Jamie Kleinman, PhD
Summer Book Club

Discussion Questions for *Sharp* by David Fitzpatrick

1. Did you like this book? Why or why not? This question can be a bit simplistic, especially for a book like this. Maybe it is more meaningful to ask whether or not you learned anything from this book, or whether it moved you or changed the way you thought. Is there anything you disliked about this book?
2. This book is exceptionally raw and at times very graphic. When it was first released in 2012, it was highly anticipated by many mental health groups, and was chosen for numerous discussion groups. However, many of them included in their review of the book that it could be highly triggering. Do you think this is the case? Do you think this book shouldn't be read by some people? Why or why not?
3. Do you think that David Fitzpatrick glorified himself or the presentation of his illness in any way? Do you think that someone might be encouraged to engage in self-mutilation after reading his tale? Why do you think he included such graphic detail about his self-harm? Conversely, do you think he crossed a boundary with making his acts seem so exceptionally grotesque that people would not be encouraged to re-enact them? Some people describe this book as like watching a very slow train wreck. You don't want to watch, but you can't seem to pull yourself away. Did you have that experience when reading this?
4. Describe David from the bio-psycho-social perspective. What aspects were contributory to the development and prolonged nature of his illness? What aspects were protective. Was there anything that was simultaneously helpful and contributory?
5. What did you think about David's early relationship with his older brother (Chapter 1)? Do you think his portrayal of the instances of abuse are fully accurate? Why or why not? How was it possible for their parents to miss these?
6. How did David's early romantic relationships impact his development (Chapter 2)? What about the unwanted male attention that David seemed to attract (pgs. 34-37)? Do you think there are certain people who attract this type of attention? What is it about them that draws others in in this way? Or, do you just think it is random/bad luck?
7. One of the most jarring sections of the book is David's recounting of the torment he received at the hands of his roommates, "The Four Pricks of the Apocolypse" (Chapter 4). What did you make of all this? Was David truly a victim or could/should he have done something more proactive to make them stop? How did this experience contribute to his decline? Assuming his portrayal of their actions was 100% accurate, what did you make of their behavior? Was it simply drug-fueled stupidity or was it more sinister?
8. David spent a significant amount of time as a patient in various mental hospitals (Chapters 7-10). One of the many recurring themes was the notion of one-upmanship that occurred amongst the patients. From page 270, "Dr. Krav suggested that my acting out was a desperate attempt to be good at anything in the midst of the confusing pain twirling in my skull. It was a way to be a unique performance artist." Do you think that in general this was an unintended negative

consequence of his hospitalizations? Did this make him get worse? Did David experience anything positive from his relationships with other patients?

9. David was given numerous different medications to treat his illness. Clearly, the drugs alone were not enough to bring him to health. David devotes a significant amount of time describing his relationships with his therapists in this book. Did you find it surprising that the drugs alone could not cure him? In our modern life, we are bombarded by advertisements for psychopharmaceuticals. Do you think the general public thinks that taking these medications will truly solve a person's problems? Do you feel this way?
10. Compare and contrast David's two main therapists, Dr. Collander and Dr. Laney. How do you think they were portrayed in the book? What do you think they thought of David? Imagine you were the therapist and he was your patient. How do you think you would feel? What did you make of Dr. Presley? At one point David muses about whether or not he might have been able to recover more quickly with him as his therapist (pgs. 216-217). Do you think this is correct? Why or why not?
11. Modern inpatient hospitalizations are not nearly as lengthy as the ones that David experienced. Do you think that this is for the better? Do you think that the fact that David had such excellent health insurance that was able to cover his lengthy hospitalizations in part contributed to the duration of his illness?
12. How accurate a reporter do you think David is? Other reviews of this book have noted that one of his previous therapists kept a number of David's journals and he utilized them to write this book. He also developed a correspondence with author Wally Lamb, who served as a mentor to David, and was able to use letters exchanged between them as well. Even assuming that these letters and journal entries were written a very short time period after the events that transpired, do you think David was able to accurately remember everything that happened? And, does this even matter? Is someone's perception and memory of an event more "real" to them than the actual, undisputed actions that happened?
13. What were some of the most positive relationships that David experienced? Who were they with and what made them this way?
14. Do you think the people that were in David's life recognized themselves in this book? Do you think they would consider their representations to be positive? How might you feel if you were written about in something like this.
15. Some critics of the book state that David spends a tremendous number of pages setting up his breakdown, then detailing his experiences in the various inpatient hospitals, and then when it comes time to talk about his recovery, he spends only a chapter or two (Chapters 12 and 13). Why do you think this was? Would you have liked a more balanced presentation? Why or why not?
16. Would you recommend this book to people to read? Why or why not? If so, to whom would you recommend it? Would you read other works by this same author, or of this same genre (mental illness memoir)?

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Bipolar II Disorder

Diagnosis of this Bipolar Disorder requires neither a Manic nor a Mixed Episode, but does require at least one episode of hypomania in addition to an episode of Major Depression.

Diagnostic criteria for 296.89 Bipolar II Disorder

A. Presence (or history) of one or more Major Depressive Episodes.

B. Presence (or history) of at least one Hypomanic Episode.

C. There has never been a Manic Episode or a Mixed Episode.

D. The mood symptoms in Criteria A and B are not better accounted for bySchizoaffective Disorder and are not superimposed on Schizophrenia,Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify current or most recent episode:

Hypomanic: if currently (or most recently) in a Hypomanic Episode **Depressed:** if currently (or most recently) in a Major Depressive Episode

Specify (for current or most recent Major Depressive Episode only if it is the most recent type of mood episode):

Severity/Psychotic/Remission Specifiers Note: Fifth-digit codes specified on p. 377 cannot be used here because the code for Bipolar II Disorder already uses the fifth digit. **Chronic With Catatonic Features With Melancholic Features With Atypical Features With Postpartum Onset**

Specify:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) With Rapid Cycling

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Major Depressive Episode

When an individual experiences a discrete episode of persistent and pervasive emotional depression, this term may be applied. The individual may be diagnosed with one of the Mood Disorders, either Major Depressive Disorder or a Bipolar Disorder.

Diagnostic criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either

(1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-
incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood. (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others) (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains. (4) Insomnia or Hypersomnia nearly every
day (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) (6) fatigue or loss of energy nearly every day (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others) (9) recurrent thoughts of death (not just fear of dying), recurrentsuicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode (see p. 335).

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance(e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

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Hypomanic Episode

When an individual experiences a discrete episode of persistent and pervasive emotional hypomania, this term may be applied.

Diagnostic criteria for Hypomanic Episode

A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual non depressed mood.

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep) (3) more talkative than usual or pressure to keep talking (4) flight of ideas or subjective experience that thoughts are racing (5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.

F. The symptoms are not due to the direct physiological effects of a substance(e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Hypomanic-like episodes that are clearly caused by somaticantidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar II Disorder.

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Generalized Anxiety Disorder

Excessive and hard to control worry and anxiety occurring persistently characterize this Anxiety Disorder. There may be associated tension, fatigue, insomnia, and impaired concentration.

Diagnostic criteria for 300.02 Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children.

(1) restlessness or feeling keyed up or on edge (2) being easily fatigued (3) difficulty concentrating or mind going blank (4) irritability (5) muscle tension (6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

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Avoidant Personality Disorder

Individuals with this Cluster C Personality Disorder are socially inhibited, usually feel inadequate and are overly sensitive to criticism.

Diagnostic criteria for 301.82 Avoidant Personality Disorder

(DSM IV - TR)

(cautionary statement)
A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection

(2) is unwilling to get involved with people unless certain of being liked

(3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed

(4) is preoccupied with being criticized or rejected in social situations

(5) is inhibited in new interpersonal situations because of feelings of inadequacy

(6) views self as socially inept, personally unappealing, or inferior to others

(7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing