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# A question of diagnosis : mood and character in a case of emerging mental illness

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Tandeka Hiya Guilderson  
A Question of Diagnosis:  
Mood and Character in a  
Case of Emerging Mental  
Illness

## ABSTRACT

My thesis will use case material from a patient with an emerging diagnosis of a major mental illness (Bipolar Disorder) to examine the intersection of mood, character, medical comorbidity, substance abuse, to better understand how these factors contribute to the diagnosis and treatment of a patient with a complicated, but in no way unique presentation, of this complicated and unique disorder. The case material utilized will be based on patient records and process recordings from our treatment sessions. The theoretical thesis structurally is comprised of an analysis of two bodies of knowledge, a phenomenon, and a synthesis. The first area I selected that frames the patient's clinical picture is the diagnosis of Bipolar Disorder. The second area selected for this thesis was self-psychology. Because of its emphasis on the selfobject transferences of mirroring, idealizing, and twinship and the developmental lines of healthy and unhealthy narcissistic development, self-psychology seemed an appropriate choice for the theory. I will end with recommendations for how the case could have been handled differently. My hope is that the thesis will prove thought provoking and that the material on the diagnostic process, treatment considerations, and cultural context will stimulate discussion.

A QUESTION OF DIAGNOSIS: MOOD AND CHARACTER IN A CASE OF  
EMERGING MENTAL ILLNESS

A project based on independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2008

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I would like to thank my mother, who has been my most loyal and steadfast supporter throughout my life, through thick and thin.

I would like to thank my friends whose laughter makes life ever so much more enjoyable and whose insight makes it so much more meaningful.

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I dedicate this thesis to D.D. who told me once he wanted to be a monk, but who has so much to share with the world that I hope he's changed his mind.

## TABLE OF CONTENTS

ACKNOWLEDGEMENTS .....	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I INTRODUCTION.....	1
II THE DIAGNOSTIC PROCESS.....	7
III BIPOLAR DISORDER .....	23
IV SELF PSYCHOLOGY .....	35
V SYNTHESIS .....	43
REFERENCES .....	72
APPENDICES	
Appendix A: Diagnostic Criteria for a Manic Episode.....	75
Appendix B: Diagnostic Criteria for a Major Depressive Episode .....	77
Appendix C: Diagnostic Criteria for Bipolar I Disorder .....	79
Appendix D: Diagnostic Criteria for Antisocial Personality Disorder .....	80
Appendix E: Diagnostic Criteria for Narcissistic Personality Disorder .....	82
Appendix F: Diagnostic Criteria for a Mixed Episode.....	83
Appendix G: Diagnostic Criteria for a Hypomanic Episode .....	84
Appendix H: Diagnostic Criteria for Bipolar II Disorder .....	86
Appendix I: Diagnostic Criteria for Cyclothymic Disorder .....	87
Appendix J: Diagnostic Criteria for Bipolar Disorder, Not Otherwise Specified .....	89

## CHAPTER I

### INTRODUCTION

For the patient faced with an emerging diagnosis of mental illness it is often a confusing, disorienting time that can last for months, even years while the symptom picture clarifies and the treatments, therapies, and medications are fine tuned to the patient's particular needs. All of this presumes that the patient is accepting of the diagnosis(es) and compliant with the plan. In the event that these factors are not the case, the course of treatment can be difficult and the diagnostic picture much less certain, attributable in part to that lack of compliance. A patient's compliance can depend as much upon his or her temperament, current circumstances, or family history as the diagnosis. Gaining an understanding of the details and circumstances of the patient's life is tremendously important when formulating an analysis of the constellation of symptoms and behavioral presentation. In the event of a major mental illness, a longitudinal diagnosis is warranted which requires an assiduous study of the patient's behavior over time and the numerous, at times conflicting, circumstances and confusing, sometimes paradoxical behaviors.

Diagnosis is a difficult and laborious process. It is by no means an exact science. Much is left to the discretion of the clinician. Diagnoses are often made provisionally and with the designation "not otherwise specified" with the intention being vague so that the clinician has room to change his or her mind as evidence becomes clear, and while data are mined, so that judgments are not rushed to. Time is required to gather sufficient

data about a patient's family history. For example, while a patient may tell you the summary details of a story about a parent in one session, over time a much more textured version of that same story will emerge in the therapy room that allows for the fullness of how that parent's mental illness played out in the family structure and affected the patient influencing the patient's own symptomatology (Belardinelli, Hatch, Olvera, Fonseca, Caetano, Nicoletti, Pliszka, & Soares, 2008). Time and observation are the diagnostician's most valued allies.

Other significant factors that can confuse the diagnostic picture are comorbidities, medical conditions whose symptoms can cloud the diagnostic picture by overlapping with the presenting mood disorder. Prescribing clinicians must be ever vigilant when treating patients with conflicting comorbidities, especially when dealing with patients with pain management issues or substance abuse histories whose medication histories may preclude certain psychopharmacological treatments, which would otherwise be very routine (Johnson & Leahy, 2004). The multitude of factors that render the diagnostic process as complicated and exacting as it is are indicative of how potentially impactful it can be on the patient's life. Diagnosis is an issue each clinician faces daily. We make decisions that influence our patient's lives sometimes for years to come and yet we must ask ourselves, how closely are we examining this decision making process? How well do we understand how these decisions are made? How is diagnosis used (Widiger, 2003)?

My thesis will use case material from a patient with an emerging diagnosis of a major mental illness (Bipolar Disorder) to examine the intersection of mood, character, medical comorbidity, and substance abuse, to better understand how these factors contribute to the diagnosis and treatment of a patient with a complicated, but in no way

unique presentation, of this complicated and unique disorder. The case material utilized will be based on patient records and process recordings from our treatment sessions. The identifying information will be concealed to protect the patient's identity, using only the most pertinent case data germane to the phenomenon to be examined by the thesis, namely the intersection of mood and character and how these are complicated by social factors such as racial identity and medical comorbidities such as, in this case, substance abuse.

The case in question was a case of an emerging Bipolar I diagnosis that was referred to me as a new evaluation after the patient's inpatient hospitalization. Originally, the patient was diagnosed with Major Depressive Disorder, which I questioned from my initial meeting with the patient and which led me to become deeply interested in how diagnoses are formulated, by whom, and to what end. I believe that these questions are important to the field of social work generally because diagnosis is the bedrock of the work of most of us who work in the clinics, hospitals, and private practice where insurance companies pay for the services we provide. Those insurance companies pay based on our clinical and diagnostic assessments of our patients. Therefore, the how and why of diagnosis are unquestionably important to the field. In this particular case, the diagnosis of Bipolar Disorder is further relevant because of its disproportionate media coverage and arguable overdiagnosis today. Bipolar Disorder (formerly Manic-depressive illness) is one of the oldest mental illnesses on record. We probably know more about its etiology, course and treatment than any other major mental illness other than Schizophrenia (Goodwin & Jamison, 2007). For that reason, the abundance of literature on the subject lends itself well to the thesis.



The theoretical thesis structurally is comprised of an analysis of two bodies of knowledge, a phenomenon, and a synthesis. The first topic for examination I selected that frames the patient's clinical picture is the diagnosis of Bipolar Disorder. In the United States, Bipolar Disorder has emerged as one of the most dramatic mental disorders in our popular awareness today. Though diagnosed in less than five percent of the population, it looms large in public perception (American Psychological Association, 2000). The stigma attached to it can make the acceptance of its diagnosis for the patient a bitter pill to swallow. From the practitioner's perspective, its over-diagnosis and misdiagnosis, particularly in young people, make many clinicians reluctant to diagnose this illness. An overview of Bipolar Disorder and related disorders is detailed in Chapter III. A review of the symptoms, etiology, and treatment considerations will be provided to instruct the reader in the fundamentals of the illness in order to be able to interpret the case in an informed manner. Because the illness has several distinctive phasic presentations, different aspects of the illness will be examined to illuminate the complexity of the course of illness for the patient (Winkour, Clayton, & Reich, 1969).

The second area selected to frame this thesis was self-psychology, which will be explored in Chapter IV. Because of its emphasis on the selfobject transferences of mirroring, idealizing, and twinship and the developmental lines of healthy and unhealthy narcissistic development, self-psychology seemed an appropriate choice for the theory (Kohut, 1971, 1984). When he first came to treatment, the patient had a very isolated sense of identity and had extensive mirroring needs. He also brought an intense idealizing transference frequently iterating, "you're the only one who understands me." The twinship component to our relationship was often realized through the commonality

of our multiracial identities. And finally, the narcissistic components of his personality, specific to both his Bipolar diagnosis and the speculative Axis II aspects of his diagnostic picture seemed relevant to understanding his case. Self-psychology seemed like the most cohesive theoretical choice to tie up all of the elements of the clinical picture.

The phenomenon to be captured by the thesis is the nature of the diagnostic distinction between mood, diagnosis on what the DSM IV describes as Axis I, and character, diagnosis on what the DSM IV describes as Axis II (American Psychological Association, 2000). This presents a difficult task for even the most seasoned clinician, since differentiating between mental disorders and character disorders is a tall order. Chapter II will focus on an examination of the diagnostic criteria of Bipolar I Disorder as well as the diagnostic criteria for Antisocial Personality Disorder, Narcissistic Personality Disorder, all of which were considered as part of the diagnostic picture for the case in question. I will attempt to elaborate on which criteria the patient met and why and which he did not meet and why and which were confusing and why.

The synthesis Chapter V describes how the case brings all of these variables together. It includes the case material itself in its entirety, my impressions of the particulars of the case, the hospital setting, the patient's medical comorbidities and their relevance, the character considerations, family history and the issues particular to the therapy, such as what it was like to work with the patient, the course of treatment, his medical history and cultural context, and my analysis of all of these factors. In the case of this patient, there were multiple crisis points, hospitalizations and medications that affected the treatment outcomes.

I hope to give the case its proper due and demonstrate why a case like this is truly important for the field. The synthesis will analyze extenuating factors of Axis I diagnosis, Axis II diagnosis, and other diagnostic considerations such as collateral information. I will end with recommendations for how the case could have been handled differently. My hope is that the thesis will prove thought provoking and that the material on the diagnostic process, treatment considerations, and cultural context will stimulate debate among those in the field and lead to a closer examination of the diagnostic process for all clinicians. This was a case very dear to my clinical heart because for better or for worse it demonstrated how diagnosis remains the focus of our clinical work. I hope with this thesis to shed some light on how we make the important decisions that we do.

## CHAPTER II

### THE DIAGNOSTIC PROCESS

In this chapter, I will review all of the relevant diagnostic terms both considered and applied to the case in question: Multiaxial Assessment (Axis I and Axis II), mood, character, Cluster B, Bipolar Disorder, Antisocial Personality Disorder and Narcissistic Personality Disorder. These terms, in some instances, have been the subject of debate for a number of years in the psychiatric community. In order to understand how and why terms are used and applied, a definition of the terms is provided in both a general sense and as directly understood in relationship to Patient D's specific course of treatment. The definitions and terms are provided along with their clinical contexts to best demonstrate how matters of diagnosis are decided.

The Diagnostic and Statistical Manual of Mental Disorders uses a multiaxial system to classify the myriad sorts of health conditions that can potentially affect a patient. Currently, a five axis system exists. Prior to 1980, all mental disorders were classified on Axis I. In 1980 the DSM III added a second axis to its classification of mental disorders to allow for the diagnosis of characterological disorders (American Psychological Association, 1980). The DSM IV now classifies mental disorders on Axis I which includes all clinical disorders and other conditions that may be a focus of clinical attention such as relational problems, problems related to abuse or neglect, medication induced disorders, eating disorders, sleep disorders, and many other types of disorders. Axis II is used to classify personality disorders and mental retardation (and other

developmental disorders) exclusively. Axis III is used to indicate general medical conditions. Axis IV is used to denote psychosocial stressors. The fifth axis is used to indicate the Global Assessment of Functioning, not unlike a school report card for overall social functioning (American Psychological Association, 2000).

