Chapter 5
Mood Disorders

Mood is a state of mind or feeling or spirit. The word *mood* comes from the Old English *mod*, which means “disposition.” Moods can range from very low, or “depressed,” to very high, or “manic.” It is normal to have mild mood changes from normal to low when stressed and to joyful when something really good happens. Most people have had times of very low moods, but very high moods are much less frequent.

The two types of mood disorders are Depressive Disorders, in which the only mood problem is depression, and Bipolar Disorders, in which there are manic moods with or without a history of depressed moods.

Section 1: Depressive Disorders

> The melancholy days are come, the saddest of the
> year,
> Of wailing winds, and naked woods, and
> meadows brown and sere.
>
> William Cullen Bryant, *The Death of the Flowers*, 1832

What Is the Definition?

The word *depress* comes from the Middle English word *depressen*, which means “to push down.” To *be depressed* means to have a “pressing down” of the spirits or to feel “low.” A depressive disorder occurs when symptoms cause major distress or trouble in social situations, working, school, or other crucial aspects of daily living.

What Are the Symptoms?

Depressed persons have a depressed mood most of the time on almost every day. Adults by and large know when they are depressed and can describe feelings of painful distress, but children and teens may only know they are angry or cranky or they may “misbehave.” Depressed persons have lost the ability to enjoy things or to be interested in doing anything, and they often have weight loss and seriously interrupted sleep (although for some people there may be weight gain or increased sleeping). They may feel very wound up and yet

find it hard to be at all active. They often feel very tired and lack vigor. They can feel worthless, with extreme, undue guilt. They frequently have lowered power to think or concentrate and have trouble making up their minds. They can feel hopeless, and they often have thoughts of wishing for death, or suicidal thoughts and plans.

The two major depressive disorders are Major Depressive Disorder and Dysthymic (from the Greek for "bad mind or soul") Disorder. In Major Depressive Disorder, the symptoms cited above are severe, whereas in Dysthymic Disorder, the symptoms are less severe but much more chronic, having been present for at least two years, often since the early teens or even childhood. A Major Depressive Disorder evolves over days to weeks. Anxiety symptoms may have been present for weeks or months prior to the depressed symptoms and may have concealed them for a time.

There are other types of depression, such as those that occur in certain seasons, during major holidays, after childbirth (postnatal), or on a regular basis during the menstrual cycle. In older persons, it can be hard to tell whether symptoms are due to a mood disorder or to a dementia, such as Alzheimer's Disease. In both cases, there can be a depressed mood and a loss of interests, with weight and sleep changes, mental turmoil, and poor ability to think and make up one's mind. Careful evaluation is the key, since in dementia there is a disease that is likely to become worse, and in the other case, there is a mood disorder that can be treated with success.

Who Is Affected?

A nationwide survey found that almost one person in ten had a Depressive Disorder at some point in 1990. Major Depressions occur twice as often in women as in men, while Dysthymia occurs up to three times as often in women, except in childhood where it occurs about equally.

Causes of depression can be roughly listed as "constitutional" or "environmental." With the former, there is often a family history of mood problems. Such families may include people with a high sensitivity to the feelings and needs of others as well as family beliefs and attitudes that foster depression. Environmental causes are countless, including early childhood loss of a parent, child abuse, medical illness, and the many traumas that can occur in one's private and working life.

Onset and Course

Depressions can occur at any age, including early childhood. If not treated, a Major Depression will often last six months or longer. Most people recover fully; however, 40 percent continue to have significant

symptoms of the Major Depression for a year or more. A large number of people who have fully or partly improved have one or more later episodes. About 10 percent of teenagers who have repeated Major Depressions later develop Bipolar Disorder.

Depression can threaten life. The most serious possibility is suicide, and this must always be kept in mind in dealing with a person who is depressed. Any sign that he or she might be thinking of suicide must be taken seriously, even if at the moment the person is not planning suicide or seems to be only making a threat or trying to attract attention.

Treatment

Self-Help. People who know that they are depressed can learn ways to help themselves, such as confiding in trusted friends and spouses, engaging in hobbies, and exercising regularly. The more depressed a person is, the simpler such plans usually have to be. There are certain groups that can be helpful, such as the Depression and Related Affective Disorders Association (DRADA), National Alliance for the Mentally Ill (NAMI), and Mental Health Association. There are a number of good books describing personal experiences with depression, including Meri Nana-Ama Danquah's *Willow Weep for Me: A Black Woman's Journal through Depression*, and William Styron's *Darkness Visible: A Memoir of Madness*.

Professional Help. The type of treatment depends on the degree of the depression. In milder cases, talking with one's physician or psychotherapist can help greatly. Often, talking about the symptoms, knowing their cause, and learning that one will most likely recover fully helps the person to find strength to struggle against self-critical ideas and to solve the real-life problems facing him or her. In more severe depressions, psychotherapy with an expert is required, and antidepressant drugs may also be essential. In the case of very severe depression, with or without the risk of suicide, a brief time in a hospital may be required, and in a very small number of such cases, when severe symptoms and the danger of suicide persist, the doctors may suggest a brief course of electroconvulsive treatment.

If depressions recur, "maintenance" drug treatment on a long-term basis may be needed, along with psychotherapy that may be less frequent (e.g., monthly) depending on the kinds of life problems that the person must resolve, including the presence of other psychiatric or medical problems.

Section 2: Bipolar Disorders

Misled by fancy's meteor ray,

By passion driven;
But yet the light that led astray
Was light from heaven.
, *The Vision*, 1786 Robert Burns

What Is the Definition?

The prefix *bi* comes from the Latin *bis* or *bi*, meaning "two," and *polar* comes from the Latin *palus*, meaning "stake" or "pole." *Bipolar* means having two poles or extremes of moods. A person with this illness must have had at least one "high" or manic phase. These manic states tend to occur in cycles that often—but not always—alternate with periods of depressed moods.

What Are the Symptoms?

The person with a "high," or manic mood is most often very cheerful, which may cause others to feel the same way. The mood is likely to be expansive, in that the person is fervent about many topics and may start talking intimately with strangers. Less often, the major mood is irritable, and the person may become quite angry when there is any dissent or hindrance to his or her wishes. Irritability may be the key symptom in children. Other symptoms and behaviors can include very high trust and belief in oneself despite extremely poor judgment, intense activity with little need for sleep, being in turmoil, and talking nonstop, sometimes with dramatic gestures and sing-song speech. The person may act on impulse with probable distressing results, such as going on buying sprees, engaging in rash sexual acts, or entering into foolish business ventures. In very severe cases, there may be short-lived delusions or hallucinations.

There are three major types of Bipolar Disorder: Bipolar I Disorder, Bipolar II Disorder, and Cyclothymic Disorder. In Bipolar I Disorder, both the manic and depressed states are severe. In Bipolar II Disorder, severe depressed states alternate with milder highs called "hypomanic" moods. Hypomanic moods never include delusions or hallucinations and do not require hospitalization. People with this disorder may even function much better in some ways during these times and may be very successful in careers as a result. However, they can also make the same kinds of errors in judgment as those with true manic states. The hypomanic state, while often sensed by those who are close, may not be seen at all by friends, strangers, or by the affected person. In Cyclothymic Disorder, there are cycles of mild lows and mild highs that have been present for at least two years, of such a frequency that the person has not been without symptoms for more than two months at any one time.

Who Is Affected?

Whereas most people feel depressed at times and significant clinical depression occurs during the lifetime of about one in five people, Bipolar Disorder is much less frequent. There are often relatives with mood disorders, and in the case of identical twins, there is a particularly high chance (75 percent) that if one twin has Bipolar Disorder, the other will have it also. It is therefore thought that Bipolar Disorder has a strong genetic basis, but it is not clear yet whether the basis is for bipolar illness itself or for a poorly regulated response of mood to chronic childhood stresses, such as family conflict and loss. In some cases, mood swings are more frequent in certain seasons. Bipolar Disorder occurs in about equal numbers in males and females.

Onset and Course

A first mood cycle may occur at any age from childhood to old age. Most people with Bipolar Disorder recover fully between periods of illness, but about one in four have continuing signs of mood and work difficulties between episodes. There is an increased frequency of alcohol and drug abuse problems. Rash acts during manic moods can have devastating consequences, such as financial ruin, divorce, and serious legal problems, any of which may be followed by severe guilt-ridden depression and suicide. The course of the disorder can be greatly affected by the person's ability and inclination to see that this is an illness and that he or she must seek help when moods start to change. If the person accepts this, then the illness can be managed with good success. There are a small number of cases in which the mood swings occur more and more often, called "rapid cycling." Three out of four such patients are women. More frequent hospitalizations and very close guidance are required in these cases.

Treatment

Self-Help. A person with Bipolar Disorder may go through a number of manic states before he or she agrees that this is an illness. This is because the manic state feels great, and the person is certain that he or she is in perfect mental health. Local chapters of DRADA, NAMI, and the Mental Health Association can be very helpful. In *An Unquiet Mind* (Vintage Books, 1996), Kay Redfield Jamison, professor of psychiatry at Johns Hopkins University, writes movingly about Bipolar Disorder both from her own personal experience as well as from a professional perspective.

Professional Help. Both medication and psychotherapy are required, and there may be short hospitalizations. There are now a number of drugs for manic states (some of these drugs, known as “mood stabilizers,” can also be used to treat epileptic seizures). Most patients must remain on these drugs for a long time and may also need to take antidepressant drugs. When people are getting over manic states, the doctor must be alert to the possibility of sudden swings into depressed states, because a person may now have great shame and guilt after seeing how foolish and even harmful his or her actions were when in the manic state.

L. Park

Chapter 6
Anxiety Disorders

Anxiety Disorders are a group of syndromes in which a heightened state of unease, worry, or fear is the basis for the symptoms. These syndromes are set apart from each other by kinds and degrees of anxious symptoms, along with the ways the individual has learned to try to prevent the symptoms. People with anxiety disorders often have some symptoms of depression and vice versa, and sometimes a person has one or more Anxiety Disorders along with a Depressive Disorder.

The major Anxiety Disorders are Panic Disorder, Phobias, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, and Generalized Anxiety Disorder.

Section 1: Panic Disorder and Phobias

> The thing I fear most is fear.
>
> Michel Eyquem de Montaigne, *Essays*, 1580

What Is the Definition?

Panic states and phobias are both described in this section. They often occur together in the same person because phobias can arise as ways to try to avoid panic attacks. The word *panic* comes from Pan, a Greek god who was a source of fright or terror to flocks and herds. To feel panic is to be seized by a sudden, frantic feeling of fright and an urgent wish to flee. The word *phobia* comes from the Greek, meaning “fear.” People have a phobia when there is an anticipated fear of another person, object, or setting to such a degree that they feel compelled to avoid contact. Very often this contact avoidance occurs following an episode of sudden, extreme, and frantic fear, that is, a panic attack.

What Are the Symptoms?

A Panic Disorder is diagnosed when a person has attacks of panic that occur without warning. These attacks begin suddenly and build up to a peak, usually in less than ten minutes, and are often accompanied by a sense of great danger or doom and an intense urge to escape. Some of the physical and mental symptoms are a rapid and pounding heartbeat, pain or pressure in the chest, feeling short of breath or about to choke or smother, sweating, trembling, nausea, feeling dizzy or faint, feeling unreal, fear of losing control or going crazy, fear of dying, numbing or tingling feelings, and cold or hot sensations. Panic attacks can occur with other anxiety disorders, and the key to diagnosing a separate Panic Disorder is if the attacks occur with no warning.

Just one or two panic attacks can change a person's life, because he or she will likely begin to make urgent efforts to prevent any more attacks. Since the attacks tend to occur without any known rhyme or reason, the person often assumes they can be prevented by staying away from the kind of place where an attack has occurred or where one can imagine it might occur. In this way the person may also develop a certain kind of phobia called Agoraphobia, which refers to the fear of being in places or settings from which it might be hard or awkward to escape, or in which help will likely not come if panic symptoms occur (*agora* is Greek for "marketplace"). This kind of fear tends to expand to the point that eventually the person cannot go to stores, travel, be in a crowd, or in some cases even leave the home. Sometimes a person has only one or a few panic attacks before he or she becomes imprisoned by a highly restrained life, even if the feared panic attacks never or rarely occur again.

