Progress in Psychodiagnostics: *DSM-5-TR* (from -*5* and *IV-TR*)

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Vignettes

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Titanic Tantrums[1]

Dillon, an 8-year-old boy living with his parents and his younger brother, was evaluated because his parents were at their "wits' end" regarding how to handle his explosive outbursts, which were occurring several times a day. Ms. A., Dillon's mother, stated, "It has gotten to the point where I dislike my child."

At the time of the evaluation, Dillon was exhibiting temper outbursts several times a day that lasted approximately 10 minutes, and more intense 30-minute outbursts multiple times a week, during which he became physically aggressive. For example, during a recent tantrum, Dillon kicked and punched holes in his bedroom door, causing such destruction that the door needed to be replaced. Additionally, Ms. A. reported that she always had bruises on her arms from blocking Dillon's strikes. Dillon's parents described him as irritable and cranky for the better part of the day on most days. When irritable, Dillon appeared agitated and restless and often expressed that he wanted to be left alone. Attempts to cheer him up were typically unsuccessful and sometimes worsened his irritability.

Dillon was in the second grade in a restrictive classroom environment, classified under special education as emotionally disturbed. In the past school year, Dillon had been suspended three times—for physical aggression toward school personnel, for throwing a chair in the classroom, and for knocking over a bookcase. Despite his average to superior cognitive abilities, Dillon struggled academically, partly because of the large amount of time he spent out of the classroom due to his disruptive behavior. Teachers noted that Dillon often appeared to be in an irritable, agitated mood and that he rarely smiled or appeared happy. They often felt they were walking on eggshells to avoid his rageful outbursts.

Ms. A. reported that Dillon had always been a difficult child. As a baby, he was colicky and cried incessantly for several hours each day. As a toddler, he threw tantrums multiple times per day, which Ms. A. attributed to the "terrible twos." Unfortunately, Dillon's outbursts escalated as he grew older. By the time Dillon was 5, his temper tantrums included hitting and kicking his parents and throwing breakable objects. His difficulties were also manifest outside the home, as evidenced by his expulsion from prekindergarten because of unmanageable behavior.

Dillon's tantrums and noncompliance at home increased once he entered school, as homework added another source of frustration and negative interactions. He was highly distractible and exhibited strong opposition when asked to do homework. He was constantly restless, fidgeting, and getting out of his seat, and he was difficult to control. He also tried to avoid daily routines, such as picking up his clothes and brushing his teeth, and he threw tantrums regularly to avoid them. During this time, Dillon's irritability worsened as well. Around the time he started first grade, he began to appear constantly "on edge" and was easily bothered by little things, such as others sitting too close to him. His mood remained cranky for most of the day, sometimes for several days at a time. When his parents tried to cheer him up by suggesting a fun activity, he would snap, demanding to be left alone. Dillon also started to make hostile attributions regarding his peers' intentions. For example, when playing tag, Dillon would get angry, believing the others had hit him on purpose when they were merely tagging him. He also expressed the negative thoughts that no one liked him, that he did not have any friends, and that his parents did not love him. At times, Dillon had difficulty controlling these thoughts, in episodes that Ms. A. referred to as "mind spirals." Dillon would bring up an angering event out of nowhere, such as being yelled at by his teacher a few days earlier, and remain upset for several hours.

Dillon's outbursts at school led to his classification as emotionally disturbed, and he was moved to a smaller classroom. Despite this more supportive environment, Dillon continued to be disruptive and to have difficulty focusing, following instructions, and completing class work. He became bored easily and refused to do his work. Over time, Dillon's academic progress declined. Teachers eventually placed fewer academic demands on him to avoid outbursts.

In Dillon's early schooling, he made friends and enjoyed interacting with peers. However, because of his temper tantrums and hostile attributions, his peers began to avoid him. His parents restricted family outings. They stopped attending Mass when Dillon was in second grade because he could not sit still and would throw tantrums in church. They cut back on family gatherings and avoided including Dillon on errands, because of the embarrassment caused by his tantrums.

Dillon's parents and Dillon consulted with a child psychiatrist to discuss medication. The psychiatrist prescribed methylphenidate in the hope that it would improve Dillon's hyperactivity and frustration tolerance and thus reduce his tantrums. Because Dillon's outbursts at home had become a means of avoiding demands, and his parents were unsure about managing them, the parents were referred for parent management training, which offers specific strategies that enhance effective communication and discipline. At the same time, Dillon received individual cognitive-behavioral therapy aimed at teaching him how to better regulate his mood and improve his frustration tolerance. He was taught coping skills to regulate his anger and to identify and relabel distortions that contributed to his hostile reactions. Finally, a school behavior daily report card was developed that functioned like a token economy through which Dillon was rewarded for specific positive behaviors in the classroom.

