Gunderson: The Borderline Personality Disorder

A prominent advocate of the *borderline* concept, Gunderson has made a number of important contributions to the refinement of its definition on the basis of meticulous analysis of the literature as well as subsequent clinical observation (Gunderson and Singer, 1975; Gunderson, Carpenter, and Strauss, 1975; Carpenter, Gunderson, and Strauss, 1976). From the systematic examination of the ingredients of the term "borderline"—as utilized by his predecessors—Gunderson has teased out a number of essential features; these, in turn, have become embodied as criteria for the syndrome he proposes: the *borderline personality disorder* (BPD). The manner in which these features were isolated, via discriminant function analysis, is described in a more recent article (Gunderson and Kolb, 1978).

In order to render the diagnosis of *borderline personality disorder* more objective, Gunderson and Kolb (1976) elaborated a semistructured interview (the Diagnostic Interview for Borderlines, or DIB). The DIB contains 123 items, tapping twenty-nine characteristics of borderline patients in five main areas of function: *social adaptation, impulse-action patterns, affects, psychosis,* and *interpersonal relations.*

Correspondences between the Gunderson (G) and Kernberg (K) variables may be drawn up in the following fashion: (1) the *reality-testing* item (K) resembles the section entitled "Psychosis" (G); (2) some of the specific questions in the section "Affect" (G) tap information about *anxiety tolerance* (K); (3) both systems have separate questions or scales relating to impulse control; (4) *sublimatory capacity* (K) can be partially assessed by several of the questions on "Social Adaptation" (G)—namely, number 9, "Do you have any special talents or skills . . . ?" and number 10, "Have there been periods when you were particularly effective in school or work?"; and, finally, (5) some of the questions asked in order to assess "Interpersonal Relations" (G) resemble areas for special attention in the "Structural Interview" (K).

The DIB has thus far been administered chiefly to young (ages sixteen to thirty-five) hospitalized patients with average to better-than-average intelligence and in whom drug or alcohol abuse is not a primary diagnosis. Results suggest that a borderline group can be reliably separated out from a schizophrenic and from a neurotic group.

Discriminating BPD from Schizophrenia

In contrast to the patient with BPD, the schizophrenic (here, in the sense of the *core* schizophrenic) will often have *flattening of affect* and episodes of severe derealization. The schizophrenic is often a *loner;* the borderline patient is clingingly dependent or else manipulative and demanding—but in either case, feels a strong need to be in the company of others. Gunderson found that serious and repeated abuse of illicit drugs was far more common

in the borderline group than in either schizophrenics or neurotics (1977a, p. 179). This may reflect patient-sample variation, since this has not been uniformly so in the author's experience: both at New York Psychiatric Institute and at New York Hospital–Westchester Division, mild to moderate abuse of marijuana and hallucinogens is almost universal in hospitalized patients under thirty, irrespective of diagnostic subgroup.

Discriminating BPD from the Neurotic Group

Borderline patients frequently experienced *brief psychotic episodes;* this rarely occurred among the neurotics. *Dysphoria* and *anhedonia* were more common in BPD, as was a *deviant pattern of sexuality*. The latter might include either promiscuity or one of the perversions. *Antisocial patterns* were more frequently noted in the borderlines, who also tended to show *poor achievement or work* records. *Intolerance of being alone* was typical in BPD, yet close relationships were characteristically unstable, dependency alternating with devaluation and exploitation. In the hospital setting, staff were often "split" into two or more groups, each with markedly contrasting responses to the borderline patient.

Impulse-action patterns and interpersonal relationships emerged as the most highly discriminating variables in relation to both schizophrenia and neurosis. Gunderson has summarized his findings in the area of social adaptation with the observation (1977) that (*a*) *borderlines* show *good awareness of social conventions* in contrast to the *schizophrenic* but (*b*) show a *poor work–achievement* record when compared with the *neurotic*.

Diagnostic Criteria for BPD

The most discriminating items from the DIB could, through factor analysis, be condensed into a smaller number of recurring features that now constitute the criteria for Gunderson's borderline personality disorder (Gunderson and Kolb, 1978). These are outlined in Table 9–3, which also includes the results on psychological testing characteristically noted (Gunderson and Singer, 1975) in BPD patients.

Inspection of Table 9–3 will make clear that the Gunderson criteria represent a mixture of clinical-phenomenological items (brief psychotic episodes, rageful affect, and so on), derived primarily from direct observation, and other more abstract items (problems with closeness) derived from anamnesis and from experience with the patient over time.

There is less emphasis on defense mechanisms in the Gunderson criteria than in Kernberg's formulations, though it is obvious that anyone satisfying BPD criteria would have the kind of primitivity in defense structure that Kernberg speaks of. The same may be said for disturbance in identity formation: this is alluded to in the Gunderson schema ("shifting identifications" resembles Deutsch's "as if" personality) but underlined directly in

TABLE 9–3

Gunderson's Borderline Personality Disorder

Diagnostic Criteria

1. *Lowered Achievement* (diminished work capacity)
2. *Impulsivity* (especially drug abuse and promiscuity)
3. *Manipulative Suicidal Threats* (namely, wrist cutting)
4. *Mild or Brief Psychotic Episodes* (often of a paranoid quality and sometimes more sustained in duration, if provoked by abuse of psychotomimetic drugs; but severe depersonalization, or widespread delusions, in absence of drugs, contraindicates the diagnosis)
5. *Good Socialization* (mostly a superficial adaptiveness, beneath which is a disturbed identity camouflaged by rapid and shifting identifications with others)
6. *Disturbances in Close Relationships*
   a. Tendency to be depressive in the presence of the important other, and to be enraged or suicidal should the latter threaten to leave; tendency to have psychotic reactions when alone
   b. In general, a predominance of rageful affect rather than emotional warmth

NOTE: Psychological tests will tend to show good performance on the structured portions of the test and poor performance (with the emergence of primitive ideation) on the unstructured portions. Except for possible temporary lapses, reality testing is preserved.

the Kernberg schema. The occurrence of brief psychotic episodes, on the other hand, is spelled out in so many words as part of the BPD, whereas by Kernberg it is simply acknowledged that these episodes are common and quite compatible with his "borderline personality organization." This difference may be a reflection of a greater affiliation in spirit, on Gunderson's part, to Grinker and to the traditional views of hospital psychiatry, and, on Kernberg's part, to Melanie Klein and Rosenfeld, and to the structuralist/psychoanalytic viewpoint. In connection with this it should be kept in mind that Gunderson, although he mentions parenthetically the generally good reality testing of his BPD sample, does not set up as a criterion the feature so central to Kernberg's schema, namely, preservation of reality testing even in the interpersonal sphere. It is this difference which (in my opinion) accounts for the greater ease with which a schizotypal borderline patient (or "borderline schizophrenic," à la Kety) can meet Gunderson's, in comparison to Kernberg's, criteria. Certain schizotypal borderline patients (but not all) therefore constitute an area of nonoverlap with the Kernberg borderline realm.

Since Gunderson and Kolb's DIB requires a lengthier examination than the Spitzer checklist but a less analytically oriented psychiatric interview than Kernberg's diagnostic procedure, the Gunderson schema may be seen as one of intermediate complexity. Because many alcoholic and other substance-abuse patients show Kernberg's borderline organization, Gunderson's BPD occupies a smaller territory on the total psychodiagnostic map, *mostly* within the Kernberg realm, but less slanted toward the affective pole and, indeed, containing a larger "tail" in the realm of borderline schizophrenia than is exhibited by Kernberg's sample. These relationships are reflected in the Venn diagram of Chapter 2.

Gunderson has expressed the hope that the borderline personality disorder, already a definite syndrome as he and his colleagues have defined it, will be validated as a coherent psychiatric disorder. Gunderson and Kolb mention as external frames of reference, in relation to which their syndrome must be further evaluated, *psychological coherence, treatment response, clinical course,* and *etiology*. With respect to treatment response, BPD already seems to correspond well with the particular set of patients in the intermediate range of function, for whom intensive analytically oriented therapy is best suited. Some patients in the group are schizotypal, clinically if not constitutionally, and are still captured by the Gunderson definition. The Kernberg definition, because it is broader, also includes most of the patients destined to benefit from this mode of treatment. But many substance-abusing and antisocial or otherwise intensely narcissistic patients are borderline in Kernberg's sense (but not in Gunderson's), while a number of "Gunderson-positive" schizotypal borderline patients are "Kernberg-negative" because their reality testing does not improve, initially, on confrontation. It will be interesting to see which definition, as further follow-up studies are performed, more closely overlaps with the set of patients responding well to intensive psychotherapy.

Regarding etiology, I have already expressed my view that both the Gunderson and the Kernberg definitions of borderline embrace a heterogeneous population, with the difference that Gunderson's BPD includes more schizotypal patients—probably with more schizophrenic and borderline-schizophrenic relatives—than does the more affectively tilted Kernberg definition.

As with other definitions of *borderline,* the female-to-male ratio in the Gunderson syndrome is approximately 2:1.

A Note on Psychological Testing in Borderlines

In their 1975 paper, Gunderson and Singer drew attention to a psychological test result they considered characteristic of the "borderline" patient. Typically one observed good performance on the structured portions of the test battery (such as the WAIS or the Bender Visual Motor Gestalt Test) but poor performance on unstructured portions. In the Ror-

schach, for example, borderline patients might respond in a way that suggested weakening of ego boundaries. Bizarre or highly idiosyncratic responses were common; on some records, confabulation and a preponderance of "minus"-form ($F-$) responses were noted. These were the abnormalities to which McCully (1962) drew attention in his report on the Rorschach findings in "borderline schizophrenia." It is not clear, however, what diagnostic criteria McCully required in using that term, nor to what extent those criteria may coincide with the Gunderson criteria for borderline personality disorder.

In my experience many patients who meet the borderline criteria of either Gunderson or Kernberg show the split in test performance Gunderson and Singer allude to, but so do a number of intellectually gifted patients (usually schizophrenic) with psychotic structure. This split, when present, cannot be understood as inhering exclusively to the realm of borderline conditions.

Psychological testing, as McCully mentions, dives below the surface of ordinary experience, therefore tapping layers of mental functioning not necessarily accessible to the clinician. If one favors the notion that *vulnerability* to schizophrenia may be present, and often suspected, even in the absence of "hard" signs, it should not be surprising to find that some recompensated (but once overt) schizophrenics continue to show bizarre responses on the unstructured portions; likewise certain persons with significant loading for schizophrenia, who have not as yet, or who may never, decompensate, may still betray "characteristic" schizophrenic signs on such testing. Those who do not adhere to the notion of vulnerability may, in contrast, experience as paradoxical the "schizophrenic" responses of certain borderline patients who, here and now at the clinical level, are "not schizophrenic."

Singer (1977) has reported on a number of studies she conducted, some in conjunction with Lyman Wynne, of psychological tests on patients at various levels of illness, and on their relatives. In one such study, the index cases were divided into five groups: normal, neurotic, borderline, remitting schizophrenia, and nonremitting schizophrenia. It was noted that on the Rorschach, borderline patients gave even more flamboyant, elaborate, and peculiarly expressed responses than did the "remitting" schizophrenics.