There are two other types of phobias that may or may not involve panic symptoms: Specific Phobia and Social Phobia. A Specific Phobia is a marked and lasting fear of certain objects or settings, such as types of insects or animals, heights, bridges, tunnels, flying, elevators, or blood (for School Phobia in children, see chapter 1, section 10, "Separation Anxiety Disorder"). Persons with Social Phobia, which can also be called Social

Anxiety Disorder, have a marked and lasting fear of social or performance situations in which they could feel shamed or where others might judge them to be fearful, ineffective, weak, crazy, or stupid. In these types of phobias, any panic symptoms occur in the known feared situations and do not occur out of the blue.

Who Is Affected?

A nationwide survey found that more than one person in ten suffered an Anxiety Disorder. These syndromes are more frequent in women than men, except for Social Phobia where the occurrence is about equal for males and females. All of the Anxiety Disorders result from complex groupings of temperament, environment, and life events. Careful study of a each person's history almost always reveals problems with self-esteem as well as sources of stress. Persons with Panic Disorder often have a parent who has had similar symptoms. Some people with Panic Disorder have symptoms brought out by underlying medical problems, such as heart or thyroid conditions, for which they should see their doctor. An individual who develops Social Phobia, which is apparently much more common than had been realized, may have a childhood history of social constraint and shyness. People who have Panic Disorder or Social Phobia often have other anxiety and depressive disorders. For instance, more than half of people with Panic Disorder have also had Major Depressive Disorder.

Onset and Course

Panic Disorder and Agoraphobia most often begin between the late teens and mid-thirties. Social Phobia usually begins in the mid-teens, whereas many Specific Phobias begin in childhood.

Once Panic Disorder occurs, Agoraphobia can then occur at any point, although most often appearing in the first year if there are repeated panic attacks. Specific Phobias developing in childhood often clear up by themselves. However, Panic and Phobic Disorders in adult life tend not to resolve themselves. The longer the symptoms exist, the more effect they will have on a person's life and the harder it will be to effect change. Social

Phobia may appear to go away, but the problem is often still there. For instance, the person who fears dating may be fine after marriage, only to have the problem recur after the death or divorce of the spouse. In all anxiety disorders, there is a risk of substance abuse as a way of self-treating symptoms.

Treatment

Self-Help. People with panic and phobic symptoms are often very private and are ashamed about their symptoms, so they endure them in painful silence. They can be helped a good deal by the many books about these syndromes that reveal that they are far from alone in having such symptoms and can also inform them about seeking help. One such book is *Triumph over Fear* by Jerilyn Ross and Rosalynn Carter. There is also a video produced by the American Psychiatric Association titled *Anxiety Disorders: New Diagnostic Issues*. Often persons with Panic Disorder and Agoraphobia are helped a great deal by joining self-help groups of others with the same types of symptoms who carry out feared activities together. Persons with Social Phobia are sometimes helped by support groups such as Dale Carnegie and Toastmasters. The Anxiety Disorders Association of America is a major advocacy organization.

Professional Help. People with Anxiety Disorders require treatment from experts to help them grasp the nature of their symptoms, the personal causes for them, how to recover and how to prevent symptoms from coming back in the future. When panic symptoms are acute and impair normal activities, prescribed drugs may be necessary.

Section 2: Obsessive-Compulsive Disorder

Doctor: What is it she does now? Look how she rubs her hands.
Gentlewoman: It is an accustomed action with her, to seem thus washing her hands. I have known her to continue in this a quarter of an hour.
Lady Macbeth: Yet here's a spot . . . Out, damned spot! out I say! . . . What! will these hands ne'er be clean?

William Shakespeare, *Macbeth*, 1606

What Is the Definition?

The word *obsess* comes from the Latin *obsidere*, “to beset” and *compulsion* comes from the Latin *compulsus*, “to compel.” A person with Obsessive-Compulsive Disorder (OCD) is beset by unwanted thoughts or impulses and feels compelled to engage in repetitive actions that have no practical purpose. Many people dwell at times on upsetting thoughts and can have minor compulsive behaviors, but a diagnosis of OCD is not made unless obsessions and compulsions cause marked distress, take up a lot of time (more than one hour a day), or block daily routines such as school, work, or friendships.

What Are the Symptoms?

Common types of obsessions are intrusive worries about being touched by someone such as in shaking hands, possibly having hit someone while driving, or having left home without locking up. A person can have fearful impulses that are most often resisted, such as urges to curse loudly in front of others. There can be great concern that everything in the home must be in its own very special location. Compulsions involve repeated acts that cannot be resisted, such as hand washing, checking if doors are locked, and repeating prayers over and over for hours, acts that are carried on in order to reduce the extreme tension that builds up while trying to resist the urges. Children may not know when their worries don’t make sense, whereas adults do know and yet feel compelled to have the thoughts and acts anyway. People with OCD also frequently have other anxiety and depressive disorders.

Who Is Affected?

A nationwide survey found that 2 percent of the population had OCD at some point in 1990. OCD may occur more often in identical twins than in fraternal twins, and it occurs equally in males and females, except in childhood where boys show symptoms more often than girls. As for other Anxiety Disorders, there are complex causes for OCD involving temperament and life events.

Onset and Course

OCD can begin in childhood but usually starts in the teen or early adult years. Its onset is most often gradual.

Most people with OCD develop a chronic illness that tends to cycle from periods when they have many symptoms to times with only a few; the symptoms are usually brought on by stress. Without expert help and after long-term failure to resist the thoughts and urges, the person may give in to them, no longer struggling, ending in a lifestyle that makes him or her a lasting prisoner of the obsessions and compulsions. This can result in isolation from others and chronic job failure.

Treatment

Self-Help. In most cases, self-help is not very useful for people with OCD, although reading about the disorder and researching what is said about it on the Internet can help a person feel less alone and perhaps push him or her to seek expert help. A major advocacy organization is the Obsessive Compulsive Foundation. A video about the disorder, *Children with OCD*, can be obtained from the American Psychiatric Association.