The DSM III allowed that “there is no satisfactory definition that specifies the precise boundaries for the concept mental disorder. (American Psychological Association, 1980). The DSM III goes on to state that “In DSM-III each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society. (When the disturbance is *limited* to a conflict between an individual and society, this may represent a social deviance, which may or may not be commendable, but is not by itself a mental disorder.)” (American Psychological Association, 1980) The DSM IV defined mental disorder as causing “clinically significant distress or impairment in social, occupational, or other important areas of functioning.” (American Psychological Association, 2000)

For years, the debate over how to account for disorders of character had continued without definitive resolution. The American Psychiatric Association’s attempt to clarify the ambiguity of the mood versus character debate by adding a separate axis for the classification of characterological illness was an attempt to rectify the situation. The addition of the second axis was purportedly to assist clinicians with diagnostic choice. The sentiment in the therapeutic and psychiatric communities was that because all coding

was done on Axis I and primarily focused on mental disorders of the most florid varieties, character pathologies were being overlooked because of their less clinically significant presentations (Widiger, 2003). The addition of the second axis was intended to provide clinicians with the option of noting substantial traits and behaviors that warranted consideration and possibly altered the course of treatment. Prior to the addition of the second axis, many clinicians felt forced to make a choice between diagnosing a mood disorder or a character pathology and invariably, the mood disorder won out because of the problematic, symptomatic nature of the mood disorder and the associated sentiment that mood disorders were eminently more treatable. Yet and still, symptoms and traits overlap between the two axes and clinicians struggle to differentiate during the diagnostic process (Sass & Jünemann, 2003).

For the purposes of the DSM III, mood as diagnosed on Axis I is not defined as a term. Loosely conceptualized, mood disorders are considered roughly akin to Freud's symptom neurosis. Mood disorders can be understood to be caused by something, environmental or biological. The resulting malady is ego dystonic for the patient. It feels bad – the symptoms feel alien and strange to the patient, not at all in sync with normal functioning. A mood disorder is fundamentally symptomatic, and though, while the prognosis may indicate an illness that is long in duration, the symptoms themselves will be cyclical and can expect to improve with appropriate treatment. The symptomatic nature and expected improvement are what differentiate a mood disorder from character pathology (Widiger, 2003).

A Personality Disorder is defined as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is

pervasive and inflexible, has an onset in adolescence or in early adulthood, is stable over time, and leads to distress or impairment.” (American Psychological Association, 2000)

Both mood disorders and personality disorders cause distress or impairment. Both can be enduring. The DSM IV does not take great pains to instruct clinicians in how to understand the differences between the two or, perhaps more importantly, understand the relationship between the two. It may be easiest to understand the difference as simply as the way in which the patient experiences the traits. Personality disorders are similar in nature to what Freud described as character neurosis. Whereas the patient with a mood disorder experiences the symptoms to be ego dystonic, or foreign and strange, the patient with a personality disorder experiences the traits to be ego syntonic or natural and in keeping with his understanding of who he is as a person (Gacono, Meloy, & Berg, 1992). Character pathology is understood to be enduring and somehow organic. It is fundamental to the patient’s nature and is perceived to be unchanging over time (Bornstein, 2006). For this reason, it is, like other enduring conditions, coded on the second axis.

The DSM IV provides the user with decision trees for each kind of classification of disorder to assist the user in making diagnoses. Upon review, these decision trees appear to factor in medically relevant data (e.g. disturbance in sleep) but, notably, do not include any clinically relevant data such as cultural or social data that might influence the patient’s illness, presentation, or symptom picture enough to significantly alter the way in which the clinician could conceivably diagnose the patient. The psychosocial element is curiously lacking from the decision tree. The DSM III decision making guidelines included much more psychosocial data and guidelines for how to code for psychosocial

factors that were clinically significant. Moreover, DSM assessment and interview tools are considered by many clinicians to be weak and inconsistent with the actual DSM diagnostic criteria. Because of these inconsistencies, the diagnostic process for personality disorders ensures their fallibility (Watson & Clark, 2006).

Finally, a troubling issue with Axis II is the stigma associated with having a diagnosed personality disorder, particularly a Cluster B personality disorder. The Cluster B personality disorders, described as dramatic include Histrionic Personality Disorder, Borderline Personality Disorder, Narcissistic Personality Disorder, and Antisocial Personality Disorder. These disorders are known for the dramatic, aggressive behavior and traits associated with the people diagnosed with these disorders. The more odd or eccentric Cluster A personality disorders include Paranoid, Schizoid, and Schizotypal personality disorders. The more anxious Cluster C personality disorders include Avoidant, Dependant, and Obsessive Compulsive personality disorders. Clusters A and C are not as negatively stigmatized as the dramatic Cluster B personality disorders probably because the associated traits do not produce behaviors that are considered as flagrantly antisocial (Widiger, 2003).

With respect to the case of Patient D, the primary point of contention between me and his psychiatrist was whether or not the primary diagnosis was on Axis I or Axis II. I, as the patient's therapist, maintained that the patient was fundamentally mood disordered and should be diagnosed on Axis I. The patient's psychiatrist was more convinced that the patient was fundamentally character disordered, that there was possibly a mood disorder (though she was either unwilling or unable to specify what she believed it to be). Moreover, the psychiatrist intimated that she believed, as a rule, that mood disorders were



overdiagnosed (she asserted this in the case of Bipolar Disorder in particular) and character disorders under diagnosed (Charles, 1982). It should be noted that the psychiatrist and I had access to the same information with respect to patient records and the discharge summary from the patient's recent hospitalization. In fact, the psychiatrist had the added benefit of the information and family history from the evaluation I had recently conducted on the patient prior to her own evaluation of the patient.

In the case of Patient D, I had advanced the notion to the patient's treating psychiatrist and my supervisor that the patient had an emerging case of Bipolar Disorder and that his symptoms were evidence of mania. I based my diagnosis on several factors. I had diagnosed him provisionally from the time of his initial evaluation, though his presenting diagnosis was Major Depressive Disorder, the diagnosis with which he was discharged from the hospital. After the evaluation interview and a subsequent therapy session, I was concerned by symptoms I had observed and by material the patient had reported. I had suspected from the outset that the patient had a diagnosis of Bipolar I Disorder largely due to his symptom picture, family history, and a childhood diagnosis of Attention Deficit Hyperactivity Disorder, which can often be a prodromal Bipolar diagnosis (Singh, DelBello, Kowatch, & Strakowski, 2006). I encountered resistance to the Bipolar diagnosis from his psychiatrist who felt a diagnosis from Cluster B on Axis II was more appropriate, suspecting sociopathy or narcissism as explaining some of the patient's more problematic behaviors.

The decision over which diagnosis was most appropriate and how to treat the patient based on that diagnosis were key components of how the case eventually unfolded. A more detailed analysis of the diagnostic process for the patient will be

undertaken in the Synthesis Chapter V. For the purposes of this chapter, however, the criteria for each of the possible diagnoses for Patient D are presented for consideration. It is important to assess how the diagnostic criteria are similar and where they diverge. Which are the most closely aligned with the patient's symptom picture? Which most accurately capture the patient's condition and reflect the patient's course of illness most precisely? The purpose of diagnosis, ultimately, is to attempt to narrow the field by ruling out maladies that are not currently afflicting the patient, isolate the symptoms and treat the illness with the appropriate interventions, be they psychopharmacological or therapeutic in nature (Magill, 2004).

Bipolar Disorder is largely biological, often inherited and while it can be managed with medication, its prognosis is often, like other major mental illness, a life sentence for the patient so diagnosed. It can be a difficult fate to accept, the reality that your life will be, at least in part, organized around managing a chronic and persistent mental illness. Depending upon the severity of symptoms, many patients can expect a course of illness that will include a protocol of multiple medications, hospitalizations, and the symptoms and vicissitudes of the illness itself with all of its attendant concerns and emotive pitfalls for the duration. Depending upon the patient's understanding of the illness, his emotional preparedness to accept the illness, his support system to help him manage his feelings about his condition, the course of treatment runs very differently for each patient (Johnson & Leahy, 2004).

There are six distinct sets of criteria for diagnosing Bipolar Disorder and at least two different types of Bipolar Disorder, which will be discussed in Chapter III. Many clinicians believe that Bipolar disorder exists on a spectrum. The diagnosis of Bipolar I

must consist of at least one episode of mania (for a diagnosis of Bipolar I no episode of major depression is required). For a diagnosis of Bipolar II at least one episode of major depression and at least one episode of or hypomania are required. The distinctions may seem slight, but each disorder is distinct and different with its own attendant affective states (American Psychological Association, 2000).

The diagnostic criteria for a Major Depressive Episode are as follows:

A. five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: in children and adolescents, can be irritable mood.
2. markedly diminished interest or pleasure in all, or almost all activities most of the day nearly every day (as indicated by either subjective account or observation made by others)
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: in children consider failure to make expected weight gains.
4. insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
  6. fatigue or loss of energy nearly every day
  7. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional nearly every day (not merely self-reproach or guilt about being sick)
  8. diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
  9. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. the symptoms do not meet criteria for a Mixed Episode.
- C. the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- D. the symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).
- E. the symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

In my clinical judgment, Patient D met at least six of the nine diagnostic criteria (1, 2, 4, 6, 7, and 9) for major depressive disorder (with which he was diagnosed during his inpatient hospitalization immediately prior to his beginning treatment with me on an outpatient basis). At that time, there was no reason to believe that the patient was abusing any substances. He had, however, demonstrated some potentially manic behaviors.

The criteria for a Manic Episode, which must also be met for a diagnosis of Bipolar Disorder, are as follows:

- A. A distinct period of abnormally and persistently elevated, expansive or irritable mood lasting at least one week (or any duration if hospitalization is necessary).
- B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
  - (1) inflated self-esteem or grandiosity
  - (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
  - (3) more talkative than usual or pressure to keep talking
  - (4) flight of ideas or subjective experience that thoughts are racing
  - (5) distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli
  - (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

- (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
- C. The symptoms do not meet criteria for a Mixed Episode
- D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- E. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication, or other treatment) or a general medical condition (e.g. hypothyroidism).

In my clinical judgment, the patient met criteria 2-7 of the list for mania.

Notably, the only symptom the patient did not openly demonstrate was the grandiosity so typically associated with Bipolarity. However, the fact that he met all of the other criteria is fairly striking.

The diagnostic criteria for the DSM IV diagnosis of Bipolar I Disorder Most Recent Episode Unspecified (meaning neither manic, depressed, mixed or hypomanic) is as follows:

- a. Criteria, except for duration, are currently (or most recently) met for a manic, a hypomanic, a mixed, or a major depressive episode.
- b. there has previously been at least one manic episode or mixed episode.
- c. the mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- d. the mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified
- e. the mood symptoms in Criteria A and B are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Antisocial Personality Disorder is an Axis II personality Disorder which is characterized by several features all of which demonstrate a marked disregard for the rights of other people. This disregard is a pattern that is established in childhood and persists throughout adulthood. The disorder cannot be diagnosed until a person is eighteen years of age, but the individual must have been symptomatic prior to age fifteen. The antisocial person can be charming, conniving, criminal, impulsive, reckless, violent, and lack empathy. Generally speaking, they are considered to be dangerous people to be involved with. Their charm can render them particularly dangerous to the unsuspecting.

The diagnostic criteria for Antisocial Personality Disorder are as follows:

- A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, 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 repeated 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
- B. The individual is at least 18 years of age
- C. There is evidence of Conduct Disorder with onset before age 15 years
- D. the occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

Because I was not the clinician asserting sociopathy in Patient D's case, I can only speculate as to which traits were cause for the proposed diagnosis of Antisocial Personality Disorder. Both the treating psychiatrist at the hospital during Patient D's second inpatient hospitalization and his own outpatient psychiatrist had asserted sociopathy as a potential diagnosis. The inpatient psychiatrist attributed his diagnosis to Patient D's reported aggression, lack of cooperation, and disdain for protocols on the unit. The criteria that he actually met, in my clinical judgment, was criteria 4, irritability and aggressiveness (also features of Bipolarity). Arguments could be for criterion 3, impulsivity and criterion 5 reckless disregard for the safety of others (if the reports that



he tried to commit suicide were true, but they were never conclusive). Impulsivity could also be attributed to the mania of Bipolar Disorder. This discussion will be taken up more fully in the Synthesis Chapter V.

The diagnostic criteria for Narcissistic Personality Disorder are as follows:

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in variety of contexts, as indicated by five (or more) of the following:

- (1) has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
- (2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
- (3) 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)
- (4) requires excessive admiration
- (5) has a sense of entitlement
- (6) is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
- (7) lacks empathy, is unwilling to recognize or identify with the feelings and needs of others
- (8) is often envious of others or believes that others are envious of him or her
- (9) shows arrogant, haughty behaviors or attitudes

In fairness to Patient D, only one clinician associated with the case ever leveled an assertion that narcissism may be a factor for consideration. The chief psychologist on our unit had an encounter with him one day when he was particularly dysregulated and demanding medication. He had come to the clinic after being non-compliant with his mood stabilizers, but having taken Ativan for his spine condition for over two weeks, and he had decompensated considerably. He appeared at the clinic angry, in pain, demanding medication, and wearing sunglasses. Apparently, the fact that he was as dysregulated and drug seeking as he was (he was demanding more Ativan) and wearing sunglasses inside prompted the unit chief to remark that he was “a narcissist.” She stated, “He has a crowded Axis II.” I asked her to elaborate and she replied, “There’s definitely some sociopathy and some narcissism there.” To clarify, I had reviewed the case with my clinical team, of which she was a member, on two occasions so she was somewhat familiar with his story. However, that was the first time she had actually met him and the entirety of their encounter lasted about six minutes. Ultimately, she ended his treatment at the clinic that day because of his comportment. He cursed her and made a scene when she provided him with prescriptions he was not interested in taking. While his behavior had never in the past been threatening or violent, it was sufficiently provocative on this one occasion to prevent him from ever receiving services again at the hospital.

And therein lays the important difference between the diagnoses on the axes. The association with the second axis is so potentially damaging (Conus, Berk, & McGorry, 2006) that I feel that it influenced how this incident was resolved. I feel quite certain that a patient with a diagnosis of schizophrenia who had come in and behaved similarly would not have had his treatment terminated. I feel that way because I have witnessed such

occurrences. The perceptions and feelings associated with personality disorders, particularly Cluster B (dramatic) personality disorders, are inherently negative. Socioeconomic, racial, or cultural factors can be even more marginalizing dynamics for the patient. Patient D is a poor, Latino man who raised his voice at the wrong time to the wrong person who perceived him in a way that probably caused him to stop receiving care at a critical juncture in his emerging illness, quite unfortunately for him. A discussion of the role of socio-cultural factors in diagnosis, while provocative, is beyond the scope of this thesis.

## CHAPTER III

### BIPOLAR DISORDER

Bipolar Disorder, also known as Manic Depressive illness, is one of the oldest and best known mental disorders. It has been noted, observed, and described by doctors, clergy, and philosophers dating back to the first century BC. In the introduction to their seminal work on Bipolar illness, Kay Redfield Jamison and Guy Goodwin quote Araeteaus of Cappadocia writing around 100 AD who said “Melancholia is the beginning and a part of mania....The development of a mania is really a worsening of the disease (melancholia) rather than a change into another disease.” (Goodwin & Jamison, 2007) Depression and mania are inextricably linked in form and function. In addition to dementia praecox (schizophrenia), Bipolar Disorder may be the most studied and catalogued mental illness throughout history. Certainly, it could lay claim to being the oldest.

For the past century, Manic Depressive Illness has been considered to exist on something of a spectrum. This notion was first advanced in the late 19<sup>th</sup> century by the father of psychiatry, Emily Kraepelin, who recognized the shifting nature of the illness with all of its vicissitudes. He believed that there were a variety of related kinds of illness linked by their manic and depressive symptoms. Not all illnesses in the group would reach full blown mania or major depressive lows, but they share enough in common to be captured by a spectrum. Heritability, believed Kraepelin, factored heavily into the symptomatology of the relatedness of the illnesses. While the presentation of

symptoms may vary across the spectrum for different illnesses, the defining feature of the disease itself is mania. However, as its title implies, it can have recurring depressions (that differ in quality from other depressions) that are unique to this malady. Bipolar depression differs from unipolar depression primarily in age of onset (later, typically in late 20s or early 30s), in the presentation of atypical features (including hypersomnia, increased appetite, rejection sensitivity, leaden paralysis, mood reactivity, and rejection sensitivity), and the presence of psychotic symptoms (Ghaemi & El Mallakh, 2006)

There are several important factors that link the Bipolar Spectrum illnesses. All of the diagnoses are longitudinal in nature. For that reason, clinicians must observe patients over time and rely heavily on self reports, as well as the observations of friends and family members, who are routinely involved in the diagnostic process as collateral sources of information during the interview process. It should be noted as well that another defining feature of the spectrum is the recurring nature of the episodes, both the mania and the depression. However, the polarity for which it was originally named is mania, and for Bipolar Disorder mania remains its essential defining characteristic. For example, according to the DSM IV, more than 90% of individuals who have a single Manic Episode will go on to have future episodes (American Psychological Association, 2000). The criteria for a Manic Episode are as follows:

- A. A distinct period of abnormally and persistently elevated, expansive or irritable mood lasting at least 1 week (or any duration if hospitalization is necessary).

- B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
- (1) inflated self-esteem or grandiosity
  - (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
  - (3) more talkative than usual or pressure to keep talking
  - (4) flight of ideas or subjective experience that thoughts are racing
  - (5) distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli)
  - (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
  - (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
- C. The symptoms do not meet criteria for a Mixed Episode
- D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features

- E. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication, or other treatment) or a general medical condition (e.g. hypothyroidism).

The diagnostic criteria for Bipolar Disorder were reviewed in the previous chapter and are available for review in Appendix C. I have included the diagnostic criteria for all of the Bipolar Spectrum Disorders to provide a sense of the continuum of illness (Appendices A-C and E-J). However, I will briefly summarize the differential diagnostic criteria for each of the primary spectrum disorders here. A diagnosis of Bipolar I Disorder does not necessitate the history of a Major Depressive Episode, only a manic episode. A diagnosis of Bipolar II disorder requires a history of both hypomanic episodes and *recurrent* Major Depressive Episodes. A diagnosis of Cyclothymic Disorder requires the presence of both hypomanic and depressive symptoms that are not sufficient to meet the diagnosis of a Major Depressive Episode. It is important to note the difference between hypomania and mania. Hypomanic symptoms can be thought of as pre-manic. Hypomanic symptoms, also by comparison, must be present for at least four days as opposed to one week (or until a hospitalization occurs) in the case of mania.

Hypomanic symptoms are follows:

- A. A distinct period of persistently elevated, expansive, or irritable mood lasting throughout at least 4 days, that is clearly different from the usual non depressed mood.
- B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

- (1) inflated self-esteem or grandiosity
- (2) decreased need for sleep (e.g. feels rested after only 3 hours of sleep)
- (3) more talkative than usual or pressure to keep talking
- (4) flight of ideas or subjective experience that thoughts are racing
- (5) distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli)
- (6) increase in goal-directed activity (either socially, at work or school, or psychomotor agitation)
- (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

A diagnosis of Cyclothymic Disorder is made over a period of at least two years. For that diagnosis to be made, during that time there must have been the presence of numerous periods of both hypomanic and depressive symptoms that do *not* meet criteria for a Major Depressive Episodes. The individual cannot be asymptomatic for more than two months at a time, nor can there be a Major Depressive Episode, a Manic Episode or a Mixed Episode during the two year period.

Bipolar Disorder is thought to be caused by biological factors and is highly heritable, being passed down from multiple genetic sources. Unlike schizophrenia, studies have not demonstrated that there is cause to believe that there are environmental



or neurodevelopmental defects that trigger Bipolar Disorder. It is believed, however, that psychosocial stressors significantly contribute to the development of a Bipolar Disorder spectrum illness. Studies have examined the impact that mood disruption can have on neurobiology and the connection to mood disorder. The extent of that connection has not been definitively determined, yet some link clearly exists. The fact that so many psychopharmacological interventions have been used with success is indicative of the fundamental biological nature of the illness. Mania specifically is linked to dopamine hyperactivity. Bipolar patients are often known to have abnormal cortisol and thyroid function as well, which are linked to mood dysregulation and euphoria respectively (Goodwin & Sachs, 2004).

The epidemiology of Bipolar Disorder is complicated because it is a growing disorder not without its controversy. The DSM IV states that the percentage of people diagnosed with Bipolar I in community samples ranges from 0.4-1.6%. For Bipolar II that number is 0.5%. These numbers probably do not take into account the staggering growth in childhood Bipolar diagnosis which, according to some reports, has grown at a rate of over 4000% in the last ten years alone (Gavira, 2007). It is a difficult diagnosis to make, due to many factors, not the least of which is its longitudinal nature and the complexity of the symptom picture. It is often said that it is the most overdiagnosed and the most underdiagnosed mental illness. Indeed, in the case of Patient D, his psychiatrist stated to me that she was reluctant to diagnose him, even in the face of what was a compelling symptom picture, because she felt the disorder was overdiagnosed.

Bipolar Disorder is characterized by several features and presentations. These are Mania, Hypomania, Depression, what is called a Mixed state and what is called a state of

Rapid Cycling. Mania can be indicated by several factors, chief among them is poor judgment. Mania can exist at a psychotic level and a patient may have been symptomatic long enough to present as exhausted. Usually, however, a patient will present as elated, grandiose, and at times delusions and hallucinations may be present. A hypomanic state will never be psychotic. It will remain elevated and expansive, often grandiose, psychomotor agitation is often present. Hypomania is often goal directed; sexual indiscretion can characterize hypomania as well as excessive spending, risk taking, and other imprudent behaviors (Mansell & Pedley, 2007). Depression is characterized by psychomotor retardation, insomnia, weight loss, suicidal ideation, fatigue, an inability to concentrate, anhedonia, and guilt. A Mixed state is comprised of both manic and depressive features, often with pronounced irritability. A patient with Rapid Cycling moves from depressive to manic symptoms often without euthymic periods in between symptoms. A Rapid Cycling patient experiences at least four episodes of mood disturbance within a 12 month period. Bipolar Disorder is a complex illness with many presentations that affect patients in myriad ways (Winkour, Clayton, & Reich, 1969).

The course of the illness itself is probably the most difficult thing to capture. One can describe the symptoms, but it is impossible to capture the elation of the hypomania, the psychosis of the mania, the lethargy and eventual psychosis of the depressions, the overwhelming confusion and emotional exhaustion of the mixed states, and the roller coaster of the rapid cycling. What is it like for the patients who live with Bipolar Disorder in all of its forms? Typically, Bipolar Disorder will first afflict patients somewhere between the ages of 18 and 25 (Goodwin & Jamison, 2007). Many will remain untreated for several more years (and still more will never seek treatment).

