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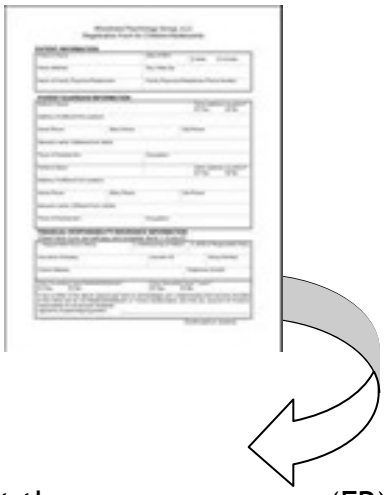

Client Profile

(✓) Male ( ) Female

Name: Gregory Baker
Age: 20 years old
Patient Number: 1001

Gregory Baker was a 20-year-old African American man who was brought t the emergency room (ER) by the campus police of the university from which he had been suspended several months earlier. The police had been called by a professor who walked into his classroom shouting "I am the Joker, I am looking for Batman." When Mr. Baker refused to leave the class, the professor contacted security.

Although Mr. Baker had much academic success as a teenager, his behavior had become increasingly odd during the past year. He quit seeing his friends and spent most of his time lying in bed staring at the ceiling. He lived with several family members but rarely spoke to any of them. He had been suspended from college because of lack of attendance. His sister said that she had recurrently seen him mumbling quietly to himself and noted that he would sometimes, at night, stand on the roof of their home and wave his arms as if he were "conducting a symphony." He denied having any intention of jumping from the roof or having any thoughts of self-harm, but claimed that he felt liberated and in tune with the music when he was on the roof. Although his father and sister had tried to encourage him to see someone at the university's student health office, Mr. Baker had never seen a psychiatrist and had no prior hospitalizations.

During the prior several months, Mr. Baker had become increasingly preoccupied with a female friend, Anne, who lived down the street. While he insisted to his family that they were engaged, Anne told Mr. Baker's sister that they had hardly ever spoken and certainly were not dating. Mr. Baker's sister also reported that he had written many letters to Anne but never mailed them; instead, they just accumulated on his desk.

On examination in the ER, Mr. Baker was a well-groomed young man who was generally uncooperative. He appeared constricted, guarded, inattentive, and preoccupied. He became enraged when the ER staff brought him dinner. He loudly insisted that all of the hospital's food was poisoned and that he would only drink a specific type of bottled water. He was noted to have paranoid, grandiose, and romantic delusions. He appeared to be internally preoccupied, although he denied hallucinations. Mr. Baker reported feeling "bad" but denied depression and had no disturbance in his sleep or appetite. His insight and judgment were deemed poor.

Mr. Baker's grandmother had died in a state psychiatric hospital, where she had lived for 30 years. Her diagnosis was unknown. Mr. Baker's mother was reportedly "crazy." She had abandoned the family when Mr. Baker was young, and he was raised by is father and paternal grandmother.

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

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Client Profile

Name: Maria Greco
Age: 23 years old
Patient Number: 1002

( )Male (✓) Female

Maria Greco was a 23-year-old single woman who was referred for psychiatric evaluation by her cardiologist. In the prior 2 months, she had come to the emergency room four times for acute complaints of palpitations, shortness of breath, sweats, trembling, and the fear that she was about to die. Each of these events had a rapid onset. The symptoms peaked within minutes, leaving her scared, exhausted, and fully convinced that she had just experienced a heart attack. Medical evaluations done right after these episodes yielded normal physical exam findings, vital signs, lab results, toxicology screens, and electrocardiograms.

The patient reported a total of five such attacks in the prior 3 months, with the symptoms occurring at work, at home, and while driving a car. She had developed a persistent fear of having other attaks, which led her to take many days off work and to avoid exercise, driving, and coffee. She avoided social relationships. She did not accept the reassurance offered to her by her friends and physicians, believing that the medical workups were negative because they were performed after the resolution of the symptoms. She continued to suspect that something was wrong with her heart and that without an accurate diagnosis, she was going to die. When she experienced these symptoms while asleep in the middle of the night, she finally agreed to see a psychiatrist.

Ms. Greco denied a history of previous psychiatric disorders except for a history of anxiety during childhood that had been diagnosed as a “school phobia.”

The patient’s mother had committed suicide by overdose 4 years earlier in the context of a recurrent major depression. At the time of the evaluation, the patient was living with her father and two younger siblings. The patient had graduated from high school, was working as a telephone operator, and was not dating anyone. Her family and social dating histories were otherwise noncontributory.

On examination, the patient was an anxious-appearing, cooperative, coherent young woman. She denied depression but did appear worried and was preoccupied with ideas of having heart disease. She denied psychotic symptoms, confusion, and all suicidality. Her cognition was in tact, insight was limited, and judgment was fair.

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Client Profile

Name: Crystal Smith
Age: 33 years old
Patient Number: 1003

( ) Male (✓) Female

Crystal Smith, a 33-year-old African American homemaker, came to an outpatient clinic seeking "someone to talk to" about feelings of despair that had intensified over the previous 8-10 months. She was particularly upset about marital conflict and an uncharacteristic mistrust of her in-laws.

Ms. Smith said she and begun to wake before dawn, feeling down and tearful. She had difficulty getting out of bed and completing her usual household activities. At times, she felt guilty for not being her "usual self." At other times, she became easily irritated with her husband and her in-laws for minor transgressions. She had previously relied on her mother-in-law to assist with the children, but she no longer entirely trusted her with that responsibility. That worry, in combination with her insomnia and fatigue, made it very difficult for Ms. Smith to get her children to school on time. In the past few months, she had lost 13 pounds without dieting. She denied current suicidal ideation, saying she "would never do something like that," but acknowledged having thought that she "should just give up" and that she "would be better off dead."

Ms. Smith lived with her husband of 13 years and two school-age children. Her husband's parents lived next door. She said her marriage was good, although her husband suggested she "so see someone" so that she would not be "yelling at everyone all the time." While historically sociable, she rarely talked to her own mothers and sisters, much less her friends. A regular churchgoer, she had quit attending because she felt her faith was "weak." Her pastor had always been supportive, but she had not contacted him with her problems because "he wouldn't want to hear about these kinds of issues."

Ms. Smith described herself as having been an outgoing, friendly child. She grew up with her parents and three siblings. She recalled feeling quite upset at age 10-11 when her parents divorced and her mom remarried. Because of fights with other kids at school, she met with a school counselor with whom she felt a bond. Ms. Smith felt the counselor did not "get into my business" and helped her recover. She said she became quieter as she entered junior high school, with fewer friends and little interest in studying. She married her husband at age 20 and worked in retail sales until the birth of their first child when she was 23 years old.

On mental status examination, Ms. Smith was a casually groomed young woman who was coherent and goal-directed. She had difficulty making eye contact with the white middle-aged therapist. She was cooperative but mildly guarded and slow to respond. She needed encouragement to elaborate her thinking. She was periodically tearful and generally appeared sad. She denied psychosis, although reported occasionally feeling mistrustful of her family. She denied confusion, hallucinations, suicidality, and homicidality. Cognition, insight, and judgment were all considered normal.

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Client Profile

( )Male (✓)Female

Name: Nancy Ingram
Age: 22 years old
Patient Number: 1004

Nancy Ingram, a 33-year-old stock analyst and married mother of two children, was brought to the emergency room (ER) after 10 days of what her husband described as “another cycle of depression,” marked by a hair-trigger temper, tearfulness, and almost no sleep. He noted that these “dark periods” had gone on as long as he had known her but that she had experienced at least a half dozen of these episodes in the prior year.

Ms. Ingram's husband said he had decided to bring her to the ER after he discovered that she had recently created a blog entitled Nancy Ingram’s Best Stock Picks. Such an activity was not only out of character but, given her job as a stock analyst for a large investment bank, was strictly against company policy. He said that she had been working on these stock picks around the clock, forgoing her own meals as well as her responsibilities at work and with her children. She countered that whew as find and that her blog would “make them rich as Croesus.”

The patient had first been diagnosed with depression in college, after the death of her father from suicide. He had been a wildly erratic, alcohol-abusing business man whom the patient loved very much. Her paternal grand mother had several “nervous breakdowns,” but her diagnosis and treatment history were unknown. Since college, her mood had generally been “down,” interspersed with recurrent bouts of enhanced dysphoria, insomnia, and uncharacteristically rapid speech and hyper alertness. She had tried psychotherapy sporadically and taken a series of antidepressant medications, but her husband noted that the baseline depression persisted and that the dark periods were increasing in frequency.

Her outpatient psychiatrist noted that Ms. Ingram appeared to have dysthymia and a recurrent major depression. He also said that he had never seen her during her periods of edginess and insomnia - she always refused to see him until the “really down” periods improved - and that she had refused him access to her husband or to any other source of collateral information.

On examination, the patient was pacing angrily in the exam room. She was dressed in jeans and a shirt that was carelessly unbuttoned. Her eyes appeared glazed and unfocused. She responded to the examiner’s entrance by sitting down and explaining that this was all a miscommunication, that she was fine and needed to get home immediately to tend to her business. Her speech was rapid, pressured, and very difficult to interrupt. She admitted to not sleeping but denied that it was a problem. She denied hallucinations but admitted, with a smile, to a unique ability to predict the stock market. She refused cognitive testing, saying she would decline the opportunity to be a “trailed seal, a guinea pig, Mr. Ed, and a barking dog, thank you very much, and may I leave now?” Her insight into her situation appeared poor, and her judgment was deemed to be impaired.

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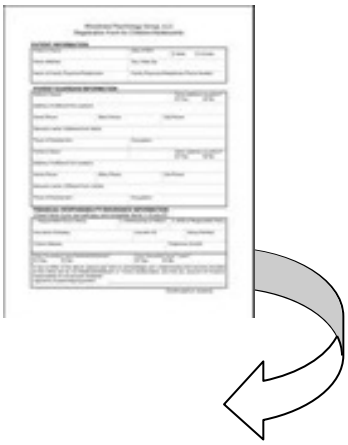

Client Profile

Name: Olaf Hendricks
Age: 51 years old
Patient Number: 1005

[✓] Male [ ] Female

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

The patient's anxiety about flying had begun 3 years earlier when he was on a plane that landed in the middle of an ice storm. He had flown 2 years earlier, reporting that he had cried on takeoff and landing. He had gone with his wife to an airport one additional time, 1 year prior to the evaluation, to fly to his daughter's wedding. Despite having drunk a significant amount of alcohol, Mr. Hendricks panicked and refused to board the airplane. After that failed effort, he tended to feel intense anxiety when he even considered the possibility of flying, and the anxiety had led him to decline a promotion at work and an external job offer because both would have involved business trips.

Mr. Hedricks described sadness and regret since realizing his limitation but denied other neurovegetative symptoms of depression. He had increased his alcohol consumption to three glasses of wine nightly in order to "unwind." He denied any history of alcohol complications or withdrawal symptoms. He also denied a family history of psychiatric problems.

He denied anxiety in other situations, indicating that his colleagues saw him as a forceful and successful businessman who could "easily" deliver speeches in front of hundreds of people. When specifically asked, he reported that as a child, he had been "petrified" that he might get attacked by a wild animal. This fear had led him to refuse to go on family camping trips or even on long hikes in the country. As an adult, he said that he had no worries about being attacks by wild animals because he lived in a large city and took vacations by train to other large urban areas.

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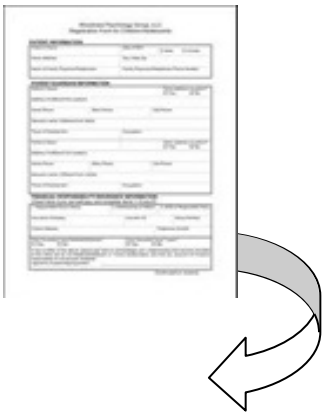

Client Profile

Name: Peggy Isaac
Age: 41 years old
Patient Number: 1006

( ) Male (✓) Female

Peggy Isaac is a 41-year-old administrative assistant who was referred for an outpatient evaluation by her primary care physician with a chief complaint of "I'm always on edge." She lived alone and had never married or had children. She had never before seen a psychologist.

Ms. Isaac had lived with her longtime boyfriend until 8 months earlier, at which time he had abruptly ended the relationship to date a younger woman. Soon thereafter, Ms. Isaac began to agonized about routine tasks and the possibility of making mistakes at work. She felt uncharacteristically tense and fatigued. She had difficulty focusing. She also started to worry excessively about money and, to economize, she moved into a cheaper apartment in a less desirable neighborhood. She repeatedly sought reassurance from her office mates and her mother. No one seemed able to help, and she worried about being "too much of a burden."

During the 3 months prior to the evaluation, Ms. Isaac began to avoid going out at night, fearing that something bad would happen and she would be unable to summon help. More recently, she avoided going out in the daytime as well. She also felt "exposed and vulnerable" walking to the grocery store three blocks away, so she avoided shopping. After describing that she had figured out how to get her food delivered, she added, "It's ridiculous. I honestly feel something terrible is going to happen in one of the aisles and no one will help me, so I won't even go in." When in her apartment, she could often relax and enjoy a good book or movie.

Ms. Isaac said she had "always been a little nervous." Through much of kindergarten, she had cried inconsolably when her mother tried to drop her off. She reported seeing a counselor at age 10, during her parents' divorce, because "my mother thought I was too clingy." She added that she had never liked being alone, having had boyfriends constantly (occasionally overlapping) since age 16. She explained, "I hated being single, and I was always pretty, so I was never single for very long." Nevertheless, until the recent breakup, she said she had always thought of herself as "fine." She had been successful at work, jogged daily, maintained a solid network of friends, and had "no real complaints."