Professional Help. People with OCD require psychotherapy and often drugs from experts skilled in treating the disorder. As in all the Anxiety Disorders, it can be very helpful to work with an expert to learn about the nature of the condition, the events in one's life that led to problems in self-esteem and in relationships with others, and the kinds of steps required to decrease the symptoms. With regard to drug treatment, certain antidepressants and related drugs have been found to be helpful for many people with this disorder.

Section 3: Posttraumatic Stress Disorder

Extreme fear can neither fight nor fly.
William Shakespeare, *The Rape of Lucrece*, 1593–94

What Is the Definition?

The word *stress* comes from the Latin *stringere*, which

means “to draw tight.” The word *trauma* is Greek, meaning “hurt or wound.” A person with Posttraumatic Stress Disorder (PTSD) has been “drawn tight” by severe stress symptoms as a result of being threatened with death or severe injury, or having witnessed another person being killed or threatened with death. To be given this diagnosis, the person must have major symptoms based on a trauma that caused extreme feelings of mortal fear or helplessness, with resulting problems in social, work, or other aspects of daily life.

What Are the Symptoms?

A person with PTSD has three types of symptoms. First, the trauma continues to recur in painful memories and dreams, with intense distress when exposed to something that reminds the individual of the event. Second, the person tries to avoid any thoughts, feelings, actions, places, or people that elicit such memories and may not even be able to recall key aspects of the trauma. There may be an associated loss of interests and a sensation of numbness about daily activities and events, along with a feeling of distance from other people, even to the extent of not being able to have feelings of affection for anyone. There may also be a sense of impending doom and an expectation of early death. Third, there are very troubling symptoms that can include poor sleep and concentration, feelings of crankiness and anger, and hypervigilance along with being easily startled. Children may become confused and agitated and may repeat the trauma in play, such as crashing toy cars when they have been in or seen a car crash.

Who Is Affected?

About one person in a hundred has this condition at some point during their lifetimes, and it occurs twice as often in females as in males. Some people can live through extreme traumas without developing PTSD, while others are very susceptible. It can occur in up to 30 percent of disaster victims. People who respond immediately to traumas by becoming numb or having strong avoidance symptoms are at higher risk for PTSD. It has been found that early life experiences can set the stage. Adult children of Holocaust survivors are more likely to develop PTSD after traumas, and one-third of persons with Borderline Personality Disorder also have PTSD (see chapter 15).

Onset and Course

PTSD can occur at any age. For children, sexual, physical, and emotional abuse can trigger PTSD, with or without clear threat of death or severe injury. Traumas that can be followed by PTSD include combat, rape, assault, domestic violence, kidnapping, torture, internment in a concentration camp, natural disasters, and life-threatening illness.

About half of those with PTSD recover within three months. Many others have symptoms that become chronic, sometimes resulting in joblessness or causing them to live almost as a hermit.

Treatment

Self-Help. A person who knows that he or she has PTSD can benefit from reading about the causes, symptoms, and paths to healing. It has been found that after a plane crash or other group disaster, survivors and involved parties can be helped by coming together and bonding. Bonding in supportive groups has also helped Vietnam and Gulf War veterans with PTSD. Powerful accounts of PTSD are found in Primo Levi's *Survival in Auschwitz: The Nazi Assault on Humanity* and William Styron's *Sophie's Choice*. The American Psychiatric Association has produced a video titled *Posttraumatic Stress Disorder*.

Professional Help. The sooner a person with PTSD symptoms seeks help from an expert, the more likely it is that the symptoms will last only a brief time. Psychotherapy is almost always necessary, beginning with crisis intervention immediately after traumas, along with group support. Many people experience great guilt about the deaths of others and must be given guidance right away. Vulnerable people with childhood histories of trauma and loss may require longer-term intensive psychotherapy. Acute symptoms may respond to drugs, chiefly antidepressants. Chronic PTSD that has lasted for many years is very hard to treat.

Section 4: Generalized Anxiety Disorder

> For as children tremble and fear everything in the blind darkness, so we in the light sometimes fear what is no more to be feared than the things children in the dark hold in terror and imagine will come true.

Lucretius [Titus Lucretius Carus], *De Rerum Natura*, 99–55 B.C.

What Is the Definition?

The word *anxious* comes from the Latin *angere*, which means "to torment." In Generalized Anxiety Disorder (GAD), the person is tormented by undue anxiety, worry, and foreboding that has been going on for at least six months and that he or she cannot control. Everyone at times feels anxiety, but the diagnosis of GAD is made only when symptoms cause considerable distress or seriously hinder work, social, or other key aspects of daily living.

What Are the Symptoms?

A person with GAD feels restless or very uneasy, tires easily, has trouble concentrating, and may lose track of his or her thoughts at times. There may be a feeling of crankiness as well. In addition, there are physical symptoms, such as tense, aching muscles and troubled sleep. This diagnosis is not made if the symptoms are part of some other disorder, such as panic states, phobias, or OCD.

Who Is Affected?

About 60 percent of people with this disorder are women, and there is a trend for family members to experience anxiety more often than in other families. About five of every one hundred people have had an episode of significant GAD in their lifetimes.

Onset and Course

Many people with GAD say that they have felt anxious and have been worriers all of their lives. In fact, about half of those with the disorder began to have definite symptoms in childhood or their teens. Children with GAD tend to be conforming, to have a need to be perfect, to be unsure of themselves, and to require extra approval and reassurance. GAD tends to become chronic if the person does not receive expert help.

A person who seems to have GAD must be asked about medical illness or drug abuse and may need a physical examination and laboratory testing, because illness as well as drugs may cause symptoms such as those of GAD.

Treatment

Self-Help. Persons with milder forms of GAD can often be helped by confiding in friends, getting comfort from them as well as good practical advice about their excessive worries. Reading about anxiety, and learning from books that they are far from alone in having such symptoms, can be quite reassuring. The character of Blanche DuBois in Tennessee Williams's *A Streetcar Named Desire* and the lead characters in Woody Allen's *Annie Hall* illustrate chronic anxiety and its effects.