Paranoid and Dangerous

Tracy Shaw, age 32, overweight and wild looking, was brought to the psychiatric emergency room by the police after she had furiously pushed a chair into a full-length mirror, shattering the mirror, in the principal's office of her child's school. The psychiatrist who examined her described her as "paranoid and dangerous to others" and recommended immediate involuntary hospitalization, if she refused to admit herself voluntarily.

Ms. Shaw refused voluntary admission. She stated that her suspicions concerning her child's unfair treatment in school were well-founded and that she would harm no one. She acknowledged that she was particularly tense, irritable, and angry because she was premenstrual. Her husband supported her decision and assumed responsibility for her and for bringing her back to see the psychiatrist the next day. That evening her menses began.

When Ms. Shaw saw the psychiatrist the next day, she appeared to be a "different person." She was relaxed, her anger and irritability had dissipated, and she displayed a sense of humor. However, her conviction that the school principal owed her an explanation of his unfair treatment of her child remained.

Ms. Shaw gave a history of monthly premenstrual symptoms beginning at menarche but worsening since her 20s. The symptoms were not the same every month. Some months she would become depressed, with thoughts of suicide; other months she would crave chocolate and gain 5–10 pounds in 1 week; some months she would break out in hives; and there were months when she had no symptoms. The symptoms were always predictable in their timing, occurring the week before her menses and remitting with onset of menses.

Ms. Shaw was the oldest daughter of a chronically depressed and fearful mother and an alcoholic father. Before marriage, she was the caregiver of her family. Her mother recovered significantly from her depression during Ms. Shaw's adolescence, only to fail rapidly physically and die when her daughter left home and married after high school.

Currently, Ms. Shaw is the mother of four grade-school children and also has primary responsibility for a sibling with alcoholism who is dying of cancer, as well as for her handicapped husband, who has been severely depressed and vocationally incapacitated since surgery 1½ years ago. She lives with her in-laws. Both her husband and his parents have significant alcohol problems.

Ms. Shaw is the family caregiver. "I can't live with myself unless I do it all. I feel guilty if I do something for myself." She can cope with the demands of her life and is not usually depressed, except when she is premenstrual, when "the whole world closes in" and she feels "pulled down."

Something of Value

Eli Wolfe, a 50-year-old man, came to the emergency room of a New York hospital complaining of malaise, fever, and a cough. An upper respiratory infection was diagnosed, but as the doctor was writing out the prescription, Mr. Wolfe tearfully revealed that he had no home to go to, was depressed, and felt that life was not worth living. The psychiatric resident who was called to see the patient obtained the following additional information.

For the past month, Mr. Wolfe had been living in the basement of his apartment building, eating in restaurants, and using a Young Men's Hebrew Association for showers. He was eating and sleeping poorly. His own apartment was so full of newspapers, magazines, and books that he could no longer get in the door, but he could not bring himself to get rid of any of his "stuff."

When he was age 12, Mr. Wolfe began collecting baseball cards, and then books and magazines. His parents were poor immigrants from Eastern Europe, and the idea of holding on to things that might someday be valuable was not strange to them. Eventually, however, the apartment became so cluttered that they threw out much of his collection. He retrieved it from the garbage, and from that point on his "collecting" has been a focus of conflict with both family and employers. He does not go out of his way to obtain things, but once he has a newspaper, book, or magazine, he cannot throw it away because "there might be something of value written in it." The thought of throwing things out makes him extremely anxious, and in the end he simply cannot do it.

For many years Mr. Wolfe worked as a doorman in elegant apartment buildings, but invariably he was fired because he brought his "stuff" to store in his workplace, and he sometimes got into fist fights with the building maintenance people who tried to throw it out. He was married for 16 years and has a 25-year-old son. His wife finally left him, unable to tolerate his behavior. He rarely sees his son.

Mr. Wolfe first entered treatment not because of his collecting but because, at age 20, "my mood took a turn for the worse. I had a breakdown." He stopped doing virtually everything—working, eating, and sleeping. "It was an effort even to lift my leg." He began seeing a psychiatrist as an outpatient, and over the years has been in therapy much of the time and has been treated with amitriptyline, desipramine, and fluoxetine (all of which are antidepressant medications); quetiapine (an antipsychotic medication); and other medications that he does not remember.

After his divorce 10 years ago, Mr. Wolfe moved some of his collection into his own apartment and rented storage space for the rest. Gradually, his new apartment filled up with newspapers, magazines, and books, and it became a struggle just to get in the front door and make his way to his bed. Finally, last month, after injuring his shoulder trying to push things aside, he abandoned the apartment for a cot in the basement of the building. He understands that his inability to throw out things is irrational, but the thought of starting to do it makes him intolerably anxious.

