DOWNLOAD PDF PERVERSION, PERVERSITY, AND NORMALITY : DIAGNOSTIC AND THERAPEUTIC CONSIDERATIONS OTTO F. KERNBERG

Chapter 1 : Library Resource Finder: Oops

tion of a patient's motivation, intrapsychic structure, and therapeutic changes provides important information regarding the origins, functions, and mecha- nisms of these changes in patients with personality disorders.

Practical Differential Diagnosis Otto F. Abstract 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 pressuressuch 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. These differentiations often involve decisions regarding immediate interventions and treatment planning. This paper is motivated by the high frequency of diagnostic errors observed under such conditions, an observation that often emerges only after the patient is seen under more stable conditions, particularly during more extended evaluation or treatment. We shall not review systematically the diagnostic criteria for the various conditions to be explored, but only highlight those aspects that facilitate a differential diagnosis under the conditions mentioned. 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 Paris3, The diagnosis of a bipolar disorder requires 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. It is important to patiently ascertain whether the patient has had, indeed, one or several periods of at least three to four days in which an unusually euphoric, angry or irritated mood predominated, together with a sense of heightened energy, affective dyscontrol, significantly 1 2 3 2 reduced need for 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 consists in confusing the chronic emotional instability and affect storms of personality disordered patients with a truly hypomanic or manic behavior. Therefore, the confusion between bipolar illness and BPD is usually reduced to cases of presumed hypomanic behavior used as the basis to diagnose bipolar II in patients. In about 19 percent of patients with borderline personality disorder, however, a comobidity with bipolar disorder may be present, and the patient shows both severe, chronic affective instability and clear hypomanic episodes Gunderson4 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 lives appropriately. 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 maintaining stable commitments to work and profession as well as to intimate relationships. 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 indication for 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 Association5, Major Depressive Episode The differential diagnosis between an episode of major depression and a chronic dysthymic reaction, or characterological depression, in borderline personality disorder is more difficult, but eminently feasible - if enough time is available to clarify four major areas of pathology. First, the psychic symptoms of a depressive spectrum of illness. Typically, thought processes are severely selfdemeaning and self-accusatoryâ€"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, to extreme, delusional self-devaluations and self-accusations. Such combination of chronic reduction in behavior, lowering in mood, and self-devaluation over a period of weeks to several months, combined with consistent daily fluctuations of symptoms: Frequently patients may state that they feel chronically hopeless and helpless, which would reflect a total depressive despondency. However, when one asks the patient, what he or she feels hopeless about, and in what way does the patient feel helpless, patients have difficulty conveying a response that would be harmonious with a general self-devaluation, and, to the contrary, in the case of severe personality disorders with characterologically based dysthymic reactions, the patient 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, the patient withdraws from social contacts and may feel worse when efforts are made to stimulate him 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. 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 and not of a major depression. Again, the patient rapidly shifting in his 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. In these cases, usually, there is 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 depressive features have acquired a characterological stability in the psychic equilibrium of such patients. There are patients who report that they have been depressed all of their lives, and these usually present severe personality disorders. However, a certain percentage of patients with major depression, probably around 30 percent, may become chronic with refractory depression persisting over many years Rush et al6, ; McGrath et al7, These refractory cases may present welldocumented 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. This is particularly frequent in forms of narcissistic personality 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: There are patients with atypical major depression where 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 earlier, before reaching a definite conclusion. Patients with genetic predisposition to affective disorders may show neurovegetative 6 6 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 do not, usually, 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 is a major depression; the more predominant the personality disposition and the environmental triggers, the more likely is a characterological depression. These cases require, first, the treatment of the episode of major depression. 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 non-depressed 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, that may be motivated by intense envy. Both this type of 7 7 chronic suicidal tendancy, and the acute, repetitive suicidal attempts under conditions of frustration or anger of borderline patients are typical of severe personality disorders. Patients who present chronic suicidal and parasuicidal behavior without depression require highly specialized psychotherapeutic treatment. Many of these cases may be helped effectively with both an integrative cognitive behavioral treatment Dialectic Behavior Therapy, Linehan8, or a psychodynamic psychotherapy Transference Focused Psychotherapy, Clarkin et al9, or Mentalization Based Therapy Bateman and Fonagy10, 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 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, in cases 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. The diagnosis of a specific episode of depression, in terms of whether it is a major depressive syndrome or a chronic dysthymia reflecting a characterological predisposition in a personality disorder requires more time and is more difficult than the assessment of whether the patient has had or not has 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 8 9 10 8 problem. The treatment of all affective disorders combines medication - antidepressants and mood stabilizers, with the addition of neuroleptic medication in cases with extreme anxiety or complications with hallucinatory or delusional symptoms â€" with specific forms of therapy. 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. Yet Lequesne and Hersh11, 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, as are 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: 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. The two types of 11 9 disorder occasionally present comorbidly, but, in the large majority of cases, it is only one of these diagnoses that characterize the patient, and the risk of misdiagnosis is high. 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 speak for the diagnosis of ADHD. The absence of significant antisocial behavior from early childhood on, the capacity of the establishment of friendships in depth, 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. Severe pathology of interpersonal 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, irresponsibility regarding tasks and human relations. The differential diagnosis of ADHD from a bipolar disorder is facilitated by the episodic nature of bipolar illness, with 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 the extreme severity of the lack of intimate relations in depth, 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 10 considers himself 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 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, non-specific but diffuse indications of cognitive limitations and a learning disorder would point into 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. Post-traumatic Stress Disorder Another important differential diagnosis is