Prognosis is good for those who do seek assistance. Treatments typically include a combination of psychopharmacology and/or psychotherapy. Patients who are diagnosed with Bipolar Disorder are notoriously non-compliant with their medications (Goodwin & Jamison, 2007). Often, when patients begin to stabilize they suspend use of medications and soon become dysregulated, plummeting into another depression or spiraling off again into another mania (Lam & Wong, 2005). Family interventions such as assistance with medication and doctor's visits as well as family therapy can be positively indicated in the successful treatment of Bipolar Disorder (Fredman, Baucom, Miklowitz, & Stanton, 2008). Compliance with the psychopharmacological protocols appears to be imperative for successful treatment (Conus, Berk, & McGorry, 2006).

There are a number of psychopharmacological interventions used routinely to treat Bipolar Disorder. These fall roughly into the following categories: antipsychotics (such as haliperidol and divalproex sodium); antiepileptics (e.g. lamotrigine and topiramate); new (atypical) antipsychotics (e.g. risperidone and ziprasidone), benzodiazepam and antidepressants (e.g. fluoxetine and citalopram). The oldest and most popular mood stabilizer used to treat Bipolar Disorder is Lithium. Lithium, a combination of chemical salts, has been used for the treatment of Manic Depressive illness in the United States since 1970. It is the preferred treatment for Bipolar Disorder because of its neutralizing effects on both depression and mania. It is most often used in conjunction with an antipsychotic. Another less widely used intervention is Electro Convulsive Therapy (ECT) which is used only in cases of severe mania or depression. A number of these drugs have side effects that make their use impossible with certain patients. Additionally, antidepressants have been known to trigger mania in Bipolar

patients rendering their use ineffective at best and harmful at worst, and effectively having sidelined them (Goodwin & Sachs, 2004).

Psychotherapeutic interventions for the treatment of Bipolar Disorder can vary. Interestingly, patients with Manic Depressive illness were for some time perceived to be poor candidates for psychotherapy, particularly prior to the deployment of Lithium. Patient presentation during periods of hypomania and mania made them difficult subjects at best. Some were even considered dangerous to the analyst due to their insight. (Goodwin & Jamison, 2007) The management of medication and ensuring compliance emerges as a key theme in the therapeutic dyad with Bipolar patients and their treating clinicians according to almost all sources. Lack of compliance to a psychopharmacological protocol leads to all sorts of ills, suicide, drug abuse, impulsive spending, gambling and debts, relationship difficulties, and problems at work. Routines of all sorts seem to suit the Bipolar population. Predictable schedules help organize and routinize their lives helping them stay grounded. Tangible practical strategies for keeping things on an even keel help them feel ordered and less manic. Similarly, cognitive behavioral therapies are positively indicated as thoughts are taught to influence behavior. Group Therapies can also be recommended as patients can learn about how their behaviors impact those around them and glean much needed insights into the wider social aspects and impact of their comportment from the group experience (Johnson & Leahy, 2004).

The list of comorbidities common to patients diagnosed with Bipolar Disorder is loosely grouped into two categories: psychological comorbidities and general medical comorbidities. With respect to general medical conditions, it is not uncommon to find

patients with cardiovascular issues, diabetes, thyroid problems, and obesity (Kim, Kim, Son, & Joo 2008). Many patients with Bipolar Disorder gain weight as a result of the antipsychotic medications that they take, almost all of which, even the new atypical types, cause weight gain. Additionally, research has shown that there may be links between Bipolar Disorder and thyroid function (Goodwin & Sachs, 2004). With respect to psychological conditions, often patients with a diagnosis of Bipolar Disorder most often have comorbid diagnoses of anxiety disorders and personality disorders. As many as 93% of patients diagnosed with Bipolar Disorder are also diagnosed with anxiety disorders at some point in their lives. Additionally, many, many Bipolar patients struggle with substance abuse issues on and off throughout their lives. It has been estimated that up to 72% of patients diagnosed with Bipolar Disorder will struggle with a substance abuse problem (Goodwin & Jamison, 2007).

Suicide is a significant issue in the clinical picture for patients diagnosed with Bipolar Disorder. Always a concern for patients with any diagnosis, for patients with significant mood lability, with questionable psychopharmacological compliance, and for whom both the high and the low of their illness is psychosis, suicide is a real threat for the Bipolar patient. It is estimated that about 15% of patients diagnosed with manic depressive illness have committed suicide. That statistic has varied. In some studies that number has been as high as 60%. At 15% the number is 30 times greater than the suicide rate for the general population (Goodwin & Jamison, 2007). With regard to gender difference, women make more attempts and complete more (14.9 % for men and 21.1% for women) (Goodwin & Jamison, 2007). Recently, studies have shown that the suicide

rate for the clinical population of patients with manic depressive illness has declined, which may be largely due to the efficacy of psychopharmacological interventions.

With respect to the case of Patient D, it is interesting to note that many of the issues pertinent to the course of Bipolar illness were certainly relevant in his case. He had difficulty with medication compliance; struggled with parasuicidal behaviors and impulsivity, particularly with regard to his temper and authority figures; he had substance abuse problems and a suspected personality disorder comorbidity issues; and his family were very involved in his care and treatment. Additionally, had he remained in treatment, in all likelihood he may well have been diagnosed with an anxiety disorder as he consistently reported that he was anxious most of the time. In fact, the day his care was terminated at the clinic he was demanding Ativan (a benzodiazepam used for treating anxiety) stating that it was the only thing that managed his near constant anxiety. Moreover, he appeared to be bright, sensitive and extremely creative, all traits positively correlated with patients diagnosed with manic depressive illness.

Doctors, philosophers, clerics, and observers have written about manic depressives for centuries. Manic depressives have been some of our most thoughtful, creative contributors to society. The list of artists, composers, and philosophers who have been manic depressives is as long as it is impressive. There is a positive correlation between manic depressive illness and creativity attributable to the increased cognition that happens during mania. (Goodwin & Jamison, 2007) By all accounts, these are special people, both gifted and afflicted. The symptom picture can be confusing in its polarity; the patient can be confounding in his presentation; but with time, observation an

appropriate diagnosis can be made, treatment begun, and the road to recovery embarked upon quite successfully. This is an illness that is eminently treatable.

## CHAPTER IV

### SELF PSYCHOLOGY

This chapter introduces the theory of self psychology and its principal author, Heinz Kohut. I chose this theory because of its suitability for Patient D's case largely because of its focus on narcissistic development and the different types of transferences a patient can bring to therapy. Indeed, while Kohut's body of work contains many significant contributions to the field, I will focus on his selections on narcissism and selfobject transferences in particular as they are most germane to the case material. During the brief course of Patient D's case, I had the opportunity to consider his treatment from a number of different perspectives, but self-psychology always felt like the most natural fit because he was such a thoughtful, considerate patient, and Kohut always placed great emphasis on the consideration of the analytic process of the patient (Kohut, 1984; Mitchell & Black, 1995).

Self psychology is the field of psychology that concerns itself primarily with the analysis of the self, as Kohut defined it (nuclear self, grandiose self, bipolar self, cohesive self) (Kohut, 1985). Stemming from the line of ego psychology, self psychology owes some of its own development to formal Freudian thought. Kohut studied traditional psychoanalysis in Vienna early in his career and developed and his thinking grew out of that early training. Kohut was also enjoyed close relationships to Heinz Hartmann and Anna Freud, and so some of his thinking was undoubtedly influenced by their own (Mitchell & Black, 1995). The primary difference between Freud and Kohut was really



one of perspective, Freud tended to see the individual as battling his primal nature whereas Kohut regarded man's fundamental struggle as a relational one with the fundamental question being, "where do I fit in to my world and how do I make sense of these relationships." The relational capacity and the ability to make meaning of it were the qualitative difference for Kohut. Freud believed that a person's psychology was dictated by his drives while Kohut believed that a person's psychology was dictated by his early environment (Goldstein, 2001). This shift in perspective led to a radical change in the way he perceived the function of analysis later in his career.

Self Psychology is again different from Ego Psychology as it is from traditional Freudian Drive Theory. It builds from Ego Psychology and Kohut certainly was well versed in the classical analytic traditions and the later work of Freud's followers as they expanded upon his work. However, while ego psychologists tended to focus on the pathology of an individual and the neurosis and functioning of the defenses, Kohut was interested in the impact of external forces (Goldstein, 1995). Kohut was inherently fascinated by man's interface with his external world. Kohut believed deeply that what shaped man was the interplay between what was innate and inborn in man and how that was developed by the world around him. Social forces, from parents, to larger family circles, to group memberships, all of these had important roles to play in an individual's construction of self (Goldstein, 2001).

Self Psychology also differs from Object Relations in its orientation, form, content, and treatment considerations. While Object Relations stresses a basic human need to relate to one another and makes meaning of that through patterns of attachment, self psychology stresses the need for the idealization of others and the need to be like

others as well as the need to have others respond favorably to you. For the school of Object Relations, people are fundamentally object seeking, looking to fill their world with object representations. For self psychologists, people are born fundamentally who they are and are looking to have that reinforced through selfobject transference and verification. Self psychology represents a very different developmental line from Object Relations than as it did from ego psychology as well (Goldstein, 2001).

Kohut, like Freud, was a Viennese Jew born in 1913 into a well to do, assimilated family in Austria. He was trained as a physician and became interested in psychoanalysis which was growing in popularity in certain circles at the time, particularly in the Jewish and intellectual communities. He entered into psychoanalysis initially while still in Vienna. Like so many Jews during that period, he was forced to flee Europe and relocated to the United States. He moved to Chicago where he remained for the rest of his life. While in Chicago, he began his formal training in psychoanalysis and became immersed in the psychoanalytic community there where he remained firmly ensconced until his death in the 1981 (Goldstein, 2001).

Kohut's definitive departure from ego psychology came with his 1977 work *The Restoration of the Self*. In this groundbreaking venture, he severed ties with classical psychoanalytic tradition and set about a new way of understanding how the psyche is formed. Kohut essentially stated that people are born with a fledgling sense of self that requires a validating environment to respond to it favorably for it to flourish. He referred to these needs as "selfobject" needs. An individual's selfobject needs could and should be met by a variety of people in his life including family and friends. A whole person required an assortment of selfobject influences to create a balanced and healthy

individual with enough texture to support healthy selfobject regulatory function (Kohut, 1977).

Initially, Kohut thought of the self as a bipolar self; an ambitious pole that captured a young child's (age 2-4) grandiose fantasies; another one that captured his more emotionally formed, idealized objectives (about ages 4-6); as well as a third self that represented a middle ground that formed a bridge between the two (Goldstein, 2005). He later revised this line of thinking to become more inclusive. Kohut is best known for his thinking about healthy and unhealthy narcissistic development which he wrote about extensively. Healthy narcissistic development would include responsive mirroring by parents that reflect back appropriate, healthy, and realistic images of what the child is skilled at and capable of. Unhealthy narcissistic development might include a lack of mirroring and too few instances of optimal frustration where a child received either too much praise or too little so the child developed an unrealistic assessment of his or her value and abilities. Kohut's writing on narcissism incorporates his earlier writing on the bipolar self and the child's ambitions and strivings and the importance of the child's need for mirroring and the idealizing goals of the child (Kohut, 1971).

Kohut believed that each person was born with a core *nuclear* self. That self had selfobject needs that each person would attempt to gratify through a process of transmuting internalization. The transmuting internalization is the process that promotes the formation of the psychic structure by incorporating selfobject transferences. The path of healthy narcissistic development would include appropriate optimal frustration experiences that would regulate a child's normal grandiosity. A small child, for instance, believes that he has magical powers and can make anything happen, because in his

limited experience, he has experienced omnipotence. As the child grows, he experiences the limits of his power in what are called optimally frustrating experiences. This kind of transmuting internalization of these frustrations serve to limit the child's grandiosity promoting a healthy narcissism. The child recognizes the limits of his own power, and gains a healthy respect for the power and limitations of power of others. Without these optimal frustrations that are appropriately internalized, unhealthy narcissism is developed. Kohut believed that frustration tolerance and the internalization of the experience of normal frustration were essential in promoting healthy narcissism (Kohut, 1977)

Kohut also believed that individuals had very specific selfobject needs for normal, nonpathological development. He spoke of three kinds of selfobject transferences that were necessary for the attainment of a cohesive self. These are the mirroring transference, the idealizing transference, and the twinship transference. All of these selfobject needs, he argued, were critical for the healthy development of the self. He posited that this development takes place along three axes: the grandiosity axis, the idealization axis and the alter ego-connectedness axis (Bania, Mikulincer, & Shaver 2005). He wrote about each of these axes extensively in his seminal work, *The Analysis of the Self*. A solid self comes from healthy developmental lines across all three of these axes (Kohut, 1971).

