DSM-IV™

CASE BOOK

A Learning Companion to the Diagnostic and Statistical Manual of Mental Disorders • Fourth Edition

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Note: The authors have worked to ensure that all information in this book concerning drug dosages, schedules, and routes of administration is accurate as of the time of publication and consistent with standards set by the U.S. Food and Drug Administration and the general medical community. As medical research and practice advance, however, therapeutic standards may change. For this reason and because human and mechanical errors sometimes occur, we recommend that readers follow the advice of a physician who is directly involved in their care or in the care of a member of their family.

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Introduction and How To Use This Book

Introduction

This collection of cases grew out of our experience in teaching DSM-III and DSM-III-R and participating in the development of DSM-IV. Reading these accounts of real patients, edited to focus on information relevant to differential diagnosis, has proven to be an effective and enjoyable way for clinicians and students to get experience applying the principles of differential diagnosis to a wide range of patients.

We have chosen focused, edited descriptions of patients, since in standard case summaries discussions of diagnosis often get bogged down in a swamp of details not relevant to the purpose of establishing a diagnosis. (Nondiagnostic information, such as details of childhood and family relationships, however, is often necessary in actual clinical records.) In addition, routine case summaries often inadvertently omit crucial diagnostic information, whereas the cases in this book have been prepared to ensure that all available information necessary for making a diagnosis has been included.

These cases have been drawn from our own experience and from the practices of a large number of clinicians, among them many well-known experts in particular areas of diagnosis and treatment. The identities of the patients have been disguised by altering such details as age and occupation and, occasionally, locale. Often we needed to go back to the contributors of the cases to obtain diagnostically crucial information; we have avoided the temptation to manufacture the missing details. Sometimes, as in the real world, this has led to diagnoses that had to be made provisionally or noted as part of the differential diagnosis.

Following Freud's example, we have provided names for each case in order to make them easier to refer to. We have included a number of historical cases from the writings of such great nosologists as Emil Kraepelin, Eugen Bleuler, and Sigmund Freud himself. We have made no effort to disguise the identity of these historical patients; we have, however, taken the liberty of providing appropriate names for those who lacked them.

Each case is followed by a discussion of our differential diagnosis, made according to the diagnostic criteria in the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). (To aid the reader we have noted in parentheses the page number of the diagnostic criteria in the DSM-IV manual.) These discussions include important diagnostic considerations, such as the rationale for making each particular diagnosis, other disorders to be considered in formulating each diagnosis, and, in some cases, recognition of diagnostic uncertainty because of inadequate information, ambiguity in the clinical features, or problems in the classification itself.

These discussions are focused on differential diagnosis, not on the treatment implications of the diagnosis. However, for some of the cases we have been able to obtain follow-up information, which usually includes response to treatment. Often the follow-up information confirms the original diagnosis; occasionally, it raises doubts or leads to a change in diagnosis.

Some degree of ambiguity in diagnosis is still inevitable, despite the increase in reliability made possible by the use of diagnostic criteria. The reader, who may not always agree with our assessment, should understand that we sometimes disagreed with each other about the correct diagnosis. We trust that he or she will seriously consider our formulations, but not regard them as infallible.

These cases can be used for a variety of purposes. They should be of value to experienced clinicians, facilitating their understanding of the concepts and terminology in DSM-IV. All clinicians, regardless of their level of experience and training, may benefit from reading descriptions of cases that are examples of diagnostic categories rarely seen in their treatment settings. Teachers and students of abnormal psychology in the disciplines of psychology, psychiatry, social work, and psychiatric nursing will find these cases useful as illustrations of various types of psychopathology. Similarly, other professionals, such as primary care physicians, internists, and attorneys, may find them instructive.

These cases should prove helpful to professionals studying for specialty examinations, such as the psychiatry boards; they can serve as a means of testing one's knowledge of diagnosis. Research investigators can use them to assess the level of diagnostic expertise and the reliability with which members of their staff can make diagnostic assessments. Finally, these cases provide a historical point of reference as illustrations of diagnostic concepts in the United States in the 1990s and, by means of the historical cases, a comparison with diagnostic concepts of the past.

There are five chapters dealing, respectively, with adults, children and adolescents, multiaxial assessment, international cases, and historical cases. The international cases are grouped by geographic region, and the historical cases by their authors.

The original *DSM-III Case Book* was published in 1981, a year after the publication of DSM-III, and revised in 1988, a year after the publication of DSM-III-R. As with the previous revision, in the *DSM-IV Casebook* we have eliminated some of the earlier cases and added a large number of new cases (these are the first cases in Chapters 1 and 2). The new cases have enabled us to expand the coverage of disorders so that we now have at least one example of virtually every diagnostic category in DSM-IV.