Professional Help. Very often stress, abuse, and loss in childhood and the teen years, as well as other prior painful life events, are the background for a present-day vulnerability to stress; in such cases, people require professional help from experts. Since a person may be confused about the meaning of the prior life experiences, and may have even learned to blame himself or herself wrongly, it is necessary for the expert to have had thorough training and experience in detecting key aspects of a person's unique history and in helping the patient to understand them. With reassurance and self-knowledge, people can improve greatly and learn to deal successfully with stress in the future. In the case of severe symptoms, there are many antianxiety drugs that can be used temporarily, and because depression often occurs along with GAD, some patients may require both antianxiety and antidepressant drugs.

L. Park

Chapter 13
Impulse-Control Disorders

The word *impulse* comes from the Latin *impellere*, meaning “to impel” or “to drive.” People with Impulse-Control Disorders feel driven to performs acts that are harmful to themselves or to others. A sense of tension before the impulsive act often leads to relief or pleasure after the act is over. There may also be regret and guilt later. There are five major Impulse-Control Disorders.

Many people can have trouble with impulse control, but minor or rare impulsive acts are not considered a disorder. People with other mental disorders can also have problems with impulse control, but a diagnosis of the disorders discussed in this chapter is made only when the acts are not part of another mental condition.

Section 1: Intermittent Explosive Disorder

To whom can I speak today?
Gentleness has perished
And the violent man has come down on everyone.

Anonymous, *The Man Who Was Tired of Life* , ca. 1990 B.C.

What Is the Definition?

The word *explosive* comes from the Latin *explodere*, meaning “to drive out with a violent noise.” A person with Intermittent Explosive Disorder has a pattern of sudden acts during which he or she is driven by violent urges to assault or verbally threaten someone or to destroy property. These acts are much more severe than could be justified on the basis of any offense by the other person.

What Are the Symptoms?

A person with Intermittent Explosive Disorder will tend to have sudden rages at times when he or she feels stressed. There may be physical symptoms before the outbursts, such as palpitations and tightness in the chest. After an episode of rage, there may be feelings of tiredness and depression. Between such acts, this same person may show no sign of a problem, although some do show a frequently impulsive or hostile way of thinking. “Road rage” may sometimes belong under this heading.

Who Is Affected?

Intermittent Explosive Disorder is thought to be rare. It occurs more often in males than in females. In as many as 50 percent of people with this disorder, there are vague findings in neurological, brainwave, or psychological tests. There may be a record of head injury or seizures during fevers in childhood. It is not understood as yet how such findings might be related to the violent urges or the poor control of them.

Onset and Course

The onset of Intermittent Explosive Disorder can occur from childhood into the twenties, and the first observed act may occur without any warning.

Little is known about the disorder’s long-term course, but it may be that as a person reaches the fifties and older, these acts are less likely to occur. Explosive episodes can occur on a regular basis over many years or may occur only infrequently. As a result of the acts, people can lose jobs and friends, be divorced, have accidents, and receive injuries and jail terms.

Treatment

Self-Help. Violence is of increasing concern in our country and worldwide. There are many resources for helping people manage violent feelings, although Intermittent Explosive Disorder itself is so infrequent that there are no major organizations and few

readings directed to helping with this specific type of problem. Because of the recent violent tragedies in schools, there are accelerating efforts to develop methods for identifying and helping children and adolescents who have problems with anger and a potential for violence. Advocacy and support organizations include the Center for the Prevention of School Violence, the National Center for Injury Prevention and Control, the American Association of School Administrators, the American School Counselor Association, the National Education Association, and the National PTA. Many schools are developing successful programs for conflict resolution, emotional literacy, and peer counseling.

Professional Help. A person with this disorder is likely to be required by others to seek help. If the individual is violent, hospital treatment may be required. Careful study of the person's stress level, temperament, neurological symptoms, life events, and family and social life is important. Sometimes medications can help. Psychological education may help the person learn that the acts are not rational but rather are a sign of a disorder and need to be controlled.

Section 2: Kleptomania

> Adam was but human—this explains it all. He did not want the apple for the apple's sake, he wanted it only because it was forbidden.
>
> Mark Twain, *Pudd'nhead Wilson*, 1894

What Is the Definition?

Klepto- comes from the Greek *kleptein*, meaning "to steal," and *mania* comes from the Greek word meaning "madness." Kleptomania is a "stealing madness." The person with Kleptomania fails to resist the impulse to steal items that have no real use or value for him or her.

What Are the Symptoms?

Stolen items typically have little cash value, such as inexpensive pens, jewelry, or watches. Even wealthy people have been arrested for shoplifting cheap items. Most of the time, the thefts are not planned, and often there is not much effort to avoid being caught. Immediately after the act, there is pleasure or relief. Because persons with Kleptomania know that the acts are wrong and seem senseless, they may feel depressed and guilty later and may then fear being arrested.

Who Is Affected?

Kleptomania is quite rare and seems to be the case in less than 5 percent of detained shoplifters, most of them being females. The cause for the senseless acts of stealing is not known. It has been suggested that these acts are those of a child stealing as a substitute for love or to punish others by hurting themselves. There may be a childhood history of problems in the family.

Onset and Course

Acts of stealing may begin anywhere from childhood to adulthood. In one study the highest rate of stealing was twenty-seven times a month. People with Kleptomania may also have Mood Disorders, especially Major Depressive Disorder, as well as Anxiety Disorders and Eating Disorders. They may also have a pattern of compulsive buying.

Little is known about the course of Kleptomania. Three patterns have been described: brief episodes followed by long periods without such acts; long and intense periods of stealing; and courses without a clear pattern. Despite many arrests, the acts may persist, leading to heavy legal expenses, financial ruin, family breakup, and career damage.

Treatment

Self-Help. Kleptomania is not well understood. It is likely that people keep their problem secret, without anyone to talk to about it. Kleptomania has some similarities to addictions in that there is a compulsion and pleasure in the act of stealing. People are most likely to be motivated to seek help right after they are

caught stealing and the behavior is revealed to family and friends. Family insistence on some kind of counseling, if combined with emotional support, can be very helpful. Supportive organizations include Shoplifters Alternative and the National Curriculum and Training Institute.

