THANJAVUR MEDICAL COLLEGE

DEPARTMENT OF PSYCHIATRY

PSYCHIATRY CASE RECORD SUBMITTED TO

THE TAMILNADU Dr. M. G. R. MEDICAL UNIVERSITY

In partial fulfillment of the requirements for the

DIPLOMA IN PSYCHOLOGICAL MEDICINE

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CERTIFICATE

This is to certify that this Psychiatry case record is a bonafide record of work done by **Dr. JEYANTHI P.** in the Department of Psychiatry, Thanjavur Medical College, Thanjavur.

Dean,
Thanjavur Medical college,
Thanjavur.

Professor & Head,
Department of Psychiatry,
Thanjavur Medical College,
Thanjavur.

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CASE: 1

NEUROCYSTICERCOSIS PRESENTING WITH PSYCHOSIS

Introduction:

Cysticercosis is the most common parasitic disease of human central nervous system. The word cysticercosis derived from Greek KYSITS (cyst) and KERKOS(tail). Cysticercosis is endemic in some parts of all continents except Australia and Antartica.

Cysticercosis consists of infection with the small bladder-like larvae of the pork tapeworm Taeniasolium. The life cycle of parasite is maintained between man and pig infected with cysticerci. Epilepsy is the most common presentation of neurocysticercosis; focal signs, headache, involuntary movements and global mental deterioration are other symptoms. Psychosis is a rare presentation and may be seen in up to 5% of patients

CASE REPORT

Name : Mr. Manikandan

Age : 16 yrs.

Sex : Male

Education : 10^{th} Standard

Language : Tamil

Socio Economic status : Low

Status of Religion : Hindu

Informant	Competency	Reliability
1. Manikandan – Patient	Good	Good
2. Mukkaian - Father	Good	Good

REASONS FOR PSYCHIATRY CONSULTATION

1. Suspicious ideas
2. Poor academic performance
3. Muttering to self and smiling to self
4. Staying aloof
5. Restlessness, Irritability
6. Behavior abnormality
7. Sleep disturbances

HISTORY OF PRESENT ILLNESS

Duration: 6 months, Symptoms started gradually and progressive in nature. Course continuous, patient never touched normalcy in between, no major precipitating factors.

Patient was apparently normal 6 months back. He was found not eating properly. He had suspicious ideas that his friends mixed sand in his food which was not true. Later he refused to go to school and write exams. Gradually he found sitting aloof, muttering to self during day time. He became aggressive when asked to eat. Once he jumped from a truck and injured himself.

He developed sleep disturbances had difficulty in initiation and maintaining sleep. Found leaving the home in the middle of the night at times. He was found

standing more than one hour and muttering to self at times. He spent more time in toilet of more than one hour and came out only when he was asked so. He had poor personal hygiene. Once he left the home without informing and was found lying in a deserted place after four to five hours. For this complaint, magico religious rituals done. Later he consulted local doctors and CT brain was done and admitted in neuro medicine ward at TMCH.

After admission at TMCH, his muttering to self increased, showed anger outburst, standing aimlessly, clapping and moving his limbs without any reason and hence referred to psychiatric department.

PAST MEDICAL HISTORY.

History of ear discharge since childhood present – not treated

History of seizure once when he was three years old – not on Anti Epileptic Drug

No past history of Tuberculosis / Head injury / Encephalitis / Hypertension / Diabetes.

FAMILY HISTORY

Father : Agriculturer 45 years

Mother : Home Maker 42 years

Has one younger brother

PERSONAL HISTORY

Birth and Development History : Normal

Home Atmosphere : Satisfactory

No behavioral and emotional problems during adolescence

Educational history : Discontinued in 10th Standard

Sexual History : no history of pre marital contact, masturbation

Substance abuse history : nil

PREMORBID PERSONALITY

Attached to parents, siblings, and has friends, ambivert, obedient.

General Examination

Conscious, afebrile, not anemic, not jaundiced, no goiter

Pulse-80 min, BP- 120/80mm of Hg, CVS, RS- normal, PA- soft. CNS- no focal deficit

MENTAL STATUS EXAMINATION

General appearance and behavior

Alert ambulant, hair kempt dressed shabbily. Co-operative at times, Eye to eye contact present not maintained, Rapport partially established. Nail biting, gesturing, and muttering to self present. Disinhibited behavior in form of spitting while examination present.

Psychomotor activity increased.

Speech

Irrelevant at times, Coherent

Initiation : Speaks when spoken to

Reaction time : Increased

Rate : Slow

Quantity : Decreased

Volume : Normal

Tone : Normal

Prosody : Maintained

Mood : Cheerful

Affect : Inappropriate smile and laughter present range of mood present, reactivity decreased ,incongruent

Thought

Form : Loosening of association present.

Perception

Hearing known female voices – calling his name when no one could here - auditory hallucinations present

Attention and concentration

Attention-aroused, Concentration not sustained

Orientation

Orientation to time, place, person, day and year present. Date and month absent

Memory

Immediate, recent and past memory intact.

General intelligence : Average

Judgment : Impaired

Insight : Grade1

ENT opinion : Chronic suppurative otitis media left ear with out any complications

INVESTIGATION

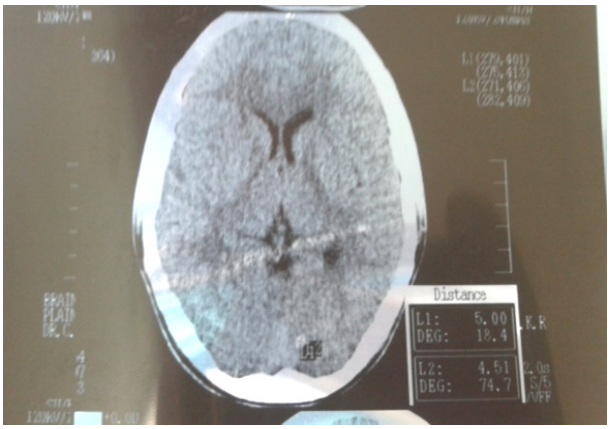
1. CT Brain

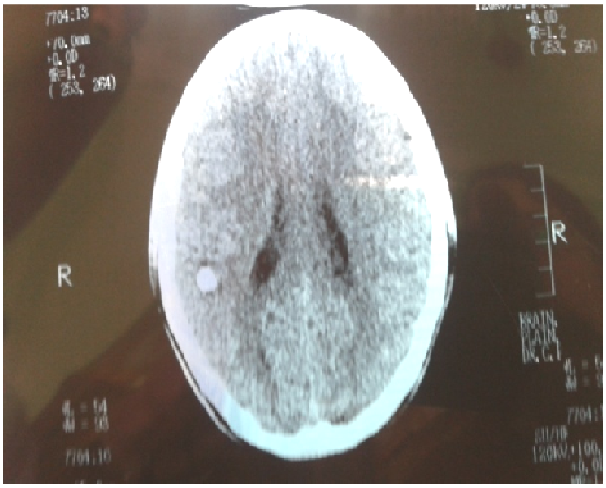
CT brain –showed

Multiple discrete calcification in both cerebral hemisphere

Hypodence focus in right temporal lobe

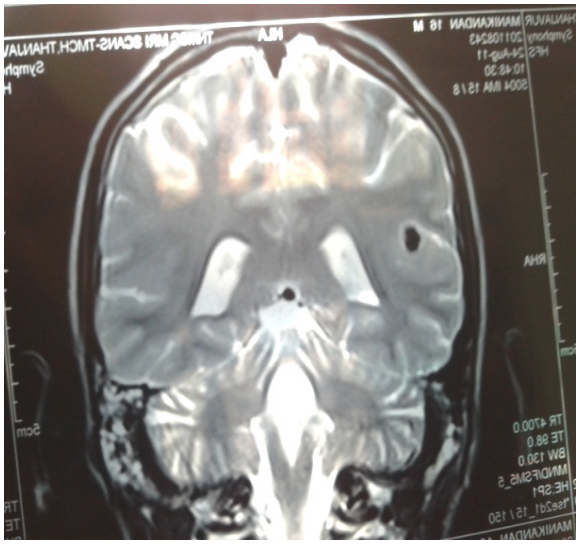
Feature suggestive of cysticercosis.