Clinical evaluation of the relatives of these different groups revealed that one parent was borderline or psychotic in 16 percent of the borderline cases. This figure increased with increasing severity in the index case: 21 percent in the remitting Sz group, 35 percent in the nonremitting group. In addition, both parents were *at least* borderline in 40 percent of the nonremitting cases—whereas no instances of combined illness were noted in parents of the less ill cases. On Rorschach study of the parents, Singer noted that the parents of borderlines gave strikingly more responses with *affective* connotations than did parents in the other categories.

Although Singer states that persons who become labeled "borderline" do not conform to a solitary nosological entity, two relationships are suggested by her observations. First, many borderlines are schizotypal not only in their Rorschach responses but also clinically—and some come from families where there are schizophrenic or schizoid relatives. Second, the affective coloration of responses among the (often emotionally ill) parents of her borderline cases mirrors my finding that a high percentage of parents of borderlines suffer affective illnesses within the manic-depressive fold. It may be that some of the patients Singer is calling borderline are indeed borderline schizophrenics, in Kety's sense, and deserve inclusion within the spectrum of schizophrenia.[3] Another subgroup may consist of patients, such as those making up the majority of my sample, with incipient or spectrum affective disorders. As with all "borderline" samples, Singer, too, alludes to a youthful (age sixteen to forty) group of high socioeconomic class, most of whom have attained college level.

Further study is still required before we know the degree of correlation between clinical diagnosis of a borderline condition and the psychometric data. Until then, information obtained through testing should be set to one side as a potential source of validation (or refutation) of clinical diagnosis.

Kernberg's Borderline Structure and Borderline Personality Organization

Over the past decade Kernberg has been influential both as advocate of the "borderline" concept and as theoretician, redefining the concept (as it took shape in the writings of Knight and Grinker) in a more precise and manageable fashion. Kernberg's description of borderline is from the psychostructural[4] point of view, placing particular reliance on the nature and vicissitudes of internalized representations of the self and of others. Hence his classification, strictly speaking, is one of personality organizations, of which "borderline" represents the intermediate variant between neurotic and psychotic organizations. Though by no means divorced from clinical

[3]Singer mentions, for example, that "we found the borderlines and remitting schizophrenics difficult to differentiate on many [Rorschach] items" (1977, p. 209).

[4]Kernberg's psychostructural theory represents a further stage in the development of traditional psychoanalytic metapsychology. There is a direct chain of evolution beginning with Freud's *topographic* model (1900), stressing "unconscious-preconscious-conscious," and passing through Freud's 1923 revision—the *structural* model, stressing ego, id, and superego, in which certain conflicts could be viewed as tensions between two of these three compartments. A full exposition of structural theory would, of course, require a lengthy book in itself. The interested reader should pay particular attention to the seminal ego-psychological papers of Hartmann (1939) and of Rapaport and Gill (1959). An attempt to encompass schizophrenic phenomenology in structural terms was made by Arlow and Brenner (1964); Kohut (1971) has extended structural theory to embrace narcissistic disorders, a task also undertaken (in my view, more successfully) by Kernberg (1975).

signs and symptoms, Kernberg's model is less dependent on purely observational or phenomenological data than is Grinker's model. The critical points in the diagnostic spectrum, psychostructurally viewed, are *reality testing* and *ego integration*. Reality testing demarcates borderline from psychotic structure. The tradition for this distinction in psychiatry is of course well established. Ego integration, which is well developed in neurotic structures but enfeebled in the borderline, is conceptually less easily defined. A crucial aspect of faulty ego integration is the presence of sharply contradictory attitudes permeating vital sectors of the personality and interfering with everyday life, especially in the area of interpersonal relations.

Kernberg also speaks of certain "nonspecific" signs including lowered anxiety tolerance, poor impulse control, and poor sublimatory capacity. Low anxiety tolerance overlaps considerably with the concept of vulnerability, used by the geneticists, but, like faulty ego integration, is an abstraction derived from a specialized confrontational interview or from long acquaintance with the patient. Neither concept permits of easy appraisal within the realm of readily observable behavior. Interrater reliability has been achieved among several raters present at a "structural" interview (of which more below), but reliability has not yet been tested between interviews of the same patient done blindly by separate interviewers.[5] Faulty ego integration remains in any event the least readily teachable ingredient of Kernberg's model.

The mental mechanism by which contradictory attitudes are maintained side by side—without evoking a sense of contradictoriness in the patient—is called *splitting* (corresponding to *vertical splitting* in Kohut's terminology). Splitting that serves to protect the patient from awareness of his ambivalence is thus an important aspect of borderline personality organization. The same mechanism, protecting this time against *fragmentation* of the ego, is frequently encountered in *psychotic* structure, as Bergeret has pointed out (1974).

It should be kept clear that Kernberg's use of *borderline, neurotic,* and *psychotic* to denote structural levels[6] is divorced from the issue of distal

[5]As advocated, for example, by Lee Robins and R. Cloninger of the Washington University Department of Psychiatry in St. Louis.

[6]Speaking from an object-relational point of view, Kernberg makes some very comprehensible distinctions among the three structural types. If one thinks of a person's mental representations of himself, and again, of others, these may be subdivided, each, into positive aspects and negative aspects (yielding four "species" of inner representations). In schizophrenia (the paradigm case of psychotic structure), distinctions between self and object(s) are blurred: good and bad part representations of self and object are all mixed higgledy-piggledy. There is no firm sense of *self;* therefore, as Kernberg rightly points out, it is hopeless to "explain" the schizophrenic's mental life in ego-id-superego terms. It makes no sense to speak of those structures as having developed in the still psychotic schizophrenic. (With good therapy and time, these structures may begin to take shape.)

etiology. Thus manics and core schizophrenics will equally demonstrate psychotic *structure* on confrontational interview during the acute phase of their illness. "Psychotic structure" is used in a manner analogous to the psychogeneticist's notion of "state," where manic-depressives are concerned. Many manic-depressives, because of their tendency to reorganize to a high level upon subsidence of a psychotic episode, will be seen to fluctuate with respect to internal personality structure. In some, however, their functioning remains at the borderline level even during the interpsychotic phases of their illness. Most unequivocal schizophrenics, in contrast, will exhibit "psychotic structure," as Kernberg defines it, even during the phase of recompensation. This is because of the tendency in this group of patients to maintain highly unrealistic notions in the interpersonal sphere—unrealistic images of themselves and of other people—even when no longer grossly delusional. For this reason, *psychotic structure* has, in the realm of schizophrenia, a *trait*like stability (in the psychogeneticist's sense) not usually noted among the primary affective disorders.