Professional Help. People with this disorder are likely to get treatment only when required to by legal or other authority. Because there may be underlying mood disorders or other mental conditions, treatment of those conditions may help end the tension-reducing acts of stealing. The person is likely to benefit from the supportive empathy of an expert who helps him or her to understand and put into perspective a troubled childhood and personal life.

Section 3: Pyromania

> Tyger! Tyger! burning bright
> In the forests of the night.
>
> William Blake, "The Tyger," 1794

What Is the Definition?

Pyro- comes from the Greek for "fire," and *mania* comes from the Greek of the same word, meaning "madness." Pyromania is a "fire-setting madness." The basic feature of Pyromania is repeated acts of deliberate fire-setting. The person is excited with the thrill of fires and does not set them for profit, or because of anger, or for any specific purpose other than the urge to commit the act.

What Are the Symptoms?

Persons with Pyromania report tension or a sense of stimulation before starting fires. Because of their high interest in the topic of fire, they tend to watch fires, set off false alarms, and visit the firehouse, and may even become firefighters. They may plan in a careful manner before starting a fire, yet not care at all about harm to others or damage to property, and they may even enjoy such damage.

Who Is Affected?

The frequency of Pyromania is unknown but it seems to be

rare. It occurs much more often in males than in females, and more often in people who have had learning problems, Attention-Deficit Disorder, or poor social skills. It can also be associated with alcohol problems.

Onset and Course

Acts of fire-setting can be carried out by children and teens, with more than 40 percent of those arrested being under eighteen years old. However, the specific diagnosis of Pyromania can be made only rarely in these cases.

Because it is seen rarely, the usual course of Pyromania is not known. In fact, it is not known yet what the tie might be between fire-setting in childhood and in adulthood. It seems that people tend to set fires infrequently and may stop for long periods, but the long-term course is unknown. There are significant risks to this behavior, including criminal prosecution and incarceration, serious property damage, and deaths of firefighters and citizens.

Treatment

Self-Help. Because Pyromania is diagnosed only when there is fascination and excitement in fire-setting, the person is likely to be motivated for help only when he or she has been caught. The United States Fire Administration has compiled a great deal of information about the characteristics of people who set fires, which can provide useful advice for determining whether fire-setting is based on Pyromania or other motivations and what rehabilitative resources are available.

Professional Help. It is likely that most persons seeking help are forced to do so. With treatment, the great majority of children stop setting fires. Typical response of adults to expert help is not known, but it has been suggested that 70 percent or more cease fire-setting.

Section 4: Pathological Gambling

But I do guess mos peoples gonna lose.
John Berryman, *77 Dream Songs,* “Poem No. 1,” 1964

What Is the Definition?

Patho- comes from the Greek *pathos*, meaning "suffering." *Gamble* comes from the Old English *gamen*, meaning "fun." The basic feature of Pathological Gambling is habitual gambling acts that may start out as enjoyable but end up in suffering, playing havoc with one's personal, family, and work life. This urge to gamble is an addiction, in that the person acts from feelings rather than with the mental discipline and careful thought of a professional gambler. As a result, whereas the latter may often win, pathological gamblers invariably lose over time.

What Are the Symptoms?

Persons who have a Pathological Gambling disorder dwell almost all the time on gambling. Gambling tends to put them in an energized, excited state. They may lie about their gambling and may begin to steal as their losses increase. When trying to avoid gambling, they may become restless and moody.

Who Is Affected?

Pathological Gambling occurs in 1 to 3 percent of adults. Its frequency is increased in areas where gambling is more easily available. Pathological gambling and alcohol problems are more common in the parents of these persons. About one in three compulsive gamblers are females, who are more likely than males to be depressed and to gamble for relief.

Onset and Course

Pathological Gambling most often begins in the early teens in males but later in females. In most cases, there are several years of recreational gambling with more and more risk-taking over time. Pathological gamblers are often competitive, seek stimulation, and become bored when times are calm, and they may have shown signs of restlessness as children. They may be workaholics with an exaggerated need for approval. The urge to gamble often increases when under stress. They may develop medical problems linked to stress, such as high blood pressure and migraine headaches. There seems to be a high frequency of Major Depressive Disorder, and such persons may gamble as a way to relieve painful feelings.

The person may gamble on a regular basis or only at times,

but either way, the course is most often chronic, even though the person has often made multiple attempts to reduce or stop gambling behaviors. It is thought that Pathological Gambling is an addiction akin to alcoholism and that the courses of both conditions are similar, with risks of job loss, divorce, pauperization, unpaid debts, and even suicide. Teenage internet gambling is now becoming a serious problem.

Treatment

Self-Help. Gamblers Anonymous, Gam-Anon (for families and spouses), and Gam-a-Teen (for teenage children of gamblers) are available, and they are run much like Alcoholics Anonymous. Dropout rates can be high. The National Collegiate Athletic Association (NCAA) and Harvard Medical School Division on Addictions can provide information and advice about problems of student gambling. A video, *Compulsive Gambling: The Invisible Disease*, is available from the American Psychiatric Association.

Professional Help. When gamblers seek expert help, they are often very depressed. Twenty percent of pathological gamblers who seek treatment report having made suicide attempts. Psychological support, treatment of depression, and assistance in learning to understand the nature of their illness can be very helpful to those who stay in treatment. Hospitalization is sometimes required. As with alcoholism, it can be hard to keep the person motivated for abstinence. Long-term results of treatment efforts are likely to be about the same as for the treatment of alcoholism.

Section 5: Trichotillomania

I dream of Jeanie with the light brown hair,
Floating, like a vapor, on the soft summer air.
Stephen Collins Foster, “Jeanie with the Light Brown Hair,” 1854

What Is the Definition?

Trichotillo- comes from the Greek, meaning “hair pulling,” and *mania* comes from the Greek word for “madness.” Trichotillomania is “hair-pulling madness.” Trichotillomania involves repeated, compulsive pulling out of one’s hair, to the extent that hair loss can be seen by others. The person feels

tense before pulling out hair, especially when trying to resist the impulse, with a feeling of relief or even pleasure when the hair-pulling begins.

What Are the Symptoms?