2. **MRI** including **MRA** and **MRV**

Finding suggestive of multiple calcified granulomas with focal dilatation in right temporal horn of lateral ventricles .



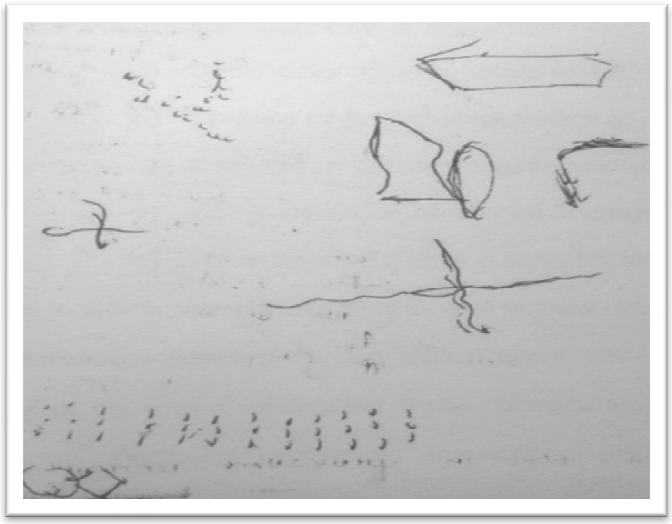
Diagnosed as **F06.2 organic delusional (schizophrenia-like) disorder**.

(Neurocysticercosis Presenting with schizophreniform Psychosis)

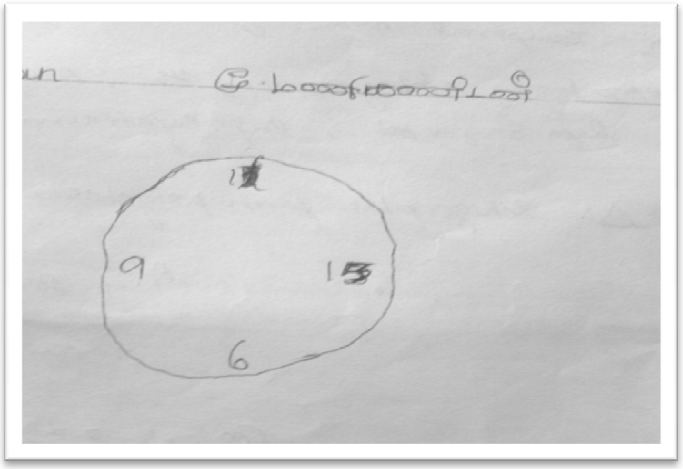
PSYCHOMETRY

Psychological tests administered revealed mild cognitive impairment after treatment. BGT showed organicity. MMSE score was 20. In weschler Memory Scale he was having M.Q of 85. In WAIS he had I.Q of 85

Bender Gestalt Test



CLOCK DRAWING TEST



POSITIVE AND NEGATIVE SYNDROME SCALE

He scored high in positive scale in Conceptual disorganization, Hallucinatory behavior dimensions.

DISCUSSION AND MANAGEMENT

Neurocysticercosis is the infection of the human central system by the larval stage of pork tapeworm, taenia solium. Average age 24 to 35 years with slight male bias. It is endemic In countries like latin America, Asia, Africa and it is absent in Israel and muselum countries.

In India 40 percent of focal seizure are due to neurocysticercosis .

Stages of neurocysticercosis

1. Vesicular stage
2. Colloidal stage
3. Granular stage
4. Calcified stage

Paranchymal cysticercosis present with epilepsy, brain system dysfunction, signs of cognitive changes ,cerebellar ataxia and psychosis.

Neurocysticercosis may present as psychosis. The commonest presentation is epilepsy in 50 % to 80 % of cases.

Clinical manifestations in order of decreasing frequency are:

Seizures (80%)

Headache (40%)

Visual changes (20%)

Confusion (15%)

Ataxia (6%)

Psychosis (5%)

and in minority, cranial nerve palsies or other focal neurological manifestations

It is worth mentioning that any patients presenting with Psychosis from endemic area of Neurocysticercosis, we have to think of organic cause for etiology.

The patient was treated with :

1. **Albendazole** (is the drug of choice for antiparasitic therapy 15 mg/kg/day for 7 days with steroids)
2. **Antiepileptic drugs:**

   Tab. Carbamazipine 200mg 1-0-1

   Tab.Clobazam 10 mg 0-0-1
3. **T.Risperiden** 4mg in divided dose
4. **Tab.Trihexyphenidil** 2 mg

After 2 months of follow up the patient is free of seizures and Psychosis.

CASE:2

OBSESSIVE COMPULSIVE DISORDER WITH COMORBID RECURRENT DEPRESSION current episode SEVERE

CASE REPORT

Name : **Mr. Venkatesh**

Age : 26 yrs.

Sex : Male

Education : 12th Standard

Language : Tamil

Occupation : Courier office man

Socio Economic status : Middle Class

Religion : Hindu

Informant	Competency	Reliability
3. Venkatesh – Patient	Good	Good
4. Kasiammal - Mother	Good	Good

REASONS FOR PSYCHIATRY CONSULTATION

1. Repeated thoughts of something harm might happen to him or his parents
2. Repeatedly washing the hands
3. Taking bath for long hours
4. Checking and counting
5. Drinking water repeatedly 10 to 15 times
6. Fatigue
7. Inability to work
8. Crying at times
9. Feeling of hopelessness / worthlessness

Present for past 5 years, increased for past 1 year

HISTORY OF PRESENT ILLNESS

Duration: 5 years, Symptoms started gradually and increased in nature.

Course: Continuous, Waxing and Waning present, patient never touched normalcy in between, no major precipitating factors.

History of repeated thoughts of contamination with dirt present for which he washed hands repeatedly. History of repeated thoughts of something harm might happen to him or his parents. History of excessive brushing the teeth, showering, bathing by repeatedly applying the soap and for which he takes about two hours. Staying in toilet for more than one hour until somebody calls him. History of drinking water repeatedly 10-15 times per day. History of checking and counting things repeatedly and arranges it in a particular order again and again. Chants prayer several times mentally. If he goes to temple goes round it exactly eleven times and prays

three times. Before going to bed he stand and count for hundred. History of feeling he has to do all these otherwise something harm might happen to his family. He feels these thoughts of his own, tries to resist but couldn't. It causes great distress in him. Feels relieved by these acts. History of doing things very slowly present. It interferes with his social and motor functioning.

History of fatigue, generalized weakness, inability to do work present. History of sad feelings present throughout the day, History of hopelessness, worthlessness present. History of inability to indulge in pleasurable activity, history of reduced self esteem and confidence, has feeling he might better die. No history of suicidal attempts or feeling others is talking about him.

COURSE

Symptoms present since 2007. In 2008 again had depression taken tablets for two weeks then discontinued. In March 2010, another episode of depression, took tablets and then discontinued. April 2010 another episode of depression since then taking tablets.

PAST MEDICAL HISTORY

No past history of Seizures/ Head injury / Encephalitis / Hypertension / Diabetes.

FAMILY HISTORY

Father : 57 years

Mother : Home Maker 50 years

Has one elder brother and three sisters. Elder sister taking treatment for recurrent depression

PERSONAL HISTORY

Birth and Development History : Normal

Home Atmosphere : Satisfactory

No behavioral and emotional problems during adolescence

Educational history : Studied 12th Standard

Worked as : Courier office man

Sexual History : No history of pre marital contact, masturbation

Substance abuse history : Nil

PREMORBID PERSONALITY

Attached to parents, siblings, and has few friends, character- shy, sensitive to criticism, religious, sincere in work

General Examination

Conscious, afebrile, not anemic, not jaundiced, no goiter Pulse-80 / min, BP- 120/80, mm of Hg, CVS –normal. RS- normal, PA- soft. CNS- normal

MENTAL STATUS EXAMINATION

General appearance and behavior

Looking ones age, sits with hunched back, hair unkempt. Co-operative. Eye to eye contact present. Rapport established. No abnormal gesturing – posturing, movements.

Psychomotor activity decreased.

