Case 1 DSM-5™ Clinical Cases
by Michael Gitlin, M.D.
Adapted

Nancy Ingram, a 33-year old stock analyst and married mother of two children, was brought to the emergency room (ER) after 10 days of what her husband described as “another cycle of dark days.” His wife was tearful, then explosive, and she had almost no sleep.

Ms. Ingram’s husband said he had decided to bring her to the ER after he discovered that she had recently created a blog entitled Nancy Ingram’s Best Stock Picks. Such an activity not only was out of character but, given her job as a stock analyst for a large investment bank, was strictly against company policy.

Mr. Ingram said his wife was working on the stock picks around the clock, forgoing her own meals as well as her responsibilities at work and with her children. Ms. Ingram argued with her husband at this time and said, her blog “would make them rich.”

The patient had first been diagnosed with depression in college, after the death of her father from suicide. On examination, the patient was pacing angrily in the exam room. Her eyes appeared glazed and unfocused. She responded to the examiner’s entrance by sitting down and explaining that this was all a miscommunication, that she was fine and needed to get home immediately to tend to her business. She was speaking so rapidly, it was difficult for the examiner to interrupt.

She denied hallucinations, but admitted with a smile, to a unique ability to predict the stock market. She refused to be cognitively tested and she said, “I will not be a trained seal, a guinea pig, or a barking dog, thank you very much, and may I leave now?”

TEACHER COPY:

- Bipolar disorder, current episode manic, with mixed features and rapid cycling

Distinct period of elevated, irritable mood with increased goal-directed activity. Decreased need for sleep.

Increased goal-directed activity. This is typically an energized and enjoyable feeling for the patient: They tend to feel more effective, overall. This period includes symptoms like euphoria, racing thoughts, and a variety of behavioral indiscretions.

Decreased need for sleep.

Pressure to keep talking. Push of speech. Talkativeness.

Grandiosity exaggerated belief in one’s importance, sometimes reaching delusional proportions. Sometimes referred to as grandiose delusions.

Irritability can be part of depression, but it is especially typical of people who have mixed features of both depression and mania. Her mocking, dismissive attitude substantiates this.

*Formerly known as manic-depression

Mania: One episode, 7 days
Hypomania: only 4 days
Irene Upton was a 29-year-old special education teacher who sought a psychiatric consultation because “I’m tired of always being sad and alone.” She had been hospitalized twice for suicidal ideation and severe self-cutting that required stitches.

She told the therapist that her sister reported “weird sexual touching” by their father when Ms. Upton was 13. There had never been a police investigation, but her father apologized to the patient and her sister as part of a church intervention for his alcoholism and sex abuse. Ms. Upton casually dismissed the possibility that she had ever been abused. She denied any negative feelings toward her father and said, “He took care of the problem. I have no reason to be mad at him.”

Ms. Upton reported little memory for her life between about ages 7 and 13 years. Her siblings would joke about her inability to recall family holidays, school events, and vacation trips. She explained this by saying, “Maybe nothing important happened and that’s why I don’t remember.”

Ms. Upton described being “socially withdrawn” until high school, at which point she became academically successful and a member of numerous teams and clubs. She did well in college. She excelled at her job and was regarded as a distinguished teacher of autistic children.

She denied use of alcohol or drugs, and described intense nausea and stomach pain at even the smell of alcohol. She reported an intense startle reaction and avoidance of dating men.

She described herself as “numb” and said thoughts of suicide were “always around.” She denied flashbacks or intrusive memories, but reported recurrent nightmares of being chased by a “dangerous man” from whom she could not escape. She did not have instances of time loss or unexplained possessions or inexplicable skills, habits and/or knowledge.

TEACHER COPY:
- Dissociative Amnesia;
- Major depressive disorder, chronic, with suicidal ideation;
- Posttraumatic stress disorder

Fatigue, feelings of worthlessness, and suicidiality (Major depression)

Although her sister reported the incident with father: He apologized to both daughters. The likelihood of trauma detected.

Although patient casually denies abuse, she describes a 6-year autobiographical memory gap that seems to have ended at the exact time of her father’s intervention.

The apparent child sexual abuse in conjunction with a 6-year memory deficit conforms well to a DSM-5 diagnosis of dissociative amnesia (DA).

Her memory loss was not just in the moments of trauma, but extended for a period of time beyond – ages 7-13. This makes memory loss a core symptom during those years.

Smell of alcohol is associated with intense disgust: Father was an alcoholic. She experiences hyperarousal/hyperreactivity (startle reaction) to threats or perceived danger. (PTSD) She avoids relations with men. Distress of social interactions. (PTSD)

Numbness or lack of feeling (Major Depression) Nightmares are recurrent/intrusive. (PTSD)

Her memory loss is not associated with DID b/c in addition to memory gaps; disruption of identity includes two or more distinct personality states. She is not told of any unrecalled behaviors.
Paulina Davis, a 32-year-old single African American woman with epilepsy first diagnosed during adolescence. She was admitted to a medical center after her family found her convulsing in her bedroom.