On initial interview, Ms. Isaac said she had been sad for a few weeks after her boyfriend left, but denied ever having felt worthless, guilty, hopeless, or suicidal. She said her weight was unchanged and her sleep was fine. She denied psychomotor changes. She did describe significant anxiety, with a Beck Anxiety Inventory score of 28, indicating severe anxiety.

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Client Profile

Name: Trevor Lucas
Age: 32 years old
Patient Number: 1007

(✓) Male ( ) Female

Trevor Lucas, a 32-year-old single man living with his parents, was brought to his psychiatric consultation by his mother. She noted that since adolescence he had been concerned with germs, which led to long-standing hand-washing and shower rituals. During the prior 6 months, his symptoms had markedly worsened. He had become preoccupied with being infected by HIV and spent the day cleaning not only his body but all of his clothing and linen. He had begun to insist that the family also wash their clothing and linen regularly, and this had led to the current consultation.

Mr. Lucas had in the past received treatment for his symptoms. These had had some positive effect, and he had been able to complete high school successfully. Nevertheless, his symptoms had prevented him from completing college or working outside the home; he had long felt that home was relatively germ-free in comparison to the outside world. However, over the past 6 months he had increasingly indicated that home, too, was contaminated, including with HIV.

At the time of his appointment, Mr. Lucas had no other symptoms involving sexual, religious, or other repetitive thoughts; appearance or acquisition preoccupations; or body-focused repetitive behaviors. However, in the past he had also experienced obsessions concerning harm to self and others, together with related checking compulsions (e.g., checking that the stove was switched off). He had a childhood history of motor tics. During high school, he found that marijuana reduced his anxiety. Referencing his social isolation, he denied having had access to marijuana or any other psychoactive substance for at least a decade.

On mental status examination, Mr. Lucas appeared disheveled and unkempt. He was completely convinced that HIV had contaminated his home and that his washing and cleaning were necessary to stay uninfected. When challenged with the information that HIV was spread only by bodily fluids, he answered that HIV might have come into the home via the sweat or saliva of visitors. In any event, the virus might well be surviving on clothes or linen, and could enter his body via his mouth, eyes, or other orifices. He added that his parents had tried to convince him that he was excessively worried, but not only did he not believe them but his worries kept returning even when he tried to think of something else. There was no evidence of hallucinations or of formal thought disorder. He denied an intention to harm or kill himself or others. He was cognitively intact.

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Client Profile

Name: Eric Reynolds
Age: 56 years old
Patient Number: 1008

[✓] Male [ ] Female

Eric Reynolds is a 56-year-old married Vietnam War veteran who referred himself to the Veterans Affairs outpatient mental health clinic fora chief complaint of having “a short fuse” and being “easily triggered.”

Mr. Reynolds’s symptoms began more than three decades earlier, soon after he left he combat zone in Vietnam, where he had served as a field radio operator. He had never sought help for his symptoms, apparently because of his strong need to be independent. An early retirement led to greater recognition of symptoms and a stronger desire to seek help.

Mr. Reynolds’s symptoms included uncontrollable rage when unexpectedly startled; recurrent intrusive thoughts and memories of death-related experiences; weekly vivid nightmares of combat operations that led to nighttime fright and insomnia; isolation, vigilance, and anxiety; loss of interest in hobbies that involve people; and excessive distractibility.

Although all of these symptoms are very distressing, Mr. Reynolds is most worried about his uncontrollable aggression. Examples of his “hair-trigger temper” included confrontations with drivers who cut him off, curses directed at strangers who stood too close in checkout lines, and shifts into “attack mode” when coworkers inadvertently surprised him. Most recently, as he was drifting off to sleep on his physician’s examination table a nurse touched his foot and he kept up, cursing and threatening. His involuntary reaction scared the nurse as well as the patient.

Mr. Reynolds said that no words, thoughts, or images intervened between the unexpected stimulation and his aggression. These moments reminded him of a time in the military when he was on guard at the front gate and, while he was dozing, an incoming mortar round stunned him into action. Although he kept a handgun in the console of his car for self-protection, Mr. Reynolds had no intention of harming others. He was always remorseful after a threatening incident and had long been worried that he might inadvertently hurt someone.

On examination, Mr. Reynolds was a well-groomed African American man who appeared anxious and somewhat guarded. He was coherent and articulate. his speech was at a normal rate, but the pace accelerated when he discussed disturbing content. He denied depression but was anxious. His affect was somewhat constricted but appropriate to content. His thought process was coherent and linear. He denied all suicidal and homicidal ideation. He had no psychotic symptoms, delusions, or hallucinations. He had very good insight. He was well oriented and seemed to have above average intelligence.

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Client Profile

Name: Irene Upton
Age: 29 years old
Patient Number: 1009

( )Male (✓) Female

Irene Upton was a 29-year-old special education teacher who sought a psychiatric consultation because “I’m tired of always being sad and alone.”

Ms. Upton reported that previous therapists had focused on the likelihood of trauma, but she casually dismissed the possibility that she had ever been abused. It had been her younger sister who had reported “weird sexual touching” by their father when Ms. Upton was 13. There had never been a police investigation, but her father had apologized to the patient and her sister as part of a resultant church intervention and an inpatient treatment for alcoholism and “sex addiction.” She denied any feelings about these events and said, “He took care of the problem. I have no reason to be mad at him.”

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

She reported a “good” relationship with both parents. Her father remained “controlling” toward her mother and still had “anger issues,” but had been abstinent from alcohol for 16 years. On closer questioning, Ms. Upton reported that her self-injurious and suicidal behavior primarily occurred after visits to see her family or when her parents surprised her by visiting.

Ms. Upton described being “socially withdrawn” until high school, at which point she became academically successful and a member of numerous teams and clubs. She did well in college. She excelled at her job and was regarded as a gifted teacher of autistic children. She described several friendships of many years. She reported difficulty with intimacy with men, experiencing intense fear and disgust at any attempted sexual advances. Whenever she did get at all involved with a man, she felt intense shame and a sense of her own “badness,” although she felt worthless at other times as well. She tended to sleep poorly and often felt tired.

On mental status examination, the patient was well groomed and cooperative. Her responses were coherent and goal directed, but often devoid of emotional content. She appeared sad and constricted. She described herself as “numb.”

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Client Profile

Name: Oscar Capek
Age: 43 years old
Patient Number: 1010

[✓] Male [ ] Female

Oscar Capek, a 43-year-old man, was brought by his wife to an emergency room (ER) for what he described as a relapse of his chronic Lyme disease. He explained that he had been fatigued for a month and bedridden for a week. Saying he was too tired and confused to give much information, he asked the ER team to call his psychiatrist.

The psychiatrist reported that he had treated Mr. Capek for more than two decades. He first saw Mr. Capek for what appeared to be a panic attack. It resolved quickly, but Mr. Capek continued to see him for help coping with his chronic illness. Initially a graduate student pursuing a master's degree in accounting, Mr. Capek dropped out of school over worries that the demands of his study would exacerbate his disease. Since then, his wife, a registered nurse, had been his primary support. He supplemented their income with small accounting jobs but limited these lest the stress affect his health.

Mr. Capek usually felt physically and emotionally well. He deemed that his occasional fatigue, anxiety, and concentration difficulties were "controllable" and did not require treatment. His psychiatric sessions were commonly devoted to concerns about his underlying disease; he would often bring in articles on chronic Lyme disease for discussion and was active in a local Lyme disease support group.

Mr. Capek's symptoms would occasionally worsen. This occurred less than yearly, and these exacerbations usually related to some obvious stress. The worst was 1 year earlier when his wife briefly left him after she found out he was having an affair. Mr. Capek expressed shame about his behavior toward his wife – both the affair and his inability to support her. The psychiatrist speculated that similar stress was behind his current symptoms.

The psychiatrist communicated regularly with Mr. Capek's internist. All testing for Lyme disease thus far had been negative. When the internist explained this, Mr. Capek became defensive and produced literature on the inaccuracy of Lyme disease testing. Eventually, the internist and psychiatrist had agreed on a conservative treatment approach with a neutral stance regarding the disease's validity.

On examination, Mr. Capek was a healthy, well-developed adult male. He frequently lost his train of thought, but with encouragement and patience, he could give a detailed history that was consistent with the psychiatrist's account. Physical examination was unremarkable. Lyme disease testing was deferred given his past negative tests. A standard laboratory screen was normal with the exception of a slightly low hemoglobin value. On hearing about the low hemoglobin, Mr. Capek became alarmed, dismissed reassurances, and insisted this be investigated further.

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Client Profile

Name: Pauline Davis
Age: 43 years old
Patient Number: 1011

( )Male (✓) Female

Pauline Davis, a 32-year-old single African American woman with epilepsy first diagnosed during adolescence and no known psychiatric history, was admitted to an academic medical center after her family found her convulsing in her bedroom. Upon arriving at the ER, she was administered a drug that successfully stopped the convulsive activity. Laboratory studies of samples obtained in the ER revealed therapeutic levels of her usual anti-seizure drugs and no evidence of any infection or metabolic disturbance. Urine toxicology screens were negative for use of illicit substances. Ms. Davis was subsequently admitted to the neurology service for further monitoring.

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

On interview, Ms. Davis denied prior psychiatric evaluations, diagnoses, or treatments. She denied having depressed mood or any disturbance of sleep, energy, concentration, or appetite. She reported no thoughts of harming herself or others. She endorsed no signs or symptoms consistent with mania or psychosis. There was no family history of psychiatric illness or substance abuse. Her examination revealed a well-groomed woman, sitting on her hospital bed with EEG leads in place. She was pleasant and easily engaged and made good eye contact. Cognitive testing revealed no deficits.

Ms. Davis noted that she had recently moved to the state to start graduate school; she was excited to start her studies and “finally get my career on track.” She denied any recent specific psychosocial stressors other than her move and stated, “My life is finally where I want it to be.” She was future oriented and concerned about the impact that her seizures might have on her long-term health and was worried that an extended hospitalization might cause her to miss the first day of classes (only a week away from the time of the interview). Moreover, she was quite concerned about the costs of her hospitalization because her health insurance coverage did not begin until the school semester began and the payment for extended benefits coverage from her previous employer would have a significant impact on her budget.

When the findings of the vEEG study were discussed with Ms. Davis, she quickly became irritable, asking, “So, everyone thinks I’m just making this up?” She was not calmed by her treaters’ attempts to clarify that they did not believe her to be faking her symptoms or by their reassurance that her symptoms might be helped by psychotherapy.

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Client Profile

Name: Ike Crocker
Age: 34 years old
Patient Number: 1012

(✓) Male ( ) Female

Ike Crocker is a 32-year-old man referred for a mental health evaluation by the human resources department of a large construction business that had been his employer for 2 weeks. At his initial job interview, Mr. Crocker presented as very motivated and provided two carpentry school certifications that indicated a high level of skill and training. Since his employment began, his supervisors had noted frequent arguments, absenteeism, poor workmanship, and multiple errors that might have been dangerous. When confronted, he was reportedly dismissive, indicating that the problem was “cheap wood” and “bad management” and added that if someone got hurt, “it’s because of their own stupidity.”

When the head of human resources met with him to discuss termination, Mr. Crocker quickly pointed out that he had both attention-deficit/hyperactivity disorder and bipolar disorder. He said that if not granted an accommodation under the Americans with Disabilities Act, he would sue.

During his requested mental health evaluation, Mr. Crocker focused on unfairness at the company and how he was “a hell of a better carpenter than anyone there could ever be.” He claimed that his two marriages ended because of jealousy. He said that his wives were “always thinking I was with other women,” which is why “they both lied to judges and got restraining orders saying I’d hit them.” As “payback for the jail time,” he refused to pay child support for his two children. He had no interest in seeing either of his two boys because they were “little liars” like their mothers.

Mr. Crocker said he “must have been smart” because he had been able to make Cs in school despite showing up only half the time. He spent time in juvenile hall at age 14 for stealing “kid stuff, like tennis shoes and wallets that were practically empty.” He left school at age 15 after being “framed for stealing a car” by his principal. Mr. Crocker pointed out these historical facts as evidence that he was able to overcome injustice and adversity.

Mr. Crocker concluded the interview by demanding a note from the examiner that he had “bipolar” and “ADHD.” He said that he was “bipolar” because he had “ups and downs” and got “mad real fast.” Mr. Crocker denied other symptoms of mania. He learned about ADHD because “both of my boys got it.” He concluded the interview with a request for medications.

The head of human resources did a background check during the course of the psychiatric evaluation. Phone calls revealed that Mr. Crocker had been expelled from two carpentry training programs and that both his graduation certificates had been falsified. He had been fired from his job at one local construction company after a fistfight with his supervisor and from another job after abruptly leaving a job site. A quick review of their records indicated that he had provided them with the same false documentation.

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Client Profile

Name: Juanita Delgado
Age: 33 years old
Patient Number: 1013

( ) Male (✓) Female

Juanita Delgado, a single, unemployed Hispanic woman, sought therapy at age 33 for treatment of depressed mood, chronic suicidal thoughts, social isolation, and poor personal hygiene. She had spent the prior 6 months isolated in her apartment, lying in bed, eating junk food, watching television, ad doing more online shopping than she could afford.

Ms. Delgado was the middle of three children in an upper-middle-class immigrant family in which the father reportedly valued professional achievement over all else. She felt isolated throughout her school years and experienced recurrent periods of depressed mood. Within her family, she was known for angry outbursts. She had done well academically in high school but dropped out of college because of frustrations with a roommate and a professor. She attempted a series of internships and entry-level jobs with the expectation that she would return to college, but she kept quitting because "bosses are idiots. They come across as great and they all turn out to be twisted." These "traumas" always left her feeling terrible about herself ("I can't even succeed as a clerk?") and angry at her bosses ("I could run the place and probably will"). She had dated men when she was younger but never let them get too close physically because she became too anxious when any intimacy began to develop.

Ms. Delgado's history included cutting herself superficially on a number of occasions, along with persistent thoughts that she would be better off dead. She said that she was generally "down and depressed" but that she had had dozens of 1- to 2-day "manias" in which she was energized and edgy and pulled all-nighters. She tended to "crash" the next day and sleep for 12 hours.

During the interview, she was casually groomed and somewhat unkempt woman who was cooperative, coherent, ad goal directed. She was generally dysphoric with a constricted affect but did smile appropriately several times. She described shame at her poor performance but also believed she was "on Earth to do something great." She described her father as a spectacular success, but he was also a "Machiavellian loser who was always trying to manipulate people." She described quitting jobs because people were disrespectful. For example, she said that when she worked as a clerk at a department store, people would often be rude or unappreciative ("and I was there only in preparation to become a buyer; it was ridiculous"). Toward the end of the initial session, she became angry with the interviewer after he glanced at the clock ("Are you bored already?"). She said she knew people in the neighborhood, but most of them had become "frauds or losers." There were a few people from school who were "Facebook friends," doing amazing things all over the world. Although she had not seen them in years, she intended to "meet up with them if they ever come back to town."

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Client Profile

Name: Karmen Fuentes
Age: 50 years old
Patient Number: 1014

( ) Male (✓) Female

Karmen Fuentes was a 50-year-old married Hispanic woman who came to the psychiatric emergency room (ER) at the urging of her outpatient psychiatrist after telling him that she had been thinking about overdosing on Advil.

In the ER, Ms. Fuentes explained that her back had been "killing" her since she fell several days earlier at the family-owned grocery store where she had worked for many years. The f all had left her downcast and depressed, although she denied other depressive symptoms aside from a poor mood. She spoke at length about the fall and how it reminded her of a fall that she had sustained a few years earlier. At that time, she had gone to see a neurosurgeon, who told her to rest and take nonsteroidal anti-inflammatory drugs. She described feeling "abandoned and not cared about" by him. The pain had diminished her ability to exercise, and she was upset that she had gained weight. While relating the events surrounding the fall, Ms. Fuentes began to cry.

When asked about her suicidal comments, she said they were "no big deal." She reported that they were "just a threat" aimed at her husband to "teach him a lesson" because "he has no compassion for me" and had not been supportive since the fall. She insisted her comments about overdosing did not have other meaning. When her ER interviewer expressed concern about the possibility that she would kill herself, she exclaimed with a smile, "Oh wow, I didn't realize it's so serious. I guess I shouldn't do that again." She then shrugged and laughed. She went on to talk about how "nice and sweet" it was that so many doctors and social workers wanted to hear her story, calling many of them by their first names. She was also somewhat flirtatious with her male resident interviewer, who had mentioned that she was the "best-dressed woman in the ER."

According to her outpatient psychiatrist of 3 years, she had never before expressed suicidal ideation until this week, and he would be unable to check in on her until after he left on vacation the next day. Ms. Fuentes's husband reported that she talked about suicide "like other people complain about the weather. She's just trying to get me worried, but it doesn't work anymore." He said he would never have suggested she go to the ER and thought the psychiatrist had overreacted.

Ms. Fuentes described being "an early bloomer." She became sexually active with older men when she was in high school. She said dating had been the most fun thing she had ever done and that she missed seeing men "jump through hoops" to sleep with her. She lived with her 73-year-old husband. Her 25-year-old son lived nearby with his wife and young son. She described her husband as a "very famous" musician. She said that he had never helped around the house or with child-rearing and did not appreciate how much work she put into taking care of their son and grandson.

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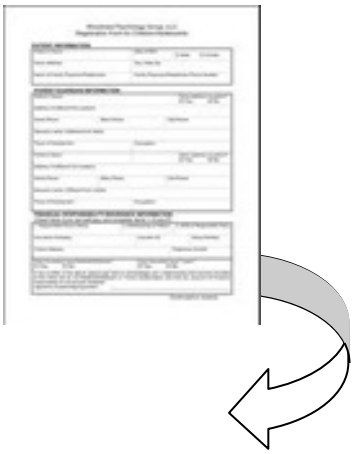

Client Profile

Name: Larry Goranov
Age: 57 years old
Patient Number: 1015

[✓] Male [ ] Female

Larry Goranov was a 57-year-old single unemployed white man who was asking for a review of his treatment at the psychiatric clinic. He had been in weekly psychotherapy for 7 years and complained that the treatment had been of little help. He wanted to make sure that the doctors were on the right track.

Mr. Goranov reported a long-standing history of low-grade depressed mood and decreased energy. He had to "drag" himself out of bed every morning and rarely looked forward to anything. He had lost his job 3 years earlier, had broken up with a girlfriend slightly later, and doubted that he would ever work or date again. He was embarrassed that he still lived with his 83-year-old mother.

Mr. Goranov expressed frustration at his lack of improvement, the nature of his treatment, and his specific therapy. He found it "humiliating" that he was forced to see trainees who rated off his case every year or two. He frequently found that the psychiatry residents were not especially educated, cultured, or sophisticated, and felt they knew less about psychotherapy than he did. He much preferred to work with female therapists, because men were "too competitive and envious."

Mr. Goranov previously worked as an insurance broker. He explained, "It's ridiculous. I was the best broker they had ever seen, but they won't rehire me. I think the problem is that the profession is filled with big egos, and I can't keep my mouth shut about it." After being denied employment by insurance agencies, Mr. Goranov did not work for 5 years, until he was hired by an automobile dealer. He said that although it was beneath him to sell cars, he was successful, and "in no time, I was running the place." He quit within a few months after an argument with the owner. Despite encouragement from several therapists, Mr. Goranov had not applied for a job or pursued employment rehabilitation or volunteer work; he strongly viewed these options as beneath him.

Mr. Goranov has "given up on women." He had many partners as a younger man, but he generally found them unappreciative and "only in it for the free meals." The psychiatric resident notes indicated that he responded to demonstrations of interest with suspicion. This tendency held true in regard to both women who had tried to befriend him and residents who had taken an interest in his care. Mr. Goranov described himself as someone who had a lot of love to give, but said that the world was full of manipulators. He said he had a few buddies, but his mother was the only one he truly cared about. He enjoyed fine restaurants and "five-star hotels," but he added that he could no longer afford them. He exercised daily and was concerned about maintaining his body.

On examination, the patient was neatly groomed, had slicked-back hair, and wore clothing that appeared to be by a hip-hop designer generally favored by men in their 20s. He was coherent, goal directed, and generally cooperative.

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Client Profile

Name: Sara Judd
Age: 28 years old
Patient Number: 1016

[ ] Male [✓] Female

Sara Judd and her boyfriend, Peter Kleinman, came to couples therapy to address escalating conflict around the issue of moving in together. Mr. Kleinman described a several-month-long apartment search that was made "agonizing" by Ms. Judd's rigid work schedule and her "endless" list of apartment demands. They were unable to come to a decision, and eventually they decided to just share Ms. Judd's apartment. As Mr. Kleinman concluded, "Sara won."

Ms. Judd refused to hire movers for her boyfriend's belongings, insisting on personally packing and taking an inventory of every item in her boyfriend's place. What should have taken 2 days took 1 week. Once the items were transported to Ms. Judd's apartment, Mr. Kleinman began to complain about Ms. Judd's "crazy rules" about where items could be placed on the bookshelf, which direction the hangers in the closet faced, and whether their clothes could be intermingled. Moreover, Mr. Kleinman complained that there was hardly any space before his possessions because Ms. Judd never threw anything away. "I'm terrified of losing something important," added Ms. Judd.

Over the ensuing weeks, arguments broke out nightly as they unpacked boxes and settled in. Making matters worse, Ms. Judd would often come home after 9:00 or 10:00 P.M., because she had a personal rule to always have a blank "to-do" list by the end of the day. Mr. Kleinman would often wake early in the morning to find Ms. Judd grimly organizing shelves or closets or sorting books alphabetically by author. Throughout this process, Ms. Judd appeared to be working hard at everything while enjoying herself less and getting less done. Mr. Kleinman found himself feeling increasingly detached from his girlfriend the longer they lived together.

Ms. Judd said that she had never experimented with cigarettes or alcohol, adding, "I wouldn't want to feel like I was out of control." She was raised in a two-parent household and was an above average high school and college student. She was an only child and first shared a room as a college freshman. She described that experience as being difficult due to "conflicting styles – she was a mess and I knew that things should be kept neat." She moved mid-year into a single dorm room and had not lived with anyone until Mr. Kleinman moved in. Ms. Judd was well liked by her boss, earning recognition as "employee of the month" three times in 2 years. Feedback from colleagues and subordinates was less enthusiastic, indicating that she was overly rigid, perfectionistic, and critical.

On examination, Ms. Judd was a thin woman who was meticulously dressed. She was cooperative with the interview and sat quietly while her boyfriend spoke, interrupting on a few occasions to contradict. Her speech was normal in rate and tone. Her affect was irritable. At the end of the consultation, Ms. Judd remarked, "I know I'm difficult, but I really do want this to work out."