychopaths tended to make more recognition errors than controls with a particularly high rate of error for sad and fearful vocal affect.

Stroop tasks

A 2004 experiment tested the hypothesis of overselective attention in psychopaths using two forms of the Stroop color-word and picture-word tasks: with color/picture and word separated and with color/picture and word together. Psychopaths performed significantly worse than controls in the separated Stroop tasks, but performed as well as the controls on standard Stroop tasks.

When split into low-anxious and high-anxious groups, low-anxious psychopaths and low-anxious controls showed less interference on the separated Stroop tasks than their high-anxious counterparts; for low-anxious psychopaths, interference was very nearly zero. Researchers concluded the inability to integrate contextual cues depends on the cues' relationship to "the deliberately attended, goal-relevant information."

Causes

One twin study suggests that psychopathy has a strong genetic component. The study demonstrates that children with anti-social behavior can be classified into two groups: those who were *also* callous acquired their behavior by genetic influences, and those who were *not* callous acquired it from their environment. "The amygdala is crucial for stimulus-reinforcement learning and responding to emotional expressions, particularly fearful expressions that, as reinforcers, are important initiators of stimulus-reinforcement

learning. Moreover, the amygdala is involved in the formation of both stimulus-punishment and stimulus-reward associations. Individuals with psychopathy show impairment in stimulus-reinforcement learning (whether punishment or reward based) and responding to fearful and sad expressions. It is argued that this impairment drives much of the syndrome of psychopathy"(Blair, 2008).

People scoring ≥25 in the Psychopathy Checklist Revised, with an associated history of violent behavior, appear to have significantly reduced microstructural integrity in their uncinate fasciculus - white matter connecting the amygdala and orbitofrontal cortex. The more extreme the psychopathy, the greater the abnormality.

Pathophysiology

Recent studies have triggered theories on determining whether there is a biological relationship between the brain and psychopathy. One theory suggests that psychopathy is associated with both the amygdala, which is associated with emotional reactions and emotion learning, and the prefrontal cortex, associated with impulse control, decision-making, emotional learning and behavioral adaptation. Some studies have shown there is less "gray matter" in these areas in psychopaths than in non-psychopaths.

There is DT-MRI evidence of breakdowns in the white matter connections between these two important areas in a small British study of 9 criminal psychopaths. This evidence suggests that the degree of abnormality was significantly related to the degree of psychopathy and may explain the offending behaviors.

A 2008 review found various abnormalities (based on group differences from average) reported in the literature, centred on a prefrontal-temporo-limbic circuit — regions that are involved in emotional and learning processes, as well as many other processes. However, the authors report that the people classed as "psychopathic" cannot in fact be seen as a homogeneous group (i.e. as all having the same characteristics), and that the associations between structural changes and psychopathic characteristics do not enable causal conclusions to be drawn. They conclude that psychopathic characteristics involve multifactorial processes including neurobiological, genetic, epidemiological, and sociobiographical (the person's life in society) factors.

Diagnosis

Currently, there are no diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders for psychopathy. Labeling a person as a psychopath involves forensic measurement, using a diagnostic tool such as the Hare Psychopathy Checklist (PCL-R). The PCL-R is widely considered the "gold standard" for assessing psychopathy. Psychopathy is most strongly correlated with DSM-IV *antisocial personality disorder (ASPD)*, and the ICD-10 *antisocial personality disorder* and *dissocial personality disorder (DPD)*. However, the PCL-R criteria for identifying a psychopath are stricter than the diagnostic criteria for ASPD or DPD; psychopaths represent a subset of those with ASPD, and psychopaths' traits are more severe.

One issue related to the assessment of individuals who may exhibit affective, interpersonal, and behavioral features associated with psychopathy is the ability to overcome gender myths when the psychopathy features are present in females. The Hare Psychopathy Checklist-Revised has both percentiles and T-score tables for male and female offenders.

Hare Psychopathy Checklist

Psychopathy is most commonly assessed with the *PCL-R*, which is a clinical rating scale with 20 items. Each of the items in the PCL-R is scored on a three-point (0, 1, 2) scale according to two factors. *PCL-R* Factor 2 is associated with reactive anger, anxiety, increased risk of suicide, criminality, and impulsive violence.

PCL-R Factor 1, in contrast, is associated with extraversion and positive affect. Factor 1, the so-called core personality traits of psychopathy, may even be beneficial for the psychopath (in terms of non-deviant social functioning). A psychopath will score high on both factors, whereas someone with ASPD will score high only on Factor 2. Both case history and a semi-structured interview are used in the analysis.

Because an individual's scores may have important consequences for his or her future, the potential for harm if the test is used or administered incorrectly is considerable. The test can only be considered valid if administered by a suitably qualified and experienced clinician under controlled conditions.

PCL-R items

The following findings are for research purposes only, and are not used in clinical diagnosis. These items cover the affective, interpersonal, and behavioral features. Each item is rated on a score from zero to two. The sum total determines the extent of a person's psychopathy.

Factor 1
: Aggressive narcissism

1. Glibness/superficial charm
2. Grandiose sense of self-worth
3. Pathological lying
4. Cunning/manipulative
5. Lack of remorse or guilt
6. Emotionally shallow
7. Callous/lack of empathy
8. Failure to accept responsibility for own actions

Factor 2
: Socially deviant lifestyle

1. Need for stimulation/proneness to boredom
2. Parasitic lifestyle
3. Poor behavioral control
4. Promiscuous sexual behavior
5. Lack of realistic, long-term goals
6. Impulsiveness
7. Irresponsibility
8. Juvenile delinquency
9. Early behavioral problems
10. Revocation of conditional release

Traits not correlated with either factor

1. Many short-term marital relationships
2. Criminal versatility

Comorbidity

Psychopaths may have various mental conditions, although, in contrast to people with antisocial personality disorder, comorbidity among psychopaths is generally found to be low.

Substance abuse has been associated with psychopathy, particularly Factor 2 (anti-social behaviour), but not Factor 1 (emotional) scores of the PCL-R. Conduct disorder and ADHD have both been associated with psychopathy; which may be explained by disruption to dorsolateral prefrontal cortex. This area is associated with executive function, which is affected in all three disorders.

There is some evidence of an association between ASPD and other personality disorders (i.e. histrionic, narcissistic and borderline personality disorders), however, evidence for a link with psychopathy is more tentative.

Anxiety may be associated positively with antisocial behaviour, but it is inversely associated with Factor I (emotional) scores on the PCL-R. Depression is inversely associated with psychopathy. Although violence may be associated with schizophrenia, there is no conclusive evidence for a link between psychopathy and schizophrenia.

It has been suggested that psychopathy may be comorbid with several other diagnoses than these, however limited work on comorbidity has been carried out. This may be because of difficulties in using inpatient groups from certain institutions to assess comorbidity, owing to the likelihood of some bias in sample selection. Furthermore, comorbidity may be more reflective of poor discriminant validity of categories in the DSM-IV than reflective of underlying aetiologically separate conditions.

No evidence for propensity to sexually-oriented murder

No clinical definition of psychopathy indicates that psychopaths are especially prone to commit sexually-oriented murders, and scientific studies do not suggest that a large proportion of psychopaths have committed these crimes. Although some claim a large proportion of such offenders have been classified as psychopathic, this evidence comes from a single, unrepeated research study using the Rorschach Inkblot Test, an invalid test for psychopathy and for sex offenders, references not considering psychopathy, and studies concerning sexual homicide, a somewhat different population than the general class of sex offenders and not from meta-studies combining repeatable results.

Conceptual models

As a discrete disorder

Hare believes that the *Diagnostic and Statistical Manual of Mental Disorders* should list psychopathy as a unique disorder, given that psychopathy has no precise equivalent in either the *DSM-IV-TR*, where it is most strongly correlated with the diagnosis of antisocial personality disorder, or the *ICD-10*, which has a partly similar condition called dissocial personality disorder.

Primary-secondary distinction

Primary psychopathy was defined by those following this theory as the root disorder in patients diagnosed with it, whereas secondary psychopathy was defined as an aspect of another psychiatric disorder or social circumstances. Today, primary psychopaths are considered to have mostly Factor 1 traits from the *PCL-R* (arrogance, callousness, manipulativeness, lying) whereas secondary psychopaths have a majority of Factor 2 traits (impulsivity, boredom proneness, irresponsibility, lack of long-term goals).

Secondary psychopaths show normal to above-normal physiological responses to (perceived) potential threats; their crimes tend to be unplanned and impulsive with little thought of the consequences. According to those using this theory, this type have hot tempers and are prone to reactive aggression. They experience normal to above-normal levels of anxiety but are nevertheless highly stimulus-seeking and have trouble tolerating boredom. Their lifestyle may lead to depression and even suicide.

Mealey uses the term "primary psychopathy" to differentiate between psychopathy that is biological in origin and "secondary psychopathy" that results from a combination of genetic and environmental influences. Lykken prefers sociopathy to describe the latter.

Sellbom and Ben-Porath (2005) describe the distinction:

Some people who engage in violent behavior possess psychopathic personality traits, such as callousness, grandiosity, and fearlessness, and presumably engage in such conduct because they care little about others. Others are impulsive and experience

considerable anger, anxiety, and distress and may commit violent acts as a reaction to negative emotions, which are sometimes referred to as "crimes of passion." Indeed, the distinction between primary and secondary psychopathy (including so-called neurotic psychopathy) has long been noted in the psychopathy literature (Karpman, 1947; Lykken, 1995).

This distinction closely resembles the distinction between instrumental and impulsive/reactive crime/violence in the field of criminology.

Joseph P. Newman *et al.,* who use this concept of psychopathy, have validated David T. Lykken's conceptualization of psychopathy subtypes in relation to Gray's behavioral activation system and behavioral inhibition system. Newman *et al.* found measures of primary psychopathy to be negatively correlated with Gray's behavioral inhibition system, a construct intended to measure behavioral inhibition from cues of punishment or nonreward. In contrast, measures of secondary psychopathy to be positively correlated with Gray's behavioral activation system, a construct intended to measure sensitivity to cues of behavioral approach.

Psychopathy vs. sociopathy

Hare writes that the difference between sociopathy and psychopathy may "reflect the user's views on the origins and determinates of the disorder."

In the preface to the fifth edition of *The Mask of Sanity*, Cleckly stated, "... revisions of the nomenclature have been made by the American Psychiatric Association. The classification of psychopathic personality was changed to that of sociopathic personality in 1958", suggesting that he did not recognise any difference between the conditions.

David T. Lykken proposes psychopathy and sociopathy are two distinct kinds of antisocial personality disorder. He believes psychopaths are born with temperamental differences such as impulsivity, cortical underarousal, and fearlessness that lead them to risk-seeking behavior and an inability to internalize social norms. On the other hand, he claims sociopaths have relatively normal temperaments; their personality disorder being more an effect of negative sociological factors like parental neglect, delinquent peers, poverty, and extremely low or extremely high intelligence. Both personality disorders are the result of an interaction between genetic predispositions and environmental factors, but psychopathy leans towards the hereditary whereas sociopathy tends towards the environmental.

Three-factor model

Recent statistical analysis using confirmatory factor analysis by Cooke and Michie indicated a three-factor structure, with those items from factor 2 strictly relating to antisocial behaviour (criminal versatility, juvenile delinquency, revocation of conditional release, early behavioural problems, and poor behavioural controls) removed from the final model. The remaining items are divided into three factors: Arrogant and Deceitful

Interpersonal Style, Deficient Affective Experience, and Impulsive and Irresponsible Behavioural Style.

Hare and colleagues have published detailed critiques of the Cooke & Michie hierarchical 'three'-factor model, citing severe statistical problems. Hare and colleagues note that the Cooke & Michie model actually contains ten factors, and results in impossible parameters (negative variances). Hare and colleagues also note conceptual problems with this model.

Discrete vs. continuous

As part of the larger debate on whether personality disorders are distinct from normal personality, or if they are extremes on various dimensions of normal personality, is the debate on whether psychopathy represents something "qualitatively different" from normal personality, or a "continuous dimension" shading from normality into severely psychopathic. Otto Kernberg believed psychopathy should fall under a spectrum of pathological narcissism, that ranged from narcissistic personality on the low end, malignant narcissism in the middle, and psychopathy at the high end.

Early taxonometric analysis from Harris and colleagues indicated a discrete category may underlie psychopathy, however this was only found for the behavioural Factor 2 items, indicating this analysis may be related to Anti-social Personality Disorder rather than psychopathy per se. Marcus, John, and Edens more recently performed a series of statistical analysis on previously attained PCL–R and PPI scores and concluded psychopathy may best be conceptualized as having a "dimensional latent structure" like depression.

Screening

Childhood precursors

Psychopathic tendencies can sometimes be recognized in childhood or early adolescence. If recognized, a diagnosis of Conduct Disorder, or possibly the related Oppositional Defiant Disorder, may be given. However, while these childhood signs have been found in a significantly higher proportion of psychopaths than in the general population, it must be stressed that not all such childhood diagnoses turn out to be psychopaths as adults, or even disordered at all. Therefore, psychopathy is not normally diagnosed in children or adolescents, and some jurisdictions explicitly forbid diagnosing minors with psychopathy and similar personality disorders. This is because such a diagnosis "fails to capture the emotional, cognitive, and interpersonality traits — egocentricity and lack of remorse, empathy, or guilt - that are so important in the diagnosis of psychopathy."

Children showing strong psychopathic precursors often appear immune to punishment; nothing seems to modify their undesirable behavior. Consequently parents usually give up, and the behavior worsens.

The following childhood indicators are to be seen not as to the type of behavior, but as to its relentless and unvarying occurrence. Not all must be present concurrently, but at least a number of them need to be present over a period of years. These indicators are sufficient - but not necessary - indicators of possible psychopathy.

- An extended period of bedwetting past the preschool years not due to any medical problem.
- Precocious sadism, often expressed as profound animal abuse.
- Pathological firesetting lacking in obvious homicidal intent. Not to be confused with playing with matches, which is not uncommon for preschoolers. This is the deliberate setting of destructive fires with utter disregard for the property and lives of others.
- Lying, often without discernible objectives, extending beyond a child's normal impulse not to be punished. These lies are so extensive it is often impossible to know lies from truth.
- Theft and truancy.
- Aggression to peers and relatives, which can include physical and verbal abuse, getting others into trouble, or a campaign of psychological torment.

The three indicators—bedwetting, cruelty to animals and firestarting, known as the Macdonald triad—were first described by J.M. MacDonald as "red flag" indicators of psychopathy and future episodic aggressive behavior. However, subsequent research has found that bedwetting is not a significant factor. Moreover, as mentioned previously, these indicators are sufficient - but not necessary - indicators of possible psychopathy.

The question of whether young children with early indicators of psychopathy respond poorly to intervention compared to conduct disordered children without these traits have only recently been examined in controlled clinical research. The empirical findings from this research have been consistent with broader anecdotal evidence, pointing to poor treatment outcomes.

Management

Clinical management

In practice, mental health professionals rarely treat psychopathic personality disorders as they are often considered untreatable and no interventions have proved to be effective. However, some of the difficulty has been attributed to the lack of clarity around the concept and diagnosis of psychopathy; the threat of danger to staff, or deceit or poor motivation from patients; and a lack of follow-up to test effectiveness. Despite pessimism, as of 1999, treatment of patients still takes place in a variety of psychiatric hospitals and secure units, and the research has indicated that some individuals do show some improvements when the right treatment is identified, and that longer periods of therapy often produce better results.

It has been shown that punishment and behavior modification techniques do not improve the behavior of psychopaths. Psychopathic individuals have been regularly observed to become more cunning and better able to hide their behaviour. It has been suggested that traditional therapeutic approaches actually make psychopaths more adept at manipulating others and concealing their behavior. They are generally considered to be not only incurable but also untreatable.

However, some researchers suggest that psychopaths can benefit as much as others from psychological treatment, at least in terms of criminal behaviors. For example, one therapeutic approach to juveniles reports reduced re-offending over a two year period compared to usual care.

Legal response

United Kingdom

In the United Kingdom, "Psychopathic Disorder" was legally defined in the Mental Health Act (UK) as, "a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned." This term, which did not equate to psychopathy, was intended to reflect the presence of a personality disorder, in terms of conditions for detention under the Mental Health Act 1983. With the subsequent amendments to the Mental Health Act 1983 within the Mental Health Act 2007, the term 'psychopathic disorder' has been abolished, with all conditions for detention (e.g. mental illness, personality disorder, etc.) now being contained within the generic term of 'mental disorder'.

In England and Wales the diagnosis of dissocial personality disorder is grounds for detention in secure psychiatric hospitals under the Mental Health Act if they have committed serious crimes, but since such individuals are disruptive for other patients and not responsive to treatment this alternative to prison is not often used.

United States

Psychopathy has quite separate legal and judicial definitions that should not be confused with the medical definition. The American Psychiatric Association is vigorously opposing any non-medical or legal definition of what purports to be a medical condition "without regard for scientific and clinical knowledge." Various states and nations have at various times enacted laws specific to dealing with psychopaths.

In the United States approximately twenty states currently have provisions for the involuntary civil commitment for sex offenders or sexual predators, under Sexually violent predator acts, avoiding the use of the term "psychopath." These statutes and provisions are controversial and are being reviewed by the U.S. Supreme Court as a violation of a person's Fourteenth Amendment rights.

Washington

Washington State Legislature defines a "Psychopathic personality" to mean "the existence in any person of such hereditary, congenital or acquired condition affecting the emotional or volitional rather than the intellectual field and manifested by anomalies of such character as to render satisfactory social adjustment of such person difficult or impossible." The same statute defines the "sexual psychopath" as "any person who is affected in a form of psychoneurosis or in a form of psychopathic personality, which form predisposes such person to the commission of sexual offenses in a degree constituting him a menace to the health or safety of others" for prison sentencing purposes in the Sentencing Reform Act of 1981.

California

California enacted a psychopathic offender law in 1939, since greatly outmoded and revised, that defined a psychopath solely in terms of offenders with a predisposition "to the commission of sexual offenses against children." A 1941 law attempted to further clarify this to the point where anyone examined and found to be psychopathic was to be committed to a state hospital and anyone else was to be sentenced by the courts. However, these laws were enacted years before the American Psychiatric Association began publishing the Diagnostic and Statistical Manual of Mental Disorders which is used today for diagnosis and does not include "psychopathic offender". Hence, these laws are of historical interest only.

Prognosis

Release rate among convicted criminals

Findings indicate psychopathic convicts have a 2.5 time higher probability of being released from jail than undiagnosed convicts, even though they are more likely to recidivate.

Epidemiology

It is estimated that approximately one percent of the general population are psychopaths. According to an unsourced article in popular science magazine Scientific American, studies indicate that about 25% of prison inmates meet diagnostic criteria for psychopathy. However, recent British studies have reported a community prevalence of 0.6%, consistent with the estimate given by the screening version of the psychopathy checklist and a prisoner prevalence of 7.7% in men and 1.9% in women.

Chapter 3

Borderline Personality Disorder

Borderline personality disorder (**BPD**) is a personality disorder described as a prolonged disturbance of personality function in a person (generally over the age of eighteen years, although it is also found in adolescents), characterized by depth and variability of moods. The disorder typically involves unusual levels of instability in mood; black and white thinking, or splitting; the disorder often manifests itself in idealization and devaluation episodes, as well as chaotic and unstable interpersonal relationships, self-image, identity, and behavior; as well as a disturbance in the individual's sense of self. In extreme cases, this disturbance in the sense of self can lead to periods of dissociation.

BPD splitting includes a switch between idealizing and demonizing others. This, combined with mood disturbances, can undermine relationships with family, friends, and co-workers. BPD disturbances also may include self-harm. Without treatment, symptoms may worsen, leading (in extreme cases) to suicide attempts.

There is an ongoing debate among clinicians and patients worldwide about terminology and the use of the word *borderline*, and some have suggested that this disorder should be renamed. The ICD-10 manual has an alternative definition and terminology to this disorder, called *Emotionally unstable personality disorder*.

There is related concern that the diagnosis of BPD stigmatizes people and supports pejorative and discriminatory practices. It is common for those suffering from borderline personality disorder and their families to feel compounded by a lack of clear diagnoses, effective treatments, and accurate information. This is true especially because of evidence that this disorder originates in the families of those who suffer from it and has a lot to do with Axis IV factors, rather than belonging strictly in Axis II. Conceptual, as well as therapeutic, relief may be obtained through evidence that BPD is closely related to traumatic events during childhood and to post-traumatic stress disorder (PTSD), about which much more is known.

Signs and symptoms

Borderline personality disorder is a diagnosis about which many articles and books have been written, yet about which very little is known based on empirical research.

Studies suggest that individuals with BPD tend to experience frequent, strong and long-lasting states of aversive tension, often triggered by perceived rejection, being alone or perceived failure. Individuals with BPD may show lability (changeability) between anger and anxiety or between depression and anxiety and temperamental sensitivity to emotive stimuli.

The negative emotional states specific to BPD may be grouped into four categories: destructive or self-destructive feelings; extreme feelings in general; feelings of fragmentation or lack of identity; and feelings of victimization.

Individuals with BPD can be very sensitive to the way others treat them, reacting strongly to perceived criticism or hurtfulness. Their feelings about others often shift from positive to negative, generally after a disappointment or perceived threat of losing someone. Self-image can also change rapidly from extremely positive to extremely negative. Impulsive behaviors are common, including alcohol or drug abuse, unsafe sex, gambling and recklessness in general. Attachment studies suggest individuals with BPD, while being high in intimacy- or novelty-seeking, can be hyper-alert to signs of rejection or not being valued and tend toward insecure, avoidant or ambivalent, or fearfully preoccupied patterns in relationships. They tend to view the world generally as dangerous and

malevolent, and tend to view themselves as powerless, vulnerable, unacceptable and unsure in self-identity.

Individuals with BPD are often described, including by some mental health professionals (and in the DSM-IV), as deliberately manipulative or difficult, but analysis and findings generally trace behaviors to inner pain and turmoil, powerlessness and defensive reactions, or limited coping and communication skills. There has been limited research on family members' understanding of borderline personality disorder and the extent of burden or negative emotion experienced or expressed by family members.

Parents of individuals with BPD have been reported to show co-existing extremes of over-involvement and under-involvement. BPD has been linked to increased levels of chronic stress and conflict in romantic relationships, decreased satisfaction of romantic partners, abuse and unwanted pregnancy; these links may be general to personality disorder and subsyndromal problems.

Suicidal or self-harming behavior is one of the core diagnostic criteria in DSM IV-TR, and management of and recovery from this can be complex and challenging. The suicide rate is approximately 8 to 10 percent. Self-injury attempts are highly common among patients and may or may not be carried out with suicidal intent. BPD is often characterized by multiple low-lethality suicide attempts triggered by seemingly minor incidents, and less commonly by high-lethality attempts that are attributed to impulsiveness or comorbid major depression, with interpersonal stressors appearing to be particularly common triggers. Ongoing family interactions and associated vulnerabilities can lead to self-destructive behavior. Stressful life events related to sexual abuse have been found to be a particular trigger for suicide attempts by adolescents with a BPD diagnosis.

Diagnosis

Diagnosis is based on a clinical assessment by a qualified mental health professional. The assessment incorporates the patient's self-reported experiences as well as the clinician's observations. The resulting profile may be supported or corroborated by long-term patterns of behavior as reported by family members, friends or co-workers. The list of criteria that must be met for diagnosis is outlined in the DSM-IV-TR.

Borderline personality disorder was once classified as a subset of schizophrenia (describing patients with borderline schizophrenic tendencies). Today BPD is used more generally to describe individuals who display emotional dysregulation and instability, with paranoid schizophrenic ideation or delusions being only one criterion (criterion #9) of a total of 9 criteria, of which 5, or more, must be present for this diagnosis.

Individuals with BPD are at high risk of developing other psychological disorders such as anxiety and depression. Other symptoms of BPD, such as dissociation, are frequently linked to severely traumatic childhood experiences, which some put forth as one of the many root causes of the borderline personality.

Adolescence

Onset of symptoms typically occurs during adolescence or young adulthood. Symptoms may persist for several years, but the majority of symptoms lessen in severity over time, with some individuals fully recovering. The mainstay of treatment is various forms of psychotherapy, although medication and other approaches may also improve symptoms. While borderline personality disorder can manifest itself in children and teenagers, therapists are discouraged from diagnosing anyone before the age of 18, due to adolescence and a still-developing personality.

There are some instances when BPD can be evident and diagnosed before the age of 18. The DSM-IV states: "To diagnose a personality disorder in an individual under 18 years, the features must have been present for at least 1 year." In other words, it is possible to diagnose the disorder in children and adolescents, but a more conservative approach should be taken.

There is some evidence that BPD diagnosed in adolescence is predictive of the disease continuing into adulthood. It is possible that the diagnosis, if applicable, would be helpful in creating a more effective treatment plan for the child or teen.

Diagnostic and Statistical Manual

The Diagnostic and Statistical Manual of Mental Disorders fourth edition, DSM IV-TR, a widely used manual for diagnosing mental disorders, defines borderline personality disorder (in Axis II Cluster B) as:

> A pervasive pattern of instability of interpersonal relationships, self-image and affects, as well as marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
>
> 1. Frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-injuring behavior covered in Criterion 5
> 2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
> 3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
> 4. Impulsivity in at least two areas that are potentially self-damaging (e.g., promiscuous sex, eating disorders, binge eating, substance abuse, reckless driving). **Note:** Do not include suicidal or self-injuring behavior covered in Criterion 5
> 5. Recurrent suicidal behavior, gestures, threats or self-injuring behavior such as cutting, interfering with the healing of scars (excoriation) or picking at oneself.
> 6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days).

7. Chronic feelings of emptiness
8. Inappropriate anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation, delusions or severe dissociative symptoms

It is a requirement of DSM-IV that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

International Classification of Disease

The World Health Organization's ICD-10 defines a conceptually similar disorder to borderline personality disorder called *(F60.3) Emotionally unstable personality disorder*. It has two subtypes described below.

F60.30 Impulsive type

At least three of the following must be present, one of which must be (2):

1. marked tendency to act unexpectedly and without consideration of the consequences;
2. marked tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or criticized;
3. liability to outbursts of anger or violence, with inability to control the resulting behavioural explosions;
4. difficulty in maintaining any course of action that offers no immediate reward;
5. unstable and capricious mood.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

F60.31 Borderline type

At least three of the symptoms mentioned in *F60.30 Impulsive type* must be present [see above], with at least two of the following in addition:

1. disturbances in and uncertainty about self-image, aims, and internal preferences (including sexual);
2. liability to become involved in intense and unstable relationships, often leading to emotional crisis;
3. excessive efforts to avoid abandonment;
4. recurrent threats or acts of self-harm;
5. chronic feelings of emptiness.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Chinese Society of Psychiatry

The Chinese Society of Psychiatry's CCMD has a comparable diagnosis of Impulsive Personality Disorder (IPD). A patient diagnosed as having IPD must display "affective outbursts" and "marked impulsive behavior," plus at least three out of eight other symptoms. The construct has been described as a hybrid of the impulsive and borderline subtypes of the ICD-10's Emotionally Unstable Personality Disorder, and also incorporates six of the nine DSM BPD criteria.

Millon's subtypes

Theodore Millon identified four subtypes of borderline. Any individual borderline may exhibit none, or one or more of the following:

- Discouraged borderline — including avoidant, depressive or dependent features
- Impulsive borderline — including histrionic or antisocial features
- Petulant borderline — including negativistic (passive-aggressive) features
- Self-destructive borderline — including depressive or masochistic features

Differential diagnosis

Common comorbid (co-occurring) conditions are mental disorders such as substance abuse, depression and other mood and personality disorders.

Borderline personality disorder and mood disorders often appear concurrently. Some features of borderline personality disorder may overlap with those of mood disorders, complicating the differential diagnostic assessment.

Both diagnoses involve symptoms commonly known as "mood swings." In borderline personality disorder, the term refers to the marked lability and reactivity of mood defined as emotional dysregulation. The behavior is typically in response to external psychosocial and intrapsychic stressors, and may arise or subside, or both, suddenly and dramatically and last for seconds, minutes, hours, days, weeks or months.

Bipolar depression is generally more pervasive with sleep and appetite disturbances, as well as a marked nonreactivity of mood, whereas mood with respect to borderline personality and co-occurring dysthymia remains markedly reactive and sleep disturbance not acute.

The relationship between bipolar disorder and borderline personality disorder has been debated. Some hold that the latter represents a subthreshold form of affective disorder, while others maintain the distinctness between the disorders, noting they often co-occur.

Some findings suggest that BPD may lie on a bipolar spectrum, with a number of points of phenomenological and biological overlap between the affective lability criterion of borderline personality disorder and the extremely rapid cycling bipolar disorders. Some

findings suggest that the DSM-IV BPD diagnosis mixes up two sets of unrelated items—an affective instability dimension related to Bipolar-II, and an impulsivity dimension not related to Bipolar-II.

It is important to emphasize that medical conditions which cause organic behavioral function may result in a clinical picture that mimics to some degree BPD. Hormonal dysfunction over a long period, or brain dysfunction (e.g. the encephalopathy caused by lyme disease) can result in identity disturbance and mood lability, as can many other chronic medical conditions such as lupus. These conditions may isolate the patient socially and emotionally, and/or cause limbic damage to the brain. However, this is not borderline personality disorder which results, but rather a reaction to the isolating circumstances caused by a medical condition and the possibly coincident struggles of the patient to control his or her mood given damage to the brain's limbic system. Heavy alcohol usage over a long period itself can cause an encephalopathy which may cause limbic damage. Various frontal lobe syndromes can result in disinhibition and impulsive behavior.

Comorbid (co-occurring) conditions in BPD are common. When comparing individuals diagnosed with BPD to those diagnosed with other personality disorders, the former showed a higher rate of also meeting criteria for:

- anxiety disorders
- mood disorders (including clinical depression and bipolar disorder)
- eating disorders (including anorexia nervosa and bulimia)
- and, to a lesser extent, somatoform or factitious disorders
- dissociative disorders
- Substance abuse is a common problem in BPD, whether due to impulsivity or as a coping mechanism, and 50 percent to 70 percent of psychiatric inpatients with BPD have been found to meet criteria for a substance use disorder, especially alcohol dependence or abuse which is often combined with the abuse of other drugs.

Causes

As with other mental disorders, the causes of BPD are complex and not fully understood. One finding is a history of childhood trauma, abuse or neglect, although researchers have suggested diverse possible causes, such as a genetic predisposition, neurobiological factors, environmental factors, or brain abnormalities.

There is evidence that suggests that BPD and post-traumatic stress disorder (PTSD) are closely related. Evidence further suggests that BPD might result from a combination that can involve a traumatic childhood, a vulnerable temperament and stressful maturational events during adolescence or adulthood.

Childhood abuse

Numerous studies have shown a strong correlation between child abuse, especially child sexual abuse, and development of BPD. Many individuals with BPD report to have had a history of abuse and neglect as young children. Patients with BPD have been found to be significantly more likely to report having been verbally, emotionally, physically or sexually abused by caregivers of either gender. There has also been a high incidence of incest and loss of caregivers in early childhood for people with borderline personality disorder. They were also much more likely to report having caregivers (of both genders) deny the validity of their thoughts and feelings. They were also reported to have failed to provide needed protection, and neglected their child's physical care. Parents (of both sexes) were typically reported to have withdrawn from the child emotionally, and to have treated the child inconsistently. Additionally, women with BPD who reported a previous history of neglect by a female caregiver and abuse by a male caregiver were consequently at significantly higher risk for being sexually abused by a noncaregiver (not a parent). It has been suggested that children who experience chronic early maltreatment and attachment difficulties may go on to develop borderline personality disorder.

Other developmental factors

Some studies suggest that BPD may not necessarily be a trauma-spectrum disorder and that it is biologically distinct from the post-traumatic stress disorder that could be a precursor. The personality symptom clusters seem to be related to specific abuses, but they may be related to more persistent aspects of interpersonal and family environments in childhood.

Otto Kernberg formulated the theory of borderline personality based on a premise of failure to develop in childhood. Writing in the psychoanalytic tradition, Kernberg argued that failure to achieve the developmental task of *psychic clarification of self and other* can result in an increased risk to develop varieties of psychosis, while failure to *overcome splitting* results in an increased risk to develop a borderline personality.

Genetics

An overview of the existing literature suggested that traits related to BPD are influenced by genes. A major twin study found that if one identical twin met criteria for BPD, the other also met criteria in 35 percent of cases. People that have BPD influenced by genes usually have a close relative with the disorder.

Twin, sibling and other family studies indicate a partially heritable basis for impulsive aggression, but studies of serotonin-related genes to date have suggested only modest contributions to behavior.

Mediators and moderators

While research has examined variables that predict the development of borderline personality disorder (BPD), researchers have only recently begun to examine the variables that mediate and moderate the relationships between these variables and the development of the disorder. A mediator is a variable that affects how the relationship occurs. Mediation is said to be present when both the predictor variable and the mediating variable are significantly correlated with the dependent variable, and when the relationship between the predictor variable and the outcome variable is significantly reduced when controlling for the mediating variable. A moderating variable by contrast specifies the conditions under which a given outcome will occur. Moderation is said to occur when there is an interaction effect between the predicting variable and the moderating variable on the dependent variable. More specifically, the effect of the predicting variable is different depending on the level of the moderating variable.

Research has found statistically significant relationships between BPD symptoms and both sexual and physical abuse. Other factors including family environment variables also contribute to the development of the disorder. Bradley et al. found that both child sexual abuse (CSA) and childhood physical abuse and BPD symptoms were significantly related, and both CSA and childhood physical abuse were significantly related to family environment. When family environment and childhood physical abuse were entered simultaneously into a regression equation, family environment was related to BPD symptoms and childhood physical abuse was related to BPD symptoms, although the relationship between BPD symptoms and childhood physical abuse was reduced. Therefore, CSA and childhood physical abuse both directly influence the development of BPD symptoms directly and are mediated by family environment.

Other research has examined the relationship between negative affectivity, thought suppression and BPD symptoms. The results of the mediational models in this study found that thought suppression mediated the relationship between negative affectivity and BPD symptoms. While negative affectivity significantly predicted BPD symptoms after controlling for CSA, this relationship was greatly reduced when thought suppression was introduced into the model. Thus, the relationship of negative affectivity to BPD symptoms is mediated by thought suppression.

Ayduk et al. (2008) found an interaction between rejection sensitivity and executive control in the prediction of BPD symptoms. This study found that BPD features were positively associated with rejection sensitivity (RS) and neuroticism and negatively associated with emotional control (EC). Their statistical analysis indicated that among those low in EC, RS was positively related to BPD features and among those high in RS, EC was negatively associated with BPD. By contrast, among those high in EC, RS was not significantly related to BP features, and among those low in RS, EC was not related to BPD features. In Study 2, BPD features were positively correlated to RS and negatively correlated with executive control. Additionally, the authors found that delay gratification times at age 4 had no significant relationship with BPD features at the time of the current study. Again, as in Study 1, the RS x EC interaction was significant.

Among those low in EC, RS was positively related to BPD features, while among those high in EC, the effect of RS was reduced to marginal significance. Moreover, among those high in RS, EC was negatively associated with BPD features, but among those low in RS, EC was unrelated to BPD features.

Parker, Boldero and Bell (2006) indicated that both AI and AO self-discrepancy magnitudes were strongly correlated to each other and to BPD features. Self-complexity was not significantly related to any of the other factors. Among those high in self-complexity, the relationship between AI self-discrepancy magnitudes and BPD features was lower than among those with less self-complexity. Actual-ought self-discrepancy relationship with BPD features was not significantly moderated by self-complexity.

BPD is complex, and several factors have an impact on whether clinical features of BPD are present. None of the prediction factors above are sufficient to be the key factor in the development of BPD features. Increased knowledge of the development of the disorder may help prevent symptom aggravation and identify new treatment strategies. Future research should integrate the knowledge gained from these areas and study these variables simultaneously. Studies in which these variables are simultaneously examined would provide greater specificity in the relationships between the variables. These articles taken together not only increase our knowledge of what factors and variables lead to the development of BPD features and BPD itself but also, when taken together, indicate future lines of research yet to be studied.

Treatment

The American Psychiatric Association reports that recent advancements have led to treatments reaching an 86% remission rate 10 years after treatment.

Management

Treatments include dialectical behavioral therapy (DBT), a form of cognitive behavioral therapy (CBT). FDA recommendations quote the American Psychiatric Association: "The APA's Practice Guideline for BPD, for example, suggests medications by sign and does not suggest any specific class of medication for the whole Disorder." Atypical antipsychotics and medications used to treat other mood disorders such as anti-depressants are commonly prescribed for those suffering from BPD.

The UK's National Institute for Health and Clinical Excellence (NICE) in 2009 also indicates that BPD treatments should be based on individual cases rather than upon the diagnosis of BPD per se. NICE encourages doctors to use co-morbid conditions to determine which medications, if any, are appropriate. A Cochrane review from 2006 arrived at the same conclusion. Antidepressants, antipsychotics and mood stabilisers (such as lithium) are regularly used to treat co-morbid symptoms such as depression.

Services and recovery

Individuals with BPD sometimes use mental health services extensively. People with this diagnosis accounted for about 20 percent of psychiatric hospitalizations in one survey. The majority of BPD patients continue to use outpatient treatment in a sustained manner for several years, but the number using the more restrictive and costly forms of treatment, such as inpatient admission, declines with time. Experience of services varies. Assessing suicide risk can be a challenge for mental health services (and patients themselves tend to underestimate the lethality of self-injurious behaviours) with typically a chronically elevated risk of suicide much above that of the general population and a history of multiple attempts when in crisis.

Particular difficulties have been observed in the relationship between care providers and individuals diagnosed with BPD. A majority of psychiatric staff report finding individuals with BPD moderately to extremely difficult to work with, and more difficult than other client groups. Some clients feel a diagnosis is helpful, allowing them to understand they are not alone, and to connect with others who have BPD and who have developed helpful coping mechanisms. On the other hand, some with the diagnosis of BPD have reported that the term "BPD" felt like a pejorative label rather than a helpful diagnosis, that self-destructive behaviour was incorrectly perceived as manipulative, and that they had limited access to care. Attempts are made to improve public and staff attitudes.

Epidemiology

The prevalence of BPD in the general population ranges from 1 to 2 percent. The diagnosis appears to be several times more common in (especially young) women than in men, by as much as 3:1, according to the DSM-IV-TR, although the reasons for this are not clear.

The prevalence of BPD in the United States has been calculated as 1 percent to 3 percent of the adult population, with approximately 75 percent of those diagnosed being female. It has been found to account for 20 percent of psychiatric hospitalizations.

History

Since the earliest record of medical history, the coexistence of intense, divergent moods within an individual has been recognized by such writers as Homer, Hippocrates and Aretaeus, the last describing the vacillating presence of impulsive anger, melancholia and mania within a single person. After medieval suppression of the concept, it was revived by Swiss physician Théophile Bonet in 1684, who, using the term *folie maniaco-mélancolique*, noted the erratic and unstable moods with periodic highs and lows that rarely followed a regular course. His observations were followed by those of other writers who noted the same pattern, including writers such as the American psychiatrist C. Hughes in 1884 and J.C. Rosse in 1890, who described "borderline insanity". Kraepelin,

in 1921, identified an "excitable personality" that closely parallels the borderline features outlined in the current concept of borderline.

Adolf Stern wrote the first significant psychoanalytic work to use the term "borderline" in 1938, referring to a group of patients with what was thought to be a mild form of schizophrenia, on the borderline between neurosis and psychosis. For the next decade the term was in popular and colloquial use, a loosely conceived designation mostly used by theorists of the psychoanalytic and biological schools of thought. Increasingly, theorists who focused on the operation of social forces were recognized as well.

The 1960s and 1970s saw a shift from thinking of the borderline syndrome as borderline *schizophrenia* to thinking of it as a borderline *affective disorder* (mood disorder), on the fringes of manic depression, cyclothymia and dysthymia. In DSM-II, stressing the affective components, it was called cyclothymic personality (affective personality). In parallel to this evolution of the term "borderline" to refer to a distinct category of disorder, psychoanalysts such as Otto Kernberg were using it to refer to a broad spectrum of issues, describing an intermediate level of personality organization between neurotic and psychotic processes.

Standardized criteria were developed to distinguish BPD from affective disorders and other Axis I disorders, and BPD became a personality disorder diagnosis in 1980 with the publication of DSM-III. The diagnosis was formulated predominantly in terms of mood and behavior, distinguished from sub-syndromal schizophrenia which was termed "Schizotypal personality disorder". The final terminology in use by the DSM today was decided by the DSM-IV Axis II Work Group of the American Psychiatric Association.

Controversies

Gender

The diagnosis of BPD has been criticized from a feminist perspective. This is because some of the diagnostic criteria/symptoms of the disorder uphold common gender stereotypes about women. For example, the criteria of "a pattern of unstable personal relationships, unstable self-image, and instability of mood," can all be linked to the stereotype that women are "neither decisive nor constant". The question has also been raised of why women are three times more likely to be diagnosed with BPD than men. Some think that people with BPD commonly have a history of sexual abuse in childhood. One feminist critique suggests that BPD is a stigmatizing diagnosis that can sometimes evoke negative responses from health care providers, and additionally, that women who have survived sexual abuse in childhood are therefore sometimes re-traumatized by any such abusive mental health service.

Some feminist writers have suggested it would be better to give these women the diagnosis of a post-traumatic disorder as this would acknowledge their abuse, but others have argued that the use of the PTSD diagnosis merely medicalizes abuse rather than addressing the root causes in society. Women may be more likely to receive a personality

disorder diagnosis if they reject the female role by being hostile, successful or sexually active; alternatively if a woman presents with psychiatric symptoms but does not conform to a traditional passive sick role, she may be labelled as a "difficult" patient and given the stigmatizing diagnosis of BPD.

Stigma

The features of BPD include emotional instability, intense unstable interpersonal relationships, a need for relatedness and a fear of rejection. As a result, people with BPD often evoke intense emotions in those around them. Pejorative terms to describe persons with BPD such as “difficult,” “treatment resistant,” “manipulative,” “demanding” and “attention seeking" are often used, and may become a self-fulfilling prophecy as the clinician's negative response triggers further self-destructive behaviour. In psychoanalytic theory, this stigmatization may be thought to reflect countertransference (when a therapist projects their own feelings on to a client), as people with BPD are prone to use defense mechanisms such as splitting and projective identification. Thus the diagnosis "often says more about the clinician's negative reaction to the patient than it does about the patient ... as an expression of counter transference hate, borderline explains away the breakdown in empathy between the therapist and the patient and becomes an institutional epithet in the guise of pseudoscientific jargon" (Aronson, p 217).

This inadvertent counter transference can give rise to inappropriate clinical responses including excessive use of medication, inappropriate mothering and punitive use of limit setting and interpretation. People with BPD are seen as among the most challenging groups of patients, requiring a high degree of skill and training in the psychiatrists, therapists and nurses involved in their treatment. While some clinicians agree with the diagnosis under the name "borderline personality disorder", some would like the name to be changed. One critique says that some who are labeled "Borderline Personality Disorder" feel this name is unhelpful, stigmatizing, and/or inaccurate.

The Treatment and Research Advancements National Association for Personality Disorders (TARA-APD) campaigns to change the name and designation of BPD in DSM-5. The paper *How Advocacy is Bringing BPD into the Light* reports that "the name BPD is confusing, imparts no relevant or descriptive information, and reinforces existing stigma...".

Terminology

Because of the above concerns, and because of a move away from the original theoretical basis for the term, there is ongoing debate about renaming BPD. Alternative suggestions for names include *emotional regulation disorder* or *emotional dysregulation disorder*. *Impulse disorder* and *interpersonal regulatory disorder* are other valid alternatives, according to John Gunderson of McLean Hospital in the United States. Another term (for example, by psychiatrist Carolyn Quadrio) is *post traumatic personality disorganization* (PTPD), reflecting the condition's status as (often) both a form of chronic post traumatic stress disorder (PTSD) and a personality disorder in the belief that it is a common

outcome of developmental or attachment trauma. Some people do not report any kind of traumatic event.

Chapter 4

Management of Borderline Personality Disorder

The mainstay of **management of borderline personality disorder** is various forms of psychotherapy with medications being found to be of little use.

Psychotherapy

There has traditionally been skepticism about the psychological treatment of personality disorders, but several specific types of psychotherapy for BPD have developed in recent years. The limited studies to date do not allow confident claims of effectiveness but do suggest that people with BPD can benefit on at least some outcome measures. Supportive therapy alone may enhance self-esteem and mobilize the existing strengths of individuals with BPD. Specific psychotherapies may involve sessions over several months or, as is particularly common for personality disorders, several years. Psychotherapy can often be conducted either with individuals or with groups. Group therapy can aid the learning and practice of interpersonal skills and self-awareness by individuals with BPD, though drop-out rates may be problematic.

Dialectical behavioral therapy

University of Washington psychology professor Marsha Linehan is credited with developing the first empirically supported standard treatment for BPD, termed dialectical behavioral therapy (DBT). DBT grew dramatically in popularity among mental health professionals following the publication of Linehan's treatment manuals for DBT in 1993. DBT was originally developed as an intervention for patients who meet criteria for BPD and particularly those who are highly suicidal.

DBT draws its principles from behavioral science (including cognitive-behavioral techniques), dialectical philosophy and Zen practice. The treatment emphasizes balancing acceptance and change (hence dialectic), with the overall goal of helping patients not just survive but build a life worth living. Treatment is delivered in four stages, with self-harm and other life-threatening issues taking priority. In the second stage, patients are encouraged to experience the painful emotions that they have been avoiding. Stage three addresses problems of living such as career and marital problems. Finally, stage four focuses on helping clients feel complete and reducing feelings of emptiness and boredom.

DBT encompasses four modes of therapy, the first being traditional individual therapy between a single therapist and client. The second mode of therapy is skills training; a core component of DBT is learning new behavioral skills, including mindfulness, interpersonal effectiveness (e.g. assertiveness and social skill), coping adaptively with distress and crises, and identifying and regulating emotional reactions.

The third mode of therapy used is skills generalization, which focuses on helping clients integrate the skills taught in DBT into real-life situations. This usually involves coaching in the form of telephone contact outside of normal therapy hours. The calls are usually brief interactions focused on helping clients apply specific skills to circumstances they are experiencing. The fourth mode of therapy is the use of a consultation team designed to support the therapists. These teams have several important functions including reducing therapist burnout, providing therapy for the therapists, improving empathy for clients and providing ongoing consultations for client difficulties.

The goal of all DBT treatment approaches is to reduce the ineffective action tendencies linked to dysregulated emotions. DBT is based on a biosocial theory of personality functioning in which the core problem is seen as the breakdown of the patient's cognitive, behavioral and emotional regulation systems when experiencing intense emotions. The etiology of BPD is seen as a biological predisposition toward emotional dysregulation combined with a perceived invalidating social environment.

DBT can be based on a biosocial theory of personality functioning in which BPD is seen as a biological disorder of emotional regulation in a social environment experienced as invalidating by the borderline patient.

Several random controlled trials (RCTs) comparing DBT to other forms of treatment have favored the use of DBT to treat borderline patients. Specifically, DBT has been found to significantly reduce self-injury, suicidal behavior, impulsivity, self-rated anger and the use of crisis services among borderline patients. These reductions have been found even when controlling for other treatment factors such as therapist experience, affordability of treatment, gender of therapist and the number of hours spent in individual therapy. However, the additional efficacy in the overall treatment of BPD is less clear; future research is needed to isolate the specific components of DBT that are most effective in treating BPD. Furthermore, little research has examined the efficacy of DBT in treating male and minority patients with BPD. Training nurses in the use of DBT has been found to replace a therapeutic pessimism with a more optimistic understanding and outlook.

Schema therapy

Schema therapy (also called schema-focused therapy) is an integrative approach based on cognitive-behavioral or skills-based techniques along with object relations and gestalt approaches. It directly targets deeper aspects of emotion, personality and schemas (fundamental ways of categorizing and reacting to the world). The treatment also focuses on the relationship with the therapist (including a process of "limited re-parenting"), daily

life outside of therapy and traumatic childhood experiences. It was developed by Jeffrey Young and became established in the 1990s. Limited recent research suggests it is significantly more effective than transference-focused psychotherapy, with half of individuals with borderline personality disorder assessed as having achieved full recovery after four years, with two-thirds showing clinically significant improvement. Another very small trial has also suggested efficacy.

Cognitive behavioral therapy

Cognitive behavioral therapy (CBT) is the most widely used and established psychological treatment for mental disorders, but has appeared less successful in BPD, due partly to difficulties in developing a therapeutic relationship and treatment adherence. Approaches such as DBT and Schema-focused therapy developed partly as an attempt to expand and add to traditional CBT, which uses a limited number of sessions to target specific maladaptive patterns of thought, perception and behavior. A recent study did find a number of sustained benefits of CBT, in addition to treatment as usual, after an average of 16 sessions over one year.

Marital or family therapy

Marital therapy can be helpful in stabilizing the marital relationship and in reducing marital conflict and stress that can worsen BPD symptoms. Family therapy or family psychoeducation can help educate family members regarding BPD, improve family communication and problem solving, and provide support to family members in dealing with their loved one's illness.

Two patterns of family involvement can help clinicians plan family interventions: overinvolvement and neglect. Borderline patients who are from overinvolved families are often actively struggling with a dependency issue by denial or by anger at their parents.

Interest in the use of psychoeducation and skills training approaches for families with borderline members is growing.

Psychoanalysis

It is in the apparition of the DSM-IV that the term took two orientations: psychiatric one behavioral and the other, included in a psychoanalytical psychopathology. According to this split, the diagnosis takes on, or a character objectivizing with ascendancy of symptoms to be eradicated or it indicates a particular type of patients of psychoanalysts to treat in modalities different from those typical cures.

Transference-focused psychotherapy

Transference-focused psychotherapy (TFP) is a form of psychoanalytic therapy dating to the 1960s, rooted in the conceptions of Otto Kernberg on BPD and its underlying structure (borderline personality organization). Unlike in the case of traditional

psychoanalysis, the therapist plays a very active role in TFP. In session the therapist works on the relationship between the patient and the therapist. The therapist will try to explore and clarify aspects of this relationship so the underlying object relations dyads become clear. Some limited research on TFP suggests it may reduce some symptoms of BPD by affecting certain underlying processes, and that TFP in comparison to dialectical behavioral therapy and supportive therapy results in increased reflective functioning (the ability to realistically think about how others think) and a more secure attachment style. Furthermore, TFP has been shown to be as effective as DBT in improvement of suicidal behavior, and has been more effective than DBT in alleviating anger and in reducing verbal or direct assaultive behavior. Limited research suggests that TFP appears to be less effective than schema-focused therapy, while being more effective than no treatment.

Cognitive analytic therapy

Cognitive analytic therapy (CAT) combines cognitive and psychoanalytic approaches and has been adapted for use with individuals with BPD with mixed results.

Mentalization based treatment

Mentalization based treatment, developed by Peter Fonagy and Antony Bateman, rests on the assumption that people with BPD have a disturbance of attachment due to problems in the early childhood parent-child relationship. Fonagy and Bateman hypothesize that inadequate parental mirroring and attunement in early childhood lead to a deficit in mentalization, "the capacity to think about mental states as separate from, yet potentially causing actions"; in other words the capacity to intuitively understand the thoughts, intentions and motivations of others, and the connections between one's own thoughts, feelings and actions. Mentalization failure is thought to underlie BPD patients' problems with impulse control, mood instability and difficulties sustaining intimate relationships. Mentalization based treatment aims to develop patients' self-regulation capacity through a psychodynamically informed multi-modal treatment program that incorporates group psychotherapy and individual psychotherapy in a therapeutic community, partial hospitalization or outpatient context. In a randomized controlled trial, a group of BPD patients received 18 months of intensive partial-hospitalization MBT followed by 18 months of group psychotherapy, and were followed up over five years. The treatment group showed significant benefits aross a range of measures including number of suicide attempts, reduced time in hospital and reduced use of medication.

Medication

The UK's National Institute for Health and Clinical Excellence (NICE) in 2009 recommends against the use of medication for treating borderline personality disorder and that they should only be considered for comorbid conditions. A Cochrane review from 2006 arrived at the same conclusion.

Antidepressants

Selective serotonin reuptake inhibitor (SSRI) antidepressants have been shown in randomized controlled trials to improve the attendant symptoms of anxiety and depression, such as anger and hostility, associated with BPD in some patients. According to *Listening to Prozac*, it takes a higher dose of an SSRI to treat mood disorders associated with BPD than depression alone. It also takes about three months for benefit to appear, compared to the three to six weeks for depression.

Antipsychotics

The newer atypical antipsychotics are claimed to have an improved adverse effect profile than the typical antipsychotics. Antipsychotics are also sometimes used to treat distortions in thinking or false perceptions. Use of antipsychotics is generally short-term. One meta-analysis of two randomly controlled trials, four non-controlled open-label studies and eight case reports has suggested that several atypical antipsychotics, including olanzapine, clozapine, quetiapine and risperidone, may help BPD patients with psychotic-like, impulsive or suicidal symptoms. However, there are numerous adverse effects of antipsychotics, notably Tardive dyskinesia (TD). Atypical antipsychotics are known for often causing considerable weight gain, with associated health complications.

Mood stabilizers

Mood stabilizers (used primarily to treat Bipolar disorder) such as lithium or lamotrigine may be of some use to help depressed or labile periods, as well as rapid changes in mood.

Services and recovery

Individuals with BPD sometimes use mental health services extensively. People with this diagnosis accounted for about 20 percent of psychiatric hospitalizations in one survey. The majority of BPD patients continue to use outpatient treatment in a sustained manner for several years, but the number using the more restrictive and costly forms of treatment, such as inpatient admission, declines with time. Experience of services varies. Assessing suicide risk can be a challenge for mental health services (and patients themselves tend to underestimate the lethality of self-injurious behaviours) with typically a chronically elevated risk of suicide much above that of the general population and a history of multiple attempts when in crisis.

Particular difficulties have been observed in the relationship between care providers and individuals diagnosed with BPD. A majority of psychiatric staff report finding individuals with BPD moderately to extremely difficult to work with, and more difficult than other client groups. On the other hand, those with the diagnosis of BPD have reported that the term "BPD" felt like a pejorative label rather than a helpful diagnosis, that self-destructive behaviour was incorrectly perceived as manipulative, and that they had limited access to care. Attempts are made to improve public and staff attitudes.

Combining pharmacotherapy and psychotherapy

In practice, psychotherapy and medication may often be combined, but there are limited data on clinical practice. Efficacy studies often assess the effectiveness of interventions when added to "treatment as usual" (TAU), which may involve general psychiatric services, supportive counselling, medication and psychotherapy.

One small study, which excluded individuals with a comorbid Axis 1 disorder, has indicated that outpatients undergoing Dialectical Behavioral Therapy and taking the antipsychotic Olanzapine show significantly more improvement on some measures related to BPD, compared to those undergoing DBT and taking a placebo pill, although they also experienced weight gain and raised cholesterol. Another small study found that patients who had undergone DBT and then took fluoxetine (Prozac) showed no significant improvements, whereas those who underwent DBT and then took a placebo pill did show significant improvements.

Difficulties in therapy

There can be unique challenges in the treatment of BPD, such as hospital care. In psychotherapy, a client may be unusually sensitive to rejection and abandonment and may react negatively (e.g., by harming themselves or withdrawing from treatment) if they sense this. In addition, clinicians may emotionally distance themselves from individuals with BPD for self-protection or due to the stigma associated with the diagnosis, leading to a self-fulfilling prophecy and a cycle of stigmatization to which both patient and therapist can contribute.

Some psychotherapies, including DBT, were developed partly to overcome problems with interpersonal sensitivity and maintaining a therapeutic relationship. Adherence to medication regimens is also a problem, due in part to adverse effects, with drop-out rates of between 50 percent and 88 percent in medication trials. Comorbid disorders, particularly substance use disorders, can complicate attempts to achieve remission.

Other strategies

Psychotherapies and medications form a part of the overall context of mental health services and psychosocial needs related to BPD. The evidence base is limited for both, and some individuals may forego them or not benefit (enough) from them. It has been argued that diagnostic categorization can have limited utility in directing therapeutic work in this area, and that in some cases it is only with reference to past and current relationships that "borderline" behavior can be understood as partly adaptive and how people can best be helped.

Numerous other strategies may be used, including alternative medicine techniques; exercise and physical fitness, including team sports; occupational therapy techniques, including creative arts; having structure and routine to the days, particularly through

employment - helping feelings of competence (e.g. self-efficacy), having a social role and being valued by others, boosting self-esteem.

Group-based psychological services encourage clients to socialize and participate in both solitary and group activities. These may be in day centers. Therapeutic communities are an example of this, particularly in Europe; although their usage has declined many have specialised in the treatment of severe personality disorder.

Psychiatric rehabilitation services aimed at helping people with mental health problems reduce psychosocial disability, engage in meaningful activities and avoid stigma and social exclusion may be of value to people who suffer from BPD. There are also many mutual-support or co-counseling groups run by and for individuals with BPD. Services, or individual goals, are increasingly based on a recovery model that supports and emphasizes an individual's personal journey and potential.

Data indicate that the diagnosis of BPD is more variable over time than the DSM implies. Substantial percentages (for example around a third, depending on criteria) of people diagnosed with BPD achieve remission within a year or two. A longitudinal study found that, six years after being diagnosed with BPD, 56 percent showed good psychosocial functioning, compared to 26 percent at baseline. Although vocational achievement was more limited even compared to those with other personality disorders, those whose symptoms had remitted were significantly more likely to have a good relationship with a spouse/partner and at least one parent, good work/school performance, a sustained work/school history, good global functioning and good psychosocial functioning.

Chapter 5

Antisocial and Avoidant Personality Disorder

Antisocial personality disorder

Antisocial personality disorder (**adyp** or **Atu**) is defined by the American Psychiatric Association's *Diagnostic and Statistical Manual* as "...a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood."

Antisocial personality disorder is sometimes known as sociopathic personality disorder. It is also sometimes referred to as psychopathy or sociopathy. However, the two are not to be used interchangably. Some researchers believe that antisocial personality disorder and psychopathic personality are different conditions.

Signs and symptoms

Characteristics of people with antisocial personality disorder may include:

- Persistent lying or stealing
- Apparent lack of remorse or empathy for others
- Cruelty to animals
- Poor behavioral controls — expressions of irritability, annoyance, impatience, threats, aggression, and verbal abuse; inadequate control of anger and temper
- A history of childhood conduct disorder
- Recurring difficulties with the law
- Promiscuity
- Tendency to violate the boundaries and rights of others
- Aggressive, often violent behavior; prone to getting involved in fights
- Inability to tolerate boredom
- Disregard for right and wrong
- Poor or abusive relationships
- Irresponsible work behavior
- Disregard for safety

Between the most common characteristics of the TPA they find the absence of empathy and remorse, also a vision of the distorted autoesteem, a constant search of new sensations (that can come to unusual ends), the dehumanisation of the victim or the lack of worry to the consequences. The egocentrismo, the megalomania, the lack of responsibility, the extroversion, the excess of hedonism, high places levels of impulsiveness, or the motivation for experiencing sensations of control and being able also are very common. This type of psychosis does not relate to assaults of panic or to schizophrenia.

Diagnosis

DSM

The Diagnostic and Statistical Manual of Mental Disorders fourth edition, DSM IV-TR = 301.7, a widely used manual for diagnosing mental disorders, defines antisocial personality disorder (in Axis II Cluster B) as:

> A) There is a pervasive pattern of disregard for and violation of the rights of others occurring for as long as either childhood, or in the case of many who are influenced by environmental factors, around age 15, as indicated by three (or more) of the following:
>
> 1. failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest;
> 2. deceitfulness, as indicated by repeatedly lying, use of aliases, or conning others for personal profit or pleasure;
> 3. impulsivity or failure to plan ahead;
> 4. irritability and aggressiveness, as indicated by repeated physical fights or assaults;
> 5. reckless disregard for safety of self or others;
> 6. consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations;
> 7. lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another;
> 8. promiscuity;
> 9. having shallow or seemingly nonexistent feelings.

New evidence points to the fact that children often develop Antisocial Personality Disorder as a cause of their environment, as well as their genetic line. The individual must be at least 18 years of age to be diagnosed with this disorder (Criterion B) But those commonly diagnosed with ASPD as adults, were diagnosed with Conduct Disorder as children. The prevalence of this disorder is 3% in males and 1% from females, as stated from the DSM IV-TR.

Criticism

Researchers have heavily criticized the ASPD DSM-IV criteria because not enough emphasis was placed on traditional psychopathic traits such as a lack of empathy, superficial charm, and inflated self appraisal.

These latter traits are harder to assess than behavioral problems (like impulsivity and acting out). Thus, the DSM-IV framers sacrificed validity for reliability. That is, the ASPD diagnosis focuses on behavioral traits, but only limited emphasis is placed on affective and unemotional interpersonal traits.

Researchers debate about whether psychopathy/sociopathy are incorrectly put together under ASPD. These clinicians and researchers who believe that it was incorrect to label the two in the same category are upset that an important distinction has been lost between these two disorders. In other words, the DSM-IV-TR considers ASPD and psychopathy to be the same, or similar. However, they are not the same since antisocial personality disorder is diagnosed via behavior and social deviance, whereas psychopathy also includes affective and interpersonal personality factors.

Also, ASPD, unlike psychopathy, does not have biological markers confirmed to underpin the disorder. Other criticisms of ASPD are that it is essentially synonymous with criminality. Nearly 80%–95% of felons will meet criteria for ASPD — thus ASPD predicts nothing in criminal justice populations, whereas psychopathy (using the Hare Psychopathy Checklist-Revised (PCL-R)) is found in only roughly 20% of inmates and PCL-R is considered one of the best predictors of violent recidivism. Also, the DSM-IV field trials never included incarcerated populations.

The official stance of the American Psychiatric Association as presented in the DSM-IV-TR is that "psychopathy" and "sociopathy" are obsolete synonyms. The World Health Organization takes a similar stance in its ICD-10 by referring to psychopathy, antisocial personality, asocial personality, and amoral personality as synonyms for dissocial personality disorder.

WHO

The World Health Organization's ICD-10 defines a conceptually similar disorder to antisocial personality disorder called *(F60.2) Dissocial personality disorder*.

It is characterized by at least 3 of the following:

1. Callous unconcern for the feelings of others and lack of the capacity for empathy.
2. Gross and persistent attitude of irresponsibility and disregard for social norms, rules, and obligations.
3. Incapacity to maintain enduring relationships.

4. Very low tolerance to frustration and a low threshold for discharge of aggression, including violence.
5. Incapacity to experience guilt and to profit from experience, particularly punishment.
6. Markedly prone to blame others or to offer plausible rationalizations for the behavior bringing the subject into conflict.
7. Persistent irritability.

The criteria specifically rule out conduct disorders. Dissocial personality disorder criteria differ from those for antisocial and sociopathic personality disorders.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Millon's subtypes

Theodore Millon identified five subtypes of antisocial behavior. Any antisocial individual may exhibit none, one or more than one of the following:

- **covetous antisocial** - variant of the pure pattern where individuals feel that life has not given them their due.
- **reputation-defending antisocial** - including narcissistic features
- **risk-taking antisocial** - including histrionic features
- **nomadic antisocial** - including schizoid, avoidant features
- **malevolent antisocial** - including sadistic, paranoid features.

Differential diagnosis

The following conditions commonly coexist with antisocial personality disorder:

- Anxiety disorders
- Depressive disorder
- Substance-related disorders
- Somatization disorder
- Pathological risk-seeking
- Borderline personality disorder
- Histrionic personality disorder
- Narcissistic personality disorder

When combined with alcoholism, people may show frontal function deficits on neuropsychological tests greater than those associated with each condition.

Treatment

To date there have been no controlled studies reported which found an effective treatment for ASPD, although contingency management programs, or a reward system, has been

shown moderately effective for behavioral change. Some studies have found that the presence of ASPD does not significantly interfere with treatment for other disorders, such as substance abuse, although others have reported contradictory findings. Schema therapy is being investigated as a treatment for antisocial personality disorder, as well as medicinal marijuana treatments.

Epidemiology

Antisocial personality disorder in the general population is about 3% in males and 1% in females.

It is seen in 3% to 30% of psychiatric outpatients. The prevalence of the disorder is even higher in selected populations, such as people in prisons (who include many violent offenders). Similarly, the prevalence of ASPD is higher among patients in alcohol or other drug (AOD) abuse treatment programs than in the general population (Hare 1983), suggesting a link between ASPD and AOD abuse and dependence.

History

The history of the origins of antisocial personality disorder are closely related to the history of psychopathy.

Avoidant personality disorder

Avoidant personality disorder (**AvPD**) (or **anxious personality disorder**) is a personality disorder recognized in the DSM-IV TR handbook in a person over the age of eighteen years as characterized by a pervasive pattern of social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation, and avoidance of social interaction.

People with AvPD often consider themselves to be socially inept or personally unappealing, and avoid social interaction for fear of being ridiculed, humiliated, rejected, or disliked.

AvPD is usually first noticed in early adulthood, and is associated with perceived or actual rejection by parents or peers during childhood. Whether the feeling of rejection is due to the extreme interpersonal monitoring attributed to people with the disorder is still disputed.

Signs and symptoms

People with AvPD are preoccupied with their own shortcomings and form relationships with others only if they believe they will not be rejected. Loss and rejection are so painful that these individuals will choose to be lonely rather than risk trying to connect with others.

- Hypersensitivity to criticism or rejection
- Self-imposed social isolation
- Extreme shyness or anxiety in social situations, though feels a strong desire for close relationships
- Avoids physical contact because it has been associated with an unpleasant or painful stimulus
- Avoids interpersonal relationships
- Feelings of inadequacy
- Severe low self-esteem
- Self-loathing
- Mistrust of others
- Emotional distancing related to intimacy
- Highly self-conscious
- Self-critical about their problems relating to others
- Problems in occupational functioning
- Lonely self-perception, although others may find the relationship with them meaningful
- Feeling inferior to others
- In some more extreme cases — agoraphobia
- Utilizes fantasy as a form of escapism and to interrupt painful thoughts

Causes

The cause of AvPD is not clearly defined, and may be influenced by a combination of social, genetic, and psychological factors. The disorder may be related to temperamental factors that are inherited. Specifically, various anxiety disorders in childhood and adolescence have been associated with a temperament characterized by behavioral inhibition, including features of being shy, fearful, and withdrawn in new situations. These inherited characteristics may give an individual a genetic predisposition towards AvPD.

Many people diagnosed with AvPD have had painful early experiences of chronic parental and/or peer-group criticism or rejection. The need to bond with the rejecting parents or peers makes the person with AvPD hungry for relationships, but their longing gradually develops into a defensive shell of self-protection against repeated criticisms.

Diagnosis

World Health Organization

The World Health Organization's ICD-10 lists avoidant personality disorder as *(F60.6) Anxious (avoidant) personality disorder*.

> It is characterized by at least four of the following:
>
> 1. persistent and pervasive feelings of tension and apprehension;
> 2. belief that one is socially inept, personally unappealing, or inferior to others;
> 3. excessive preoccupation with being criticized or rejected in social situations;
> 4. unwillingness to become involved with people unless certain of being liked;
> 5. restrictions in lifestyle because of need to have physical security;
> 6. avoidance of social or occupational activities that involve significant interpersonal contact because of fear of criticism, disapproval, or rejection.
>
> Associated features may include hypersensitivity to rejection and criticism.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfy a set of general personality disorder criteria.

Millon's subtypes

Psychologist Theodore Millon identified four subtypes of avoidant personality disorder. Any individual avoidant may exhibit none or one of the following:

- **conflicted avoidant** - including negativistic (passive-aggressive) features

  The conflicted avoidant feels ambivalent towards themselves and others. They can idealize those close to them but under stress they may feel under-appreciated or misunderstood and wish to hurt others in revenge. They may be perceived as petulant or to be sulking.

- **hypersensitive avoidant** - including paranoid features

  The hypersensitive avoidant experiences paranoia, mistrustfulness and fear, but to a lesser extent than an individual with paranoid personality disorder. They may be perceived as petulant or "high-strung".

- **phobic avoidant** - including dependent features

- **self-deserting avoidant** - including depressive features

Differential diagnosis

Research suggests that people with AvPD, in common with sufferers of chronic social anxiety disorder (also called social phobia), excessively monitor their own internal reactions when they are involved in social interaction. However, unlike social phobics, people with AvPD may also excessively monitor the reactions of the people with whom they are interacting.

The extreme tension created by this monitoring may account for the hesitant speech and taciturnity of many people with AvPD; they are so preoccupied with monitoring themselves and others that producing fluent speech is difficult.

AvPD is reported to be especially prevalent in people with anxiety disorders, although estimates of comorbidity vary widely due to differences in (among others) diagnostic instruments. Research suggests that approximately 10–50% of people who have panic disorder with agoraphobia have AvPD, as well as about 20–40% of people who have social phobia (social anxiety disorder).

Some studies report prevalence rates of up to 45% among people with generalized anxiety disorder and up to 56% of those with obsessive-compulsive disorder. Although it is not mentioned in the DSM-IV, earlier theorists have proposed a personality disorder which has a combination of features from borderline personality disorder and AvPD, called "avoidant-borderline mixed personality" (AvPD/BPD).

Treatment

Treatment of AvPD can employ various techniques, such as social skills training, cognitive therapy, exposure treatment to gradually increase social contacts, group therapy for practising social skills, and sometimes drug therapy. A key issue in treatment is gaining and keeping the patient's trust, since people with AvPD will often start to avoid treatment sessions if they distrust the therapist or fear rejection. The primary purpose of both individual therapy and social skills group training is for individuals with AvPD to begin challenging their exaggerated negative beliefs about themselves.

Epidemiology

According to the DSM-IV-TR, AvPD occurs in approximately 0.5% to 1% of the general population. It is seen in about 10% of psychiatric outpatients.

History

The avoidant personality has been described in several sources as far back as the early 1900s, although it was not so named for some time. Swiss psychiatrist Eugen Bleuler described patients who exhibited signs of AvPD in his 1911 work *Dementia Praecox: Or the Group of Schizophrenias*. Avoidant and schizoid patterns were frequently confused or

referred to synonymously until Kretschmer (1921), in providing the first relatively complete description, developed a distinction.