During her hospital admission, a routine electroencephalogram (EEG) was ordered. Shortly after the study began, Ms. Davis began convulsing. When the EEG was reviewed, no epileptiform activity was identified. Ms. Davis was subsequently placed on video-EEG (vEEG) monitoring. In the course of her monitoring, Ms. Davis had several episodes of convulsive motor activity; none were associated with epileptiform activity on the EEG. Psychiatric consultation was requested.

On interview, Ms. Davis noted that she had recently moved to the state to start graduate school; she was excited to start her studies and “finally get my career on track.” She denied any recent specific psychosocial stressors other than her move and stated, “My life is finally where I want it to be.” She was worried about missing the first day of classes (only a week away from the time of the interview). She was also worried about the costs of her hospitalization because her health insurance coverage did not begin until the school semester commenced.

When the findings of the vEEG study were discussed with Ms. Davis, she quickly became quite irritable asking, “So, everyone thinks I’m just making this up?” The psychiatrist/clinician tried to ease Ms. Davis’ concerns by telling her that about 10% of people with epilepsy also experience non-epileptic seizures (NES). NES can be caused by subconscious thoughts, emotions or ‘stress’, not abnormal electrical activity in the brain. Professionals do not believe that the seizures are purposely or fictitiously produced. The clinician told Ms. Davis she would not be exposed to unnecessary medication or studies, and that treatment, in the form of psychotherapy was available.

Conversion disorder: One or more symptoms of altered sensory or motor function that cause significant distress or impairment of function and that cannot be accounted for by a recognized medical or neurological condition.

DSM-5 includes changes in duration – one can be diagnosed with acute (less than 6 months) or persistent (more than 6 months) conversion disorder.

New to DSM-5, the diagnosing clinician is no longer required to identify stressors, conflicts, or other psychological factors believed to precipitate or exacerbate the presenting symptoms.

Because Ms. Davis’ worries are not focused on the symptoms of the illness, she is not diagnosed with somatic symptom disorder. For a diagnosis of illness anxiety disorder (formerly hypochondriasis) symptoms are either completely absent or only mild in intensity.

NES or non-epileptic seizures variant of conversion disorder makes up about ¼ of all conversion disorder presentations.

If it is believed that the patient is deliberately producing the symptoms – this may be diagnosed with another disorder: factitious disorder.

Patients can become angry at learning of diagnosis, but the good news is no medication needed.
Norma Balaban is a 37-year-old married woman who was referred to a psychiatrist by her primary care physician. Other than obesity and undergoing gastric bypass surgery 6 years earlier, Ms. Balaban had been generally healthy.

As she entered the consulting room, Ms. Balaban handed the psychiatrist a three-page summary of her physical concerns that have been occurring over the past year. Nocturnal leg spasms and daytime aches were her initial concerns. She then developed sleep difficulties that led to “brain fog” and head heaviness. She had intermittent cold sensations in her extremities, face, ears, eyes, and nasal passages. She also had neck stiffness with accompanying upper back spasms.

Ms. Balaban’s primary care physician had evaluated the initial symptoms and then referred her to specialists. A rheumatologist (arthritis and autoimmune diseases) diagnosed mechanical back pain without evidence of inflammatory arthritis. Several neurologists examined her and diagnosed possible migraines.

A review of tests done at the two local medical centers indicated that she had received the following essentially normal tests: two electroencephalograms (EEG), ... three brain and three spinal magnetic resonance images (MRI), ... and serial laboratory exams. Ms. Balaban shared with the psychiatrist that she was very frustrated that despite having seen several specialists, she had received no clear diagnosis and she was still very concerned about her symptoms.

Ms. Balaban found it difficult to concentrate and complete her work and was spending a lot of time on the Internet researching her symptoms. She also felt bad about not spending enough time with her children or husband.

Patients with SSD generally do not have medical problems, but the psychiatric focus becomes the ways their thoughts, feelings, and behaviors are affected by their physical complaints.

DSM-5 does not require that the somatic symptoms are medically unexplained. This leads to excessive testing.

She devotes an inordinate amount of time and energy (excessive) to thinking about, documenting, and seeking care for her somatic symptoms. They interfere with her ability to function (maladaptive).

Some students may mistake this clinical case for “illness anxiety disorder”—formerly hypochondriasis; however, symptoms of IAD are either completely absent of only mild in intensity. IAD preoccupied with having acquired illness.
Thomas, an 8-year-old boy with a mild to moderate intellectual disability was brought into the emergency room (ER) by his parents after his abdominal pain of the past several weeks had worsened over the prior 24 hours.

The teachers at his special education classroom and parents agreed that Thomas often looked distressed, rocking, crying, and clutching his stomach. A pediatrician had diagnosed chronic constipation and recommended over-the-counter laxative, which did not help.

