PSYCHOLOGICAL CASE RECORD

Submitted to the Tamil Nadu Dr. M.G.R. Medical University in part fulfillment of the requirements for the Diploma in Psychological Medicine Examination in September 2008

By

Dr. MINJU K.A.

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I would like to express my sincere thanks to all the patients and their families who kindly co-operated with me even though they themselves were in agony.

CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr.Minju K.A.** during the year 2006-2008. I also certify that this record is an independent work done by the candidate under my supervision.

Dr. K.S.JACOB

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Department of Psychiatry

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Mrs. Sushila Russell, M.Phil,

Lecturer in Clinical Psychology

Department of Psychiatry

Christian Medical College

Vellore 632 002.

CONTENTS

NAME:	EV
AGE:	20 Years
SEX:	Male
EDUCATION:	Dip ITI
OCCUPATION:	Student
MARITAL STATUS:	Single
INFORMANT:	Mother
RELIABILITY:	Inconsistent and incomplete

CHIEF COMPLAINTS

Preoccupation, withdrawn behavior and decline in academic performance for past two years.

Muttering and smiling to self for the past four months.

DURATION OF ILLNESS: 2 years.

MODE OF ONSET: Insidious.

HISTORY OF PRESENTING ILLNESS

He was apparently normal until two years back when his mother noted that he was becoming more aloof, distant, withdrawn and preoccupied. His academic performance

gradually declined. He would not socialize with his family members as well as his friends. He would not take any interest in doing any sort of work. She also noticed some peculiar mannerisms like grinding his teeth and twisting his hands. Over the last four months mother has observed him smiling and talking to self. There was no history suggestive of organicity, substance abuse, first rank symptoms, mood symptoms, obsessive-compulsive symptoms or anxiety symptoms.

PAST HISTORY: Nil significant.

FAMILY HISTORY

He was staying with his mother who was working until recently as a bank employee. His parents were separated when he was seven years old and his brother lived with his father. According to the mother, patients father was a womanizer, abusive to his wife and sons and often neglected the family. There was no history of mental illness, substance abuse or epilepsy.

PREMORBID PERSONALITY

He was described to be a reserved and introverted person from his childhood. He never showed any attachment to the family members and scarcely expressed his feelings to others .He hardly had any friends and was more interested in books and cars. There were no other reports of any other deviant personality traits.

PHYSICAL EXAMINATION

General and systemic examination was within normal limits.

MENTAL STATUS EXAMINATION

He was moderately built and adequately kempt. Eye contact was poor and rapport was difficult. He was defensive and guarded. His primary mental functions were intact. His speech was hesitant, with decreased productivity and prolonged reaction time. He did not reveal his thought content and denied perceptual abnormalities. His affect was blunted with restricted emotional reactivity. He did not have any insight into his illness. His abstract thinking and judgment were intact.

DIFFERENTIAL DIAGNOSIS

1. Paranoid Schizophrenia –continuous course
2. Schizoid personality disorder

AIMS OF PSYCHOLOGICAL TESTING

1. History was not fully complete and consistent.
2. Diagnostic clarification

TESTS ADMINISTERED

1. Bender Visuo-motor Gestalt test
2. Draw a Person test
3. Sack's Sentence Completion Test

4. Thematic Apperception Test
5. Rorschach inkblot test
6. Object Sorting Test
7. PANSS

RATIONALE FOR USING THE TESTS

1. Bender Visuomotor Gestalt Test was used to understand about the Visuo motor coordination of the patient and also as a test to introduce the patient to the testing situation.
2. Draw a person test was used as an assessment of his personality and psychopathology.
3. Sack's sentence completion test was administered to assess the patient's adjustment in interpersonal relationships and also to understand his self-concept and other conflict areas so as to aid in the management of his illness and to counsel the family members.
4. Thematic Apperception Test was given to get an insight on the level of psychopathology and to throw light on patient's personality and interpersonal relationship.
5. Rorschach inkblot test was administered for understanding the dynamic aspect of his personality and to have a detailed analysis of the psychopathology.
6. Object Sorting Test was done to study thought process, concept formation and abstract thinking.
7. PANSS was used to assess the baseline score and severity of his symptoms.

BEHAVIOURAL OBSERVATIONS

The patient was willing and cooperative for the testing. He could comprehend the instructions given to him. He was oriented to the immediate environment and was cooperative for the entire sessions. Assessment was completed over 8 sessions.