The selfobject need of mirroring is a need to be responded to based on achievements, innate qualities, and developmental tasks. A child who requires mirroring must have his sense of healthy grandiosity reflected back to him. Someone must take note of his progress and comment upon it. "You are good, kind, wise, you have done that

well.” These are the comments that mirror back a task well performed and are examples of appropriate mirroring. Kohut later spoke of it in terms of “verification” (Pinel & Constantino, 2003). People need to have the things they know or suspect about themselves verified to complete their sense of self esteem.

The idealizing transference stems from a need to internalize images of important people in a person’s life and to feel a sense of merger with them. This is especially important for children who need to feel a sense of adoration and regard for their parents, a sense of holding them to a higher standard, to which they will also hold themselves. This standard helps children to set goals of comportment for themselves and manage them realistically (again through optimal frustration and transmuting internalization). The sense of merger comes from wanting to be like the qualities they admire. For instance, children who want to learn to play violin must learn through practice but must possess the discipline to practice every day, have to want to do so, and must regulate themselves and take the direction of parents who will encourage them as well. They can watch the example of parents who manage their time and sense of discipline with goals that they have set for themselves and watch them work towards those goals with a sense of discipline. With measured out work these children will deservedly feel a sense of accomplishment over time (Banai, Mikulincer, & Shaver, 2005).

The selfobject transference of twinship is characterized by a sense of sameness with an object. In this transference, a child wants to feel similar to another person or people and part of a group (or family). Protective elements can be at work as well as affiliative ones, a sense of belonging, “they are like me.” Present in this transference, are

elements of empathy, social involvement, social responsibility, and other regulatory type functions which are routinely involved (Kohut, 1971).

Kohut's work in developing a unified theory of the self was groundbreaking not only because of the thoroughness of his theoretical considerations, but also because of the radical departures of his treatment modalities. Kohut broke significantly from the psychoanalytic traditions by introducing the notion that patients had a role to play in understanding the analysis and offering a perspective on the analysis itself. Moreover, Kohut introduced the notion that the analyst should have empathy for the patient as opposed to serving as a blank slate as the analysand splays open his life and feelings for dissection (Silverstein, 2007).

With respect to Patient D, I am struck by how neatly he presented selfobject transference in our work together. He also seemed, in certain respects, to be a good case of healthy narcissistic development, which is why I chose to focus on these particular elements of Kohut's work. I will explore more of the particulars in the next chapter, but I will make a few points here. Patient D came from a very close knit family of which he was the oldest child. In our work together I felt a strong need to mirror him, often verifying his strengths as he stated them and I perceived them. Additionally, he brought a strong idealizing transference that would manifest itself in statements like "you're the only person who I can trust." The twinship transference could be felt in our shared multiracial identity which he explored often and often asked me about my notions about race and identity to verify his own perceptions (Leary, 1995).

Moreover, I have considered what it may have been like to treat a patient such as he had he not been someone as reflective about his own case as he was. I also consider

what it may have been like to have treated someone like him had I not been trained in a psychoanalytic tradition that emphasized empathy with a patient as a primary treatment goal. Certainly, those two dynamics were central to the way I approached the case with him and remain with me as I continue writing about him now. He was remarkably thoughtful about what it meant to him to be mentally ill and how that would ultimately impact his life long term. I intuitively felt that Patient D had been thinking about that for some time, as I suspect he had known he was sick for longer than he had been coming to treatment.

## CHAPTER V

### SYNTHESIS

This chapter will synthesize the previous chapters in a case study and discussion format. The case study will present the history and context of Patient D as I encountered and treated him over the course of several months during the fall and winter of 2007-2008. It will also introduce the issues of diagnosis as they came up during the course of treatment along with the theoretical considerations that emerged during the case. I will proceed to an analysis of the diagnostic considerations specific to Axis I (mood) and Axis II (character) as they emerged and my own decision tree.

#### *Agency Context*

A small, neighborhood hospital which is a satellite service of a parent hospital that operates out of a large metropolitan area, the Mental Health/Social Services Department is an Outpatient Psychiatry Clinic which serves about 600 patients a week approximately 85% of whom are people of color and about 60% of whom are Spanish speaking. Approximately 50% of those patients have Posttraumatic Stress Disorder (PTSD) as a primary diagnosis. The Mental Health/Social Services unit offers individual, group, and couples therapy, psychiatric and psychopharmacological services, as well as neuropsychological testing services.

The clinical staff consists of approximately 40 clinicians. The staff is comprised of psychiatrists, clinical psychologists (Ph.D.s), professional psychologists (Psy.D.s), social workers, and a psychiatric nurse. The unit chief is a Psy.D. who has been working



in the field for approximately fifteen years and who trained in the clinic prior to working there. There is also a chief psychiatrist who is the second most senior clinician on the unit. The staff is encouraged to seek consultation with as many clinicians as possible when working on cases due to the intense nature of the clinical work on the unit. Because so many patients see more than one provider for services, consultation is also encouraged because of the likelihood of patients to split the transference (Chernus, 2005).

Another common practice on the unit is participation in weekly clinical team meetings. I participated in one such team. Both the unit chief and the chief psychiatrist were on my clinical team. They both offered consultation on the case in question and the unit chief later became involved in the decision to terminate services to Patient D.

#### *Client Information and History*

Patient D was a 21 year old working class Puerto Rican man. He was born and raised in eastern Massachusetts. Patient D was heterosexual and involved in a primarily monogamous relationship with the mother of his four year old daughter when he entered treatment. He was not specifically religious, though he was raised Catholic. At the time he began treatment he was unemployed, though he later became employed as a laborer with a home goods store. While not currently disabled, Patient D had previously collected Social Security Disability Insurance for Attention Deficit Hyperactivity Disorder with which he was diagnosed since middle childhood. He reported that he suspended collection of benefits once he turned 18, at which time he also stopped taking his medication for this disorder. Patient D was referred to the clinic by the parent hospital at which he was an involuntarily committed inpatient after a parasuicidal incident in October of 2007. He began treatment at our clinic in November 2007. He

was referred for evaluation, which I performed over the course of two sessions. I made a determination to also refer him for a psychopharmacological evaluation with a psychiatrist, which he had and began treatment with her as well. He then began what was intended to be weekly therapy. He began seeing his psychiatrist for evaluation about two weeks after he saw me initially. He saw her initially for an hour long evaluation and then for 20 minute follow up appointments monthly.

Patient D described his reasons for coming to therapy as “they told me I had to come.” He was referring to the fact that he was instructed to follow up with outpatient therapy after his inpatient hospitalization after a bout of major depression that resulted in a suicide scare a month prior to him beginning treatment in the clinic. The hospital was concerned about future incidents because of his family history of depression (his father apparently had a history of depression and suicidality). Both of his parents were patients at the clinic and had serious concerns about Patient D’s potential for suicide. In addition to his parasuicidal behaviors and depressive symptoms, Patient D described other symptoms that were troubling. He described laying around for days unable to move, anhedonia, sudden bursts of energy and wanting to do things like clean the house or get organized, insomnia, or alternatively hypersomnia, and he described a flight of ideas in which his thoughts moved from one thing to another quite rapidly.

Patient D described the onset of his depression as having begun in high school when he found out that his girlfriend had become pregnant with their now four year old daughter. At that time, he had been what he and his parents described as a good student, in ROTC, and prequalified for Army service upon successful graduation from high school. Once the news of the pregnancy came, he suspended plans for the Army,

dropped out of school to find work, and by all reports, became quite depressed. He opted for full time work over school believing, he said, that it was his responsibility to support his child. At that time he reported his depression had taken the form of insomnia, anhedonia, loss of appetite, weight loss, and irritability. He also reported staying in his room and leaden paralysis. Patient D noted that he did not seek treatment for his depression at that time. In fact, he had never before sought treatment for his depression prior to his hospitalization.

More recently, he had returned from a job training program that he had enjoyed very well and reported that the current depression was in direct relationship to the end of the training program. After not having left the house for days, the patient had experienced decreased sleep, appetite, concentration, anhedonia (not dressing, leaving his room, or indeed participating in any discernable activity for several days), crying, and refusal to engage in even routine conversations with family members. This behavior led Patient D's parents to bring him to the emergency room in October where he was admitted for a period of six days while he was stabilized, observed, diagnosed, treated, and instructed to seek outpatient follow up care.

While he was in the hospital, Patient D experienced some difficulty. According to the discharge summary, he demonstrated behaviors that the hospital listed as hostile and combative. The summary described him as reluctant to engage and disinterested in treatment. He reportedly refused to participate in all but one group session and refused to meet individually with the therapist assigned to him. He was also reported to have had problems with his roommate by whom he was attacked his first night in the hospital. In the discharge summary, he was described as sarcastic and dismissive towards the staff.

In that same summary, the clinician responsible for writing indicated concern about whether or not Patient D would be compliant with the psychopharmacological protocols established in the hospital. At the time, he was prescribed Fluoxetine, Seroquel, and Ativan. He was only interested in complying with the Ativan; though he did take all of medications prescribed, he reported responding best to the Ativan. It should be noted that on his toxicology screen for that hospital admission nothing showed up with respect to street drugs, though this would not be the case on future toxicology screens.

Patient D's family was of Puerto Rican descent. His parents were born in Puerto Rico and immigrated to the United States many years earlier. They married very early. Patient D was the oldest of four children born to his parents. Both of his parents were working class with high school educations. His parents appeared to share a close relationship, and I frequently saw them together at the clinic and again at the hospital when the patient was later hospitalized. I would describe the family as close, though Patient D was not as close to the other family members and chose to keep his distance from them. He reported wanting to be independent from them and feeling guilty about living at home without a job and over his lack of self sufficiency. All of the family members continued to live at home including adult children and grandchildren. Patient D did move out for a period during our treatment together but he maintained a close connection to the family. His parents were very concerned about his treatment and were helpful about providing information about his childhood and history.

Patient D, according to his reports, was a good student who enjoyed school for the most part. He struggled when he was a young child with attention and behavioral issues until his parents worked with teachers and doctors to determine that he had a diagnosis of

Attention Deficit Hyperactivity Disorder. Apparently, the disorder was severe enough to merit disabled status by the government because Patient D received Social Security Disability Insurance until his 18<sup>th</sup> birthday at which time he voluntarily suspended collecting benefits. While I did not have the neuropsychological testing results on Patient D, I always suspected that his intelligence was high normal or above average. His cognition was fast and he was bright and interested in many different things. He made reference to interesting facts and demonstrated knowledge about a variety of subjects.

While in high school, he entered ROTC and was prequalified for a commission for the United States Army upon successful graduation from high school. During his senior year his girlfriend became pregnant. He decided to drop out of high school to find a job and support his girlfriend and new family. He explained that he felt that this was the right thing to do because he believed everyone else expected him to abdicate his responsibilities and it was important to him to prove them all wrong. He reported feeling certain that because he was a Puerto Rican man, the assumption was that he would not be a responsible provider for his daughter and that he would have to work hard to counter that assumption. The pregnancy, according to him, sent him spiraling into a profound depression. He looked for work and struggled to find it. According to him, he questioned the relationship with the girlfriend. He reported feeling resentful of the pregnancy.

