Borderline personality disorder, bipolar disorder, depression, attention deficit/hyperactivity disorder, and narcissistic personality disorder: Practical differential diagnosis

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The challenge of accurate diagnosis remains at the heart of good psychiatric treatment. In the current state of psychiatry, a confluence of forces has increased this challenge for the clinician. These include practical pressures—such as limited time for diagnostic evaluation, the question of what is reimbursed by insurance, and the issue of directing patients to acute treatments—and also trends in nosology, such as the descriptive focus on signs and symptoms in the current official diagnostic system. The authors offer observations that we hope will help clinicians who have to make difficult diagnostic differentiations often under pressured circumstances. The paper is motivated both by the high frequency of diagnostic errors observed under such conditions and also by the belief that considering symptoms in the context of the patient's sense of self, quality of interpersonal relations, and level of functioning over time will help guide the diagnostic process. (Bulletin of the Menninger Clinic, 77[1], 1–22)

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What follows are clinical observations directed to psychiatrists who have to make difficult diagnostic differentiations, often under circumstances of pressured time. These differentiations often involve decisions regarding immediate interventions and treatment planning. This article is motivated by the high frequency of diagnostic errors observed under such conditions, an observation that emerges only when the patient is seen under more stable conditions, particularly during more extended evaluation. We shall not review systematically the diagnostic criteria for the various conditions to be jointly explored, but only highlight those aspects of mental status examination that facilitate a differential diagnosis under the conditions mentioned.

We have observed that about 50% of patients who enter the personality disorders unit of our hospital with the diagnosis of bipolar disorder or major depression turn out to present neither, but rather a severe personality disorder organized at the borderline level (Kernberg, 1975, 1984), particularly borderline personality disorder (BPD), severe narcissistic personality disorder, or various disorders in which recurrent suicidal ideation, parasuicidal traits, and/or antisocial behavior are the main symptoms, or where an acute drug dependency or alcoholism dominates the picture. Erroneous diagnostic conclusions have frequently been reached, particularly in the case of patients with strong negativistic features, who refuse or are unable to provide adequate information about themselves, or, occasionally, may wish to exaggerate certain symptoms in order to obtain hospitalization.

Bipolar disorder

The clinical range of bipolar illness remains a subject of debate (Paris, 2009). The diagnosis of a bipolar disorder requires, in *DSM-IV-TR*, the presence of at least one episode of a major depression and one manic (Bipolar I) or hypomanic (Bipolar II) episode. The accurate assessment of the presence of manic or hypomanic episodes is essential. The experience of multiple prior evaluations may predispose patients to give a history that fits a manic or hypomanic episode because of the standard nature of questions asked, and we have frequently observed some patients'

tendency to conform to questions that have a "leading" quality with regard to standard manic or depressive symptoms. It is important to patiently ascertain whether the patient has indeed had one or several periods of at least 3 to 4 days in which an unusually euphoric, angry, or irritated mood predominated, together with a sense of heightened energy, affective dyscontrol, significantly reduced need to sleep, hyperactivity, and unusual behavior in sharp contrast to the usual personality of the patient. Such behavior may involve inappropriate sexual exposure or behavior, grave mismanagement of money or other properties, socially inappropriate approaches to others, and possibly increase of sexual drive together with a general expansiveness of mood and behavior. Symptoms of a true manic episode often involve loss of reality testing as manifested by behavior that does not correspond to socially accepted norms without awareness of the deviation from the norm.

The most frequent mistake, in our experience, consists in confusing the chronic emotional instability and affect storms of personality disordered patients with a truly hypomanic or manic behavior. In the case of manic behavior, the differentiation is easier; here the clear loss of reality testing, the presence of hallucinations and/or delusions, or inappropriate social behavior usually leads to intervention by others to control the patient, interventions that are typical enough to confirm loss of reality testing and to warrant the diagnosis of a bipolar disorder. Therefore, the confusion between bipolar illness and BPD is usually reduced to cases of assumed hypomanic behavior used as the basis to diagnose bipolar II in patients.

In about 19% of patients with borderline personality disorder, however, a comorbidity with bipolar disorder may be present, and the patient shows both severe, chronic affective instability and clear hypomanic episodes (Gunderson et al., 2006). To ascertain the presence or absence of BPD in these cases, it is helpful to evaluate the general nature of the patient's relationships with significant others. Cases of pure bipolar symptomatology do not show severe pathology of object relations during periods of normal functioning, and even chronic bipolar patients, who suffer from both manic episodes and major depressive episodes,

maintain the capacity for relationships in depth, stability in their relations with others, and the capacity for assessing themselves and the most significant persons in their life appropriately (Stone, 2006).

In contrast, in severe personality disorders with the syndrome of identity diffusion, there is a marked incapacity to assess others in depth, a lack of integration of the concept of self, with severe, chronic discrepancies in the assessment of self and others, and chronic interpersonal conflicts, together with the difficulty of maintaining stable commitments to work and profession as well as to intimate relationships.

The combination of absence of affective stability, absence of significant and mature relations with others, and instability in work or profession, in love relations, and in self-assessment confirms the diagnosis of a severe personality disorder even if, at the same time, bona fide symptomatology of a bipolar I, or bipolar II type is effectively present. In short, the presence of a consistent and marked immaturity of all object relations, and emotional immaturity in general, *outside* bona fide episodes of manic, hypomanic, or depressive symptomatology is characteristic of borderline personality disorder.

The therapeutic implications of this differentiation reside in the essential indications of psychopharmacological treatment with mood stabilizers in the case of bipolar patients and, in general, in major affective illness, in contrast to the predominant requirement for appropriate psychosocial and psychotherapeutic interventions in the case of severe personality disorders (American Psychiatric Association, 2001).

Major depressive episode

The differential diagnosis between an episode of major depression and a chronic dysthymic reaction in borderline personality disorder is more difficult, but eminently feasible—if enough time is available to clarify the four major areas of symptoms.

First are the psychic symptoms of a depressive spectrum of illness. In major depressions, there is a significant slow-down of the patient's thought processes and the patient's psychomotor

behavior, severe depression of mood that varies between profound sadness to the total unavailability of any subjective sense of feeling—a sense of total freezing of all emotional experience in the most severe cases. Typically, thought processes are severely self-demeaning and self-accusatory—rather than focused on accusing and blaming others. The patient may present severe guilt feelings that may range from chronic exaggeration of whatever real deficits or faults the patient has detected in himself or herself to extreme, delusional self-devaluations and self-accusations. This combination of chronic slowing down in behavior, lowering in mood, and self-devaluation over a period of weeks to several months, combined with consistent daily fluctuations of symptoms—the patient feeling worse in the mornings and mood improving gradually every evening, with a relentless repetitiveness of such daily cycles over weeks—characterizes a typical major depressive episode.

While it may be clear that these symptoms are typical of a major depressive episode, in our experience, many patients tend to respond to the routinized questions on hurried mental status examinations in a way that conveys the impression to the examiner that they suffer from this syndrome. The clinicians and/or the patients wish to diagnose an Axis I condition because these conditions fit more readily into acute treatment plans based on pharmacological interventions and also have less stigma than personality disorders. Frequently patients may state that they feel chronically hopeless and helpless, which would reflect a total depressive despondency. However, when one asks patients what they feel hopeless about and in what way do they feel helpless, patients have difficulty conveying a response that is harmonious with a general self-devaluation, and, to the contrary, in the case of severe personality disorders with characterologically based dysthymic reactions, patients may respond with accusations and rage against others with an affect that seems more angry than depressed.

This predominance of rageful reactions while professing total self-devaluating depression is quite characteristic of personality disorders, and should raise questions about the assumed major depression. In the case of major depressions, patients withdraw

from social contacts and may feel worse when efforts are made to stimulate them to socialize; premature efforts of encouragement may have the opposite effect and, in fact, increase suicidal tendencies in patients with major depression. The depressive reactions in personality disorders are usually less severe and are irregular in their appearance and duration. They may shift abruptly from one day to the next, even from one hour to the next, and are clearly influenced, in positive or negative ways, by the patient's immediate social environment. Shifts of the symptomatology according to different social circumstances—for example, if the patient is apparently more deeply depressed during the week but on weekends, in the presence of friends, engages in animated social interactions, only to reverse to a state of depression on the following days—are characteristic of a personality disorder with a characterological depression—dysthymic disorder[1]—and not of a major depression.

In general, the patient's gross physical neglect of appearance, the incapacity to carry out ordinary activities of daily living, staying in dirty clothes, and indicating an unusual neglect of his or her appearance are more characteristic of a major depression in the context of all the psychic symptoms mentioned. Again, the patient's rapid shifting in behavior under conditions of desirable social interactions is more characteristic of the symptoms of characterological depression in a personality disorder.

A second area of exploration of the differential diagnosis is the evaluation of the personality structure that predated the beginning of the depressed episode. Patients with severe narcissistic personality disorder, borderline personality disorder, histrionic personality disorder, and masochistic/depressive personality disorder are prone to severe dysthymic reactions characterized by frequent days with symptoms of depression without reaching the intensity, consistency, and duration of major depressive episodes. In these cases, there is usually a history of chronic minor depressive episodes or dysthymic reactions extending over many years, a lack of clear periods of at least months' duration in which the patient evinced no depression at all, so that dysthymic symptoms have acquired a relative stability in the psychic equilibrium of

1. A prevalent form of chronic, characterologically based depression.

such patients. There are patients who report that they have been depressed all of their lives, and these patients usually present severe personality disorders. But these symptomatic features have to be differentiated from the characterological features of the masochistic/depressive personality. However, a certain percentage of patients with major depression, probably around 30%, may become chronic with refractory depression persisting over many years (McGrath & Miller, 2008; Rush et al., 2006). These refractory cases may present well-documented symptoms of major depression and a remarkable lack of response to all psychopharmacological and other, physical treatment interventions. With electroconvulsive treatment, some of these patients may significantly improve for several weeks and then often revert to chronic depression again. It is especially important to make a correct diagnosis in such cases because some patients with "refractory" depression may have a characterological depression that would benefit from appropriate psychotherapy, and it is important to differentiate these latter features in cases of "double depression." Gunderson et al. (2004) found that the rate of remission from major depressive disorder was significantly reduced in cases with co-occurring BPD. However, the rate of remission from BPD was not affected by co-occurring major depressive disorder.

A third area of inquiry facilitating the differential diagnosis between major depression and characterologically based dysthymic reactions involves the following neurovegetative symptoms that point to major depressions: severe insomnia, particularly consistent early awakening hours before the usual waking time; loss of appetite with severe weight loss; consistent loss of sexual desire; possibly impotence in men and suspension of menstrual periods in women; chronic, severe constipation (considering, naturally, that this may be secondary to the use of antidepressive medication); a heightened sensitivity to cold temperature and, in severe cases, a typical "mask like" facial expression of severe depression. There are patients with atypical major depression for whom the depressed mood is worse in the evenings rather than in the mornings, and who present a tendency to hyperphagia and gaining weight. These cases have to be evaluated very carefully regarding the psychic symptoms of depression mentioned ear-

lier before reaching a definite conclusion. Patients with genetic predisposition to affective disorders may show neurovegetative symptoms even under conditions of relatively lighter depression within the frame of a major depressive illness.

A fourth area of diagnostic relevance for the evaluation of depression is the analysis of environmental triggers that may have preceded a depressive episode. Typically, in chronic dysthymic, characterological reactions, environmental conditions may trigger depressive reactions, and these environmental conditions are often remarkably minor, while the patient pays a disproportionate attention to their symbolic value. Major depressions usually do not show such a direct relationship between environmental triggers and depression, although the combination of strong genetic disposition and environmental triggers can occur.

In conclusion, regarding these four areas of inquiry, the more severe the psychic symptoms and the neurovegetative symptoms, the more likely there is a major depression; the more predominant the personality disposition and the environmental triggers, the more likely there is a dysthymic disorder (characterological depression). There are patients, however, who present a "double depression," that is, an acute episode of a major depression in the context of a chronic characterological depression. These cases require, first, the treatment of the episode of major depression. Only after the resolution of that episode by psychopharmacological and/or other physical treatments will a complete and accurate diagnosis, prognosis, and treatment plan for the characterologically based dysthymic disorder become feasible.

Self-destructive behaviors in major depression and in personality disorders

One major prognostic and therapeutic issue, both in the case of all depressions and in severe personality disorders, is the presence of suicidal tendencies and parasuicidal behavior. In general, acute or chronic parasuicidal behavior, such as repeated cutting or burning—particularly under conditions of intense emotional agitation, temper tantrums, or acute frustrations—is typical of severe personality disorders, particularly borderline personality

disorder. Intense suicidality can present in the context of depression, but is not limited to that condition. An example of suicidality in a nondepressed patient is the dangerous, chronic, methodical preparation for a severe suicide attempt that can be seen in patients with no symptoms of depression but with the syndrome of malignant narcissism in which suicide may be experienced as a final triumph over others, which may be motivated by intense envy. Both this type of chronic suicidal tendancy and the acute, repetitive suicidal attempts under conditions of frustration or anger of borderline patients are typical of severe personality disorders. The latter type can seem "out of the blue" and can correspond to an outburst of temper without the background of symptoms of a major depression. Patients who present chronic suicidal and parasuicidal behavior without depression require highly specialized psychotherapeutic treatment. Many of these patients may be helped effectively with an integrative cognitive-behavioral treatment (Dialectical Behavior Therapy; Linehan, 1993), a psychodynamic psychotherapy (Transference Focused Psychotherapy; Clarkin, Yeomans, & Kernberg, 2006), or Mentalization Based Therapy (Bateman & Fonagy, 2004).

In contrast to this picture in personality disorders, suicide attempts in the context of symptoms of severe depression are typical of major depressive disorders and require a careful diagnostic assessment of the conditions under which suicidal behavior occurred. The types of suicidality generally found in patients with personality disorders that we have just discussed can most often be treated with outpatient psychotherapy. However, suicide attempts in the context of major depression have severe prognostic implications; require immediate, systematic psychopharmacological treatment; may require hospitalization; and, with patients who do not respond to other treatments, may need electroconvulsive treatment. In spite of this overall distinction between the presentation and treatment of patients with characterological depression and those with major depression, there are some patients with a severe personality disorder who may present severe depressive mood accompanied by suicidal behavior that also requires psychopharmacological treatment of the depression together with starting a psychotherapeutic treatment for the personality

disorder. It has to be kept in mind that up to approximately 10% of patients with borderline personality disorder commit suicide.

The diagnosis of a concrete episode of depression, in terms of whether it is a major depressive syndrome or a chronic dysthymic reaction corresponding to a characterological predisposition in a severe personality disorder, requires more time and is more difficult than the assessment of whether the patient has or has not had an episode of hypomanic or manic behavior. While the differentiation of a severe personality disorder from a bipolar disorder requires, in practice, only the precise differentiation regarding a hypomanic or manic episode, the differentiation of characterological depression and major depression requires consideration of all the criteria. With adequate review of these criteria, the diagnostic distinction should not remain a major problem. The treatment of all affective disorders is centered on antidepressants and mood stabilizers, with the addition of neuroleptic medication in cases with extreme anxiety or complications with hallucinatory or delusional symptoms. In our experience, the treatment of severe depressive reactions in personality disorders, particularly with suicidal tendencies, also warrants the use of antidepressive medication, but psychotherapeutic treatment, as mentioned before, is the central focus of the clinicians' effort.

Sometimes, sadly, erroneous diagnoses do not reflect clinical criteria, but social pressures, for example, the refusal of third-party payers to reimburse treatment for personality disorders, limiting themselves to payment for affective disorders. Also, still-prevalent biases and fears regarding the diagnosis of personality disorder, and a general reluctance on the part of patients as well as families to look into the psychological conflicts related to severe personality disorders, may foster the diagnosis of a major depression or bipolar illness as a "chemical imbalance," experienced as a "preferable" diagnostic conclusion. Yet Lequesne and Hersh (2004) found that BPD patients do better when the diagnosis is named and described. Insofar as, at this time, effective treatment methods for personality disorders are available, such erroneous diagnostic conclusions are definitely damaging. They postpone the time of adequate treatment and expose patients with severe personality disorders to additional, unnecessary

risks, such as those involved in some psychopharmacological approaches that provide patients who are unable to be responsible regarding the use of such medications with an additional potential for suicidal and parasuicidal behavior. It may seem trivial to state it once again: An adequate diagnosis is the first step to an effective treatment.

Attention deficit/hyperactivity disorder

One other relatively frequent and often difficult differential diagnosis is that between a severe personality disorder, particularly a borderline personality disorder or a narcissistic personality disorder functioning on an overt borderline level with antisocial features, and an attention deficit/hyperactivity disorder (ADHD) in adolescent or adult patients. The prominence of inattentiveness, the inability to concentrate, the presence of school or work failure, and/or the hyperactivity/impulsivity of ADHD may be confused with the breakdown of the capacity to study or to work, the impulsivity and emotional lability of a severe personality disorder. The two types of disorder occasionally present comorbidly, but in the large majority of cases only one of these diagnoses characterizes the patient, and the risk of misdiagnosis is high.

A diagnosis of ADHD should be confirmed by information from home and school regarding symptoms of inattention and/or impulsive hyperactivity from early childhood, predating other symptoms that characterize a severe personality disorder. The capacity for a relatively normal adjustment to the social life at school and to a good relationship with the parents within the stress given by the academic difficulties would suggest the diagnosis of ADHD. The absence of significant antisocial behavior from early childhood, the capacity to establish in-depth friendships and loyalties, and the presence of normal identity integration favor the diagnosis of ADHD, even if irritability, depressive reactions, and explosive resentment when faced with the consequence of the cognitive disabilities are present. The capacity for deep interpersonal relations, concern over one's functioning and relationships, and the capacity to establish an honest and reliable relation with a therapist characterize the simple ADHD pa-

tient's presentation in adulthood, in addition to the therapeutic test given by stimulant medication that usually improves ADHD symptoms significantly and rapidly.

Severe pathology of object relations with marked incapacity to establish friendships from early childhood on, significant difficulties at home with parents and siblings that are present together with severe identity disturbance as evaluated in the clinical interviews, and possible chronic antisocial behavior from early childhood on speak for a personality disorder, particularly if the diagnosis of ADHD has only been suggested in late adolescence or early adulthood, as one more attempt to explain severe school failure, emotional lability, and irresponsibility regarding tasks and human relations.

The differential diagnosis of ADHD from a bipolar disorder is facilitated by the episodic nature of bipolar illness, which has clearly marked periods of normal functioning disrupted by well-documented hypomanic or manic episodes, in addition to the usual differential diagnosis of major depression from chronic dysthymic disorder. Narcissistic personality disorder should also be considered in cases where there is difficulty learning. In the case of a narcissistic personality functioning on an overt borderline level, the grandiosity, entitlement, inordinate envy, and extreme severity of the lack of intimate in-depth relations differentiate this condition from ADHD. In addition, in the case of narcissistic personality disorder, one sees a characteristic discrepancy between excellent cognitive functioning in areas where the patient considers himself or herself superior and is gifted enough to carry out tasks without any efforts, in contrast to complete failure in other areas where intense learning and the overcoming of difficulties are required, and where the patient responds by devaluing what he or she cannot achieve easily.

Neuropsychological and projective psychodynamic testing may provide additional significant evidence in this clinical assessment. Projective psychodynamic testing would add important information regarding the nature and severity of the personality disorder, while significant, nonspecific, but diffuse indications of cognitive limitations and a learning disorder would point in the direction of ADHD. It is questionable whether a diagnosis of ADHD, first

considered during the adulthood of a patient, can be justified in the absence of confirmatory evidence from neuropsychological testing.

Posttraumatic stress disorder

Another important differential diagnosis is that between a borderline personality disorder and a posttraumatic stress disorder. A movement in the 1990s argued that BPD was not an entity unto itself, but a misunderstood form of PTSD (Herman, 1992). However, a review of the literature finds that only a third of the BPD population has a history of severe and extended abuse and, furthermore, that only 20% of individuals with a history of serious abuse go on to have serious psychopathology as adults (Paris, 2008). Potential confusion between BPD and PTSD derives from the fact that traumatic experience or ongoing, repeated traumatization, which can be sexual, physical, or psychological, particularly in early childhood, constitutes an important etiological factor in the development of a severe personality disorder, particularly borderline personality disorder.

The typical symptoms of PTSD arise within the first 6 months after a traumatic event and may last up to 2 or 3 years following the event. Symptoms include insomnia, irritability, angry outbursts, difficulty concentrating, hypervigilance, exaggerated startle response, and intensive reliving of the trauma in the form of nightmares, "flashbacks," and repeated memories of the trauma. The development of further symptoms many years after the actual, real, or assumed trauma, including somatization symptoms, dissociative symptoms, emotional lability, impulsivity, self-destructive behavior, and, particularly, chronic interpersonal difficulties with manifestations of emotional immaturity are symptoms of a structured personality disorder, which may derive from trauma or a combination of personality disposition and traumatic experiences.

This differentiation is important from a therapeutic standpoint: Treatment of PTSD requires a psychotherapeutic approach that facilitates the controlled reliving and working through of the traumatic experience in the context of a safe and secure psycho-

therapeutic relationship. In contrast, when traumatic experiences are at the origin of a personality disorder, the unconscious conflicts triggered by the trauma usually take the form of an unconscious identification with the traumatic relationship, that is, an unconscious identification with both victim and perpetrator of the trauma. In the transference focused psychotherapy of these patients, they have to be helped to acquire conscious awareness of this double identification and resolve it in the course of transference analysis. This represents a very different psychotherapeutic approach than that required for the treatment of PTSD (Koenigsberg et al., 2000).

Narcissistic as compared with borderline personality disorder

One final, important differential diagnosis of borderline personality disorder is that with the diagnosis of narcissistic personality disorder (NPD) functioning on an overt borderline level in terms of the lack of an integrated identity. In contrast to BPD patients who present different aspects of their internal world from one moment to the next, patients with NPD at the borderline level mask the fragmentation and weakness of their identity under a brittle and fragile grandiose self that they present to the world and to themselves (Kernberg, 1992). Patients with a severe narcissistic personality disorder may present symptoms strikingly similar to those of borderline patients: general impulsivity, severe chaos in relations with significant others, severe breakdown in their capacity for work and emotional intimacy, and parasuicidal and self-mutilating behavior. In addition, these patients are also prone to antisocial behavior that, therefore, also requires the differential diagnosis among different types of narcissistic pathology with different levels of antisocial features (see below).

The most important differential features are, first, the NPD patient's difficulty in accepting any dependent relationship, their severe lack of investment in relations with significant others except in exploitative or parasitic relationships, and an aloofness that contrasts with the highly ambivalent, yet clinging and dependent relationships of patients with borderline personality disorder. Second, patients with NPD show rather extreme fluctuations be-

tween severe feelings of inferiority and failure, and corresponding depressive reactions, on the one hand, and, on the other hand, an inordinate sense of superiority and grandiosity that shows in their contemptuous and dismissing behavior toward others, including their therapist. Borderline patients may alter their relationship between clinging dependency and idealization, on the one hand, and angry rejection and dismissal, on the other hand, but they do not show the chronically contemptuous and dismissive attitude that narcissistic patients present. Third, and as a consequence of these characteristics, the most severe narcissistic patients functioning on an overt borderline level are usually isolated socially, even if they are externally part of an intense social network. They lose their friends and do not maintain relationships over an extended period of time, and their objective loneliness contrasts with the complicated, contradictory yet enmeshed relationships of borderline patients.

Antisocial behavior may also be a complicating symptom of borderline personality disorder, but may be more central in lower levels of narcissistic personality disorder; it is always a negative prognostic factor. This is particularly true for the syndrome of malignant narcissism, the most most severe form of the narcissistic personality that is characterized by ego-syntonic aggression, paranoia, and antisocial traits, and for the antisocial personality disorder proper. These are important differential diagnostic considerations when the clinical picture appears to be, at first sight, a borderline personality disorder, and they need to be considered in the differential diagnosis of all patients within this spectrum of pathology who do present chronic antisocial behaviors.

Evaluation of antisocial behavior and traits

The combination of a history of ADHD, a learning disorder, and significant antisocial behavior from early childhood on is not infrequent, and raises the question as to what extent some general brain dysfunction may operate as an etiological factor for all these conditions. For practical purposes, however, one cannot conclude that the antisocial behavior is a complication of ADHD or a learning disorder if it continues as a severe disturbance

throughout adolescence and into adulthood, characterized by the prevalence of passive/parasitic or aggressive behavior directed against others and property, combined with an absence of the capacity for feelings of guilt and concern, and lack of capacity for empathy with others.

In other words, when antisocial behavior is chronic, pervasive, and dominates the psychopathology, it usually reflects a severe personality disorder regardless of whether ADHD was diagnosed in early childhood. We can consider the personality disorders in terms of most severe to least severe with regard to antisocial characteristics: the antisocial personality disorder proper; the syndrome of malignant narcissism; the narcissistic personality with antisocial features; other severe but nonnarcissistic personality disorders with antisocial features and identity diffusion; antisocial behavior in a neurotic personality organization; and antisocial behavior as a temporary symptom in adjustment disorders in adolescents. In addition, the antisocial behavior of youngsters who are members of an antisocial subculture, such as street gangs, has to be evaluated in terms of whether it presents a personality disorder or only an adaptation to a negative subculture, that is, a "dissocial disorder." Cases where severe, chronic antisocial behavior is the major presenting symptom require detailed, extensive work-up, including information from family and other sources.

The most important differential diagnosis is that of antisocial personality proper, the most severe of the personality disorders, which has a very bad prognosis under any circumstances. In these cases, at times treatment has to be limited to protecting family and society and establishing firm social controls that control antisocial behavior and, under optimal conditions, that may eventually permit a tentative psychotherapeutic approach. In practice, it should not be difficult to differentiate the occasional antisocial behavior that may be part of bona fide hypomanic or manic episodes or an occasional complication of affect storms in severe personality disorders from the chronic, pervasive antisocial behavior that requires the complex differential diagnosis referred to before. We define an antisocial personality proper by a total lack of concern for others, in contrast to the *DSM-IV* diagnosis, which

is largely based on behaviors. The essential features are long-term passive-parasitic and/or aggressive antisocial behavior from early childhood on, a lack of any capacity for authentic feelings of guilt or remorse over this behavior, a lack of concern for others that implies callous indifference, insensitivity, or simply occasional outbursts of hatred, if not sadistic pleasure at attacking or sadistically treating others. These more severe characteristics are in addition to all the criteria of a narcissistic personality disorder itself. A chronic parasitic, exploitative lifestyle with irresponsibility regarding social obligations and financial reality typically is accompanied by a lack of any concern for or consideration of the future: It is as if the patients were living in an eternal present with total disregard for the implications of their behavior for their future life.

In antisocial personality disorder, patients show a lack of empathy with the moral dimension or ethical values of other people so that, even if they may shrewdly assess others' motivations and manipulate them, they are not able to include an ethical dimension in their assessment. The indifference toward others is matched with a deep indifference toward their own lives, reflected in recklessness, and, in our experience when driven into a corner, they present a potential suicidal tendency to escape from external threats.

Malignant narcissism is the most serious level of personality disorder that can respond to treatment. The treatment must include special emphasis on a strong treatment frame to maximally protect patient and therapist from the patient's capacity for aggression, and interpretation of the intense envy that could motivate the patient to attack himself or herself or the treatment as a proof of strength and as an attempt to triumph over the therapist.

In contrast to those with malignant narcissism, individuals with "ordinary narcissistic personalities," in spite of any antisocial behavior that may be part of their presentation, have the capacity for experiencing feelings of guilt and concern, for loyalty, and for investment in relationships (Kernberg, 2004).

Still less severe cases present antisocial behavior that is not part of a personality disorder at all, but of an adjustment disorder of adolescence or as a secondary symptom in manic or hypo-

manic episodes. Finally, one has to consider the presence of antisocial behavior in the members of socially isolated or marginalized groups, such as adolescent members of a criminal gang who, separated from the gang, would manifest no further antisocial behavior.

Case illustration of a patient with narcissistic personality disorder misdiagnosed as refractory depression

C, a 31-year-old man, came for consultation after a having been discharged from the hospital where he had received electroconvulsive therapy (ECT) for depression. His parents initiated the consultation. They had supported C through a series of psychotherapies and a number of hospitalizations for 14 years and were frustrated with the lack of apparent progress. C had worked 2 years earlier as an assistant to a publisher and left that job when he entered a graduate program in journalism. His graduate studies lasted only a few weeks before he withdrew due to "depression and anxiety," with a particular anxiety about speaking up in class. After that, he isolated himself in his apartment, sometimes being unable to get out of bed and rarely leaving his apartment except to see his parents. During these visits, C described with perseveration his feelings that his life was over and he might as well be dead. After 6 months in this state, his parents initiated the consultation.

In the first consultation meeting, C presented as a good-looking, well-dressed, and well-groomed young man. His chief complaint was depression with suicidal ideation and inability to function. He lived alone in an apartment and had no source of income except his parents. He spoke mostly about his intense wish to become a journalist and his feeling that life would be worthless and he would rather be dead if he did not achieve this goal. C reported a limited social life with a few friends.

Past history included a suicide attempt by overdose at age 16 that led to his first hospitalization and a series of psychotherapies and trials of medication. C estimated that he had had 10 previous therapies with no benefit, and he reported trials of 40 medications—antidepressants, low-dose neuroleptics, and mood

stabilizers—also with no benefit. The only treatment that he felt had helped was ECT, but he was reluctant to try it again because of concerns about impairment of his cognitive functioning.

His current goal, which was almost an obsession, was to return to a graduate program in journalism, but he felt paralyzed in his efforts to take the steps to do so. He attributed this to depression and, in spite of his reservations about the organic effects, was almost pleading for another course of ECT.

While C described his mood as depressed and anxious, Dr. A was struck by the patient's angry and confrontative stance as represented in his initial comment: "I've been seeing therapists since I was 16 and look at the result! I'm more depressed now than I was then."

In a review of symptoms, C reported being depressed "all his life" with intermittent difficulty getting out of bed and a chronic inability to interact with others; he felt that everything he said and did was "wrong" and that others found him bizarre. Dr. A carefully assessed the signs of depression. C did not present with motor retardation or unavailability of any feeling. While C reported extreme depression and inability to function, he was quite energetic in his criticisms of therapy and of his parents. His thought processes were severely self-demeaning, but equally harsh on others. His mood did not demonstrate diurnal variation, but changes were noted around other people where he could appear polite and appropriate, if reserved, at family gatherings. This was in contrast to his presentation when just with his parents, which was characterized by angry accusations that they were not providing him enough support. In short, C often seemed more angry than depressed. And while his depressed state was severe and appeared to be his baseline mood, it did demonstrate shifts in response to his social environment.

With regard to neurovegetative symptoms, C reported periodic difficulty falling and staying asleep. His appetite and libido were intact.

In terms of triggers to depression, in addition to his chronic self-castigation for not being a journalist, C showed an exquisite sensitivity to his performance in any setting. For instance, if he met with friends for dinner, the next day he would review and

disparage his participation in the conversation. The anticipation of a family gathering led to despair about how incapable he felt at sustaining a conversation.

Diagnostic impression: The combination of the chronicity of C's depression and his attentiveness to his appearance, reactivity to situations, and level of energy and anger in criticizing self and others, along with a lack of multiple neurovegetative symptoms suggested a characterological depression associated with a personality disorder. Nevertheless, his psychiatric history was significant for years of treatment for a major depressive disorder. It is possible that C suffered from a "double depression": a baseline characterological depression with superimposed episodes of major depression that justified the hospitalizations and ECT. However, there was little evidence of past treatment efforts that addressed his character pathology as such.

After two consultation sessions with the patient, Dr. A explained his diagnostic impression and discussed the possibility of narcissistic issues involving difficulty with self-esteem regulation and harsh evaluations of self and others. C did not disagree that these were issues but felt that Dr. A did not understand that the main issue was "a problem with his brain." Dr. A did not disagree with that view but added that the most helpful treatment option might be an intensive psychotherapy since the mind and the brain are intimately linked and psychotherapy has been shown to effect changes in the brain. After repeating his earlier statement that his years of psychotherapy had been useless, C ambivalently agreed to begin an intensive therapy focusing on characterological depression. Thus, the first phase of therapy had begun since C proceeded to regularly devalue Dr. A and his therapy throughout the first phase of treatment. As therapy proceeded, Dr. A used a combination of attention to the holding environment of therapy to allow for an alliance to build and "therapist-centered" interpretations (Diamond, Yeomans, & Levy, 2011; Steiner, 1993) to explore the patient's internal devalued sense of self as it was projected onto the therapist. After a year of treatment, C gave evidence of a small but demonstrable increase in flexibility in his capacity to deal with the challenges of life and with others. The case is ongoing at this point.

Conclusion

Diagnostic questions around bipolar illness, major depressive episodes, ADHD, and severe personality disorders are extremely important for the clinician to make appropriate treatment recommendations. These questions can be resolved by careful evaluation of (1) the depressive symptomatology, (2) the presence and nature of suicidality, (3) the presence or absence of true manic or hypomanic episodes, (4) cognitive functions, (5) the quality of interpersonal relations, (6) characteristics of personality disorders, (7) the role of substance abuse, and (8) the presence or absence and type of antisocial behavior. Adequate diagnosis facilitates optimal treatment.

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