SUMMARY OF TEST FINDINGS

In **PANSS**, positive subscale score was 7,negative subscale score was 35 and general psychopathology score was 36, which might be clinically significant. Domains affected were in the negative functions and general functioning.

BGT did not reveal any distortions.

TAT, SSCT & DADT showed the need to excel but with lack of resources to back him up. He had thoughts pertaining to fear of rejection, fear of failure, low self-esteem and dissatisfaction with self. There was a need for acceptance. He viewed the environment as threatening and felt overwhelmed at his inability to cope with it. There appeared to significant conflicts in the area of interpersonal relationships especially within his family.

Rorschach and OST revealed under productivity and an impoverished thought process. Mentation was slow. Reaction time was variable. Rejection was present on some of the cards. His reaction to the emotional aspects of his environment was poor. Emotional withdrawal was present. He was not able to perceive and differentiate the various aspects of his environment. His organizational capacity was poor. There was no acknowledgement of impulses. Aspiration was high but productive resources were low. He had low ego strength. Perseveration, Response impotency and responses with bizarre content were present. His ties with reality were not strong. He appeared to have

repression of his affectional and emotional aspects of his personality. Findings were suggestive of a schizophrenic illness.

FINAL DIAGNOSIS

Paranoid Schizophrenia

MANAGEMENT

Risperidone was started and gradually increased to 6 mg. Patient and family was educated regarding his illness, course and prognosis. Psychological reactions to medicines and its side effects were addressed and necessary information provided. Drug compliance was stressed upon. His negative symptoms were addressed with the help of occupational therapy unit by scheduling his daily activities, giving reinforcement and through social skills training. Family was allowed to ventilate their distress and supported. They were advised to cut down their expressed emotions. He was asked to continue his studies and vocational guidance was also given. He was asked to come for follow up after one month.

On discharge he had significantly improved in terms of his negative symptoms.

NAME:	SK
AGE:	40years
SEX:	Male
EDUCATION:	ITI Ceramics
OCCUPATION:	Supervisor
MARITAL STATUS:	Divorced
INFORMANTS:	Patient himself
RELIABILITY:	History is incomplete and inconsistent

CHIEF COMPLAINTS

Decreased sleep.

Suspicious of women.

DURATION: 6 years

MODE OF ONSET: Insidious

PRECIPITATING FACTORS: Marital discord

HISTORY OF PRESENTING ILLNESS

He was apparently well until 6 years back when he got married. According to the patient there were severe problems since the beginning of their marital life; and once he found his wife along with his friend in their house at odd time. He also was suspecting that she is having relationship with other males at different times. He even compelled his wife to abort their first child believing that the child may not be his. Because of

these reasons, his wife separated from him last year. Since then he became suspicious of each and every woman who is talking to males. He often reports about their behaviour to the girl's parents or goes and advice them. Because of this those girls are angry and accuses of being simply suspicious. But according to him he is just being cautious to prevent any future difficulties. He does not believe that those girls are truly in love. He would be feeling sad occasionally about not being settled in life. There was no history suggestive of organicity, substance abuse, first rank symptoms, mood or OC symptoms.

PAST HISTORY: Nothing significant.

FAMILY HISTORY

There was family history of alcohol use in father and one of his brothers. Father died of alcohol related complications and brother is abstinent for the past one year. There is no history of any other neuropsychiatric morbidity in the family.

PERSONAL HISTORY

He had normal appetite and disturbed sleep. His self-care is adequate.

BIRTH AND DEVELOPMENTAL HISTORY: Normal.

EDUCATIONAL HISTORY: Studied ITI diploma.

VOCATIONAL HISTORY:

He is working as a supervisor in a private company. He is satisfied in his job.

PREMORBID PERSONALITY

Premorbidly described to be very strict who wants to follow the rules and regulations and would prompt others to do the same stringently. He never allows women of his family to go out freely and does not allow them to talk to males. He always believed that woman should not be outgoing and he also tends to be conservative in every sphere of life. He used to be responsible at his work and would tries to do it properly.

PHYSICAL EXAMINATION

General and systemic examination was within normal limits.

MENTAL STATUS EXAMINATION

He was thinly built and adequately kempt. Rapport was restricted to specific areas. Primary mental functions were grossly intact. There were no abnormalities in the form, stream and possession of thought. Content of thought revealed suspiciousness of females and some depressive cognitions related to divorce and being alone. He denied any perceptional abnormality. Intelligence was average. Insight was present.

DIFFERENTIAL DIAGNOSIS

1. Delusional Disorder
2. Paranoid personality disorder.

AIMS FOR PSYCHOLOGICAL TESTING

1. History was incomplete.
2. Diagnostic clarification.

TESTS ADMINISTERED

1. Bender Gestalt Test (BGT)
2. 16 PF Test
3. Sacks Sentence Completion Test (SSCT)
4. ICD - 10 International Personality Disorder Examination (IPDE)
5. Thematic Apperception Test (TAT)
6. Rorschach Inkblot Test.

RATIONALE FOR PSYCHOLOGICAL TESTING

1. BGT: Administered to introduce him to the tests, build rapport and rule out any organicity
2. 16 PF: To measure personality factors under various dimensions
3. IPDE: To highlight the personality profile
4. SSCT: To evaluate the patient's adjustment in interpersonal relationships and also her self-concept to aid in the management of his illness and to counsel family members
5. TAT was given to get an insight on the level of psychopathology and to throw light on patient's personality and interpersonal relationship.
6. Rorschach inkblot test was administered for details of psychopathology and psychodynamics.

BEHAVIORAL OBSERVATION

The patient was cooperative and motivated to do the tests. His attention could be aroused but would get distracted if the topic were not of his own interest.

TEST FINDINGS

1) BGT- BGT drawings did not indicate any trace of organicity. He is having good Visuo-motor coordination.
2) 16PF –Analysis of protocol indicates that patient is socially detached and emotionally unstable. There is a lack of empathy and a tendency to be conventional which is characterized by critical and rule bound. He seems to be stubborn in nature and prefers his own decisions.
3) IPDE - On IPDE, his score in the domain of paranoid personality was above the cutoff score, and so it requires detailed clinical interviewing regarding the personality disorder
4) On the SSCT conflicts were noted in the area of past and in the relationship with opposite gender
5) Thematic apperception test: The stories were poorly organized, however, he identifies with hero. The stories show a high need for dominance, nurturance and achievement. The environment is perceived as marked by lack of love or loss and the lack of environmental or familial support**.**
6) Rorschach inkblot test: The protocol was inadequate as the number of responses was less, which might be due to some level of defensiveness. He might be having difficulty accepting and adjusting to change and tends to overemphasize the concrete and obvious aspects of situations. However, he has adequate tolerance of stressors of everyday living. There is a tendency to withdraw from interpersonal relationships and his emotional responses are restricted. He is very conventional and approaches the world in a stereotyped manner. Popular responses were low indicating weak reality orientation.

IMPRESSION

The findings from the psychological tests revealed difficulties in establishing and maintaining interpersonal relationship and poor contact with reality. Taking the whole clinical picture into consideration findings are suggestive of a probable paranoid personality disorder

FINAL DIAGNOSIS: Paranoid Personality Disorder

MANAGEMENT

Interpersonal relationships, negative cognitions and necessary changes in lifestyle will be addressed in psychotherapy. Plans for long-term psychotherapy will be discussed.

NAME:	N
AGE:	24 years
SEX:	Male
OCCUPATION:	Student
MARITAL STATUS:	Single
INFORMANTS:	Parents
RELIABILITY:	Good

CHIEF COMPLAINTS: Decreased memory

DURATION OF ILLNESS: 3 years

MODE OF ONSET: Insidious

HISTORY OF PRESENTING ILLNESS

Patient met with a road traffic accident in 2004.He had closed head injury and was admitted in a hospital in Chennai. At that time he had weakness of lower limbs and difficulty of speech, which gradually improved significantly. He was on tracheotomy and later weaned off. There was no history of seizures. There is no history of substance abuse, psychotic symptoms and mood or OC symptoms.

He was searching for a job to lead an independent life and wanted to know how much he could function. Therefore he came for a psychiatric evaluation and was subsequently referred for neuropsychological assessment.

PAST HISTORY: Nil significant

FAMILY HISTORY

He was born of non-consanguineous parents. No family history of mental illness, epilepsy and substance abuse.

PREMORBID PERSONALITY

He was a sociable and responsible person. He was not reported to have any deviant personality traits.

PHYSICAL EXAMINATION

General and systemic examination was within normal limits.