Mr. Wolfe was admitted to the psychiatric hospital, diagnosed as having Major Depressive Disorder, and started on fluoxetine, an antidepressant that had helped him with his depressed mood in the past. The dosage was gradually raised to 80 mg/day, and after 4 weeks, with considerable pressure from his psychotherapist, Mr. Wolfe was able to clear the foyer of his apartment, so he could at least get in the door. His mood improved, and he began eating and sleeping better. In the succeeding 6 months, he has slowly and methodically discarded bundles of articles. Although he is now able to live in his apartment, it remains cluttered with his things.

Going Off With Strangers

Harlow, age 37 months, and her three siblings were referred to an intervention program for maltreated young children. According to Child Protective Services (CPS), Harlow and her siblings were wandering in the family's front yard with no adults in sight, and the agency was contacted. CPS found the home in disarray, with trash and several bottles of alcohol scattered about. The children all had severe diaper rashes and scattered bruises on their bodies. The children had poor hygiene and grooming, as well. Two children were placed in one foster home, and Harlow and her 18-month-old brother went to another.

In the initial home visit by a clinician, 1 week after her placement, Harlow immediately ran up to the clinician and began to hug her, despite never having met the clinician before that home visit. During the visit, Harlow's foster mother reported that when the children were first placed into her home, Harlow and her brother tended to "shovel" food into their mouths at mealtimes, and both drank copious amounts of water. The foster mother also reported that the children were afraid of bath time and protested when it was time to get into the water. The foster mother recalled that about a week after Harlow was placed with her, Harlow ran into the street. This was quite concerning to the foster mother, who had to be vigilant about setting limits and had begun to teach Harlow the boundaries of remaining safe.

When in unfamiliar places with her foster mother, Harlow did not stay close; instead, "she [ran] around all over the place" and did not check back with her foster mother. If separated from her foster mother, Harlow did not seem especially bothered by the separation. The foster mother said that it seemed that Harlow did not have any "connections" with anyone. She also noted that Harlow seemed to constantly seek attention and that she craved this attention "any way she [could] get it." Harlow often smiled coyly at strangers on the bus, for example.

When Harlow was first placed in foster care, she did not have a preference for any particular adult and was reported to "run up to anybody" without hesitation. When hurt or frightened, Harlow grabbed onto anyone who was around her, whether or not she knew the person. However, she did tend to respond to others' attempts to comfort her. Harlow was always friendly and affectionate with strangers—for example, hugging strangers as if she had "known them for years." When a family friend came to the home to visit, Harlow ran over to the friend, whom she had never met, and hugged her and wanted to be picked up by her. The foster mother said that Harlow would most certainly "go off" with an unfamiliar adult, as demonstrated by Harlow's responses in numerous encounters she had had with strangers since entering foster care. When Harlow encountered strangers, Harlow told them, "I'm going with you."

Eyewitness

Karen Davidoff is a 39-year-old TV reporter who saw a psychologist at her network employee assistance program a few weeks after being an eyewitness at the execution of a murderer. For several years she had been following the story of the inmate as he approached execution. The execution itself was remarkably protracted and gruesome: along with colleagues, she maintained a death watch for several hours while various last-minute reprieves were granted and then set aside by judicial bodies. At one point the inmate was actually strapped onto the gurney when a phone call from a federal judge, literally at the last minute, reprieved him, and the inmate was removed from the death chamber alive. When execution finally occurred, Ms. Davidoff and her colleagues watched from a distance of about 10 feet through the windows between the witness room and the death chamber. The inmate's eyes rolled back in his head, and he began gasping for air and drooling as he writhed on the table and struggled at the straps of the gurney. After approximately 5 minutes, his body was still, and he was declared dead by prison authorities.

Ms. Davidoff told the psychologist, "Once you see someone die, you don't forget what it looks like." She felt that her professional role as an objective recorder was helpful to her initially in that it separated her from her emotional response. She recalled, for example, the sensation of her mouth going dry just at the moment of execution, but the sensation was detached from any emotional response. This detached feeling, which she described as "surreal and macabre," persisted for some days after the event. For a week after the execution, she continued to be detached from her feelings and was "in a daze and not like my usual self."

For the last few weeks, since the execution, she has been unable to concentrate on her work, has felt uninterested in it, and has been dissatisfied with it. She was sur-

constantly during the period of abduction. Since that time, she "chews the skin off her fingers below the nails and twists her hands. She is scared of the dark and wakes up seeing things or thinks someone is after her or coming into her room." She describes scary dreams of "monsters" and has trouble sleeping.

Her parents were unhappy and quarreled frequently during their 2 years together. Her father came from a financially poor family and did not complete high school. He always talked as if he had lots of money; however, after they had separated, the mother discovered that he had a long police record, involving rape and assault and battery. He was involved in using illegal credit cards, doing contract work without a license, and not paying state and federal income taxes. There was a warrant out for his arrest in their state.