He remained with the girlfriend and eventually found work but the relationship faltered. During this period he got involved in some legal trouble and received a charge of receiving stolen goods for which there was a probationary period. He had no criminal record prior to this, according to him and his family members. Eventually, he decided to

join a job training program that also assisted with GED training. The program took him to the western part of the state for two years where he trained in cement work and masonry. According to him, this period was the best time in his life. He felt he really found himself and his truest nature.

He described this period as a time when he was out from under the thumb of the low expectations that everyone had for him. He stated that he felt free particularly in relationship to what people expected from him as a Puerto Rican man. He described a place where no one knew what Puerto Rican was. No one knew if he was black or white, only that he was somewhere in the middle so they didn't know how to treat him (Landale & Oropesa, 2002). He felt that in the area in which he was living the people were simply nice to him, something he was altogether unused to. He reported feeling felt free and happy for the first time in his life. He mentioned very specifically how he could see the stars and constellations in the country that he could not see in the sky in the city and that he was able to leave his door unlocked for the first time. He often talked of how he never wanted to leave and spoke of returning to the area with longing. But when the time came and the program was over, he returned to his hometown and found the relationship, fatherhood, and expectations he left behind were all waiting for him. Two months after his return he was depressed, suicidal, and hospitalized.

### *Cultural Background*

Patient D's Puerto Rican culture seemed to be of importance to him because his ideas about it came up repeatedly in our work together. Ethnic identity and how he was perceived by others seemed to almost preoccupy him. This was a particular issue when it came to the parents of his girlfriend. For example, Patient D described one of his chief

motivators for behaving responsibly with respect to his expectant girlfriend were what he perceived to be the judging eyes of her family. As a Puerto Rican man, he described feeling judged by her white parents. His girlfriend was of Italian descent and he felt negatively judged and stereotyped by her parents, whom he felt had very low expectations of him. He was sure that they felt that he would amount to very little, that ultimately he would not stick around to support his now four year old daughter, and he reported feeling continually, silently judged by her parents despite their financial and logistical (babysitting) support of the couple.

Patient D readily identified as Puerto Rican, but seemed to have conflicted feelings about his skin color. His father was very light skinned with fair hair and green eyes. His mother was dark skinned and dark eyed like him. He often complained that he had inherited the depression and hemorrhoids from his father but lamented over why he could not have inherited the straight hair and the green eyes. He said he was joking but this lament was often repeated. While he talked openly and often of his ethnic and racial issues, he never spoke about his religious background and it appeared to have little meaning for him. He seemed to have experienced a sense of loss about his cultural identity and appeared resentful about perceptions he felt people held about Puerto Ricans. He mentioned hating “Spanish” women on more than one occasion, referring to his Spanish speaking probation officer as a ‘bitch.’ He went on to say that he would never date a Spanish speaking woman because all they did was scream and yell and asked why he needed that kind of behavior when he had grown up with it all of this life. His feelings of self worth about his Latino identity appeared to be both proud and conflicted (Alarcón, Szalacha, Erkut, & Fields, 2000).

### *Diagnostic Process*

With respect to diagnosis, it should be mentioned that the discharge notice from Patient D's hospitalization noted a diagnosis of Major Depressive Disorder. I disagreed with this diagnosis and suspected a diagnosis of Bipolar Disorder immediately based on family history, patient observation, his childhood history of ADHD, and both his and his family members' description of his symptoms. Patient D's psychiatrist disagreed with me. She diagnosed him with Mood Disorder, NOS and suspected an Axis II disorder, mentioning the possibility of sociopathy during our discussion. When I asked her about Bipolar disorder she stated that she thought that it was overdiagnosed and that she was reluctant to diagnose it. She noted that many psychological problems are more often characterological and that clinicians frequently diagnose on Axis I when Axis II diagnoses might be more accurate but less palatable, because no one likes to say that disorders are characterological.

I acknowledged that this could be the case, but listed his symptoms: racing thoughts, irritability, suicidality, leaden paralysis, grandiosity, anhedonia, increased activity (goal directed), insomnia and hypersomnia, noting that he had a history of both depressive and manic symptoms over time (Ghaemi & El Mallakh, 2006). She said to keep watching him, which I assured her I would do. She was to follow him monthly for the first three months and then once every three months for psychopharmacology. The practice of the clinic was to make patient notes into the electronic medical record after each session. We agreed to read each other's notes for updates.

### *Medical History*



Patient D's medical history is notable for several factors. During the course of our treatment he reactivated a back injury (sciatic nerve) that caused him to begin using benzodiazepam for pain. He appeared to develop a dependency on those drugs that complicated his therapeutic treatment and his psychopharmacological treatment in particular, though that is not the focus of this study. However, it did make a complicated symptom picture that much more confusing and his manic presentation much more emphatic. In addition to his use of benzodiazepam, Patient D clearly was using cocaine at least recreationally if not more regularly. During the course of my treatment with him he was hospitalized twice, once it was necessary for me to hospitalize him after a particularly unsettling incident with his probation officer, and then once again he was hospitalized after a suicide attempt at his home. Both times his toxicology screens came back positive for cocaine use.

#### *Mental Status Examination*

##### *Appearance/Behavior*

Patient D was clean and well groomed. His manner of dress was appropriate for the circumstances and conditions, though his appearance could seem somewhat eccentric (wearing sunglasses inside, for instance). He appeared somewhat older than his stated age. D was sometimes calm and cooperative displaying no unusual movements or psychomotor agitation. Other times he was appeared manic and became quite agitated. During these periods he did display some psychomotor agitation, sometimes pacing and quite frantic, he could gesticulate wildly.

##### *Speech*

Patient D's speech varied. Sometimes it was of normal rate and volume. At times, Patient D's speech could become pressured to the point where it was difficult to follow his train of thought. This was mostly due to his flight of ideas during which his thoughts would jump from subject to subject. This would mostly occur during phone messages he would leave me, not as much during our sessions.

#### *Mood/Affect*

Patient D's affect was sometimes reactive, mood congruent and within the normal range of expression, unless he was manic. In his manic periods his moods were quite dramatically altered and very expansive. In classically manic fashion, he could be grandiose and flamboyant. Often, he could be quite irritable and angry with other people as well, often showing impatience with their perceived shortcomings.

#### *Thought Process/Content*

Patient D's thought process was occasionally goal directed and logical. His thinking could be quite disorganized, particularly when overwhelmed by affect, which was not uncommon. His content was notable for parasuicidal ideations ("I want to throw myself in front of a truck"). In other areas, his thought processes and content appeared relatively normative, but in this regard he seemed impaired. His mania was also so advanced at one point he was psychotic. His thought processes at that point were notable for delusional content and perceptual disturbances.

#### *Cognition/Intellectual Functioning*

Patient D was sometimes oriented to person, place and time. He passed the short and long term memory tests I administered to him. He demonstrated very limited judgment as evidenced by his suicide attempts and drug use, and at times fair, though

limited insight. However, he during one of his hospitalizations, he reported having forgotten that I was there to visit him and what the content of our conversations were. I cannot be sure what to attribute this to whether or not it this was due to the mania or the drugs in his system at the time (the toxicology report came back positive for cocaine, but he was also taking prescribed benzodiazepams as well).

*DSM IV Diagnosis (which I performed)*

*Axis I* 296 Bipolar I Disorder

*Axis II* v71.09 No diagnosis on Axis II, narcissistic personality traits

*Axis III* sciatic nerve damage, smoking, migraines

*Axis IV* occupational problems, problems with primary support group,

*Axis V* GAF 55

*Case Formulation*

With respect to a theoretical framework that I used in this case, self psychology was most useful as I considered Patient D for several reasons. Issues of self, identity and relationship to his environment were paramount in the treatment. All of these considerations are central to Kohut's developmental lines. Specifically, I considered the paths of healthy and unhealthy narcissistic development as well as the three principal selfobject transferences: idealizing, mirroring, and twinship (Kohut, 1971).

In Patient D's case, examples of healthy narcissistic development could include his often healthy self esteem and self worth. He often demonstrated a good self regard and ability to value his good qualities which he considered to be his intelligence, self-

direction, and discipline. These values were demonstrated very clearly in his ability to seek out and complete both the ROTC programs and the job training program quite successfully. His early experiences of optimal frustration through his parents' mirroring of both his ability to succeed at his endeavors and a realistic assessment of his limitations provided him with an ability to set healthy goals for himself that he could meet and achieve provided the necessary transmuted internalization (Banai, Mikulincer, & Shaver, 2005). Another example of this could be the experience Patient D had managing his ADHD which provided him with another optimal frustration. In that instance, he had to again learn (probably over and over again) the limits of his abilities and internalize what that meant while maintaining a respect for what abilities he did have.

In terms of Patient D's unhealthy narcissistic development, several examples came up during the course of our treatment together. Patient D at times could demonstrate an inability to feel empathy for his daughter which was striking. He described an incident during which he was prepared to let her burn herself on the stove in their family's kitchen in order to let her learn to stay away from it rather than talk to her about its dangers. He stated that his method would be a more effective deterrent. He talked often about his feelings about using corporal punishment with her because it had been used on him and that he didn't feel her life should be any easier than his had been. He also attempted suicide with his daughter in the house at one point. This apparent lack of empathy with a small child who also was his own progeny was notable (Imbesi, 1999).

Another example of his unhealthy narcissism was his internalized self-hatred as expressed as rage towards Spanish (Latina and more specifically Puerto Rican) women. Low self-esteem expressing itself at that level could certainly be considered an example

of unhealthy narcissistic development (Kohut, 1985). This self-hatred was taken to a marked degree by his refusal to engage in intimate relationships with women with whom he shared a common ethnic identity. He reported that he had never been involved with a woman of his own ethnic background. He described his mother as having an incendiary temper, constantly screaming and asked me why he needed to be involved with anyone who behaved in that manner, as if all Latina women behaved in the same manner. However, he seemed to expect that all Latina women would behave accordingly. Indeed, he described an incident with his probation officer, a Puerto Rican woman, which was so disruptive that he decompensated to the point where he had to be hospitalized. He described the incident in one of our sessions during which he reported she refused to make eye contact with him or interact with him with what he considered to be common human understanding and he felt rejected by her refusal to engage him. This appeared to reinforce his intense dislike and distrust of Latina women in a very destabilizing way. Immediately following this incident he presented at the clinic.

Patient D's self object transferences were also pronounced. Patient D brought a strong idealizing transference to our work. It is important to remember that he also had a psychiatrist whom he saw for psychopharmacological services. She was concerned about him splitting the transference largely because of her concerns about a diagnosis on Axis II. I did not share her concerns in this regard. Nor did it appear that he had a particularly strong alliance with the psychiatrist. What was apparent was that he did have a strong idealizing transference of me (Kohut, 1977).

This idealizing transference was present in several interesting ways. Patient D contacted me by telephone regularly between sessions, often on the day of a scheduled

session. He would leave me messages informing me of various aspects of his life and updates as to his mood and temper. Often the content of these messages would contain information about how someone had wronged him. He was usually quite angry and wanted to tell me the nature of the slight and how he felt about it. Sometimes it was to prepare me for the session and what the transference would be in session. Other times it would appear to be merely to let off steam. He appeared to need me to help him regulate his anger and make sense of the perceived slights and injustices he faced as he moved through his world. He would often tell me that I was the only one who tried to help him, that I was the only one he could talk to, that I was the only one he had ever opened up to in this way, and that I was the only one he could trust (Kohut, 1971).

