<table>
<thead>
<tr>
<th>DSM-5™ Clinical Cases (2014) ed. John W. Barnhill, M. D.</th>
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<tr>
<td>Adapted by Maria Vita, Penn Manor HS, Millersville, PA</td>
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<tr>
<th>Schizophrenic</th>
<th>Schizophrenia; Delusional disorder</th>
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<tr>
<td><strong>Anxiety</strong></td>
<td>Generalized Anxiety Disorder (GAD); Specific Phobias; Agoraphobia (now distinct diagnosis); Social Anxiety; Panic Disorder; Panic attacks used as specifier</td>
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<tr>
<td><strong>Personality</strong></td>
<td>Cluster A Odd/Eccentric (paranoid; schizoid; schizotypal); Cluster B Dramatic (antisocial; borderline; narcissistic; histrionic); Cluster C Fearful (avoidant; dependent; OCPD – dysfunctional perfectionism)</td>
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<td><em>often comorbid</em></td>
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<td><em>especially unlikely</em></td>
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<td>to be isolated diagnosis</td>
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<td><strong>Depressive</strong></td>
<td>Major depression; SAD-seasonal affective disorder; Persistent depression (dysthymic)</td>
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<tr>
<td><strong>Bipolar</strong></td>
<td>Bipolar; Cyclothymic (multiple hypomanic &amp; depressive episodes); “mixed” refers to coexisting mood states, rather than oscillation between two poles</td>
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<tr>
<td><strong>Neurodevelopmental</strong></td>
<td>Attention Deficit Hyperactivity Disorder (ADHD); Autism Spectrum disorder; Tourette’s; Fluency disorder (formerly stuttering);</td>
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<td><strong>formerly infancy</strong></td>
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<td><strong>Obsessive-Compulsive</strong></td>
<td>OCD; Hoarding; Trichotillomania; Excoriation (Skin-Picking); Body dysmorphic disorder</td>
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<td><strong>Disorders</strong></td>
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<td><strong>Trauma/Stress</strong></td>
<td>Post traumatic stress disorder (PTSD)</td>
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<td><strong>Dissociative</strong></td>
<td>Dissociative identity (DID); Dissociative amnesia (DA) with or without fugue</td>
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<td><strong>Disorders</strong></td>
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<tr>
<td><strong>Somatic Symptom</strong></td>
<td>Conversion disorder (Functional Neurological Symptom Disorder); Somatic Symptom (SSD); Illness Anxiety Disorder (IAD) –formerly hypochondriasis</td>
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<td><strong>and related disorders</strong></td>
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<td><strong>Feeding and eating</strong></td>
<td>Pica; Binge-eating; Anorexia-Nervosa; Bulimia Nervosa</td>
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<tr>
<td><strong>Sleep disorders</strong></td>
<td>Obstructive sleep apnea; narcolepsy; insomnia</td>
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Kahoot for category recognition https://play.kahoot.it/#/k/7fd1c9b1-ad0e-4935-a6e5-65b2dba76045
Kahoot for symptom practice https://play.kahoot.it/#/k/3d7a5233-3cb2-4fb9-881b-8c735cf6d9cb
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?”
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.... 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 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 reported an intense startle reaction and avoidance of dating men. She did not have instances of time loss or unexplained possessions or inexplicable skills, habits and/or knowledge.
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.
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.
Case 5 DSM-5™ Clinical Cases
by Susan Samuels, M.D.
Adapted

**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 in 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.

Case 6 DSM-5™ Clinical Cases
by Susan L. McElroy, M.D.
Adapted

**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.
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. 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.

Wanda Hoffman was a 24-year-old white woman who presented with a chief complaint: “I have problems throwing up.” These problems began in early adolescence, when she began dieting despite a normal BMI. At age 18, she went away to college and began to overeat in the context of new academic and social demands. A 10-pound weight gain led her to routinely skip breakfast. She often skipped lunch as well, but then famished, would overeat in the late afternoon and evening. She felt out of control. Worried her habits would lead to weight gain; she saw self-induced vomiting as a way of controlling her fears. She appeared well nourished: Her BMI was normal at 23.
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 string of text 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.
Case 10 DSM-5™ Clinical Cases
Robert Haskell, M.D.
John T. Walkup, M.D.
Adapted

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.

Case 11 DSM-5™ Clinical Cases
Brian Palen, M.D.
Vishesh K. Kapur, M.D., M.P.H.
Adapted

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
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.”
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.
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 one. 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.
Case 15 DSM-5™ Clinical Cases  
Frank Yeomans, M.D., Ph.D.  
Otto Kernberg, M.D.  
Adapted

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.”
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.

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.
**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.”

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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 wore clothing that appeared to be by a hip-hop designer generally favored by men in their 20s.
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 refused 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 was 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.
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.

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.
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.