unlikely that superior performance of medication combinations was attributable to mirtazapine alone, although without a pure placebo control, we cannot be sure that mirtazapine alone was effective. Definite and conclusive evidence for this treatment strategy will obviously have to come from larger trials carried out in more than one center with these or other medications. Thus, as reflected in the article as well as the accompanying editorial, much work is still needed to establish whether, which, and for which patients antidepressant combinations are more effective than monotherapy.

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Dr. Blier's disclosures accompany the original article. Dr. Rush's disclosures accompany the original editorial.

This letter (doi: 10.1176/appi.ajp.2010.10030453r) was accepted for publication in May 2010.

The Difficulty of Making a Sole Diagnosis of Antisocial Personality Disorder

TO THE EDITOR: Several actions and recommendations made by Daniel Antonius, Ph.D., et al. (1) in their Clinical Case Conference, published in the March 2010 issue of the *Journal*, are laudable. Much of the case conference was focused on assessing and treating assaultive behavior in patients with antisocial personality disorder comorbid with an axis I major mental illness. The authors' assertion that "Mr. J" had a major mental illness, however, appears to be erroneous. They stated, "In the case of Mr. J, the presence of an axis I diagnosis of mental illness is relatively obvious (1, p. 255). This statement was confusing in light of the lack of substantiation for an axis I disorder in the clinical vignette. The symptoms Dr. Antonius et al. cited for an axis I disorder were self-injurious behavior, mood lability, "hopelessness about the future, and reported insomnia due to nightmares, which [the patient] attributed to a previously undisclosed sexual assault that occurred during a past incarceration" (1, p. 254). The patient was given the axis I diagnosis of mood disorder not otherwise specified in addition to antisocial personality disorder. However, DSM-IV-TR criteria for antisocial personality disorder include impulsivity, irritability, and disregard for the safety of self or others, which would explain the mood lability and self-injurious behavior (2). It is unclear why an additional diagnosis of mood disorder not otherwise specified was made.

The authors appear to have been basing much of their diagnosis of an axis I disorder on the isolated symptoms of mood lability, self-injurious behavior (including suicide attempts), and hopelessness. To the extent that hopelessness may be related to a depressive affect, it has been shown in certain samples of youth with antisocial behavior that gang involvement is associated with negative affect but not major depressive disorder (3). The patient's history of suicidal behavior is consistent with studies that have shown an increased rate of suicidal behavior in individuals with antisocial personality disorder comorbid with substance abuse, and Mr. J had a history of cannabis and alcohol abuse (4). This leaves "insomnia due to nightmares," an isolated posttraumatic stress disorder symptom, as the only symptom not accounted for by antisocial personality disorder. This isolated symptom, however, would not qualify for an axis I psychiatric disorder, including anxiety disorder not otherwise specified, because of the lack of "prominent anxiety or phobic avoidance" that is a requirement for the diagnosis. (2).

With the increased number of forensic psychiatric hospital admissions over the past several years, it is important that psychiatrists make accurate diagnoses in this population. Although quite difficult, being able to make the diagnosis of antisocial personality disorder in the absence of comorbid mental illness and then making an appropriate disposition that does not include psychiatric hospitalization is crucial in preventing the victimization of those with severe mental illnesses.

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The author reports no financial relationships with commercial interests.

This letter (doi: 10.1176/appi.ajp.2010.10030394) was accepted for publication in June 2010.

Reply to Freeman Letter

TO THE EDITOR: We appreciate Dr. Freeman's insightful comments on our case conference. Our assertion that this was an "obvious" case of an axis I disorder may not have been that obvious after all. The patient described in the case presented with a myriad of past diagnoses and had previously been prescribed a variety of antipsychotics and other medications. However, during the hospital course, many of the symptoms exhibited by the patient could potentially, as eloquently pointed out by Dr. Freeman, be attributed to a diagnosis of antisocial personality disorder. Somewhat unclear in this clinical picture are the effects of medications. It is possible that pharmacological treatment may have reduced the psychiatric symptoms, but not the antisocial behavior (1), which continued to be in full display on the unit. Additional information from records from other hospitals to thoroughly examine the patient's life course of psychiatric issues and antisocial be-