How To Use This Book

The reader who chooses to begin with Chapter 1 and read straight through the book will find cases in no particular diagnostic order. Those who are interested in examples of particular diagnoses (e.g., mood disorders) should consult Appendix D, Index of Cases by DSM-IV Diagnoses. Readers who are interested in cases from any of the following categories should consult Appendix B, Cases by Special Interest: forensic, difficult or unusual differential diagnosis, physical disorder, or medical setting.

Appendix A, Index of Case Names, will be useful to the reader who remembers cases by their names. Appendix C, DSM-IV Classification, can be used to see how a particular diagnosis fits into the rest of the classification.

Our own residents in the Department of Psychiatry at Columbia University, College of Physicians and Surgeons, who reviewed the cases in the previous casebook, tell us that they found the cases not only very educational but also fun to read. We hope you will as well.

March 1, 1994

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Appendix D

Chapter 1

Mental Disorders in Adults

Brujeria

Celia Vega is a 21-year-old woman, born in Puerto Rico, who is brought, by the police, to the emergency room of a city hospital in handcuffs and leg chains. She is interviewed by an attending psychiatrist, called by the emergency room staff for a consultation. Ms. Vega is a tiny, appealing, childlike woman with dyed red hair who is dressed in hospital clothes. Her face and arms are covered with bruises and scratches from the events of the night before. She is smiling and seductive, rolling her eyes, crossing and recrossing her legs.

The interview takes place in a small, windowless interviewing room into which are crowded the attending psychiatrist, five psychiatric residents, and two social workers. The attending psychiatrist asks her to describe what happened to her, and she says she was washing dishes at her boyfriend's house, where she had been living, and began to have chest pains. Her boyfriend's mother told her to lie down, and the next thing she remembers, she was in the emergency room in chains. The family told her that she "got wild" and tried to bite people. She explains that this has happened many times before, since she was 17. Her boyfriend, who has seen many prior episodes, called the police this time because, as he told her, she had a knife and he was afraid she might kill him.

She has been told that during these episodes she screams, bites, and kicks, and sometimes has tried to get a knife to cut herself. The interviewer asks her, "What do you call these attacks or spells that keep happening to you?" She then says she doesn't want to talk with all the people in the room. She could talk to two or three people, but not eight.

The interviewer tries to convince her that these are all people who can help her, and the more the better. She refuses. He then asks if she understands how fortunate she is to be in a famous teaching hospital. She has never heard of it, and will not budge. He tells her that these people can help her if she is able to talk to them about what's troubling her. No response. He says, "You have a lot of secrets." More silence.

The interviewer changes tactics. "I'm just going to ask you some questions, and you answer those that you want to."

Interviewer: Do you cry a lot?
Patient: Yes. (Her eyes fill up.)
Interviewer (on a hunch): Bad things have happened to you, right? (She nods.)
Interviewer: Do you ever tell people about the bad things that have happened?
Patient: No. I don't tell nobody nothing.
Interviewer: Do you dream about bad things that have happened?
Patient: Yes, but in the dream it happens to my sister.
Interviewer: What happens? (Silence.) Were you very young when it happened?
Patient: Yes.
Interviewer: 12, 13, 14?
Patient: No.
Interviewer: 15, 16?
Patient: No, the other direction.
Interviewer: 10, 9?
Patient: Yes. When I was 9. Someone did something to me. It changed me. From then on I was different. (She cannot say in what way she was different, and she still will not say what happened.)
Interviewer: Was it someone in your family?
Patient: No. Someone in the neighborhood.
Interviewer: Did it happen over and over?
Patient: No, just a few times.
Interviewer: Did you tell anyone about it?
Patient: No, but my sister told my mother. It happened to my sister too.
Interviewer: What did your mother do?
Patient: Nothing.
Interviewer: Did you feel like it was your fault?

Patient: No. I dream that it happens to my sister, and I wake up crying.

Interviewer: Do you think what happened then has anything to do with these things that happen to you now? What do you call them . . . these attacks, spells?

She says, embarrassed, that they are called *brujeria* (witchcraft). She explains that she was married to a Dominican boy who was a drug dealer. He was sent to prison. His mother blamed her, told her that she would pay for it. After that, 4 years ago, she began having these spells. She now adds that they usually last about 2 hours and that during them she often sees a man's face on the wall.

Interviewer: Who is he? (No answer.) Is he the person who hurt you?

She begins to cry, covers her face with hair, gets very tense. She looks extremely upset, and everyone in the room thinks she's going to have an attack on the spot. The interviewer, recognizing that it would be unwise to pursue this subject further in a group setting, suggests that she now talk to her doctor alone.

Ms. Vega remained in the emergency room overnight and, during several interviews with a social worker, revealed the following additional history. When she was age 9 she and her sister were repeatedly raped by an uncle who used to pick them up from school. Her sister told her mother who did not believe it and did nothing about it. She acknowledged that the face she saw during the attacks was her uncle's.

She was married at age 14 and had two children, but says that she has never been able to enjoy sex and can have intercourse only if she is high on drugs. During intercourse she often sees the face of her uncle. After her husband went to prison for selling drugs, her mother-in-law got custody of her two children. Why this happened, she was unable to explain. She now says that although she loves her children, she gets "nervous" when she has to spend a lot of time with them.

She has not been able to get her life together and finish school or stick with a job. She now lives with her boyfriend's family and spends most of her time watching soap operas. She acknowledges often being quite irritable. She frequently has trouble sleeping and often awakens from bad dreams. Since she had an abortion several months ago, she has been depressed and has had thoughts that she would be better off dead.

Discussion of "Brujeria"

The report that this patient was aggressive, out of control, and brought to the emergency room in restraints suggests either a psychotic episode or drug intoxication. During the interview it appears that neither is likely, and the key question is the nature of the recurrent episodes that the patient has been having for several years. The fact that her behavior during the episodes is so at variance with her normal behavior, and the fact that she does not remember much of what occurs, suggests that she is experiencing recurrent dissociative episodes, or possibly an unusual manifestation of temporal lobe epilepsy. Evidence of the dissociative nature of these episodes emerges as she tells the social worker that the face she sees is that of her uncle who repeatedly raped her when she was a child. (We acknowledge that we have only the patient's report that she was raped, yet we see no reason to doubt her veracity. She has nothing to gain from telling this story, and her distress in speaking about it seems entirely genuine.)

One wonders whether the dissociative episodes may represent a switching to another identity, as in Dissociative Identity Disorder (Multiple Personality Disorder) (see "Mary Quite Contrary," p. 56). However, that diagnosis requires that the alternate personalities have their own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self, and there is no evidence that this occurs during Ms. Vega's dissociative episodes.

We are not surprised to learn later that this patient has many of the symptoms of Posttraumatic Stress Disorder (PTSD). The rapes meet the entry criterion for a traumatic event. The dissociative episodes represent the reexperiencing of the trauma (i.e., fighting off her uncle's sexual advances) as do the dreams and recurrent recollections during sex. PTSD also requires three symptoms of avoidance of stimuli associated with the trauma and numbing of general responsiveness. She clearly avoids sex, and her inability to finish school or work suggests that she may also have markedly diminished interests and a sense of a foreshortened future, which would be evidence of avoidance or numbing. Her difficulty sleeping and irritability satisfy the criterion requirement of increased arousal.

The diagnosis of PTSD is easier to make when a single trauma

seems to result in a markedly changed level of functioning. In this case the effect of the trauma is hard to disentangle from the other noxious environmental features of her life. We do not know whether she would have finished school, found a job, and had more satisfying interpersonal relationships if she had not experienced the rape trauma. Still, with all of this uncertainty, our best guess is that the dissociative episodes, which were the ticket to her admission to the mental health system, are symptoms of the more pervasive disorder, Posttraumatic Stress Disorder (DSM-IV, p. 427).

Follow-up

Ms. Vega was released from the emergency room to live at her sister's house, and was visited the next day by the psychiatric resident, along with a social worker from the mobile crisis team. The resident arranged a family meeting with the mother, from whom the patient had really been estranged, and set up a schedule of home visits with the mobile crisis team to engage the patient in psychotherapy. For reasons that are not clear, the follow-up plan did not work, and the patient reappeared in the emergency room 2 weeks later, tearful, "nervous" and wanting to talk to the emergency room social worker. Another appointment was made for ongoing psychotherapy, which the patient never kept.

Agent Johnson

A tall, well-groomed, 30-year-old African American man walked into the emergency room of a large urban hospital, registered under the name Harry Backman, and asked to be admitted to Ward Three of the psychiatric division. He claimed that, despite the fact that all of his identification cards bore the name Harry Backman, his real name was Johnson. "And your first name?" asked the resident psychiatrist. "We're not allowed to divulge our first names," he confided. He went on to explain that in fact he was Agent Johnson, an FBI agent on a mission to find Harry Backman, who had last been seen in Pittsburgh several years earlier. He claimed to have followed Harry from city to city, often posing as a patient in the psychiatric hospitals where Harry had been treated in order to obtain information about him. Harry had a seizure disorder for which he took phenytoin and