Chapter 6

Dependent and Depressive Personality Disorder

Dependent personality disorder

Dependent personality disorder (DPD), formerly known as **asthenic personality disorder**, is a personality disorder that is characterized by a pervasive psychological dependence on other people.

The difference between a 'dependent personality' and a 'dependent personality disorder' is somewhat subjective, which makes diagnosis sensitive to cultural influences such as gender role expectations.

Characteristics

View of others

Individuals with DPD see other people as much more capable to shoulder life's responsibilities, to navigate a complex world, and to deal with the competitions of life. Other people are powerful, competent, and capable of providing a sense of security and support to individuals with DPD. Dependent individuals avoid situations that require them to accept responsibility for themselves; they look to others to take the lead and provide continuous support. DPD judgment of others is distorted by their inclination to see others as they wish they were rather than as they are. These individuals are fixated in the past. They maintain youthful impressions; they retain unsophisticated ideas and childlike views of the people toward whom they remain totally submissive. Individuals with DPD view strong caretakers, in particular, in an idealized manner; they believe they will be all right as long as the strong figure upon whom they depend is accessible.

Self-image

Individuals with DPD see themselves as inadequate and helpless; they believe they are in a cold and dangerous world and are unable to cope on their own. They define themselves as inept and abdicate self-responsibility; they turn their fate over to others. These individuals will decline to be ambitious and believe that they lack abilities, virtues and

attractiveness. The solution to being helpless in a frightening world is to find capable people who will be nurturing and supportive toward those with DPD. Within protective relationships, individuals with DPD will be self-effacing, obsequious, agreeable, docile, and ingratiating. They will deny their individuality and subordinate their desires to significant others. They internalize the beliefs and values of significant others. They imagine themselves to be one with or a part of more powerful and supporting others. By seeing themselves as protected by the power of others, they do not have to feel the anxiety attached to their own helplessness and impotence. However, to be comfortable with themselves and their inordinate helplessness, individuals with DPD must deny the feelings they experience and the deceptive strategies they employ. They limit their awareness of both themselves and others. Their limited perceptiveness allows them to be naive and uncritical. Their limited tolerance for negative feelings, perceptions, or interaction results in the interpersonal and logistical ineptness that they already believe to be true about themselves. Their defensive structure reinforces and actually results in verification of the self-image they already hold.

Relationships

Individuals with DPD see relationships with significant others as necessary for survival. They do not define themselves as able to function independently; they have to be in supportive relationships to be able to manage their lives. In order to establish and maintain these life-sustaining relationships, people with DPD will avoid even covert expressions of anger. They will be more than meek and docile; they will be admiring, loving, and willing to give their all. They will be loyal, unquestioning, and affectionate. They will be tender and considerate toward those upon whom they depend.

Dependent individuals play the inferior role to the superior other very well; they communicate to the dominant people in their lives that they are useful, sympathetic, strong, and competent. With these methods, individuals with DPD are often able to get along with unpredictable, isolated, or unpleasant people. To further make this possible, individuals with DPD will approach both their own and others' failures and shortcomings with a saccharine attitude and indulgent tolerance. They will engage in a mawkish minimization, denial, or distortion of both their own and others' negative, self-defeating, or destructive behaviors to sustain an idealized, and sometimes fictional, story of the relationships upon which they depend. They will deny their individuality, their differences, and ask for little other than acceptance and support.

Not only will individuals with DPD subordinate their needs to those of others, they will meet unreasonable demands and submit to abuse and intimidation to avoid isolation and abandonment. Dependent individuals so fear being unable to function alone that they will agree with things they believe are wrong rather than risk losing the help of people upon whom they depend. They will volunteer for unpleasant tasks if that will bring them the care and support they need. They will make extraordinary self-sacrifices to maintain important bonds.

It is important to note that individuals with DPD, in spite of the intensity of their need for others, do not necessarily attach strongly to specific individuals, i.e., they will become quickly and indiscriminately attached to others when they have lost a significant relationship. It is the strength of the dependency needs that is being addressed; attachment figures are basically interchangeable. Attachment to others is a self-referenced and, at times, haphazard process of securing the protection of the most readily available powerful other willing to provide nurturance and care. Both DPD and HPD are distinguished from other personality disorders by their need for social approval and affection and by their willingness to live in accord with the desires of others. They both feel paralyzed when they are alone and need constant assurance that they will not be abandoned. Individuals with DPD are passive individuals who lean on others to guide their lives. People with HPD are active individuals who take the initiative to arrange and modify the circumstances of their lives. They have the will and ability to take charge of their lives and to make active demands on others.

Causes

No studies of genetics or of biological traits for dependents have been conducted. Central to their psychodynamic constellation is an insecure form of attachment to others, which may be the result of clinging parental behavior.

DSM-IV

The Diagnostic and Statistical Manual of Mental Disorders fourth edition, DSM IV-TR, a widely used manual for diagnosing mental disorders, defines dependant personality disorder (in Axis II Cluster C) as:

1. has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
2. needs others to assume responsibility for most major areas of his or her life
3. has difficulty expressing disagreement with others because of fear of loss of support or approval. Note: do not include realistic fears of retribution.
4. has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
5. goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
6. feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
7. urgently seeks another relationship as a source of care and support when a close relationship ends
8. is unrealistically preoccupied with fears of being left to take care of himself or herself

It is a requirement of DSM-IV that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Diagnosis

The following questions when assessing individuals for DPD:

- Some people enjoy making decisions. Others prefer to have someone they trust guide them. Which do you prefer?
- Do you seek advice for everyday decisions? (Are the decisions you make understood by the practitioner?)
- Do you find yourself in situations where other people have made decisions about important areas in your life, e.g. what job to take?, Symptoms you have they do not understand?
- Is it hard for you to express a different opinion with someone you are close to? What do you think might happen if you did?
- Do you often pretend to agree with others even if you do not? Why? Could it get you into trouble if you disagree?
- Do you often need help to get started on a project?
- Do you ever volunteer to do unpleasant things for others so they will take care of you when you need it?
- Are you uncomfortable when you are alone? Are you afraid you will not be able to take care of yourself?
- Have you found that you are desperate to get into another relationship right away when a close relationship ends? Even if the new relationship might not be the best person for you?
- Do you worry about important people in your life leaving you?

World Health Organization

The World Health Organization's ICD-10 lists dependent personality disorder as *F60.7 Dependent personality disorder*.

It is characterized by at least 3 of the following:

1. encouraging or allowing others to make most of one's important life decisions;
2. subordination of one's own needs to those of others on whom one is dependent, and undue compliance with their wishes;
3. unwillingness to make even reasonable demands on the people one depends on;
4. feeling uncomfortable or helpless when alone, because of exaggerated fears of inability to care for oneself;
5. preoccupation with fears of being abandoned by a person with whom one has a close relationship, and of being left to care for oneself;
6. limited capacity to make everyday decisions without an excessive amount of advice and reassurance from others.

Associated features may include perceiving oneself as helpless, incompetent, and lacking stamina.
Includes:

- asthenic, inadequate, passive, and self-defeating personality (disorder)

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Millon's subtypes

Psychologist Theodore Millon identified five adult subtypes of dependent personality disorder. Any individual dependent may exhibit none or one of the following:

- **disquieted dependant** — including avoidant features
- **accommodating dependant** — including histrionic features
- **immature dependant** — variant of pure pattern
- **ineffectual dependant** — including schizoid features
- **selfless dependant** — including masochistic features

Differential diagnosis

The following conditions commonly coexist (comorbid) with dependent personality disorder:

- mood disorders
- anxiety disorders
- adjustment disorder
- borderline personality disorder
- avoidant personality disorder
- histrionic personality disorder

Treatment

Adler suggests that treatment goals for all personality disorders include: preventing further deterioration, regaining an adaptive equilibrium, alleviating symptoms, restoring lost skills, and fostering improved adaptive capacity. Goals may not necessarily include characterological restructuring. The focus of treatment is adaptation, i.e., how individuals respond to the environment. Treatment interventions teach more adaptive methods of managing distress, improving interpersonal effectiveness, and building skills for affective regulation.

For individuals with DPD, the goal of treatment is not independence but autonomy. Autonomy has been defined as the capacity for independence and the ability to develop intimate relationships. Sperry suggests that the basic goal for DPD treatment is self-efficacy. Individuals with DPD must recognize their dependent patterns and the high price they pay to maintain those patterns. This allows them to explore alternatives. The long-range goal is to increase DPD individuals' sense of independence and ability to function. Clients with DPD must build strength rather than foster neediness.

As with other personality disorders, treatment goals should not be in contradiction to the basic personality and temperament of these individuals. They can work toward a more functional version of those characteristics that are intrinsic to their style. Oldham suggests seven traits and behaviors of the "devoted personality style," i.e., the non-personality-disordered version of DPD:

- ability to make commitments;
- enjoyment of intimacy;
- skills as a team player—without need to compete with the leader;
- willingness to seek the opinions and advice of others;
- ability to promote interpersonal harmony;
- thoughtfulness and consideration for others; and,
- willingness to self-correct in response to criticism.

Group psychotherapy

Several reports suggest that group psychotherapy can be successful for the treatment of dependent personality disorder. Montgomery used group therapy for dependent patients who used medications for chronic complaints such as insomnia and nervousness. All but 3 of 30 patients eventually discontinued medications and began to confront their anger at being dependent on the therapist.

Sadoff and Collins administered weekly group psychotherapy to 22 patients who stuttered, most of whom had passive-dependent traits. Although the dropout rate was high, the authors found that the interpretation of passive-dependent behavior and attitudes (e.g., asking for help, believing that others are responsible for helping them) as a defense against recognizing and expressing anger proved helpful. Both stuttering and passive dependency improved in 2 patients who became angry and were able to confront their anger.

Torgersen studied college students who attended a weekend-long encounter group. On follow-up several weeks later, individuals who initially scored high on dependent traits had mixed responses. Although the group experience left them feeling disturbed and anxious, they also reported becoming more accepting of their own feelings and opinions. No other changes were found.

Attrition tends to be higher in group than in individual therapy for personality disorders but may be less of a problem for individuals with dependent personality disorder.

Budman et al. reported moderate improvements after an 18-month group for personality disorders (10% with dependent personality disorder), with some changes not beginning until after 6 months.

These reports suggest the usefulness of group psychotherapy for dependent personality disorder. Most clinicians use weekly sessions of an hour to an hour and a half. Treatment generally lasts several years.

Biological therapies

Four studies have explored the use of medications in the treatment of dependent personality disorder, and two studies have investigated their use in the treatment of dependent traits. Diagnostic and other limitations of the studies prevent firm conclusions about the efficacy of medications.

Klein and colleagues compared placebo with either imipramine or chlorpromazine in hospitalized patients with passive-aggressive and passive-dependent personality disorders that had been diagnosed according to DSM criteria. None of the patients showed a positive drug response.

Patients with major depressive disorder and an anxious-cluster personality disorder, many with dependent personality disorder, showed significant improvement in depression with imipramine or psychotherapeutic treatment. Fewer patients with Cluster C disorders fully recovered, however, and social adjustment problems remained.

Tyrer et al. drew a similar conclusion after studying patients with "general neurotic syndrome," which includes mixed anxiety-depression and dependent or obsessive personality. Although such patients initially appeared to be as responsive as others to 10-week treatments, including dothiepin (an antidepressant), diazepam, placebo, cognitive-behavioral therapy, or self-help, at 2-year follow-up, they had greater symptom levels and did significantly worse than other outpatients.

Ekselius and von Knorring studied 145 depressed patients, 61% of whom scored in the personality disorder range by self-report questionnaire, who received sertraline or citalopram for 24 weeks. From baseline to termination, the percentage above the cutoff score for dependent personality disorder improved significantly (21% versus 8%) as did the mean number of dependent personality disorder criteria met by the whole sample (3.3 versus 2.3). The self-reported change in dependent personality disorder criteria was significant, even after controlling for change in observer-rated depressive symptoms. Although the comparison across two different measurement perspectives complicates these findings, self-reported dependent symptoms seem to improve with 24 weeks of selective serotonin reuptake inhibitor treatment. Whether this generalizes to observer-rated improvement in life functioning is unknown.

Residential and day treatment therapies

Although hospitalization is sometimes necessary for the treatment of an Axis I disorder in individuals with dependent personality disorder, residential treatments are generally not indicated. However, residential and day treatment may provide support necessary to allow definitive psychotherapy to continue, when dependent personality disorder is complicated by recurrent depression, severe anxiety disorders, repetitive suicide attempts, other more severe personality disorders (such as borderline personality) or overwhelming life stress.

Several day treatment and residential programs for severe personality disorders have included individuals with dependent personality disorder. Active treatment days varied from 4 to 5 days per week over a range of 17–30 weeks and usually involved both group and individual sessions, most within a dynamic framework. All had moderate to large effect sizes. Piper et al. (1993) conducted a randomized controlled trial and found significantly greater changes in the day treatment than in the control groups. These data suggest a valuable role for these modalities when dependent personality disorder is not responsive to other outpatient therapies.

Medication

There is little evidence to suggest that the use of medication will result in long-term benefits in the personality functioning of individuals with DPD. DPD is not amenable to pharmacological measures; treatment relies upon verbal therapies. It is recommended that target symptoms rather than specific personality disorders be medicated. One of these target symptoms of particular importance is dysphoria -- marked by low energy, leaden fatigue, and depression. Dysphoria can also be associated with a craving for chocolate and for stimulants, e.g. cocaine. DPD is one of the most vulnerable personality disorders to dysphoria and some individuals with DPD respond well to antidepressant medications.

People with DPD are prone to both depressive and anxiety disorders. Stone suggests that these individuals may respond well to benzodiazepines in a crisis. However, clients with DPD are likely to abuse anxiolytics and their use should be limited and monitored with caution.

Unfortunately, individuals with DPD tend to be appealing clients. They are not inclined to be demanding and provocative. This can be precisely why they are given benzodiazepines by psychiatrists who may feel both benevolent and protective. Their inclination to use denial and escape to manage their lives makes the use of sedative-hypnotics familiar and pleasant. Iatrogenic addiction is a serious concern.

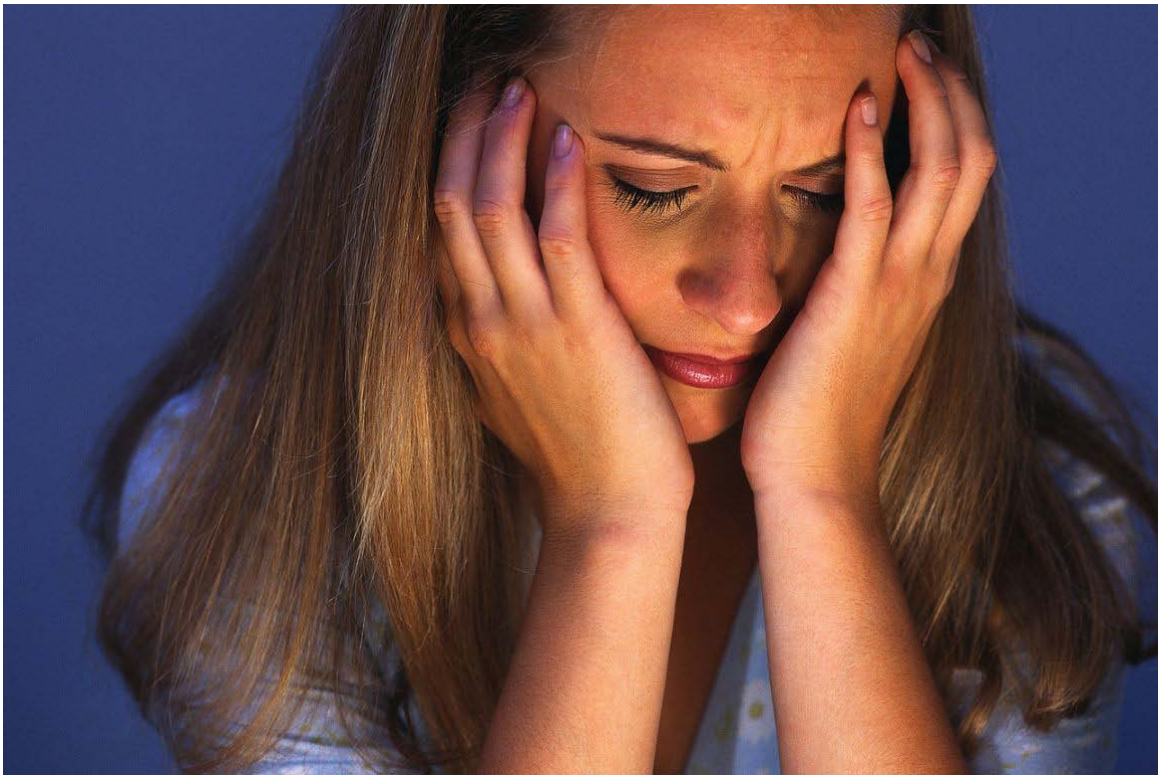
Epidemiology

Dependent personality disorder occurs in about 0.5% of the general population. It is more frequent in females.

History

Clinical interest in dependent personality disorder has existed since Karl Abraham first described it. As a disorder, the personality type first appeared in a United States Department of War technical bulletin in 1945 and later in the first edition of the Diagnostic and Statistical Manual in 1952 (American Psychiatric Association, 1952) as a subtype of passive-aggressive personality disorder. Since then, a surprising number of studies have upheld the descriptive validity of dependent personality traits, viewed as submissiveness, oral character traits, oral dependence, or passive dependence, or as a constellation of both pathological and adaptive traits under the rubric

Depressive personality disorder



Depressive Personality Disorder (also known as melancholic personality disorder) is a controversial psychiatric diagnosis that denotes a personality disorder with depressive features.

Originally included in the American Psychiatric Association's DSM-II, depressive personality disorder was removed from the DSM-III and DSM-III-R. Recently, it has been reconsidered for reinstatement as a diagnosis. Depressive personality disorder is

currently described in Appendix B in the DSM-IV-TR as worthy of further study. Although no longer listed in the manual's personality disorder category, the diagnosis is included under the section “personality disorder not otherwise specified”.

While depressive personality disorder shares some similarities with mood disorders such as dysthymic disorder, it also shares many similarities with personality disorders including avoidant personality disorder. Despite these similarities at first glance, recent research has shown it to be a distinct and valid diagnosis.

Characteristics

The DSM-IV defines depressive personality disorder as "a pervasive pattern of depressive cognitions and behaviors beginning by early adulthood and occurring in a variety of contexts." Depressive personality disorder occurs before, during, and after major depressive episodes, making it a distinct diagnosis not included in the definition of either major depressive episodes or dysthymic disorder. Specifically, five or more of the following must be present most days for at least two years in order for a diagnosis of depressive personality disorder to be made:

- Usual mood is dominated by dejection, gloominess, cheerlessness, joylessness, and unhappiness
- Self-concept centers around beliefs of inadequacy, worthlessness, and low self-esteem
- Is critical, blaming, and derogatory towards the self
- Is brooding and given to worry
- Is negativistic, critical, and judgmental toward others
- Is pessimistic
- Is prone to feeling guilty or remorseful

People with depressive personality disorder have a generally gloomy outlook on life, themselves, the past and the future. They are plagued by issues developing and maintaining relationships. In addition, studies have found that people with depressive personality disorder are more likely to seek psychotherapy than people with Axis I depression spectrums diagnoses.

Recent studies have concluded that people with depressive personality disorder are at a greater risk of developing dysthymic disorder than a comparable group of people without depressive personality disorder. These findings lead to the fact that depressive personality disorder is a potential precursor to dysthymia or other depression spectrum diagnoses. If included in the DSM-V, depressive personality disorder would be included as a warning sign for potential development of more severe depressive episodes.

Researchers at McLean Hospital in Massachusetts looked at the comorbidity of depressive personality disorder and a variety of other disorders. It was found that subjects with depressive personality disorder were more likely than the subjects without depressive personality disorder to currently have major depression and an eating disorder.

Subjects with and without depressive personality disorder were statistically equally likely to have any of the other disorders examined.

Axis I Disorders in Subjects With and Without Depressive Personality Disorder

	Present (N=30)		Absent (N=24)		
Disorder	**N**	**%**	**N**	**%**	**pa**
Major Depression					
Current	12	40	7	29	0.57
Lifetime	25	83	17	71	0.33
Bipolar Disorder					
Current	2	7	2	8	1.00
Lifetime	2	7	4	17	0.39
Dysthymia					
All Types	11	37	8	33	1.00
Primary early onset	5	17	5	21	0.74
Any mood disorder					
Current	20	67	14	58	0.58
Lifetime	28	93	22	92	1.00
Substance use disorders (lifetime)	11	37	7	29	0.77
Anxiety use disorders (lifetime)	15	50	11	46	0.79
Somatoform disorders (lifetime)	2	7	1	4	1.00
Eating disorders (lifetime)	7	23	1	4	0.06

Millon's Subtypes

Theodore Millon, a former professor of Harvard Medical School and University of Miami and a respected psychiatrist, identified five subtypes of depression. Any individual depressive may exhibit none, or one or more of the following:

- **Ill-humored depressive**, including negativistic (passive-aggressive) features. Patients in this subtype are often hypochondriacal, cantankerous and irritable, and guilt-ridden and self-condemning. In general, ill-humored depressives are down on themselves and think the worst of everything.
- **Voguish depressive**, including histrionic, narcissistic features. Voguish depressives see unhappiness as a popular and stylish mode of social disenchantment, personal depression as self-glorifying, and suffering as ennobling. The attention from friends, family, and doctors is seen as a positive aspect of the voguish depressive's condition.
- **Self-derogating depressive**, including dependent features. Patients who fall under this subtype are self-deriding, discrediting, odious, dishonorable, and

disparage themselves for weaknesses and shortcomings. These patients blame themselves for not being good enough.
- **Morbid depressive**, including masochistic features. Morbid depressives experience profound dejection and gloom, are highly lugubrious, and often feel drained and oppressed.
- **Restive depressive**, including avoidant features. Patients who fall under this subtype are consistently unsettled, agitated, wrought in despair, and perturbed. This is the subtype most likely to commit suicide in order to avoid all the despair in life.

Not all patients with a depressive disorder fall into a subtype. These subtypes are multidimensional in that patients usually experience multiple subtypes, instead of being limited to fitting into one subtype category. Currently, this set of subtypes is associated with melancholic personality disorders. All depression spectrum personality disorders are melancholic and can be looked at in terms of these subtypes.

Criticisms of the Inclusion of Depressive Personality Disorder in the DSM-V

Similarities to Dysthymic Disorder

Much of the controversy surrounding the potential inclusion of depressive personality disorder in the DSM-V stems from its apparent similarities to dysthymic disorder, a diagnosis already included in the DSM-IV. Dysthymic disorder is characterized by a variety of depressive symptoms, such as hypersomnia or fatigue, low self esteem, poor appetite, or difficulty making decisions, for over two years, with symptoms never numerous or severe enough to qualify as major depressive disorder. Patients with dysthymic disorder may experience social withdrawal, pessimism, and feelings of inadequacy at higher rates than other depression spectrum patients. Early-onset dysthymia is the diagnosis most closely related to depressive personality disorder.

The key difference between dysthymic disorder and depressive personality disorder is the focus of the symptoms used to diagnose. Dysthymic disorder is diagnosed by looking at the somatic senses, the more tangible senses. Depressive personality disorder is diagnosed by looking at the cognitive and intrapsychic symptoms. The symptoms of dysthymic disorder and depressive personality disorder may look similar at first glance, but the way these symptoms are considered distinguish the two diagnoses.

Comorbidity with Other Disorders

Many researchers believe that depressive personality disorder is so highly comorbid with other depressive disorders, manic-depressive episodes and dysthymic disorder, that it is redundant to include it as a distinct diagnosis. Recent studies however, have found that dysthymic disorder and depressive personality disorder are not as comorbid as previously thought. It was found that almost two thirds of the test subjects with depressive personality disorder did not have dysthymic disorder, and 83% did not have early-onset

dysthymia. The comorbidity with Axis I depressive disorders is not as high as had been assumed. An experiment conducted by American psychologists showed that depressive personality disorder shows a high comorbidity rate with major depression experienced at some point in a lifetime and with any mood disorders experienced at any point in a lifetime. A high comorbidity rate with these disorders is expected of many diagnoses. As for the extremely high comorbidity rate with mood disorders, it has been found that essentially all mood disorders are comorbid with at least one other, especially when looking at a lifetime sample size.

Changes to Cluster C

If depressive personality disorder were added to the DSM-V, it would be included in the Cluster C personality disorders, anxious and fearful personality disorders. At this time, those include avoidant, obsessive-compulsive, and dependent personality disorders. The make-up of Cluster C would have to be rethought, as the figure shown below could no longer represent all of the disorders if depressive personality disorder were to be included. The relation shown in the Venn diagram has been accepted for years and would have to be rethought and redesigned if depressive personality disorder were to be added. Further studies are in progress looking into the comorbidity of Cluster C disorders and depressive personality disorder, as well as how these disorders interact with each other in patients diagnosed with multiple Cluster C disorders.

Chapter 7

Histrionic and Narcissistic Personality Disorder

Histrionic Personality Disorder

Histrionic personality disorder (HPD) is defined by the American Psychiatric Association as a personality disorder characterized by a pattern of excessive emotionality and attention-seeking, including an excessive need for approval and inappropriate seductiveness, usually beginning in early adulthood. These individuals are lively, dramatic, enthusiastic, and flirtatious.

They may be inappropriately sexually provocative, express strong emotions with an impressionistic style, and be easily influenced by others. Associated features may include egocentrism, self-indulgence, continuous longing for appreciation, feelings that are easily hurt, and persistent manipulative behavior to achieve their own needs.

Characteristics

People with this disorder are usually able to function at a high level and can be successful socially and professionally. People with histrionic personality disorder usually have good social skills, but they tend to use these skills to manipulate other people and become the center of attention. Furthermore, histrionic personality disorder may affect a person's social or romantic relationships or their ability to cope with losses or failures.

People with this disorder lack genuine empathy. They start relationships well but tend to falter when depth and durability are needed, alternating between extremes of idealization and devaluation. They may seek treatment for depression when romantic relationships end, although this is by no means a feature exclusive to this disorder.

They often fail to see their own personal situation realistically, instead tending to dramatize and exaggerate their difficulties. They may go through frequent job changes, as they become easily bored and have trouble dealing with frustration. Because they tend to crave novelty and excitement, they may place themselves in risky situations. All of these factors may lead to greater risk of developing depression.

Additional symptoms include:

- Exhibitionist behavior.
- Constant seeking of reassurance or approval.
- Excessive dramatics with exaggerated displays of emotions, such as hugging someone they have just met or crying uncontrollably during a sad movie (Svrakie & Cloninger, 2005).
- Excessive sensitivity to criticism or disapproval.
- Inappropriately seductive appearance or behavior.
- Excessive concern with physical appearance.
- Somatic symptoms, and using these symptoms as a means of garnering attention.
- A need to be the center of attention.
- Low tolerance for frustration or delayed gratification.
- Rapidly shifting emotional states that may appear superficial or exaggerated to others.
- Tendency to believe that relationships are more intimate than they actually are.
- Making rash decisions.

Causes

The cause of this disorder is unknown, but childhood events such as deaths in the immediate family, illnesses within the immediate family which present constant anxiety, divorce of parents and genetics may be involved. Histrionic Personality Disorder is more often diagnosed in women than men; men with some quite similar symptoms are often diagnosed with antisocial personality disorder.

Little research has been conducted to determine the biological sources, if any, of this disorder. Psychoanalytic theories incriminate authoritarian or distant attitudes by one (mainly mother); or both of the parents of these patients, or love based on expectations from the child that can never be fully met.

Diagnosis

The person's appearance, behavior, and history, along with a psychological evaluation, are usually sufficient to establish the diagnosis. There is no test to confirm this diagnosis. Because the criteria are subjective, some people may be wrongly diagnosed as having the disorder while others with the disorder may not be diagnosed. Treatment is often prompted by depression associated with dissolved romantic relationships. Medication does little to affect this personality disorder, but may be helpful with symptoms such as depression. Psychotherapy may also be of benefit.

World Health Organization

The World Health Organization's ICD-10 lists histrionic personality disorder as *(F60.4) Histrionic personality disorder*.

> It is characterized by at least 3 of the following:
>
> 1. self-dramatization, theatricality, exaggerated expression of emotions;
> 2. suggestibility, easily influenced by others or by circumstances;
> 3. shallow and labile affectivity;
> 4. continual seeking for excitement and activities in which the patient is the center of attention;
> 5. inappropriate seductiveness in appearance or behavior;
> 6. over-concern with physical attractiveness.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Millon's subtypes

Theodore Millon identified six subtypes of histrionic. Any individual histrionic may exhibit none or one of the following:

- **Theatrical histrionic** - especially dramatic, romantic and attention seeking.
- **Infantile histrionic** - including borderline features.
- **Vivacious histrionic** - synthesizes the seductiveness of the histrionic with the energy level typical of hypomania.
- **Appeasing histrionic** - including dependent and compulsive features.
- **Tempestuous histrionic** - including negativistic (passive-aggressive) features.
- **Disingenuous histrionic** - antisocial features.

Mnemonic

A mnemonic that can be used to remember the criteria for histrionic personality disorder is ***PRAISE ME***:

- **P** - provocative (or seductive) behavior
- **R** - relationships, considered more intimate than they are
- **A** - attention, must be at center of
- **I** - influenced easily
- **S** - speech (style) - wants to impress, lacks detail
- **E** - emotional lability, shallowness

- **M** - make-up - physical appearance used to draw attention to self
- **E** - exaggerated emotions - theatrical

Differential diagnosis

- Clinical depression
- Anxiety disorders
- Panic disorder
- Somatoform disorders

A person suffering from HPD is highly reactive. If there is another major disorder present, such as delusional disorder, then emotional intensity will create anger, rage, abuse and distance in relationships.

It is important for the therapist and family members to monitor and record all situations that trigger the HPD so that the deep underlying overload of pain can be accessed and released for therapeutic change.

Treatment

Because of the lack of research support for work on personality disorders and long-term treatment with psychotherapy, the empirical findings on the treatment of these disorders remain based on the case report method and not on clinical trials. On the basis of case presentations, the treatment of choice is psychotherapy and/or cognitive-behavioral therapy, aimed at self-development through resolution of conflict and advancement of inhibited developmental lines. Group therapy can assist individuals with HPD to learn to decrease the display of excessively dramatic behaviors, but must be closely monitored because it may provide the person with an audience to play to (perform for), thus giving opportunity to perpetuate histrionic behavior.

- Family therapy
- Medications
- Alternative therapies
- Cognitive behavioral therapy

Epidemiology

Major character traits may be inherited. Other character traits due to a phenotypical combination of genetics and environment, including childhood experiences

History

Histrionic personality disorder shares a divergent history with conversion disorder and somatization disorder. Historically, they are linked to the ancient notion of hysteria, or "wandering womb."(Note, however, that according to the Online Etymology Dictionary, the word "histrionic" derives not from the Greek *hystera*, but from the Latin *histrionicus*, "pertaining to an actor.") Ancient Greeks thought that excessive emotionality in women was caused by a displaced uterus and sexual discontent.

Christian ascetics during the Middle Ages blamed women's mental problems on witchcraft, sexual hunger, moral weakness, and demonic possession. By the 19th century, medical explanations proposed a weakness of women's nervous system related to biological sex. Thus, "hysteria" reflected the stereotype for women as vulnerable, inferior, and emotionally unbalanced. The extent to which the definition of histrionic personality disorder currently reflects gender bias remains the subject of controversy.

"Hysteria" differentiated into conversion hysteria (later to become conversion disorder) and hysterical personality (later to become histrionic personality disorder) in the psychoanalytic literature as well as with the writings of Kraepelin, Schneider, and others. Sigmund Freud wrote primarily about conversion hysteria. Wilhelm Reich wrote about hysteria as a set of personality characteristics and differentiated conversion hysteria as a transient disorder from hysterical character. These early conceptualizations of both kinds of hysteria carried notions of women's deficiency due to penis envy and feelings of castration. Paul Chodoff has written about the ways in which these diagnoses paralleled the misogynistic sentiment of the times.

The concept of hysterical personality was well developed by the mid-20th century and strongly resembled the current definition of histrionic personality disorder. The first DSM featured a symptom-based category, "hysteria" (conversion) and a personality-based category, "emotionally unstable personality." DSM-II distinguished between hysterical neurosis (conversion reaction and dissociative reaction) and hysterical (histrionic) personality.

In DSM-III, the term hysterical personality changed to histrionic personality disorder to emphasize the histrionic (derived from the Latin word *histrio*, or actor) behavior pattern and to reduce the confusion caused by the historical links of hysteria to conversion symptoms. The landmark case of Ruth E. helped to fully define and emphasize the characteristics of the current DSM-IV diagnostic. DSM-III-R attempted to reduce the overlap between Histrionic Personality Disorder and borderline personality disorder by dropping three overlapping criteria and adding two criteria that emphasized histrionicity. DSM-IV dropped two more criteria that did not appear to contribute to the consistency of the diagnosis, according to research done by Bruce Pfohl.

Narcissistic personality disorder

Narcissistic personality disorder (**NPD**) is a personality disorder

The narcissist is described as being excessively preoccupied with issues of personal adequacy, power, prestige and vanity. Narcissistic personality disorder is closely linked to self-centeredness.

Classification

Theodore Millon identified five subtypes of narcissist. Any individual narcissist may exhibit none or one of the following:

- **Amorous narcissist** - including histrionic features. The Don Juan of our times - is erotic, exhibitionist.

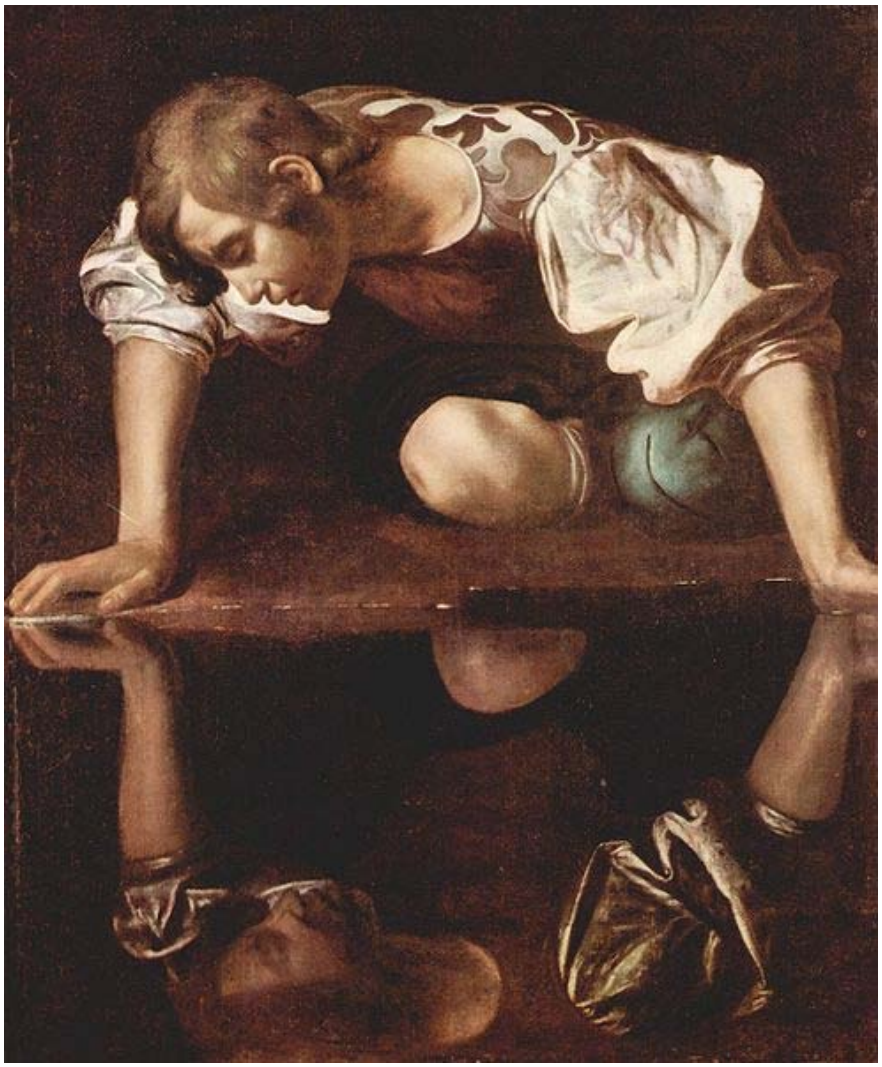
- **Compensatory narcissist** - including negativistic (passive-aggressive), avoidant features.

- **Elitist narcissist** - variant of pure pattern. Corresponds to Wilhelm Reich's "phallic narcissistic" personality type.

- **Fanatic type** - including paranoid features. A severely narcissistically wounded individual, usually with major paranoid tendencies who holds onto an illusion of omnipotence.

- **Unprincipled narcissist** - including antisocial features. A charlatan - is a fraudulent, exploitative, deceptive and unscrupulous individual.

Causes



Narcissus by Caravaggio. Narcissus gazing at his own reflection.

The cause of this disorder is unknown, according to Groopman and Cooper. However, they list the following factors identified by various researchers as possibilities.

- An oversensitive temperament at birth is the main symptomatic chronic form
- Being praised for perceived exceptional looks or talents by adults
- Excessive admiration that is never balanced with realistic feedback
- Excessive praise for good behaviors or excessive criticism for poor behaviors in childhood
- Overindulgence and overvaluation by parents
- Severe emotional abuse in childhood
- Unpredictable or unreliable caregiving from parents
- Valued by parents as a means to regulate their own self-esteem

Some narcissistic traits are common and a normal developmental phase. When these traits are compounded by a failure of the interpersonal environment and continue into adulthood, they may intensify to the point where NPD is diagnosed. Some psychotherapists believe that the etiology of the disorder is, in Freudian terms, the result of fixation to early childhood development. If a child does not receive sufficient recognition for their talents during about ages 3–7 they will never mature and continue to be in the narcissistic early development stage. It has been suggested that NPD may be exacerbated by the onset of aging and the physical, mental, and occupational restrictions it imposes as can most personality traits.

A 1994 study by Gabbard and Twemlow reports that histories of incest, especially mother-son incest are associated with NPD in some male patients.

Theories

Pathological narcissism occurs in a spectrum of severity. In its more extreme forms, it is narcissistic personality disorder (NPD). NPD is considered to result from a person's belief that they are flawed in a way that makes them fundamentally unacceptable to others. This belief is held below the person's conscious awareness; such a person would typically deny thinking such a thing, if questioned. In order to protect themselves against the intolerably painful rejection and isolation that (they imagine) would follow if others recognized their supposedly defective nature, such people make strong attempts to control others' view of them and behavior towards them.

Pathological narcissism can develop from an impairment in the quality of the person's relationship with their primary caregivers, usually their parents, in that the parents were unable to form a healthy, empathic attachment to them. This results in the child conceiving of themselves as unimportant and unconnected to others. The child typically comes to believe they have some personality defect that makes them unvalued and unwanted.

Narcissistic personality disorder is isolating, disenfranchising, painful, and formidable for those living with it and often those who are in a relationship with them. Distinctions need

to be made among those who have NPD because not each and every person with NPD is the same. Even with similar core issues, the way in which one's individual narcissism manifests itself in his or her relationships varies.

To the extent that people are pathologically narcissistic, they can be controlling, blaming, self-absorbed, intolerant of others' views, unaware of others' needs and of the effects of their behavior on others, and insistent that others see them as they wish to be seen.

People who are overly narcissistic commonly feel rejected, humiliated and threatened when criticised. To protect themselves from these dangers, they often react with disdain, rage, and/or defiance to any slight criticism, real or imagined. To avoid such situations, some narcissistic people withdraw socially and may feign modesty or humility. In the case of feeling the lack of admiration, adulation, attention and affirmation the person can also manifest wishes to be feared and to be notorious (narcissistic supply).

Though individuals with NPD are often ambitious and capable, the inability to tolerate setbacks, disagreements or criticism, along with lack of empathy, make it difficult for such individuals to work cooperatively with others or to maintain long-term professional achievements. With narcissistic personality disorder, the person's perceived fantastic grandiosity, often coupled with a hypomanic mood, is typically not commensurate with his or her real accomplishments.

The exploitativeness, sense of entitlement, lack of empathy, disregard for others, and constant need for attention inherent in NPD adversely affect interpersonal relationships.

Relationship to shame

It has been suggested that narcissistic personality disorder may be related to defenses against shame.

Glen Gabbard suggested NPD could be broken down into two subtypes. He saw the "oblivious" subtype as being grandiose, arrogant and thick-skinned and the "hypervigilant" subtype as easily hurt, oversensitive and ashamed.

He suggested that the oblivious subtype presents a large, powerful, grandiose self to be admired, envied and appreciated. This self is the antithesis of the weakened and internalized self that hides in a generic state of shame. This is how the internalized self fends off devaluation, while the hypervigilant subtype neutralizes devaluation by seeing others as unjust abusers. This hypervigilant type does not fend off devaluation; he is obsessed with it.

Jeffrey Young, who coined the term "Schema Therapy", a technique originally developed by Aaron T. Beck (1979), also links shame to NPD. He sees the so-called Defectiveness Schema as a core schema of NPD, next to the Emotional Deprivation and Entitlement Schemas. All Schemas may incorporate maladaptive coping styles, for example, the defectiveness schema may include:

- **Surrender:** Chooses critical partners and significant others; puts him- or herself down.
- **Avoidance:** Avoids sharing "shameful" thoughts and feelings with partners and significant others due to fear of rejection.
- **Overcompensation:** Behaves in a critical or superior way toward others; tries to come across as perfect.

Note that an individual with this schema might not employ all three maladaptive coping responses.

Diagnosis

The World Health Organization's ICD-10 lists narcissistic personality disorder under *(F60.8) Other specific personality disorders*.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Diagnostic criteria (DSM-IV):

The essential feature of Narcissistic Personality Disorder is a pervasive pattern of grandiosity (either in fantasy or actual behavior), need for admiration, and lack of empathy that begins by early adulthood and is present in a variety of situations and environments.

In order for a person to be diagnosed with narcissistic personality disorder (NPD) they must meet five or more of the following symptoms:

- Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
- Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
- Believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).
- Rarely acknowledges mistakes and/or imperfections
- Requires excessive admiration
- Has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
- Is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
- Lacks empathy: is unwilling or unable to recognize or identify with the feelings and needs of others.
- Is often envious of others or believes that others are envious of him or her
- Shows arrogant, haughty behaviors or attitude.

Differential diagnosis

The following conditions commonly coexist (comorbid) with narcissistic personality disorder:

- Anorexia nervosa
- Antisocial personality disorder
- Borderline personality disorder
- Dysthymia
- Histrionic personality disorder
- Hypomania
- Major depressive disorder
- Paranoid personality disorder
- Substance-related disorders (especially cocaine)

Proposed removal from *DSM-5*

The *Personality and Personality Work Group* has proposed eliminating NPD as a distinct disorder in DSM-5 as part of a major revamping of the diagnostic criteria for personal disorders, replacing a categorical with a dimensional approach based on the severity of dysfunctional personality trait domains, raising objections from some clinicians who characterize the new diagnostic system as an "unwieldy conglomeration of disparate models that cannot happily coexist" and may have limited usefulness in clinical practice.

Treatment

Most psychiatrists and psychologists regard NPD as a relatively stable condition when experienced as a primary disorder. Stephen M. Johnson outlines a prominent approach to healing NPD, while discussing a continuum of severity and the kinds of therapy most effective in different cases.

Schema Therapy, a form of therapy developed by Jeffrey Young that integrates several therapeutic approaches (psychodynamic, cognitive, behavioral etc.), also offers an approach for the treatment of NPD. It is unusual for people to seek therapy for NPD. Subconscious fears of exposure or inadequacy often cause defensive disdain of therapeutic processes. Pharmacotherapy is rarely effective.

Epidemiology

Lifetime prevalence is estimated at 1% in the general population and 2% to 16% in clinical populations.

History

The history of narcissism predates the discovery of narcissistic personality disorder. The term "narcissistic personality structure" was introduced by Kernberg in 1967 and "narcissistic personality disorder" first proposed by Heinz Kohut in 1968.

Cultural depictions

In the film *To Die For*, Nicole Kidman's character wants to appear on television at all costs, even if this involves murdering her husband. A psychiatric assessment of her character noted that she "was seen as a prototypical narcissistic person by the raters: on average, she satisfied 8 of 9 criteria for narcissistic personality disorder... had she been evaluated for personality disorders, she would receive a diagnosis of narcissistic personality disorder."

Chapter 8

Paranoid & Schizoid Personality Disorders

Paranoid Personality Disorder

Paranoid personality disorder is a psychiatric diagnosis characterized by paranoia and a pervasive, long-standing suspiciousness and generalized mistrust of others.

Those with the condition are hypersensitive, are easily slighted, and habitually relate to the world by vigilant scanning of the environment for clues or suggestions to validate their prejudicial ideas or biases. Paranoid individuals are eager observers. They think they are in danger and look for signs and threats of that danger, disregarding any facts. (Waldinger, 1997). They tend to be guarded and suspicious and have quite constricted emotional lives. Their incapacity for meaningful emotional involvement and the general pattern of isolated withdrawal often lend a quality of schizoid isolation to their life experience.

Causes

A genetic contribution to paranoid traits and a possible genetic link between this personality disorder and schizophrenia exist. Psychosocial theories implicate projection of negative internal feelings and parental modeling.

Diagnosis

WHO

The World Health Organization's ICD-10 lists paranoid personality disorder as *(F60.0) Paranoid personality disorder*.

It is characterized by at least 3 of the following:

1. excessive sensitivity to setbacks and rebuffs;
2. tendency to bear grudges persistently, i.e. refusal to forgive insults and injuries or slights;

3. suspiciousness and a pervasive tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous;
4. a combative and tenacious sense of personal rights out of keeping with the actual situation;
5. recurrent suspicions, without justification, regarding sexual fidelity of spouse or sexual partner;
6. tendency to experience excessive self-importance, manifest in a persistent self-referential attitude;
7. preoccupation with unsubstantiated "conspiratorial" explanations of events both immediate to the patient and in the world at large.

Includes:

- expansive paranoid, fanatic, querulant and sensitive paranoid personality (disorder)

Excludes:

- delusional disorder
- schizophrenia

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Cultural sensitivities

World Health Organization, in the ICD-10, points out for different cultures it may be necessary to develop specific sets of criteria with regard to social norms, rules and obligations.

Millon's subtypes

Theodore Millon identified five subtypes of paranoid. Any individual paranoid may exhibit none or one of the following:

- **fanatic paranoid** - including narcissistic features
- **malignant paranoid** - including sadistic features
- **objurate paranoid** - including compulsive features
- **querulous paranoid** - including negativistic (passive-aggressive) features
- **insular paranoid** - including avoidant features

Differential diagnosis

The following conditions commonly coexist (comorbid) with paranoid personality disorder:

- very brief psychotic episodes (lasting minutes to hours)
- delusional disorder
- schizophrenia
- major depressive disorder
- agoraphobia
- obsessive-compulsive disorder
- alcohol and substance-related disorders
- schizoid personality disorder
- schizotypal personality disorder
- narcissistic personality disorder
- avoidant personality disorder
- borderline personality disorder

Treatment

Because of reduced levels of trust, there can be challenges in treating paranoid personality disorder. However, psychotherapy, antidepressants, antipsychotics and anti-anxiety medications can play a role when an individual is receptive to intervention.

Epidemiology

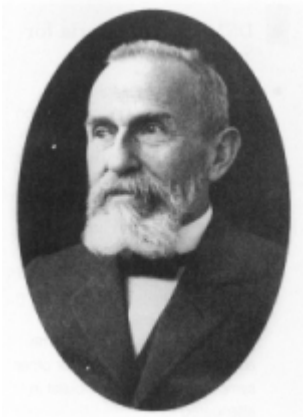
Paranoid personality disorder occurs in about 0.5%-2.5% of the general population. It is seen in 2%-10% of psychiatric outpatients. It occurs more commonly in males.

A large long-term Norwegian twin study found paranoid personality disorder to be modestly heritable and to share a portion of its genetic and environmental risk factors with schizoid and schizotypal personality disorder.

Schizoid Personality Disorder

Schizoid personality disorder (SPD) is a personality disorder characterized by a lack of interest in social relationships, a tendency towards a solitary lifestyle, secretiveness, and emotional coldness. There is increased prevalence of the disorder in families with schizophrenia. SPD is not the same as schizophrenia, although they share some similar characteristics such as detachment or blunted affect.

History



Dr. Eugen Bleuler 1911

The term schizoid was coined in 1908 by Eugen Bleuler to designate a natural human tendency to direct attention toward one's inner life and away from the external world, a concept akin to introversion in that it was not viewed in terms of psychopathology. Bleuler also labeled the exaggeration of this tendency the “schizoid personality”.

Since then, studies on the schizoid personality have developed along two separate paths; firstly, the *descriptive psychiatry tradition* which focuses on overtly observable, behavioral, and describable symptoms which finds its clearest exposition in the DSM-IV revised, and secondly, the *dynamic psychiatry tradition* which includes the exploration of covert or unconscious motivation and character structure as elaborated by classic psychoanalysis and object-relations theory.

The descriptive tradition began in Ernst Kretschmer’s (1925) portrayal of observable schizoid behaviours which he organized into three groups of characteristics:

1. unsociability, quietness, reservedness, seriousness, and eccentricity
2. timidity, shyness with feelings, sensitivity, nervousness, excitability, and fondness of nature and books
3. pliability, kindliness, honesty, indifference, silence, and cold emotional attitudes.

In these characteristics one can see the precursors of the DSM-IV division of schizoid character into three distinct personality disorders, though Kretschmer himself did not conceive of separating these behaviours to the point of radical isolation, considering them instead as simultaneously present as varying potentials in schizoid individuals. For Kretschmer the majority of schizoids are not *either* oversensitive *or* cold, but they are oversensitive and cold “at the same time” in quite different relative proportions, with a tendency to move along these dimensions from one behavior to the other.

The second path, that of dynamic psychiatry, began with observations by Eugen Bleuler (1924) who observed that the schizoid person and schizoid pathology were not things to be set apart. In 1940 W. R. D. Fairbairn presented his seminal work on the schizoid

personality in which most of what is known today about schizoid phenomena can be found. Here Fairbairn delineated four central schizoid themes; firstly, the need to regulate interpersonal distance as a central focus of concern; secondly, the ability to mobilize self-preservative defenses and self-reliance; thirdly a pervasive tension between the anxiety-laden need for attachment, and the defensive need for distance, which manifests in observable behavior as *indifference*; and fourthly an overvaluation of the inner world at the expense of the outer world. Following Fairbairn, the dynamic psychiatry tradition has continued to produce rich explorations on the schizoid character, most notably from writers Nannarello (1953); Laing (1960); Winnicott (1965); Guntrip (1969); Khan (1974); Akhtar (1987); Seinfeld (1991); Manfield (1992); and Klein (1995).

Signs and symptoms

People with SPD are seen as aloof, cold and indifferent, which causes some social problems. Most individuals diagnosed with SPD have difficulty establishing personal relationships or expressing their feelings in a meaningful way, and may remain passive in the face of unfavourable situations. Their communication with other people at times may be indifferent and concise. Because of their lack of communication with other people, those who are diagnosed with SPD are not able to have a reflection of themselves and how well they get along with others. The reflection is important so they can be more aware of themselves and their own actions in social surroundings. R. D. Laing suggests that without being enriched by injections of interpersonal reality there occurs an impoverishment in which one's self-image becomes more and more empty and volatilized, leading the individual himself to feel unreal.

According to Gunderson, "people with SPD “feel lost” without the people they are normally around because they need a sense of security and stability. However, when the patient’s personal space is violated, they feel suffocated and feel the need to free themselves and be independent. Those people who have SPD are happiest when they are in a relationship in which the partner places few emotional or intimate demands on them, as it is not *people* as such that they want to avoid, but both negative and positive emotions, emotional intimacy, and self disclosure.

This means that it is *possible* for schizoid individuals to form relationships with others based on intellectual, physical, familial, occupational, or recreational activities as long as these modes of relating do not require or force the need for emotional intimacy, which the individual will reject.

Donald Winnicott sums up the schizoid need to modulate emotional interaction with others with his comment that schizoid individuals "prefer to make relationships on their own terms and not in terms of the impulses of other people," and that if they cannot do so, they prefer isolation.

Schizoid sexuality

People with SPD are sometimes sexually apathetic, though they do not normally suffer from anorgasmia. Many schizoids have a normal sex drive but some prefer to masturbate rather than deal with the social aspects of finding a sexual partner. Therefore, their need for sex may appear less than for those who do not have SPD, as the individuals with SPD prefer remaining alone and detached. When having sex, individuals with SPD often feel that their personal space is being violated, and they commonly feel that masturbation or sexual abstinence is preferable to the emotional closeness they must tolerate when having sex. Significantly broadening this picture are notable exceptions of SPD individuals who engage in occasional or even frequent sexual activities with others.

Harry Guntrip describes the "secret sexual affair" entered into by some married schizoid individuals as an attempt to reduce the quantity of emotional intimacy focused within a single relationship, a sentiment echoed by Karen Horney's *resigned personality* who may exclude sex as being "too intimate for a permanent relationship, and instead satisfy his sexual needs with a stranger. Conversely he may more or less restrict a relationship to merely sexual contacts and not share other experiences with the partner." More recently, Jeffrey Seinfeld, professor of social work at New York University, has published a volume on SPD in which he details examples of "schizoid hunger" which may manifest as sexual promiscuity. Seinfeld provides an example of a schizoid woman who would covertly attend various bars to meet men for the purposes of gaining impersonal sexual gratification, an act, says Seinfeld, which alleviated her feelings of hunger and emptiness.

Salman Akhtar describes this dynamic interplay of overt versus covert sexuality and motivations of some SPD individuals with greater accuracy. Rather than following the narrow proposition that schizoid individuals are either sexual or asexual, Akhtar suggests that these forces may *both* be present in an individual despite their rather contradictory aims. For Akhtar, therefore, a clinically accurate picture of schizoid sexuality must include both the *overt* signs: "asexual, sometimes celibate; free of romantic interests; averse to sexual gossip and innuendo," along with possible *covert* manifestations of "secret voyeuristic and pornographic interests; vulnerable to erotomania; tendency towards compulsive masturbation and perversions," although none of these necessarily apply to all people with SPD.

The 'secret schizoid'

According to Ralph Klein there are many fundamentally schizoid individuals who present with an engaging, interactive personality style which contradicts the timidity, reluctance, or avoidance of the external world and interpersonal relationships as emphasized by the DSM-IV and ICD-10 definitions of the schizoid personality. Klein classifies these individuals as *secret schizoids* who present themselves as socially available, interested, engaged, and involved in interacting in the eyes of the observer, while at the same time, he or she is apart, emotionally withdrawn, and sequestered in a safe place in his or her own internal world. So, while withdrawnness or detachment from the outer world is a characteristic feature of schizoid pathology, it is sometimes overt and sometimes covert.

While it is overt it matches the usual description of the schizoid personality offered in the DSM-IV. According to Klein, though, it is "just as often" a covert, hidden internal state of the patient in which what meets the objective eye may not be what is present in the subjective, internal world of the patient. Klein therefore cautions that one should not miss identifying the schizoid patient because one cannot see the patient's withdrawnness through the patient's defensive, compensatory, engaging interaction with external reality. Klein suggests that one need only ask the patient what his or her subjective experience is in order to detect the presence of the schizoid refusal of emotional intimacy.

Descriptions of the schizoid personality as *hidden* behind an outward appearance of emotional engagement have long been recognized, beginning with Fairbairn's (1940) description of 'schizoid exhibitionism' in which he remarked that the schizoid individual is able to express quite a lot of feeling and to make what appear to be impressive social contacts but in reality giving nothing and losing nothing, because since he is only *playing a part* his own personality is not involved. According to Fairbairn, the person "...disowns the part which he is playing and thus the schizoid individual seeks to preserve his own personality intact and immune from compromise." Further references to the secret schizoid come from Masud Khan, Jeffrey Seinfeld, and Philip Manfield, who gives a palpable description of an SPD individual who actually "enjoys" regular public speaking engagements, but experiences great difficulty in the breaks when audience members would attempt to engage him emotionally. These references expose the problems involved in relying singularly on outer observable behavior for assessing the presence of personality disorders in certain individuals.

Avoidant attachment style

The question of whether SPD qualifies as a full personality disorder or simply as an avoidant attachment style is a contentious one. If what has been known as schizoid personality disorder is no more than an attachment style requiring more distant emotional proximity, then many of the more problematic reactions these individuals show in interpersonal situations may be partly accounted for by the social judgments commonly imposed on those with this style. To date several sources have confirmed the synonymity of SPD and avoidant attachment style which leaves open the question of how researchers might approach this subject best in future diagnostic manuals, and in therapeutic practice.

Causes

There is some evidence to suggest that there is an increased prevalence of schizoid personality disorder in relatives of people with schizophrenia or schizotypal personality disorder. Unloving or neglectful parenting is hypothesized to play a role.

Diagnosis

DSM

The *Diagnostic and Statistical Manual of Mental Disorders* fourth edition, a widely used manual for diagnosing mental disorders, defines schizoid personality disorder (in Axis II Cluster A) as:

> A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood (age eighteen or older) and present in a variety of contexts, as indicated by four (or more) of the following:
>
> 1. neither desires nor enjoys close relationships, including being part of a family
> 2. almost always chooses solitary activities
> 3. has little, if any, interest in having sexual experiences with another person
> 4. takes pleasure in few, if any, activities
> 5. lacks close friends or confidants other than first-degree relatives
> 6. appears indifferent to the praise or criticism of others
> 7. shows emotional coldness, detachment, or flattened affect
>
> B. Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, another psychotic disorder, or a pervasive developmental disorder and is not due to the direct physiological effects of a general medical condition.

It is a requirement of DSM-IV that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

In the draft of the DSM-V it is proposed that schizoid personality disorder should be represented and diagnosed by a combination of core impairment in personality functioning and specific pathological personality traits, rather than as a specific type.

WHO

The World Health Organization's ICD-10 lists schizoid personality disorder as *(F60.1) Schizoid personality disorder*.

> It is characterized by at least four of the following criteria:
>
> 1. Emotional coldness, detachment or reduced affection.
> 2. Limited capacity to express either positive or negative emotions towards others.
> 3. Consistent preference for solitary activities.

4. Very few, if any, close friends or relationships, and a lack of desire for such.
5. Indifference to either praise or criticism.
6. Taking pleasure in few, if any, activities.
7. Indifference to social norms and conventions.
8. Preoccupation with fantasy and introspection.
9. Lack of desire for sexual experiences with another person.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Millon's subtypes

Theodore Millon identified four subtypes of schizoid. Any individual schizoid may exhibit none or one of the following:

- **languid schizoid**—including depressive features
- **remote schizoid**—including avoidant, schizotypal features
- **depersonalised schizoid**—including schizotypal features
- **affectless schizoid**—including compulsive features

Dynamic diagnostic criteria

Ralph Klein, 1995 brought new light into the commonly held beliefs about the schizoid which focus mainly on the schizoid's apparent disinterest in relationship. Clarifying the causes and conditions underlying the characteristics listed above, Klein describes a 'split' in the object relations of the schizoid. This split involves: on the one hand, the "slave/master" relationship, a relationship characterised by exploitation, appropriation, and dehumanisation, and on the other, the "self in exile". It is in aversion, or recoil from the exploitive relationship that the self goes into exile. It is this, the self in exile, that is the more commonly recognised aspect of the schizoid, as described in the DSM—the distanced or unresponsive person. As Klein puts it: the..."seeming detachment from feelings should never be accepted as the real state of affairs" p. 135. Of particular significance is the correlation between the Narcissistic disorder and the schizoid. For example the "over entitlement" of the narcissist in a family can result in the "under-entitlement" of the schizoid. It is also the disavowed shame of the narcissist that is often absorbed by, or projected into the schizoid, thus giving rise to the experience of psychic invasion, and the vulnerability to intrusiveness. Paradoxically, a schizoid may also be attracted to exploitive relationships, where they long to experience significance and recognition by serving a need of the other. Yet this same person may be highly aware of any forms of corruption or exploitation outside of this relationship. In this approach diagnosis is based on the dynamic of this split, and all its consequences, as opposed to diagnosis on the basis of a list of external behaviours.

Guntrip criteria

Ralph Klein, Clinical Director of the Masterson Institute delineates the following nine characteristics of the schizoid personality as described by Harry Guntrip: introversion, withdrawnness, narcissism, self-sufficiency, a sense of superiority, loss of affect, loneliness, depersonalization, and regression.

Introversion

According to Guntrip, "By the very meaning of the term the schizoid is described as cut off from the world of outer reality in an emotional sense. All this libidinal desire and striving is directed inward toward internal objects and he lives an intense inner life often revealed in an astonishing wealth and richness of fantasy and imaginative life whenever that becomes accessible to observation. Though mostly his varied fantasy life is carried on in secret, hidden away." The schizoid person is cut off from outer reality to such a degree that he or she experiences outer reality as dangerous. It is a natural human response to turn away from sources of danger and toward sources of safety. The schizoid individual, therefore, is primarily concerned with avoiding danger and ensuring safety.

Withdrawnness

According to Guntrip, withdrawnness means detachment from the outer world, the other side of introversion. While there are many schizoid individuals who will present with obvious withdrawnness (a clear and obvious timidity, reluctance, or avoidance of the external world and interpersonal relationships), this defines only a portion of such individuals. Many fundamentally schizoid people present with an engaging, interactive personality style. Such a person can appear to be available, interested, engaged, and involved in interacting with others; however, in reality, he or she is emotionally withdrawn and sequestered in a safe place in an internal world. While withdrawnness or detachment from the outer world is a characteristic feature of schizoid pathology, it is sometimes overt and sometimes covert. When it is overt it matches the usual description of the schizoid personality. Just as often, it is a covert, hidden internal state of the patient.

Several points are important to review at this time. First, what meets the objective eye may not be what is present in the subjective, internal world of the patient. Second, one should not mistake introversion for indifference. Third, one should not miss identifying the schizoid patient because one cannot see the forest of the patient’s withdrawnness through the trees of the patient’s defensive, compensatory, engaging interaction with external reality.

Narcissism

Guntrip: "Narcissism is a characteristic that arises out of the predominately interior life the schizoid lives. His love objects are all inside him and moreover he is greatly identified with them so that his libidinal attachments appear to be in himself. The question, however, is whether the intense inner life of the schizoid is due to a desire for

hungry incorporation of external objects or due to withdrawal from the outer to a presumed safer inner world." The need for attachment as a primary motivational force is as strong in the schizoid person as in any other human being. However, because the schizoid's love objects are internal, he or she finds safety without connecting and attaching to objects in the real world.

Self-sufficiency

Guntrip writes, "This introverted narcissistic self-sufficiency, which does without real external relationships while all emotional relations are carried on in the internal world, is a safeguard against anxiety breaking out in dealing with actual people." The more that schizoids can rely on themselves, the less they have to rely on other people and expose themselves to the potential dangers and anxieties associated with that reliance or, even worse, dependence. The vast majority of schizoid individuals show an enormous capacity for self-sufficiency, for the ability to operate alone, independently and autonomously, in managing their worlds.

Sense of superiority

Guntrip states, "a sense of superiority naturally goes with self-sufficiency. One has no need of other people, they can be dispensed with... There often goes with it a feeling of being different from other people." The sense of superiority of the schizoid has nothing to do with the grandiose self of the narcissistic disorder. It does not find expression in the schizoid through the need to devalue or annihilate others who are perceived as offending, criticizing, shaming, or humiliating. This type of superiority was described by a young schizoid man:

> "If I am superior to others, if I am above others, then I do not need others. When I say that I am above others, it does not mean that I feel better than them, it means that I am at a distance from them, a safe distance."

It is a feeling of being horizontally, rather than vertically distant.

Loss of affect

According to Guntrip, "Loss of affect in external situations is an inevitable part of the total picture." Because of the tremendous investment made in the self—the need to be self-contained, self-sufficient, and self-reliant—there is inevitable interference in the desire and ability to feel another person’s experience, to be empathic and sensitive. Often these things seem secondary, a luxury that has to await securing one's own defensive, safe position. The subjective experience is one of loss of affect. For some patients, the loss of affect is present to such a degree that the insensitivity becomes manifest in the extreme as cynicism, callousness, or even cruelty. The patient appears to have no awareness of how his or her comments or actions affect and hurt other people. More frequently, the loss of affect is manifest within the patient as genuine confusion, a sense of something missing in his or her emotional life.

Loneliness

According to Guntrip, "Loneliness is an inescapable result of schizoid introversion and abolition of external relationships. It reveals itself in the intense longing for friendship and love which repeatedly break through. Loneliness in the midst of a crowd is the experience of the schizoid cut off from affective rapport." This is a central experience of the schizoid that is often lost to the observer. Contrary to the familiar caricature of the schizoid as uncaring and cold, the vast majority of schizoid persons who become patients express at some point in their treatment their longing for friendship and love. This is not the schizoid patient as described in the DSMs. Such longing, however, may not break through except in the schizoid's fantasy life, to which the therapist may not be allowed access for quite a long period in treatment. If longing is immediately present, however, it is more likely avoidant personality disorder.

There is a very narrow range of schizoid individuals—the classic DSM-defined schizoid—for whom the hope of relationship is so minimal as to be almost extinct; therefore, the longing for closeness and attachment is almost unidentifiable to the schizoid themselves. These individuals will not become patients. The schizoid individual who becomes a patient does so often because of the twin motivations of loneliness and longing. This schizoid patient still believes that some kind of connection and attachment is possible and is well suited to psychotherapy. Yet the irony of the DSMs is that they may lead the psychotherapist to approach the schizoid patient with a sense of therapeutic pessimism, if not nihilism, misreading the patient by believing that the patient's wariness is indifference and that caution is coldness.

Depersonalization

Guntrip describes depersonalization as a loss of a sense of identity and individuality. Depersonalization is a dissociative defense. Depersonalization is often described by the schizoid patient as a tuning out or a turning off, or as the experience of a separation between the observing and the participating ego. It is experienced by those with schizoid personality disorder when anxieties seem overwhelming. It is a more extreme form of loss of affect than that described earlier. Whereas the loss of affect is a more chronic state in schizoid personality disorder, depersonalization is an acute defense against more immediate experiences of overwhelming anxiety or danger.

Regression

Guntrip defined regression as "Representing the fact that the schizoid person at bottom feels overwhelmed by their external world and is in flight from it both inwards and as it were backwards to the safety of the metaphorical womb." Such a process of regression encompasses two different mechanisms: inward and backwards. Regression inward speaks to the magnitude of the reliance on primitive forms of fantasy and self-containment, often of an autoerotic or even objectless nature. Regression backwards to the safety of the womb is a unique schizoid phenomenon and represents the most intense form of schizoid defensive withdrawal in an effort to find safety and to avoid destruction

by external reality. The fantasy of regression to the womb is the fantasy of regression to a place of ultimate safety.

The description of the nine characteristics first articulated by Guntrip should bring more clearly into focus some of the major differences that exist between the traditional descriptive (track 1, DSM) portrait of the schizoid disorder and the traditional psychoanalytically informed (track 2, object relations) view. All nine characteristics are internally consistent. Most, if not all, should be present in order to diagnose a schizoid disorder.

Akhtar's phenomenological profile

In an article in the American Journal of Psychotherapy, Salman Akhtar, M.D., provides a comprehensive phenomenological profile of Schizoid Personality Disorder in which classic and contemporary descriptive views are synthesized with psychoanalytic observations. This profile is summarized in a table (reproduced below) listing clinical features, involving six areas of psychosocial functioning and designated by "overt" and "covert" manifestations. Dr. Akhtar states that "these designations do not imply conscious or unconscious but denote seemingly contradictory aspects that are phenomenologically more or less easily discernible," and that "this manner of organizing symptomology emphasizes the centrality of splitting and identity confusion in schizoid personality."

Clinical Features of Schizoid Personality Disorder

Area	Features	
	Overt	**Covert**
Self-Concept	• compliant • stoic • noncompetitive • self-sufficient • lacking assertiveness • feeling inferior and an outsider in life	• cynical • inauthentic • depersonalized • alternately feeling empty, robot-like, and full of omnipotent, vengeful fantasies • hidden grandiosity
Interpersonal Relations	• withdrawn • aloof • have few close friends • impervious to others' emotions • afraid of intimacy	• exquisitely sensitive • deeply curious about others • hungry for love • envious of others' spontaneity • intensely needy of involvement with others • capable of excitement with carefully selected intimates
Social Adaptation	• prefer solitary occupational and recreational activities	• lack clarity of goals • weak ethnic affiliation • usually capable of steady work

	• marginal or eclectically sociable in groups • vulnerable to esoteric movements owing to a strong need to belong • tend to be lazy and indolent	• sometimes quite creative and may make unique and original contributions • capable of passionate endurance in certain spheres of interest
Love and Sexuality	• asexual, sometimes celibate • free of romantic interests • averse to sexual gossip and innuendo	• secret voyeuristic interests • vulnerable to erotomania • tendency towards compulsive perversions
Ethics, Standards, and Ideals	• idiosyncratic moral and political beliefs • tendency towards spiritual, mystical and para-psychological interests	• moral unevenness • occasionally strikingly amoral and vulnerable to odd crimes, at other times altruistically self sacrificing
Cognitive Style	• absent-minded • engrossed in fantasy • vague and stilted speech • alternations between eloquence and inarticulateness	• autistic thinking • fluctuations between sharp contact with external reality and hyperreflectiveness about the self • autocentric use of language.

One patient with SPD commented that he could not fully enjoy the life he has because he feels that he is living in a shell. Furthermore, he noted that his inability distressed his wife. According to Beck and Freeman, "Patients with schizoid personality disorders consider themselves to be observers, rather than participants, in the world around them."

Differential diagnosis

Although SPD shares several aspects with other psychological conditions, there are some important differentiating features:

- **Depression**: While people who have SPD can also suffer from clinical depression, this is certainly not always the case. Unlike depressed people, persons with SPD generally do not consider themselves inferior to others, although they will probably recognise that they are different.
- **Avoidant personality disorder**: Unlike avoidant personality disorder, those affected with SPD do not avoid social interactions due to anxiety or feelings of

incompetence, but because they are genuinely indifferent to social relationships; however, in a 1989 study, "schizoid and avoidant personalities were found to display equivalent levels of anxiety, depression, and psychotic tendencies as compared to psychiatric control patients." One SPD patient remarked that previous knowledge, expectations, or assumptions may result in such elevated levels. Patients can mentally simulate damaging scenarios in order to flatten negative effects, should one occur.

- **Asperger syndrome**: Asperger syndrome is an autism-spectrum disorder. Unlike AS, SPD does not involve an impairment in nonverbal communication (e.g., lack of eye-contact or unusual prosody) or a pattern of restricted interests or repetitive behaviors (e.g., a strict adherence to routines or rituals, or an unusually intense interest in a single topic). Compared to AS, SPD is characterized by prominent conduct disorder, better adult adjustment, and a slightly increased risk of schizophrenia.

Under stress, some people with schizoid personality features may occasionally experience instances of brief reactive psychosis. Schizoid individuals are also prone to developing pathological reliance on fantasizing activity as concomitant with their withdrawal from the world. Viewed in this fashion, fantasy constitutes a core component of the self-in-exile, though on closer examination fantasizing in schizoid individuals reveals as far more complicated than a means of facilitating withdrawal. Fantasy is also relationship with the world and with others by proxy. It is a *substitute* relationship, but a relationship nonetheless, characterized by idealized, defensive, and compensatory mechanisms. It is an expression of the self-in-exile because it is self-contained and free from the dangers and anxieties associated with emotional connection to real persons and situations. According to Klein it is "an expression of the self struggling to connect to objects, albeit internal objects. Fantasy permits schizoid patients to feel connected, and yet still free from the imprisonment in relationships. In short, in fantasy one can be attached (to internal objects) and still be free." This aspect of schizoid pathology has been generously elaborated in works by Laing (1960); Winnicott; (1971); and Klein (1995).

According to Seinfeld, schizoid individuals frequently act out with substance and alcohol abuse and other addictions which serve as substitutes for human relationships. The substitute of a nonhuman for a human object serves as a schizoid defense. Providing examples of how the schizoid individual creates a personal relation with the drug, Seinfeld tells how "one addict called heroin his 'soothing white pet.' Another referred to crack as his 'bad mama.' I knew a female addict who termed crack her 'boyfriend.' Not all addicts name their drug, but there often is the trace of a personal feeling about the relationship." The object relations view emphasizes that the drug use and alcoholism reinforce the fantasy of union with an internal object, while enabling the addict to be indifferent to the external object world. Addiction is therefore viewed as a schizoid and symbiotic defense.

S. C. Ekleberry suggests that marijuana "may be the single most egosyntonic drug for individuals with SPD because it allows a detached state of fantasy and distance from others, provides a richer internal experience than these individuals can normally create,

and reduces an internal sense of emptiness and failure to participate in life. Also, alcohol, readily available and safe to obtain, is another obvious drug of choice for these individuals. Some will use both marijuana and alcohol and see little point in giving up either. They are likely to use in isolation for the effect on internal processes."

According to Ralph Klein, suicide may also be a running theme for schizoid individuals, though they are not likely to actually attempt one. They might be down and depressed when all possible connections have been cut off, but as long as there is some relationship or even hope for one the risk will be low. The idea of suicide is a driving force against the person's schizoid defenses. As Klein says: "For some schizoid patients, its presence is like a faint, barely discernible background noise, and rarely reaches a level that breaks into consciousness. For others, it is an ominous presence, an emotional sword of Damocles. In any case, it is an underlying dread that they all experience."

Treatment

Since schizoid traits are very similar to negative schizophrenic symptoms, atypical antipsychotics may have efficacy in alleviating them. Those who do seek treatment have the option of medication or therapy. For medication, the schizoid personality disorder seems to have similar negative symptoms of schizophrenia such as anhedonia, blunted affect, and low energy. The medication that is most recently used to treat the negative symptoms is risperidone. Before this, there was no psychotropic medication that made an impact on the negative symptoms. According to Joseph, low doses of risperidone or olanzapine also work for the social deficits and blunted affect; Wellbutrin (bupropion) for anhedonia. Furthermore, the use of SSRIs, TCAs, MAOIs, low dose benzodiazepines, and beta-blockers may help social anxiety in the SPD. However, social anxiety may not be a main concern for the people who have SPD. Supportive psychotherapy is also used in an inpatient or outpatient setting by a trained personnel that focuses on areas such as: coping skills, improving social skills and social interactions, communication, and self esteem issues. Mark Zimmerman suggested the following questions for evaluation of patients with SPD:

- Do you have close relationships with friends or family? If yes, with whom? If no, does this bother you?
- Do you wish you had close relationships with others?
- Some people prefer to spend time alone, others prefer to be with people. How would you describe yourself?
- Do you frequently choose to do things by yourself?
- Would it bother you to go a long time without a sexual relationship? Does your sex life seem important or could you get along as well without it?
- What kind of activities do you enjoy?
- Do you confide in anyone who is not in your immediate family?
- How do you react when someone criticizes you?
- How do you react when someone compliments you?

In the assessment process, note if these individuals make eye contact, smile or express affect nonverbally.

According to Beck and Freeman, people with SPD have "defective perceptual scanning which results in missing environmental cues. The defective perceptual scanning is characterized by a tendency to miss differences and to diffuse the varied elements of experience." The perception of varied events only increases their fear for intimacy and limits them in their interpersonal relationships. Also because of their aloofness, this barrier does not allow them to use their social skills and behavior to help them pursue relationships. Therefore, socialization groups may help these people with SPD. As said by Will, educational strategies also work with people who have SPD by having them identify their positive and negative emotions. They use the identification to learn about their own emotions; the emotions they draw out from others; and feeling the common emotions with other people whom they relate with. This can help people with SPD create empathy with the outside world.

Shorter-term treatment

According to Ralph Klein, Clinical Director of the Masterson Institute, the concept of *closer compromise* means that the schizoid patient may be encouraged to experience intermediate positions between the extremes of emotional closeness, and permanent exile.

As mentioned by Laing without being enriched by injections of interpersonal reality there occurs an impoverishment in which the schizoid individual's self-image becomes more and more empty and volatilized, leading the individual himself to feel unreal. Therefore to create a more adaptive and self-enriching interaction with others in which one "feels real" the patient is encouraged to take risks by creating less interpersonal distance through greater connection, communication, and the sharing of ideas, feelings, and actions. Closer compromise means that while the schizoid patient's vulnerability to the anxieties is not overcome, it is modified and managed more adaptively. Here the therapist repeatedly conveys to the patient that anxiety is inevitable, yet manageable, without any illusion that the schizoid vulnerability to such anxiety can be permanently dispensed with. The limiting factor is the point at which the dangers of intimacy become overwhelming and the patient must again retreat.

Klein suggests that closer compromise must be directly stated as the patient's responsibility; "It seems to me that in order to accomplish your goals, it is necessary to put yourself at risk," or "It seems to me that your willingness to come here (to treatment) and struggle with your anxieties must be mirrored by your willingness to challenge yourself outside of here," or "It seems to me that your efforts to connect with me are only half the battle; the other half must take place in the more dangerous arena of your life outside this office," i.e. therapist is always conveying that these are the therapists impressions. He or she is not reading the patient's mind or imposing an agenda, but is simply stating a position. Also, the therapist's position is an extension of the patient's therapeutic wish ("your goals," "your willingness," and "your efforts"). Finally, the

therapist specifically directs attention to the need for employing these actions outside the therapeutic setting.

Longer-term therapy

Klein suggests that *working through* is the second longer-term tier of psychotherapeutic work with schizoid patients. Its goals are to change fundamentally the old ways of feeling and thinking, and to rid oneself of the vulnerability to experiencing those emotions associated with old feelings and thoughts. A new therapeutic operation of 'remembering with feeling' is called for.

One must remember with feeling the coming into being of one's false self through childhood. This means that one must remember the conditions and proscriptions that were imposed on the individual's freedom to experience the self in company with others. Ultimately, remembering with feeling leads the patient to the understanding that he or she had no choice in the process of developing a schizoid stance toward others. The patient did not have the opportunity to choose from a selection of possible ways of experiencing the self and of relating with others, rather, the patient had few if any options. The false self was simply the best way in which the patient could experience repetitive predictable acknowledgment, affirmation, and approval (the emotional supplies necessary for emotional survival), while warding off the effects associated with the abandonment depression.

If the goal of shorter-term therapy is for patients to understand that they are not the way they appear to be and can act differently, then the longer-term goal of working through is for patients to understand who and what they are as human beings, what they truly are like and what they truly contain. The goal of working through is not achieved by the patient's sudden discovering of a hidden, fully formed talented and creative self living inside but is a process of slowly freeing oneself from the confinement of abandonment depression in order to have the opportunity to uncover a potential. It is a process of experimentation with the spontaneous, nonreactive elements that can be experienced in relationship with others.

Working through abandonment depression is a complicated, lengthy, and conflicted process which can be an enormously painful experience in terms of what is remembered and what must be felt. It involves a mourning, a grieving, for the loss of the illusion that the patient had adequate support for the emergence of the real self. Also, it is a mourning for the loss of an identity, the false self, which the person constructed and with which he or she has negotiated much of his or her life. The dismantling of the false self requires a relinquishing the only way of being that the patient has ever known of his interactions with others, an interaction which was better than no stable, organized experience of the self, no matter how false, defensive, or destructive that identity may be.

According to Klein the dismantling of the false self "leaves the impaired real self with the opportunity to convert its potential and its possibilities into actualities." The process of working through brings with it its own unique rewards, of which the most important

element in new self-awareness is the growing realization by the individual that they have a fundamental, internal need for relatedness, which they may express in a variety of ways. "Only schizoid patients", suggests Klein, "who have worked through the abandonment depression ... ultimately will believe that the capacity for relatedness and the wish for relatedness are woven into the structure of their beings, that they are truly part of who the patients are and what they contain as human beings. It is this sense that finally allows the schizoid patient to feel the most intimate sense of being connected with humanity more generally, and with another person more personally. For the schizoid patient, this degree of certainty is the most gratifying revelation, and a profound new organizer of the self experience."

Chapter 9

Mood Disorder

Mood disorder	
ICD-10	F30.-F39.
ICD-9	296
MeSH	D019964

Mood disorder is the term designating a group of diagnoses in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR) classification system where a disturbance in the person's mood is hypothesized to be the main underlying feature. The classification is known as *mood (affective) disorders* in ICD 10.

English psychiatrist Henry Maudsley proposed an overarching category of *affective disorder*. The term was then replaced by *mood disorder*, as the latter term refers to the underlying or longitudinal emotional state, whereas the former refers to the external expression observed by others.

Two groups of mood disorders are broadly recognized; the division is based on whether the person has ever had a manic or hypomanic episode. Thus, there are depressive disorders, of which the best known and most researched is **major depressive disorder (MDD)** commonly called *clinical depression* or *major depression*, and **bipolar disorder (BD)**, formerly known as *manic depression* and characterized by intermittent episodes of mania or hypomania, usually interlaced with depressive episodes.

Classification

Depressive disorders

- **Major depressive disorder** (**MDD**), commonly called major depression, unipolar depression, or clinical depression, where a person has one or more major depressive episodes. After a single episode, Major Depressive Disorder (single episode) would be diagnosed. After more than one episode, the diagnosis becomes Major Depressive Disorder (Recurrent). Depression without periods of

mania is sometimes referred to as *unipolar depression* because the mood remains at one emotional state or "pole".

Individuals with a major depressive episode or major depressive disorder are at increased risk for suicide. Seeking help and treatment from a health professional dramatically reduces the individual's risk for suicide. Studies have demonstrated that asking if a depressed friend or family member has thought of committing suicide is an effective way of identifying those at risk, and it does not "plant" the idea or increase an individual's risk for suicide in any way. Epidemiological studies carried out in Europe suggest that at this moment, roughly 8.5 percent of the worlds population are suffering from a depressive disorder. No age group seems to be exempt from depression and studies have found that depression appears in infants as young as 6 months old who have been separated from their mothers.
Diagnosticians recognize several subtypes or course specifiers:

- *Atypical depression* (*AD*) is characterized by mood reactivity (paradoxical anhedonia) and positivity, significant weight gain or increased appetite ("comfort eating"), excessive sleep or somnolence (hypersomnia), a sensation of heaviness in limbs known as leaden paralysis, and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection. Difficulties in measuring this subtype have led to questions of its validity and prevalence.

- *Melancholic depression* is characterized by a loss of pleasure (anhedonia) in most or all activities, a failure of reactivity to pleasurable stimuli, a quality of depressed mood more pronounced than that of grief or loss, a worsening of symptoms in the morning hours, early morning waking, psychomotor retardation, excessive weight loss, or excessive guilt.

- *Psychotic major depression* (*PMD*), or simply psychotic depression, is the term for a major depressive episode, particularly of melancholic nature, where the patient experiences psychotic symptoms such as delusions or, less commonly, hallucinations. These are most commonly mood-congruent (content coincident with depressive themes).

- *Catatonic depression* is a rare and severe form of major depression involving disturbances of motor behavior and other symptoms. Here the person is mute and almost stuporose, and either immobile or exhibits purposeless or even bizarre movements. Catatonic symptoms can also occur in schizophrenia, a manic episode, or be due to neuroleptic malignant syndrome.

- *Postpartum depression* (*PPD*) is listed as a course specifier in DSM-IV-TR; it refers to the intense, sustained and sometimes disabling depression experienced by women after giving birth. Postpartum depression, which

has incidence rate of 10–15%, typically sets in within three months of labor, and lasts as long as three months. It is quite common for women to experience a short term feeling of tiredness and sadness in the first few weeks after giving birth; however, postpartum depression is different because it can cause significant hardship and impaired functioning at home, work, or school as well as possibly difficulty in relationships with family members, spouses, friends, or even problems bonding with the newborn. In the treatment of postpartum major depressive disorders and other unipolar depressions in women who are breastfeeding, nortriptyline, paroxetine (Paxil), and sertraline (Zoloft) are generally considered to be the preferred medications.

    - *Seasonal affective disorder* (*SAD*), also known as "winter depression" or "winter blues", is a specifier. Some people have a seasonal pattern, with depressive episodes coming on in the autumn or winter, and resolving in spring. The diagnosis is made if at least two episodes have occurred in colder months with none at other times over a two-year period or longer. It is commonly hypothesised that people who live at higher latitudes tend to have less sunlight exposure in the winter and therefore experience higher rates of SAD, but the epidemiological support for this proposition is not strong (and latitude is not the only determinant of the amount of sunlight reaching the eyes in winter). SAD is also more prevalent in people who are younger and typically affects more females than males.

- **Dysthymia**, which is a chronic, different mood disturbance where a person reports a low mood almost daily over a span of at least two years. The symptoms are not as severe as those for major depression, although people with dysthymia are vulnerable to secondary episodes of major depression (sometimes referred to as *double depression*). The treatment of dysthymia is largely the same as for major depression, including antidepressant medications and psychotherapy.

- **Depressive Disorder Not Otherwise Specified** (**DD-NOS**) is designated by the code *311* for depressive disorders that are impairing but do not fit any of the officially specified diagnoses. According to the DSM-IV, DD-NOS encompasses *"any depressive disorder that does not meet the criteria for a specific disorder."* It includes the research diagnoses of *recurrent brief depression*, and *minor depressive disorder* listed below.

    - *Recurrent brief depression* (*RBD*), distinguished from major depressive disorder primarily by differences in duration. People with RBD have depressive episodes about once per month, with individual episodes lasting less than two weeks and typically less than 2–3 days. Diagnosis of RBD requires that the episodes occur over the span of at least one year and, in female patients, independently of the menstrual cycle. People with clinical depression can develop RBD, and vice versa, and both illnesses have similar risks.

- *Minor depressive disorder*, or simply minor depression, which refers to a depression that does not meet full criteria for major depression but in which at least two symptoms are present for two weeks.

Bipolar disorders

- **Bipolar disorder** (**BD**), a mood disorder formerly known as "manic depression" and described by alternating periods of mania and depression (and in some cases rapid cycling, mixed states, and psychotic symptoms). Subtypes include:

    - *Bipolar I* is distinguished by the presence or history of one or more manic episodes or mixed episodes with or without major depressive episodes. A depressive episode is not required for the diagnosis of Bipolar I disorder, but depressive episodes are often part of the course of the illness.
    - *Bipolar II* consisting of recurrent intermittent hypomanic and depressive episodes.
    - *Cyclothymia* is a form of bipolar disorder, consisting of recurrent hypomanic and dysthymic episodes, but no full manic episodes or full major depressive episodes.
    - *Bipolar Disorder Not Otherwise Specified* (*BD-NOS*), sometimes called "sub-threshold" bipolar, indicates that the patient suffers from some symptoms in the bipolar spectrum (e.g. manic and depressive symptoms) but does not fully qualify for any of the three formal bipolar DSM-IV diagnoses mentioned above.

    It is estimated that roughly one percent of the adult population suffers from bipolar I, roughly one percent of the adult population suffers from bipolar II or cyclothymia, and somewhere between two and five percent suffer from "sub-threshold" forms of bipolar disorder.

Substance induced mood disorders

A mood disorder can be classified as substance-induced if its etiology can be traced to the direct physiologic effects of a psychoactive drug or other chemical substance, or if the development of the mood disorder occurred contemporaneously with substance intoxication or withdrawal. Alternately, an individual may have a mood disorder coexisting with a substance abuse disorder. Substance-induced mood disorders can have features of a manic, hypomanic, mixed, or depressive episode. Most substances can induce a variety of mood disorders. For example, stimulants such as amphetamine, methamphetamine, and cocaine can cause manic, hypomanic, mixed, and depressive episodes.

Alcohol induced mood disorders

High rates of major depressive disorder occur in heavy drinkers and those with alcoholism. Controversy has previously surrounded whether those who abused alcohol

and developed depression were self-medicating their pre-existing depression, but recent research has concluded that, while this may be true in some cases, alcohol misuse directly causes the development of depression in a significant number of heavy drinkers. High rates of suicide also occur in those who have alcohol-related problems. It is usually possible to differentiate between alcohol-related depression and depression which is not related to alcohol intake by taking a careful history of the patient. Depression and other mental health problems associated with alcohol misuse may be due to distortion of brain chemistry, as they tend to improve on their own after a period of abstinence.

Benzodiazepine induced mood disorders

The long-term use of benzodiazepines, such as Valium and Librium, may have a similar effect on the brain as alcohol, and are also implicated in depression. Major depressive disorder can also develop as a result of chronic use of benzodiazepines or as part of a protracted withdrawal syndrome. Benzodiazepines are a class of medication which are commonly used to treat insomnia, anxiety and muscular spasms. As with alcohol, the effects of benzodiazepine on neurochemistry, such as decreased levels of serotonin and norepinephrine, are believed to be responsible for the increased depression. Major depressive disorder may also occur as part of the benzodiazepine withdrawal syndrome. In a long-term follow-up study of patients dependent on benzodiazepines, it was found that 10 people (20%) had taken drug overdoses while on chronic benzodiazepine medication despite only two people ever having had any pre-existing depressive disorder. A year after a gradual withdrawal program, no patients had taken any further overdoses. Depression resulting from withdrawal from benzodiazepines usually subsides after a few months but in some cases may persist for 6–12 months.

Interferon-alpha induced mood disorders

Combination therapy with interferon-α and ribavirin for chronic hepatitis C virus (HCV) infection may induce major depression. In the study by Leutscher et al, evaluating 325 chronically HCV infected patients undergoing antiviral therapy, it was observed that (1) depressive symptoms among patients undergoing HCV therapy are commonly overlooked by routine clinical interviews, (2) the emergence of depression compromises the outcome of HCV therapy, and (3) the Major Depression Inventory (MDI) scale may be useful in identifying patients at risk for treatment-induced depression.

Origin

A number of authors have suggested that mood disorders are an evolutionary adaptation. A low or depressed mood can increase an individual's ability to cope with situations in which the effort to pursue a major goal could result in danger, loss, or wasted effort. In such situations, low motivation may give an advantage by inhibiting certain actions. This theory helps to explain why mood disorders are so prevalent, and why they so often strike people during their peak reproductive years. These characteristics would be difficult to understand if depression were a dysfunction.

A depressed mood is a predictable response to certain types of life occurrences, such as loss of status, divorce, or death of a child or spouse. These are events that signal a loss of reproductive ability or potential, or that did so in humans' ancestral environment. A depressed mood can be seen as an adaptive response, in the sense that it causes an individual to turn away from the earlier (and reproductively unsuccessful) modes of behavior.

A depressed mood is common during illnesses, such as influenza. It has been argued that this is an evolved mechanism that assists the individual in recovering by limiting his/her physical activity. The occurrence of low-level depression during the winter months, or seasonal affective disorder, may have been adaptive in the past, by limiting physical activity at times when food was scarce. It is argued that humans have retained the instinct to experience low mood during the winter months, even if the availability of food is no longer determined by the weather.

Epidemiology

According to a substantial amount of epidemiology studies conducted, women are twice as likely to develop mood disorders as men.

Chapter 10

Psychotic Depression

Psychotic major depression (PMD) is a type of depression that can include symptoms and treatments that are different from those of non-psychotic major depressive disorder (NPMD). PMD is estimated to affect about 0.4% of the population (or one in every 250 people). Many people with psychotic depression experience delusions, which are beliefs or feelings that are untrue or unsupported.

PMD is sometimes mistaken for NPMD, schizoaffective disorder, schizophrenia or other psychotic disorders. Bipolar patients may experience PMD during depressed states. PMD is usually episodic, lasting for a defined amount of time, but in some cases can be chronic. PMD has unique biological features, which have led to innovative treatments. While PMD is often treated with a combination of antidepressants and antipsychotics, researchers have been developing new treatments that address the pathophysiology of PMD more directly.

Symptoms

Currently, PMD is considered a severe form of major depression, but patients with mild or moderate depression may still have psychotic features. Many people with PMD experience delusions, which are beliefs or feelings that are untrue or unsupported; these are usually misinterpretations of events or phenomena. Paranoid delusions or delusions of guilt may be the most common psychotic symptoms in PMD. Patients with PMD often have concerns that people are paying special attention to them or are trying to persecute them. Patients who experience delusional guilt may believe that they are being punished for past misdeeds or are responsible for problems they couldn't possibly be responsible for.

Other common delusions include those in which people are concerned that something is terribly wrong with their bodies and physical health, when actually there isn't anything wrong. Unlike other psychotic disorders, the delusions in PMD may not be very obvious. Delusions appear to be more common than hallucinations in PMD, but some people with PMD do hallucinate, or see or hear things that others do not. Auditory hallucinations (sounds) are perhaps the most common hallucinations seen in PMD. While other patients may report seeing, touching or smelling things that are not there, it is less common.

Other symptoms that are common in PMD are agitation, difficulty falling asleep, and frequent waking during the night. In addition, patients with PMD may have a greater suicide risk than patients with NPMD. Finally, those with PMD may have greater cognitive deficits (e.g., memory problems) than those with NPMD.

Course

The course of PMD may be helpful in distinguishing it from other disorders. Most PMD patients report having an initial episode between the ages of 20 and 40. Over a lifetime, it appears that PMD patients experience an average of 4 to 9 episodes. As with NPMD, the episodes of PMD tend to last for a certain amount of time and subside. While PMD can be chronic (lasting more than 2 years), most PMD episodes last less than 24 months. Unlike psychotic disorders such as schizophrenia and schizoaffective disorder, patients with PMD generally function well between episodes, both socially and professionally.

Diagnostic criteria

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM), a widely used manual for diagnosing mental disorders, patients who show at least six of the following symptoms in a period of two weeks may be diagnosed with PMD. In order to qualify for a PMD diagnosis, patients need to report either (1) or (3), and (10), along with three or four other symptoms (for a total of six). These symptoms also must be different from how patients felt or behaved at a previous time.

1. depressed mood most of the day nearly every day
2. noticeably increased or decreased sex drive
3. loss of interest or pleasure in all, or almost all, activities most of the day nearly every day
4. significant weight loss or weight gain, OR decrease or increase in appetite nearly every day
5. insomnia OR hypersomnia (sleeping excessively) nearly everyday
6. psychomotor agitation (moving more quickly) OR retardation (moving more slowly) nearly every day, so much that other people notice
7. fatigue OR loss of energy nearly every day
8. feelings of worthlessness OR excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
9. diminished ability to think or concentrate, OR indecisiveness, nearly every day
10. recurrent thoughts of death (not just fear of dying), recurrent ideas about suicide without a specific plan, or a suicide attempt or specific plan for committing suicide
11. delusions or hallucinations
12. increased and intense daydreaming

The symptoms cannot meet criteria for a Mixed Episode (diagnosed by a clinician) or be due to the effects of a substance or illness. The symptoms also must cause distress or impairment in functioning.

Differential diagnosis

PMD is most frequently confused with NPMD, but it may also be mistaken for the schizophrenia spectrum disorders, including schizoaffective disorder. These are differentiated from PMD by the presence of psychotic symptoms outside of a major depressive episode. In a schizoaffective patient, hallucinations and delusions will occur in the absence of major depressive episodes.

Schizophrenia generally has more disordered thinking and delusional symptoms than PMD. It is unusual for PMD patients to show flight of ideas, loose association, echolalia (repeating what others say), word salad (meaningless speech), and other elements of thought disorders that characterize schizophrenia. Likewise, the presence of bizarre delusions ("Aliens have planted a receiver in my head") appears to be less common in PMD than schizophrenia. However, neither bizarre delusions, nor marked thought disorder necessarily eliminate a diagnosis of PMD. Bipolar disorder can sometimes present with PMD. It is estimated that as many as 42% of patients with PMD in adolescence or young adulthood are likely to develop some type of manic episode later. It is important to take a history of manic symptoms in any younger patient who presents with PMD.

Other psychotic disorders with which PMD is sometimes confused include delusional disorder, substance induced psychotic disorder (with MDD), post-psychotic depressive disorder of schizophrenia, and brief psychotic disorder. The primary way of distinguishing between PMD and any of these disorders lies more in evaluating the course of the illness rather than simply identifying specific symptoms.

Pathophysiology

There are a number of biological features that may distinguish PMD from NPMD. The most significant difference may be the presence of an abnormality in the hypothalamic pituitary adrenal (HPA) axis. The HPA axis, which is sometimes referred to as the stress hormone axis, appears to be chronically over-activated in PMD. Other abnormalities found in PMD include sleep abnormalities and changes in other areas of brain function. Finally, the incidence of psychotic depression has been reported to increase when the barometric pressure is low.

History of treatments

Before electroconvulsive therapy (ECT) was invented in the 1930s, it was frequently observed that patients experiencing delusions with depression had poorer response to medication treatment. ECT seemed to have similar effects for depressed patients both with and without psychotic symptoms. The interest in psychotic depression increased after tricyclic antidepressants (TCAs) became available, because while NPMD responded to TCAs, PMD did not. In the past 40 years there has been a renewed interest in PMD. The FDA is considering a special class of drugs for the treatment of PMD as researchers learn more about the biology of the disease.

Many studies have suggested that PMD differs from MDD in treatment response. PMD is less likely than MDD to respond to placebo and to the use of only an antidepressant or an antipsychotic. The combination of an antidepressant and an antipsychotic appears to be necessary for the treatment of PMD. Early studies suggest an 80-90% response rate in PMD with combination treatment.

Established treatment strategies

While there is some evidence that anti-depressant pharmacotherapy with selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs) may be effective in treating PMD, patients with PMD often do not respond to monotherapy and require a combination of anti-depressant and anti-psychotic medication.

Electroconvulsive therapy (ECT), along with combination antidepressant-antipsychotic treatment, is the other established treatment of PMD. ECT may have a more reliable track record in improving symptoms than pharmacological treatments. However, the stigma, cost, and cognitive side effects often make it a second or third line treatment except in special circumstances. For example, if a patient's PMD is imminently life threatening as a result of suicide risk or cachexia, ECT may be considered first line treatment. In addition, a patient who cannot tolerate medications, or has responded more favorably to ECT in the past, may be considered for ECT first.

Experimental treatment strategies

The current treatments of PMD are reasonably effective but tend to carry a high side effect burden and may take a long time to work. Combination treatment with atypical antipsychotics and SSRIs tend to be associated with significant weight gain and sexual dysfunction. TCAs are lethal in overdose and some are associated with extra-pyramidal side effects including tardive dyskinesia. Finally, ECT has side effects of temporary cognitive deficits (e.g., confusion, memory problems), in addition to the burden of repeated exposures to general anesthesia.

Among the newer experimental treatments is the study of glucocorticoid antagonists, including mifepristone. These strategies may treat the underlying pathophysiology of PMD by correcting an overactive HPA axis. By competitively blocking certain neuro-receptors, these medications render cortisol less able to directly act on the brain.

Transcranial magnetic stimulation (TMS) is being investigated as an alternative to ECT in the treatment of depression. TMS involves the administration of a focused electromagnetic field to the cortex to stimulate specific nerve pathways. A number of early studies have shown promise of TMS in MDD with few side effects. TMS does not require anesthesia and has not been associated with significant cognitive deficits.

Chapter 11

Dysthymia

Dysthymic Disorder	
ICD-10	F34.1
ICD-9	300.4
MeSH	D019263

Dysthymia (pronounced *dis*-**thahy**-*mee-uh*) is a chronic mood disorder that falls within the depression spectrum. It is considered a chronic depression, but with less severity than major depressive disorder. This disorder tends to be a chronic, long-lasting illness. The term was first used by James Kocsis during the 1970s.

Dysthymia is a type of mild depression. Harvard Health Publications states that "the Greek word dysthymia means 'bad state of mind' or 'ill humor'. As one of the two chief forms of clinical depression, it usually has fewer or less serious symptoms than major depression but lasts longer." Harvard Health Publications also says, "at least three-quarters of patients with dysthymia also have a chronic physical illness or another psychiatric disorder such as one of the anxiety disorders, drug addiction, or alcoholism". The Primary Care Journal says that dysthymia "affects approximately three percent of the population and is associated with significant functional impairment". Harvard Health Publications says: "The rate of depression in the families of people with dysthymia is as high as fifty percent for the early-onset form of the disorder. [...] Most people with dysthymia can't tell for sure when they first became depressed".

Dysthymia is a chronic long-lasting form of depression sharing many characteristic symptoms of major depressive disorder (in the form of the melancholic depression subtype). These symptoms tend to be less severe but do fluctuate in intensity. To be diagnosed, an adult must experience 2 or more of the following symptoms for at least two years:

- Feelings of hopelessness
- Insomnia or hypersomnia
- Poor concentration or difficulty making decisions
- Poor appetite or overeating

- Low energy or fatigue
- Low self-esteem
- Low sex drive
- Irritability

Symptoms exclude "manic, hypomanic or mixed episodes commonly associated with bipolar disorder". (If a person experiences these episodes, they may suffer from cyclothymia.)

People with dysthymia have a higher-than-average chance of developing major depression. Fluctuating symptoms intensity can trigger a full-blown episode of major depression. This situation is sometimes called "double depression" because the intense episode exists with the usual feelings of low mood.

As dysthymia is a chronic disorder, sufferers may experience symptoms for many years before it is diagnosed, if diagnosis occurs at all. As a result, they may to believe that depression is a part of their character, so they may not even discuss their symptoms with doctors, family members, or friends.

Dysthymia, like major depression, tends to run in families. It is two to three times more common in women than in men. Some sufferers describe being under chronic stress. When treating diagnosed individuals, it is often difficult to tell whether they are under unusually high environmental stress or the dysthymia is causing them to be more psychologically stressed in a standard environment.

Diagnostic criteria

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association, characterizes dysthymic disorder. The essential symptom involves the individual feeling depressed for the majority of days and parts of the day for at least two years. Low energy, disturbances in sleep or in appetite, and low self-esteem typically contribute to the clinical picture as well. Sufferers have often experienced dysthymia for many years before it is diagnosed. People around them come to believe that the sufferer is 'just a moody person'. Note the following diagnostic criteria:

1. During a majority of days for two years or more, the adult patient reports depressed mood or appears depressed to others for most of the day.
2. When depressed, the patient has two or more of:
    1. decreased or increased appetite
    2. decreased or increased sleep (insomnia or hypersomnia)
    3. Fatigue or low energy
    4. Reduced self-esteem
    5. Decreased concentration or problems making decisions
    6. Feels hopeless or pessimistic
3. During this two-year period, the above symptoms are never absent longer than two consecutive months.

4. During the first two years of this syndrome, the patient has not had a major depressive episode.
5. The patient has not had any manic, hypomanic, or mixed episodes.
6. The patient has never fulfilled criteria for cyclothymic disorder.
7. The depression does not exist only as part of a chronic psychosis (such as schizophrenia or delusional disorder).
8. The symptoms are often not directly caused by a medical illness or by substances, including drug abuse, or other medications.
9. The symptoms may cause significant problems or distress in social, work, academic, or other major areas of life functioning.

People suffering from dysthymia aren't always well capable of coping with their everyday lives. Dysthymics who cope well with daily life tend to follow particular routines that provide certainty.

In children and adolescents, mood can be irritable, and duration must be at least one year, in contrast to two years needed for diagnosis in adults.

Treatments

Medications

If medication is deemed necessary, the most commonly prescribed anti-depressants for this disorder are the selective serotonin reuptake inhibitors (SSRIs), which include fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), paroxetine (Paxil), and citalopram (Celexa). Other anti-depressants which may be used include newer dual-acting agents such as bupropion (Wellbutrin), venlafaxine (Effexor), mirtazapine (Remeron, Avanza), and duloxetine (Cymbalta).

Sometimes two different anti-depressant medications are prescribed together, or a physician may prescribe a mood stabilizer or anti-anxiety medication in combination with an anti-depressant.

Side-effects of medications

Some side-effects for SSRIs are "sexual dysfunction, nausea…diarrhea, sleepiness or insomnia, short-term memory loss and tremors". Antidepressant medications can also cause suicidality and aggression in some cases, in particular, in children and teens. Some antidepressants are ineffective in some patients. Older antidepressants such as a tricyclic antidepressant or an MAOI can be tried in such cases. Tricyclic antidepressants are more effective but have worse side-effects. Side-effects for tricyclic antidepressants are "weight gain, dry mouth, blurry vision, sexual dysfunction, and low blood pressure".

Psychotherapy

Some evidence suggests that the combination of medication and psychotherapy may result in the greatest improvement. The type of psychotherapy that will help depends on a number of factors, including the nature of any stressful events, the availability of family and other social support, and personal preference. Therapy should include education about depression. Support is essential. Cognitive behavioral therapy is designed to examine and help correct faulty, self-critical thought patterns and correct the cognitive distortions that persons with mood disorders commonly experience. Psychodynamic, insight-oriented or interpersonal psychotherapy can help a person sort out conflicts in important relationships or explore the history behind the symptoms.

Friends and family

Anecdotal evidence indicates that sufferers' awareness that they form an important part in the lives of the people familiar to them, both near and far, helps them to cope.

Chapter 12

Bipolar Disorder

Bipolar disorder	

Many people involved with the arts, such as Vincent van Gogh, are believed to have suffered from bipolar disorder

ICD-10	F31.
ICD-9	296.80
OMIM	125480 309200
DiseasesDB	7812
MedlinePlus	001528
eMedicine	med/229
MeSH	D001714

Bipolar disorder or **manic-depressive disorder**, also referred to as **bipolar affective disorder** or **manic depression**, is a psychiatric diagnosis that describes a category of mood disorders defined by the presence of one or more episodes of abnormally elevated energy levels, cognition, and mood with or without one or more depressive episodes. The elevated moods are clinically referred to as mania or, if milder, hypomania. Individuals who experience manic episodes also commonly experience depressive episodes, or symptoms, or mixed episodes in which features of both mania and depression are present

at the same time. These episodes are usually separated by periods of "normal" mood; but, in some individuals, depression and mania may rapidly alternate, which is known as rapid cycling. Extreme manic episodes can sometimes lead to such psychotic symptoms as delusions and hallucinations. The disorder has been subdivided into bipolar I, bipolar II, cyclothymia, and other types, based on the nature and severity of mood episodes experienced; the range is often described as the bipolar spectrum.

Data from the United States on lifetime prevalence varies; but it indicates a rate of around 1% for bipolar I, 0.5%–1% for bipolar II or cyclothymia, and 2%–5% for subthreshold cases meeting some, but not all, criteria. The onset of full symptoms generally occurs in late adolescence or young adulthood. Diagnosis is based on the person's self-reported experiences, as well as observed behavior. Episodes of abnormality are associated with distress and disruption and an elevated risk of suicide, especially during depressive episodes. In some cases, it can be a devastating long-lasting disorder. In others, it has also been associated with creativity, goal striving, and positive achievements. There is significant evidence to suggest that many people with creative talents have also suffered from some form of bipolar disorder.

Genetic factors contribute substantially to the likelihood of developing bipolar disorder, and environmental factors are also implicated. Bipolar disorder is often treated with mood stabilizing medications and, sometimes, other psychiatric drugs. Psychotherapy also has a role, often when there has been some recovery of the subject's stability. In serious cases, in which there is a risk of harm to oneself or others, involuntary commitment may be used. These cases generally involve severe manic episodes with dangerous behavior or depressive episodes with suicidal ideation. There are widespread problems with social stigma, stereotypes, and prejudice against individuals with a diagnosis of bipolar disorder. People with bipolar disorder exhibiting psychotic symptoms can sometimes be misdiagnosed as having schizophrenia, another serious mental illness.

The current term "bipolar disorder" is of fairly recent origin and refers to the cycling between high and low episodes (poles). A relationship between mania and melancholia had long been observed, although the basis of the current conceptualisation can be traced back to French psychiatrists in the 1850s. The term "manic-depressive illness" or psychosis was coined by German psychiatrist Emil Kraepelin in the late nineteenth century, originally referring to all kinds of mood disorder. German psychiatrist Karl Leonhard split the classification again in 1957, employing the terms unipolar disorder (major depressive disorder) and bipolar disorder.

Signs and symptoms

Bipolar disorder is a condition in which people experience abnormally elevated (manic or hypomanic) and, in many cases, abnormally depressed states for periods of time in a way that interferes with functioning. Not everyone's symptoms are the same, and there is no simple physiological test to confirm the disorder. Bipolar disorder can appear to be unipolar depression. Diagnosing bipolar disorder is often difficult, even for mental health

professionals. What distinguishes bipolar disorder from unipolar depression is that the affected person experiences states of mania and depression. Often bipolar is inconsistent among patients because some people feel depressed more often than not and experience little mania whereas others experience predominantly manic symptoms. Additionally, the younger the age of onset—bipolar disorder starts in childhood or early adulthood in most patients—the more likely the first few episodes are to be depression. Because a bipolar diagnosis requires a manic or hypomanic episode, many patients are initially diagnosed and treated as having major depression.

Depressive episode

Signs and symptoms of the depressive phase of bipolar disorder include persistent feelings of sadness, anxiety, guilt, anger, isolation, or hopelessness; disturbances in sleep and appetite; fatigue and loss of interest in usually enjoyable activities; problems concentrating; loneliness, self-loathing, apathy or indifference; depersonalization; loss of interest in sexual activity; shyness or social anxiety; irritability, chronic pain (with or without a known cause); lack of motivation; and morbid suicidal ideation. In severe cases, the individual may become psychotic, a condition also known as severe bipolar depression with psychotic features. These symptoms include delusions or, less commonly, hallucinations, usually unpleasant. A major depressive episode persists for at least two weeks, and may continue for over six months if left untreated.

Manic episode

Mania is the signature characteristic of bipolar disorder and, depending on its severity, is how the disorder is classified. Mania is generally characterized by a distinct period of an elevated mood, which can take the form of euphoria. People commonly experience an increase in energy and a decreased need for sleep, with many often getting as little as 3 or 4 hours of sleep per night, while others can go days without sleeping. A person may exhibit pressured speech, with thoughts experienced as racing. Attention span is low, and a person in a manic state may be easily distracted. Judgment may become impaired, and sufferers may go on spending sprees or engage in behavior that is quite abnormal for them. They may indulge in substance abuse, particularly alcohol or other depressants, cocaine or other stimulants, or sleeping pills. Their behavior may become aggressive, intolerant, or intrusive. People may feel out of control or unstoppable, or as if they have been "chosen" and are "on a special mission" or have other grandiose or delusional ideas. Sexual drive may increase. At more extreme phases of bipolar I, a person in a manic state can begin to experience psychosis, or a break with reality, where thinking is affected along with mood. Some people in a manic state experience severe anxiety and are very irritable (to the point of rage), while others are euphoric and grandiose.

To be diagnosed with mania according to the Diagnostic and Statistical Manual of Mental Disorders (DSM), a person must experience this state of elevated or irritable mood, as well as other symptoms, for at least one week, less if hospitalization is required.

Severity of manic symptoms can be measured by rating scales such as self-reported Altman Self-Rating Mania Scale and clinician-based Young Mania Rating Scale .

Hypomanic episode

Hypomania is generally a mild to moderate level of mania, characterized by optimism, pressure of speech and activity, and decreased need for sleep. Generally, hypomania does not inhibit functioning like mania. Many people with hypomania are actually in fact more productive than usual, while manic individuals have difficulty completing tasks due to a shortened attention span. Some people have increased creativity while others demonstrate poor judgment and irritability. Many people experience signature hypersexuality. These persons generally have increased energy and tend to become more active than usual. They do not, however, have delusions or hallucinations. Hypomania can be difficult to diagnose because it may masquerade as mere happiness, though it carries the same risks as mania.

Hypomania may feel good to the person who experiences it. Thus, even when family and friends learn to recognize the mood swings, the individual often will deny that anything is wrong. Also, the individual may not be able to recall the events that took place while they were experiencing hypomania. What might be called a "hypomanic event", if not accompanied by complementary depressive episodes ("downs", etc.), is not typically deemed as problematic: The "problem" arises when mood changes are uncontrollable and, more importantly, volatile or "mercurial". If unaccompanied by depressive counterpart episodes or otherwise general irritability, this behavior is typically called hyperthymia, or happiness, which is, of course, perfectly normal. Indeed, the most elementary definition of bipolar disorder is an often "violent" or "jarring" state of essentially uncontrollable oscillation between hyperthymia and dysthymia. If left untreated, an episode of hypomania can last anywhere from a few days to several years. Most commonly, symptoms continue for a few weeks to a few months.

Mixed affective episode

In the context of bipolar disorder, a mixed state is a condition during which symptoms of mania and clinical depression occur simultaneously. Typical examples include tearfulness during a manic episode or racing thoughts during a depressive episode. Individuals may also feel incredibly frustrated in this state, since one may feel like a failure and at the same time have a flight of ideas. Mixed states are often the most dangerous period of mood disorders, during which substance abuse, panic disorder, suicide attempts, and other complications increase greatly.

Associated features

Associated features are clinical phenomena that often accompany the disorder but are not part of the diagnostic criteria for the disorder. There are several childhood precursors in children who later receive a diagnosis of bipolar disorder. They may show subtle early traits such as mood abnormalities, full major depressive episodes, and ADHD. BD is also

accompanied by changes in cognitive processes and abilities. This include reduced attentional and executive capabilities and impaired memory. How the individual processes the world also depends on the phase of the disorder, with differential characteristics between the manic, hypomanic and depressive states. Some studies have found a significant association between bipolar disorder and creativity.

Causes

The causes of bipolar disorder likely vary between individuals. Twin studies have been limited by relatively small sample sizes but have indicated a substantial genetic contribution, as well as environmental influence. For bipolar I, the (probandwise) concordance rates in modern studies have been consistently put at around 40% in monozygotic twins (same genes), compared to 0 to 10% in dizygotic twins. A combination of bipolar I, II and cyclothymia produced concordance rates of 42% vs 11%, with a relatively lower ratio for bipolar II that likely reflects heterogeneity. The overall heritability of the bipolar spectrum has been put at 0.71. There is overlap with unipolar depression and if this is also counted in the co-twin the concordance with bipolar disorder rises to 67% in monozigotic twins and 19% in dizigotic. The relatively low concordance between dizygotic twins brought up together suggests that shared family environmental effects are limited, although the ability to detect them has been limited by small sample sizes.

Genetic

Genetic studies have suggested many chromosomal regions and candidate genes appearing to relate to the development of bipolar disorder, but the results are not consistent and often not replicated.

Although the first genetic linkage finding for mania was in 1969, the linkage studies have been inconsistent. Meta-analyses of linkage studies detected either no significant genome-wide findings or, using a different methodology, only two genome-wide significant peaks, on chromosome 6q and on 8q21. Genome-wide association studies neither brought a consistent focus — each has identified new loci.

Findings point strongly to heterogeneity, with different genes being implicated in different families. A review seeking to identify the more consistent findings suggested several genes related to serotonin (SLC6A4 and TPH2), dopamine (DRD4 and SLC6A3), glutamate (DAOA and DTNBP1), and cell growth and/or maintenance pathways (NRG1, DISC1 and BDNF), although noting a high risk of false positives in the published literature. It was also suggested that individual genes are likely to have only a small effect and to be involved in some aspect related to the disorder (and a broad range of "normal" human behavior) rather than the disorder per se.

Advanced paternal age has been linked to a somewhat increased chance of bipolar disorder in offspring, consistent with a hypothesis of increased new genetic mutations.

Physiological

Abnormalities in the structure and/or function of certain brain circuits could underlie bipolar. A general reduction of brain volume and anatomically specific differences in areas such as the prefrontal cortex and the globus pallidus are most commonly found.

The "kindling" theory asserts that people who are genetically predisposed toward bipolar disorder can experience a series of stressful events, each of which lowers the threshold at which mood changes occur. Eventually, a mood episode can start (and become recurrent) by itself. There is evidence of hypothalamic-pituitary-adrenal axis (HPA axis) abnormalities in bipolar disorder due to stress.

Other brain components which have been proposed to play a role are the mitochondria, and a sodium ATPase pump, causing cyclical periods of poor neuron firing (depression) and hyper sensitive neuron firing (mania). This may only apply for type one, but type two apparently results from a large confluence of factors. Circadian rhythms and melatonin activity also seem to be altered.

Environmental

Evidence suggests that environmental factors play a significant role in the development and course of bipolar disorder, and that individual psychosocial variables may interact with genetic dispositions. There is fairly consistent evidence from prospective studies that recent life events and interpersonal relationships contribute to the likelihood of onsets and recurrences of bipolar mood episodes, as they do for onsets and recurrences of unipolar depression. There have been repeated findings that between a third and a half of adults diagnosed with bipolar disorder report traumatic/abusive experiences in childhood, which is associated on average with earlier onset, a worse course, and more co-occurring disorders such as PTSD. The total number of reported stressful events in childhood is higher in those with an adult diagnosis of bipolar spectrum disorder compared to those without, particularly events stemming from a harsh environment rather than from the child's own behavior. Early experiences of adversity and conflict are likely to make subsequent developmental challenges in adolescence more difficult, and are likely a potentiating factor in those at risk of developing bipolar disorder.

Diagnosis

Diagnosis is based on the self-reported experiences of an individual as well as abnormalities in behavior reported by family members, friends or co-workers, followed by secondary signs observed by a psychiatrist, nurse, social worker, clinical psychologist or other clinician in a clinical assessment. There are lists of criteria for someone to be so diagnosed. These depend on both the presence and duration of certain signs and symptoms. Assessment is usually done on an outpatient basis; admission to an inpatient facility is considered if there is a risk to oneself or others. The most widely used criteria for diagnosing bipolar disorder are from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, the current version being DSM-

IV-TR, and the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, currently the ICD-10. The latter criteria are typically used in Europe and other regions while the DSM criteria are used in the USA and other regions, as well as prevailing in research studies.

An initial assessment may include a physical exam by a physician. Although there are no biological tests which confirm bipolar disorder, tests may be carried out to exclude medical illnesses such as hypo- or hyperthyroidism, metabolic disturbance, a systemic infection or chronic disease, and syphilis or HIV infection. An EEG may be used to exclude epilepsy, and a CT scan of the head to exclude brain lesions. Investigations are not generally repeated for relapse unless there is a specific *medical* indication.

Several rating scales for the screening and evaluation of BD exist, such as the Bipolar spectrum diagnostic scale. The use of evaluation scales can not substitute a full clinical interview but they serve to systematize the recollection of symptoms. On the other hand instruments for the screening of BD have low sensitivity and limited diagnostic validity.

Criteria and subtypes

There is no clear consensus as to how many types of bipolar disorder exist. In DSM-IV-TR and ICD-10, bipolar disorder is conceptualized as a spectrum of disorders occurring on a continuum. The DSM-IV-TR lists three specific subtypes and one for non-specified:

Bipolar I disorder
: One or more manic episodes. Subcategories specify whether there has been more than one episode, and the type of the most recent episode. A depressive or hypomanic episode is not required for diagnosis, but it frequently occurs.

Bipolar II disorder
: No manic episodes, but one or more hypomanic episodes and one or more major depressive episode. However, a bipolar II diagnosis is not a guarantee that they will not eventually suffer from such an episode in the future. Hypomanic episodes do not go to the full extremes of mania (*i.e.*, do not usually cause severe social or occupational impairment, and are without psychosis), and this can make bipolar II more difficult to diagnose, since the hypomanic episodes may simply appear as a period of successful high productivity and is reported less frequently than a distressing, crippling depression.

Cyclothymia
: A history of hypomanic episodes with periods of depression that do not meet criteria for major depressive episodes. There is a low-grade cycling of mood which appears to the observer as a personality trait, and interferes with functioning.

Bipolar Disorder NOS (Not Otherwise Specified)
: This is a catchall category, diagnosed when the disorder does not fall within a specific subtype. Bipolar NOS can still significantly impair and adversely affect the quality of life of the patient.

The bipolar I and II categories have specifiers that indicate the presentation and course of the disorder. For example, the "with full interepisode recovery" specifier applies if there was full remission between the two most recent episodes.

Rapid cycling

Most people who meet criteria for bipolar disorder experience a number of episodes, on average 0.4 to 0.7 per year, lasting three to six months. *Rapid cycling*, however, is a course specifier that may be applied to any of the above subtypes. It is defined as having four or more episodes per year and is found in a significant fraction of individuals with bipolar disorder. The definition of rapid cycling most frequently cited in the literature (including the DSM) is that of Dunner and Fieve: at least four major depressive, manic, hypomanic or mixed episodes are required to have occurred during a 12-month period. Ultra-rapid (days) or ultra-ultra rapid or ultradian (within a day) cycling have also been described.

Differential diagnosis

There are several other mental disorders which may involve similar symptoms to bipolar disorder. These include schizophrenia, schizoaffective disorder, drug intoxication, brief drug-induced psychosis, schizophreniform disorder and borderline personality disorder. Both borderline personality and bipolar disorder can involve what are referred to as "mood swings". In bipolar disorder, the term refers to the cyclic episodes of elevated and depressed mood which generally last weeks or months. The term in borderline personality refers to the marked lability and reactivity of mood, known as emotional dysregulation, due to response to external psychosocial and intrapsychic stressors; these may arise or subside suddenly and dramatically and last for seconds, minutes, hours or days. A bipolar depression is generally more pervasive with sleep, appetite disturbance and nonreactive mood, whereas the mood in dysthymia of borderline personality remains markedly reactive and sleep disturbance not acute. Some hold that borderline personality disorder represents a subthreshold form of mood disorder while others maintain the distinctness, though noting they often coexist.

Challenges

The experiences and behaviors involved in bipolar disorder are often not understood by individuals or recognized by mental health professionals, so diagnosis may sometimes be delayed for over 10 years. The treatment lag is apparently not decreasing, even though there is increased public awareness of the condition.

Individuals are commonly misdiagnosed. An individual may appear simply depressed when they are seen by a health professional. This can result in misdiagnosis of Major Depressive Disorder. However, there is also a long-standing issue in the research literature as to whether a categorical classificatory divide between unipolar and bipolar depression is actually valid, or whether it is more accurate to talk of a continuum involving dimensions of depression and mania.

It has been noted that the bipolar disorder diagnosis is officially characterised in historical terms such that, technically, anyone with a history of (hypo)mania and depression has bipolar disorder whatever their current or future functioning and vulnerability. This has been described as "an ethical and methodological issue", as it means no one can be considered as being recovered (only "in remission") from bipolar disorder according to the official criteria. This is considered especially problematic given that brief hypomanic episodes are widespread among people generally and not necessarily associated with dysfunction.

Flux is the fundamental nature of bipolar disorder. Individuals with the illness have continual changes in energy, mood, thought, sleep, and activity. The diagnostic subtypes of bipolar disorder are thus static descriptions—snapshots, perhaps—of an illness in continual flux, with a great diversity of symptoms and varying degrees of severity. Individuals may stay in one subtype, or change into another, over the course of their illness. The DSM-V, to be published in 2013, will likely include further and more accurate sub-typing (Akiskal and Ghaemi, 2006).

The diagnosis of bipolar disorder can be complicated by coexisting psychiatric conditions such as obsessive-compulsive disorder, social phobia, panic disorder, or attention-deficit/hyperactivity disorder. Substance abuse may predate the appearance of bipolar symptoms, further complicating the diagnosis. A careful longitudinal analysis of symptoms and episodes, enriched if possible by discussions with friends and family members, is crucial to establishing a treatment plan where these comorbidities exist.

Management

There are a number of pharmacological and psychotherapeutic techniques used to treat Bipolar Disorder. Individuals may use self-help and pursue a personal recovery journey.

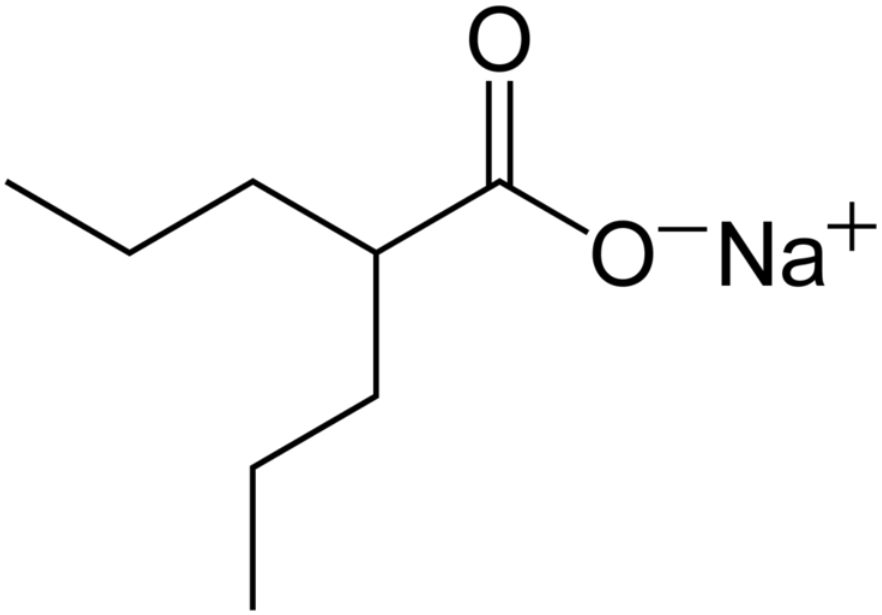
Hospitalization may be required especially with the manic episodes present in bipolar I. This can be voluntary or (if mental health legislation allows and varying state-to-state regulations in the USA) involuntary (called civil or involuntary commitment). Long-term inpatient stays are now less common due to deinstitutionalization, although these can still occur. Following (or in lieu of) a hospital admission, support services available can include drop-in centers, visits from members of a community mental health team or Assertive Community Treatment team, supported employment and patient-led support groups, intensive outpatient programs. These are sometimes referred to partial-inpatient programs.

Psychosocial

Psychotherapy is aimed at alleviating core symptoms, recognizing episode triggers, reducing negative expressed emotion in relationships, recognizing prodromal symptoms before full-blown recurrence, and, practicing the factors that lead to maintenance of remission Cognitive behavioural therapy, family-focused therapy, and psychoeducation have the most evidence for efficacy in regard to relapse prevention, while interpersonal

and social rhythm therapy and cognitive-behavioural therapy appear the most effective in regard to residual depressive symptoms. Most studies have been based only on bipolar I, however, and treatment during the acute phase can be a particular challenge. Some clinicians emphasize the need to talk with individuals experiencing mania, to develop a therapeutic alliance in support of recovery.

Medication



Sodium valproate is a common mood stabilizer

The mainstay of treatment is a mood stabilizer medication such as lithium carbonate or lamotrigine. Lamotrigine has been found to be best for preventing depressions, while lithium is the only drug proven to reduce suicide in bipolar patients. These two drugs comprise several unrelated compounds which have been shown to be effective in preventing relapses of manic, or in the one case, depressive episodes. The first known and "gold standard" mood stabilizer is lithium, while almost as widely used is sodium valproate, also used as an anticonvulsant. Other anticonvulsants used in bipolar disorder include carbamazepine, reportedly more effective in rapid cycling bipolar disorder, and lamotrigine, which is the first anticonvulsant shown to be of benefit in bipolar depression. Depending on the severity of the case, anti-convulsants may be used in combination with lithium-based products or on their own.

Treatment of the agitation in acute manic episodes has often required the use of antipsychotic medications, such as chlorpromazine and the atypical antipsychotics quetiapine and olanzapine. More recently, olanzapine and quetiapine have been approved as effective monotherapy for the maintenance of bipolar disorder. A head-to-head

randomized control trial in 2005 has also shown olanzapine monotherapy to be as effective and safe as lithium in prophylaxis.

The use of antidepressants in bipolar disorder has been debated, with some studies reporting a worse outcome with their use triggering manic, hypomanic or mixed episodes, especially if no mood stabiliser is used. However, most mood stabilizers are of limited effectiveness in depressive episodes. Rapid cycling can be induced or made worse by antidepressants, unless there is adjunctive treatment with a mood stabilizer. One large-scale study found that depression in bipolar disorder responds no better to an antidepressant with mood stabilizer than it does to a mood stabilizer alone. Omega 3 fatty acids, in addition to normal pharmacological treatment, may have beneficial effects on depressive symptoms, although studies have been scarce and of variable quality. Topiramate is an anticonvulsant sometimes prescribed as a mood stabilizer. However its efficay is unproven.

Prognosis

For many individuals with bipolar disorder a good prognosis results from good treatment, which, in turn, results from an accurate diagnosis. Because bipolar disorder can have a high rate of both under-diagnosis and misdiagnosis, it is often difficult for individuals with the condition to receive timely and competent treatment.

Bipolar disorder can be a severely disabling medical condition. However, many individuals with bipolar disorder can live full and satisfying lives. Quite often, medication is needed to enable this. Persons with bipolar disorder may have periods of normal or near normal functioning between episodes.

Prognosis depends on many factors such as the right medicines and dosage, comprehensive knowledge of the disease and its effects; a positive relationship with a competent medical doctor and therapist; and good physical health, which includes exercise, nutrition, and a regulated stress level. There are other factors that lead to a good prognosis, such as being very aware of small changes in a person's energy, mood, sleep and eating behaviors.

Functioning

A recent 20-year prospective study on bipolar I and II found that functioning varied over time along a spectrum from good to fair to poor. During periods of major depression or mania (in BPI), functioning was on average poor, with depression being more persistently associated with disability than mania. Functioning between episodes was on average good — more or less normal. Subthreshold symptoms were generally still substantially impairing, however, except for hypomania (below or above threshold) which was associated with improved functioning.

Another study confirmed the seriousness of the disorder as "the standardized all-cause mortality ratio among patients with BD is increased approximately two-fold." Bipolar

disorder is currently regarded "as possibly the most costly category of mental disorders in the United States." Episodes of abnormality are associated with distress and disruption, and an elevated risk of suicide, especially during depressive episodes.

Recovery and recurrence

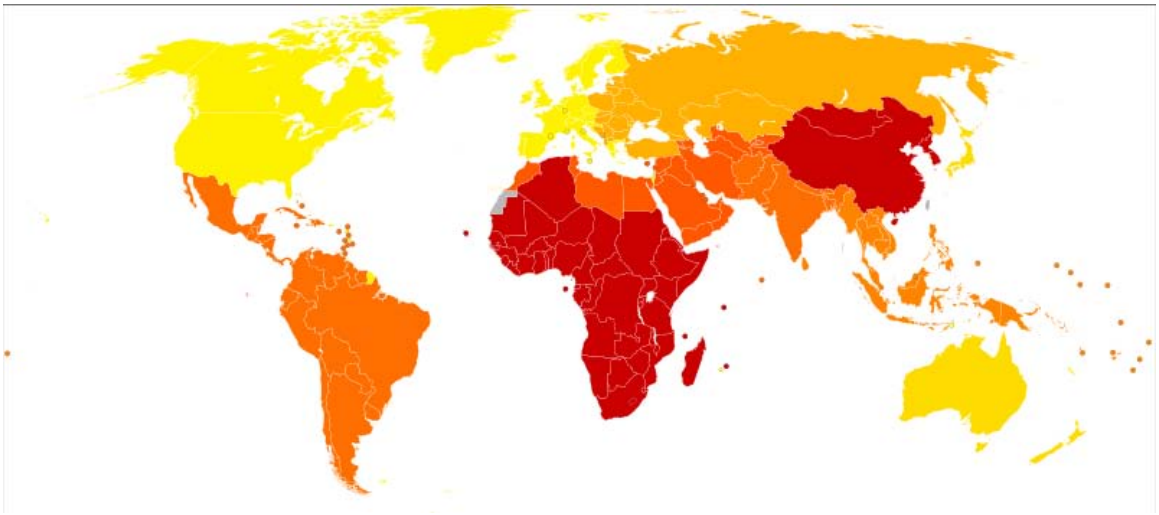
A naturalistic study from first admission for mania or mixed episode (representing the hospitalized and therefore most severe cases) found that 50% achieved syndromal recovery (no longer meeting criteria for the diagnosis) within six weeks and 98% within two years. 72% achieved symptomatic recovery (no symptoms at all) and 43% achieved functional recovery (regaining of prior occupational and residential status). However, 40% went on to experience a new episode of mania or depression within 2 years of syndromal recovery, and 19% switched phases without recovery.

Symptoms precceding a relapse (prodromal), specially those related to mania, can be reliably identified by people with BD. There have been intents to teach patients coping strategies when noticing such symptoms with encouraging results.

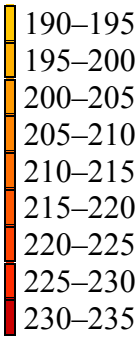
Mortality

Bipolar disorder can cause suicidal ideation that leads to suicidal attempts. One out of 3 people with bipolar disorder report past attempts of suicide or complete it, and the annual average suicide rate is 0.4%, which is 10 to 20 times that of the general population. The standardized mortality ratio from suicide in BD is between 18 and 25.

Epidemiology



Disability-adjusted life year for bipolar disorder per 100,000 inhabitants in 2002.
no data
less than 180
180–186
186–190



When broadly defined 4% of people experience bipolar at some point in their life. The lifetime prevalence of bipolar disorder type I, which includes at least a lifetime manic episode, has generally been estimated at 2%. It is equally prevalent in men and women and is found across all cultures and ethnic groups.

A reanalysis of data from the National Epidemiological Catchment Area survey in the United States, however, suggested that 0.8 percent experience a manic episode at least once (the diagnostic threshold for bipolar I) and 0.5 a hypomanic episode (the diagnostic threshold for bipolar II or cyclothymia). Including sub-threshold diagnostic criteria, such as one or two symptoms over a short time-period, an additional 5.1 percent of the population, adding up to a total of 6.4 percent, were classed as having a bipolar spectrum disorder. A more recent analysis of data from a second US National Comorbidity Survey found that 1% met lifetime prevalence criteria for bipolar 1, 1.1% for bipolar II, and 2.4% for subthreshold symptoms. There are conceptual and methodological limitations and variations in the findings. Prevalence studies of bipolar disorder are typically carried out by lay interviewers who follow fully structured/fixed interview schemes; responses to single items from such interviews may suffer limited validity. In addition, diagnosis and prevalence rates are dependent on whether a categorical or spectrum approach is used. Concerns have arisen about the potential for both underdiagnosis and overdiagnosis.

Late adolescence and early adulthood are peak years for the onset of bipolar disorder. One study also found that in 10% of bi-polar cases, the onset of mania had happened after the patient had turned 50.

History

Variations in moods and energy levels have been observed as part of the human experience since time immemorial. The words "melancholia" (an old word for depression) and "mania" have their etymologies in Ancient Greek. The word melancholia is derived from *melas*/μελας, meaning "black", and *chole*/χολη, meaning "bile" or "gall", indicative of the term's origins in pre-Hippocratic humoral theories. Within the humoral theories, mania was viewed as arising from an excess of yellow bile, or a mixture of black and yellow bile. The linguistic origins of mania, however, are not so clear-cut. Several etymologies are proposed by the Roman physician Caelius Aurelianus, including the Greek word ‘ania’, meaning to produce great mental anguish, and ‘manos’, meaning relaxed or loose, which would contextually approximate to an excessive relaxing of the

mind or soul (Angst and Marneros 2001). There are at least five other candidates, and part of the confusion surrounding the exact etymology of the word mania is its varied usage in the pre-Hippocratic poetry and mythologies (Angst and Marneros 2001).

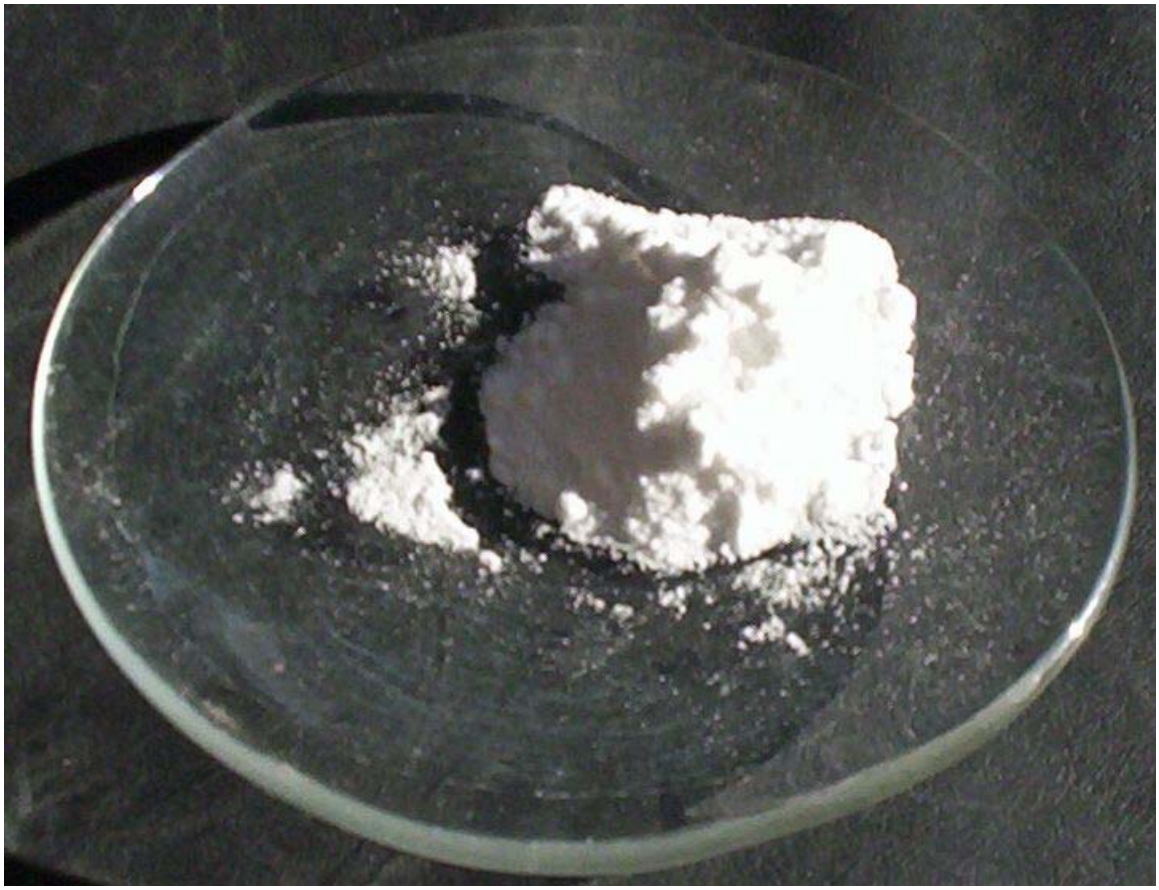
The basis of the current conceptualisation of manic-depressive illness can be traced back to the 1850s; on January 31, 1854, Jules Baillarger described to the French Imperial Academy of Medicine a biphasic mental illness causing recurrent oscillations between mania and depression, which he termed *folie à double forme* ('dual-form insanity'). Two weeks later, on February 14, 1854, Jean-Pierre Falret presented a description to the Academy on what was essentially the same disorder, and designated *folie circulaire* ('circular insanity') by him.(Sedler 1983) The two bitterly disputed as to who had been the first to conceptualise the condition.

These concepts were developed by the German psychiatrist Emil Kraepelin (1856–1926), who, using Kahlbaum's concept of cyclothymia, categorized and studied the natural course of untreated bipolar patients. He coined the term *manic depressive psychosis*, after noting that periods of acute illness, manic or depressive, were generally punctuated by relatively symptom-free intervals where the patient was able to function normally.

The term "manic-depressive *reaction*" appeared in the first American Psychiatric Association Diagnostic Manual in 1952, influenced by the legacy of Adolf Meyer who had introduced the paradigm illness as a reaction of biogenetic factors to psychological and social influences. Subclassification of bipolar disorder was first proposed by German psychiatrist Karl Leonhard in 1957; he was also the first to introduce the terms *bipolar* (for those with mania) and *unipolar* (for those with depressive episodes only).

Specific populations

In children



Lithium carbonate. Lithium is the only drug approved for children with BD by the FDA

Emil Kraepelin in the 1920s noted that mania episodes were rare before puberty. In general BD in children was not recognized in the first half of the XX century this issue diminishing with an increased following of the DSM criteria in the last part of the XXth century.

While in adults the course of BD is characterized by discrete episodes of depression and mania with no clear symptomatology between them, in chidren and adolescents very fast mood changes or even chronic symptoms are the norm. On the other hand pediactric BD instead of euphoric mania commonly develops with outbursts of anger, irritability and psychosis, less common in adults.

The diagnosis of childhood BD is controversial, although it is not under discussion that BD typical symptoms have negative consequences for minors suffering them. Main discussion is centered on whether what is called BD in children refers to the same disorder than when diagnosing adults, and the related question on whether adults criteria for diagnosis are useful and accurate when applied to children. Regarding diagnosis of

children some experts recommend to follow the DSM criteria. Others believe that these criteria do not separate correctly children with BD from other problems such as ADHD, and emphasize fast mood cycles. Still others argue that what accurately differentiates children with BD is irritability. The practice parameters of the AACAP encourage the first strategy. American children and adolescents diagnosed of BD in community hospitals increased 4-fold reaching rates of up to 40% in 10 years around the beginning of the current century, while in outpatient clinics it doubled reaching the 6%. The data suggest that doctors had been more aggressively applying the diagnosis to children. The reasons for this increase are unclear. Consensus regarding the diagnosis in the pediatric age seems to apply only to the USA. Studies using DSM criteria show that up to 1% of youth may have BD.

Treatment involves medication and psychotherapy. Drug prescription usually consists in mood stabilizers and atypical antipsychotics. Among the formers lithium is the only compound approved by the FDA for children. Psychological treatment combines normally education on the disease, group therapy and cognitive behavioral therapy. Chronic medication is often needed.

Current research directions for BD in children include optimizing treatments, increasing the knowledge of the genetic and neurobiological basis of the pediatric disorder and improving diagnostic criteria. The DSM-V has proposed a new diagnosis which is considered to cover some presentations currently thought of as childhood-onset bipolar.

In the elderly

There is a relative lack of knowledge about bipolar disorder in late life. There is evidence that it becomes less prevalent with age but nevertheless accounts for a similar percentage of psychiatric admissions; that older bipolar patients had first experienced symptoms at a later age; that later onset of mania is associated with more neurologic impairment; that substance abuse is considerably less common in older groups; and that there is probably a greater degree of variation in presentation and course, for instance individuals may develop new-onset mania associated with vascular changes, or become manic only after recurrent depressive episodes, or may have been diagnosed with bipolar disorder at an early age and still meet criteria. There is also some weak evidence that mania is less intense and there is a higher prevalence of mixed episodes, although there may be a reduced response to treatment. Overall there are likely more similarities than differences from younger adults. In the elderly, recognition and treatment of bipolar disorder may be complicated by the presence of dementia or the side effects of medications being taken for other conditions.

Chapter 13

Bipolar I Disorder and Bipolar II Disorder

Bipolar I disorder

Bipolar I disorder	
ICD-9	296.7

Bipolar I disorder is a mood disorder that is characterized by at least one manic or mixed episode. There may be episodes of hypomania or major depression as well. It is a sub-diagnosis of bipolar disorder, and conforms to the classic concept of manic-depressive illness.

DSM-IV-TR diagnostic criteria

The essential feature of bipolar I disorder is a clinical course that is characterized by the occurrence of one or more manic episodes or mixed episodes. Often individuals have also had one or more major depressive episodes. Episodes of substance-induced mood disorder due to the direct effects of a medication, or other somatic treatments for depression, drug abuse, or toxin exposure, or of mood disorder due to a general medical condition need to be excluded before a diagnosis of bipolar I disorder can be made. In addition, the episodes must not be better accounted for by schizoaffective disorder or superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or a psychotic disorder not otherwise specified.

General diagnosis codes DSM-IV-TR

Dx Code #	Disorder	Description
296.0x	Bipolar I disorder	Single manic episode
296.40	Bipolar I disorder	Most recent episode hypomanic
296.4x	Bipolar I disorder	Most recent episode manic
296.6x	Bipolar I disorder	Most recent episode mixed

296.5x Bipolar I disorder Most recent episode depressed
296.7 Bipolar I disorder Most recent episode unspecified

Treatment

Medical assessment

Routine medical assessments are often prescribed to rule-out or identify a somatic cause for bipolar I symptoms. These tests can include ultrasounds of the head, x-ray computed tomography (CAT scan), electroencephalogram, HIV test, full blood count, thyroid function test, liver function test, urea and creatinine levels and if patient is on lithium, lithium levels are taken. Drug screening includes recreational drugs, particularly cannabinoids, and exposure to toxins.

Medication

Mood stabilizers

1. Lithium carbonate, the mainstay in the management of bipolar disorder, but it has a narrow therapeutic range and typically requires monitoring
2. Anticonvulsants, such as sodium valproate, carbamazepine or lamotrigine
3. Antipsychotics, such as quetiapine, risperidone, olanzapine or aripiprazole
4. Electroconvulsive therapy, a psychiatric treatment in which seizures are electrically induced in anesthetized patients for therapeutic effect

Some antidepressants have been found to precipitate a manic episode.

Patient education

Information on the condition, importance of regular sleep patterns, routines and eating habits and the importance of compliance with medication as prescribed. Behavior modification through counselling can have positive influence to help reduce the effects of risky behavior during the manic phase.

ICD-10 diagnostic criteria

- F31 Bipolar Affective Disorder
- F31.6 Bipolar Affective Disorder, Current Episode Mixed
- F30 Manic Episode
- F30.0 Hypomania
- F30.1 Mania Without Psychotic Symptoms
- F30.2 Mania With Psychotic Symptoms
- F32 Depressive Episode
- F32.0 Mild Depressive Episode
- F32.1 Moderate Depressive Episode
- F32.2 Severe Depressive Episode Without Psychotic Symptoms

- F32.3 Severe Depressive Episode With Psychotic Symptoms

Bipolar II disorder

Bipolar II disorder	
ICD-10	F31.8

Bipolar II disorder is a bipolar spectrum disorder characterized by at least one hypomanic episode and at least one major depressive episode; with this disorder, depressive episodes are more frequent and more intense than manic episodes. It is believed to be under-diagnosed because hypomanic behavior often presents as incredibly high-functioning behavior. Indeed, to a physician or psychologist specializing in mood disorders, highly confident ambition might appear to be symptomatic of hypomania only if that individual's goals are viewed as unrealistic.

Treatments

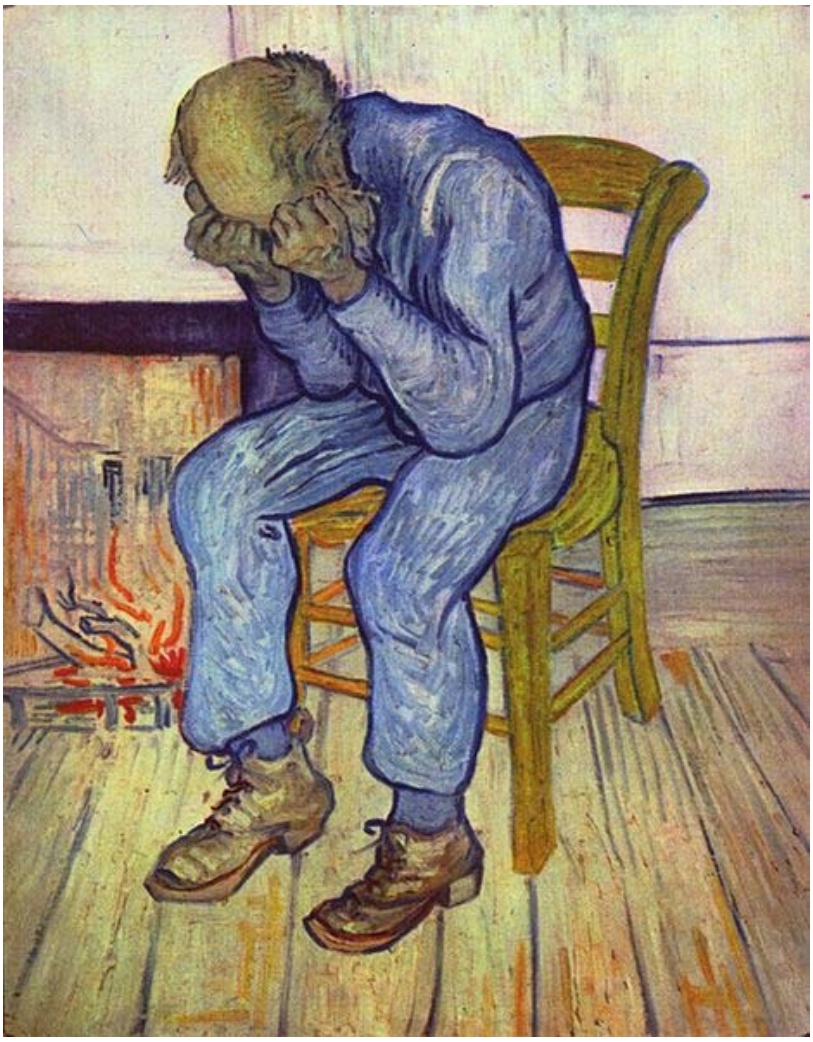
The most common treatment for reducing bipolar II disorder symptoms is medication, usually in the form of mood stabilizers. However, treatment with mood stabilizers often produces a flat affect in the patient. Concurrent use of SSRI antidepressants may help some with bipolar II disorder, though they should be used with caution because they exacerbate manic symptoms in some people. Non-medication therapies can also help those with the illness. These include psychodynamic therapy, psychoanalysis, social rhythm therapy, interpersonal therapy, behavioral therapy, cognitive therapy, Music therapy, psychoeducation, light therapy, and family-focused therapy. Relapses can still occur, even with continued medication and therapy.

Specifiers

- Chronic
- With catatonic features
- With melancholic features
- With psychotic features
- With atypical features
- With postpartum onset
- Longitudinal course specifiers (with and without inter-episode recovery)
- With seasonal pattern (applies only to the pattern of major depressive episodes)
- With rapid cycling

Chapter 14

Major Depressive Disorder



Vincent van Gogh's 1890 painting
At Eternity's Gate

Major depressive disorder (**MDD**) (also known as **recurrent depressive disorder**, **clinical depression**, **major depression**, **unipolar depression**, or **unipolar disorder**) is a mental disorder characterized by an all-encompassing low mood accompanied by low

self-esteem, and by loss of interest or pleasure in normally enjoyable activities. This cluster of symptoms (syndrome) was named, described and classified as one of the mood disorders in the 1980 edition of the American Psychiatric Association's diagnostic manual. The term "depression" is ambiguous. It is often used to denote this syndrome but may refer to any or all of the mood disorders. Major depressive disorder is a disabling condition which adversely affects a person's family, work or school life, sleeping and eating habits, and general health. In the United States, around 3.4% of people with major depression commit suicide, and up to 60% of people who commit suicide had depression or another mood disorder.

The diagnosis of major depressive disorder is based on the patient's self-reported experiences, behavior reported by relatives or friends, and a mental status examination. There is no laboratory test for major depression, although physicians generally request tests for physical conditions that may cause similar symptoms. If depressive disorder is not detected in the early stages it may result in a slow recovery and affect or worsen the person's physical health. The most common time of onset is between the ages of 20 and 30 years, with a later peak between 30 and 40 years.

Typically, patients are treated with antidepressant medication and, in many cases, also receive psychotherapy or counseling although the effectiveness of medication for mild or moderate cases is questionable. Hospitalization may be necessary in cases with associated self-neglect or a significant risk of harm to self or others. A minority are treated with electroconvulsive therapy (ECT), under a short-acting general anaesthetic. The course of the disorder varies widely, from one episode lasting weeks to a lifelong disorder with recurrent major depressive episodes. Depressed individuals have shorter life expectancies than those without depression, in part because of greater susceptibility to medical illnesses and suicide. It is unclear whether or not medications affect the risk of suicide. Current and former patients may be stigmatized.

The understanding of the nature and causes of depression has evolved over the centuries, though this understanding is incomplete and has left many aspects of depression as the subject of discussion and research. Proposed causes include psychological, psycho-social, hereditary, evolutionary and biological factors. Certain types of long-term drug use can both cause and worsen depressive symptoms. Psychological treatments are based on theories of personality, interpersonal communication, and learning. Most biological theories focus on the monoamine chemicals serotonin, norepinephrine and dopamine, which are naturally present in the brain and assist communication between nerve cells.

Symptoms and signs

Major depression significantly affects a person's family and personal relationships, work or school life, sleeping and eating habits, and general health. Its impact on functioning and well-being has been equated to that of chronic medical conditions such as diabetes.

A person having a major depressive episode usually exhibits a very low mood, which pervades all aspects of life, and an inability to experience pleasure in activities that were

formerly enjoyed. Depressed people may be preoccupied with, or ruminate over, thoughts and feelings of worthlessness, inappropriate guilt or regret, helplessness, hopelessness, and self-hatred. In severe cases, depressed people may have symptoms of psychosis. These symptoms include delusions or, less commonly, hallucinations, usually unpleasant. Other symptoms of depression include poor concentration and memory (especially in those with melancholic or psychotic features), withdrawal from social situations and activities, reduced sex drive, and thoughts of death or suicide.

Insomnia is common among the depressed. In the typical pattern, a person wakes very early and cannot get back to sleep, but insomnia can also include difficulty falling asleep. Insomnia affects at least 80% of depressed people. Hypersomnia, or oversleeping, can also happen, affecting 15% of depressed people. Some antidepressants may also cause insomnia due to their stimulating effect.

A depressed person may report multiple physical symptoms such as fatigue, headaches, or digestive problems; physical complaints are the most common presenting problem in developing countries, according to the World Health Organization's criteria for depression. Appetite often decreases, with resulting weight loss, although increased appetite and weight gain occasionally occur. Family and friends may notice that the person's behavior is either agitated or lethargic.

The concept of depression is more controversial in regards to children, and depends on the view that is taken about when self-image develops and becomes fully established. Depressed children may often display an irritable mood rather than a depressed mood, and show varying symptoms depending on age and situation. Most lose interest in school and show a decline in academic performance. They may be described as clingy, demanding, dependent, or insecure. Diagnosis may be delayed or missed when symptoms are interpreted as normal moodiness. Depression may also coexist with attention-deficit hyperactivity disorder (ADHD), complicating the diagnosis and treatment of both.

Older depressed people may have cognitive symptoms of recent onset, such as forgetfulness, and a more noticeable slowing of movements. Depression often coexists with physical disorders common among the elderly, such as stroke, other cardiovascular diseases, Parkinson's disease, and chronic obstructive pulmonary disease.

Causes

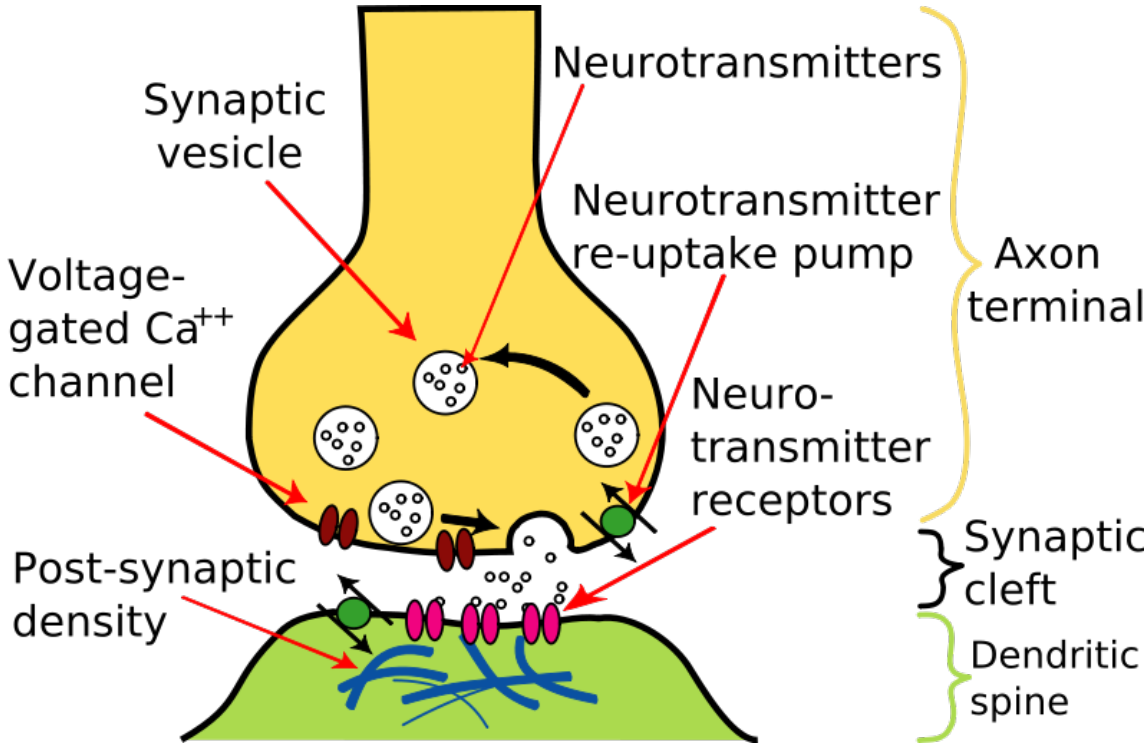
The biopsychosocial model proposes that biological, psychological, and social factors all play a role in causing depression. The diathesis–stress model specifies that depression results when a preexisting vulnerability, or diathesis, is activated by stressful life events. The preexisting vulnerability can be either genetic, implying an interaction between nature and nurture, or schematic, resulting from views of the world learned in childhood.

These interactive models have gained empirical support. For example, researchers in New Zealand took a prospective approach to studying depression, by documenting over time how depression emerged among an initially normal cohort of people. The

researchers concluded that variation among the serotonin transporter (5-HTT) gene affects the chances that people who have dealt with very stressful life events will go on to experience depression. Specifically, depression may follow such events, but seems more likely to appear in people with one or two short alleles of the 5-HTT gene. Additionally, a Swedish study estimated the heritability of depression—the degree to which individual differences in occurrence are associated with genetic differences—to be around 40% for women and 30% for men, and evolutionary psychologists have proposed that the genetic basis for depression lies deep in the history of naturally selected adaptations. A substance-induced mood disorder resembling major depression has been causally linked to long-term drug use or drug abuse, or to withdrawal from certain sedative and hypnotic drugs.

Biological

Monoamine hypothesis



Of approximately 30 neurotransmitters that have been identified, researchers have discovered associations between clinical depression and the function of three primary neurochemicals: serotonin, norepinephrine, and dopamine. Antidepressants influence the overall balance of these three neurotransmitters function within structures of the brain that regulate emotions, reactions to stress, and the physical drives of sleep, appetite, and sexuality.

Most antidepressant medications increase the levels of one or more of the monoamines—the neurotransmitters serotonin, norepinephrine and dopamine—in the synaptic cleft between neurons in the brain. Some medications affect the monoamine receptors directly.

Serotonin is hypothesized to regulate other neurotransmitter systems; decreased serotonin activity may allow these systems to act in unusual and erratic ways. According to this "permissive hypothesis", depression arises when low serotonin levels promote low levels of norepinephrine, another monoamine neurotransmitter. Some antidepressants enhance the levels of norepinephrine directly, whereas others raise the levels of dopamine, a third monoamine neurotransmitter. These observations gave rise to the monoamine hypothesis of depression. In its contemporary formulation, the monoamine hypothesis postulates that a deficiency of certain neurotransmitters is responsible for the corresponding features of depression: "Norepinephrine may be related to alertness and energy as well as anxiety, attention, and interest in life; [lack of] serotonin to anxiety, obsessions, and compulsions; and dopamine to attention, motivation, pleasure, and reward, as well as interest in life." The proponents of this theory recommend the choice of an antidepressant with mechanism of action that impacts the most prominent symptoms. Anxious and irritable patients should be treated with SSRIs or norepinephrine reuptake inhibitors, and those experiencing a loss of energy and enjoyment of life with norepinephrine- and dopamine-enhancing drugs.

Besides the clinical observations that drugs which increase the amount of available monoamines are effective antidepressants, recent advances in psychiatric genetics indicate that phenotypic variation in central monoamine function may be marginally associated with vulnerability to depression. Despite these findings, the cause of depression is not simply monoamine deficiency. In the past two decades, research has revealed multiple limitations of the monoamine hypothesis, and its explanatory inadequacy has been highlighted within the psychiatric community. A counterargument is that the mood-enhancing effect of MAO inhibitors and SSRIs takes weeks of treatment to develop, even though the boost in available monoamines occurs within hours. Another counterargument is based on experiments with pharmacological agents that cause depletion of monoamines; while deliberate reduction in the concentration of centrally available monoamines may slightly lower the mood of unmedicated depressed patients, this reduction does not affect the mood of healthy people. An intact monoamine system is necessary for antidepressants to achieve therapeutic effectiveness, but some medications like tianeptine and opipramol have antidepressant properties despite the fact that the former is a serotonin reuptake enhancer and the latter has no effect on the monoamine system. The monoamine hypothesis, already limited, has been further oversimplified when presented to the general public as a mass marketing tool, usually phrased as a "chemical imbalance".

In 2003 a gene-environment interaction (GxE) was hypothesized to explain why life stress is a predictor for depressive episodes in some individuals, but not in others, depending on an allelic variation of the serotonin-transporter-linked promoter region (5-HTTLPR); a 2009 meta-analysis showed stressful life events was associated with depression, but found no evidence for an association with the 5-HTTLPR genotype. Another 2009 meta-analysis agreed with the latter finding. A 2010 review of studies in this area found a systematic relationship between the method used to assess environmental adversity and the results of the studies; this review also found that both

2009 meta-analyses were significantly biased toward negative studies, which used self-report measures of adversity.

Other theories

MRI scans of patients with depression have revealed a number of differences in brain structure compared to those who are not depressed. Although there is some inconsistency in the results, meta-analyses have shown there is evidence for smaller hippocampal volumes and increased numbers of hyperintensive lesions. Hyperintensities have been associated with patients with a late age of onset, and have led to the development of the theory of vascular depression.

There may be a link between depression and neurogenesis of the hippocampus, a center for both mood and memory. Loss of hippocampal neurons is found in some depressed individuals and correlates with impaired memory and dysthymic mood. Drugs may increase serotonin levels in the brain, stimulating neurogenesis and thus increasing the total mass of the hippocampus. This increase may help to restore mood and memory. Similar relationships have been observed between depression and an area of the anterior cingulate cortex implicated in the modulation of emotional behavior. One of the neurotrophins responsible for neurogenesis is brain-derived neurotrophic factor (BDNF). The level of BDNF in the blood plasma of depressed subjects is drastically reduced (more than threefold) as compared to the norm. Antidepressant treatment increases the blood level of BDNF. Although decreased plasma BDNF levels have been found in many other disorders, there is some evidence that BDNF is involved in the cause of depression and the mechanism of action of antidepressants.

There is some evidence that major depression may be caused in part by an overactive hypothalamic-pituitary-adrenal axis (HPA axis) that results in an effect similar to the neuro-endocrine response to stress. Investigations reveal increased levels of the hormone cortisol and enlarged pituitary and adrenal glands, suggesting disturbances of the endocrine system may play a role in some psychiatric disorders, including major depression. Oversecretion of corticotropin-releasing hormone from the hypothalamus is thought to drive this, and is implicated in the cognitive and arousal symptoms.

The hormone estrogen has been implicated in depressive disorders due to the increase in risk of depressive episodes after puberty, the antenatal period, and reduced rates after menopause. Conversely, the premenstrual and postpartum periods of low estrogen levels are also associated with increased risk. Sudden withdrawal of, fluctuations in or periods of sustained low levels of estrogen have been linked to significant mood lowering. Clinical recovery from depression postpartum, perimenopause, and postmenopause was shown to be effective after levels of estrogen were stabilized or restored.

Other research has explored potential roles of molecules necessary for overall cellular functioning: cytokines. The symptoms of major depressive disorder are nearly identical to those of sickness behavior, the response of the body when the immune system is fighting an infection. This raises the possibility that depression can result from a maladaptive

manifestation of sickness behavior as a result of abnormalities in circulating cytokines. The involvement of pro-inflammatory cytokines in depression is strongly suggested by a meta-analysis of the clinical literature showing higher blood concentrations of IL-6 and TNF-α in depressed subjects compared to controls.

Finally, some relationships have been reported between specific subtypes of depression and climatic conditions. Thus, the incidence of psychotic depression has been found to increase when the barometric pressure is low, while the incidence of melancholic depression has been found to increase when the temperature and/or sunlight are low.

Psychological

Various aspects of personality and its development appear to be integral to the occurrence and persistence of depression, with negative emotionality as a common precursor. Although depressive episodes are strongly correlated with adverse events, a person's characteristic style of coping may be correlated with their resilience. Additionally, low self-esteem and self-defeating or distorted thinking are related to depression. Depression is less likely to occur, as well as quicker to remit, among those who are religious. It is not always clear which factors are causes or which are effects of depression; however, depressed persons who are able to reflect upon and challenge their thinking patterns often show improved mood and self-esteem.

American psychiatrist Aaron T. Beck, following on from the earlier work of George Kelly and Albert Ellis, developed what is now known as a cognitive model of depression in the early 1960s. He proposed that three concepts underlie depression: a triad of negative thoughts composed of cognitive errors about oneself, one's world, and one's future; recurrent patterns of depressive thinking, or *schemas*; and distorted information processing. From these principles, he developed the structured technique of cognitive behavioral therapy (CBT). According to American psychologist Martin Seligman, depression in humans is similar to learned helplessness in laboratory animals, who remain in unpleasant situations when they are able to escape, but do not because they initially learned they had no control.

Attachment theory, which was developed by English psychiatrist John Bowlby in the 1960s, predicts a relationship between depressive disorder in adulthood and the quality of the earlier bond between the infant and their adult caregiver. In particular, it is thought that "the experiences of early loss, separation and rejection by the parent or caregiver (conveying the message that the child is unlovable) may all lead to insecure internal working models ... Internal cognitive representations of the self as unlovable and of attachment figures as unloving [or] untrustworthy would be consistent with parts of Beck’s cognitive triad". While a wide variety of studies has upheld the basic tenets of attachment theory, research has been inconclusive as to whether self-reported early attachment and later depression are demonstrably related.

Depressed individuals often blame themselves for negative events, and, as shown in a 1993 study of hospitalized adolescents with self-reported depression, those who blame

themselves for negative occurrences may not take credit for positive outcomes. This tendency is characteristic of a depressive attributional, or pessimistic explanatory style. According to Albert Bandura, a Canadian social psychologist associated with social cognitive theory, depressed individuals have negative beliefs about themselves, based on experiences of failure, observing the failure of social models, a lack of social persuasion that they can succeed, and their own somatic and emotional states including tension and stress. These influences may result in a negative self-concept and a lack of self-efficacy; that is, they do not believe they can influence events or achieve personal goals.

An examination of depression in women indicates that vulnerability factors—such as early maternal loss, lack of a confiding relationship, responsibility for the care of several young children at home, and unemployment—can interact with life stressors to increase the risk of depression. For older adults, the factors are often health problems, changes in relationships with a spouse or adult children due to the transition to a care-giving or care-needing role, the death of a significant other, or a change in the availability or quality of social relationships with older friends because of their own health-related life changes.

The understanding of depression has also received contributions from the psychoanalytic and humanistic branches of psychology. From the classical psychoanalytic perspective of Austrian psychiatrist Sigmund Freud, depression, or *melancholia*, may be related to interpersonal loss and early life experiences. Existential therapists have connected depression to the lack of both meaning in the present and a vision of the future. The founder of humanistic psychology, American psychologist Abraham Maslow, suggested that depression could arise when people are unable to attain their needs or to self-actualize (to realize their full potential).

Social

Poverty and social isolation are associated with increased risk of mental health problems in general. Child abuse (physical, emotional, sexual, or neglect) is also associated with increased risk of developing depressive disorders later in life. Such a link has good face validity given that it is during the years of development that a child is learning how to become a social being. Abuse of the child by the caregiver is bound to distort the developing personality and create a much greater risk for depression and many other debilitating mental and emotional states. Disturbances in family functioning, such as parental (particularly maternal) depression, severe marital conflict or divorce, death of a parent, or other disturbances in parenting are additional risk factors. In adulthood, stressful life events are strongly associated with the onset of major depressive episodes. In this context, life events connected to social rejection appear to be particularly related to depression. Evidence that a first episode of depression is more likely to be immediately preceded by stressful life events than are recurrent ones is consistent with the hypothesis that people may become increasingly sensitized to life stress over successive recurrences of depression.

The relationship between stressful life events and social support has been a matter of some debate; the lack of social support may increase the likelihood that life stress will

lead to depression, or the absence of social support may constitute a form of strain that leads to depression directly. There is evidence that neighborhood social disorder, for example, due to crime or illicit drugs, is a risk factor, and that a high neighborhood socioeconomic status, with better amenities, is a protective factor. Adverse conditions at work, particularly demanding jobs with little scope for decision-making, are associated with depression, although diversity and confounding factors make it difficult to confirm that the relationship is causal.

Evolutionary

From the standpoint of evolutionary theory, major depression is hypothesized, in some instances, to increase an individual's reproductive fitness. Evolutionary approaches to depression and evolutionary psychology posit specific mechanisms by which depression may have been genetically incorporated into the human gene pool, accounting for the high heritability and prevalence of depression by proposing that certain components of depression are adaptations, such as the behaviors relating to attachment and social rank. Current behaviors can be explained as adaptations to regulate relationships or resources, although the result may be maladaptive in modern environments.

From another viewpoint, a counseling therapist may see depression, not as a biochemical illness or disorder, but as "a species-wide evolved suite of emotional programmes that are mostly activated by a perception, almost always over-negative, of a major decline in personal usefulness, that can sometimes be linked to guilt, shame or perceived rejection". This suite may have manifested in aging hunters in humans' foraging past, who were marginalized by their declining skills, and may continue to appear in alienated members of today's society. The feelings of uselessness generated by such marginalization could hypothetically prompt support from friends and kin. Additionally, in a manner analogous to that in which physical pain has evolved to hinder actions that may cause further injury, "psychic misery" may have evolved to prevent hasty and maladaptive reactions to distressing situations.

Drug and alcohol use

According to the DSM-IV, a diagnosis of mood disorder cannot be made if the cause is believed to be due to "the direct physiological effects of a substance"; when a syndrome resembling major depression is believed to be caused immediately by substance abuse or by an adverse drug reaction, it is referred to as, "substance-induced mood disturbance". Alcoholism or excessive alcohol consumption significantly increases the risk of developing major depression. Like alcohol, the benzodiazepines are central nervous system depressants; this class of medication is commonly used to treat insomnia, anxiety, and muscular spasms. Similar to alcohol, benzodiazepines increase the risk of developing major depression. This increased risk may be due in part to the effects of drugs on neurochemistry, such as decreased levels of serotonin and norepinephrine. Chronic use of benzodiazepines also can cause or worsen depression, or depression may be part of a protracted withdrawal syndrome.

Diagnosis

Clinical assessment

A diagnostic assessment may be conducted by a suitably trained general practitioner, or by a psychiatrist or psychologist, who records the person's current circumstances, biographical history, current symptoms and family history. The broad clinical aim is to formulate the relevant biological, psychological and social factors that may be impacting on the individual's mood. The assessor may also discuss the person's current ways of regulating their mood (healthy or otherwise) such as alcohol and drug use. The assessment also includes a mental state examination, which is an assessment of the person's current mood and thought content, in particular the presence of themes of hopelessness or pessimism, self-harm or suicide, and an absence of positive thoughts or plans. Specialist mental health services are rare in rural areas, and thus diagnosis and management is largely left to primary care clinicians. This issue is even more marked in developing countries. The score on a rating scale alone is insufficient to diagnose depression, but it provides an indication of the severity of symptoms for a time period, so a person who scores above a given cut-off point can be more thoroughly evaluated for a depressive disorder diagnosis. Several rating scales are used for this purpose. Screening programs have been advocated to improve detection of depression, but there is evidence that they do not improve detection rates, treatment, or outcome.

Primary care physicians and other non-psychiatrist physicians have difficulty diagnosing depression, in part because they are trained to recognize and treat physical symptoms, and depression can cause a myriad of physical (psychosomatic) symptoms. Non-psychiatrists miss two-thirds of cases and unnecessarily treat other patients.

Before diagnosing a major depressive disorder, a doctor generally performs a medical examination and selected investigations to rule out other causes of symptoms. These include blood tests measuring TSH and thyroxine to exclude hypothyroidism; basic electrolytes and serum calcium to rule out a metabolic disturbance; and a full blood count including ESR to rule out a systemic infection or chronic disease. Adverse affective reactions to medications or alcohol misuse are often ruled out, as well. Testosterone levels may be evaluated to diagnose hypogonadism, a cause of depression in men.

Subjective cognitive complaints appear in older depressed people, but they can also be indicative of the onset of a dementing disorder, such as Alzheimer's disease. Cognitive testing and brain imaging can help distinguish depression from dementia. A CT scan can exclude brain pathology in those with psychotic, rapid-onset or otherwise unusual symptoms. No biological tests confirm major depression. Investigations are not generally repeated for a subsequent episode unless there is a medical indication.

DSM-IV-TR and ICD-10 criteria

The most widely used criteria for diagnosing depressive conditions are found in the American Psychiatric Association's revised fourth edition of the *Diagnostic and*

Statistical Manual of Mental Disorders (DSM-IV-TR), and the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) which uses the name *recurrent depressive disorder*. The latter system is typically used in European countries, while the former is used in the US and many other non-European nations, and the authors of both have worked towards conforming one with the other.

Major depressive disorder is classified as a mood disorder in DSM-IV-TR. The diagnosis hinges on the presence of single or recurrent major depressive episodes. Further qualifiers are used to classify both the episode itself and the course of the disorder. The category Depressive Disorder Not Otherwise Specified is diagnosed if the depressive episode's manifestation does not meet the criteria for a major depressive episode. The ICD-10 system does not use the term *major depressive disorder*, but lists very similar criteria for the diagnosis of a depressive episode (mild, moderate or severe); the term *recurrent* may be added if there have been multiple episodes without mania.

Major depressive episode

A major depressive episode is characterized by the presence of a severely depressed mood that persists for at least two weeks. Episodes may be isolated or recurrent and are categorized as mild (few symptoms in excess of minimum criteria), moderate, or severe (marked impact on social or occupational functioning). An episode with psychotic features—commonly referred to as *psychotic depression*—is automatically rated as severe. If the patient has had an episode of mania or markedly elevated mood, a diagnosis of bipolar disorder is made instead. Depression without mania is sometimes referred to as *unipolar* because the mood remains at one emotional state or "pole".

DSM-IV-TR excludes cases where the symptoms are a result of bereavement, although it is possible for normal bereavement to evolve into a depressive episode if the mood persists and the characteristic features of a major depressive episode develop. The criteria have been criticized because they do not take into account any other aspects of the personal and social context in which depression can occur. In addition, some studies have found little empirical support for the DSM-IV cut-off criteria, indicating they are a diagnostic convention imposed on a continuum of depressive symptoms of varying severity and duration: Excluded are a range of related diagnoses, including dysthymia, which involves a chronic but milder mood disturbance; recurrent brief depression, consisting of briefer depressive episodes; minor depressive disorder, whereby only some of the symptoms of major depression are present; and adjustment disorder with depressed mood, which denotes low mood resulting from a psychological response to an identifiable event or stressor.

Subtypes

The DSM-IV-TR recognizes five further subtypes of MDD, called *specifiers*, in addition to noting the length, severity and presence of psychotic features:

- **Melancholic depression** is characterized by a loss of pleasure in most or all activities, a failure of reactivity to pleasurable stimuli, a quality of depressed mood more pronounced than that of grief or loss, a worsening of symptoms in the morning hours, early morning waking, psychomotor retardation, excessive weight loss or excessive guilt.
- **Atypical depression** is characterized by mood reactivity (paradoxical anhedonia) and positivity, significant weight gain or increased appetite (comfort eating), excessive sleep or sleepiness (hypersomnia), a sensation of heaviness in limbs known as leaden paralysis, and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection.
- **Catatonic depression** is a rare and severe form of major depression involving disturbances of motor behavior and other symptoms. Here the person is mute and almost stuporous, and either remains immobile or exhibits purposeless or even bizarre movements. Catatonic symptoms also occur in schizophrenia or in manic episodes, or may be caused by neuroleptic malignant syndrome.
- **Postpartum depression**, or **mental and behavioural disorders associated with the puerperium, not elsewhere classified**, refers to the intense, sustained and sometimes disabling depression experienced by women after giving birth. Postpartum depression has an incidence rate of 10–15% among new mothers. The DSM-IV mandates that, in order to qualify as postpartum depression, onset occur within one month of delivery. It has been said that postpartum depression can last as long as three months.
- **Seasonal affective disorder** (SAD) is a form of depression in which depressive episodes come on in the autumn or winter, and resolve in spring. The diagnosis is made if at least two episodes have occurred in colder months with none at other times, over a two-year period or longer.

Differential diagnoses

To confer major depressive disorder as the most likely diagnosis, other potential diagnoses must be considered, including dysthymia, adjustment disorder with depressed mood or bipolar disorder. Dysthymia is a chronic, milder mood disturbance in which a person reports a low mood almost daily over a span of at least two years. The symptoms are not as severe as those for major depression, although people with dysthymia are vulnerable to secondary episodes of major depression (sometimes referred to as *double depression*). Adjustment disorder with depressed mood is a mood disturbance appearing as a psychological response to an identifiable event or stressor, in which the resulting emotional or behavioral symptoms are significant but do not meet the criteria for a major depressive episode. Bipolar disorder, also known as *manic–depressive disorder*, is a condition in which depressive phases alternate with periods of mania or hypomania. Although depression is currently categorized as a separate disorder, there is ongoing debate because individuals diagnosed with major depression often experience some hypomanic symptoms, indicating a mood disorder continuum.

Other disorders need to be ruled out before diagnosing major depressive disorder. They include depressions due to physical illness, medications, and substance abuse. Depression

due to physical illness is diagnosed as a mood disorder due to a general medical condition. This condition is determined based on history, laboratory findings, or physical examination. When the depression is caused by a substance abused including a drug of abuse, a medication, or exposure to a toxin, it is then diagnosed as a substance-induced mood disorder. In such cases, a substance is judged to be etiologically related to the mood disturbance.

Schizoaffective disorder is different from major depressive disorder with psychotic features because in the schizoaffective disorder at least two weeks of delusions or hallucinations must occur in the absence of prominent mood symptoms.

Depressive symptoms may be identified during schizophrenia, delusional disorder, and psychotic disorder not otherwise specified, and in such cases those symptoms are considered associated features of these disorders, therefore, a separate diagnosis is not deemed necessary unless the depressive symptoms meet full criteria for a major depressive episode. In that case, a diagnosis of depressive disorder not otherwise specified may be made as well as a diagnosis of schizophrenia.

Some cognitive symptoms of dementia such as disorientation, apathy, difficulty concentrating and memory loss may get confused with a major depressive episode in major depressive disorder. They are especially difficult to determine in elderly patients. In such cases, the premorbid state of the patient may be helpful to differentiate both disorders. In the case of dementia, there tends to be a premorbid history of declining cognitive function. In the case of a major depressive disorder patients tend to exhibit a relatively normal premorbid state and abrupt cognitive decline associated with the depression.

Prevention

Behavioral interventions, such as interpersonal therapy, are effective at preventing new onset depression. Because such interventions appear to be most effective when delivered to individuals or small groups, it has been suggested that they may be able to reach their large target audience most efficiently through the Internet. However, an earlier meta-analysis found preventive programs with a competence-enhancing component to be superior to behaviorally oriented programs overall, and found behavioral programs to be particularly unhelpful for older people, for whom social support programs were uniquely beneficial. Additionally, the programs that best prevented depression comprised more than eight sessions, each lasting between 60 and 90 minutes; were provided by a combination of lay and professional workers; had a high-quality research design; reported attrition rates; and had a well-defined intervention. The "Coping with Depression" course (CWD) is claimed to be the most successful of psychoeducational interventions for the treatment and prevention of depression (both for its adaptability to various populations and its results), with a risk reduction of 38% in major depression and an efficacy as a treatment comparing favorably to other psychotherapies.

Management

The three most common treatments for depression are psychotherapy, medication, and electroconvulsive therapy. Psychotherapy is the treatment of choice for people under 18, while electroconvulsive therapy is only used as a last resort. Care is usually given on an outpatient basis, while treatment in an inpatient unit is considered if there is a significant risk to self or others.

Treatment options are much more limited in developing countries, where access to mental health staff, medication, and psychotherapy is often difficult. Development of mental health services is minimal in many countries; depression is viewed as a phenomenon of the developed world despite evidence to the contrary, and not as an inherently life-threatening condition. Physical exercise is recommended for management of mild depression, but it has only a moderate, statistically insignificant effect on symptoms in most cases of major depressive disorder.

Psychotherapy

Psychotherapy can be delivered, to individuals or groups, by mental health professionals, including psychotherapists, psychiatrists, psychologists, clinical social workers, counselors, and suitably trained psychiatric nurses. With more complex and chronic forms of depression, a combination of medication and psychotherapy may be used. In people under 18, according to the National Institute for Health and Clinical Excellence, medication should only be offered in conjunction with a psychological therapy, such as CBT, interpersonal therapy, or family therapy. Psychotherapy has been shown to be effective in older people. Successful psychotherapy appears to reduce the recurrence of depression even after it has been terminated or replaced by occasional booster sessions.

The most-studied form of psychotherapy for depression is CBT, which teaches clients to challenge self-defeating, but enduring ways of thinking (cognitions) and change counter-productive behaviours. Research beginning in the mid-1990s suggested that CBT could perform as well or better than antidepressants in patients with moderate to severe depression. CBT may be effective in depressed adolescents, although its effects on severe episodes are not definitively known. Combining fluoxetine with CBT appeared to bring no additional benefit, or, at the most, only marginal benefit. Several variables predict success for cognitive behavioral therapy in adolescents: higher levels of rational thoughts, less hopelessness, fewer negative thoughts, and fewer cognitive distortions. CBT is particularly beneficial in preventing relapse. Several variants of cognitive behavior therapy have been used in depressed patients, most notably rational emotive behavior therapy, and more recently mindfulness-based cognitive therapy.

Psychoanalysis is a school of thought, founded by Sigmund Freud, which emphasizes the resolution of unconscious mental conflicts. Psychoanalytic techniques are used by some practitioners to treat clients presenting with major depression. A more widely practiced, eclectic technique, called psychodynamic psychotherapy, is loosely based on psychoanalysis and has an additional social and interpersonal focus. In a meta-analysis of

three controlled trials of Short Psychodynamic Supportive Psychotherapy, this modification was found to be as effective as medication for mild to moderate depression.

Logotherapy, a form of existential psychotherapy developed by Austrian psychiatrist Viktor Frankl, addresses the filling of an "existential vacuum" associated with feelings of futility and meaninglessness. It is posited that this type of psychotherapy may be useful for depression in older adolescents.

Antidepressants

Zoloft (sertraline) is primarily used to treat major depression in adult outpatients. In 2007, it was the most prescribed antidepressant on the U.S. retail market, with 29,652,000 prescriptions.

The effectiveness of antidepressants are none to minimal in those with mild or moderate depression but significant in those with very severe disease. The effects of antidepressants are somewhat superior to those of psychotherapy, especially in cases of chronic major depression, although in short-term trials more patients—especially those

with less serious forms of depression—cease medication than cease psychotherapy, most likely due to adverse effects from the medication and to patients' preferences for psychological therapies over pharmacological treatments.

To find the most effective antidepressant medication with minimal side effects, the dosages can be adjusted, and if necessary, combinations of different classes of antidepressants can be tried. Response rates to the first antidepressant administered range from 50–75%, and it can take at least six to eight weeks from the start of medication to remission, when the patient is back to their normal self. Antidepressant medication treatment is usually continued for 16 to 20 weeks after remission, to minimize the chance of recurrence, and even up to one year of continuation is recommended. People with chronic depression may need to take medication indefinitely to avoid relapse.

Selective serotonin reuptake inhibitors (SSRIs) are the primary medications prescribed owing to their effectiveness, relatively mild side effects, and because they are less toxic in overdose than other antidepressants. Patients who do not respond to one SSRI can be switched to another antidepressant, and this results in improvement in almost 50% of cases. Another option is to switch to the atypical antidepressant bupropion. Venlafaxine, an antidepressant with a different mechanism of action, may be modestly more effective than SSRIs. However, venlafaxine is not recommended in the UK as a first-line treatment because of evidence suggesting its risks may outweigh benefits, and it is specifically discouraged in children and adolescents. For adolescent depression, fluoxetine and escitalopram are the two recommended choices. Antidepressants have not been found to be beneficial in children. Any antidepressant can cause low serum sodium levels (also called hyponatremia); nevertheless, it has been reported more often with SSRIs. It is not uncommon for SSRIs to cause or worsen insomnia; the sedating antidepressant mirtazapine can be used in such cases.

Monoamine oxidase inhibitors, an older class of antidepressants, have been plagued by potentially life-threatening dietary and drug interactions. They are still used only rarely, although newer and better tolerated agents of this class have been developed.

The terms "refractory depression" and "treatment-resistant depression" are used to describe cases that do not respond to adequate courses of at least two antidepressants. In many major studies, only about 35% of patients respond well to medical treatment. It may be difficult for a doctor to decide when someone has treatment-resistant depression or whether the problem is due to coexisting disorders, which are common among patients with major depression.

A team of psychologists from multiple American universities found that antidepressant drugs hardly have better effects than a placebo in cases of mild or moderate depression. The study focused on paroxetine and imipramine.

For children, adolescents, and probably young adults between 18–24 years old, there is a higher risk of both suicidal ideations and suicidal behavior in those treated with SSRIs. For adults, it is unclear whether or not SSRIs affect the risk of suicidality. One review

found no connection; another an increased risk; and a third no risk in those 25–65 years old and a decrease risk in those more than 65. Epidemiological data has found that the widespread use of antidepressants in the new "SSRI-era" is associated with a significant decline in suicide rates in most countries with traditionally high baseline suicide rates. The causality of the relationship is inconclusive. A black box warning was introduced in the United States in 2007 on SSRI and other antidepressant medications due to increased risk of suicide in patients younger than 24 years old. Similar precautionary notice revisions were implemented by the Japanese Ministry of Health.

Electroconvulsive therapy

Electroconvulsive therapy (ECT) is a procedure whereby pulses of electricity are sent through the brain via two electrodes, usually one on each temple, to induce a seizure while the patient is under a brief period of general anaesthesia. Hospital psychiatrists may recommend ECT for cases of severe major depression which have not responded to antidepressant medication or, less often, psychotherapy or supportive interventions. ECT can have a quicker effect than antidepressant therapy and thus may be the treatment of choice in emergencies such as catatonic depression where the patient has stopped eating and drinking, or where a patient is severely suicidal. ECT is probably more effective than pharmacotherapy for depression in the immediate short-term, although a landmark community-based study found much lower remission rates in routine practice. When ECT is used on its own, the relapse rate within the first six months is very high; early studies put the rate at around 50%, while a more recent controlled trial found rates of 84% even with placebos. The early relapse rate may be reduced by the use of psychiatric medications or further ECT (although the latter is not recommended by some authorities) but remains high. Common initial adverse effects from ECT include short and long-term memory loss, disorientation and headache. Although memory disturbance after ECT usually resolves within one month, ECT remains a controversial treatment, and debate on its efficacy and safety continues.

Prognosis

Major depressive episodes often resolve over time whether or not they are treated. Outpatients on a waiting list show a 10–15% reduction in symptoms within a few months, with approximately 20% no longer meeting the full criteria for a depressive disorder. The median duration of an episode has been estimated to be 23 weeks, with the highest rate of recovery in the first three months.

Studies have shown that 80% of those suffering from their first major depressive episode will suffer from at least 1 more during their life, with a lifetime average of 4 episodes. Other general population studies indicate around half those who have an episode (whether treated or not) recover and remain well, while the other half will have at least one more, and around 15% of those experience chronic recurrence. Studies recruiting from selective inpatient sources suggest lower recovery and higher chronicity, while studies of mostly outpatients show that nearly all recover, with a median episode duration

of 11 months. Around 90% of those with severe or psychotic depression, most of whom also meet criteria for other mental disorders, experience recurrence.

Recurrence is more likely if symptoms have not fully resolved with treatment. Current guidelines recommend continuing antidepressants for four to six months after remission to prevent relapse. Evidence from many randomized controlled trials indicates continuing antidepressant medications after recovery can reduce the chance of relapse by 70% (41% on placebo vs. 18% on antidepressant). The preventive effect probably lasts for at least the first 36 months of use.

Those people who experience repeated episodes of depression are required quick and ongoing treatment in order to prevent more severe, long-term depression. In some cases, people need to take medications for long periods of time or for the rest of their lives.

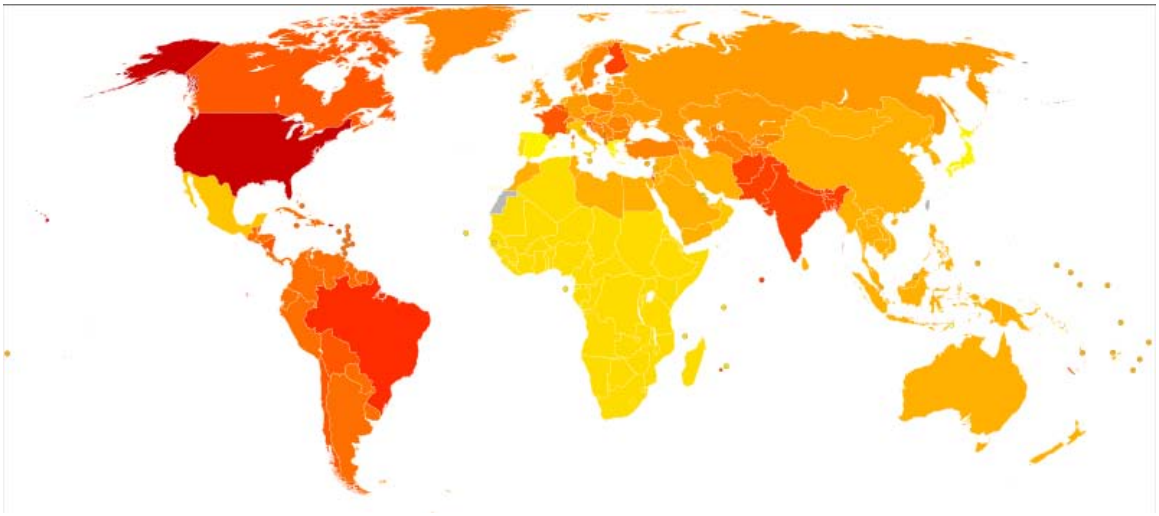
Cases when outcome is poor are associated with inappropriate treatment, severe initial symptoms that may include psychosis, early age of onset, more previous episodes, incomplete recovery after 1 year, pre-existing severe mental or medical disorder, and family dysfunction as well.

Depressed individuals have a shorter life expectancy than those without depression, in part because depressed patients are at risk of dying by suicide. However, they also have a higher rate of dying from other causes, being more susceptible to medical conditions such as heart disease. Up to 60% of people who commit suicide have a mood disorder such as major depression, and the risk is especially high if a person has a marked sense of hopelessness or has both depression and borderline personality disorder. The lifetime risk of suicide associated with a diagnosis of major depression in the US is estimated at 3.4%, which averages two highly disparate figures of almost 7% for men and 1% for women (although suicide attempts are more frequent in women). The estimate is substantially lower than a previously accepted figure of 15% which had been derived from older studies of hospitalized patients.

Depression is often associated with unemployment and poverty. Major depression is currently the leading cause of disease burden in North America and other high-income countries, and the fourth-leading cause worldwide. In the year 2030, it is predicted to be the second-leading cause of disease burden worldwide after HIV, according to the World Health Organization. Delay or failure in seeking treatment after relapse, and the failure of health professionals to provide treatment, are two barriers to reducing disability.

Epidemiology

Prevalence



Age-standardised disability-adjusted life year (DALY) rates of unipolar depressive disorders by country (per 100,000 inhabitants) in 2004.

Depression is a major cause of morbidity worldwide. Lifetime prevalence varies widely, from 3% in Japan to 17% in the US. In most countries the number of people who would suffer from depression during their lives falls within an 8–12% range. In North America the probability of having a major depressive episode within a year-long period is 3–5% for males and 8–10% for females. Population studies have consistently shown major depression to be about twice as common in women as in men, although it is unclear why this is so, and whether factors unaccounted for are contributing to this. The relative increase in occurrence is related to pubertal development rather than chronological age, reaches adult ratios between the ages of 15 and 18, and appears associated with psychosocial more than hormonal factors.

People are most likely to suffer their first depressive episode between the ages of 30 and 40, and there is a second, smaller peak of incidence between ages 50 and 60. The risk of major depression is increased with neurological conditions such as stroke, Parkinson's disease, or multiple sclerosis and during the first year after childbirth. It is also more common after cardiovascular illnesses, and is related more to a poor outcome than to a better one. Studies conflict on the prevalence of depression in the elderly, but most data suggest there is a reduction in this age group. Depressive disorder are most common to observe in urban than in rural population and the prevalence is in groups with higher socioeconomic factors i.e. homeless people

Comorbidity

Major depression frequently co-occurs with other psychiatric problems. The 1990–92 *National Comorbidity Survey* (US) reports that 51% of those with major depression also

suffer from lifetime anxiety. Anxiety symptoms can have a major impact on the course of a depressive illness, with delayed recovery, increased risk of relapse, greater disability and increased suicide attempts. American neuroendocrinologist Robert Sapolsky similarly argues that the relationship between stress, anxiety, and depression could be measured and demonstrated biologically. There are increased rates of alcohol and drug abuse and particularly dependence, and around a third of individuals diagnosed with ADHD develop comorbid depression. Post-traumatic stress disorder and depression often co-occur.

Depression and pain often co-occur. This may be for the simple reason that is obviously depressing to be in pain, especially if it is chronic or cannot be controlled. This also fits with Seligman's theory of learned helplessness. One or more pain symptoms is present in 65% of depressed patients, and anywhere from five to 85% of patients with pain will be suffering from depression, depending on the setting; there is a lower prevalence in general practice, and higher in specialty clinics. The diagnosis of depression is often delayed or missed, and the outcome worsens. The outcome can also obviously worsen if the depression is noticed but completely misunderstood

Depression is also associated with a 1.5- to 2-fold increased risk of cardiovascular disease, independent of other known risk factors, and is itself linked directly or indirectly to risk factors such as smoking and obesity. People with major depression are less likely to follow medical recommendations for treating cardiovascular disorders, which further increases their risk. In addition, cardiologists may not recognize underlying depression that complicates a cardiovascular problem under their care.

History

The Ancient Greek physician Hippocrates described a syndrome of melancholia as a distinct disease with particular mental and physical symptoms; he characterized all "fears and despondencies, if they last a long time" as being symptomatic of the ailment. It was a similar but far broader concept than today's depression; prominence was given to a clustering of the symptoms of sadness, dejection, and despondency, and often fear, anger, delusions and obsessions were included.

The term *depression* itself was derived from the Latin verb *deprimere*, "to press down". From the 14th century, "to depress" meant to subjugate or to bring down in spirits. It was used in 1665 in English author Richard Baker's *Chronicle* to refer to someone having "a great depression of spirit", and by English author Samuel Johnson in a similar sense in 1753. The term also came in to use in physiology and economics. An early usage referring to a psychiatric symptom was by French psychiatrist Louis Delasiauve in 1856, and by the 1860s it was appearing in medical dictionaries to refer to a physiological and metaphorical lowering of emotional function. Since Aristotle, melancholia had been associated with men of learning and intellectual brilliance, a hazard of contemplation and creativity. The newer concept abandoned these associations and through the 19th century, became more associated with women.

Although *melancholia* remained the dominant diagnostic term, *depression* gained increasing currency in medical treatises and was a synonym by the end of the century; German psychiatrist Emil Kraepelin may have been the first to use it as the overarching term, referring to different kinds of melancholia as *depressive states*.

Sigmund Freud likened the state of melancholia to mourning in his 1917 paper *Mourning and Melancholia*. He theorized that objective loss, such as the loss of a valued relationship through death or a romantic break-up, results in subjective loss as well; the depressed individual has identified with the object of affection through an unconscious, narcissistic process called the *libidinal cathexis* of the ego. Such loss results in severe melancholic symptoms more profound than mourning; not only is the outside world viewed negatively, but the ego itself is compromised. The patient's decline of self-perception is revealed in his belief of his own blame, inferiority, and unworthiness. He also emphasized early life experiences as a predisposing factor. Meyer put forward a mixed social and biological framework emphasizing *reactions* in the context of an individual's life, and argued that the term *depression* should be used instead of *melancholia*. The first version of the DSM (DSM-I, 1952) contained *depressive reaction* and the DSM-II (1968) *depressive neurosis*, defined as an excessive reaction to internal conflict or an identifiable event, and also included a depressive type of manic-depressive psychosis within Major affective disorders.

In the mid-20th century, researchers theorized that depression was caused by a chemical imbalance in neurotransmitters in the brain, a theory based on observations made in the 1950s of the effects of reserpine and isoniazid in altering monoamine neurotransmitter levels and affecting depressive symptoms.

The term *Major depressive disorder* was introduced by a group of US clinicians in the mid-1970s as part of proposals for diagnostic criteria based on patterns of symptoms (called the "Research Diagnostic Criteria", building on earlier Feighner Criteria), and was incorporated in to the DSM-III in 1980. To maintain consistency the ICD-10 used the same criteria, with only minor alterations, but using the DSM diagnostic threshold to mark a *mild depressive episode*, adding higher threshold categories for moderate and severe episodes. The ancient idea of *melancholia* still survives in the notion of a melancholic subtype.

The new definitions of depression were widely accepted, albeit with some conflicting findings and views. There have been some continued empirically based arguments for a return to the diagnosis of melancholia. There has been some criticism of the expansion of coverage of the diagnosis, related to the development and promotion of antidepressants and the biological model since the late 1950s.

Chapter 15

Cyclothymia

Cyclothymia	
ICD-10	F34.0
ICD-9	301.13
MeSH	D003527

Cyclothymia is a serious mood and mental disorder that causes both hypomanic and depressive episodes. It is defined medically within the bipolar spectrum. To be specific, this disorder is a milder form of bipolar II disorder, consisting of recurrent disturbances between sudden hypomania and dysthymic episodes. A single episode of hypomania is sufficient to diagnose cyclothymic disorder; however, most individuals also have major dysthymic periods. The diagnosis of cyclothymic disorder is not made when there is a history of mania or major depressive episode or mixed episode. The lifetime pre-eminence of cyclothymic disorder is 0.4-1%. The rate appears equal in men and women, though women more often seek treatment. Unlike some forms of bipolar disorder (to be specific, bipolar I disorder), people with cyclothymia are almost always fully functioning, sometimes even hyper-productive.

Cyclothymia is similar to bipolar II disorder in that it presents itself in signature hypomanic episodes. Because hypomania is often associated with exceptionally creative, outgoing, and high-functioning behavior, both conditions are often undiagnosed. As with most of the disorders in the bipolar spectrum, it is the depressive phase that leads most sufferers to get help. The term derives from the Greek κύκλος (*kuklos*), "circle" + θυμός (*thumos*), "temper".

Differential diagnosis

This disorder is common in the relatives of patients with bipolar disorder, and some individuals with cyclothymia eventually develop bipolar disorder themselves. It may persist throughout adult life, cease temporarily or permanently, or develop into more severe mood swings, meeting the criteria for bipolar disorder or recurrent depressive disorder in rare cases.

Symptoms

Dysthymic phase

Symptoms of the *dysthymic phase* include difficulty making decisions, problems concentrating, poor memory recall, guilt, self-criticism, low self-esteem, pessimism, self-destructive thinking, continuously feeling sad, apathy, hopelessness, helplessness, irritability, quick temper, lack of motivation, social withdrawal, appetite change, lack of sexual desire, self-neglect, fatigue, and insomnia.

Euphoric phase

Symptoms of the *euphoric phase* include unusually good mood or cheerfulness (euphoria), extreme optimism, inflated self-esteem, poor judgment, rapid speech, racing thoughts, aggressive or hostile behavior, being inconsiderate of others, agitation, massively increased physical activity, risky behavior, spending sprees, increased drive to perform or achieve goals, increased sexual drive, decreased need for sleep, tendency to be easily distracted, and inability to concentrate.

Causes

Biological

- Family
  One is 2-3 times more likely to have the disorder if someone in the immediate family has it or if an identical twin has it. In a study by Bertelsen, Harvard, and Huage (1977), if an identical twin had depression, 59% of the identical twins had it also.
  Gender
  Heritability for women ranges from 36-44%; for men, 18-24%.
  Genes
  The same genes may contribute to depression and anxiety.
  Serotonin
  Serotonin regulates other hormones like norepinephrine and dopamine, so, when serotonin is low, the other chemicals may fluctuate, causing irritability, impulsivity, and mood irregularities such as dysthymia and depression.
  Cortisol
  Depressed individuals can have high cortisol levels. Cortisol is a stress hormone, and mood disorders often occur during stressful points in one's life. Elevated stress hormones can affect functioning of the hippocampus, an important centre for memory and cognitive processes. Overproducing cortisol can also impair the brain's ability to regenerate neurons in the hippocampus.

Psychological

- Stressful events, as perceived by the individual
  Relationship failure, job loss, identity change, natural disaster, learned helplessness and hopelessness, extreme feelings, negative thinking patterns.

Social

- Environment
  Influences the disorder 60-80% of the time.
  Parenting styles

Treatment

Exercise

It has been repeatedly demonstrated that regular, vigorous physical exercise can help with mood regulation and emotional stability.

Medications

- Anti-seizure medication/anticonvulsants (e.g., valproic acid, divalproex, and lamotrigine) are options.
- Seroquel
- Klonopin

Therapy

- Cognitive behavioural therapy (CBT)
- Interpersonal psychotherapy (IT)
- Group therapy
- Integrative therapy
- Psychodynamic Therapy

Famous sufferers

- Winston Churchill
- Stephen Fry
- Burgess Meredith
- Franz Schubert

Chapter 16

Hypomania

Hypomania	
ICD-10	F30.0

Hypomania (literally, **below mania**) is a mood state characterized by persistent and pervasive elevated (euphoric) or irritable mood, as well as thoughts and behaviors that are consistent with such a mood state. Individuals in a hypomanic state have a decreased need for sleep, are extremely outgoing and competitive, and have a great deal of energy. However, unlike with full mania, those with hypomanic systems are fully functioning, and are often actually more productive than usual. Specifically, hypomania is distinguished from mania by the absence of psychotic symptoms and by its lower degree of impact on functioning. Hypomania is a feature of bipolar II disorder and cyclothymia, but can also occur in schizoaffective disorder. Hypomania is sometimes credited with increasing creativity and productive energy. A significant number of people with creative talents have reportedly experienced hypomania or other symptoms of bipolar disorder and attribute their success to it. Classic symptoms of hypomania include mild euphoria, a flood of ideas, endless energy, and a desire and drive for success. A lesser form of hypomania is called hyperthymia.

Hypomania is also a side effect of numerous medications, often—though not always—those used in psychopharmacotherapy. Patients suffering from severe depression who experience hypomania as a side effect of (for example) antidepressants, may prove to have a form of bipolar disorder that has previously gone unrecognized. However, drug-induced hypomania is not invariably indicative of bipolar affective disorders. The difference between uni- and bi-polar disorders is essential for analysis of switches. Consequently, it is important for researchers and mental health professionals to distinguish drug-induced hypomania in bipolar patients from drug-induced hypomania in unipolar (non-bipolar) depressives. Nevertheless if antidepressants trigger the first episode of hypomania, it is strongly suggestive of an underlying diagnosis of Bipolar Disorder, particularly if the manic symptoms (mild, moderate or severe) last for a lengthy period of time after they start. In cases of true drug-induced hypomania, cessation of the antidepressant or whichever drug has triggered this mood state - for example steroid therapy or stimulants such as amphetamine - usually causes a fairly swift return to normal mood. It is far less likely to be a side effect in those with pure Clinical Unipolar

Depression, unless for example tricyclic antidepressants are given in very high doses. SSRIs are less likely to trigger manic symptoms except in those individuals where there is an underlying Bipolar Disorder, particularly if administered without a mood stabilizer.

Often in those who have experienced their first episode of hypomania (which is a level of mild to moderate mania) - generally without psychotic features - there will have been a long or recent history of depression prior to the emergence of manic symptoms, and commonly this surfaces in the mid to late teens. Due to this being an emotionally charged time, it is not unusual for mood swings to be passed off as hormonal or teenage ups and downs and for a diagnosis of Bipolar Disorder to be missed until there is evidence of an obvious manic/hypomanic phase.

Hypomania may also occur as a side effect of pharmaceuticals prescribed for conditions/diseases other than psychological states or mood disorders. In those instances, as in cases of drug-induced hypomanic episodes in unipolar depressives, the hypomania can almost invariably be eliminated by lowering medication dosage, withdrawing the drug entirely, or changing to a different medication if discontinuation of treatment is not possible.

Symptomatic recognition

The DSM-IV-TR defines a hypomanic episode as including, over the course of at least four days, elevated mood plus three of the following symptoms OR irritable mood plus four of the following symptoms:

- pressured speech;
- inflated self-esteem or grandiosity;
- decreased need for sleep;
- flight of ideas or the subjective experience that thoughts are racing;
- easy distractibility and attention-deficit (superficially similar to attention deficit hyperactivity disorder);
- increase in psychomotor agitation; and
- involvement in pleasurable activities that may have a high potential for negative psycho-social or physical consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, reckless driving, or foolish business investments).

Explanation of common symptoms

- In the hypomanic state, people may feel that they cannot slow their minds down, and that their speeding thoughts are crafted exceptionally well. Some examples are speaking or writing in rhyme or alliteration without planning it first; quick responses to people talking; or the ability to improvise easily.

- People in hypomanic episodes do not have delusions or hallucinations. They do not lose touch with reality in the sense that they know who they are and what is

real. What can be a problem, however, is that people in a hypomanic state can sometimes overestimate their capabilities and fail to see the risks involved in their ventures. For example, a person may suddenly decide to expand a business in a way that is not really practical or set up schemes for which he or she is ill-prepared, or pursue an unrealistic love interest.

- Hypomanic individuals may also experience difficulty with decision making, resulting in behavior such as reckless driving, gambling, spending sprees and sexual adventures. To a varying degree, promiscuity, loss of social inhibitions, and risk taking, are all very common in hypomanic episodes. Many have described hypomanic individuals as 'the life of the party'.

It is unknown to what degree hypomanic symptoms can occur without a depressive component. Patients may be relatively unlikely to seek psychiatric treatment for hypomania alone. However, many hypomanic patients also experience:

- obsessive behavior, whether mild or severe
- excessive risk-taking (e.g., gambling, foolish business decisions)
- general poor judgment
- a decreased need for sleep. Many hypomanic individuals may get as little as 3–6 hours of sleep a night
- uncontrolled, or only partially controllable, impulsivity
- excessive sexual activity or sexual risk taking

Plus other out-of-character behaviors that the person may regret following the conclusion of the mood episode. A more mild form of elevated mood, which has fewer negative behaviors, is hyperthymic temperament.

Hypomania can signal the beginning of a more severe manic episode, and often does result in a more severe manic episode if the hypomanic episode remains untreated. A hypomanic episode can also directly precede a depressive episode.

Possible benefits

Some commentators believe that hypomania actually has an evolutionary advantage. People with hypomania are generally perceived as being energetic, euphoric, visionary, overflowing with new ideas, and sometimes over-confident and very charismatic, yet—unlike those with full-blown mania—are sufficiently capable of coherent thought and action to participate in everyday activities. Like mania, there seems to be a significant correlation between hypomania and creativity. A person in the state of hypomania might be immune to fear and doubt and have little social and sexual inhibition. People experiencing hypomania are often the "life of the party." They may talk to strangers easily, offer solutions to problems, and find pleasure in small activities. Such advantages may render them unwilling to submit to treatment, especially when disadvantages are minimal.

Relationship with disorders

Cyclothymia is a condition of continued mood fluctuations between hypomania and depressive symptoms that do not meet the criteria for a Major Depressive Episode. These are often interspersed with periods of normal moods.

When a patient presents with a history of one or more hypomanic episodes and one or more depressive episodes that meet the criteria for a Major Depressive Episode, Bipolar II Disorder is diagnosed.

If left untreated, hypomania can transition into mania and sometimes psychosis, in which case, Bipolar I Disorder is often diagnosed.

Treatment

Clinical trials of medications for the non-depressive phases of bipolar illnesses generally treat patients for psychotic mania during the initial, or acute, phase of mania. High doses are justified in the case of mania, in order to remove the patient from immediate danger. Hypomania, however, involves different considerations and almost always requires more in-depth clinical judgment. Medications typically prescribed for hypomania include mood stabilizers such as valproic acid and lithium carbonate as well as atypical antipsychotics such as olanzapine and quetiapine.

Famous individuals with hypomanic symptoms

Radiohead front man Thom Yorke reportedly responded, "Hypomania? Yes, that's exactly what it was," when asked about his mental state after the release of the group's album *OK Computer*. Iggy Pop was diagnosed with hypomania during his stay in a mental hospital in the mid-1970s. It has also been suggested that Richey Edwards, the "fatalistic Manic Street Preacher" (*Mojo*, 2003), and the late Syd Barrett of the band Pink Floyd have experienced hypomania. In the biographical documentary *An Unreasonable Man*, Ralph Nader is described as having hypomania.

John Gartner's book *The Hypomanic Edge* claims notable people including Christopher Columbus, Alexander Hamilton, Andrew Carnegie, Howard Zinn and Louis B. Mayer owe their innovation and drive, as well as their eccentricities, to hypomanic temperaments. Gartner suggests that the constructive behaviors associated with hypomania may contribute to bipolar disorder's evolutionary survival. Critics charge that Gartner vastly overstates his case, however. He fails to address the possibility that the depressive component may be an evolutionary adaptive mechanism instead, a theory that has been postulated by various evolutionary psychologists.