An abdominal X-ray revealed multiple small metallic particles throughout the gastrointestinal tract. The family’s bathroom was in the process of being renovated because its paint was old and peeling. Thomas’ blood lead level was 4 times the normal amount. Endoscopy successfully extricated three antique toy soldiers from Thomas’ stomach.

Yasmine Isherwood, a 55-year-old married woman, had been in psychiatric treatment for 6 months for an episode of major depression.

She began to complain of weight gain, so the psychiatrist clarified her eating history. Her BMI was 23.3, which is considered normal. Ms. Isherwood had recurrent, distressing episodes of uncontrollable eating of large amounts of food. She reported that the episodes occurred two or three times per week. She ate rapidly and alone, until uncomfortably full. She reported exercising for an hour almost every day but denied being “addicted” to it. She did report that in her late 20s, she had become a competitive runner. At that time, she had often run 10-kilometer races and averaged about 36 miles a week. She reached her lowest weight ever of 113. She felt “vital and in control.” A foot injury eventually forced her to shift to swimming, biking, and the elliptical machine.

While there can be greater rates of obesity (BMI equal to or over 30), it is not a requirement for this disorder. One-third of patients are not obese.

DSM-IV criteria was two binge episodes per week for 6 months; DSM-5 requires one binge eating episode per week for three months.

If someone has bulimia nervosa or anorexia nervosa, they should not be given diagnosis of binge-eating disorder. Patients with BED can have past histories of other eating disorders. In her 20s, when she felt “vital and in control,” she may have had bulimia nervosa if that period included both binge eating and competitive running that was intended to compensate for binging.
**Case 7 DSM-5™ Clinical Cases**
Jennifer J. Thomas, Ph.D.
Anne E. Becker, M.D., Ph.D.
*Adapted*

**Valerie Gaspard** a 20-year-old single black woman who had recently immigrated to the United States from West Africa with her family to do missionary work. She visited the hospital due to frequent headaches, poor concentration, and chronic fatigue. She was only 78 pounds and her height was 5 feet 1 inch, resulting in a body mass index (BMI) of 14.7. This is severely underweight. Ms. Gaspard had missed her last menstrual period. When Ms. Gaspard recalled her meals the day before she was consuming only 600 calories. And one to two glasses of water a day. Ms. Gaspard provided multiple reasons for her poor intake. The first was lack of appetite: “My brain doesn’t even signal that I’m hungry,” she said, “I have no desire to eat throughout the whole day. Secondly, she said, “I just feel so uncomfortable after eating.”

She walked approximately 3-4 hours per day. She denied that her activity was motivated by a desire to burn calories. She did not have a car and disliked waiting for the bus. Ms. Gaspard said, “I know I need to gain weight. I’m too skinny. She said her family had been “nagging” for a year about it.

**TEACHER COPY:**
- Anorexia Nervosa (AN)

Dehydration and malnutrition (i.e., headaches...) suggest that she may not grasp the seriousness of her low weight.

**Significantly low weight** is first criterion for AN. World Health Organization’s lower limit is 18.5 BMI for adults.

Amenorrhea (i.e. lack of menses for 3 months or more) was a DSM-IV criterion for AN, but DSM-5 no longer requires amenorrhea – in other words patient with AN can menstruate regularly.

Lack of interest in or an aversion to eating. AN does not require a explicit concerns about weight and shape. Intense fear of weight gain was essential to DSM-IV. **DSM-5: fat phobia or behaviors that interfere with weight gain.**

Discomfort after meals (bloating, nausea) is common in AN because the stomach contractions are abnormal and there is often slowed digestion.

Malnutrition and excessive physical activity
She admitted worrying about her low-weight, yet she viewed her family’s appropriate concern as “nagging.”

**TEACHER COPY:**
- Bulimia nervosa (BN)

Binge-eating is defined as eating an inappropriately large amount of food in a discrete period of time (e.g., at a meal), in conjunction with a sense of loss of control.

Inappropriate compensatory behavior: **Once per week for three months.** Vast majority engage in self-induced vomiting. Usually begins out of fear that binge eating will result in weight gain. Most induce vomiting with fingers, but can develop capacity to vomit at will. Some may also use laxatives to induce diarrhea; actually induces dehydration and electrolyte abnormalities. Many experiment with diet pills, fasting, and excessive exercise. **DSM-5 does not use word purge.**
Brandon was a 12-year-old boy brought in by his mother for psychiatric evaluation for temper tantrums.

Even Brandon's teachers noted that he often cried and rarely spoke in class. They said he was academically capable but that he had little ability to make friends. In recent months, multiple teachers heard him screaming at other boys, generally in the hallway, but sometimes in the middle of class. The teachers assumed he was responding to a provocation.

When interviewed alone, Brandon responded with nonspontaneous mumbles when asked questions about school, classmates, and his family. When the examiner asked if he was interested in toy cars, however, Brandon lit up. He pulled several cars, trucks, and airplanes from his backpack and, while not making good eye contact, did talk at length about vehicles, using their apparently accurate names (e.g., front-end loader, B-52, Jaguar).

When asked again about school, Brandon pulled out his cell phone and showed a strong of test messages: “dumbo!!!!, mr stutter, LoSeR, freak!, EVERYBODY HATES YOU.” Brandon added that other boys would whisper “bad words” to him in class and then scream in his ears in the hall. “And I hate loud noises.”

According to his mother, he had always been “very shy” and had never had a best friend. He struggled with jokes and typical childhood banter because “he takes things so literally.”

On examination, Brandon stumbled over his words, paused excessively, and sometimes rapidly repeated words or parts of words. Brandon said he felt okay but added he was scared of school.

TEACHER COPY:

- Autism spectrum disorder (ASD)
  - Without accompanying intellectual impairment
  - With accompanying language impairment
- Childhood onset fluency disorder (stuttering)

Autism spectrum disorder (ASD) is new diagnosis in DSM-5. Incorporates several previously separate disorders, namely autistic disorder (autism) and Asperger's disorder...

Prior to DSM-5, Brandon would have met criteria for Asperger's due to normal intelligence.

Two main symptoms in DSM-5

- **Fixated set of interests and repetitive behaviors** (interest in cars and trains and little else; no insight that others do not share his enthusiasm)

- **Social communication deficits** (unable to form friendships; unable to interpret facial expressions, body language, humor)

Fluency (formerly stuttering) is characterized by frequent repetitions or prolongations of sounds, broken words, pauses in speech, and using many words when fewer would suffice...
Ethan, a 9-year-old boy, was referred to a psychiatric clinic by his teacher who noticed his attention was flagging. The teacher told Ethan's parents that although Ethan had been among the best students in his class in the fall, his grades had slipped during the spring semester. He tended to get fidgety and distracted when the academic work became more challenging.

Ethan's mother agreed: She had noticed that he often seemed to be shrugging his shoulders, grimacing, and blinking, which she took to be a sign of anxiety. These movements worsened when he was tired or frustrated, and they diminished in frequency during calm, focused activities like clarinet practice.

Cesar Lopez, a 57-year-old Hispanic man complained of worsening fatigue, daytime sleepiness, and generally “not feeling good.” He lacked the energy to do his usual activities. On physical examination, he was 5 feet 10 inches tall, weighed 235 pounds, and had a BMI of 34. His neck circumference was 20 inches.

His wife had to sleep in the guest bedroom because he snored very loudly. She said he often woke with choking sound. Mr. Lopez said, “All the men in family are snorers. I’ve snored ever since I was a child.”

A sleep study (polysomnography) showed the following sleep stages throughout the night:

- Time in Non-REM 1 (N1 sleep): 20%
- Time in Non-REM 2 (N2 sleep): 60%
- Time in Non-REM 3 (N3 sleep): 10%
- Time in REM sleep: 10%

REM is typically 15-20% for adults.
Case 12 DSM-5™ Clinical Cases  
Ming T. Tsuang, M.D., Ph.D., D.Sc.  
William S. Stone, Ph.D.  
Adapted  

Gregory Baker was a 20-year-old African American man who was brought to the emergency room (ER) by campus police of his university. He refused to leave a classroom after randomly walking into a lecture hall and shouting to the audience.

His sister said that he had quit seeing his friends and spent most of his time lying in bed staring at the ceiling. She also explained that she repeatedly saw him mumbling quietly to himself and noted that he would sometimes, at night, stand on the roof of their home and wave his arms as if he were conducting a symphony. Mr. Baker defended himself by saying that he felt liberated and in tune with the music when he was on the roof.

During the prior several months, Mr. Baker had become increasingly preoccupied with a female friend, Anne, who lived down the street. While he insisted to his family that they were engaged, Anne told Mr. Baker’s sister that they had hardly ever spoken and certainly were not dating.

On examination in the ER, Mr. Baker became enraged when the staff brought him dinner. He loudly insisted that all of the hospital’s food was poisoned and that he would only drink a specific type of bottled water.

Ultimately, Mr. Baker agreed to sign himself into the psychiatric unit, stating, “I don’t mind staying here. Anne will probably be there, so I can spend my time with her.”