The criteria for the psychostructural diagnosis of borderline personality organization are outlined in Table 9–4.

The other two nonspecific signs, as noted in the table, include *poor impulse control* and *poor sublimatory capacity*. The former is an item mentioned in all schemata for borderline diagnosis, and may include such tendencies as self-destructive or self-mutilative acts, sexual promiscuity, strong tendencies to "act out" transference situations, and the like. The connection between impulsivity, defined in this way, and the driven, impulse-ridden quality to the lives of many bipolar patients (of both full-blown and dilute forms) has been mentioned elsewhere (Stone, 1978b). The presence of marked impulsivity in a borderline patient should alert the clinician to the possibility that he may be dealing with a "spectrum" affective disorder (see pp. 285–287, Klein's "hysteroid dysphoria").

Poor capacity for sublimatory channeling is a common feature in border-

In the "borderline," self and object(s) are properly differentiated. But the good and bad aspects of each are not blended; they are somehow held apart, compartmentalized, in such a way that the patient is not consciously aware of his *ambivalence*, that is, of both aspects of self or of both aspects of (the important) other(s). Intensive therapy aims at uniting these polarized views into an integrated set of inner representations, characteristic of the healthier "neurotic" structure.

The neurotic, in other words, has available to him a mature and blended view of himself and of others, and is simultaneously in touch with his—and their—virtues and shortcomings.

From the above it will become clear how it is that Kernberg views his "borderline" level of psychic organization as a category. With respect to *structural* metapsychology, it is defined as a homogeneous entity, with upper and lower boundaries. From the standpoint of *etiology*, as I have stressed repeatedly, the patients embodying this structural level are by no means homogeneous. Many have affective illnesses, some schizophrenic, and so on (a point also made by D. Klein, 1975).

phenomena are more widespread in the general population than classical mania and schizophrenia; hence, one encounters greater difficulty in separating those depressive cases that are largely under genetic control from those in which the hereditary factor is minimal or lacking. Klein, like Guze and others of the St. Louis school, is unhappy with the traditional endogenous-reactive dichotomy because there are many depressed patients with strong family histories of affective disorder who nevertheless appear to have been precipitated into serious depression by severe environmental stressors. More recently Quitkin, Rifkin, and Klein (1978) have presented evidence to the effect that "psychotic depression" responds favorably to imipramine just as do the nonpsychotic recurrent cases: one cannot use the presence of (depressive) delusions as a reliable discriminator between "endogenous" and "reactive" cases or between drug-sensitive versus drug-resistant cases. Yet "endogenous" (genetic; constitutional) factors do appear operative in many instances of severe depression, but in a manner that shades, in continuum fashion, into the general population, taking a variety of phenomenological twists and turns along the way. At the clinical level the end results may be a "straightforward" unipolar depressive illness or one of the somewhat rarer syndromes of Klein's nosology.

The importance of these remarks, for our purposes, resides in the high frequency with which the more severe depressive conditions, including those of special interest to Klein, fulfill the criteria for a *borderline* syndrome as defined by the other investigators discussed in this chapter. The dozen patients with hysteroid dysphoria who have come under my care, for example, all began with borderline psychic structure (Kernberg)—though many graduated to neurotic structure after several years of medication and intensive psychotherapy. These patients also met the criteria of Gunderson and of Spitzer (for the "unstable" type of "borderline personality").

Special Syndromes

Phobic-Anxiety Reaction Patients with this syndrome are characteristically anxious, clinging, and (episodically) depressed. In this sense they resemble Grinker's type-IV borderline condition. They are subject to repeated bouts of overwhelming panic, which may be accompanied by "rapid breathing, palpitations, weakness, a feeling of impending death, and occasionally depersonalization" (D. Klein, 1967, p. 121). Despite the frequency of depressive symptoms (namely, sense of futility, profound dysphoria), vegetative signs are customarily absent. Agoraphobic and other severe "neurotic" symptoms may dominate the clinical picture and becloud the underlying depressive diagnosis. Terrifying dreams (e.g., mutilation of the dreamer's body) may occur at the height of the panic attack. Such dreams rarely, if ever, occur in patients with neurotic structure (see

pp. 310–316, this chapter). Often borderline in structure, the phobic-anxious patient seldom responds to psychotherapy alone; medication is routinely required, usually imipramine, though MAO inhibitors may also be helpful (Schuyler, Klein, et al., 1977).

Emotionally Unstable Character Disorder (EUCD) This syndrome Donald Klein (1975) likens to Grinker's type-II borderline condition. Though sharing some features of the *hysterical* character disorder, patients with EUCD experience mood swings which "appear to have less relevance to social effect and environmental circumstances" (Klein, 1967). Their lability is not necessarily a response to personal rejection, as is so often the case with the hysteroid dysphoric patient, yet they show a more serious characterological disorder than that found in *cyclothymic* persons. Therapy usually requires psychoactive medication; namely, Mellaril (Rifkin, Levitan, et al., 1972) or lithium (Rifkin, Quitkin, et al., 1972).

Hysteroid Dysphoria (HD) This syndrome, described by Klein and Davis in 1969, bears some resemblance to Grinker's type-I borderline condition (D. Klein, 1975, p. 82).

Exquisitely sensitive to personal rejection, the hysteroid dysphoric patient is nonetheless usually free from anhedonic symptoms; the depressive component can often be alleviated by supportive psychotherapy of a sort aimed at bolstering self-esteem. Praise may even lead to a mild state of giddiness and euphoria. Klein has recently set forth a table of criteria in which the diagnostic features of this syndrome are outlined in a precise fashion (see Table 9–6). Some items overlap with those of Gunderson's borderline personality disorder (suicide gestures, good socialization), but there is more emphasis on histrionic and seductive characterological features and less on rageful affect. The syndrome is to be found almost exclusively in females; heightened premenstrual irritability is common though not universal. Kinship to the major affective disorders is more clearly spelled out in Klein's description of hysteroid dysphoria than is the case with the Kernberg or Gunderson criteria. Some HD patients appear "borderline" with respect to *bipolar* illness; a few even have distinct hypomanic episodes, at times precipitated by antidepressants. HD patients function, when first diagnosed, at the borderline level in most instances. Rarely, mild "schizophrenic" stigmata may be exhibited, amidst the more obvious affective ones, so that the patient emerges in Region IV or even III (see case illustration 16).

Patients with HD are often amenable to intensive psychotherapy; some of my most rewarding experiences with this form of treatment, within the borderline realm, have stemmed from patients with this syndrome. In the beginning phases, however, medication has uniformly been necessary. In Klein's work with this group, he has noted a specificity of drug response, MAO inhibitors appearing to induce a marked improvement not elicited by

TABLE 9–6
Donald Klein's Hysteroid Dysphoria
Diagnostic Criteria

1. Intolerance of personal rejection with particularly severe vulnerability to loss of romantic attachment, as manifest by more than usual difficulty seeking or maintaining intimate relationships or work.
2. A depressive, painful, crashlike reaction to interpersonal rejection.
3. The dysphoric response to rejection is usually associated with either a, b, or c:
   a. Overeating any food or craving for sweets
   b. Oversleeping or spending more time in bed
   c. A sense of extreme fatigue, leaden paralysis, or inertia
4. During the past two years has had at least six periods of depressed mood in response to feeling rejected that were associated with some impairment of daily functioning (i.e., social withdrawal, missing a day of work, neglect of home or appearance, self-medicating with drugs or alcohol). These episodes may or may not have been of sufficient duration to meet the criteria for RDC major or minor depressive disorder, but should occur at a time when a person is not already in a major or minor depressive episode. (Six episodes for definite, four for probable.)
5. Self-esteem is dependent on constant external approval, and markedly diminished by loss of that approval.
6. The rejection-precipitated depressions are usually nonautonomous in that the patient can be brought out of them by well-meaning attention and applause. In an occasional extreme state will be rejecting of help and self-isolating.
7. Normal state is at least one of the following: histrionic, flamboyant, intrusive, seductive, self-centered, demanding, or greatly concerned with appearance (use observational data as well).
8. At least three of the following:
   a. Abuses alcohol, marijuana, or sedatives episodically when depressed
   b. Abuses stimulants on occasion when depressed; may become habituated to them
   c. Normal mood is expansive and active
   d. Chronic dieting is necessary to maintain normal weight
   e. Overidealization of love objects, with poor social judgments
   f. Applause is usually highly stimulating
   g. Usually socially withdrawn when depressed
   h. Makes suicide gestures or threats
   i. Is often physically self-abusing when depressed
9. Above symptoms not due to any other mental disorder such as somatization disorder, schizophrenia, schizoaffective disorder, or cyclothymic disorder.

NOTE: All nine criteria must be met. "Probable" or "definite" is determined by the rating of item 4.
SOURCE: Developed by Donald F. Klein and M. R. Liebowitz (1979, unpublished).

administration of tricyclics.[11] He has postulated that an abnormality of the dopamine precursor phenylethylamine (actively broken down in the CNS by MAO-B) may be operative in HD patients. Others, such as V. Ziegler in St. Louis (1977), question the correlation claimed by Klein, having observed favorable responses to the tricyclics as well. My own experience has been in line with Ziegler's. Those HD patients who have been able to solidify their gains from a combined psychotherapy-antidepressant approach have, after six to eighteen months, continued to remain well without further medication (whereas discontinuance at the height of the illness usually provokes relapse). The question of MAO specificity, still speculative, requires further investigation, such as the double-blind study currently underway at the New York State Psychiatric Institute. Regardless of the outcome, hysteroid dysphoria deserves a place in our nosology, in my opinion, if only because of the high incidence of analogous or identical disorders in close relatives of HD probands (see Chapter 7 and case illustration 29). Furthermore, HD cases are very homogeneous from a clinical standpoint, almost all being concentrated in Region V (pure affective disorders) in the borderline compartment.

A strongly positive family history for serious affective disorders is found in many of the "borderline" affective disorders, not only in HD but also in the other syndromes Klein has described, as well as in the more widely known disorders. Pardue (1975), for example, has offered a five-generation pedigree of persons suffering from unipolar depressive illness and responsive to tricyclic antidepressants. Methodical family studies have not as yet been carried out, however, for some of the affective syndromes (namely, the phobic-anxiety reaction or the EUCD syndrome).

Broader Categories of Depressive Disorders

Endogenomorphic Depression The endogenomorphic variety of depressive disorder is, as Klein defines it, characterized by vegetative signs (including anhedonia for food and sex); some examples appear to be "reactive" to various psychological stresses, but others are not. Some instances

[11]Klein has, in fact, put forward a theoretical model calling for a new nosology more attentive to drug response. The justification for such a revision, he believes, rests on the close link between certain pharmacological agents and the presumed basic biochemical defects underlying the major functional psychoses. In this regard one might call to mind Snyder's work at Johns Hopkins (Snyder et al., 1974; and Snyder, 1976) demonstrating not only the superiority of the phenothiazines to barbiturates or placebos in alleviating schizophrenic symptoms but the high specificity of the phenothiazines in blocking the postsynaptic receptor sites of the dopamine-sensitive neurons in the CNS. Snyder and others have postulated that abnormalities in the CNS dopaminergic neuron tracts may be crucial to the ultimate behavioral manifestations we call "schizophrenia."

Mixed States

Patients who simultaneously display significant symptoms of depression and mania are said to be in a *mixed state.* There are various theories as to the causes of the mixed state: one is that it is a transitional phase in which depression "switches" to mania and the patient becomes trapped in the switch state. This theory leaves much unexplained, but it is generally well accepted that patients who experience mixed states are more difficult to treat than those people who have manic episodes well separated from their depressive ones.

The following case history demonstrates a kind of mixed state:

> F. L. was a sixty-year-old woman who came to the hospital with all the signs and symptoms of a psychotic, agitated depression. This was her fourth episode during the last twenty-one years. For two of the episodes she had received electroconvulsive therapy (ECT). For the third she had received an antidepressant medication and experienced improvement without remission. The remission finally occurred on its own a year later.
>
> The present episode had begun with obsessive concerns about her invalid husband. She continually worried about mistakes she had made in her husband's diet and care and began to feel that death lurked everywhere. She became apprehensive, then agitated. She had trouble falling asleep and awoke early in the morning, her obsessive concerns whirling in her head. But throughout this typical melancholic picture ran another thread of delusional idea. On occasion she would experience an upsurge of exhilaration and energy. She would begin to sing religious songs and, if others were around, preach to them vigorously and intrusively. She would then smile beatifically saying that she was suffused with the love of God because she and Jesus were saving the world. But through it all her facial expression looked depressed and she was always on the verge of tears. Family history showed paternal uncles who were gamblers and alcoholics while she had two sisters who had experienced typical agitated depressions.
>
> Three weeks of treatment in the hospital with the antidepressant that had finally worked in the earlier episode ended her agitation and apprehension, but her religious talk and depressive mood continued. In the out-patient clinic it was decided that she was suffering the effects of a mixed manic-depressive state and she was started on lithium. After two weeks she was in remission and has remained symptom-free on maintenance lithium alone for three years.

Although the patient might have been thought to have a unipolar "agitated depression" with psychotic features, the presence of manic symptoms in the midst of severe depressive symptoms is a clue to recognizing the mixed state. F. L.'s grandiose, radiant, beatific religious delusions were out of tune with the patient's misery. The correct diagnosis of a mixed state was extremely important because rather than receiving electroconvulsive therapy when the antidepressant, imipramine, failed, F. L. received lithium and improved rather rapidly.

Cyclothymia

A milder manifestation of manic-depressive illness is *cyclothymia.* People who receive this diagnosis experience short and irregular cycles of depression and hypomania. The episodes are not of sufficient duration or severity to qualify as a major affective disorder as the cycles typically last for days, not weeks. The cycles often begin in the teens or early childhood, and the problem may appear to be a personality disorder or hyperactivity. The mood states can change so frequently that patients often remark that they awaken with a distinctly different mood than they had the day before.

Dr. Hagop Akiskal, the director of the Affective Disorders Clinic of the University of Tennessee, and his colleagues feel that cyclothymia has a two-phased course and that people with the disorder have certain identifiable problems in their behavior and relationships. These are summarized as follows:

Two-Phased Course

1. There is an increased need for sleep alternating with decreased need for sleep (although intermittent insomnia can also occur).
2. The self-esteem is shaky. It can alternate from a lack of self-confidence to a naive or grandiose overconfidence.
3. There are periods of mental confusion and apathy, alternating with periods of sharpened and creative thinking.
4. There is a marked unevenness in quantity and quality of productivity, often associated with unusual working hours.

5. There is uninhibited people-seeking (which may lead to excessive sexuality) alternating with introverted self-absorption.

Typical Behaviors

1. Irritable-angry-explosive outbursts that alienate others
2. Episodic promiscuity; repeated failures of marriages or romances
3. Frequent changes in careers, academic pursuits and future plans
4. Alcohol and drug abuse as a means of self-treatment or augmenting excitement
5. Occasional financial extravagance

The family pedigree of people with cyclothymia is often "loaded" with all types of affective and "related" disorders, including depressive and manic-depressive illness, alcoholism and drug dependence and suicide.

Approximately 60 percent of the patients diagnosed with cyclothymia respond to lithium. However, much remains to be explored about this bipolar subtype and its treatment.

Chronic Depression

Although a majority of patients have major depressive episodes that are separated by periods of normal functioning, 15 to 20 percent of patients do not recover fully from any given episode and have symptoms of depression that persist for at least two years. They are said to have *chronic depression.* The painful symptoms of the acute episode fade into an emotional aridity and these patients live without any positive feelings. Their mood is low, they lack energy and their outlook on the future is generally bleak.

DSM–III defines *dysthymia* as a depression in which a person is bothered most or all of the time during a two-year period by a depressive syndrome or symptoms of depression that are not of sufficient severity or duration to meet the criteria for a major depressive episode. The DSM–IIIR excludes from this category patients whose chronic depressive symptoms were preceded by a major depression. It is thought that a significant number of Americans suffer from dysthymia, which can begin early in life or have a late onset.

Unfortunately, not a lot is known about the classification and

treatment of these milder disorders. This is perhaps because the people who suffer them don't end up in emergency rooms or hospitals and are thus rarely the subjects of research. Also, many psychiatrists have not commonly viewed these long-term depressive syndromes as mood disorders but rather as personality disorders. Recently, investigators have begun to explore the use of antidepressants and different kinds of psychotherapies for these milder depressions. Such studies may lead to a better understanding of these disorders and further define their treatment.