Hair-pulling may occur on any part of the body but happens most often on the head, eyebrows, and eyelashes. People with Trichotillomania may try to conceal visible signs of hair loss and deny causing it. Episodes of hair-pulling may range from brief and irregular bouts to periods that last for many hours. Hair-pulling can increase with stress but can also occur when a person seems to be relaxed. People most often engage in hair-pulling when not being observed by others. There may be a preoccupation with looking at hairs that are pulled out, along with Trichophagia, that is, eating hair. Trichophagia may lead to hair balls, which can cause pain, vomiting, bleeding, and obstruction of the intestines. Some people feel the urge to pull hairs from other people, pets, and clothes such as sweaters. Nail biting and skin scratching may also occur.

Who Is Affected?

In children, hair-pulling occurs equally in females and males, but in adults it seems to be much more frequent among females. The disorder occurs in as many as 1 to 2 percent of the population. These individuals frequently have other disorders such as mood, anxiety, eating, and substance abuse disorders.

Onset and Course

Hair-pulling most often begins in childhood or the early teens. In children, bouts may be rather common, often occurring in the setting of family or other kinds of stress, and the behavior may clear up on its own, so the diagnosis of Trichotillomania is not made unless the hair-pulling lasts for many months.

Whereas hair-pulling often clears up in childhood, this habit can be chronic in adults, often involving diverse body areas. The behavior can come and go or can be continuous for many years. Risks include embarrassed social isolation, need for hairpieces or other modes of concealment, and even plastic surgery.

Treatment

Self-Help. There are a number of books about Trichotillomania, such as *Trichotillomania: A Guide* by James Jefferson and John Greist, as well as Internet sites and chat-rooms, such as the Trichotillomania Mailing List and "Go Ask Alice," produced by Columbia University. This disorder has characteristics of an Obsessive-Compulsive Disorder and information about it can be found through the Obsessive-Compulsive Foundation.

Professional Help. In the case of children, the pediatrician may look for signs of stress in the family and offer helpful suggestions that result in a better home setting, which may put an end to the hair-pulling. Psychotherapy may also be helpful for Trichotillomania. Most often, with proper professional treatment of the other disorders present, such as Mood and Anxiety Disorders, the hair-pulling stops or occurs much less often.

L. Park

Chapter 14
Adjustment Disorders

From winter, plague and pestilence, good Lord, deliver us!
Thomas Nashe, *Summer's Last Will and Testament*, 1600

What Is the Definition?

The word *adjustment* comes from the Latin *adiuxtare*, meaning "to put close to." A person with an Adjustment Disorder has symptoms that are "close to," that is, triggered by, specific events. To be certain that the symptoms are actually a reaction to these events or "stressors," the symptoms must start within three months after the stressor begins and disappear within six months after the stressor ends. The stressor must either trigger strong distress that is greater than one would normally expect or result in obvious harm to one's social or working patterns. This disorder fits into what is called a "residual" category, because the diagnosis is only made if the symptoms do not fit another disorder. Response to death of a loved one is not included ("Bereavement"—see chapter 16).

What Are the Symptoms?

There are five types of Adjustment Disorder grouped on the basis of predominant types of symptoms or behaviors: Adjustment Disorder With Depressed Mood, With Anxiety, With Mixed Anxiety and Depressed Mood, With Disturbance of Conduct, and With Mixed Disturbance of Emotions and Conduct. Disturbance of Conduct refers to acts such as reckless driving, fighting, damaging property, and refusing legal duties. There can be one or more stressors, such as loss of a job, separation and divorce, natural disaster, end of a romance, illness, retirement, and severe money crisis from stock market or other investment losses.

Who Is Affected?

The rate of occurrence of this disorder in the general population has not been determined, but it appears to be rather high. In a general hospital survey, it was found in 5 percent of patients admitted, and it is seen in 10 to 30 percent of patients in mental health offices and clinics. In the case of children and adolescents, Adjustment Disorder is seen in equal numbers of boys and girls, but in adults, it is seen twice as often in females.

Onset and Course

The onset of Adjustment Disorder tends to be rapid and with acute symptoms. Friends and others may notice a change in the person's mood as well as his or her work or study habits. Most often, an Adjustment Disorder is not long-lasting, since by definition, it must last no more than six months after the stressor is over. There can be a risk of substance abuse or even suicide. When additional symptoms occur as a result of a health problem, they may hinder recovery. There are many cases in which the stressor goes on for a long period of time, such as losing a job and being unemployed, chronic illness, or severe and lasting marital conflict. In such situations, symptoms may progress to another, more serious disorder, such as severe depression. Certain stressors can occur on a regular basis, such as for farmers living in climates with frequent floods or droughts. With natural disasters or group events, such as school shootings, a number of persons may have acute stress, but if severe symptoms are still present six months after the event has passed, then the condition may well be Posttraumatic Stress Disorder or Major Depressive Disorder (see chapters 5 and 6).

Treatment

Self-Help. Persons with Adjustment Disorders can help themselves by reaching out to their friends. If they are loners or feel they cannot talk about the symptoms or the stressor, their symptoms are likely to continue. If the person is part of a group of people hurt by the stressor, support and comfort may be available from many agencies, including the Emergency Services and Disaster Relief Branch of the Center for Mental Health Services (CMHS), the National Organization for Victim Assistance, Red Cross Disaster Services, and local social agencies and

religious support groups, as well as hot lines such as Project Pave, which offers counseling for adolescent victims of violence. See appendix B for recommended books.

Professional Help. Persons with this disorder can be helped greatly when they seek professional treatment from an expert. They almost always respond well to support and to help in understanding more clearly what happened and what they can do about it. In some cases, there may be intense, inappropriate feelings of responsibility and guilt regarding serious injuries and deaths, especially in situations such as natural disasters and shootings. These feelings require very attentive support, comforting, and monitoring. Medications may be prescribed if severe symptoms do not begin to clear up fairly promptly. Even persons who have been burdened with chronic stressors can usually be helped.

