APPENDIX B

Descriptions of Selected Disorders

In this appendix, I give brief descriptions of the typical symptoms and course for those mental disorders that are relatively common and reasonably well studied. It is *always* important to rule out both substance use and general medical conditions as the cause, and to determine that the patient suffers distress or impaired functioning at work or school or getting along with other people.

Please remember that these paragraphs are meant to be descriptive, not diagnostic, of the various disorders. If you need criteria, see appropriate texts (or consult Dr. Google).

MOOD DISORDERS

Depression is an altered mood in which the patient feels abnormally low in spirits, sometimes melancholic. The patient experiences great distress, feels a loss of control over mood, and often has suicidal ideas. Depression can take a number of forms, each of which has been given a name—and sometimes several alternative names. These forms of depression are often overlapping, so that a given patient could actually be classifiable as belonging to more than one category. Here I give prominent features of the more important varieties of depression.

Major Depressive Disorder

- Major depressive disorder involves discrete episodes during which patients usually describe themselves as feeling depressed, though sometimes all they can identify is a feeling of irritability or a loss of enjoyment or interest in activities they usually like. In any case, there is a definite change from the patients' previous level of functioning.

- They also have a number of associated symptoms, including increased or decreased appetite, often with consequent gain or loss of weight; increased or decreased sleep; psychomotor speeding or slowing; fatigue or decreased energy; feelings of worthlessness or guilt; trouble concentrating; and thoughts of death, death wishes, and suicidal ideas.
- These symptoms may be mild, perhaps resulting in only minor inconvenience, though still enough that the patient feels distressed or experiences impaired functioning. When severe, depression can even involve psychosis—serious impairment, indeed.
- A major rule-out is depression due to medical disease or substance use.

Perhaps 25% of depressed patients also have episodes of mania or hypomania, in which case the diagnosis would be bipolar I or bipolar II disorder (see "Bipolar Disorders," below). With no history of mood upswings, a major depressive episode would be diagnosed as unipolar depression (major depressive disorder, either single episode or recurrent).

There's another problem here, one that diagnostic manuals don't do much to clarify. That's the fact that many depressed patients have other major disorders that ought to outrank the depression when it comes to treatment, yet don't. Here's an example: A patient with what I still prefer to call somatization disorder (see "Somatization Disorder," below) may very well also be depressed, and would at one time have been diagnosed with *secondary depression*. It's good to know about this sort of depression because, over the long term, it tends to respond poorly to physical methods such as drugs and electroconvulsive therapy. Another example would be a depression that dogs the heels of substance use.

Melancholia

Officially termed *major depressive episode with melancholic features*, the form of depression traditionally known as melancholia has sometimes been called *endogenous depression* because we cannot identify a precipitating stressor. These patients may have multiple episodes of depression from which they recover completely; they are likely to have relatives who have also suffered from depression.

- When ill, the patients take little pleasure from usual activities and may not cheer up when with people whose company they normally enjoy. They typically awaken early in the morning, well before it is time to arise—and, that's the time of day when they feel worst. Often they eat little; weight loss can be profound. They may demonstrate psychomotor slowing or speeding.
- They will admit that they feel worse than they have felt at the death of a spouse or other relative. They may have little insight into the fact that they are ill: Even if they have recovered completely from previous episodes, they may strenuously deny that recovery is a likely outcome.
- Partly due to feelings of profound guilt, they are at severe risk for suicide attempts; untreated, perhaps 15% ultimately kill themselves.

Atypical Depression

Patients with atypical depression have a major depressive episode—with a twist. Their symptoms are rather the opposite of what you expect from a typical, severe depression.

- Rather than insomnia, they tend to sleep too much (hypersomnia).
- Rather than having anorexia, they eat more than usual (for them) and may gain weight.
- If their mood varies during the day, it is one in which they feel better in the morning, worse at night.
- Depressed or not, these people tend to be especially sensitive to criticism.

Persistent Depressive Disorder (Dysthymia)

- Compared with episodes of major depression, dysthymia is less severe but lasts longer (at least 2 years). Some dysthymic patients seem depressed virtually lifelong.
- They have some of the same symptoms found in "basic" major depression and in melancholia, but the symptoms are fewer and less severe (they have neither psychotic symptoms nor suicidal ideas/behaviors). Although they typically remain able to work and to take care of themselves and their families, they don't much enjoy life. They seldom require hospitalization, unless a major depressive episode supervenes.
- As usual, there must be no question of causation by a general medical disorder or by substance use.