When interviewed, Kaitlyn had her hair attractively styled with pigtails and wore small red earrings and colorful play clothes. She was cooperative and left her mother with only slight hesitation. She quickly showed the interviewer that she could tie her own shoelaces with ease. She easily became engaged in play, but her play involved many frightening themes: a father puppet repeatedly scared a baby puppet, a tiger choked a mouse, and a cow was eaten up by a frog.

The Wreck

Enrique Casales is a 40-year-old married carpenter who was involved in a motor vehicle accident that "totaled" his car approximately 2 years ago. He sustained no head trauma or loss of consciousness. He was hospitalized for 1 day with a diagnosis of neck strain and inflammation of the spinal nerve to the trapezius muscle in his back. A course of physical therapy and anti-inflammatory medication was prescribed.

In the months that followed the accident, Mr. Casales experienced occasional involuntary thoughts of it. He had trouble falling asleep, irritability, anxious mood, impaired concentration, and increased appetite, with a 30-pound weight gain. These symptoms tended to wax and wane over the subsequent months. The patient suffered no avoidance behavior and no loss of interest in his usual activities, including sexual interest, and he continued to socialize with his friends. He drove an automobile and was comfortable as a passenger in a car; however, there was some transient anxiety when he drove past the accident site.

Mr. Casales' orthopedic injuries prevented him from returning to work as a carpenter, but he continued to work actively at various "side" businesses. His marital life began to deteriorate as he became increasingly irritable at home. Despite these difficulties, he was able to enjoy himself on a 3-day camping trip with some friends.

After approximately 2 years of physical therapy, Mr. Casales decided to undergo recommended surgery. Mr. Casales tolerated the surgery well, but the procedure left him with a temporary disability (a restriction in range of motion and loss of strength) in his right shoulder and arm. As soon as he returned home, his emotional status changed dramatically. In addition to having concerns about the ultimate outcome of the surgery, he began thinking about the accident continually, despite efforts to avoid such thoughts by distracting himself. He was unable to sleep, in large part because of terrifying dreams that would awaken him and leave him sweating and unable to return to sleep for 2 or more hours. He lost interest in sex and reported that he now "did not care about anybody or anything." He developed an exaggerated startle response to loud noises, such as the honking of a horn or the slamming of a door.

Mr. Casales' postsurgery disability prevented him from driving. When he was a passenger in a car, Mr. Casales became acutely anxious, broke out in a sweat, felt nauseated, and often gave vent to abusive verbal outbursts at other drivers on the road. He had a similar response when passing an accident. He was unable to concentrate on his side businesses. His marital situation deteriorated, because of an increasing sense of emotional isolation from his wife, to the point of a planned divorce. After 6 weeks of symptoms, the patient sought assistance from his orthopedic surgeon, who made a psychiatric referral.

"I am a wreck," Mr. Casales reported to the psychiatric consultant. The psychiatrist treated the patient with an antidepressant, sertraline, and supportive psychotherapy, which resulted in prompt control of his symptoms. During the next 2 months, his postsurgical disability resolved, so that he had full range of motion and nearly full strength. After 6 months, attempts were made to reduce the dosage of sertraline, but the dreams, sleep disturbances, and high level of anxiety promptly returned.

Eating Until It Hurts

Andrea Simpson, age 35, weighed 230 pounds when she returned to her therapist to get help for the eating and weight problems that had caused her grief since she was a child. She was again having uncontrollable eating binges and had gained over 50 pounds in 6 months.

Ms. Simpson remembered being called "fatty" by her schoolmates in early elementary school and having frequent arguments with her mother about her excessive eating and weight throughout childhood and adolescence. During high school she nibbled throughout the day. After each bite she vowed to herself that this would be the last, and she would go on a diet but was never able to keep her vow. She felt very ashamed of her weight, but she gradually gained more. She did most of her eating in private so others would not see. At graduation from high school, with a height of 5'5", she weighed 203 pounds.

Ms. Simpson believes that her binge eating began in college. She lost about 40 pounds by dieting when she began college, and then she began to alternate between periods of dieting and overeating, lasting several weeks to several months. During periods of overeating, she often ate a large breakfast (e.g., several eggs with cheese, two or three slices of toast, and two large glasses of orange juice) in the university cafeteria. She would then take large quantities of food back to her dorm room (e.g., two or three peanut butter sandwiches, two or three dozen cookies, potato chips, cheese), which she ate over the next few hours. She ate until she felt physically uncomfortable and then fell asleep. She felt very depressed and ashamed about her weight during this time. She does not recall feeling out of control during the eating because she always believed that she would stop when she had finished whatever piece of food she was eating, although this seldom happened. She had a number of weight fluctuations in college; her weight ranged from 170 to 230 pounds.