that between a borderline personality disorder and a post-traumatic stress disorder. Potential confusion between BPD and PTSD derives from the fact that traumatic experience, or ongoing, repeated traumatization, that 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 and may last up to two or three years following this traumatic event. The development of further symptoms, many years after the actual, real or assumed trauma, of 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, that may derive from trauma or a combination of personality disposition and traumatic experiences. This differentiation is important from a therapeutic standpoint: PTSD treatment requires a psychotherapeutic approach that facilitates the controlled reliving and working through of the traumatic experience in the context of a safe and secure psychotherapeutic 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 psychotherapeutic treatment 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. 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 Kernberg14, Patients with a severe narcissistic personality disorder may present strikingly similar symptoms to borderline patients: 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. Second, narcissistic personalities show rather extreme fluctuations between severe feelings of inferiority and failure, and corresponding depressive reactions, on the one hand, and 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, but 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.

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Practical differential diagnosis Otto F. Kernberg, MD Frank E. Yeomans, MD The challenge of accurate diagnosis remains at the heart of good psychiatric treatment. Bulletin of the Menninger Clinic, 77[1], 1â€”22 Dr. Correspondence may be sent to Dr. 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. 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, The accurate assessment of the presence of manic or hypomanic episodes is essential. 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. 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. 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, Vol. 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, First are the psychic symptoms of a depressive spectrum of illness. Typically, thought processes are severely self-demeaning and self-accusatoryâ€”rather than focused on accusing and blaming others. 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. 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 Vol. The depressive reactions in personality disorders are usually less severe and are irregular in their appearance and duration. Shifts of the symptomatology according to different social circumstancesâ€”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 daysâ€”are characteristic of a personality disorder with a characterological depressionâ€”dysthymic disorder1â€”and not of a major depression. A second area of exploration of the differential diagnosis is the evaluation of the

personality structure that predated the beginning of the depressed episode. A prevalent form of chronic, characterologically based depression. There are patients who report that they have been depressed all of their lives, and these patients usually present severe personality disorders. 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. 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: 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- Vol. 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. 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 burningâ€”particularly under conditions of intense emotional agitation, temper tantrums, or acute frustrationsâ€”is typical of severe personality disorders, particularly borderline personality 8 Bulletin of the Menninger Clinic Differential diagnosis disorder. Intense suicidality can present in the context of depression, but is not limited to that condition. 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. Patients who present chronic suicidal and parasuicidal behavior without depression require highly specialized psychotherapeutic treatment. 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 Vol. 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. Yet Lequesne and Hersh found that BPD patients do better when the diagnosis is named and described. They postpone the time of adequate treatment and expose patients with severe personality disorders to additional, unnecessary 10 Bulletin of the Menninger Clinic Differential diagnosis 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: 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. 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 welldocumented hypomanic or manic episodes, in addition to the usual differential diagnosis of major depression from chronic dysthymic disorder. 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. Posttraumatic stress disorder Another important differential diagnosis is that between a borderline personality disorder and a posttraumatic stress disorder. 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. 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- Vol. This represents a very different psychotherapeutic approach than that required for the treatment of PTSD Koenigsberg et al. 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, Patients with a severe narcissistic personality disorder may present symptoms strikingly similar to those of borderline patients: 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. 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. 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 Vol. We can consider the personality disorders in terms of most severe to least severe with regard to antisocial characteristics: 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. These more severe characteristics are in addition to all the criteria of a narcissistic personality disorder itself. 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. Malignant narcissism is the most serious level of personality disorder that can respond to treatment. 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- Vol. 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 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. 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. 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. 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 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.

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Chapter 3 : Kernberg Borderline Personality Disorder Diag Dif - calendrierdelascience.com

Locating perversion, dislocating psychoanalysis / Dany Nobus --Perversion, perversity, and normality: diagnostic and therapeutic considerations / Otto F. Kernberg --An overview of perverse behaviour / Arnold Goldberg --Perversion and charity: an ethical approach / Sergio Benvenuto --The problem of inscription and its clinical meaning in.