**TEACHER COPY:**
- Schizophrenia, first episode, currently in acute episode

**DSM-5:** Two of five subtypes (at least one must be positive symptom)
- Delusions
- Hallucinations
- Disorganized Speech
- Disorganized Behavior or Catatonia
- Negative symptoms (e.g. flat affect or anhedonia)

*Each assessed for severity using 0-4 scale*

**Negative symptoms**- lying in bed all day

Appears to be responding to internal stimuli or possible auditory hallucinations of music/voices

**Grandiose and romantic delusions** – exaggerated beliefs about relationship with neighbor

**Prominent delusions** – not important to identify as paranoid; now clinician will consider if this is first episode or multiple and whether or not it is severe
Ike Crocker was a 32-year-old man referred for a mental health evaluation by the human resources department at a construction site. Although he presented as a very motivated and skilled worker at the interview with two carpentry certificates, in the first two weeks of employment, he has had frequent arguments, absenteeism, and made many dangerous mistakes. When confronted by supervisors, he was dismissive of the problem and said if someone got hurt, “it’s because of their own stupidity.”

When the head of human resources met with him to discuss termination, Mr. Crocker said he would sue on the grounds of the American Disability Act: He demanded a psychiatric evaluation for attention-deficit/hyperactivity disorder (ADHD) and bipolar.

During the mental health evaluation, Mr. Crocker focused on unfairness at the company and how he was “a hell of a better carpenter than anyone there could ever be.” He had been married twice and had two children. Mr. Crocker refused to pay child support, which is why he said both ex-wives “lied to judges and got restraining orders saying I’d hit them.” He was not interested in seeing his children. He said they were “little liars” like their mothers.

During high school, he said he “must have been smart” because he was able to make Cs in school despite only showing up half the time. He spent time in juvenile hall at age 14 for stealing “kid stuff, like tennis shoes and wallets” that were practically empty. He left school at age 15 after being “framed for stealing a car.” He pointed this out to show how he had overcome injustice. Mr. Crocker concluded the interview by demanding a note from the examiner that said he had “bipolar” and “ADHD.”

Phone calls revealed that Mr. Crocker had been expelled from two carpentry-training programs and that both of his certificates had been falsified. He got fired from his job at one local construction company after a fistfight with his supervisor.

**TEACHER COPY:**
- Antisocial personality disorder

Pattern of disregard for and violation of the rights of others – no regard for the safety of his coworkers

No remorse

Exploitive, manipulative

Arrogant self-appraisal (common in APD)

Pattern of disregard for and violation of the rights of others – he was arrested twice for domestic violence. From two separate marriages. He spent time in jail.

Calls his children liars and has **no remorse** for how his actions negatively affect his family

Antisocial personality diagnoses cannot be made for those under age 18, but it does require evidence of conduct disorder before age 15. He has evidence of truancy, adjudication for theft, and expulsion from school for car theft.

Four DSM-5 categories for conduct disorder are aggression to people and animals, destruction of property, deceitfulness or theft, and serious rule violations. An ADHD diagnosis requires impairment before age 12.

Exploitive during evaluation

Callous disregard for feelings of others

Impulsivity, aggression, deceit
Rachel, a 15-year-old girl, was referred for a psychiatric evaluation because of worsening difficulties at home and at school over the prior year. The mother said her chief concern was that Rachel’s grades had dropped from As and Bs to Cs and Ds.

Instead of being a “bubbly teenager,” Rachel would spend days by herself and hardly speak to anyone. These periods of persistent sadness began around age 14: She slept more than usual, complained that her friends didn’t like her anymore, and did not seem interested in anything.

At other times, her mom said she would yell at the family to the point that everyone was “walking on eggshells” in fear of upsetting her. The clinician asked whether there had been times in which Rachel was in an especially good mood. The mother recalled multiple periods in which her daughter would be “giddy” for a week or two. She would laugh at “anything” and would enthusiastically help out and even initiate household chores.

On examination while alone, Rachel appeared wary and sad. She did not like how she had been feeling, saying she felt depressed for a week, then okay, then “hilarious” for a few days, then so angry like someone was “churning up” her “insides.” She did not know why she felt like that, and she hated not knowing how she would be feeling the next day.

TEACHER COPY:

- Cyclothymic disorder [mild bipolar]

DSM-5 cyclothymic requires

- Multiple hypomanic episodes (less severe)
- Multiple [mild] subsyndromal depressive episodes

Over 2-year period for adults
Over 1-year period for adolescents

Subsyndromal depression increased sleep; decreased self-worth; loss of interest in activities

Mood fluctuations

Irritability and dysphoria (general dissatisfaction) could be part of her development as a teenager

For adolescents, it is important to explore their own perspective on their mood states

Rachel clarified that she did not like the mood fluctuations and she expressed that there were no precipitants or events that triggered her moods. The most striking clinical feature are Rachel’s emotional states.

She has hypomania, followed by a week or two of sadness followed by a couple weeks of irritability...
Juanita Delago was a 35-year-old single, unemployed Hispanic woman who sought therapy at age 33 for chronic suicidal thoughts. She had done well academically in high school but dropped out of college. She kept quitting entry-level jobs because she said the "bosses were idiots." This also left her feeling terrible about herself ("I can't even succeed as a clerk?") She said in the department store, people would often be rude: "it was ridiculous."

She had a history of cutting herself superficially along with persistent thoughts that she'd be better off dead. Toward the end of the first session, she became angry at the interviewer after he glanced at the clock. She asked, "Are you bored already?" She had few friends and felt most people in the neighborhood had become "frauds or losers."

Case 16 DSM-5™ Clinical Cases
Katharine A. Phillips
Adapted

Vincent Mancini, a 26-year-old single white man, was brought for an evaluation by his parents. They were distressed that since age 13, Mr. Mancini had been excessively preoccupied with his "scarred" skin, "thinning" hair, "asymmetrical" ears, and "wimpy" muscular build. His parents thought he looked normal, but he thought he looked "ugly" and "hideous." He believed others made fun of him because of his appearance.

Mr. Mancini spent 5-6 hours a day looking in mirrors and other reflective surfaces checking the areas he disliked. He would pull on his ears to "even them up." He used a razor blade to pick his skin and "clear it up." He lifted weights daily and wore multiple t-shirts to look bigger. He almost always wore a cap in the gym to cover his hair. He had received dermatological treatment for his skin concerns but felt it had not helped. He felt life was not worth living "if I look like a freak."

TEACHER COPY:
• Borderline Personality disorder

• Difficultly controlling anger

Preoccupations are accusatory (rather than self-accusatory like depression)
And there is "identity diffusion" in that she feels both superior and inadequate

• Self mutilating behavior

• Feelings of emptiness

• Unstable interpersonal relations

TEACHER COPY:
• Body dysmorphic disorder, with absent insight

Preoccupied with flaws or defects in appearance that are not observable to others
Affects more females, than males, typically. 2 out of 3 cases have onset in childhood or adolescence.

Perform repetitive behaviors or mental acts (e.g. comparing), intended to fix, check, hide, or obtain reassurance about perceived defects.

Because it is intended to improve perceived skin defects – this is not excoriation (skin picking disorder)

Muscle dymorphia: Think body is too small

80% BDD have lifetime suicidal ideation
**Case 17 DSM-5™ Clinical Cases**  
**Richard A. Friedman, M.D.**  
*Adapted*

**Andrew Quinn** a 60-year-old businessman, returned to see his longtime psychiatrist 2 weeks after the death of his 24-year old son. The young man was tragically killed in a car accident.

Mr. Quinn was very close to his son and he immediately felt crushed, like life had lost its meaning. In the ensuing 2 weeks, he felt constantly sad, withdrew from his usual social life, and was unable to concentrate on his work. His psychiatrist told him he was struggling with grief and that such a reaction was normal. Mr. Quinn was to return for ongoing assessment.

By the sixth week, of visiting the psychiatrist, his symptoms had worsened. He started to become preoccupied that he should have been the one to die, not his son. He had trouble falling asleep, but he also tended to wake up at 4:30 A.M. and just stare at the ceiling, feeling overwhelmed with fatigue and sadness.

**TEACHER COPY:**
- **Major depressive disorder (MDD)**
  
  Mr. Quinn probably had psychiatric history if he knew the psychiatrist: Possible history of depression.

  Grief is normal and healthy. In the DSM-IV, there was a *bereavement exclusion* that stated someone could not be diagnosed with depression between 2 weeks and 2 months after loss. **DSM-5** dropped this exclusion. Grief is still normal; however, if patients are showing signs of depression, it can be addressed prior to the 2-month cut-off.

  Grief is painful and includes emptiness and loss. Depression has *diminished pleasure* – even when something is humorous – it is hard to break away from sadness.

  **Self-criticism; pessimistic ruminations; feelings of worthlessness;**

  **Insomnia;**

**Case 18 DSM-5™ Clinical Cases**  
**Katharina Meyerbröker, Ph.D.**  
*Adapted*

**Olaf Hendricks** a 51-year-old businessman, complained of his inability to travel by plane. His only daughter had just delivered a baby, and although he desperately wanted to meet his first granddaughter, he felt unable to fly across the Atlantic Ocean to where his daughter lived.

Mr. Hendrick’s colleagues saw him as a forceful and successful businessman who could “easily” deliver speeches in front of hundreds of people. When specifically asked, he reported that as a child, he had been “petrified” that he might get attacked by a wild animal. This fear had led him to refuse to go on family camping trips or even on long hikes in the country. As an adult he did not have these fears because he lived in a large city and took vacations by train to other large urban areas.

**TEACHER COPY:**
- **Specific phobia, situational (flying on airplanes)**
- **Specific phobia, animals**

  The highly distressing fear of flying led to *avoidance, distress, and dysfunction* in life (unable to visit his daughter).

  **Specific phobia categories include**
  - Situational (elevators, enclosed spaces)
  - Animals
  - Natural environment (heights, storms)
  - Blood-injection-injury (needles)
  - Other stimuli (loud sounds, costumed ppl.)