Ms. Simpson got down to a normal weight in her last year of college and got married after graduation. She began to overeat again on her honeymoon. Her husband was angry

dishonesty concerning her eating (motivated largely by shame about what she had eaten). She feels that her eating problems contributed significantly to her subsequent divorce.

Over the next several years, Ms. Simpson continued to struggle with her weight and eating. She went to Weight Watchers several times, tried numerous diets in magazines, used prescribed and illicit amphetamines to decrease her appetite, and spoke to internists about her weight and tried diets they gave her. However, she continued to be overweight with marked weight fluctuations. During periods of dieting, she was preoccupied with food and urges to eat.

Ms. Simpson was in psychotherapy in her mid-20s for issues related to her divorce and family. Although she tried to discuss her weight and eating problems, the therapy was ineffective for these issues because the therapist's interventions were largely limited to suggesting diets.

Ms. Simpson describes the periods of binge eating as "a nightmare," during which she is preoccupied with fighting the urge to eat, planning additional eating, and feeling guilty and ashamed about her eating and the inevitable weight gain that will follow. Her worst period of daily binge eating, lasting about 10 months, occurred approximately 2 years ago. She ate boxes of cookies, ice cream and other sweets; large amounts of peanut butter and bread; and many bowls of cereal when nothing else was in the house. She felt out of control of her eating and desperate about her inability to stop binge eating. She often ate until she had stomach pain, never felt hungry because she was always eating so much, essentially lost all semblance of a meal structure, avoided eating in front of others because she was ashamed of the eating, and constantly felt depressed. She gained 90 pounds during this period of binge eating.

When she returned to her therapist at age 35, she was encouraged to join OA. She found the combination of OA and psychotherapy helpful. She lost about 80 pounds, without rigid or restrictive dieting, and has kept off 60 of these pounds for about 5 years. She is pleased that she does not often feel preoccupied with food or urges to eat between meals, although she continues to have trouble controlling the size of her meals. She feels quite sure that she will never be entirely free of her eating problem and could begin binge eating again at some unpredictable future time. For this reason, she continues to attend OA meetings.

No Parking

Vanessa Abernathy, a 36-year-old traffic enforcement agent, was referred for psychiatric examination by her lawyer. About 10 months previously, moments after she had written a ticket and placed it on the windshield of an illegally parked car, a man dashed out of a barbershop; ran up to her, swearing and shaking his fist; and hit her in the jaw with enough force to knock her down. A fellow worker came to her aid and summoned the police, who caught the man a few blocks away and arrested him.

Ms. Abernathy was taken to the hospital, where a hairline fracture of the jaw was diagnosed by X-ray. The fracture did not require that her jaw be wired, but she was placed on a soft diet for 4 weeks. Several different physicians, including her own, found her physically fit to return to work after 1 month. The patient, however, complained of severe pain and muscle tension in her neck and back that virtually immobilized her. She spent most of her days sitting in a chair or lying on a bed board on her bed. She talked about her pain incessantly with her family and friends, to the point that her friends stopped calling her because they were sick of hearing her complain. She also enlisted the services of a lawyer because the Workers' Compensation Board was cutting off her payments and her employer was threatening her with suspension if she did not return to work.

Ms. Abernathy shuffled slowly and laboriously into the psychiatrist's office and lowered herself with great care into a chair. She was attractively dressed, was well made up, and wore a neck brace. She related her story with vivid detail and with considerable anger directed at her assailant, her employer, and the compensation board. It was as if the incident had occurred yesterday. Regarding her ability to work, she said that she wanted to return to the job and would soon be severely strapped financially, but was physically not up to even the lightest office work.

Ms. Abernathy denied any previous psychological problems and initially described her childhood and family life as storybook perfect. In subsequent interviews, however, she admitted that as a child, she had frequently been beaten by her alcoholic father, and had once suffered a broken arm as a result, and that she had often been locked in a closet for hours at a time as punishment for misbehavior.

The Radiologist

Malcolm Davies, a 38-year-old radiologist, is evaluated after returning from a 10-day stay at a famous out-of-state diagnostic center to which he had been referred by a local gastroenterologist after "he reached the end of the line with me." Mr. Davies reports that he underwent extensive physical and laboratory examinations, X-ray examinations of the entire gastrointestinal tract, and endoscopic evaluations of his esophagus, stomach, and colon. Although he was told that the results of the examinations were negative for significant physical disease, he appears resentful and disappointed rather than relieved at the findings. He was seen briefly for a "routine" evaluation by a psychiatrist at the diagnostic center, but had difficulty relating to her on more than a superficial level.

On further inquiry concerning his physical symptoms, Mr. Davies describes occasional twinges of mild abdominal pain, sensations of "fullness," "bowel rumblings," and a "firm abdominal mass" that he can sometimes feel in the left lower quadrant of his abdomen. Over the last 6 months, he has gradually become more aware of these sensations and convinced that they may be due to a carcinoma of the colon. He tests his stool for occult (i.e., not visible) blood weekly and spends 15–20 minutes every 2–3 days carefully palpating his abdomen as he lies in bed at home. He has secretly performed several X-ray studies on himself in his own office after hours.

Although he is successful in his work, has an excellent attendance record, and is active in community life, Mr. Davies spends much of his leisure time at home surfing the Web to look up information about illnesses he worries that he might have. His wife, an instructor at a local school of nursing, is angry and bitter about this behavior, which she describes as "robbing us of what we've worked so hard and postponed so much for." Although she and her husband share many values and genuinely love each other, his behavior causes a real strain on their marriage.

When the patient was 13 years old, a heart murmur was detected on a school physical examination. Because a younger brother had died in early childhood of congenital heart disease, Mr. Davies was removed from gym class until the murmur could be evaluated. The evaluation proved the murmur to be benign (i.e., not harmful), but he began to worry that the evaluation might have "missed something" and considered the occasional sensations of "skipping a beat" as evidence that this was so. He kept his fears to himself, and they subsided over the next 2 years but never entirely left him.

As a second-year medical student, Mr. Davies was relieved to share some of his health concerns with his classmates, who also worried about having the diseases they were learning about in pathology. He realized, however, that he was much more preoccupied with and worried about his health than they were. Since graduating from medical school, he has repeatedly experienced a series of concerns, each following the same pattern: noticing a symptom, becoming increasingly preoccupied with what it might mean, and having a negative physical evaluation. At times he returns to an "old" concern but is too embarrassed to pursue it with physicians he knows, such as when he discovered a "suspicious" mole only 1 week after he had persuaded a dermatologist to biopsy one that proved to be entirely benign.

Mr. Davies tells his story with a sincere, discouraged tone, brightened only by a note of real pleasure and enthusiasm as he provides a detailed account of the discovery of a genuine, but clinically insignificant, anomaly in his urethra as the result of an intravenous pyelogram (X-ray of the kidneys and urinary tract made after an intravenous injection of dye) he had ordered himself. Near the end of the interview, he explains that his coming in for evaluation now is largely at his own insistence, precipitated by an encounter with his 9-year-old son. The boy had accidentally walked in while he was palpating his own abdomen for "masses" and asked, "What do you think it is this time, Dad?" As he describes his shame and anger (mostly at himself) about this incident, his eyes fill with tears.

Medical Miscreant

Chris, an 11-year-old boy, suffered a nasty fall from a spiral staircase while at a party with his family when he was age 6. Despite a complete recovery within days of the accident, he has continued to receive medical attention for a bewildering array of problems, many unrelated to his fall. At the insistence of his mother, a 41-year-old hospital clerk, Chris has been assessed by neurologists in California for seizures, visual deficits, and severe headaches suggestive of fluid buildup in the brain. She has taken him to out-of-state hospitals for investigation of vocal cord dysfunction, thyroiditis (inflammation of the thyroid gland), difficulty eating and drinking, excessive urination, and autoimmune disease. Chris has even been examined by psychiatrists for amnesia, autism, post-traumatic stress symptoms, and Attention-Deficit/Hyperactivity Disorder (ADHD), following reports from his mother of poor behavior and difficulty concentrating. However, at no point during his extensive workup have any objective signs of illness been found, and on examination Chris has generally appeared to be a normal, healthy boy. In fact, when interviewed, Chris has been unable to describe any of his symptoms, much to the amazement of his care team, who are under the impression that he suffers from a host of chronic and severe disorders. This confusion is due to the false medical history provided to them by his mother, who knows perfectly well that Chris is not sick.

Faced with a confusing clinical picture and unrelenting pressure from Chris's mother, many clinicians have been convinced to pursue aggressive diagnostic studies or treatments. At times, his mother has supplemented her child's fabricated history with more false information, claiming variously to be a registered nurse with pediatric expertise, to have medical documents that confirm the findings of serious illnesses, or to have witnessed the negligence of staff members formerly involved in Chris's care. The medical history she relates on her son's behalf is often inconsistent and occasionally outright nonsensical. Sometimes, Chris's "symptoms" take the form of illnesses his mother herself has falsely claimed to have, including ADHD and autoimmune disease. When she has been unable to gain the support of a doctor, she has sought an alternative opinion or traveled to another hospital.

In the course of his mother's deception, Chris has undergone a disturbing series of procedures. His mother has welcomed, if not actively solicited, even very uncomfortable procedures for her son. Remarkably, these interventions have included a period of water deprivation to investigate his alleged excessive urination and the installation of a feeding tube. For 5 years, no specialist or subspecialist has been able to achieve the slightest improvement of his "symptoms." Indeed, in combination with a heavy medication regimen, these treatments have resulted in considerable disability for Chris. His impairments, both real and falsified, have made his family eligible for state financial support. While Chris has been deprived of his social life, his mother has thrived on the opportunity to present herself to her peers as the heroic, if not indefatigable, caregiver of a sick child.

Chris has recently been removed from his mother's care, following a report filed with Child Protective Services by a teacher concerned that he has needlessly been enrolled by his mother in a school for autistic children. His health has since improved, and he has been weaned successfully from most of the medications he has been taking. His mother has been arrested and charged with child endangerment.

Rocking and Reading

Betsy, age 22 years, was referred for evaluation by the staff of her group home. She had been placed in the group home 3 months earlier, following court-ordered "deinstitutionalization" from a large residential facility for the "mentally retarded." The evaluation was requested because Betsy "didn't fit in" with other clients and had developed some problem behaviors, particularly aggression directed toward herself and, less commonly, toward others. Unlike other clients in the group home, she tended to "stay to herself" and had essentially no peer relations, although she did respond positively to some staff members. Her self-abusive and aggressive behaviors usually were triggered by changes made in her routine. Self-abusive behavior consisted of repeated pounding of her legs and biting of her hand.

Betsy had been placed in residential treatment when she was 4 years old and had remained in some kind of residential setting ever since. Her parents had both died by the time she was 18, and she had no contact with her only sibling. At the time of her transfer to the group home, she was reported to have had several abnormal electroencephalograms, but no seizures or other medical problems had been noted. When last given psychological tests, she achieved a full-scale IQ of 55, with comparable deficits in adaptive behaviors.

During the evaluation, Betsy spent much of her time looking at a children's book she discovered in the waiting room. Her voice was flat and monotonic. She was unable to respond to any questions about the book she was reading and reacted to interruptions of her ongoing activity by pounding her legs with her fist. She rocked back and forth continually during the interview. She made eye contact with the examiner initially but otherwise seemed oblivious of everyone around her. She did not initiate activities, imitate the play of the examiner, or respond to attempts to interest her in alternative activities, such as playing with a doll. From time to time she repeated a single phrase in a monotonic voice, "Blum, blum." Physical examination revealed extensive bruises covering most of her lower extremities.

Betsy was the product of a normal pregnancy, labor, and delivery. She was noted to have been an unusually easy baby. Her parents had first become concerned when she failed to speak by age 2. Motor milestones were also delayed. Her parents initially thought she might be deaf, but this was obviously not the case, because she responded with panic to the sound of a vacuum cleaner. As a young child, Betsy had been noted to "live in her own world," had not formed attachments to her parents, had idiosyncratic responses to some sounds, and always became extremely upset when there were changes in her environment.

By age 4, Betsy was still not speaking, and placement in the state institution was recommended following a diagnosis of Childhood Schizophrenia. In the year after her placement, Betsy began speaking. However, she did not typically use speech for communication; instead, she merely repeated phrases over and over. She had an unusual ability to memorize and became fascinated with reading, even though she appeared not to comprehend anything she read. She exhibited a variety of stereotyped repetitive behaviors, including body rocking and head banging, requiring a great deal of attention from the staff.

Backstage With Rosie[1]

Rosie Shapiro, a 70-year-old lifelong New Yorker, was brought by her niece to an evaluation and treatment center specializing in problems in the elderly. The niece, who lives in a rural community 70 miles away, had become concerned after a regular monthly visit to her aunt's apartment in the city. On the visit, the niece noticed that her aunt's supply of food was unusually low. The few fruits and vegetables in the refrigerator were rotten, and unopened mail was piling up. When she asked her aunt about these, the elderly woman looked surprised and said, "Well, I guess I didn't get around to my chores this week!" Otherwise, she seemed her normal self.

In fact, Mrs. Shapiro's niece had become increasingly uneasy about her aunt's living situation over the past year. Her aunt had no children of her own and, since her husband's death 5 years before, had been living alone in an apartment that she had inhabited for 35 years. The niece, as the closest living family member, had assumed the responsibility for a monthly drive to the city to visit and to check on Mrs. Shapiro's well-being.

In earlier years, Mrs. Shapiro had had a weekly routine that she always followed: going on Mondays to the grocery store, doing her laundry on Tuesdays, and so forth. But for a year, her schedule seems to have become disrupted. She seemed also to be constantly misplacing things in her apartment and repeating stories and details of her daily life that she had told her niece on previous visits.

When the psychiatrist interviewed Mrs. Shapiro, he found that she was a woman with a rich and exciting past. Both she and her husband had been in the theater, her husband a manager and Mrs. Shapiro a wardrobe designer. Her eyes lit up as she spoke of shows like *Cabaret* and *A Chorus Line* and shared some ancient gossip about romantic liaisons between actors and actresses who starred in movies and who were on the covers of magazines when the psychiatrist was a child.

When asked to name the current President of the United States, she replied, "you know, what's his name." But no matter how hard she tried, Mrs. Shapiro could not remember the President's name. In addition, many other current common facts and events eluded Mrs. Shapiro's recall. She would look up at the ceiling and then at the psychiatrist, shaking her head and saying, "I knew that, you know. I just can't seem to think of it right now." As for her reason for coming to the hospital, she said, "Well, I was due for a checkup. A friend of the family is an internist and he insisted that I come over."

Mrs. Shapiro was unable to remember any of three objects a few minutes after she had repeated them. She struggled but performed the serial 7s task (i.e., a test of cognitive functioning in which a person is asked to count backward from 100 by 7s) with only two mistakes. She was able to repeat six numbers and find similarities between objects and, except for some difficulty with word and name finding, showed no marked aphasia (language impairment), apraxia (impairment in ability to perform purposeful movements), agnosia (impairment in the ability to interpret sensations and hence to recognize things), or constructional difficulties (e.g., copying figures, picture drawing). She admitted that her forgetfulness was "getting to be a problem" and agreed to let the psychiatrist and her niece arrange for some home assistance.

A workup for the presence of a medical problem that might be responsible for Mrs. Shapiro's memory decline was negative except for the beginning signs of cortical atrophy (shrinkage of her cerebral cortex) on a CT scan.

Underground Sex

Chad Hughes was age 45 when he was referred for psychiatric consultation by his New York City parole officer following his second arrest for rubbing up against a woman in the subway. According to Mr. Hughes, he had a "good" sexual relationship with his wife of 15 years when he began, 10 years ago, to touch women in the subway. A typical episode would begin with his decision to go into the subway to rub up against a woman, usually in her 20s. He would select the woman as he walked into the subway station, move in behind her on the subway platform, and wait for the train to arrive at the station. He would be wearing plastic wrap around his penis so as not to stain his pants after ejaculating while rubbing up against his victim. As riders moved onto the train, he would follow the woman he had selected. When the doors closed, he would begin to push his penis up against her buttocks, fantasizing that they were having intercourse in a normal noncoercive manner. In about half of the episodes, he would ejaculate and then go on to work. If he failed to ejaculate, he would either give up for that day or change trains and select another victim. According to Mr. Hughes, he felt guilty immediately after each episode but would soon find himself ruminating about and anticipating the next encounter. He estimated that he has done this about twice a week for the last 10 years, which would mean that he has rubbed up against approximately 1,000 women.

During the interview, Mr. Hughes expressed extreme guilt about his behavior and often cried when talking about fears that his wife or employer would find out about his second arrest. However, he had apparently never thought about how his victims felt about what he did to them.

His personal history did not indicate any obvious mental problems other than being rather inept and unassertive socially, especially with women.

Living as a Man

A 25-year-old patient from North Dakota who was born female and now calls himself Charles Northrup requested a "sex change operation." He had for 3 years lived socially and been employed as a man. For the last 2 of these years, he had been the housemate of, economic provider for, and husband-equivalent for a bisexual woman who had fled from a bad marriage. Her two young children regarded Mr. Northrup as their stepfather, and there was a strong affectionate bond between them.

In social appearance, the patient passed as a not very virile man whose sexual development in puberty might be conjectured to have been extremely delayed or hormonally deficient. His voice was pitched low but not baritone. His shirt and jacket were bulky and successfully camouflaged tightly bound, flattened breasts. A strap-on penis produced a masculine-looking bulge in the pants; it was so constructed that in case of social necessity, it could be used as a urinary conduit in the standing position. Without success the patient had tried to obtain a mastectomy, so that in summer he could wear only a T-shirt while working outdoors as a heavy construction machine operator. He had also been unsuccessful in trying to get a prescription for testosterone to produce male secondary sex characteristics and suppress menses. The patient wanted a hysterectomy (surgical removal of the uterus) and oophorectomy (surgical removal of the ovaries), and as a long-term goal looked forward to obtaining a successful phalloplasty (surgical construction of a penis).

The patient was straightforward in his account of progressive recognition in adolescence of being able to fall in love only with a woman, following a tomboyish childhood that had finally consolidated into the transsexual role and identity.

Physical examination revealed normal female anatomy, which the patient found personally repulsive and incongruous, and which was a source of continual distress. The endocrine laboratory results were within normal limits for a female.