Practical differential diagnosis Otto F. Kernberg, MD Frank E. Yeomans, MD 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 pressuresâ€”such as limited time for diagnostic evaluation, the question of what is reimbursed by insurance, and the issue of directing patients to acute treatmentsâ€”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. Bulletin of the Menninger Glinic, 77[1], Dr. Correspondence may be sent to Dr. 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. 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, The accurate assessment of the presence of manic or hypomanic episodes is essential. 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. 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. 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. 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, First are the psychic symptoms of a depressive spectrum of illness. Typically, thought processes are severely self-demeaning and self-accusatoryâ€”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 symptomsâ€”the patient feeling worse in the mornings and mood improving gradually every evening, with a relentless repetitiveness of such daily cycles over weeksâ€”characterizes a typical major depressive episode. 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 dystbymic 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 Vol. The depressive reactions in personality disorders are usually less severe and are irregular in their appearance and duration. A second area of exploration of the differential diagnosis is the evaluation of the personality structure that predated the beginning of the depressed episode. A prevalent form of chronic, characterologically based depression. There are patients who report that they have been depressed all of their lives, and these patients usually present severe personality disorders. 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. However, the rate of remission from BPD was not affected by co-occurring major depressive disorder. 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- Vol. 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. 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. 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 burningâ€”particularly under conditions of intense emotional agitation, temper tantrums, or acute frustrationsâ€”is typical of severe personality disorders, particularly borderline personality Bulletin of the Menninger Clinic Differential diagnosis 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. 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 Vol. Tbe diagnosis of a concrete episode of depression, in terms of wbetber it is a major depressive syndrome or a cbronic dystbymic reaction corresponding to a characterological predisposition in a severe personality disorder, requires more time and is more difficult than the assessment of wbetber tbe patient has or bas not bad an episode of bypomanic or manic bebavior. While tbe differentiation of a severe personality disorder from a bipolar disorder requires, in practice, only tbe precise differentiation regarding a hypomanic or manic episode, tbe differentiation of characterological depression and major depression requires consideration of all tbe criteria. Witb adequate review of these criteria, tbe diagnostic distinction should not remain a major problem. Tbe treatment of all affective disorders is centered on antidepressants and mood stabilizers, witb tbe addition of neuroleptic medication in cases witb extreme anxiety or complications witb hallucinatory or delusional symptoms. Sometimes, sadly, erroneous diagnoses do not reflect clinical criteria, but social pressures, for example, tbe refusal of tbirdparty payers to reimburse treatment for personality disorders, limiting tbemselves to payment for affective disorders. Also, stillprevalent biases and fears regarding tbe diagnosis of personality disorder, and a general reluctance on tbe part of patients as well as families to look into tbe psycbological conflicts related to severe personality disorders, may foster tbe diagnosis of a major depression or bipolar illness as a "cbemical imbalance," experienced as a "preferable" diagnostic conclusion. Yet Lequesne and Hersb found tbat BPD patients do better wben tbe diagnosis is named and described. Insofar as, at tbis time, effective treatment metbods for personality disorders are available, sucb erroneous diagnostic conclusions are definitely damaging. Tbey postpone tbe time of adequate treatment and expose patients witb severe personality disorders to additional, unnecessary 10 Buttetin of the Menninger Ctinic Differential diagnosis 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. 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. 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. 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 welldocumented 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 12 Bulletin of the Menninger Clinic Differential diagnosis considered during the adulthood of a patient, can be justified in the absence of confirmatory evidence from neuropsycbological testing. Posttraumatic stress disorder Another important differential diagnosis is that between a borderline personality disorder and a posttraumatic stress disorder. 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- Vol. 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. 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, Patients with a severe narcissistic personality disorder may present symptoms strikingly similar to those of borderline patients: 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. Second, patients with NPD show rather extreme fluctuations be- 14 Buttetin of the Menninger Ctinic Differential diagnosis tween severe feelings of inferiority and failure, and corresponding depressive reactions, on tbe one band, and, on tbe otber band, an inordinate sense of superiority and grandiosity tbat sbows in tbeir contemptuous and dismissing bebavior toward others, including tbeir tberapist. Borderline patients may alter their relationship between clinging dependency and idealization, on tbe one band, and angry rejection and dismissal, on tbe otber band, but tbey do not sbow tbe cbronically contemptuous and dismissive attitude tbat narcissistic patients present. Third, and as a consequence of these cbaracteristics, tbe most severe narcissistic patients functioning on an overt borderline level are usually isolated socially, even if tbey are externally part of an intense social network. Tbey lose tbeir friends and do not maintain relationsbips over an extended period of time, and tbeir objective loneliness contrasts witb tbe complicated, contradictory yet enmeshed relationships of borderline patients. Antisocial bebavior 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.

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Otto F. Kernberg. What follows is an overview of my current efforts to develop a classification of the broad spectrum of disorders traditionally grouped under the heading of sexual perversions, and now referred to as paraphilias.