L. Park

Chapter 15
Personality Disorders

The root word of personality in Latin, *persona*, refers to a mask, used in ancient times by an actor to reveal a vital aspect of a story figure. It was the emblem of the character, how they were known to the audience. This chapter describes a series of such "masks," or perceived patterns, which are known to lead to impaired bonding with others. Because human beings live in a social world, such breakdowns can have a very harmful impact on love and work, and hence they are called disorders. Though it is only an aspect of the "self," it is not always easy for people to see that. The traits are not "put on," as an actor puts on a mask, but acquired over years from experiences and perhaps some inborn aspects of temperament. It is usually in place by the late teens or early adult life.

Section 5: Borderline Personality Disorder

I hate and I love. Why I do so, perhaps you ask.
I know not, but I feel it and I am in torment.
Gaius Valerius Catallus, *Carmina*, c. 54 B.C.

What Is the Definition?

Borderline means "on the border" or "on the edge." This word was first used to describe an illness with symptoms so severe and dramatic that such patients were thought to be quite close to or "on the border of" Schizophrenia. It has become clear, however, that they are neither close to nor do they become schizophrenic.

What Are the Symptoms?

Borderline Personality Disorder (BPD) is a severe, life-threatening illness that pervades most aspects of living, such as bonds to others, sense of self, mood, and conduct. Affected people tend to feel almost constant psychic pain, weighed down by self-hate and by intense, painful relationships, with longing for closeness and yet fear of trusting others, and they may make frantic efforts to avoid feared loss of the other. They often act on impulse, with results that may be harmful to them. They feel empty and depressed, sometimes with sudden cycles of severe depression and suicide attempts, and they may injure themselves as a way to reduce the psychic pain. They are often very unsure about who they are, what they value, and what they want in life. They can quickly become confused and enraged in stressful contacts with others, which can briefly progress to paranoid ideas and symptoms of dissociation (see chapter 9). At other times, they can be quite winsome, responsive to the needs of others, and even put up with abusive people.

Who Is Affected?

About 2 percent of the population has this disorder, with three out of four of those being females. Childhood histories most often reveal marked physical, sexual, and/or psychological abuse of these individuals who were often sensitive and even pliant as small children.

Onset and Course

Borderline Personality Disorder appears by the teen or early adult years. Since teens often have problems with sense of self and with relationships, care must be taken in making this diagnosis before adulthood.

Ten percent of borderline persons commit suicide, most often in the early years of their illness. In one major study, it was found that more than a third of women who had Borderline Personality Disorder along with marked depression and alcohol abuse committed suicide.

Many people have thought of those with this disorder as unreliable and not helped by treatment, making suicide threats and causing other crises, but follow-up studies have shown that over time with treatment, the great majority of them improve. By fifteen years after initial diagnosis, two-thirds of surviving patients are no longer borderline and are functioning normally or with only minimal symptoms.

Treatment

Self-Help. Persons with Borderline Personality Disorder often look for self-help resources, which are found in bookstores and on the Internet. They can be helped greatly by finding friends who can endure their distrust and sudden changes in mood. It is known that most people do recover, and also that they are often found, sometimes not until later, to be sensitive, intuitive, and creative. For books and other references, see appendix B.

Professional Help. People with this disorder often require both psychotherapy and medications from experts who are skilled in treating them. Skillful psychotherapy can help them through crises, provide them with steady support that promotes the growth of trust, and relieve their sense of great confusion and self-hate by helping them learn what happened to them in their early years. Although there is no specific drug treatment for the borderline disorder itself, such treatment is usually helpful for symptoms of psychic pain and distress, the most frequent and painful of which are those of depression. Patients may also require treatment for symptoms of other disorders, such as anxiety, phobic, posttraumatic, substance abuse, eating,

and panic disorders, as well as other personality disorders. Brief hospitalization may be required at times of extreme distress and suicidal intention.

L. Park

Section 7. Narcissistic Personality Disorder

> He was like a cock who thought the sun had risen to hear him crow.
>
> George Eliot, *Adam Bede*, 1859

What Is the Definition?

The word *narcissistic* comes from Narcissus, a handsome youth of Greek myth who pined away with love for his own reflection. A person with Narcissistic Personality Disorder is obsessed with an extreme need to be admired, has a very grandiose picture of himself or herself, and at the same time lacks feelings for others.

What Are the Symptoms?

People with Narcissistic Personality Disorder have a marked sense of self-importance that is not based on the facts. They believe they are special and should be admired by others, yet their self-esteem can often be shaken temporarily. They may have frequent daydreams about their talents, abilities, and great futures. They feel worthy of special notice by other people and can become very angry if it is absent. On the other hand, if things are going their way, they can often be quite charming. They tend to exploit people for what they want because they do not care to or cannot tune in to the feelings and needs of others.

They may also look down on people, and if someone has special qualities, even just being happy, they can quickly become envious. Any or all of these ways of being may be deliberately concealed so that a casual observer might see only the mask of an idealistic, driven, or highly responsible person.

Who Is Affected?

Less than 1 percent of the population has Narcissistic Personality Disorder, with apparently the majority being male. They may also have mood, eating, and substance abuse problems, as well as other personality disorders.

Onset and Course

Narcissistic Personality Disorder appears by the teens or early adult years. However, many teens who show these characteristics do not progress to the disorder as adults.

This disorder was once thought to be highly stable throughout a person's life course. However, a recent study found that there tends to be some improvement in a majority, although others don't change over time.

Treatment

Self-Help. Sometimes a person with Narcissistic Personality Disorder might have some sense that there is a problem with feeling special and may then try to learn to compensate. Many resources in literature reveal narcissistic characteristics, for example, several of Charles Dickens's characters, including Steerforth and his mother in *David Copperfield*.

Professional Help. People with this disorder believe that their ways of thinking are right, so they usually do not try to help

themselves unless they become depressed or get into trouble, for instance, with legal, job-related, financial, or marital problems. If they do look to others, quite often it is to get their way or to make others change without changing themselves. They can be helped by experts who are especially trained to look for signs of this disorder. For instance, such a person may seek help for depression resulting from failure to achieve unrealistic goals or failure to succeed in controlling others. The depression may respond to a supportive therapist who can be admiring of the person's engaging ways. However, unless the expert can detect the deeper mental outlook, the person may end up in better spirits but with the same troublesome attitudes that got him or her into difficulty in the first place.

L. Park