ROME

nergency room by his mother, pleaded, "You've got to admit nt had been taken home from reviously. The mother showed ndicated that the patient's IQ eginning at age 8. On visiting her, "Mommy, take me home." e brought home by his mother, use of his retardation and her atient was an only child whose ears. The father had moved to

the patient had increasingly t 5′9″ tall and weighed close ctive of property at home—antrums—and, more recently, her on the arm and shoulder she tried to get him to stop he mother showed her bruises mayor's office if the hospital

d to have the typical signs of features, slightly protruding Simian crease of the palms of ech, the boy insisted that he

e"

antly subaverage general acement in special schools severe concurrent deficits se two features, with onset osis of Mental Retardation

(DSM-IV, p. 46). Because the IQ level is between 35 and 55, the severity level is Moderate.

The diagnosis of Mental Retardation should be made when the criteria are met, regardless of the presence of another diagnosis. In the presence of significant Mental Retardation, the issue of a Learning Disorder is moot, as the specific deficit would have to be out of proportion to the deficits in other areas of development. A Pervasive Developmental Disorder can coexist with Mental Retardation; but unlike in this case, only when there is no interest or pleasure in social contact. Therefore, no diagnosis is warranted on Axis I.

This child, as is often the case, presents for admission because of destructive and aggressive behavior, not because of impairment in intellectual functioning. This aggressive behavior is presumably a persistent pattern; nevertheless, the additional diagnosis of Conduct Disorder is not justified because there are none of the other characteristic features of this disorder, such as stealing, lying, and running away from home.

In this case, Mental Retardation is apparently a result of Down's syndrome, which would be noted on Axis III.

The presence of any clinically relevant psychosocial or environmental problems is unclear from the available information. Therefore, one would not check any items from the Axis IV Psychosocial and Environmental Problems Checklist.

The patient's highest level of functioning in the past year is very poor, owing to marked impairment in all areas of functioning; therefore, an appropriate highest global assessment of functioning (GAF) rating is only about 20. Because of the increase in dangerous behavior recently, necessitating the visit to the emergency room, the current GAF is rated 10.

Thin Tim

Eight-year-old Tim was referred by a pediatrician who asked for an emergency evaluation because of a serious weight loss during the past year for which the pediatrician could find no medical cause. Tim is extremely concerned about his weight and weighs himself daily. He complains that he is too fat, and if he does not lose weight, he cuts back

on food. He has lost 10 pounds in the past year and still feels that he is too fat, though it is clear that he is underweight. In desperation, his parents have removed the scales from the house; as a result, Tim is keeping a record of the calories that he eats daily. He spends a lot of time on this, checking and rechecking that he has done it just right.

In addition, Tim is described as being obsessed with cleanliness and neatness. Currently he has no friends because he refuses to visit them, feeling that their houses are "dirty"; he gets upset when another child touches him. He is always checking whether he is doing things the way they "should" be done. He becomes very agitated and anxious about this. He has to get up at least two hours before leaving for school each day in order to give himself time to get ready. Recently, he woke up at 1:30 A.M. to prepare for school.

Discussion of "Thin Tim"

The emergency evaluation is because of Tim's recent weight loss. He has lost 10 pounds in the last year, during which time a boy of his age might have been expected to gain about that amount. This means he is actually 20 pounds below his expected weight for his age. Although Anorexia Nervosa is unusual in a male and in one so young, his refusal to maintain a normal weight suggests this diagnosis (DSM-IV, p. 544). Tim also has the other characteristic features of the disorder: fear of becoming fat, feeling fat even when obviously underweight.

Although not the focus of attention, Tim's preoccupation with various recurrent thoughts concerning dirtiness causes him considerable distress. Moreover, he has to check whether he is doing things the way they "should" be done, and such activities apparently interfere with his normal functioning (he has to get up several hours before school in order to get ready). Although he does not seem to experience these recurrent thoughts and repetitive acts as inappropriate, it is reasonable to assume that the thoughts do intrude into his consciousness and are beyond his control, and that his lengthy "getting ready" routines are performed in response to these thoughts. Thus, they represent true obsessions and compulsions. Because the content of these obsessions and compulsions is unrelated to Tim's Eating Disorder, an additional diagnosis of Obsessive-Compulsive Disorder (DSM-IV, p. 422) is made, and is listed second, as the initial focus of attention is the eating problem.

There is phobic avoidance (he won't visit friends' houses because they might be dirty), but the additional diagnosis of a Specific Phobia is not made because phobic avoidance is a commonly associated feature of Obsessive-Compulsive Disorder.

Nighttime Visitor

Nina was age 8 when her guidance counselor at school referred her to the Family Treatment Center in Cleveland because of disruptive, aggressive behavior. Her 11-year-old brother, Don, and her 9-year-old sister, Sara, were also evaluated, together with her mother.

Several months earlier Nina had been admitted to the hospital with vaginal bleeding and a discharge. A diagnosis of vaginal warts (*condyloma acuminatum*) was made, and the vaginal culture proved to be positive for gonorrhea. When questioned by a social worker whom the pediatrician asked to see the children, Nina revealed that she and Sara had been sexually molested by their father for the past 2 years. According to her, he would come into their bedroom regularly at night and have vaginal intercourse with her and, more rarely, with Sara. The girls noticed that if they were awake, their father often would not bother them. Nevertheless, Nina was so frightened that she would close her eyes and feign sleep during the molestation. Their father threatened them with beatings if they divulged the secret, so they had never told anyone.

Their brother, Don, after witnessing one of the molestations, told their mother. She did not believe him, told her husband, who then proceeded to beat Don. In fact, Don had often been beaten by his father. After Don's disclosure, Nina and Sara told their mother what had been happening, but she scolded them for "making up stories."

When the social worker talked with the mother about these events, she admitted that she had suspected that her children were telling the truth, but was afraid of confronting her husband about his sexual abuse because she feared his murderous rage. During their 12-year marriage, he had frequently beaten her, but she never thought of leaving him because her religion forbade divorce.