Another selfobject transference that was manifest in my work with Patient D was the twinship transference. Patient D quite rightly perceived a shared sense of ethnic identity with me. We were both from multiracial backgrounds and had a similar phenotypical appearance. He often talked with me about perceptions he had about his identity (Leary, 1995). He asked me about my own perceptions about experiences he had had to see if mine were similar to gauge his own reality testing. Once in session, he bared his skin to show me markings and discolorations that he felt sensitive about. I explained to him that variations such as he was displaying were quite common to people of our complexion and background. He seemed comforted by that. He talked quite openly with me about his experiences of life “in the middle” between black and white, particularly when he was living in the western part of the state when he was participating in the job training program. Our shared sense of identity seemed to reassure him and provide him with a sense of belonging (Romano, 2004).

The other selfobject transference that played a key role in Patient D's therapy was the mirroring transference (Kohut, 1971). This was particularly important in the early part of our work when his depressive symptoms were active and his self esteem was quite low. At that time, identifying strengths and reflecting them back to him was a crucial priority. Identifying his strengths was relatively simple as he had many; a curious mind, the ability to build lasting relationships, commitment and dedication to goals, responsibility, intelligence and loyalty. These qualities were evident in his ability to form his commitment to his ROTC and job training programs, his commitment to child rearing (though he did struggle with this his efforts were ongoing), his familial commitments, his ongoing monogamous relationship with the mother of his daughter, and his various intellectual pursuits. Patient D responded well to the mirroring work I did in our therapy together and talked openly about his wishes for himself and his beliefs about himself in the therapy. I believe that this was the genesis of the trust he later came to speak of.

### *Treatment*

The treatment goals as they were initially conceived and stated in the treatment plan upon evaluation of the patient consisted of relieving the symptoms of depression and supporting the patient as he conducted a job search and attempted to transition into a new housing situation (moving out of his parents house). Due to the patient's instability, containment became the focus of our work during many of our encounters. Patient D missed many of our scheduled sessions and would try to see me when it suited him. He would attribute this to his job search, to looking for a new apartment, and other goal directed activities that were consuming him during what was a very manic period of his life. He would call me in a frenzy asking to see me within an hour. If I could

accommodate him, I would. He was also missing appointments with his psychiatrist and, as I later found out, he was non-compliant with his psychopharmacological protocol which was undoubtedly contributing to his mania.

The differences between the actual treatment plan, the stated goals, and the reality of containment of a Bipolar patient who was actively manic, borderline psychotic, developing a drug addiction, had attempted suicide, and required hospitalization were striking. They created a situation I was wholly unprepared to face and struggled to manage with minimal supervision as my supervisor was unavoidably out of town during some of the crises that arose during the course of treatment. Because of the difficulty in treating the case, I sought consultation on several occasions with senior clinicians on staff including the senior psychiatrist and the clinical team to which I belonged.

After Patient D's second hospitalization (following the incident with the probation officer), his toxicology screen came back positive for cocaine use. He had recently begun working again, performing manual labor. Early in his employment he had injured his back. For this injury he was prescribed benzodiazepam and oxycodone for pain relief. His behavior had become even more erratic and manic than I had previously experienced. I was particularly troubled by the toxicology report and sought consultation from the clinical team about the best way to proceed with the case. All of the clinicians on the clinical team believed that he was probably a cocaine addict. I was not as convinced. He had no prior history of drug use and denied that he was a habitual user. He reported only recreational use and his prior toxicology screen (from his first hospitalization) had come back negative. Moreover, he continued to deny that he used it regularly and he did not



test positive for marijuana which he also denied using. My primary concern was the benzodiazepam and the oxycodone.

At that time, both Patient D's psychiatrist and I were instructed by the chief psychiatrist that as his providers, we must refer him to a dual diagnosis program. He missed his next several appointments (so we were never able to make the referral) and the next I heard from him he was hospitalized for a suicide attempt in his home (during which his young daughter was present in the home). I was contacted by the hospital where he was admitted and spoke to the attending psychiatrist. He immediately questioned me about Patient D's diagnosis. I explained to him that he had a diagnosis of Major Depressive Disorder given to him by the original hospital from his first inpatient stay, but that I had suspected a diagnosis of Bipolar I. The psychiatrist questioned me about a diagnosis on Axis II. I questioned him as to what his concerns were because I had never diagnosed Patient D on Axis II. The psychiatrist stated some concerns about sociopathy due to Patient D's hostility and recalcitrance over medications. Apparently, Patient D had punched a wall and injured his hand during this most recent hospitalization. The doctor asked if I could pay a visit, to which I readily agreed.

My visit to the hospital proved stabilizing for the patient, though he later had no recollection of it. He was able to calm down and talk to me about the suicide attempt and the precipitating events. I was also able to read the admission summary and the toxicology report, which also came back positive for cocaine. By this time, the patient was using benzodiazepam and oxycodone regularly for his back pain and to manage his anxiety, which was quite pronounced. The psychiatrist reported that the patient had refused to meet with the inpatient therapist and was extremely agitated and angry. He

was far less angry when I encountered him at the hospital, though he was quite manic. The psychiatrist agreed with my diagnosis of Bipolar but deferred his diagnosis on Axis II, stating that he seemed to have calmed down upon my arrival. I explained to the psychiatrist the patient's problematic history in hospitals (after the attack by the roommate during his first hospitalization) and that he may have been feeling provoked in addition to the drug use. Patient D remained hospitalized for another two days and was released.

The next time I saw Patient D he was in an advanced manic state and borderline psychotic. He came to my office for a scheduled appointment and had not taken any of the medications he had been prescribed in the hospital. Unfortunately, they had continued prescribing Ativan and it appeared to be exacerbating his mania. He was wild, pacing in the waiting room and talking about ideas of reference that were, upon retrospect, clearly psychotic. It was my own lack of clinical experience that prevented me from hospitalizing him. I recognized that he was manic and that his thought content was disturbed, but because I could recognize the content of his delusions by way of popular reference, I did not recognize how compromised his judgment was, so I did not hospitalize him.

Patient D came to the clinic the next day to pick up his prescriptions. Unfortunately, he thought he was filling a prescription for Ativan. The prescriptions he was picking up in reality were for Seroquel and Depakote. When he discovered the discrepancy, he caused a scene in the waiting room of the clinic. The unit chief, a psychologist, happened to come out into the waiting area to try to calm him down and ironically, exacerbated the situation. As he became more frustrated by his inability to

procure the Ativan, he raised his voice demanding the drugs. She informed him that no Ativan would be forthcoming and that he could have the prescriptions for the other drugs, but he was dissatisfied with that option. She asked him to leave the clinic. He demanded the Ativan. Security was called. They escorted him from the building. She informed me that Patient D could no longer be treated at the clinic. She stated that he had a “crowded Axis II” and that she suspected some sociopathy and narcissism. She was a member of my clinical team and had given consultation on the case, so had some degree of familiarity with the patient.

Patient D’s psychiatrist and I met the next day to discuss how to handle the termination of Patient D’s case. We wrote a letter explaining to him that because of his disruptive behavior, we would no longer be able to treat him at the clinic. His prescriptions (that he had previously rejected) were enclosed as were a list of providers to whom he could self-refer. I added a personal note about what a pleasure it had been to treat and to know him. I did speak to him on the phone once or twice more as he updated me on his plans to stay out of therapy and off of medication. I advised him against this strategy, but he was determined that all he needed to heal himself was time away from everyone. I was left with the feeling that if I had only hospitalized him the day before the incident that a different course of events might have unfolded.

#### *Evaluation of Diagnosis*

The diagnostic component of Patient D’s case is undoubtedly the most complex. There were a number of factors contributing to its complexity; the depressive symptoms and inpatient hospitalization that led him to become my patient initially, the childhood diagnosis of Attention Deficit Hyperactivity Disorder; the family history of depression

(and possibly other issues including domestic violence and Posttraumatic Stress Disorder), and the polysubstance abuse. Sifting through these issues to understand which symptoms belong to Axis I and which traits belong to Axis II is a process that can only be understood by a careful study of the patient and his issues. A sensitive reflection on the patient and an attunement to his culture, context, and symptom picture will allow for a reflective and accurate diagnosis in a case as complex as this one. A rush to judgment will bear no fruit in a case as muddled as this.

Toward that end, I will review diagnostic criteria for each of the disorders that Patient D was suspected to have had, Antisocial Personality Disorder and Narcissistic Personality Disorder, and consider those traits *vis a vis* the symptoms of the disorder I diagnosed him with, Bipolar I Disorder. Each of the diagnostic criteria for the personality disorders will be reviewed in turn with an explanation of why they either fit or do not apply with a plausible explanation of why they might better fit under Bipolar I Disorder. While Bipolar I Disorder is a longitudinal diagnosis and Patient D was under my care for a mere four months, I feel that a diagnosis could be made in his case given the preponderance of evidence. I will begin with an examination of the diagnosis of Antisocial Personality Disorder because it was the cause of most concern in Patient D's case.

The diagnostic criteria for Antisocial Personality Disorder are as follows:

- A. *There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:*

*failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest.*

Patient D had only one criminal charge of receiving stolen goods. This charge was made after he turned age 18. In a case of sociopathy, antisocial behaviors must be established beginning at age 15. Patient D had no juvenile history of criminal behavior according to him, his family and his probation officer. One adult charge without a repeated pattern would not suggest sociopathy. With respect to his drug use, drug abuse is indicated in Bipolar patients at rates as high as 72% (Goodwin & Jamison, 2007) This could be accounted for as a Bipolar symptom as opposed to an antisocial trait.

*deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure*

Patient D never demonstrated deceitful behavior in our experience together. Nor did he or his family relate any stories to me that suggested anything to the contrary. With respect to his drug use, he readily admitted his use of cocaine and past use of marijuana which he disclosed and never tested positive for; I have no evidence of his lying about anything and certainly no pattern of deception.

*impulsivity or failure to plan ahead*

While Patient D displayed poor impulse control on at least two notable occasions (indicated with respect to an instance of wall punching in hospital and with probation officer) these incidences were concurrent with his drug use. Other impulsivity could be better accounted for by the mania of Bipolar Disorder.

*irritability and aggressiveness, as indicated by repeated physical fights or assault*

Both Patient D's irritability and his aggressive behavior which were rare and situationally provoked (at both hospitalizations and with the probation officer) could be attributable to the cocaine in his system. No aggressive behavior was present during hospitalization where the toxicology screen came back negative. Additionally, irritability is symptom of Bipolar Disorder and could be accounted for on Axis I.

(5) *reckless disregard for safety of self or others*

The only reckless disregard for the safety of self or others that Patient D displayed during our treatment were the suicidal behaviors that he exhibited. These are probably better attributed to the depression associated with Bipolar Disorder. The clinical population affected with this Disorder has a suicide rate of 15% (Goodwin & Jamison, 2007).

(6) *consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations*

Consistent irresponsibility is not indicated in his case. Patient D was able to maintain steady employment and honor his financial obligations when he was working. Moreover, being financially responsible was something he was consistently and conscientiously concerned with.

(7) *lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another*

Patient D was able to show remorse over things he had done wrong and reported feeling very guilty over his feelings about whether or not he was a good father.

B. *The individual is at least 18 years of age*

C. *There is evidence of Conduct Disorder with onset before age 15 years.*

*D. the occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.*

This last criterion is critical because many of the behaviors that could seem questionable happened either while Patient D was manic or under the influence of substances.

While most of the questions about Patient D's diagnosis on Axis II centered around Antisocial Personality Disorder, the Unit Chief of my practice questioned also his narcissistic tendencies. Toward that end, I will review those criteria as well.

The diagnostic criteria for Narcissistic Personality Disorder are as follows:

*A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in variety of contexts, as indicated by five (or more) of the following:*

*(1) has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)*

In the case of Patient D, the grandiosity is more likely a symptom of Bipolarity than a narcissistic trait.

*(2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love*

Does not meet criteria.

*(3) 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)*

Does not meet criteria.