Patients with *double depression* are those who go a full two years in a low-grade state of depression—the dysthymia mentioned above—but who then go on to have a major depressive episode. The period of time during which the major depressive episode is layered over the dysthymic symptoms is called double depression. Often the dysthymic symptoms continue even after the resolution of the major depressive episode, and there are high rates of relapse to recurrent major depressive episodes. In fact, the longer the patient remains chronically ill before recovering from the major depression, the greater the likelihood of relapse. For these reasons, patients with double depression should receive intensive treatment during and after recovery from the major depressive disorder.

There are severe deficiencies in our knowledge of how best to treat chronic depressions. More studies need to be conducted in order to assess the efficacy of antidepressants, lithium, electroconvulsive therapy and psychotherapy. One thing seems sadly certain: the patient who remains chronically depressed over time has a reduced chance of recovering.

SYNDROMES WITH FEATURES OF AFFECTIVE DISORDERS: ANOREXIA, BULIMIA AND OBSESSIVE-COMPULSIVE DISORDER

Researchers, in investigating the symptoms, genetic patterns, neuroendocrine disturbances and pharmacological responses of the eating disorders and obsessive-compulsive disorder, have found some similarities between them and the affective disorders. *Anorexia nervosa* is a disorder characterized by a disturbed body image, severe weight loss and an intense fear of becoming obese that does not diminish as the weight loss progresses. *Bulimia* is a disorder char-

The children consulted their mother's psychiatrist, and after informing them that the antidepressant she was taking would take at least two or three weeks to work, the psychiatrist helped them devise a method of coping with the situation. They set up a schedule of two-hour shifts among themselves to ensure that someone was always in the house and nearby, but they stopped pressuring her to make immediate gains. They simply expressed confidence that time would pass and she would recover.

This family coped with the vicious cycle of tremendous effort, fluctuating hopes, exhaustion and resentment by modifying their expectations. While their mother needed to know of their continued concern and support, the children realized that their best efforts would not permanently restore her disposition. In some ways they were doubly burdening her with their wishes for early improvement. She experienced this as an impossible demand with which she was unable to comply and about which she felt increasingly guilty and frustrated.

By modifying their natural tendency to expect immediate results and improvement, the children lessened the demands they placed on themselves and on their ill mother, and they increased their stamina and capacity to endure.

SUICIDAL BEHAVIOR

Few things in life are more threatening than a relative (or patient) who expresses suicidal thoughts or behavior. When a person is overtly suicidal, most families recognize the necessity of immediate professional help. However, suicidal intentions are often expressed in more subtle and ambiguous ways. Most families are not prepared to judge the seriousness of the threat, and the lack of a plan of action or response raises their anxiety level to such a degree that the family is unable to act effectively and in a timely fashion.

If relatives even suspect that the patient is thinking about suicide, they should call the treating psychiatrist immediately and alert him to that fact. Depending on a variety of factors, hospitalization may be indicated. Suicide is often an impulsive act: the patient can be having coffee in the kitchen with someone one minute, retire to the bedroom and leap from an open window. It happens that fast; it

happens that unexpectedly. The myth that people who threaten to commit suicide never do so is a dangerous one to subscribe to. People often carry out their threats, particularly if they are ignored.

The family may have to resort to involuntary commitment to prevent the patient from killing him or herself. Family members who have a severely depressed relative should first consult with a psychiatrist. If the patient's condition warrants hospitalization, the family members should discuss with the psychiatrist the procedure for admission to a psychiatric unit. Chapter 10, on hospitalization and commitment, as well as the state laws listed in the appendices of this book should help to clarify this process.

What are the common warning signs of suicidal intention?

- Feelings of worthlessness or hopelessness
- Preoccupation with morbid topics or death
- Withdrawal from previous activities or relationships and estrangement from family and friends
- Increased risk-taking behaviors (for example, driving too fast, drinking heavily, handling knives or guns)
- Sudden brightening of mood or increased activity in someone who has been seriously depressed
- Putting one's affairs in order (for example, writing a will, giving prized possessions away, saying goodbye to people)
- Feelings of anguish or desperation
- Voices that are commanding the patient to hurt himself or other irrational experiences
- Actually thinking about a plan to take one's own life

People with a family history of suicide are at particular risk. Others before them have used suicide as a solution to a problem and they may use that self-destructive act as a model. Moreover, there is evidence to suggest that for some there is a genetic predisposition to suicide. Biological studies conducted ten years ago by Dr. Herman van Praag in Holland and Dr. Marie Asberg in Sweden revealed that certain suicide attempters had a decreased level of the metabolite of the neurotransmitter serotonin in their spinal fluid (5-hydroxyindoleacetic acid or 5-HIAA). Individuals with these lower levels of 5-HIAA were more likely to attempt suicide in an impulsive and violent

manner. Some researchers believe that this finding may one day lead to a biochemical test to predict who is at risk for suicide.

In the meantime, once the family suspects the patient's suicidal potential and has located and consulted a psychiatrist, there are some practical steps that the family can take to limit the expression of the impulse:

- Remove access to knives, guns, medications, automobiles and other potentially lethal instruments.
- Monitor the taking of medications, first to ensure that the patient is taking them (thus limiting the time that he suffers with suicidal depression), and also to guard against an overdose. Antidepressants or lithium and some sleeping pills (especially if taken with alcohol) can be fatal if taken in too large a dose.
- Let the patient talk about suicidal thoughts without the family's expressing shock and condemnation. If the family understands that suicidal thoughts and impulses are not unusual in severe depression, and conveys this understanding, the patient may feel less guilty and isolated. The patient is not forced into secrecy, and such open communication may allow both the family and the patient to better judge when protective hospitalization is necessary.

COPING WITH MANIC BEHAVIOR

Coping with a relative who is in a manic state can be exhausting and demoralizing also. A person experiencing depression is usually so fatigued and tentative that, unless he or she is suicidal, there is little likelihood that he or she will make rash and impulsive decisions that would have an impact on other family members. In mania, just the opposite is true. The patient has boundless energy, unshakable drive but little capacity to appraise the consequences of his actions realistically. It is common for individuals in a manic episode to engage in reckless buying sprees. Huge and unreconcilable debts can be incurred, and our legal system often holds families accountable for their relative's financial mismanagement. Judgment and insight can be so impaired in the manic state that patients may flout all authority and become so intrusive and demanding as to harass others and violate

social and sexual mores. At the worst, they may become irritable, aggressive or even assaultive, leading to the involvement of the police and legal authorities. The family is often placed in the unenviable position of having to set limits on someone who refuses to acknowledge the family's responsibility and concern or who becomes openly hostile when challenged.

Once an episode has reached a certain pitch and the patient cannot be reasoned with, it is both protective of the patient and expedient to move quickly toward hospitalization. Because the patient's mood can fluctuate—ranging from mild euphoria to extreme irritability—and because the patient may speak logically and coherently for periods of time, it is often difficult for families to know when to force this issue. These lucid intervals can be deceptive, however. Unless the patient is being treated aggressively with antipsychotic or mood-stabilizing medications (and the patient is taking the medication), it is unlikely that the manic episode will end safely without hospitalization. Thus the hospitalization should be viewed as a positive step as it will serve to limit the damage that people in a manic state could do to themselves, their social network and their family.

Therefore, should the family observe the following behaviors and be unable to convince the patient to see his or her psychiatrist and take the necessary medication, arrangements should be made for immediate hospitalization:

- Sleeplessness for several nights with frequent shifts of mood, pacing and agitated behavior and no acknowledgment on the part of the patient that anything is wrong
- Reckless and impulsive decisions or actions that may lead to financial ruin or social ostracism
- Threatening, menacing or assaultive behavior
- The presence of delusions or hallucinations

THREATS AND ASSAULTIVE BEHAVIOR

When someone is experiencing mania or acute psychosis, his or her mood may shift rapidly from excitement to irritability. Some manic patients become exceedingly hostile and angry. The fear that the ill

person will lose control and not be able to contain aggressive impulses paralyzes those around the patient. Family members, afraid to anger their relative or inflame an already volatile situation, often step back, trying to placate or mollify their agitated relative. Not knowing what to do or how to act, most families tend to wait it out and hope the mood will shift back to reasonableness and equanimity.

This is rare. Mania in most cases continues long after the family's patience and stamina have been exhausted. It is in no one's interest to tolerate threats and assaultive behavior. When faced with threats, the family should confront them directly. For instance, if a patient tries to intimidate a relative by saying, "I'll get you for doing this to me," the family member can respond by identifying the statement as a personal threat and refusing to accept it. He or she may say something like: "I take what you're saying to be a threat and I can't accept that. This kind of behavior shows me that you are out of control because when you are not ill, we're able to resolve our differences without threatening each other." Often, people experiencing mania are frightened by their loss of control, and a firm stance may help to establish temporary boundaries. They may be dangerous, however, and family members should not place themselves in a situation from which they cannot withdraw easily.

If this is not a first episode, and the patient has a psychiatrist, the family should naturally call and consult with the doctor. The questions most in need of answering are: How dangerous is the situation and how quickly must an intervention be made? The answers to these questions often depend on the answers to the following questions: Has the patient ever been assaultive before? At what point in the episode did this occur, and is he or she approaching that point? Has the patient been taking street drugs or drinking alcohol? Is the patient severely irrational and misperceiving or distorting events?

EMERGENCY INTERVENTION AND ITS AFTERMATH

Delusional thinking and misinterpretation of events can lead to violent or assaultive behavior. Therefore, when an ill relative expresses delusional thinking in the context of a manic episode (when the control of impulses may be lost), it is imperative that the family act

quickly to consult the psychiatrist and initiate commitment procedures. The family may even have to call the police and ask an officer to take the patient to a hospital for an evaluation. The police are trained to work with people who are psychiatrically ill and can be a tremendous help. (See the next chapter for an explanation of the commitment procedure.)

Families who have been called upon to commit a relative in the past are sometimes loathe to do it again as they feel the patient has never fully forgiven them. Something was ruptured in the relationship and both family and patient harbor fear and resentment. The family must overcome those feelings sufficiently to act responsibly, even if that requires involuntary hospitalization. Certainly it takes great courage to assume this responsibility and to see it through. Despite the toll that this exacts, there may be some consolation in knowing that you are protecting someone who is no longer able to judge the situation accurately.

The aftermath of an acute episode of mania poses another set of problems. Fearing that the least stress might set off another episode, the family lives with prolonged uncertainty and apprehension. In such an atmosphere, the patient's behavior and natural expressions of emotion—joy or sadness—come under close scrutiny or even suspicion. The family, in the position of being an "early warning system" of impending mood swings, can easily slip into the role of prosecuting attorney: the patient may be faced with seemingly endless questions and doubts and be asked to provide motives for almost every act. One woman with a history of mania told us that if she washed the dishes at midnight, she'd turn around to find her husband and children standing uneasily in the doorway, checking to see if this was a sign of sleeplessness or increased activity. They were afraid of another episode; she just wanted to clean up the kitchen and have some time to think quietly.

This is a corrosive atmosphere for everyone concerned: the patient's credibility and competence as a person are called into question by the sometimes unspoken suspicion of his motivations and emotions, and the family is placed under a terrible strain.

Thus, before the patient is discharged from the hospital it would be to everyone's advantage to meet with the psychiatrist to talk about the impact the episode has had on everyone and to develop a strategy