Bipolar Disorders

- The mania of bipolar I disorder usually begins suddenly, with euphoric or irritable mood that is accompanied by overactivity and excessive speech.
- Manic patients are easily distractible, need little sleep, and become involved in grandiose plans and schemes.
- As they become sicker, patients lose insight; judgment deteriorates. They say or do things they later regret, such as becoming sexually promiscuous, spending money they don't have, or making other problematic decisions.
- They may feel abnormally strong or powerful. Some become deluded that they have special powers or have a special religious purpose.
- Many drink excessively; perhaps they're trying to apply chemical brakes to their own behavior.

Most manic patients also have episodes of major depression, which may alternate regularly with the high phases in the pattern known as bipolar I disorder. Some bipolar patients don't have full-blown manias; their "rather highs" comprise somewhat attenuated symptoms that don't lead to psychosis or require hospitalization. This less-serious condition is termed bipolar II disorder. Even without treatment, both types of patients usually recover completely.

PSYCHOTIC DISORDERS

The Schizophrenias

Although schizophrenia is usually referred to as a single disease, in reality this category probably includes several different disorders. Some patients seem perfectly normal before the onset of the actual schizophrenia symptoms, but many spend childhood as introverted loners. Some qualify for a diagnosis of schizotypal personality disorder.

- There is usually a *prodrome* during which an individual may become interested in philosophy, religion, or witchcraft; anxiety or perplexity may be the predominant affect. Isolation may increase, and relatives or friends may note various behaviors that are peculiar, although not exactly psychotic.
- As preoccupation with inner feelings and experiences increases, the patient's functioning at work or school falls off. It may be only at this stage that relatives notice a change. Although orientation is usually retained, insight is typically lost, and judgment is severely impaired. Patients can lose impulse control and, when markedly agitated, sometimes become violent toward self or others.
- Active symptoms usually begin early in life—late teens or early 20s—and increase slowly, over a period of many months. Gradually the *hallucinations* (most often auditory) begin, becoming ever more insistent. *Delusions* (especially persecutory) usually develop. *Negative symptoms* (such as apathy or affect that is blunted, silly, or inconsequential) may appear. *Thought associations in speech* are often loose. Only a few patients develop *disordered behavior* such as catatonic symptoms. From these five classes of symptoms, you need two or more symptoms (and at least one of these must be delusions, hallucinations, or disordered thought/speech) to make the diagnosis.
- The disorder is chronic. A patient must be ill for at least 6 months to receive the diagnosis of schizophrenia in the first place. Then, though treatment with antipsychotic medicine can reduce or eliminate psychotic symptoms, few patients recover to their premorbid levels of functioning.

Patients with schizophrenia were formerly given subtype diagnoses: paranoid, catatonic, disorganized, undifferentiated, or residual. DSM-5 has done away with these divisions, partly because they don't remain constant in an individual. However, it is still sometimes useful to note that patients whose symptoms are pretty much limited to persecutory delusions and auditory hallucinations—which we used to call paranoid schizophrenia—often have affect that is well preserved and don't begin to have symptoms until they are in their 30s, or even beyond.

Warning: Schizophrenia today has carefully delineated symptoms, so be careful not to overdiagnose it. Until a few years ago it was common to see patients with severe depression, mania, personality disorders, or neurocognitive disorders misdiagnosed as having schizophrenia. Even today, it still sometimes happens. Patients who for many years have carried the diagnosis of schizophrenia should

be periodically reassessed. Be especially on the lookout for situations were psychotic symptoms are only present when the patient is experiencing a depressive or manic episode: Such a patient should *not* receive a diagnosis of schizophrenia.

Schizoaffective Disorder

The confusing diagnosis of schizoaffective disorder was introduced in 1933 by Jacob Kasanin, a well-meaning doctor who used it to describe nine patients who had both psychotic and mood symptoms. Because this description could fit so many people (patients with schizophrenia often feel depressed at some time or other), the term took off. In the intervening 80+ years, it has only grown more popular. Now it is used loosely by some clinicians, and very loosely by others: A few years ago, one psychiatrist famously wrote that he gave this diagnosis to most of his patients! Historically, however, the concept is important, in that it helped us understand that not all psychosis is schizophrenia.

- Patients with schizoaffective disorder simultaneously have two of the five major psychotic features of schizophrenia (as above, delusions, hallucinations, disordered thinking/speech, disorganized behavior, and negative symptoms) and *also* have a major depressive or manic episode (or a mood episode with mixed features) during most of the episode.
- For at least 2 weeks, the individual must have had delusions or hallucinations without prominent mood symptoms. You can specify a subtype—bipolar or depressive.

In recent years, numerous reviews have failed to substantiate schizoaffective disorder as a separate, discrete diagnosis. (Indeed, few of Kasanin's original patients would qualify by today's standards.) Both the interrater reliability and diagnostic stability for schizoaffective disorder appear to be low.

Schizophreniform Disorder

No difficulties with criteria present themselves with schizophreniform disorder. That's because this term is really just a place holder—an acknowledgment that a clinician isn't sure enough to make a definitive diagnosis.

- Schizophreniform disorder is defined exactly like schizophrenia, except that its total duration must be less than 6 months. This time frame reflects the findings from study after study that patients who have had psychotic symptoms for briefer periods of time may recover completely.
- Once 6 months have passed, a patient must be rediagnosed. If the symptoms persist, you will probably diagnose actual schizophrenia. If they have remitted, you may change the diagnosis to something different, such as a mood disorder with psychosis or a psychosis caused by a medical illness or by substance use.

If we do use the diagnosis of schizophreniform disorder, we are encouraged to assign prognosis, based on several factors. A patient will be relatively likely to

recover (that is, likely not to progress to a chronic course of illness) if any two of the following features are present: (1) Actual psychotic symptoms begin within 4 weeks of the first observable change in the patient's functioning or behavior. (2) When most psychotic, the patient seems baffled or confused. (3) Job and social functioning were good before the illness. (4) Affect is not constricted.

Delusional Disorder

- Patients with delusional disorder have delusions that are not bizarre (that is, the delusions are *not* impossible, such as being abducted by aliens). However, delusions are the only symptoms they typically have, so they don't qualify for other psychotic diagnoses such as schizophrenia (except that hallucinations of touch or smell may be present if they are related to the theme of the delusions).
- Once this illness develops, it tends to be chronic.
- There is good preservation of mood and ability to communicate; if employed, these people remain able to work. They do have trouble in the social sphere, however, and members of their families often instigate the referral for treatment.

Several types of delusional disorder have been described, based on the nature of the delusions themselves:

Erotomanic. Someone (often one who is famous or of high social station) is in love with the patient. These patients sometimes make the news for following or otherwise harassing public figures.

Grandiose. These people believe that they have some special ability or insight. Some claim to have invented something of great value, and so may haunt government agencies (patent office, police) in pursuit of their plans.

Persecutory. The patient (or a close associate) is being intentionally cheated, drugged, followed, slandered, or otherwise mistreated.

Jealousy. Most often, these individuals believe that a spouse is being unfaithful; a patient may follow a spouse or confront a supposed lover.

Somatic. These patients often seek medical help, convinced that they have a foul body odor, parasites, or infestation of insects on or under the skin, or that some body part is misshapen.

Mixed. The patient has two or more of the themes above in roughly equal portions.

Unspecified.

Psychotic Disorder Due to Substance/Medication Use or to Another Medical Condition

The category of substance/medication-induced psychotic disorder includes all psychoses caused by substances, including prescription medications. The predominant symptoms (hallucinations or delusions) can occur during withdrawal

or acute intoxication, depending on the substance. The course is usually brief and self-limited.

Classic examples of this disorder are alcoholic auditory hallucinosis and the delusional state that sometimes accompanies chronic amphetamine use. The psychotic symptoms may be indistinguishable from those of paranoid schizophrenia. Marijuana, cocaine, inhalants, opioids, phencyclidine and other hallucinogens, and sedatives/hypnotics have also been implicated in these conditions. Be careful not to make this diagnosis if the patient is having an acute delirium.

For medical conditions, the drill is much the same. A great variety of medical illnesses can produce a substantial variety of psychotic symptoms, including a full spectrum of delusions and hallucinations, as well as abnormalities of movement (such as catatonic symptoms) and negative symptoms.

By the way, similar categories (and arguments) hold for mood and anxiety disorders.

SUBSTANCE-RELATED DISORDERS

The terminology keeps changing, but the disorders themselves remain the same: alcohol and drug misuse. The 21st century presents an ever-widening variety of substances that can lead to a form of dependence DSM-5 now calls substance use disorder.

Identification of this dependence is based on the presence of some of these behaviors: tolerance to the drug (the drug has less effect with continued use, or the person must use more of it to achieve the same effect); withdrawal symptoms when the dose is decreased; using more than intended; unsuccessful attempts to control usage; spending much time obtaining or using the substance; reducing important activities because of substance use; failing to follow through on important obligations at work/school or home (such as repeated absences, neglect of children or house, or poor work performances); ongoing use despite knowing that the substance has probably caused physical or psychological problems; use of the substance even when it is physically dangerous to do so (such as driving a car); continuing to use the substance despite knowing that it has caused or worsened social or relationship problems (fights, arguments); and, finally, one nonbehavioral criterion (the person craves the substance or strongly wants to use it).

NEUROCOGNITIVE DISORDERS

Neurocognitive disorders are behavioral or psychological abnormalities that are associated with temporary or permanent brain dysfunctions. The cause can be an abnormality of brain structure, chemistry, or physiology, but the exact etiology isn't always known. Impairment can occur in any of four main areas: intellectual functioning, judgment, memory, and orientation. Some patients also have associated abnormalities of impulse control or mood. The neurocognitive disorders have traditionally been broadly categorized as either delirium or dementia; dementia is now classified in DSM-5 as major neurocognitive disorder.

Delirium

Delirium usually begins acutely, usually caused by something that occurs outside the brain. It tends to fluctuate in intensity and is usually short-lived, resolving once the underlying condition has been relieved.

- Patients cannot focus or maintain attention and are often easily distractible. Their thought processes slow down; they have trouble solving problems and reasoning.
- There is also an alteration in thinking, such as problems with orientation, use of language, executive functioning, memory, learning, or perception (hallucinations). Hallucinations may confuse patients so that they cannot tell whether they are dreaming or awake. They may accept the hallucinations as reality, thereby experiencing anxiety or fear; sometimes they attempt to run away.
- The causes of delirium include endocrine disorders, infection, brain tumor, cessation of alcohol intake, drug toxicity, vitamin deficiency, fever, seizures, liver or kidney disease, poisons, and the effects of surgical operations. Multiple causes may contribute to a single episode.
- The symptoms develop rapidly and tend to worsen at night—a phenomenon called *sundowning*. Later recall for the symptoms may be spotty or nil.

Dementia

Patients with DSM-5 major neurocognitive disorder (or dementia, as I'll usually continue to call it for the sake of brevity) show loss of ability to think and to remember that is severe enough to interfere with work and social life. Dementia can be transient, but more often it persists and progresses, frequently to the point that the patient shows impaired judgment and abstract thinking. Severely demented patients may not recognize family members; they can even become lost in their own homes. Failure of judgment and impulse control can lead to loss of the social graces, as shown by making crude jokes or by ignoring personal hygiene. Ability to use language is usually spared until late in the disease.

The major features of dementia include the following:

- Clinician, informant, and/or patient worry that the patient's cognition has declined from a previous level of performance.
- Standard neurocognitive testing (or an equivalent clinical evaluation) reveals that the patient's performance is more than 2 standard deviations below norms (for major neurocognitive disorder) or 1–2 standard deviations below (for what DSM-5 now calls mild neurocognitive disorder).
- The symptoms limit the patient's independence (for major neurocognitive disorder) or don't (in mild neurocognitive disorder, the patient can compensate with effort).
- The symptoms aren't better explained by a different major mental disorder, and they don't occur only with delirium.

Onset of dementia is usually insidious, and the misconceptions (hallucinations or illusions) so common in delirium are often absent, especially early in

the process. Usually an organic cause can be identified. Causes include primary diseases of the central nervous system, such as Alzheimer's disease, Huntington's disease, multiple sclerosis, and Parkinson's disease; infectious diseases, such as neurosyphilis and HIV/AIDS; vitamin deficiencies; tumors; trauma; and various diseases of liver, lungs, and the endocrine and cardiovascular systems. A few causes (subdural hematoma, normal-pressure hydrocephalus, hypothyroidism) can be successfully treated, leading to full recovery from the dementia symptoms. Dementias are found mainly in older patients, and the course is usually one of chronic deterioration.

A type of dementia that formerly carried its own DSM designation is amnestic disorder, in which patients rather suddenly lose short-term memory, sometimes to the extent that they cannot recall events that took place scant minutes earlier. Remote memory is usually less involved. Many patients confabulate information spontaneously or in response to prompting ("Didn't I see you in the bar last night?"). Recovery can occur, although chronicity is more the rule.

ANXIETY DISORDERS

Warning: Many mentally ill patients have anxiety symptoms as a part of their overall complaints. It is important not to let anxiety symptoms, which may be presenting complaints of many patients, obscure other diagnoses that may be even more important for diagnosis and treatment. In this regard, be especially alert for the presence of depressive syndromes and substance-related disorders.

Generalized Anxiety Disorder

- Patients with generalized anxiety disorder worry unreasonably about *multiple* life circumstances, such as money, family, health, and problems in school or on the job.
- As a result, they have symptoms of anxiety such as feeling restless or edgy, tiring easily, trouble concentrating, irritability, increased muscle tension, and trouble with sleep.
- Because they feel this way most days, they will procrastinate or otherwise avoid situations where they might have these feelings.

Generalized anxiety disorder usually starts in early adulthood; women outnumber men about 2:1. It's encountered especially among patients of internists and general practitioners. Some authorities believe that it may affect 5% of the general population; others hold that it is often misdiagnosed instead of a different anxiety or other disorder.

Panic Attack and Panic Disorder

- The patient experiences discrete episodes of anxiety or fear that begin suddenly and reach their height within minutes. (Just before such an episode, the person could be either calm or anxious.)
- During an attack the patient experiences several typical symptoms, such

as chest pain, hot flashes or chills, choking sensations, feeling unreal or detached from self, dizziness, fear of impending death, fear of "losing my mind," heart pounding or racing or skipping beats, nausea, tingling/numbness (usually of fingers), excessive perspiration, shortness of breath, and trembling.
- When unexpected panic attacks occur repeatedly and the patient is afraid of further attacks or tries to forestall them, we say that the patient has panic disorder.

Panic disorder affects perhaps 2% of all adults; it has a strong genetic component and may be somewhat more common in women than in men. Although it can start at any age, it usually develops in young adults. It is often associated with agoraphobia.

Note that panic symptoms can occur in the course of other disorders—including not only most anxiety disorders, but also substance intoxication, posttraumatic stress disorder, and obsessive–compulsive disorder, among others.

Agoraphobia

Agoraphobia originally meant "fear of the marketplace," but it now comprises fears of being in any place or situation where it might be hard to escape or to get help.

- The patient thus might avoid leaving home, markets, shops, open places, public transportation, theaters—even standing in a line or crowd.
- For 6 months or more, the patient therefore avoids the feared situations or needs a companion or suffers discomfort when confronting them.

Agoraphobia affects relatively few of us (perhaps 1 in 200 adults), women more often than men. It typically starts early in life following a panic attack or a traumatic event. Most patients with agoraphobia also have panic attacks; however, the two diagnoses can be made independently.

OBSESSIVE–COMPULSIVE DISORDER

Obsessive–compulsive disorder is a well-studied illness that begins in the teens or 20s and often persists lifelong.

- These patients have obsessions or compulsions (or both) that come unbidden into awareness, accompanied by anxiety or dread.
- Patients invest a lot of time and effort in these distressing ideas or behaviors, which seem foreign (ego-alien), silly, or irrational to them.

Usually there is insight that these ideas are products of the patient's own mind, but occasionally it can be completely absent. The main compulsive patterns include handwashing, cleaning, and compulsive checking to be sure that some action (such as turning off the stove) has in fact been accomplished. The patient feels driven to

complete these actions, which are geared toward reducing anxiety. Symptoms of depression are common. In some patients, there is a tie-in to lifelong tics.

POSTTRAUMATIC STRESS DISORDER

Posttraumatic stress disorder is a modern diagnosis comprising what was once called *shellshock* or *combat fatigue* in soldiers. It is a common sequel for anyone who has experienced rape, combat, or any other major naturally occurring or human-made calamity (earthquakes, airplane crashes) that involves actual or threatened death or injury. (The experience can be vicarious if it occurs to a close friend or relative.)

For at least a month the patient:

- Relives the traumatic event through intrusive dreams or waking thoughts.
- Avoids reminders of the event.
- Experiences negative emotions ("no future," self-blame) and altered cognitions (such as amnesia).
- Endures symptoms of hyperarousal (hypervigilance, increased startle response).

It may take weeks or years to develop symptoms, which often fluctuate over time. Severity is usually proportional to the intensity of the traumatic event. The condition is more likely to occur in children, elderly persons, and those who are socially isolated.

ANOREXIA NERVOSA

- Patients with anorexia nervosa feel that they are overweight when they are not. Even when emaciated, they perceive themselves as overweight and fear becoming fat.
- They severely limit food intake, sometimes to the point of malnutrition and (in females) the cessation of normal menses.

Patients may abuse diuretics and laxatives; some vomit to maintain low weight. Severe symptoms can lead to death. This disorder is relatively common (up to 0.5%) among young females, but occurs only about one-tenth as often in males.

SOMATIZATION DISORDER

Affecting perhaps 1% of adult women (rare in men), somatization disorder is characterized by multiple somatic complaints. Suspect it in anyone who presents a complicated or vague history; responds poorly to treatment; is dramatic, demanding, or seductive; has a family history of personality disorder; was abused sexually as a child; misuses substances; or has depression with unusual features. Many of these patients attempt suicide. This diagnosis is often overlooked even by mental health professionals.

The exact nomenclature and diagnostic criteria for this disorder have changed markedly over the past 50–60 years. In the middle of the 20th century, criteria were devised to clearly identify what was then called *Briquet's syndrome*, and to differentiate it from the hoary diagnosis of *hysteria*, which basically depended on only one criterion: that the person have a symptom apparently not due to any organic disease state. Beginning in DSM-III and continuing through DSM-III-R, DSM-IV, and DSM-IV-TR, criteria for somatization disorder spelled out sets of physical symptoms, of which certain numbers and distributions were required for diagnosis. These symptom lists were long and somewhat clumsy to use, and the suspicion that they were widely ignored by clinicians helped fuel the steady reduction in the minimum number of required symptoms.

However, DSM-5 has now stepped back to a point where patients can be diagnosed with the most recent iteration—now termed somatic symptom disorder—if they have basically a single physical symptom. It must last at least 6 months, and there must be evidence of inordinate ongoing health concern; even so, one symptom will do the job. I am deeply concerned that this retrograde step will reduce our understanding of a group of patients who have been misdiagnosed and incorrectly treated throughout the history of medicine. Nonetheless, here are the characteristics of DSM-5 somatic symptom disorder.

- For 6 months or more, at least one somatic symptom has caused distress or disruption of daily life.
- As a result, the patient has continuing high anxiety about health concerns.
- *With predominant pain* can be added as a specifier if the patient's presenting problem is mainly complaint of pain. (DSM-IV considered this a separate diagnosis and called it pain disorder.)

As a counterpoint, I've appended below the original criteria for Briquet's syndrome. It allowed diagnosis of patients who had mental/emotional symptoms as well as physical ones, and helped differentiate those with depression who might be less amenable to medical treatment from those who might benefit from drugs or electroconvulsive therapy. Furthermore, in the "Physical Complaints" section of the Appendix D structured interview (p. 338), I've used the DSM-IV criteria for somatization disorder—the disorder name I have generally chosen to use in this book. Consistency hasn't been the hallmark of mental health diagnosis over the years, so "you pays your money and takes your choice."

Briquet's Syndrome

- Beginning by age 30, the patient is chronically or recurrently ill with a dramatic, vague, or complicated medical history.
- The patient must report at least 25 medically unexplained symptoms (20–24 for a "probable" diagnosis) in 9 or 10 of the following categories:

    1. Headaches; being sickly for majority of life
    2. Blindness, paralysis, anesthesia, aphonia, fits or convulsions, unconsciousness, amnesia, deafness, hallucinations, urinary retention, trouble walking, other unexplained "neurological" symptoms

3. Fatigue, lump in throat, fainting spells, visual blurring, weakness, dysuria
4. Breathing difficulty, palpitations, anxiety attacks, chest pain, dizziness
5. Anorexia, weight loss, marked fluctuations in weight, nausea, abdominal bloating, food intolerances, diarrhea, constipation
6. Abdominal pain, vomiting
7. Dysmenorrhea, menstrual irregularity, amenorrhea, excessive menstrual bleeding
8. Sexual indifference, frigidity, dyspareunia, other sexual difficulties; vomiting all 9 months of pregnancy at least once, or hospitalization for hyperemesis gravidarum
9. Back pain, joint pain, extremity pain; burning pains of sexual organs, mouth, or rectum; other bodily pains
10. Nervousness, fears, depressed feelings; need to quit working or inability to carry on regular duties because of feeling sick; crying easily, feeling life is hopeless, thinking a good deal about dying, wanting to die, thinking about suicide, suicide attempts

PERSONALITY DISORDERS

DSM-5 lists 10 personality disorders that are defined well enough to achieve formal recognition. For 6 of them, studies have been robust enough to have a decent level of validity. I've characterized them below. In each of these personality disorders, the attitudes and behaviors are present from early adult life (sometimes much earlier) and are experienced in a variety of situations.

Schizotypal Personality Disorder

Magical thinking, ideas of reference, illusions or other unusual perceptions, and sometimes unusual mannerisms or clothing can make patients with schizotypal personality disorder seem quite odd. They may mistrust other people's intentions, leaving them isolated and anxious or otherwise uncomfortable with ordinary social relationships. Though some do marry, they typically doubt the loyalty of others and have few close friends. Their thinking may be dominated by suspicions and superstitions, which are expressed with restricted affect and speech that is vague, digressive, or excessively abstract.

Many patients with schizotypal personality disorder are depressed when they first come to clinical attention. Under stress, patients may become briefly psychotic; some eventually develop schizophrenia, a diagnosis that is more frequent in their relatives than in the general population.

This disorder occurs in up to 3% of the general population.

Antisocial Personality Disorder

Although patients with antisocial personality disorder often seem charming personally, from youth (generally beginning before age 15) they cannot follow

society's rules. Their relationships with others are characterized by exploitation rather than by mutual intimacy. These people may glibly claim to have guilt feelings, but empathy and genuine remorse aren't in evidence.

Their sense of self derives from exerting power over others or from personal pleasure or material gain; the result is callous and irresponsible behavior that affects nearly every life area. There may be substance use, fighting, lying, and dishonest (often criminal) behavior of any conceivable sort: theft, violence, confidence schemes, and child/spouse abuse. Much of their aberrant behavior is impulsive, often without real need or consideration of the possible consequences for the risk they take. Although they may complain of multiple somatic problems and will occasionally make suicide attempts, the manipulative nature of all their interactions with others makes it difficult to decide whether their complaints are genuine.

Two warnings for this one: Although patients with antisocial personality disorder often have a childhood marked by incorrigibility, delinquency, and school problems such as truancy, fewer than half of all children with this sort of background eventually develop the full adult syndrome. Therefore, this personality disorder should never be diagnosed before age 18. It is also important not to diagnose it if antisocial behavior occurs only in the context of substance use.

Borderline Personality Disorder

Patients with borderline personality disorder often appear to be in a crisis of mood (depression, anxiety, or fear), behavior, or interpersonal relationships. Feeling empty and bored, they will attach themselves strongly to others. This doesn't work so well: Inevitably they fear they are being ignored or mistreated (or fear abandonment) by those upon whom they feel dependent, and so become intensely angry or hostile. They may impulsively try to harm or mutilate themselves. Other rash actions may form a pattern of risk taking or of too-frequent, too-extreme shifts from one life goal to another.

Although unusually sensitive to possible insults toward themselves, these patients may remain oblivious to the feelings and needs of others. Indeed, they are likely to emphasize other people's faults. Regard for another person may be idealized at one time, devalued at another, resulting in alternating enmeshment and withdrawal.

Patients with borderline personality disorder tend to be markedly self-critical, sometimes to the point of dissociating when under extreme duress. However, any dissociative or psychotic episodes resolve so quickly that they are seldom confused with the endogenous psychoses. Intense, rapid mood swings, impassivity, and unstable interpersonal relationships make it difficult for these people to achieve their full potential socially, at work, or in school.

More common in women than in men (perhaps by a 3:1 ratio), this personality disorder is identified in as much as 2% of the general population and in 10–20% of mental health patients.

Warning: In my opinion, clinicians too often content themselves with a diagnosis of borderline personality disorder when patients have other disorders that require more urgent treatment. In the 21st century, it may still be the condition we most often overdiagnose.

Obsessive–Compulsive Personality Disorder

Patients with obsessive–compulsive personality disorder have a lifelong tendency to be rigid and perfectionistic. Insistence on a flawless product yields one that is never completed; as Voltaire wrote, "The perfect becomes the enemy of the good." Preoccupation with detail, order, adherence to rules, and insistence that things be done their way interfere with their effectiveness in work or social situations. They will try to push past failure long after most people would have judged the effort futile. High, often unreasonable standards (scrupulosity) create difficulty attaining goals or completing tasks. Work trumps relationships—their identity tends to be in their work, which they prefer to leisure or social activities. Stubborn rigidity also damages relationships with other people, whose feelings and ideas they have difficulty understanding.

Patients with obsessive–compulsive personality disorder may have trouble expressing affection; often they seem quite depressed. Though these moods may wax and wane, they can sometimes become severe enough to drive patients to treatment. Men are twice as often affected as women; perhaps 1 in 100 are affected in the general population.

Narcissistic Personality Disorder

People with narcissistic personality disorder have a lifelong pattern of grandiosity (in behavior and in fantasy), thirst for admiration, and efforts to attract the attention of others. With the conviction that they are more than usually special, even superior to others, they are self-centered individuals who commonly exaggerate their own accomplishments.

Despite a sometimes condescending attitude of entitlement, individuals with this personality disorder have fragile self-esteem and often feel unworthy. Even at times of great personal success (many are talented), they may feel fraudulent or undeserving. Motivated as they are by the desire for approval, they remain overly sensitive to what others think about them and may feel compelled to extract compliments. When criticized, they may cover their distress with a façade of icy indifference. As sensitive as they are about their own feelings, they have little apparent understanding of the feelings and needs of others and may feign empathy, just as they may lie to cover their own faults.

People with narcissistic personality disorder often fantasize about wild success and envy those who have achieved it. Relationships may be formed on the basis of who can help them achieve their goals, who will stoke their egos. Their job performance can suffer (due to interpersonal problems) or can be enhanced (due to their eternal drive for success).

This personality disorder is more common in males than in females; it is identified in less than 1% of the general population. (Note that narcissistic traits don't necessarily imply ultimate personality disorder in children and teenagers, who are normally self-centered.)

Avoidant Personality Disorder

People with avoidant personality disorder feel inadequate or personally unappealing and are socially inhibited. Judging themselves inferior, they are often hypersensitive to criticism and rejection.

Anxiety and worry about disapproval or some other calamity makes these people self-effacing and eager to please others, but it can usher in marked social isolation. They may misinterpret innocent comments as critical; often they will refuse to begin a relationship unless they are sure they will be accepted. They hang back in social situations for fear of saying something foolish, and will avoid goals (even occupations) that involve personal risk or social demands. Other than close relatives, they tend to have few intimate friends. Comfortable with routine, they may go to great lengths to stay in a rut. In an interview, as in social situations, they may feel tense and anxious; they may misinterpret even benign statements as criticism.

When they do engage in activities, they often don't seem to show much interest or enjoyment. Although many such people work and marry, they may become depressed or anxious if they lose their support systems.

Avoidant personality disorder probably occurs in just under 1% of the general population, sometimes associated with a disfiguring illness or condition; it is found about as often in men as in women. This personality disorder is not often seen by itself clinically; these patients tend to come for evaluation only when another illness appears. (Avoidant traits are common in children and don't necessarily imply later personality disorder.)