(4) *requires excessive admiration*

Does not meet criteria.

(5) *has a sense of entitlement*

Does not meet criteria.

(6) *is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends*

Does not meet criteria.

(7) *lacks empathy, is unwilling to recognize or identify with the feelings and needs of others*

In this instance, Patient D has demonstrated a lack of empathy (example of young daughter); this could be a tendency and is one trait. I have indicated this trait in my diagnosis of patient on Axis II as “Narcissistic personality traits.”

(8) *is often envious of others or believes that others are envious of him or her*

Does not meet criteria

(9) *shows arrogant, haughty behaviors or attitudes*

Does not meet criteria

An examination of the diagnostic criteria reveals that Patient D is not diagnosable on Axis II for either of the personality disorders listed. While he has a demonstrated lack of empathy, he does not meet any other criteria.

A careful study of the criteria for Antisocial Personality Disorder demonstrates that what on the surface may appear to be sociopathic traits are more likely Bipolar



Disorder symptoms (please refer to Appendix C for Bipolar I diagnostic criteria). Those symptoms could be confused with antisocial traits to someone who had not spent the time with the patient and really understood the difference between them. The symptoms and traits are easy to confuse. Careful scrutiny is necessitated in cases like these. It is possible that a patient such as he is easy to dismiss. Puerto Rican, young, loud, and demanding with a wild presentation, one might question the extent to which anyone is really is taking him seriously.

### *Discussion*

Patient D's case is emblematic of the problem of diagnosis for all clinicians, particularly those working cross culturally in the inner city. Who are the people we are treating and how do we come to understand them? How do we know what is mood and what is character? We might not completely understand the cultural factors and socioeconomic circumstances that have gone into shaping the characters of the individuals in the clinical populations which we serve. It should be noted that all of the clinicians who suspected characterological issues in this case were white and middle class and the patient was neither. The patient and I were the only people of color in this particular clinical picture, and the patient was the only working class individual.

What was it about the patient and his presentation that led them to immediately suspect characterological issues where I never saw them? Certainly, my lack of clinical experience could have been a factor. However, I was also willing to consider a diagnosis others were either unwilling or unable to consider possibly because of my greater exposure to the patient and greater familiarity with his intrapsychic material. But also his culture and presentation were less foreign and potentially threatening to me. His

loudness, his sunglasses (Patient D had come to the clinic in a rather outrageous pair of sunglasses the day he was escorted out), his recreational drug use, and his fast talk were all part of my cultural context.

The DSM IV specifically warns against the dangers of clinicians from the dominant culture misdiagnosing patients of socioeconomic and cultural minority backgrounds on Axis II easily because of cultural factors that white clinicians are unfamiliar with (American Psychological Association, 2000). The question is, how can clinicians sensitize themselves to material that will allow them to diagnose most effectively and, if they cannot do this, how can they suspend judgment? What led these clinicians to these perceptions? I cannot know. I can only know that Patient D made them acutely uncomfortable in the way that character disordered people do. As a result of this, he did not receive the kind of care he should have. He may have been misdiagnosed, misedicated, and mistreated as a result (Conus, Berk, & McGorry, 2006).

Patient D's narcissism, as it exists, might exist in part because of the same kind of low expectations that befell him in this instance. When mirroring is lacking in a society that is racist what do you miss out on that others take for granted? Where do you go to make up for that lack? Can you make up for it? He recognized that the expectations were low for him. If people require mirroring to provide them with appropriate opportunities to feel grandiose, then imagine the impact of that lack of opportunity in a social milieu that is racist for the person of color. Racism has a detrimental effect not a supportive one and certainly not a mirroring one. In addition to his lack of empathy, the other narcissistic trait that Patient D possessed was the fundamental narcissistic trait, low self esteem. That low self esteem may have been a function of a split off grandiosity that

was a result of insufficient mirroring from the racist society in which he lived. That grandiosity could have lent itself to an inability to regulate his self esteem and caused him difficulty with depression and rage (Miliora, 2000).

There's a feeling you get when you are sitting with someone who has a Cluster B diagnosis. Often they can make you feel angry, uncomfortable, and ill at ease. Their projective powers are considerable. People with Antisocial Personality Disorder are particularly known to be smooth and manipulative. Patient D possessed none of the slick charm of a sociopath, but the stargazing wonder of a dreamer. When discussing his back injury at one point he told me that he was like Cro Magnon man, he didn't need doctors; his bones just needed to keep breaking and heal over. He had imagination and a passion for life. It was my pleasure to work with him, though I often felt unequal to the task and up against the odds of those who could not see him for who he was.

The outcome for Patient D's case could have been quite different. Several recommendations could be suggested for consideration. First, with respect to the issues of diagnosis, clinicians should always take care in making judgments or assertions as to characterological assessments early in the course of patient encounters. The diagnostic process is a delicate one that requires careful reflection while histories are taken, patients are observed, and stories unfold. It is possible that if immediate character questions had not surfaced, more attention may have been paid to the mood symptoms that were present in Patient D's case. Next, Patient D's treatment at the clinic should have been continued. There was no sufficient reason why it should have been stopped. His outburst while ill advised was neither threatening nor dangerous. The fact that he was coming to treatment on a semi-regular basis was encouraging. He had begun to establish an alliance with me

and was willing to explore whether or not treatment could work for him. Moreover, there is evidence to suggest that a positive therapeutic alliance leads to better compliance in Bipolar patients (Zeber, Good, Fine, Bauer, & Kilbourne, 2008). Suspending his therapy at that juncture was probably disorganizing and may have had deleterious effects on him. Had I continued to work with Patient D, I would have investigated appropriate therapeutic techniques to apply in my work with him. Research on this thesis suggests that Cognitive Behavioral Therapy may have been a useful tool (Goodwin & Jamison, 2007).

Finally, there is reason to believe that an element of cultural dissonance existed in this case. It is possible that a lack of exposure to the economic and cultural factors that influenced Patient D's life may have impacted the ability of the clinicians involved with his case to fully appreciate who he was as a person. It is hard to know how to bridge this gap. Cultural sensitivity trainings and diversity workshops are insufficient. One must step into a world to know it or acknowledge the limits of one's understanding. All clinicians who aspire to work with people from cultures different from their own must endeavor to know their patients' worlds and thereby know them (Reynolds & Baluch, 2001). We are in the business of peoples' souls. We have to appreciate the subtleties of where they have come from to know who they are, to see them as they see themselves. It took some work to see him clearly, but Patient D could be seen if you looked at him the right way.

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## Appendix A

### Diagnostic Criteria for a Manic Episode

- A. A distinct period of abnormally and persistently elevated, expansive or irritable mood lasting at least 1 week (or any duration if hospitalization is necessary).
- B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
- (1) inflated self-esteem or grandiosity
  - (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
  - (3) more talkative than usual or pressure to keep talking
  - (4) flight of ideas or subjective experience that thoughts are racing
  - (5) distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli)
  - (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
  - (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
- C. The symptoms do not meet criteria for a Mixed Episode



- D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- E. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication, or other treatment) or a general medical condition (e.g. hypothyroidism).

## Appendix B

### Diagnostic Criteria for a Major Depressive Episode

- A. five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: in children and adolescents, can be irritable mood.
  2. markedly diminished interest or pleasure in all, or almost all activities most of the day nearly every day (as indicated by either subjective account or observation made by others)
  3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: in children consider failure to make expected weight gains.
  4. insomnia or hypersomnia nearly every day.
  5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

6. fatigue or loss of energy nearly every day
  7. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional nearly every day (not merely self-reproach or guilt about being sick)
  8. diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
  9. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. the symptoms do not meet criteria for a Mixed Episode.
- C. the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- D. the symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).
- E. the symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

## Appendix C

### Diagnostic Criteria for Bipolar I Disorder

- a. Criteria, except for duration, are currently (or most recently) met for a manic, a hypomanic, a mixed, or a major depressive episode.
- b. there has previously been at least one manic episode or mixed episode.
- c. the mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- d. the mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- e. the mood symptoms in Criteria A and B are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

## Appendix D

### Diagnostic Criteria for Antisocial Personality Disorder

- A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, 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 repeated 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
- B. The individual is at least 18 years of age
- C. There is evidence of Conduct Disorder with onset before age 15 years.

D. the occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

## Appendix E

### Diagnostic Criteria for Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in variety of contexts, as indicated by five (or more) of the following:

- (1) has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
- (2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
- (3) 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)
- (4) requires excessive admiration
- (5) has a sense of entitlement
- (6) is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
- (7) lacks empathy, is unwilling to recognize or identify with the feelings and needs of others
- (8) is often envious of others or believes that others are envious of him or her
- (9) shows arrogant, haughty behaviors or attitudes

## Appendix F

### Diagnostic Criteria for a Mixed Episode

- A. The criteria are met for both a Manic Episode and a Major Depressive Episode (except for duration) nearly every day during at least a 1-week period.
- B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- C. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication, or other treatment) or a general medical condition (e.g. hyperthyroidism).



## Appendix G

### Diagnostic Criteria for a Hypomanic Episode

- A. A distinct period of persistently elevated, expansive, or irritable mood lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.
- B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
  - (1) inflated self-esteem or grandiosity
  - (2) decreased need for sleep (e.g. feels rested after only 3 hours of sleep)
  - (3) more talkative than usual or pressure to keep talking
  - (4) flight of ideas or subjective experience that thoughts are racing
  - (5) distractability (i.e. attention to easily drawn to unimportant or irrelevant external stimuli)
  - (6) increase in goal directed activity (either socially, at work or school, or sexually) or psychomotor agitation
  - (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g. the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

- C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.
- D. The disturbance in mood and the change in functioning are observable by others.
- E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.
- F. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication, or other treatment) or a general medical condition (e.g. hyperthyroidism).

## Appendix H

### Diagnostic Criteria for Bipolar II Disorder

- A. Presence (or history) of one or more Major Depressive Episodes.
- B. Presence (or history) of at least one Hypomanic Episode.
- C. There has never been a Manic Episode or a Mixed Episode.
- D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on by Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder, Not Otherwise Specified.

## Appendix I

### Diagnostic Criteria for Cyclothymic Disorder

- A. For at least 2 years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet criteria for a Major Depressive Episode. **Note:** in children and adolescents, the duration must be at least 1 year.
  
- B. During the above 2-year period (1 year in children and adolescents), the person has not been without the symptoms in Criterion A for more than 2 months at a time.
  
- C. No Major Depressive Episode, Manic Episode, or Mixed Episode has been present during the first 2 years of the disturbance. **Note:** After the initial 2 years (1 year in children and adolescents) of Cyclothymic Disorder, there may be superimposed Manic or Mixed Episodes (in which case both Bipolar I Disorder and Cyclothymic Disorder may be diagnosed) or Major Depressive Episodes (in which case both Bipolar II Disorder and Cyclothymic Disorder may be diagnosed).

- D. The symptoms in Criterion A are not better accounted for by Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder, Not Otherwise Specified.
  
- E. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication, or other treatment) or a general medical condition (e.g. hyperthyroidism).
  
- F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  
- E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

## Appendix J

### Diagnostic Criteria for Bipolar Disorder, Not Otherwise Specified

1. Very rapid alternation (over days) between manic symptoms and depressive symptoms that meet symptom threshold criteria but not minimal duration criteria for Manic, Hypomanic, or Major Depressive Episodes.
2. Recurrent Hypomanic Episodes without intercurrent depressive symptoms.
3. A Manic or Mixed Episode superimposed on Delusional Disorder, residual Schizophrenia, or Psychotic Disorder, Not Otherwise Specified.
4. Hypomanic Episodes, along with chronic depressive symptoms, that are too infrequent to qualify for a diagnosis of Cyclothymic Disorder.
5. Situations in which the clinician has concluded that a Bipolar Disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced.