ICD 10 Training Kit - (in collaboration with WHO) SECTION 5

### **ICD 10 Training Kit - (in collaboration with WHO)**

## SECTION 5

**CASE HISTORIES**  
  
**Introduction**  
  
**Case exercises can be done in different ways, depending on the number of participants, and availability of rooms and materials; some possibilities are listed below:**

1. a. The participants will be assigned to small groups (12 to 15 persons), each equiped with a copy of the ICD-10 version for general clinical use. A discussion leader/rapporteur will be chosen for each small group. The written case histories will be studied one by one. The participants will make one or more diagnoses for eah of the cases. The discussion leader will make a list of problems encountered in each group. After return to the general meeting room, cases and their diagnoses will be presented. The use of criteria and problems will be discussed. A written commentary on diagnosis and classification for each case will be distributed after the discussion of the case(s).
2. b. A minimum of 5 written case histories will be presented without diagnosis. Participants are asked to fill in forms for the recording of the diagnoses, which will then be discussed, if possible with the presentation of the criteria on transparencies. The diagnosis will be discussed after each case. A written commentary on diagnosis will be distributed after the discussion of cases. The forms filled in by the participants of a one-day workshop can be analysed later: if the workshop lasts two days the results can be shown during the second afternoon. This way of proceeding would be particularly helpful for the application of the ICD-10 Diagnostic Criteria for Research.
3. c. Life interviews or video-taped interviews can be shown, in stead of written case histories.

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**Case 1**  
  
**The patient is a 70-year-old housewife with two adult children.**  
  
**Problem:** The patient had always been such an organized person, so when she began forgetting even the most basic things her husband got worried. He took her to the family doctor who referred her for a check-up at the psychiatric department of a general hospital. According to her husband, the memory problems became apparent about two years before when the patient complained she could not remember names. Her husband noticed she sometimes could not remember things that had happened the day before. As she became more and more forgetful, she had problems calculating her money when shopping and often came home without the things she needed. She had always been proud of her cooking but now she kept spoiling the food. Almost every time she prepared a meal she either put in far too much salt or none at all. She regularly forgot to turn off the stove or left the water running. In the 12 months before referral, she had been unable to do her household chores without the assistance of her husband. She c onsulted her family doctor several times and he prescribed a neurotrophic drug, apparently without noticeable results.  
  
History: The patient lived with her husband, a 72-year-old retired schoolteacher. She had once been a schoolteacher too but left her job when her first child was born and never resumed her work. Her husband described her as having always been an easy-going, sociable and jovial person. There had been no major problems within the marriage or with the children. In the months prior to her referral, however, his wife had become withdrawn, apathetic, irritable and rather suspicious.  
  
The patient's father died in a mental institution, to which he had been admitted at the age of 75 for "arteriosclerosis".  
  
Findings: On examination the patient was somewhat untidy. She was alert but obviously anxious and suspicious. She was disoriented with respect to time and place. She could remember the names of her children but could not recall their ages or dates of birth. Nor could she remember her own. She did not know the name of the president of her country. Her speech was well articulated but slow, vague and circuitous. She had difficulty finding words to express herself. She could not recall three objects after a five-minute interval. She could not copy a cube and failed completely to copy Rey's figure. She did poorly on even simple calculations and could not count backwards. She understood proverbs literally and she could not detect the error of logic in the "train story" (in this story, the patient is told that most train accidents are caused by the last wagon so it has been decided to take this wagon away). She had no insight into the nature of her problem.  
  
On neurological and physical examination no abnormal findings were detected. The patient's blood pressure was within the normal range for her age. All laboratory tests were negative, but a computerized tomography scan showed marked cortical atrophy.  
  
Discussion  
  
The patient has a decline in memory and other intellectual abilities, sufficient to impair personal activities in daily living. This is associated with a change in social behaviour (apathy, suspicion and irritability). The decline in memory and other intellectual functions has been clearly present for more than six months, the onset has been insidious, beginning after age 65, with a generally progressive, deteriorating course and no specific cause. The consciousness of the patient is clear. These findings allow us to make a confident clinical diagnosis of dementia in Alzheimer's disease with late onset (F00.1). According to the Diagnostic criteria for research, the dementia is of moderate severity since the patient is unable to function without the assistance of her husband and requires considerable supervision. In the absence of delusions, hallucinations and depressive features, the fifth character 0 can be added to the code.  
  
F00.10 Dementia in Alzheimer's disease with late onset, without additional symptoms.  
  
  
  
Case 2  
  
The patient is a 75-years-old woman. She is a widow and lives alone. She was admitted to an orthopaedic hospital ward after breaking her leg.  
  
Problem: The patient was so confused and restless that she wandered about in the orthopaedic ward at night, disturbing the other patients. She was referred for psychiatric assessment because of clouded consciousness and hyperactive behaviour. Two weeks earlier she had fallen in her bathroom and fractured her femur. She was admitted to the orthopaedic ward and had an osteosynthetic operation. After the operation her confusion began. Her consciousness became clouded with reduced attention and awareness. She could not remember what had happened to her or why she was in hospital. During the day she showed mild aimless hyperactivity. She was unable to read or to watch television and could not always recognize relatives who visited her. She pushed the nursing staff away when they tried to wash her or look after her. She was seen having conversations with imaginary persons and staring hard at a point on the ceiling. She was irritable and would burst out in anger. She knocked her meals onto the floor and refused to take any medication. Between the outbursts the patient calmed down and was able to sleep for up to half an hour, but at night-time she seemed unable to sleep at all and the hyperactivity increased. As other patients fell asleep for the night, she started wandering about the ward waking them up again. She went into other patients' rooms and tried to climb into their beds. Several times she tried to leave the hospital in her nightdress but was stopped and brought back to her room. Before her operation the patient had behaved normally and her children had noticed no recent deterioration of memory or concentration.   
  
The patient had lived alone for 20 years after the death of her husband who had been an accountant in a publishing company. She had two grown-up daughters who lived in the same district. She lived in a rented apartment and had been able to look after herself without assistance until the present episode of illness.  
  
She had always been a quiet and somewhat introverted woman, but otherwise there had never been anything unusual about her. Apart from a mild non-insulin-dependent diabetes in the last five years, she had been somatically well. She had never been admitted to hospital before the present incident. She had not received any regular medication and did not drink alcohol.  
  
On examination the patient appeared perplexed and inattentive. She was totally disoriented and uncooperative. She sat muttering to herself and hardly seemed to notice the presence of the examiner. She did not appear depressed or anxious. She was unable to cooperate in any mental tests.  
  
Physical examination, which included neurological assessment, detected no abnormalities although it was incomplete because of the patient's lack of cooperation. Laboratory findings showed moderate deviations in the serum electrolytes the first day after the operation, but at the time of the psychiatric assessment they were normalized. Blood cell and liver parameters were normal. The electrocardiogram showed a pattern of a previous minor infarction and blood pressure was a low normal.  
  
DISCUSSION  
  
The patient presents a typical case of organic delirium F05. Because of the continuing delirium, it was not possible to determine whether she displayed signs of incipient dementia, but according to the relatives' reports this was not to be suspected. The delirious state developed after an operation with anaesthesia from which she awoke in unfamiliar surroundings. Disturbed serum electrolytes may have contributed to her state. There is no evidence of other organic etiology or of alcohol or drug use. It is not unusual to observe delirious states in elderly people following a major operation with anaesthesia. This is caused by a combination of hormonal reaction to the operation, withdrawal of anaesthetics and disturbed salt-water balance. The patient's delirium therefore most probably is a case of F05.8 other delirium, which includes delirium of mixed origin.  
  
  
  
F05.8 Other delirium.  
  
  
  
Case 3  
  
The patient is a 55-year-old judge in a provincial town.  
  
Problem: The patient went to see his general practitioner because he felt that he had not recovered fully after a severe attack of influenza 3-4 weeks previously. He had been ill for a week with temperatures of around 40°C, with severe headaches, nausea, aches and pains all over his body, and fatigue. The next week he recovered from these symptoms and went back to work but had difficulties concentrating when reading and attending court sessions, and afterwards he could not remember what he had read or heard. His thinking was slowed. He had difficulty finding the right words or phrases and could not make even minor decisions. After a few days at work he had to take sick-leave again. After another week he felt improved and tried to return to his work, but he soon found out that his improvement was far from sufficient. He still could not concentrate or remember things and he had difficulty expressing himself and making decisions. He realized that he still had not reco vered fully. After yet another week he was in almost the same state so he went to see his general practitioner because he feared something was wrong with his mind.  
  
History: The patient was the second of two children. His father was a carpenter and the family lived in a provincial town. His sister, who was two years older than he, died at the age of 33 when she crashed her car into a tree. Her husband had recently left her and a suicide was suspected. His father died at the age of 75 and his mother at the age of 82. There is no information about mental illness in the family. After high school the patient studied law at university after which he took up a judicial career and succeeded in becoming a judge at the age of 43. At 28, he married a nurse two years younger and they had three children. The children are now grown up and are studying at university.  
  
The patient was always quiet and reticent with a well balanced temper. He never had mood swings or episodes of unexplained fatigue. He was always highly conscientious and hard working; sometimes he felt tense and tired, but usually recovered after a few days of rest during weekends and holidays. He had never had episodes similar to the current one.  
  
At the age of 20 the patient was admitted to hospital for an appendectomy but otherwise his physical health has been good. At the age of 50 he had a general check-up which showed no abnormalities except that he was slightly overweight.  
  
Findings: The patient seemed to be rather worried and tense. He looked slightly pale and grey, but he did not appear fatigued or depressed and denied any loss of interest or diminished capacity of experiencing pleasure or joy. He was fully oriented and no impairment of awareness or attention was observed. Testing his concentration and memory revealed mild difficulties, however. When counting backwards from 100 he became tired after a few counts and made a couple of mistakes; he managed to spell a five-letter word backwards after two attempts. His immediate recall was limited to only five digits and he forgot one of three objects after three minutes. His capacity for reading, writing, simple calculations and abstraction showed no gross impairments, but he was hesitant and tense during the test. No perceptual or delusional disorder was suspected and his mood seemed to be neutral. He stated that he was a teetotaller and that he never took medications or drugs.  
  
Medical examination including neurological examination did not reveal any abnormalities. He was referred for EEG which was normal. Laboratory investigations, including blood counts, thyroid parameters, B12 and WR, showed no abnormalities.  
  
The patient was prescribed four weeks of rest, mild physical exercise but no medication. After one month he felt much better. The mild difficulties in concentration and memory seemed to have disappeared and he was able to read books and journals for hours, though he still had mild difficulty in remembering details. He was advised to take another two weeks of rest. He then started working again but only half-time. After still another two weeks he resumed his work full-time, finally felt completely recovered and was able to work at his former level.  
  
DISCUSSION  
  
The patient presented with mild difficulties of memory, learning, concentration and thinking lasting for more than a few weeks. This condition followed a severe influenza which may be presumed to have caused transitory cerebral dysfunction, which would explain his cognitive symptoms. The mild impairment was confirmed by a slight decline in his performance on a mental status examination. The decline was too mild to meet the criteria for dementia. There is no evidence of an amnesic syndrome or a state of delirium. Post-encephalitic syndrome is not suspected because of a normal EEG. No other mental disorder was suspected and he did not have any alcohol or other psychoactive substance use. The patient therefore meets the criteria for mild cognitive disorder (F06.7).  
  
F06.7 Mild cognitive disorder.  
  
  
  
Case 4  
  
The patient a 35-year-old factory worker. He is married and has three children aged 7, 9 and 11.  
  
Problem: After falling downstairs and breaking his leg one evening, the patient was admitted to the orthopaedic department of a general hospital. On the third day of his stay, he grew increasingly nervous and started to tremble. He was asked about his drinking habits but denied having an alcohol problem. He told the doctors that he only occasionally had a glass of beer. During the night, he could not sleep and the nurses became concerned because he was talking incoherently and was obviously very anxious.  
  
History: According to his wife, the patient had drunk large quantities of beer for more than three years. During the past year, he had missed work several times and had been threatened with dismissal. Each day, he started drinking when he came home from work in the evening and did not stop until he fell asleep. On the evening when he was admitted to hospital, he came home as usual but slipped on the stairs and broke his leg before he could start drinking. Consequently he had not had a drink prior to admission. His wife felt ashamed of her husband's alcohol problem and did not have the courage to tell the orthopaedist about it when her husband went into hospital. Three days later when the doctors asked her directly she told them the full story.  
  
The woman said her husband had eaten very little during the past few weeks. She had noticed that on several occasions he could not remember even important events that had happened the day before. He had a car accident when drunk two years before, but without any major injury. The patient had had no other major health problems in the past. The relationship with his wife had, however, become extremely difficult since he started drinking and she was seriously considering a divorce. The relationship with his children had been tense. He had often argued with them but recently they had tried to avoid their father as much as possible.  
  
According to the woman, her husband's father had been a chronic alcoholic and died from liver cirrhosis when her husband was 24 years old.  
  
Findings: On examination, the patient's speech was rambling and incoherent. He thought he was still at his factory and that he had to finish a job. At times he recognized the doctors and nurses who had looked after him during the previous days, but at other times he thought they were colleagues from his factory. On several occasions, he picked at bugs that he could see on his bedsheets. He was disoriented in time, and was startled by the slightest sound from outside the room. He sweated profusely and could not hold a glass without spilling most of its contents. He was constantly trying to get out of bed and seemed unaware that his right leg was in plaster.  
  
DISCUSSION  
  
The patient has a long history of heavy alcohol use and developed severe withdrawal symptoms when he could not get alcohol. He presented with the characteristic symptoms of a delirium: clouding of consciousness, global disturbance of cognition, psychomotor agitation, disturbances of the sleep-wake cycle (insomnia), rapid onset and fluctuation of the symptoms.  
  
The presence of a withdrawal state, associated with a delirium, shortly after cessation of heavy alcohol consumption indicates alcohol withdrawal state with delirium. Since the patient did not also have convulsions, the diagnosis according to ICD-10 is F10.40.  
  
The patient's drinking problem has lasted for at least three years and the information provided by his wife gives evidence that points to an additional diagnosis of alcohol dependence syndrome (F10.2).  
  
The memory problems observed by his wife make it possible that the patient has, in addition, an amnesic syndrome due to the use of alcohol. The description, however, does not provide us with enough information to make a reliable additional diagnosis of amnesic syndrome due to use of alcohol (F10.6). This should be tested after the delirium and other withdrawal symptoms have subsided, since memory impairment is also a prominent feature in delirium.  
  
F10.40 Alcohol withdrawal state with delirium, without convulsionsand as a provisional subsidiary diagnosis  
  
F10.2 Alcohol dependence syndrome.and as a provisional subsidiary diagnosis and as a provisional subsidiary diagnosis **Case 5**  
  
**The patient is a 30-year-old married truck driver.**  
  
**Problem:** The patient was admitted to a psychiatric hospital because he felt persecuted by members of a gang who wanted to kill him. He could not explain why he should be killed, but he had been hearing the voices of people he suspected to be drug dealers and they were discussing how they should get hold of him and kill him. He had previously had encounters with drug dealers because for several years he had used methamphetamine. At the age of 25 one of his colleagues had persuaded him to try the drug. After an intravenous injection of 20 mg he started feeling good, experienced a feeling of being all-powerful, and his sleepiness and fatigue disappeared. After he had tried methamphetamine a few times, he found that he could not stop using it. He was constantly thinking about how to get the drug and he started to increase the dose he used. When he was not able to get methamphetamine he felt lethargic and sleepy, and he became irritable and dysphoric. His wife became aware of his drug use and tri ed to persuade him to stop it because it made him difficult to live with and a nuisance to her and to the children. Two months before his admission to the psychiatric hospital he had lost his job because he had been repeatedly abusive to his colleagues, claiming that they had been interfering with his work and trying to harm him. With no income he had to cut down his consumption of metamphetamine from daily injections to only occasional use and finally gave it up altogether after his wife threatened to leave with the children and divorce him. After he had stopped taking the drug, he felt very tired, seemed gloomy and often sat in his chair doing nothing. A few weeks later he told his wife that he did not dare to leave the house because he had heard some of the dealers in the street talking about him, describing how they would do away with such a useless person. At the same time he appeared tense and apprehensive. He wanted the doors and windows closed and locked, and he refused to eat because he was afr aid that his food was poisoned. His wife finally took him to a general practitioner who referred him to the psychiatric hospital.  
  
History: The patient is the younger of two sons. His father was a grocer. He did well in school, and after secondary school he had several jobs as an unskilled labourer. At the age of 21 he married a young woman of his own age who worked as a waitress in a restaurant. They moved to another city where he got a job as a truck driver. They had three children and lived in a small apartment. Their standard of living was rather poor.  
  
Patient's somatic health had previously been good but in the last few years he had complained of muscle weakness and walking difficulties. These problems occurred after he had been taking methamphetamine injections, but he did not want to consult his doctor about them.  
  
Findings: On examination the patient appeared reticent and withdrawn, giving only short answers to questions. He seemed to be in a neutral mood but admitted that he felt persecuted by a gang of drug dealers and that he could occasionally hear them talking about him, referring to him in the third person. He was in clear consciousness, fully oriented and showed no marked impairment of cognitive functions.  
  
Physical examination, including neurological examination, did not reveal any abnormalities apart from needle scars in the left arm as a result of methamphetamine injections. EEG was normal.  
  
He was treated with 6 mg of haloperidol per day. After two weeks his symptoms had disappeared and he was discharged from hospital. He did not turn up for follow-up treatment.  
  
DISCUSSION  
  
The patient presented with schizophrenia-like symptoms that developed a few weeks after he discontinued a longstanding and regular abuse of methamphetamine. The development of the psychotic disorder seems related to his substance abuse and does not seem to be accounted for by any other mental disorder. He therefore meets the criteria for late onset psychotic disorder due to use of methamphetamine (F15.75).  
  
The patient also seems to meet the criteria for a methamphetamine dependence syndrome with craving, impaired capacity to control, and withdrawal symptoms, for a period of time longer than one month.  
  
F15.75 Late onset psychotic disorder due to use of methamphetamine with a subsidiary diagnosis of  
  
F15.2 Methamphetamine dependence syndrome.

**Case 6**  
  
**The patient is 25 years old and single.**  
  
**Problem:** The patient was persuaded by his brother to seek help at a psychiatric hospital because of violent outbursts and suicidal thoughts. Five weeks before the visit the patient had attacked his mother without warning, hitting her violently until his elder brother restrained him. In the following weeks he had a number of aggressive outbursts and he threatened several times to kill himself. He explained his attack on his mother by claiming that she had tried to harm him and that he had received instructions from an alien force to beat her. After the attack he kept to himself, absorbed in his own thoughts, and frequently talked to himself even when others were around. Sometimes his family had the impression he was listening to voices that no one else could hear. He told his elder brother that he actually felt frightened that he might attack strangers or kill himself; he was afraid that he would lose control of his own actions.  
  
History: The patient grew up in a rural part of the country. He was the second of 10 children. His father had a piece of land but was opium-dependent and did little work. The mother kept the small farm going, growing some crops and even raising a few animals, with the help of some of her younger children. The patient left school in grade 9 to follow his interest in music. He left home and spent his late teenage years in the house of a musician in a nearby town, an old friend of his father, who taught him to play the guitar. He learned to play quite well and developed a passion for music. He played his guitar at several concerts but he never succeeded in getting a fixed job or even in earning enough money to support himself. His elder brother, a teacher, helped him financially. Eventually, at the age of 23, the patient moved to live with him. The two got along reasonably well so long as the brother did not interfere too much with his wish to be left alone.  
  
Before the patient became ill he had always been ambitious about his music. He was preoccupied with the idea of becoming a great musician. He would sit in his room alone for hours playing the guitar. However, he did not really like to play in the presence of others, and he appeared indifferent to praise or criticism. His interest in music was overwhelming and he had few social contacts. He showed no interest in getting a girlfriend, nor did he have any close male friends.  
  
Findings: The patient was a good-looking and appropriately dressed young man. On examination he was tense, spoke quickly and excitedly, and tended to wave his hands around for no apparent reason. His speech was often interrupted by blocking interpolations and from time to time he became incoherent and incomprehensible. He smiled superficially and inappropriately. His affect appeared constricted, with a sudden outburst of anger when he spoke about his mother. He said she wanted to have him killed. He expressed fears that his mind would be taken over by an alien power from another planet. He explained that his thoughts were being controlled by this power which gave him instructions to hurt other people. The alien power apparently discussed Ibrahim's own situation. He said it had told him that his mother wished him dead and had given him the instruction to kill her. In the last few days before coming to the hospital, Ibrahim became preoccupied with the idea of killing himself to stop the ali en power from taking complete control over him.  
  
DISCUSSION  
  
The patient shows a characteristic set of symptoms that correspond to the diagnosis of schizophrenia with a duration of his illness of more than one month. His symptoms include thought insertion, auditory hallucinations with discussing and commanding voices, persecutory delusions, delusions of control of thoughts and of being in communication with an alien power, and catatonic behaviour in the form of excitement and violent behaviour. Since hallucinations and delusions are prominent, the diagnosis is paranoid schizophrenia, with an extra character (9) for uncertain course, because the period of observation is too short.  
  
The patient's personality shows a schizoid pattern: few activities give him pleasure, he appears indifferent to both praise and criticism, he has little interest in sexual experiences, he consistently chooses solitary activities, and he has no close friends. These characteristics point to a diagnosis of schizoid personality disorder, but the general criteria for a personality disorder also need to be fulfilled: an enduring dysfunctional behaviour pattern present since adolescence, pervasive across a broad range of personal and social situations, causing personal distress or an adverse impact on the social environment and which cannot be explained as a manifestation or consequence of another mental disorder. There seems to be supporting evidence to assume that these criteria are met too in this case.  
  
F20.09 Paranoid schizophrenia, course uncertain, period of observation less than one year with a subsidiary provisional diagnosis of   
  
F60.1 Schizoid personality disorder.  
  
  
  
Case 7  
  
The patient is a 24-year-old male who lives alone on social welfare. Until a year ago he worked as an assistant clerk in a large bank.  
  
Problem: The patient was readmitted to the psychiatric hospital because for the last two months he had become increasingly depressed. He kept to himself in his apartment and, when his father visited him and found a rope on the table, the patient admitted he planned to hang himself. His father immediately took him to the psychiatric hospital and had him readmitted.  
  
Five months previously the patient had been admitted to the same hospital in a psychotic state. During the previous year he had become increasingly introverted and reclusive. He said he had the feeling that his colleagues at the bank were keeping an eye on him and talking about him behind his back. He had difficulties concentrating on his work and often left for long visits to the men's room. Also in the street he felt that people took unusual notice of him and he got the impression that they considered him to be homosexual. He had the feeling that his phone was tapped. When he was in his apartment he could hear his neighbours on both sides talking about what he did and thinking "Now he is going to the toilet again - he certainly is homosexual - we should try to get rid of him". He eventually stopped going to work and was fired from his job. After that he kept to himself in his apartment and left it only when it was dark. He had a feeling that his neighbours were trying to annoy him by sending ele ctric currents that affected his genitals, so finally he moved to a hotel. Even there he could hear the voices of the neighbours and felt their electric influences so he finally went to the police. They called for his father who said that he had been concerned about his son's condition for some time. His son had grown so uncommunicative that he would not answer telephone calls. The father took him to the doctor who had him admitted to the psychiatric hospital as an emergency. At the hospital he received treatment with haloperidol (6 mg per day) and in the course of one month he improved to the extent that he was discharged. He continued as an outpatient on haloperidol (3 mg per day) and was able to carry on living in his apartment on social welfare. He still heard voices commenting about him almost daily but now realized they were part of his illness and he did not take much notice of what they said. He showed lack of enthusiasm and spent much of the time doing nothing, looking out of the window, or s itting smoking cigarettes. He regularly kept his outpatient follow-up appointments and took his medication as prescribed. On his assessment record it was noted that he displayed apathy and blunted affect but otherwise seemed to be in a party of remission. For mild side-effects he received biperidime (4 mg per day).  
  
History: The patient was born and grew up in city where his father was an accountant in a large company. He was the third of four children. After high school he opted for a commercial career and started working in a bank. He did not have much ambition, however, and seemed to be satisfied to work as an assistant clerk. At school he did well and had many friends with whom he kept in touch for the first few years after leaving school. Later on he seemed to withdraw from the friendships and keep more and more to himself.  
  
After leaving school he dated one girl but somehow seemed to lose interest. Finally she left him for another. After that he did not seem to show much interest in getting know other females. In the bank he was a conscientious worker although with a peculiar lack of ambition and interest. He seemed to work quite mechanically and sometimes customers complained that he did not really understand what they were asking for. His father also noticed that he had changed and the family had tried to draw him out of his isolation. After he responded aggressively, however, they left him in peace although they still kept in touch by frequent telephone calls. For the last few years the patient had lived alone in a rented apartment and seemed to be able to manage on his own.  
  
There was no information about mental illness in his family. His medical health was always good and he had never been admitted to hospital.  
  
Findings: On his readmission the patient appeared to be in a moderately depressed mood. He answered questions only hesitantly and with broken sentences, admitting that for some time he had been thinking of committing suicide because he felt his situation was completely hopeless. He no longer had any interests, did not derive pleasure from anything and had no self-confidence whatsoever. Recently his sleep had been disturbed, with early wakening. His appetite was poor and he had apparently lost some weight. He still heard the voices talking about him but they had not been so frequent recently and he maintained that he paid little attention to them. He realized that he had a mental illness but he did not think about it much and he did not use it as an explanation for feeling helpless.  
  
Physical, including neurological, examination revealed no abnormalities. On his previous admission he had EEG and ET which had been quite normal and it was not found necessary to repeat these investigations at the readmission. Routine laboratory investigations were all normal.  
  
DISCUSSION  
  
The patient presented at the readmission with a depressive disorder meeting the criteria for moderate depressive episode with depressed mood, loss of interest and pleasure, low self-confidence, recurrent thoughts of suicide, difficulties thinking (perhaps due to mild psychomotor reservation), disturbed sleep and loss of weight due to low appetite. The depressive episode appeared five months after he had his first admission for a schizophrenic disorder with commenting voices, somatic passivity experiences, protectory delusions and social withdrawal that developed insidiously over more than the past six months. There was no evidence of organic brain disorder and psychoactive substance abuse was not suspected. At his previous admission the patient therefore met the criteria for paranoid schizophrenia (F20.0). On treatment with haloperidol he obtained a partial remission with commenting voices still present and with negative symptoms in the form of lack of initiative, blunting of affect and social withdraw al. With the appearance of a moderately severe depressive episode within 12 months of fulfilling the criteria for schizophrenia, the patient meets the criteria for postschizophrenic depression (F20.4). It should be noted that the patient showed some insight in his schizophrenic condition and that he did not consider that having a schizophrenic disorder was the cause of his present depression, which rather should be seen as a manifestation of his schizophrenic illness.  
  
F20.4 Post-schizophrenic depression  
  
  
  
Case 8  
  
The patient is a divorced woman of 52 years old. She has one daughter and is a teacher in a primary school. She is of average socioeconomic status.  
  
Problem: The patient complained of extreme tiredness because she had to stay awake all night to prevent anyone breaking into her house. When she was 35 she began to complain that she was the target of discrimination by the school authorities. She said the senior teachers were prejudiced against her because she had a different religion from theirs. She felt that they spied on her and had made a plot to remove her from her job as a teacher. Some years after that, she started complaining that some of her neighbours wanted to have sexual relations with her. She accused them of following her around and of laying traps for her so that they could rape her. She had security locks fixed to the doors and windows and she never went out in the evenings. Gradually her general behaviour came to be marked by anxiety and anger, and she several times alerted the police. She hardly dared to go to sleep at night and thus became increasingly fatigued.  
  
History: The patient was the second of six children. She had five brothers. Her infancy and childhood were without any notable problems. She was married in her mid-twenties and divorced when she was 34, though the reasons for the divorce are unclear. She had one daughter who lived with the father. The patient had taught at the same school for more than 20 years. She often referred to God or to religious concepts, but she did not actively participate in a religious community and she rarely went to a place of worship.  
  
The patient always had long and painful menstruations until recently when they stopped completely. After the birth of her daughter she had an episode of mild depression with overeating and sleep problems. Around the time of her divorce she was noted to be nervous and worried. Despite this she made a conscious effort to keep calm and had managed to work as usual.  
  
She was an unassertive woman and was frequently noted to be indecisive and cautious. Colleagues described her as a very meticulous and rather strict teacher.  
  
One of the patient's brothers had a strange mental condition. He gave up his job and left his family to live in a workshop that he built himself. Here he claimed to be devoting his life to studying physics and inventing a machine that could work without fuel.  
  
Findings: At the consultation the patient appeared quite normal. Her conversation was both coherent and to the point. She accused a number of people of wanting to harm her and said they were looking for a chance to force her into having sex with them. She denied any hallucinations. She was angry to have to speak about these problems and she seemed to be tired because of her persistent worries. She was absolutely convinced that her concerns were true. Although she had never actually been harmed, she strongly believed that she had every reason to think it might happen. Physical examination revealed only a slight obesity.  
  
DISCUSSION  
  
The patient has a longstanding history of persistent persecutory delusions which were not of a bizarre character. She did not have hallucinations or schizophrenia-like symptoms. A concomitant depressive syndrome was not observed. No organic or psychoactive substance use etiology was suspected. The diagnosis therefore is persistent delusional disorder of persecutory type.  
  
F22.0 Persistent delusional disorder.  
  
  
  
Case 9  
  
The patient is a 25-year-old married woman.  
  
Problem: The patient was brought by ambulance to a hospital emergency room in the city where she lived. Her husband reported that she had been perfectly normal until the previous evening when she had come home from work complaining that "strange things were going on" at her office. She had noticed that her colleagues were talking about her, that they had been quite different all of a sudden, and that they had started behaving as if they were acting a part. She was convinced that she had been put under surveillance and that someone was listening in on her telephone conversations. All day she had been feeling as if she was in a dream. When she looked in the mirror she had seemed unreal to herself. She had become increasingly anxious, incoherent and agitated during the course of the day and had not been able to sleep at all during the night. She had spent most of the night looking out of the window. Several times she pointed at the crows in a nearby tree and told her husband "the birds are com ing".  
  
In the morning, her husband found her on her knees as if she were praying. She knocked her head repeatedly against the floor and talked in a rambling way, declaring that she had been entrusted with a special mission, that her boss was a criminal, that there were spies everywhere and that something terrible would happen soon. All of a sudden, she calmed down, smiled at her husband and told him that she had decided to convert from Catholicism to Islam. At that stage she became quite elated, started laughing and shouting, and declared that she and her husband could pray to the same god from then on. Shortly afterwards she was terrified again and accused her husband of trying to poison her.  
  
History: The patient was brought up in a town where her parents owned a small restaurant. She did well in school, went on to college and university, and trained as an interpreter. During her training she met her future husband, who had come from another country to train as an interpreter himself. Since both she and her husband were agnostics, the fact that they came from different religious backgrounds had never been a problem. She took a job with an administration related to the European Communities and her husband found a position with an international interpreting company. The couple were doing well, they had bought a nice house on the outskirts of her home town and were planning to have a child in the near future.  
  
The patient's parents were in good health. She had a brother and two sisters. At age 18, her younger sister had a nervous breakdown and in the following years had been hospitalized repeatedly in a psychiatric hospital with a diagnosis of schizophrenia.  
  
Both the patient and her husband refrained from drinking alcohol and were strongly opposed to any kind of drugs, including prescription medicines.  
  
Her husband described the patient as an outgoing, sociable and perfectly normal woman. He was, however, quite worried about what was happening, all the more since she appeared to have symptoms resembling those he had observed in his sister-in-law.  
  
Findings: On admission, the patient was frightened and bewildered but was oriented in time, place and person. She was restless and constantly changed position, standing and sitting, moving about the room, shouting and screaming, weeping and laughing. She talked in a rambling way, shifting from one subject to another without any transition. Something criminal was going on at her office, she said, and she had discovered a secret plot. There were microphones hidden everywhere, she added, and "the birds are coming". She wondered whether the doctor was a real doctor or "a spy in disguise". She went on to speak about "my mission", declared that Jesus had been a false prophet, that Mohammed was the real prophet, and that she would convince the world of what was right and wrong. She then began to explain that the truth was to be found in numbers. The digit 3 signifies good, she said, and the digit 8 represents evil. Suddenly she started to weep, explaining that her parents had died and that she wish ed to join them in heaven.   
  
During the first days of hospitalization, the patient continued presenting a rapidly-changing symptomatology. Her mood frequently shifted from sadness to elation and the content of her delusions changed from persecution to mysticism. On several occasions she came out of her room and complained that she had heard people speaking about her, even when there was no one in the vicinity. When asked to describe what she was hearing, she spoke of voices coming from the corridor. She firmly denied that the voices might emanate from within her own body.  
  
The physical examination did not reveal any abnormality. The blood tests, including thyroid function, were within normal limits, as were all other special investigations such as EEG and brain scan.  
  
Course: The patient was treated with 30 mg of haloperidol during the first week, and with half this dose for the following week. After two weeks, all of her symptoms had disappeared and she was discharged on medication. She was seen once a week in the outpatient department for another month, during which the medication was progressively reduced and then stopped completely. Two months after the onset of the delusional episode, the patient continued to be free of symptoms.  
  
DISCUSSION  
  
The significant features of the disorder of this patient were acute polymorphous delusions, rapidly changing mood disturbances, perplexity, depersonalization and derealization without clouding of consciousness, and occasional auditory hallucinations. The disorder developed to its peak in 24 hours and was resolved in a few weeks, with complete recovery within six weeks. The patient had no psychiatric history.  
  
The psychiatrist who dealt with this case made a diagnosis of "bouffée délirante". This concept goes back to the French psychiatrist Magnan, whose pupil Legrain proposed the following diagnostic criteria: an acute onset of the disorder "like a bolt from the blue" in the absence of a psychosocial stressor; the presence of unsystematized and rapidly-changing "polymorphic" delusions; the presence of emotional turmoil with intense and changing feelings of anxiety, happiness or sadness; the presence of perplexity, depersonalization or derealization without clouding of consciousness; and resolution of the disorder with complete recovery within two months.  
  
In the ICD-10, the subtyping of acute and transient psychotic disorders rests upon the acuteness of the onset, the presence of typical syndromes and the presence of associated stress. In the case of this patient, the onset was abrupt (i.e. the symptoms appeared within less than 48 hours), the syndrome was polymorphic, there were no typically schizophrenic symptoms, and the onset of the disorder was not associated with acute stress. Therefore the disorder from which she suffered must be coded as acute polymorphic psychotic disorder, without symptoms of schizophrenia and without associated acute stress (F23.00). The onset of the disorder may be specified as abrupt.  
  
F23.00 Acute polymorphic psychotic disorder, without symptoms of schizophrenia, without associated acute stress.  
  
  
  
Case 10  
  
The patient is a 36-year-old sales agent. He is married and has two children.  
  
Problem: The patient was admitted to the psychiatric clinic after a nervous breakdown with psychomotor excitement, confusion and thoughts of suicide. Four weeks before admission he had attended a seven-day course on personal development, arranged by his firm. During the course he became increasingly excited and talkative. He engaged people in discussion day and night and drank excessively. He also had a sexual relationship with a female participant. On his return home he had a "breakdown", and was excited and restless with alternating moods. At times he felt extremely happy for no obvious reason, had extravagant plans, was hyperactive, talking and interfering. At other times he was downcast and fatigued with feelings of guilt, thoughts of suicide and restlessness. He told people he was able to read their thoughts and predict the future. He also said he received symbolic messages from persons on television, that he had telepathic abilities and that he had been chosen for a special mission w hich meant that certain enemies were trying to persecute him. At the same time he felt that everything around him seemed unreal, as if put on stage in front of him. At night he slept badly. All the same he somehow managed his job. The day before his admission, however, he completely broke down. At his office he appeared excited and disturbed. He announced to his colleagues that he had been made director of the company, and that they should all go on a world trip. He had to be taken home from work and was later admitted to the clinic.  
  
History: The patient was an only child. His father was a gardener in a provincial town. After secondary school he trained as a sales agent in the textile trade and from the age of 27 was employed in a major textile firm. He married when he was 24 and had two children who, at the time of his admission, were 9 and 11 years old. The family lived in their own house and he was doing fairly well financially. He had always been extrovert, active and energetic but also very self-conscious. He was ambitious and enjoyed his job. He was an efficient worker and his efforts were appreciated by his employers. **Findings:** On admission the patient appeared perplexed and anxious, but he was fully oriented. He was talkative, with flight of ideas, and at times he seemed to respond to auditory hallucinations. The following day he was increasingly excited and bewildered. He said that he had been sentenced to death and that his life was in danger. A light he saw through the window indicated to him that he was under special surveillance. A star in the sky was an unidentified flying object that had come to take him away from earth. Amid the noise of the ward he could distinguish voices that derided him and laughed at him. On television the faces and the music were distorted. He felt that other people could "swim into his mind", remove his thoughts and make him have emotions and impulses that were not his own. At times he was irritable and verbally aggressive, and he incessantly talked with flight of ideas. **Course:** On treatment with 10 mg of haloperidol per day, the patient gradually quietened down and after 10 days he no longer appeared psychotic. He was mildly depressed for another week, after which his family found that he was in his normal state of mind.  
  
DISCUSSION  
  
In the course of one or two weeks, this patient developed a psychotic disorder with moods that changed rapidly from manic to depressive, and with varying delusions that mostly were incongruent with the emotional state. He also had experiences of thought withdrawal and of impulses and emotions controlled by an external source, which are first-rank symptoms of schizophrenia. His disorder was apparently associated with a course in personal development which may have been stressful to his ambitious and sensitive personality.  
  
One of the diagnoses to be considered would be acute and transient psychotic disorder of the polymorphic subtype with symptoms of schizophrenia (F23.1), characterized by emotional turmoil, changing delusions and hallucinations plus symptoms which meet the criteria for a schizophrenic syndrome. However, for this diagnosis to be made, the condition must not meet the criteria for a manic or depressive episode. In the case of this patient, manic and depressive symptoms are present to such a degree that the criteria for both manic and severe depressive episodes are met, although with rapid alternations that constitute an episode of mixed affective state. The simultaneous occurrence of schizophrenic symptoms for at least two weeks points to a diagnosis of a schizoaffective episode of mixed subtype.  
  
F25.2 Schizoaffective disorder, mixed type.

**Case 11**  
  
**The patient is a 32-year-old woman who works as a librarian. She is married and has just given birth to a child. She is currently on maternity leave.**  
  
**Problem:** The patient was involuntarily admitted to a psychiatric hospital because of angry excitement coupled with odd and irresponsible behaviour which had developed after her delivery 10 days before.  
  
The patient had been married for five years, and had finally had a much wanted child. The pregnancy and delivery were uncomplicated. The child, a son, was a fine and healthy baby, and for the first few days after the birth everything was normal. Four days after the delivery, the patient was discharged from the maternity clinic. On arrival home, she appeared excited with angry irritability. She accused her husband of keeping the house at too low a temperature, although the house was in fact quite warm. She had heated discussions with her mother on how to use diapers, and finally lost her temper and sent her mother away when she wanted to take the baby up in her arms. The patient began talking and scolding incessantly with the result that she nearly lost her voice. She continued discussing minor details of the delivery, suspecting possible maltreatment. She phoned her friends and relatives, and also the maternity clinic, complaining about the treatment she had received. She was continuously active and would not leave the baby in peace, changing his clothes or washing him frequently. In the midst of this activity, however, she easily became distracted and might leave the baby unattended, apparently forgetting what she was doing, because something else had caught her attention. At times she would treat the child roughly, scolding or even slapping him when he cried. She slept irregularly and only for a few hours at a time, and she ate very little because she was too busy to sit down and finish her meal. Eventually she appeared quite disturbed, tried to read the time from the room thermometer, burned a tea cosy for no apparent reason, and shouted at an announcer on television. She would hear nothing of a mental disorder, and refused to see the general practitioner who was summoned by her husband. The doctor finally decided to have her involuntarily admitted to the psychiatric hospital.  
  
History: The patient was born and brought up in a small city, where she completed high school. She did quite well at school and later she went to work in a library where she has been employed ever since. Her husband worked as a computer programmer and they described their marriage as good and stable. He described her as an outgoing, sociable and reliable person, but somewhat moody with a temperament that changed rapidly.  
  
Her physical health had always been good. She did not smoke, drank only rarely on social occasions and there was no evidence of use of drugs.  
  
The father of the patient died from heart disease when she was 27. Her mother was alive and well but had been treated for recurrent episodes of depression. The patient had a twin brother who suffered from a mental handicap.  
  
Findings: On admission the patient was very angry and refused to see the registrar. She was talking incessantly with a loud and hoarse voice. Her speech was circumstantial and nonsequential, and she lost track of her thoughts several times. Every now and then she was distracted by noises or minor details in the surroundings. She could not stay seated but walked around in the room most of the time. She tried to get out of the door and became aggressive and abusive when she was refused permission to leave. There was no evidence of abnormal perceptions or delusions, and she was fully oriented as to time, place and person.  
  
On physical examination, including neurological investigation, no abnormalities were discovered. She had no fever and was found to be in a normal puerperal state. Laboratory tests, and a later on EEG, were normal.  
  
Course: After some time, the patient was persuaded to accept treatment with haloperidol, 10 mg a day. In the course of one week her symptoms gradually decreased. The treatment was then changed to lithium carbonate and after another two weeks she was in her normal mood and fully able to take care of her baby. She was discharged on lithium maintenance treatment.  
  
DISCUSSION  
  
The patient displayed angry irritability, which is an unspecific symptom that may form part of various disorders. However, she also showed hyperactivity, extreme talkativeness with flight of ideas, distractibility, restlessness, decreased need for sleep and loss of normal social inhibitions with irresponsible behaviour to such an extent that she was unable to give appropriate care to her newborn child. These symptoms fulfil the criteria for a manic episode (F30) with predominantly irritable mood. On admission, the episode had lasted just six days. While one week's duration is a requirement for this diagnosis and is not fulfilled, there is the alternative of severity requiring hospital admission, which applies in this case.  
  
An acute and transient psychotic disorder (F23) possibly associated with acute stress is ruled out because there is no evidence of psychotic symptoms such as delusions or hallucinations. Furthermore, a normal delivery with a wanted and fully normal child cannot be considered a psychosocial stressor.  
  
The possibility of an organic manic disorder (F06.30) is ruled out because there is no evidence of cerebral or any other physical disorder. The pregnancy, delivery and puerperium were all normal.  
  
A "puerperal mental disorder" (F53) is to be used only for disorders not classified elsewhere. Not being causative in itself, the puerperium with its rapid hormonal changes may play a precipitating role, and the association should be recorded by an associated diagnosis from the ICD chapter on pregnancy, childbirth and the puerperium.  
  
F30.1 Mania without psychotic symptoms and as an associated diagnosis  
  
O99.3 Mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the puerperium.  
  
  
  
Case 12  
  
The patient is a woman of 27 years old, married with no children. She is a nurse in a maternal and child health unit.  
  
Problem: The patient was taken to the psychiatric hospital by her husband because she was very excited and talkative. After an argument with her husband four days before, she angrily left her home and went to the mosque where she stayed all night praying. When she returned home in the morning her husband was annoyed with her and told her that if she wanted to spend all night at the mosque she could go and live there. She made her way to her mother's house where she began to grow more and more disturbed. She was very agitated, could not sleep, talked almost incessantly and refused her food. She recited prayers fervently but she mixed up some of the words without apparently realizing it. Her endless conversation was mainly about religion and she interrupted it only to sing religious prayers in which she accused numerous people of sinning and ordered them to pray. Her mother called the patient's husband and told him she was his responsibility. She refused treatment so her husband brought her forcibly to the hospital.  
  
History: The patient's second marriage took place two years before the current problem. Her husband was 34, a very devout Muslim who worked in a car factory. They had no children and this caused tension in their marriage. Her first marriage, when she was 21, lasted only a few months because her husband left to work in a neighbouring country and she had neither seen nor heard from him since. At the time of the patient's admission to the hospital her father was 54 and her mother 56. The patient was the fifth child of a family of two brothers and six sisters.  
  
She had developed an interest in religion at an early age. From the age of seven she was keen to learn the Koran and she memorized most sections of the book. She had a beautiful voice and was often invited to social events because she sang so well. She was a good mixer and found it easy to make friends, enjoying the fact that her skill at singing - and also dancing - often made her the centre of attention. She was an energetic woman and was usually optimistic though she admitted to sometimes feeling depressed. There was no history of mental illness in her family.  
  
At the age of 22 she had a longstanding episode of depression following the dissolution of her first marriage. She felt sad with loss of self-confidence, kept to herself and did not want to sing or attend parties. She had difficulty sleeping, woke early and felt tired with loss of appetite and weight. All the same, she managed to carry on with her job with only a few occasional days of sick-leave. She did not see a doctor, and after about six months she gradually improved and regained her usual mood and level of activity. She was involved in a traffic accident at the age of seven and suffered a broken arm. She had a goitre with a palpable nodule in the left thyroid lobe.  
  
Findings: The patient was tidily - even smartly - dressed. She appeared excited and irritable with aggressive shouting. She was very talkative and her speech was sometimes difficult to follow because she spoke very quickly, jumping from one topic to another. She felt superior to others, who were jealous because of her voice and beauty. Her intelligence was above average and she felt stronger and more healthy than ever. She was easily distractible, but fully oriented as to time, place and person, and she did not show any impairment of memory or other cognitive functions.  
  
Physical and neurological examinations, EEG and laboratory investigations, including thyroid parameters, were all normal.  
  
DISCUSSION  
  
On admission the patient had for four days displayed an irritable and expansive mood with talkativeness, agitated hyperactivity, sleeplessness and grandiosity of a nondelusional character. No psychotic symptoms were observed. There was no evidence of organic etiology, and particularly no signs of hyperthyroidism. Psychoactive substance use was not suspected. The current episode therefore meets the symptomatic criteria for mania without psychotic symptoms, and the severity qualifies for this diagnosis even if the duration is less than one week because hospital admissions were required. There had been one other affective episode in the past of mild to moderate depression, and her diagnosis therefore is:  
  
F31.1 Bipolar affective disorder, current episode manic without psychotic symptoms.  
  
  
  
Case 13  
  
The patient is a married young woman of 18 years old. She lives with her husband's family.  
  
Problem: The patient threw hot cooking oil in her husband's face and then stepped into a large open fire to try to burn herself to death. She was taken to hospital for treatment of her burns and was then referred to the psychiatric clinic because of her suicide attempt. Only three months earlier the wife of her husband's elder brother had killed herself in the same way. The patient had witnessed the sister-in-law's suicide and had been severely shocked. Since that time she lost interest in her home and her surroundings. She barely spoke to anyone and kept to herself as much as she could. She appeared fatigued, slept poorly and her appetite declined. For the last few days before her own attempt at suicide she had not eaten or spoken at all. The incident occurred as she was preparing food as she always did at that time of the day. Members of the family said she threw the oil at her husband without any warning and for no apparent reason. Several of them suffered minor burns as they pulled h er, struggling, off the fire.  
  
History: The patient grew up in a village where her father worked as a potter. In the small home there lived her parents, her maternal grandmother, her three older brothers and their wives. The family had little money and little formal education. At the age of 17 the patient was married to a man five years older. Her husband, who worked as a sweeper, was dependent on hashish and suffered from pulmonary tuberculosis. After the marriage she moved in with her husband who lived with his parents and two of his brothers and their wives in the neighbouring village.  
  
The patient was described as an outgoing and extroverted person with satisfactory interpersonal relationships. She was not particularly happy with her marriage, and sexual relations with her husband were reported to have been unsatisfactory. All the same she seemed to get on well with the members of her new family and she had not displayed any unusual behaviour or attitude before the sister-in-law's death.  
  
The biological family of the patient included several cases of psychiatric illness. Her father and two of his brothers had received ECT treatment at the psychiatric clinic in a nearby town for episodes of low mood and hypochondriacal beliefs. One of the patient's uncles later committed suicide.  
  
When she was 14 the patient was badly bitten by a dog and received treatment that included a rabies vaccination. She had regular menstrual periods from the age of 13 and had not been pregnant.  
  
Findings: At the examination the patient lay on the bed looking pale and terrified. She did not speak or move, and did not react in any way to the examination except that she followed the examiner with her eyes. Physical examination including neurological assessment showed no abnormalities except for signs of neglect and weight loss.  
  
Course: The patient was given ECT on three successive days, after which she began to improve, started eating and became able to communicate. She said that the sister-in-law, who killed herself, had cast a spell on her. After her death the sister-in-law started persecuting her. She could hear the sister-in-law's voice telling her she was no good and that she ought to die too. She came to believe that she was a burden to her new family and that she really deserved to die. Her final violent and self-destructive behaviour followed orders given to her by the voice of her dead sister-in-law.  
  
DISCUSSION  
  
On admission to the clinic the patient displayed symptoms of a severe depressive episode with depressive stupor (F32.3). After the stupor had been relieved by the ECT treatment she mentioned psychotic symptoms with a hallucinatory voice and depressive ideas congruent with her mood. There was no evidence of organic etiology. Her psychotic symptoms did not have schizophrenia-like first-rank character. Her destructive behaviour was not described as carried out or enforced upon her by an external will or force, but in the way that she herself followed the orders given her by the hallucinatory voice. No other schizophrenia-like symptoms are described.  
  
Meeting the criteria for a depressive episode rules out acute and transient psychotic disorder (F23). The same applies to trance and possession disorders (F44.3).  
  
F32.30 Severe depressive episode with mood-congruent psychotic symptoms with a subsidiary diagnosis of  
  
X76 Intentional self-harm by fire and flames.  
  
  
  
Case 14  
  
The patient is a woman of 38 years old and married. She has two children aged six and two years.  
  
Problem: The patient began to be unwell after her second pregnancy three years ago. This pregnancy was unwanted and she had considered having it terminated, but her husband persuaded her against this. She has been feeling depressed and irritable, constantly worrying about the housework and the children. She felt inadequate and unable to cope with the responsibilities as a mother of two children.  
  
History: The patient grew up in a small town. Her childhood was marked by the illness of her mother, whom she remembers only as being ill. As a child, she had to do the housework at home and she resented this because other children did not seem to have to work at home. When she was 12 years old her mother died and she recalls feeling very sad. Her father was affectionate to her but he drank excessively and was violent to her mother. There were also two brothers in the family - one 20 years older than the patient and the other 12 years older. After their mother's death, the eldest brother moved into the family home with his wife. Her brother's wife made the patient's life particularly difficult because she was demanding and always criticized her as being lazy. She left home at the age of 15 to take a residential job as a children's nanny for two years until she was old enough to enter training to be a nurse. Two months before the end of the training she left the course and never completed it . She had been absent from the course for some time because she was sick and had been told she would need to repeat part of it.  
  
She met her husband while she was on this training course. He was from another culture and was 13 years older than she. After they had known each other for three years they moved in together. He refused to marry her at that time because, he said, he could not provide for her having no permanent job. In addition, his family in his home country was hoping that he would marry a girl of his own culture and did not know about his actual relationship. She became pregnant during this time but her partner persuaded her to have an abortion, again because he could not provide for a child. After he obtained a permanent job they married, but the parents of her husband were not told about it for two years. Their relationship was stormy. The patient described her husband as "good-hearted but unreasonable". He was demanding, left all the housework to her and was unwilling to take care of the children.  
  
Findings: The patient was a thin woman, clean and tidy but seemed to have taken no special care of her appearance. She was tense and frequently broke down in tears. Her speech was spontaneous and normal in rate, tone and form. She gave appropriate answers to questions but she spoke extensively. She was preoccupied with the fear that she would not be able to cope with her domestic difficulties, and she was worried about the future of her children if she were to die, as her own mother had done. She had no abnormal beliefs or abnormal perceptions. Her cognitive state was intact and she was fully oriented. Her immediate recall and her short-term and long-term memory were good. Her insight was moderate; she recognized that she had problems but did not see how anyone could help her. Physical examination and laboratory investigations revealed nothing abnormal.  
  
  
  
Case 14  
  
Course: The patient was admitted to the psychiatric ward to relieve her from the stresses at home. She gradually became more relaxed and started to take an interest in her appearance again. In spite of strong pressures to return home, where her husband was having great difficulty coping with the small children, she stayed in the ward for nearly two weeks. During this time her mood began to improve and she and her husband were able to discuss some of the problems between them. She was discharged with a plan of outpatient follow-up for both herself and her husband. She and her husband agreed to arrange for increased help in the house and to spend some time alone together, without the children, each week.  
  
DISCUSSION  
  
For three years the patient had felt depressed and suffered from feelings of inadequacy and of not being able to cope with her responsibilities as a mother and housewife. These symptoms are not sufficient for the diagnosis of a depressive episode, even of the mild variety. However, for longstanding periods of constant or constantly recurring depressed mood, as in her case, we can consider the diagnosis of dysthymia. For this diagnosis the following criteria must be fulfilled: a period of at least two years of constant or constantly recurring depressed mood; during that period, no or very few individual episodes of depression that are sufficiently severe or long-lasting to meet the criteria for recurrent mild depressive disorder; and the presence of at least three symptoms from a list of 11 during at least some of the period of depression. These criteria are largely fulfilled in this case. All symptoms of this patient, as described here, fit within the clinical picture of dysthymia. If desired the on set may be specified as late (between 30 and 50 years of age).  
  
F34.1 Dysthymia, with late onset.   
  
Case 15  
  
The patient is a woman of 33 years old. She is married and works as a secretary in her husband's law firm.  
  
Problem: The patient visited an anxiety clinic after she read a magazine article that described hypochondriasis. In the previous 10 years she had undergone numerous medical investigations because she believed she was having a heart attack.  
  
The disorder began after the delivery of her only child. While attending a postnatal exercise class she suddenly noticed a dramatic increase in her heartbeat. She felt intense stabbing pains in her chest and had difficulty breathing. She started sweating and trembling, felt dizzy, had tingling sensations in her left arm and feared that she was going to die from a heart attack. She immediately left her baby at the class and went to the casualty ward for help. An electrocardiogram was administered but no abnormality was detected. Since then she had similar attacks of 15-30 minutes' duration about four times a month. She usually called for help and often sought medical advice. Over the 10 years she has had "far too many" medical investigations, each of them reassuring her that she had no physical disorder. After her first few attacks she developed a fear of having an attack when away from home or being in places where medical help cannot easily be obtained. The patient is now able to leave home alon e only if she carries her mobile telephone which enables her to contact emergency services if necessary. Even so, she avoids crowded places such as banks, shopping centres and cinemas, where her rapid escape might be blocked. The attacks have continued but occur only in the situations where she fears them most. She recognizes that both her symptoms and her avoidance of them are unreasonable and excessive, but all the same they have come to dominate her life. She feels mildly depressed, restless and has difficulty falling asleep. Her self-confidence is low and she also has difficulty concentrating.  
  
Initially the patient was treated with a variety of beta-blockers for an "irritable heart". Her family doctor prescribed diazepam, and she has taken 5 mg three times a day for the past eight years but to little effect.  
  
History: The patient grew up in a large city. Her father was a civil servant and her mother was a school teacher. She has a brother two years younger and he now works as an engineer. She left high school to attend a secretarial college and later on worked as a secretary for a firm of lawyers. At 22 she married a lawyer 10 years older than herself and the following year she had a child. Because of her attacks she gave up her full-time job and started working part-time for her husband. They have a good income and are fairly well off.  
  
The patient described herself as a "quiet, nervous type" who often felt tense and apprehensive in unusual situations. She has always been self-conscious, sensitive to criticism and reluctant to be involved with other people unless she knew them well.  
  
  
  
Case 15  
  
Since childhood she has feared risky situations and as a result she has developed a fear of flying and had difficulty getting a driver's licence. Her self-confidence has always been low and she has a tendency to feel inferior to other people. Her mood has been unstable with a tendency to depressive reactions when faced with disappointments or criticism.  
  
Her father was described as introverted with a low mood, but he had no contact with the psychiatric services. One of his sisters was once admitted to a psychiatric ward for "bad nerves" that presumably represented episodes of depression.  
  
In her childhood the patient was considered to have a weak constitution. She seemed to catch cold quite often and had influenza several times. She had frequent sick-leaves for minor ailments, stomach pains, or tension pains in her neck and back. Medical examinations have never detected any somatic disorder. Her only pregnancy was uncomplicated except for mild pre-eclampsia shortly before delivery which was managed successfully. Her blood pressure is normal and no cardiac disorder has ever been detected.  
  
Findings: The patient appeared not depressed, but was tense and spoke quickly with a sense of urgency. She described her complaints vividly and spontaneously, and seemed to be appealing for the examiner's help. She appeared to be quite intelligent. No psychotic symptoms were suspected.  
  
Physical examination, including neurological assessment, revealed no physical disorder. ECG, EEG and serological examinations all showed normal results and no abnormalities were seen in the thyroid parameters.  
  
DISCUSSION  
  
This patient does not have a hypochondriacal disorder as she presumed. Her recurring fear of having a heart attack was not a persistent belief but part of the symptoms of panic attacks which, apart from the fear of dying from a heart attack, also presented with palpitations, sweating, trembling, chest pain, breathing difficulties, dizziness and tingling sensations. The attacks, of which there were about four a month, started abruptly and were discrete with a duration of 15-30 minutes. She therefore fulfils the criteria for panic disorder of moderate severity (F41.0).  
  
Eventually the patient developed a fear and avoidance of crowded places and of travelling alone without her mobile telephone. Her panic attacks occur regularly in such situations. She therefore fulfils the criteria for agoraphobia (F40.0). This supersedes and includes the panic disorder, so the diagnosis is agoraphobia with panic disorder (F40.01).  
  
For some time the patient has felt mildly depressed. Could she have had an affective, depressive disorder superseding the agoraphobia? The answer must be no because a depressive episode, even of mild degree, requires at least two typical depressive symptoms, but this patient has only mildly depressed mood. Thus, even though she has three accessory depressive symptoms (low self-confidence, restlessness, and difficulties sleeping), her illness cannot be categorized as a mild depressive episode (F32.0).  
  
Organic etiology and psychoactive substance use are not suspected.  
  
The patient described herself as habitually anxious and avoidant, but hardly to a degree that is sufficiently pervasive or persistent to support a diagnosis of personality disorder.  
  
F40.01 Agoraphobia, with panic disorder.  
  
  
  
Case 16  
  
The patient is a 17-year-old female high school student.  
  
Problem: For the last six months, the patient had become so terrified of school that she was referred to a psychiatric outpatient service. Every time the teacher asked her a question in the classroom, she grew totally confused. Her heart started racing and she became so dizzy that she felt she was going to faint. She gave up participating in the school choir. For four months before referral she had not been able to join other students at lunchtime in the canteen because she felt terribly anxious. She trembled all over and was so afraid of losing control of her bladder that on several earlier occasions she had to leave the canteen in the middle of the lunch. During the last two months she had felt increasingly unhappy and lost all interest in school. She felt very tired, especially in the morning, and found difficulty in concentrating. The standard of her school work dropped considerably. Her sleep was poor, she would wake up every morning at least two hours before she would need to get out of bed. Her appetite has never been great but in the past few months it deteriorated even further. She felt that the future seemed gloomy and on several occasions she wished she was dead. Her happiest time was in the evening, when the troubles of the day were over and she could be alone in her room.  
  
History: The patient was born and raised in a small town where her father was a bricklayer. She lives with her parents and has four younger brothers and sisters. She has a room of her own. She described the relationship between her parents as harmonious, although her father tended to become annoyed from time to time because he felt that his wife was too overprotective of the patient. The girl developed normally during infancy and childhood, and she appeared happy and easygoing until the age of 14. From that age on, she seemed to change. She became increasingly self-conscious and painfully preoccupied with figuring out what other people thought about her. She always felt like hiding from others. She felt inferior, lacked confidence, and was afraid of behaving oddly or foolishly. When she was 15 she started attending a high school in a neighbouring town and she achieved reasonable grades up to six months before her referral to the outpatient service. Right from when she started at high sch ool, she felt ill at ease when she had to be with the other students. She was never able to make close friends. She has always been rather small for her age and was never a good eater. At the age of 15 she received hormone treatment because her menstruations were irregular. According to her mother, one of the aunts of the patient was also very nervous and shy and has been admitted to a psychiatric department because of depression.  
  
Findings: The patient was a delicately built, tiny girl. At the beginning of the examination, she blushed and was tense, shy and reticent. Later, however, she gradually became more confident and relaxed. She appeared anhedonic, but not depressed. There were no feelings of self-reproach, no psychomotor inhibition, and no signs of disordered thinking or psychotic features. No striving for secondary gain, neurotic appeal or tendency to dramatize were observed. The patient hesitantly admitted that her fears were excessive.  
  
DISCUSSION  
  
This patient suffered for a half year from a marked fear of being the focus of attention, and of behaving in an embarrassing way, with avoidance of situations where she feared this will happen. She had anxiety symptoms in the feared situations, such as palpitations, dizziness, trembling and fear of involuntary micturition. These symptoms are characteristic of a panic attack. However, in the ICD-10 classification, a panic attack that occurs in an established phobic situation is regarded as an expression of the severity of the phobia, which should be given diagnostic precedence. The symptoms were restricted to the feared situations. The patient was distressed by her symptoms and she recognized that her fears were unreasonable. All these symptoms fit well into the diagnosis of social phobia (F40.1).  
  
For the last two months the patient also met the criteria for a depressive episode, with depressed mood, loss of pleasure, tiredness, loss of self-confidence, recurrent thoughts of death, difficulties in concentration, and sleep disturbance.  
  
When syndromes occur simultaneously, it may be debated which of the diagnoses should be preferred as the main one. If they are fully simultaneous, a hierarchial principle may be preferred, giving precedence to the diagnosis with the lowest code number. If one of the syndromes clearly was primary, beginning a considerable time before the other syndrome (which may even be considered a reaction to the first), then the diagnosis of the primary syndrome should be preferred as the main diagnosis.  
  
Had this patient been older than 17 years, the presence of an anxious personality disorder (F60.6) could have been considered. However, as we do not know whether the personality characteristics will continue into adulthood, this diagnosis should not be made.  
  
F40.1 Social phobia with a subsidiary diagnosis of  
  
F32.10 Moderate depressive episode, without somatic symptoms.  
  
  
  
Case 17  
  
The patient is 24 years old, single and works as a clerk. He lives alone.  
  
Problem: For nearly two years the patient had suffered from nervous tension and had been unable to relax. Eventually he was referred to a psychiatric outpatient clinic because he was tense and worried, could not sleep and was plagued by feelings of inferiority. He often felt apprehensive, and he would have palpitations and start to tremble for no apparent reason. He could not concentrate and felt irritable. At night his constant worries kept him awake. In particular he worried about his sexual ability. He was afraid that he would not be able to perform sexually if he got married. At the age of 14, when visiting a friend's house, he had peeped into the bedroom of his friend's elder sister when she was changing clothes. The sight of the 19-year-old woman in her underwear excited him immensely and he often remembered the experience. From then on he did what he could to find opportunities for peeping at women while they were undressing or having a bath. Each time he did this the sexual excitem ent was intense and he masturbated. The fear of being caught masturbating made him do it in a hurry, and this actually enhanced his excitement. At the age of 22 he visited a prostitute for the first time and afterwards he did this again fairly regularly. However, in the months leading up to his referral he was unable to get an erection, which at first made him feel anxious and later made him feel he was inferior. He felt uneasy in female company and he feared that he would be unable to marry. He started to avoid his friends and kept to himself in his spare time, though he managed to carry on with his job.  
  
History: The patient was the third of three sons of a taxi driver. His two brothers were fairly successful both at school and in their subsequent careers. He passed high school with average marks and at the age of 18 began work as a clerk in a company belonging to his uncle. He moved into rented rooms where he lived alone.  
  
Before his illness the patient was said to be easygoing and extroverted. At school and later at work he got well on with his peers and colleagues. He had many acquaintances but no close friends. He was physically fit and had no serious illnesses. Nor was there any information about mental or behavioural disorders in his close family.  
  
Findings: On examination the patient appeared tense. He was reluctant to talk about his sexual behaviour but otherwise he was polite and cooperative. His mood was neutral and he made adequate emotional responses. No psychotic symptoms were suspected. As the interview progressed, he became quite talkative and kept referring to his feeling of inferiority. He seemed to be preoccupied with his experiences of impotence.  
  
Physical examination including neurological assessment did not reveal any abnormalities.  
  
DISCUSSION  
  
This patient meets the criteria for generalized anxiety disorder (F41.1) with his longstanding worries and tension and with more than four characteristic symptoms that include autonomic symptoms. There is no reason to suspect that his symptoms have an organic etiology or are caused by other mental or physical disorders.  
  
Since adolescence the patient displayed behaviour typical of voyeurism (F65.3), a disorder of sexual preference. This was eventually complicated with non-organic sexual dysfunction in the form of erectile impotence (F52.2).  
  
Even if the disorder of sexual preference was apparently primary and the other disorders could be considered secondary, the hierarchical principle of ICD-10 gives precedence to disorders with lower F-numbers - in this case the generalized anxiety disorder.  
  
F41.1 Generalized anxiety disorder and as subsidiary diagnoses  
  
F52.2 Failure of genital response  
  
F65.3 Voyeurism.  
  
  
  
Case 18  
  
The patient is a young man of 23 year old, unmarried and working unpaid on the family farm.  
  
Problem: The patient was referred to an outpatient psychiatric service by his general practitioner because of extreme slowness and indecision. His condition had grown gradually worse over the last five years. During this time the patient had been increasingly troubled by ideas that he might unwittingly have done something wrong or might have harmed other people. He felt a need to spend a lot of time checking his behaviour to make sure that he had caused no harm. He first noticed these ideas coming into his mind while he was studying at college. He was resident there and he kept having the thought that when he did his laundry he might by chance have mixed up some of the other students' clothes with his own. He also worried that he might have spent money that he had borrowed or perhaps taken from other students, although in fact he never borrowed money and always made sure that he paid everything he should. He felt compelled to keep checking that he had shut off the water or switched off the light and the electrical appliances. Otherwise, he thought, someone might be harmed or damage might be done. He finally spent so much time checking things that he had little time for studying and he left college without a qualification. The following year he was drafted for military service where he was given so much to do that he was unable to check his behaviour. When he returned home, however, the need to check everything came back even stronger than before. He was barely capable of driving a car because if he passed people or animals along the road he had to stop and check if they had been injured. He became unable to join his father in hunting because after each shot he felt he must make sure that nobody to his right or left, or even behind him, had been hit. He did this even though he knew that it was quite impossible. His working ability decreased because he had to think through every job before he could do it. And of course he had to keep checking it after it had been completed. He was often found standing motionless with downcast eyes, absorbed in his thoughts. During ordinary conversation he said very little because he got stuck in the middle of sentences, or even in the middle of words. Whenever he said anything he had to reconsider it and check it before he could continue. He tried consciously to overcome his need to check everything but did not succeed. He gradually lost his self-confidence, felt low-spirited and fatigued, lacked all initiative and spent a lot of time either resting or sleeping. He did not experience feelings of being controlled or influenced from outside, and he never had hallucinatory experiences.  
  
History: The patient was born and raised on a farm in the countryside. He did reasonably well at school and later he had various jobs as a farmhand and spent some time studying at a College of Further Education. For the two years prior to his referral by the doctor, he worked unpaid at the family farm and lived in the family home. When he was 16 years old his mother committed suicide while she was in a depressed mood. She suffered from a bipolar disorder, according to the family doctor. At the time the patient had no apparent problems in accepting her death. He has a younger brother and sister who also live at home. His father has remarried and his new wife seems to be well accepted by the children.  
  
Findings: The patient appeared reserved and somewhat distant with stiff and clumsy movements. He was dressed simply but correctly. He spoke very slowly and responded to questions only after long pauses. His mood appeared mildly depressed and his self-esteem was low. His rapport lacked emotional colouring but was otherwise normal and his speech did not appear disturbed. Psychotic symptoms were not suspected and he showed no neurotic appeal or striving for secondary gain. At the end of the first visit he had difficulty leaving the room, struggling against a compulsion to check whether he had taken anything with him that did not belong to him.  
  
DISCUSSION  
  
The symptoms of this patient meet the criteria for obsessive compulsive disorder with longstanding obsessions and compulsions, which were repetitive and unpleasant, causing distress and severe interference with social and individual functioning. He acknowledged that the obsessions and compulsions originated in his own mind, and that they were excessive and unreasonable. Initially he had tried to resist them without success, and eventually he had given up resistance. The compulsions appear predominant, which may be specified by the four character code F42.1, obsessive-compulsive disorder, predominantly compulsive acts.  
  
The disorder was accompanied by a depressed mood, fatigue, lack of initiative, lack of self-confidence and self-esteem, slowness and increased sleeping, thus meeting the criteria of at least a mild depressive episode (F32.0).  
  
Co-occurrence of a depressive episode and an obsessive compulsive disorder is not infrequent. A moderate or severe depressive episode may be accompanied by obsessions or compulsions as a part of the disorder and, if so, the diagnosis of a depressive episode takes precedence. On the other hand, a severe and disabling obsessive-compulsive disorder may lead to a depressive reaction, meeting the criteria of a depressive episode as a subsidiary diagnosis. In this case, the obsessive-compulsive disorder developed primarily, and the depressive syndrome was later and clearly secondary to the obsessive-compulsive disorder. The diagnosis therefore is:  
  
F42.1 Obsessive-compulsive disorder, predominantly compulsive acts and as a subsidiary diagnosis  
  
F32.0 Mild depressive episode.and as a subsidiary diagnosis and as a subsidiary diagnosis **Case 19**  
  
**The patient is a 32-year-old driver who formerly worked in Kuwait.**  
  
**Problem:** The patient was brought to the outpatient clinic in a state of acute panic. The patient had worked in Kuwait for five years to earn a regular income to keep his family and to pay for the education of his children. During the Iraqi invasion of Kuwait the patient was exposed to a severe trauma when his sister was raped in front of him. He was imprisoned and was subjected to severe torture during which wooden rods were pushed into his anus. Upon his release after the Gulf War he was brought back to his country where he had several operations for anal repair. Since then the patient experienced nightmares and vivid flashbacks of his torture and the rape of his sister, and he suffered anxiety spells with screaming and aggressive behaviour. The current state of panic came about after he had watched a television documentary about the Second World War.  
  
History: The patient's development was fairly normal and his work record was satisfactory. He completed nine years of basic schooling but then his father died during a cardiac operation and he left school to get a job to help support his two younger brothers and a sister. He married at the age of 22 and was divorced when he was 28. He had three children who stayed with his mother while he was in Kuwait. The patient was known to be sociable, outgoing and helpful to his neighbours. His brother described him as stubborn and impulsive but very kind and warm-hearted. He had been a heavy smoker since he was 20, but did not use drugs.  
  
Findings: During the interview his mood and behaviour fluctuated. At times the patient was intensely anxious, with bouts of sweating and hyperventilation, and with outbursts of hostility and aggression manifested in banging the desk or punching the wall. At other times his facial expression became empty, he appeared indifferent and complained of loss of feelings. He clearly expressed a sense of despair. He said he could not get rid of the horrific memories and the vivid images they had left in his mind. The memories seemed to haunt him all the time and became very distressing whenever anything - a sound, a picture or a story - reminded him of the original trauma. He did not want to talk about what he had experienced in Kuwait and avoided all that reminded him of the stressing events. He was also troubled because he could not remember certain parts of his torture. "I cannot get the complete story clear in my mind," he complained, "and yet some images and sounds do not seem to leave my mind." He felt guilty and ashamed and could not look the rest of his family in the eyes after he returned home, because he had been unable to protect the honour of his sister. Had it not been for his three children and his family who were dependent on him, he would have tried to end his life.  
  
DISCUSSION  
  
This is a classic case of a post-traumatic stress disorder (F43.1). The diagnosis should not be used unless there is evidence that the disorder arose within six months of a traumatic event of exceptional severity. The patient had repetitive, intrusive remembering or "reliving" of the stressful events in daytime imagery or in dreams, and avoidance of stimuli that reminded him of the trauma of which he had partial amnesia. The diagnosis therefore is:  
  
F43.1 Post-traumatic stress disorder.  
  
Case 20  
  
The patient is a 43-year-old housewife married to a sales agent.  
  
Problem: The patient was transferred to a psychiatric department from a neurological department where she had been admitted for examination for the third time in half a year because she feared she had a brain tumour. For the last eight months she had suffered from headaches and dizziness and she felt fatigued. Right from the beginning she had seen her general practitioner frequently. After a couple of months she was admitted to a neurological ward. Careful examination, including EEG and CT scanning, revealed nothing abnormal. The patient felt immediate relief but was unable to remain assured. She was afraid that she had a serious illness, probably a malignant brain tumor. She still had headaches, predominantly in her neck, and she thought that perhaps the examination had not taken all of her brain into consideration. Thus she again went to see her general practitioner who tried to persuade her that nothing was wrong. Finally, he gave in and referred her to the neurological department for a nother assessment. The neurologist first tried to reassure her at an outpatient visit, but she pressed for a renewed investigation and was readmitted for further examination. Afterwards the neurologist carefully explained to her that absolutely nothing was abnormal. She accepted the reassurance, but a few days after the discharge she doubted the results once more. Yet again she became increasingly preoccupied with her previous idea that she might have a malignant brain tumour. She could think of nothing but the headache and dizziness caused by the tumour that signified her impending death. The patient made plans for her own funeral and for the hymns that she would like to be sung. She made the lives of her husband and children a misery by speaking only about her condition. She was not able to do any housework and she stayed in bed most of the time. She seemed to care little about her appearance. Several times each week she phoned her general practitioner and asked him to help her by prescribing pain -killing medicine or, if possible, by arranging a readmission to the neurological department. He tried to persuade her to see a psychiatrist but she became almost furious at this suggestion, stating that her condition had nothing to do with "nerves". The last few weeks before her admission, she became increasingly depressed, seemed to have given up all hope and had mentioned that she might as well commit suicide to escape the last painful months of her illness. She had difficulties in falling asleep and lost her appetite. One week before her admission she suddenly felt that her sight had become blurred. She felt scared and believed that her death was now imminent. She immediately called the doctor and more or less forced him to have her readmitted to the neurological department for the third time. Careful examination including an opthalmological examination and renewed CT scan revealed nothing abnormal whatsoever. She was crying, appeared agitated and finally was persuaded to accept to be transferred to the psychiatric department.  
  
History: The patient grew up in a city. She was the third of four siblings. Her father worked as a civil servant and her mother as a secretary. The family was well off and after high school she was offered an academic career, but she was not interested. Shortly afterwards she married a sales agent five years her senior and moved to another city. The couple had three children and lived in a house of their own in good economic circumstances. The patient seemed to cope well with her life as a housewife.  
  
She took good care of the children, was engaged in church activities and was active in a women's club. She described her marriage as harmonious although it was later revealed that her husband had at least twice had an affair with another woman, the last time just a few months before his wife's illness. The two younger children still attended high school and the eldest, a boy, had started working in a bank.  
  
The father of the patient and two of his brothers had received treatment for affective disorders with recurrent depressions, but otherwise there was no information about mental disorders in the family.  
  
Her somatic health had always been good. She had never previously suffered from headaches or other complaints.  
  
Findings: On examination the patient appeared somewhat upset. She repeated that she was convinced that referral to a psychiatric department was a mistake and that she certainly did not have a mental disorder. She scornfully denied having experienced perceptual disorders or having harboured odd ideas but admitted that recently she had felt low-spirited and fatigued, and that she had lost hope for the future because of her brain tumour. Otherwise she denied having any mental symptoms. She was fully oriented and in clear consciousness without any indications of cognitive impairment.  
  
DISCUSSION  
  
The patient presents with an eight-month history of a persistent belief in having a serious physical disease, a brain tumour. She became preoccupied with the belief and the symptoms to an extent that interfered with her daily living and caused her considerable distress. She refused to accept medical assurances except for short intervals. She kept returning to her general practitioner and had him admit her three times to a neuromedical department before she finally accepted a psychiatric admission. She thus meets the symptomatic criteria for hypochondriacal disorder (F45.2). She also had some symptoms of depression with depressed mood, complaints of fatigue, difficulties falling asleep and thoughts of death and suicide lasting for the last few weeks, thus meeting the criteria for a mild depressive episode. However, seems clearly secondary to her hypochondriacal disorder which preceded it by seven months. Although there is a family history of depression, it is not plausible that an affective disor der would explain her hypochondriacal symptoms as being part of a depressive episode.  
  
It is a matter for discussion whether the hypochondriacal belief was of delusional character, in which case she would meet the criteria for a persistent delusional disorder (F22.0) with hypochondriacal delusions. Her beliefs, however, had more the character of a fear of having a specified physical disease than of a delusional conviction. Her fear also seemed based on somatic symptoms which may in fact have had a real background in tension headaches. The diagnosis for this patient will therefore be:  
  
F45.2 Hypochondriacal disorder and as a subsidiary diagnosis  
  
F32.0 Mild depressive episode.  
  
  
  
Case 21  
  
The patient is a man of 51 years old, married and working as social worker.  
  
Problem: The patient was referred for a psychiatric disability assessment because for the last three years he had felt increasingly fatigued. He grew easily tired after minor efforts and after a couple of hours' work he felt totally exhausted. He managed to carry on his job for some time because considerate colleagues let him have the easy tasks. Eventually he was allowed to take care of the archives - an easy job that had previously been given to staff on the verge of retirement. Nevertheless, when he returned home in the evenings he felt so tired that he had to go straight to bed. Even so, he had difficulty sleeping because of headaches and pains in his neck and back. Most of the time he felt tense and could not relax. At weekends he spent most of his time in his bed. He found it hard to concentrate and he had to give up reading and doing crossword puzzles which he had previously enjoyed. Even looking at plays on television became too much for him. He avoided his colleagues and friends as much as possible because he feared they might ask him to do something or invite him out. In fact, an evening out left him exhausted for several days. He felt increasingly inadequate at work and was scarcely able to carry out everyday activities at home. Four months before the referral he took sick-leave from his job and applied for a disability pension. However, staying away from the responsibilities of work did not improve his condition. He still lacked initiative and sat in his chair most of the day, glancing at the newspaper or looking out of the window. He did not feel depressed or unhappy. He seemed to be encouraged when he was told that his children and grandchildren were coming to visit, but the liveliness of the children soon made him tense and irritable. He was able to help his wife with the chores around the house so long as she told him exactly what to do, but everything had to be planned in advance because sudden changes made him perplexed and anxious. He had a constant fear that his a pplication for a disability pension might be refused and that he might have to go back to work, which he felt quite incapable of doing.  
  
History: The patient grew up in a provincial town in a rural part of the country. He was the second son of a primary school teacher. He finished high school with outstanding marks and trained as a social worker. At age 25 he married a nurse two years younger than himself. They moved to the capital, where he got a job as a municipal social worker. He became involved in social care and sheltered workshops for mentally retarded people and in his spare time he worked for the Association of Relatives of the Mentally Retarded. He also took part in political activities and for several years he was an elected member of the municipal council. The couple had three children who have now left home and are apparently managing well. The patient lives with his wife in a rented apartment. His economic position has deteriorated because of the reduction in his income when his job situation changed.  
  
The patient was always an extroverted and active person with plenty of energy and a bright mood. He was very interested in his work and concerned for those he was helping. He always felt mentally strong and believed that nothing could bring him down. He was always on good terms with both his colleagues and his clients. He had good relations with the members of his family and his marriage was described as harmonious. He had never suffered mood swings or previous episodes of unexplained fatigue.  
  
His elder brother was mentally retarded but otherwise there is no information about mental disorders in his family. The patient had an appendectomy at the age of 27 but otherwise he was healthy. There was no information about cerebral concussion or longstanding viral infections.  
  
Findings: On examination the patient looked older than his age. His hair was grey and he looked very tired. His mood was neutral and no psychotic symptoms were suspected. He was in clear consciousness, fully collected and oriented in time, place and person. His memory was unimpaired and no cognitive deficiencies were detected. Towards the end of the examination he appeared to be tense and apprehensive but otherwise no remarkable features were observed.  
  
Physical investigation and neurological assessment showed no abnormality. Laboratory tests, including thyroid and adrenal hormone investigation, were within normal limits. EEG and CT brain scan were normal.  
  
DISCUSSION  
  
This patient meets the criteria for neurasthenia (F48.0) since he has persistent and distressing complaints of feelings of exhaustion after only minor mental efforts, accompanied by accessory symptoms such as tension headaches, muscular aches and pains, inability to relax, sleep disturbance, and irritability. The disorder was longstanding and rest or sick-leave did not lead to any improvement. Organic etiology was not suspected.  
  
A depressive mood disorder should, of course, be taken into consideration. The patient had one of the typical symptoms (decreased energy or increased fatiguability) and two or three of the accessory symptoms (loss of self-confidence, sleep disturbance, lack of concentration). It can be debated whether his reduced interest, which clearly is caused by his inability to cope, should be considered as "loss of interests". If so, he meets the criteria for a mild depressive episode, though this diagnosis does not seem compatible with the severity of his disorder.  
  
The most probable diagnosis, therefore, is:  
  
F48.0 Neurasthenia.  
  
  
  
Case 22  
  
The patient is a young woman of 26 year old. She works as a nurse in a city hospital and lives alone.  
  
Problem: The patient would wake up at night, go to her kitchen and start eating whatever food she could lay her hands on. She stopped only after an hour or two or when she could find no more food. The bouts of overeating went on for five years until she consulted her general practitioner who referred her to outpatient psychiatric treatment for a depression related to the eating spells. Her spells of uncontrollable overeating were preceded by a feeling of severe tension and were followed by relaxation, though this was coupled with shame and despair. During the year before her referral the frequency of the overeating spells had increased to two or three times a week. They usually appeared at night after just a few hours of sleep. After eating her way through whatever she could find she would feel bloated but would not vomit. She tried to get rid of the food by taking large quantities of laxatives. Her weight was unstable but she has managed to keep it within normal limits simply by fasting be tween the overeating spells. She despised obesity, but had never really been slim. Her bouts of overeating made her feel increasingly low-spirited and despairing. She had even considered committing suicide by taking an overdose of the sleeping tablets that her general practitioner had prescribed because of her interrupted sleep. She managed to do her job adequately and had taken only a few days of sick-leave.  
  
History: The patient was brought up in a village where the father was a school teacher. After secondary school she trained as a nurse and had various jobs on geriatric wards. She had always been very sensitive, fearful of criticism with low self-esteem. She tried hard to live up to expectations and felt frustrated by minor criticisms. She had been in love more than once, but she never dared to become engaged because she feared rejection and possibly also because she feared a sexual relationship. She had only a few close friends because she had difficulties establishing close relationships. She often felt tense and diffident in company. She avoided going to meetings or parties because she feared being criticized or rejected.  
  
Findings: On examination the patient appeared quiet and reticent. Her mood was mildly depressed and she cried silently as she described her difficulties. No psychotic features were suspected. She was otherwise healthy and of average weight. She perceived her own weight to be slightly higher than the weight she would prefer. She said she was afraid of becoming obese.  
  
DISCUSSION  
  
This woman had recurrent episodes of excessive overeating at least twice a week for about one year. She was unable to control the almost compulsory craving for food, which she experienced as nightly spells. She tried to counteract the fattening effect of the food by self-induced purging and by periods of starvation because she dreaded becoming obese. However, she was of about normal weight and did not perceive herself as being too fat. She therefore meets the criteria for bulimia nervosa except for a self-perception of overweight. The diagnosis therefore is atypical bulimia nervosa.  
  
Her depressed mood, interrupted sleep, thoughts about suicide, all related to her eating spells, are depressive symptoms, but they are insufficient to meet the criteria for a depressive episode.  
  
There is evidence of pervasive dysfunctional behaviour in the areas of affectivity and interpersonal relations since her early youth. This causes some personal distress, with sensitivity to criticism, low self-esteem, difficulties establishing close relationships and avoidance of social activities because of fear of criticism or rejection. She therefore meets the criteria for a subsidiary diagnosis of anxious (avoidant) personality disorder.  
  
F50.3 Atypical bulimia nervosa and as a subsidiary diagnosis  
  
F60.6 Anxious (avoidant) personality disorder.  
  
  
  
Case 23  
  
The patient is a 58-year-old widow who works as a teacher in a secondary school. She has four healthy children - one daughter and three sons. The eldest son has been abroad for 15 years and recently came back for a vacation.  
  
Problem: The patient arrived at the clinic with her eldest son. Every day she was taking laxatives and other tablets for her digestion, sometimes several kinds at a time. Her son was alarmed at what he considered excessive use of medication so he brought his mother to the clinic and explained her habit. The patient herself admitted taking the tablets but said they hardly constituted a problem for her. On the contrary, they brought her a good deal of benefit. She explained that she had started using the substances a very long time before, perhaps even 20 years previously. She remembered taking the first ones not because of a specific illness but because she had had indigestion and constipation for two days. A friend had advised her to take a couple of laxative tablets before going to sleep and one tablet for her digestion before each meal for a few days. The patient recalled that her digestion had never been so smooth as it was when she took those first tablets. She had continued to use the m right up to the present. Without the tablets she would not necessarily develop constipation, she said, but she somehow would not feel satisfied either after eating or after emptying her bowels. She did not see how the tablets could be problematic as long as they were not "narcotics". She had come to the clinic because her son had insisted that the tablets must have something addictive about them which made her unable to stop taking them.  
  
History: The patient came from a large family of nine children. She graduated from the university arts faculty and married soon afterwards. She worked as a teacher at the same school all her life. She was a cheerful, optimistic and supportive lady with many friends and a busy daily schedule of work and family obligations. She had a successful and happy married life until her husband died of a heart attack when she was 53. She had had no major medical problems and had not undergone any surgery.  
  
Findings: The patient was a properly dressed, friendly lady, who was cooperative during the interview and answered all the questions. "I have never increased the dose," she said rather mockingly. It was clear that she was amused by the whole situation and that she had come to the clinic to satisfy her son's concern and to put him at his ease. She revealed no evidence of abnormality of thought, perception, orientation or memory. However, she was not ready to consider the possibility of stopping taking her "medication", although she did not feel it was absolutely necessary to her.  
  
DISCUSSION  
  
A wide variety of substances, although not medically prescribed or recommended in the first instance, are sometimes used unnecessarily or to excess. This is facilitated by the availability of certain substances without medical prescription. Laxatives and digestives are some of those very commonly used, as in the case of this patient. Although there is neither dependence nor withdrawal symptoms, there is usually a strong motivation to take the substances and a great resistance to any attempts to discourage or forbid their use.  
  
F55.1 Abuse of non-dependence-producing substances, laxatives.  
  
  
  
Case 24  
  
The patient is a young woman of 21 years old. She is single, lives with her parents and younger sister in a sixth-floor apartment, and works as a shop assistant in a small store in a city suburb.  
  
Problem: After an argument with her parents the patient threatened to kill herself by jumping out of the window. The parents did not know what to do and called the family doctor who referred them to the psychiatric department. The patient had been sitting in her room listening to heavy metal rock music on her stereo. She had the volume turned up high and her parents came to her room and told her to turn "that crazy music" down. She refused and "another row" developed. When her mother turned the stereo off, the patient threw open the window and threatened to jump out. After much screaming, she agreed to be taken to hospital. Once there, she agreed to stay only because "the situation at home had become quite impossible". According to her parents, the situation at home had been "catastrophic" for the last five years. The patient would be quite nice one moment but angry and quarrelsome the next for no real reason. She would seem happy and satisfied for an hour or so and then all of a sudden s he would complain that life wasn't worth living. On several occasions she had left home to live in a small apartment by herself. But each time she came back before long to stay with her parents again. She never seemed to know what she really wanted, her parents said. She was totally unrealistic in her plans for the future, and in any case she changed those plans constantly.  
  
History: According to her parents, the patient was a normal healthy child until her adolescence. At about age 13, she became more and more difficult. Although she was an intelligent girl, she had problems at school. She got very good grades in the subjects she was interested in, but failed completely in those she didn't like. In addition, her teachers complained that she behaved in a very undisciplined manner. At home, she had more and more arguments with her parents and her sister over trivial matters. At age 15, she was required to change school because she had failed her classes. She was adamant that she wanted to enter a technical school, which she did. She was the only girl in her class and a year later she left because she did not like the school any more. She began an art course at another school but soon dropped out of school altogether and began work as a shop assistant. In the next few years, she changed jobs frequently. On three occasions she was out of a job for more than sev eral months. She had begun a new job four months prior to her admission to the hospital and was already considering changing again.  
  
The parents of the patient said she had no regular friends and that she broke off relationships for minor reasons. Her relationships with other young people were described as "close" but transient. She frequently joined different groups of young people who her parents described as "undesirable", some of whom were taking drugs. Apparently the patient had not, however, ever taken any drugs herself.  
  
Findings: The patient had a rather attractive appearance and was well-dressed. When she first arrived at the hospital, she was insolent and argumentative. After a while, however, she became cooperative. She acknowledged that she had frequent feelings of anxiety and depression and that she did not really know who she was or why she behaved in the way she did. When asked about sexual preference, she said she did not know whether she was more attracted to men or to women. Although her parents reproached her for being a "loose girl", she had never had a sexual relationship with either a man or a woman. She said she believed in witchcraft and occultism, and at times had strange and frightening impulses - such as the urge to put a needle in her eyes or to swallow a piece of her jewellery. She readily admitted that she was giving her parents a hard time. Although she frequently threatened to leave home, she was in fact afraid of being abandoned by her parents. Renée admitted that she had occasionally threatened to commit suicide in the past after particularly big quarrels with her parents. The reason for these threats, she said, was partly because the world around her seemed black at the time and partly because she wanted to punish her parents. Although she had never actually tried killing herself, she said she felt that she might do it on an impulse if things became particularly bad in her life.  
  
DISCUSSION  
  
This patient shows longstanding maladaptive behaviour, pervasive across a wide range of personal and social situations, associated with personal distress and with onset during adolescence. These are characteristics of a personality disorder. Her behaviour pattern is further characterized by a marked tendency to act impulsively and to be quarrelsome, together with difficulty in maintaining any course of action that offers no immediate reward, an unstable and capricious mood, uncertainty about personal and sexual identity, liability to become involved in intense and unstable relationships, and recurrent threats of self-harm. These characteristics fit well into the diagnosis of emotionally unstable personality disorder, borderline type (F60.31). Her fluctuating feelings of depressed mood can be regarded as part of her personality disorder and do not need further specification.  
  
F60.31 Emotionally unstable personality disorder, borderline type.  
  
  
  
Case 25  
  
The patient is a man of 30 years old.  
  
Problem: The patient was brought to the psychiatric emergency room by his social worker. He had called her in the middle of the night and had told her that he could not go on any longer. He had wept and spoken about suicide. The social worker explained that her client was living alone, that she felt unable to cope with his problems and that his psychotherapist was on vacation. She advised that the patient be hospitalized.  
  
The patient was downcast and tense and apologized for the trouble he was causing. He relaxed when he was told that he could stay in the hospital, and he did not object when he was told that for the time being he would have to share a room with three elderly patients.  
  
History: The patient was born and brought up in a village in the country. When he was five years old he lost his father who died in a car accident. After his father's death, his mother managed to make a living as a waitress in a local café. The patient was an only child who did reasonably well at school and who never gave his mother any trouble. She did not remarry. He was very close to his mother and did everything possible to please her. Even as a child he seemed to understand that her life was not always easy and that he was all she had.  
  
He behaved well at school, always complying with his teachers' wishes, always ready to accept additional tasks that his schoolmates did not want to do, and apparently always happy to please everyone. When he was 16 he wanted to become a computer technician but this would have meant leaving for a city more than 100 miles away and his mother did not like the idea. He dropped out of school and took a job in a supermarket. He tried his best at work, was always ready to step in for a colleague and never complained about having to work overtime. He was regarded as a dependable worker and was up for promotion several times but somehow was passed over on each occasion. During his teenage years he would have liked to go out with his friends but he accepted that it was his responsibility to spend most of his evenings at home with his mother. She was proud to tell her neighbours that her son was "a really nice boy".  
  
When he was 20 he had his first row with his mother. She strongly disapproved of his dating a girl she did not like. When his mother told him he would have to leave home if he continued to see "that girl", he panicked, pleaded with his girlfriend to be patient, and finally let her drop him for someone else. His mother did approve of the second girl he brought home and even urged him to marry her, although he was personally not really thrilled by the idea. When his wife left him two years later he felt devastated and immediately returned to live with his mother. His mother died shortly afterwards of a heart attack. Since then, the patient had been hospitalized a number of times for depression, usually just for a day or two. He went to see a psychotherapist twice a week and asked his social worker for advice on the most trivial matters almost every day.  
  
There was no known history of mental disorders in the family.  
  
Findings: The patient was oriented in time, place and person. On the morning after his admission to hospital, he was unsure whether to stay or go home and he asked for advice. He explained that he had panicked the night before and had overreacted but that by now he was all right again. He asserted that his psychotherapist had encouraged him to avoid seeking refuge in hospitals. His social worker, on the other hand, had told him to get some "real treatment" this time and to stay for at least a couple of weeks or even months. He was neither depressed nor anxious, seemed at ease during the interview and spoke in a coherent way.  
  
When asked about his attitudes to others, the patient declared that he liked being with other people. He said he did not like being alone and that in fact he felt lost when alone. He had no problems relating to others and felt comfortable with most people. He stressed that he even had no problems getting along with colleagues who were considered difficult by others. He often felt depressed, but these feelings always vanished after a couple of hours, especially when he could talk to somebody. He also felt "panicky" whenever he had to take a decision. On close examination, however, these feelings did not include anxiety symptoms characteristic of panic attacks.  
  
The physical examination revealed no abnormalities. The blood tests, including thyroid function, were within normal limits, as were all other special investigations such as EEG and brain scan.  
  
Course: When told by the psychiatrist that there was no need for him to stay in the hospital but that there would always be someone available whenever he felt unable to cope, the patient agreed to go home. During the next two weeks, he phoned twice to enquire about trivial things and then resumed his sessions with his psychotherapist.  
  
DISCUSSION  
  
The significant feature of the disorder of this patient is a severe disturbance in his characterological constitution and behavioural tendencies, meeting the general ICD-10 criteria for personality disorder. There was no history of depressive or anxiety disorder, or of delusions, hallucinations or other psychotic symptoms.  
  
The patient presents a deeply ingrained and enduring behaviour pattern characterized by allowing others to make one's important life decisions, subordinating one's own needs to those of others, undue compliance with other people's wishes, limited capacity to make everyday decisions without an excessive amount of advice from others, preoccupation with fears of being left to care for oneself and feeling helpless when alone. This is the typical pattern of behaviour observed in dependent personality disorder.  
  
F60.7 Dependent personality disorder.