  **DSM-5** permits diagnosis of specific phobia even when stimulus is not likely to be encountered.
**Case 19 DSM-5™ Clinical Cases**
Elizabeth L. Auchincloss, M.D.

**Adapted**

**Karmen Fuentes** was a 50-year-old married Hispanic woman who threatened her psychiatrist that she would overdose on Advil. She was urged to go to the emergency room where she explained that her back was “killing” her.

When asked about her suicidal comments, she said they were “no big deal.” She said she just wanted to worry her husband to “teach him a lesson” because “he has no compassion for me.” Ever since she had a bad fall at work, she said her husband was not supportive. I feel “abandoned.” When asked if she would hurt herself with pills, Ms. Fuentes exclaimed with a smile, “Oh wow, I didn’t realize it’s so serious to make threats. I shouldn’t do that again.”

She went on to say how “nice and sweet” it was that so many doctors and social workers wanted to hear her story. *She called many of them by their first names. She was also somewhat flirtatious with her male resident interviewer, who had mentioned that she was the “best-dressed woman in the ER.”*

**TEACHER COPY:**
- **Histrionic Personality disorder**

**Excessive emotionality and attention seeking**
Ms. Fuentes may have threatened with Advil because she had learned her psychiatrist was going on vacation.

The six categories for diagnosis are
- Discomfort when not the center of attention;
- Seductive behavior; intense, but shifting and shallow emotionality; use physical appearance to draw attention; self-dramatize and theatricality; consider relationships more intimate than they are

**Seductive behaviors, unusually friendly**

NOTE: Under the DSM-5 “hybrid model” of personality disorders (still being researched in Section III), there will be a roster of six redefined categories: antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal. But this is still under research.

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**Case 20 DSM-5™ Clinical Cases**
Robert Michels, M.D.

**Adapted**

**Larry Goranov** was a 57-year-old single unemployed white man who was in weekly psychotherapy. He found it “humiliating” that he was forced to see trainees who rotated off his case every year or two. He frequently found that the psychiatry residents were not especially educated, cultured, or sophisticated and felt they knew less about psychotherapy than he did. He preferred to work with female therapists, because men were “too competitive and envious.”

He enjoyed fine restaurants and “five-star hotels,” but he added that he could no longer afford them. He quit his job where he was basically “running the place” because he got in an argument with the owner. Looking even for some volunteer work felt “beneath him.” He exercised daily and wore clothing that appeared to be by a hip-hop designer generally favored by men in their 20s.

**TEACHER COPY:**
- **Narcissistic personality disorder**

Patients’ complaints may be less revealing than the way in which they are made. Mr. Goranov appears to be chronically disappointed: The world fails to see his value. Despite his view of himself and talented and attractive, he is unemployed and underappreciated.

**Estrangement from others, diminished capacity for empathy, arrogant disdain.**

Concerned with maintaining his appearance and his attractiveness to others. His clothes and manner reflect his underlying grandiosity and conviction that he is special and deserving of appreciation.
Case 21 DSM-5™ Clinical Cases
Barbara L. Milrod, M.D.
Adapted

Nadine was a 15-year-old girl whose mother brought her for a psychiatric evaluation to help her with long standing shyness.

Although Nadine was initially reluctant to say much about herself, she said she felt constantly tense. She was generally unable to speak in any situation outside of her home or school classes. She reused to leave her house alone for fear of being forced to interact with someone. She was especially anxious around other teenagers, but she also became “too nervous” to speak to adult neighbors she had known for years. She said it felt impossible to walk into a restaurant and order from “a stranger at the counter” for fear of being humiliated.

Nadine also felt she constantly on her guard, needing to avoid the possibility of getting attacked. She was the most confident when she was alone in her room. From seventh grade to ninth grade, Nadine’s peers turned on her. The bullying was daily and included intense name-calling (for example - “stupid,” “ugly,” “crazy”) and physical threats. One girl (the ringleader) had been Nadine’s good friend in elementary school, but hit her and gave her a black eye. Nadine did not fight back. She refused to tell her parents what happened, but cried herself to sleep at night.

Nadine transferred to a specialty arts high school for ninth grade. Even though the bullying ended, she could not make friends. Nadine felt even more unable to venture into new places. She felt increasingly self-conscious that she could not do as much on her own. Nadine was even scared to read a book by herself in a local, public park. She had nightmares about the bullies in her old school. She spent whole weekends “trapped” in her home.

TEACHER COPY:

- Social Anxiety disorder (formerly social phobia), severe
- Posttraumatic stress disorder, moderate
- Agoraphobia, severe
*these are often comorbid

Agoraphobia: persistently unable to go in public alone; fear of public spaces, inability to escape
Above and beyond actual danger or threat

Social Anxiety: Embarrassment or fear of interaction/social situations (Social Phobia)

PTSD – arousal, reactivity
Intense and prolonged bullying/violence led to hypervigilance

PTSD – avoidance (of peers)
PTSD – negative views about self

PTSD – intrusion (nightmares)

Agoraphobia: persistently unable to go in public alone (unable to go to park; “trapped” in home)
Case 22 DSM-5™ Clinical Cases
Ryan E. Lawrence, M.D.
Deborah L. Cabaniss, M.D.
Adapted

Peggy Isaac was a 36-year-old administrative assistant who was referred to outpatient evaluation by her primary care physician. Ms. Isaac had lived with her longtime boyfriend until 8 months earlier, at which time he had abruptly ended the relationship. Before the break-up, she always had a boyfriend: She was alone for the first time and hated it.

Ms. Isaac began to agonize about the possibility of making mistakes at work. She felt uncharacteristically tense and fatigued. She worried about money, and to economize, she moved into a cheaper apartment in a less desirable neighborhood. She repeatedly sought reassurance from her mother and office-mates, but soon she worried about being “too much of a burden.”

She even started to get her food delivered, so she could avoid going to the store: She felt “exposed and vulnerable,” like something bad would happen.

Case 23 DSM-5™ Clinical Cases
Mayumi Okuda, M.D.
Helen Blair Simpson, M.D., Ph.D.
Adapted

Samuel King, a 52-year-old janitor smelled of strong disinfectant on examination. He said that he was worried about contracting diseases like HIV, so he washed his hands incessantly with bleach. On average, he washed his hands up to 30 times a day. He also avoided touching practically anything outside of his home, but if he felt contaminated, he would wash.

Mr. King also had intrusive images of hitting someone and fears that he might offend or disturb the neighbors. He often apologized for fear he might have sounded rude. When he showered, he made sure that the water in the tub only reached a certain level for fear he could flood his neighbors. He recognized that his fears and urges were “kinda crazy,” but he felt they were out of his control.

TEACHER COPY:
- Generalized Anxiety Disorder

Excessive worrying that cause distress and dysfunction

TEACHER COPY:
- Obsessive-Compulsive Disorder, with good or fair insight

Obsessions have two qualities
  - Persistent thoughts, urges, or images that are intrusive or unwanted
  - Individual tries to ignore or suppress or neutralize symptom

Obsessions include worries of: contracting disease, hitting someone, and offending someone; he also seeks “symmetry” by exacting the water level

Compulsion repetitive behaviors (e.g. hand washing) or mental acts (e.g., counting) that individual feels driven to perform in response to obsession. Typically excessive.

DSM-5 requires symptoms cause distress/impairment; time-consuming (1-hour/ day)

Good fair insight reveals belief in irrationality of obsessions; can be absent of insight (poor)
Case 24 DSM-5™ Clinical Cases
Kristin Cadenhead, M.D.
Adapted

Henry, a 19-year-old college sophomore, was referred to the student health center by a teaching assistant who noticed that he appeared odd, worried, and preoccupied and that his lab notebook was filled with bizarrely threatening drawings.

Henry had been suspicious of some of his classmates, believing that they were undermining his abilities. He said they were telling his instructors that he was a “weird guy” and that they did not want him as a lab partner. The fact that the school sent him to the psychiatrist, he said, was confirmation of his perception. Henry believed his thoughts often came true.

Henry had transferred to this out-of-town university after an initial year at his local community college. He blamed the transfer on his parents saying they had an agenda to get him to be like everyone else and go to parties and hang out with girls. He said all such behavior was a waste of time.

With Henry’s permission, his mother was called for collateral information. He had never had close friends, had never dated, and had denied wanting to have friends. His mother cried while explaining that she always felt bad for him because he never really “fit in,” and that she and her husband tried to coach him for years without success.

She added that ghosts, telepathy, and witchcraft had fascinated Henry since junior high school. He had long thought that he could chance the outcome of events like earthquakes and hurricanes by thinking about them.

TEACHER COPY:

- Schizotypal personality disorder
- Paranoid Personality Disorder

Personality disorders are frequently comorbid. And “paranoid personality” or PPD is especially unlikely to be an isolated diagnosis.

Schizotypal→Delusional-like symptoms
(magical thinking, suspiciousness, ideas of reference – that everything is personally directed, and grandiosity)

Paranoid→Undermining abilities…. Reads hidden meaning into benign activities, bears grudges, and is overly sensitive to perceived attacks on his character

Schizotypal - Withdrawal (few friends, avoidance of social contact) and restricted affect (emotional coldness)

If students mistook this case for “autism spectrum disorder” because of Henry not have social relationships, note that Henry lacks the other key symptom of autism: the repetitive patterns of behavior, interests, or activities.

Schizotypal→Delusional-like symptoms
(magical thinking)

Note: Under the DSM-5 “hybrid model” of personality disorders (still being researched in Section III), there will be a roster of six redefined categories: antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal. This consolidation will make the six above more inclusive and “paranoia” would be viewed as a “specifier” or “modifier;” however this is still under research.