MENTAL STATUS EXAMINATION:

He was well built, well nourished and well kempt. His psychomotor activity was normal. He was co-operative and alert. His attention and concentration was impaired .Her immediate and recent memory was impaired while remote memory was grossly intact. He was oriented to time, place and person. Speech was slurred. There was no abnormality in form, stream and possession of thoughts or perceptual abnormalities. Abstract thinking was normal. Mood was euthymic. There were no compulsive phenomena or volitional abnormalities. Insight was good and judgement was intact.

PROVISIONAL DIAGNOSIS: Organic amnestic disorder

AIMS OF NEUROPSYCHOLOGICAL TESTING

The patient presented with memory deficits and was referred for a neuropsychological assessment in order to evaluate his current cognitive functions for job purpose.

BEHAVIOURAL OBSERVATION

The patient was co-operative for psychological testing. His psychomotor activity was normal. He was motivated to do all the tests and could comprehend the instructions very well. Even though his speech was relevant it was slurred.

TESTS ADMINISTERED

1. Eysenck's Series of Digit Span Test
2. Handedness Schedule
3. P.G.I Memory Scale
4. Bender Gestalt Visuomotor Test
5. Bhattia's Battery of Performance Test of Intelligence (shortened version)
6. Nahor Benson Test
7. Digit Substitution Test
8. Digit Vigilance Test
9. Rey's Auditory Verbal Learning Test
10. Wisconsin card Sorting Test

RATIONALE FOR USING THE TESTS

1. ESDST was used to assess the attention and concentration.
2. Handedness schedule-To know the dominant hemisphere.
3. P.G.I Memory Scale was used to assess in detail the impairment in memory.
4. BGT- To find out his visuo-motor coordination and perceptual acuity.
5. Bhattia's Battery of Performance Test of Intelligence – for assessing his intelligence
6. Nahor Benson Test-For assessing spatial relations and visual acuity

7. Digit Substitution Test - To understand motor persistence, sustained attention and response speed.
8. Digit Vigilance Test – To test his capacity to sustained attention.
9. Rey's Auditory Verbal Learning Test - To assess new learning and immediate memory.
10. Wisconsin Card Sorting Test - To assess abstraction ability and executive function.

TEST FINDINGS

1. To assess the level of cognitive functioning of the subject ESDST was used. His score on Digit Forward is 5 and Digit Backward is 4 indicating intact attention span.
2. PGI Memory Scale (10 subscales) findings:

SUB SCALES	RAW SCORE	CONVERTED SCORE	DYSFUNCTION RATE
1.Remote memory	6	5+	0
2.Recent memory	5	5+	0
3.Mental balance	6	0-2	3
4.Attention& Concentration	9	3-4	2
5.Delayed recall	9	5+	0
6.Immediate recall	3	0-2	3
7.Verbal retention of Similar pair	3	0-2	3
8.Verbal retention of Dissimilar pair	0	0-2	3
9.Visual retention	6	0-2	3
10.Recognition	10	5+	0

TOTAL DYSFUNCTION RATE: 17 / 30

FRONTAL LOBE FUNCTIONS

Attention-Spontaneous arousal was present and his sustained attention was fair. His motor persistence was mildly impaired.

Executive functions- His impairment is significantly high, which are evident in concept formation and set shifting capacity.

TEMPORAL LOBE FUNCTIONS

The long-term memory is intact but his short-term memory is mildly impaired.

PARIETAL LOBE FUNCTIONS

His visuospatial planning was fair. No distortion, rotation or perseveration. He has good visuospatial perception and visual acuity. There were no focal signs of apraxia or agnosia.

IMPRESSION

The test findings are indicative of significant deficits in frontal lobe and there appears to be mild impairment in working memory functions.

MANAGEMENT

Cognitive retraining strategies in order to improve his memory as well as other cognitive functions can be planned

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NAME:	SD
AGE:	25
SEX:	Female
MARITAL STATUS:	Married
RELIGION:	Hindu
SOCIONECONOMIC STATUS:	MSES
EDUCATION:	B.A. Philosophy
OCCUPATION:	N/A
INFORMANTS:	Patient and husband

CHIEF COMPLAINTS

Cannot control anger, emotional outbursts and episodes of unresponsiveness

DURATION OF THE ILLNESS: 4 months.

MODE OF ONSET: Insidious

HISTORY OF PRESENT ILLNESS

Patient was premorbidly described to be very sensitive and emotional, used to get angry even for trivial matters. Following marriage four months back she has difficulties in coping with day-to-day problems. She also reports feeling of loneliness and chronic feeling of emptiness. She is noted by her husband as very sensitive and describes her as a short-tempered lady. She used to quarrel with her husband very often and following that she would loss her consciousness for some brief period of time. There is no history of any seizure phenomena during this episode.

There is no history of organicity, substance abuse, psychosis, mania or anxiety disorder.

PAST HISTORY: Nil

FAMILY HISTORY

Patient is the 3rd of 3 siblings, born out of a non-consanguineous marriage. Father is a lawyer and her mother is a housewife. Mother is a chronically ill patient with spinal cord problems and patient had to do housekeeping from childhood. There is no significant neuropsychiatric morbidity in the family.

EDUCATIONAL HISTORY

She has completed her graduation. Her interests include reading, going out with her husband and her ambition is to find a job.

VOCATIONAL HISTORY

She had worked in two places, but resigned as she found the colleagues not being helpful

SEXUAL HISTORY

Patient is heterosexually oriented. She denies any high-risk behaviour.

PREMORBID PERSONALITY

She is reported to be short-tempered and adamant since childhood. She describes herself as an emotional and sensitive person.

PHYSICAL EXAMINATION

Vitals were stable and systemic examination was within normal limits.

MENTAL STATUS EXAMINATION

Patient was moderately built, nourished, kempt and maintained eye contact. Rapport could be established. Psychomotor activity was normal. She was alert, conscious and cooperative. Attention, concentration, memory and orientation were intact. Speech was relevant, coherent, spontaneous, audible with normal reaction time and speed. There was no abnormality in the form or stream of thought. Thought content revealed inability to control anger and lack of affection from her parents. Abstract thinking was intact. There were no perceptual abnormalities. Mood was subjectively described as normal and objectively was euthymic. There were no compulsive phenomena or abnormalities in volition. Intelligence was average. Insight was present and judgement was intact. General information was fair.

PROVISIONAL DIAGNOSIS

1. Dissociative motor disorder
2. Emotionally unstable personality disorder

AIMS OF PSYCHOMETRY

To find out her personality traits.

To find out whether there is any co morbid psychiatric syndrome.

BEHAVIOURAL OBSERVATION

Patient was motivated for psychometric testing. Attention was adequate and she could persist on any given test for a reasonable period of time.

TEST ADMINISTERED

Bender Gestalt test

16 P.F. Test

Sack's Sentence Completion Test (SSCT)

Thematic Apperception Test (TAT)

Rorschach Ink Blot Test

RATIONALE OF THE TESTS SELECTED

BGT: Administered to introduce her to the tests, build rapport and rule out any organicity.

16 PF: To measure personality factors under various dimensions.

SSCT: To evaluate the patient's adjustment in interpersonal relationships and also her self-concept to aid in the management of her illness and to counsel family members.

TAT: To find the level of psychopathology and to throw light on the patient's personality and interpersonal relationships.

Rorschach Ink Blot Test: To find details of personality and psychodynamics.

TEST FINDINGS

BGT drawings did not indicate any trace of organicity. She is having good Visuo-motor coordination.

16 P.F is indicative of an individual who is affected by feelings, emotionally less stable and easily upset. Submissiveness marked by humility,, conformity, and accommodativeness is noted. Yet, the individual is practical, careful, conventional, and proper,

On the SSCT conflict is noted in the area of family especially towards her father. Other conflicts were noted in the areas of work and past life. Another prominent theme in most of the sentences was a related to dissatisfaction in sexual life.

On the TAT most of the stories were poorly structured, rather a mere description of the pictures on the cards. The prominent needs identified were of affiliation and nurturance.

On Rorschach the protocol indicates an individual who is defensive or resistant towards the stimuli. Simplistic responses which neglect the complexities of the stimulus field and reluctance to tackle the stimulus field. She has limited resources as contrasted to demands on her .She might be poorly adjusted and aloof from the environment. She has a tendency to withdraw from experiencing a situation fully and avoidance of perceiving all the possibilities that may be present; insecure and fearful of involvement

IMPRESSION

Test findings reveal she is emotionally unstable and gets upset easily She has limited resources and poor coping skills .She is emotionally dependent and avoids conflicting situations. Overall test findings are not indicating any specific personality disorder but have prominent emotionally unstable and dependent personality traits.

FINAL DIAGNOSIS: Dissociative motor disorder.

MANAGEMENT

She was given assertiveness and coping skills training. Problem solving techniques were discussed. Plans for long-term psychotherapy will be discussed.

NAME:	K M
AGE:	8 years 11 months
SEX:	Female
EDUCATION:	4th Std
INFORMANTS:	Parents
RELIABILITY:	Good

PRESENTING COMPLAINTS: Poor academic performance

Poor memory

DURATION: 3 years

MODE OF ONSET: Insidious.

PRECIPITATING FACTORS: Nil.

HISTORY OF PRESENTING COMPLAINT

Parents gave a history of progressively deteriorating scholastic performance after the 2nd standard. They reported decrease in the marks and having decreased attention and concentration. They also reported impairment in her memory. She was able to do all the activities of daily living independently. There was no history suggestive of organicity, substance abuse, psychotic, mood symptoms or obsessive-compulsive symptoms.

PAST HISTORY

Consulted a psychiatrist in Chennai for the same complaints. EEG done was abnormal. She was advised medications but family refused

BIRTH AND DEVELOPMENT HISTORY

She was born of a non-consanguineous marriage. Her mother had hypertension during the prenatal period and was on regular medications. It was a full term normal delivery with no significant postnatal complications or delayed developmental milestones.

She communicates well to everyone, mingles with other people, and her social adaptive skills are good

E**MOTIONAL DEVELOPMENT AND TEMPERAMENT**

She was described to have a good temperament.

SCHOOL HISTORY

She was studying in the 4th standard. She had shown a gradual decline in her academic performance after the 2nd standard. There were no other problems in adjustment with peers and teachers.

PERSONAL HISTORY: There was no impairment in her biological functions.

FAMILY HISTORY

There was family history of severe mental retardation with behavioral problems and seizure disorder in her brother.

PHYSICAL EXAMINATION

General and systemic examination was within normal limits.

MENTAL STATUS EXAMINATION

She was moderately built, well kempt. She was co-operative and alert during the interview. Primary mental functions were grossly intact. Form stream and content of thought were normal. She was euthymic. Intelligence was below average as suggested by impairment in tests of calculation, abstraction and general knowledge. Insight was partial and judgment was intact.

PROVISIONAL DIAGNOSIS

Unspecified mental retardation.

AIMS OF PSYCHOLOGICAL TESTING

As there was history suggestive of deteriorating scholastic performance and inadequate communication and social skills it was appropriate to do IQ assessment.

TESTS ADMINISTERED

1. Vineland social maturity scale (VSMS)
2. Binet_ Kamat Test (BKT)

RATIONALE FOR TESTS

1. VSMS was used to assess the social adaptation and social age.
2. BKT was to assess intelligence as it is standardized in the Indian population.

BEHAVIORAL OBSERVATIONS

The patient was cooperative and willing for the tests She was able to comprehend instructions, She was attentive and was able to persist on the task.

TEST FINDINGS

1.VSMS - The social age of the patient was 8.4 years, which was below for the patient's age. The profile of age levels across the functions were as follows:

SELF HELP GENERAL	7-8 years
SELF HELP DRESSING	8-9 years
SELF HELP EATING	8 years
COMMUNICATION	6-7years
SELF DIRECTION	6 Years
SOCIALISATION	8-9years
LOCOMOTION	5-6years
OCCUPATION	8-9years

2. Binet Kamat test:

Mental age - 7years and 8 months

Chronological age - 8years and 11 months.

Function wise –

Language-8 years

Meaningful memory-5 years

Non meaningful memory-8 years

Conceptual thinking-7 years

Nonverbal thinking-6 years

Reasoning-8 years

Motor-7 years

Social intelligence-8 years

Basal age-3years

Terminal age-9 years

The IQ of the patient was 85,which indicates low average intelligence. Considering Flynn effect, IQ is 75 indicating borderline intelligence

IMPRESSION

The tests revealed that she had significant impairment in her communication skills and the IQ according to the Binet Kamat test was suggestive of below average intelligence.

MANAGEMENT

Parents were educated regarding her scholastic capabilities. A step down in her education and changing to a simpler state syllabus was also recommended. Vocational rehabilitation was discussed with the parents.