Speech

Relevant,and Coherent

Initiation : speaks when spoken to

Reaction time : Increased

Rate : Slow

Quantity : Decreased

Volume : Decreased

Tone : Normal

Prosody : Maintained

Mood

Subjectively - He is sad and dejected

Objectively - He is depressed and crying occasionally.

Affect restricted

Thought

Have ideas of worthlessness, hopelessness

Suicidal ideas at times

Obsessional thoughts : Repeated thoughts of contamination with dirt present

Repeated thoughts of something harm might happen to him or his parents. (Aggressive obsessions, contamination obsessions, religious obsessions, obsession with need for symmetry)

Compulsions : Washing hands, chanting prayers, counting exact numbers- (Cleaning, washing compulsion, checking compulsions, ordering, arranging compulsions)

Perception

No visual or auditory hallucinations

Attention and concentration

Attention-aroused, Concentration-sustained with difficulty

Orientation

Orientation to time, place, and person-normal

Memory

Immediate, recent, and remote memory intact.

Delayed recall – slightly impaired.

General intelligence : Normal

Judgment : Average

Insight : Grade2

DIAGNOSTIC FORMULATION

Venkatesh aged 26 years from middle class family with various obsessive thoughts with something might happen to him or his family members.. And repeated thoughts of contamination, obsession with need for symmetry, cleaning, washing compulsions, checking compulsions, order arranging compulsions these thoughts are recognized as his own and they cause considerable distress and compulsions relieving it. This gives raise to obsessive compulsive disorder as a diagnosis.

And also with history of fatigue depressed mood throughout the day, inability to indulge in pleasurable activities, the three major criteria and loss of appetite, decrease self esteem and confidence, hopelessness, worthlessness, suicidal ideas satisfying depressive episode severe.

While considering both obsessive compulsive symptoms have started first and they are more prominent and severe. This gives **OBSESSIVE COMPULSIVE DISORDER w**ith both obsession and compulsion. **F42.2,** with Co morbid **RECURRENT DEPRESSIVE DISORDER**, current episode severe without psychotic symptoms **F33.2** as diagnosis.

PSYCHOMETRY

He was cooperative during the test.

I Questionnaires

Eysenck's personality questionnaire : He scored with the introversion.

Multiphasic personality inventory:

Anxiety : 12

Hysteria : 8

Depression : 9

Mania : 2

Schizophrenia : 2

Paranoia : 4

Psychopathic deviation : 6

K Scale : 2

He scored high on depression.

II Projective Tests

Sentence completion Test

Patient's attitude was self disturbed with guilt feeling and worthlessness

Thematic apperception Test

Mental productivity : Average

Identification : Fair

Predominant conflict : Self

Predominant emotion : Depression

Rorschach Ink blot Test

Mental Productivity : Below average with 8 responses

Mentation : Average

Presence of "I don't know" responses and increase in reaction time

Absence of color responses indicate depression.

Draw a person and house-tree person Test

Drawing were micrographic

No evidence of bizarreness and penetration

III . Thought process

Proverb Test

Was given 5 proverbs and he expressed familiarity to three proverbs

Objective sorting Test

No evidence of over inclusive thinking

IV. Rating scales

Yale brown obsessive compulsive scale

Score : 30 significant

Hamilton Psychiatric rating scale for depression

Score : 24 severe depression

Hamilton Rating scale for anxiety

Score : 16

Beck depression inventory

Score : 49 / 67

Suicide intent scale

Score : High and significant

Global assessment of functioning

60% impairment

Y - BOCS SYMPTOMS CHECKLIST

Showed contamination obsessions, obsession with need for symmetry accompanied by magical thinking, fear a same certain things, fear of losing things, cleaning, washing compulsions, checking compulsions, repeating rituals, counting compulsions, ordering, arranging compulsions, ritualized eating behavior.

SUMMARY OF PSYCHOMETRY:

Psychometric tests were done for 1) establishing the diagnosis 2) assessing the severity of the illness. In Eyesenck and Multiphasic personality inventory patient scored high on depression. Absence of color responses in Rorschach ink blot test indicated depression. TAT also showed predominant emotion to be depression. The patient scored high on psychiatric rating scales for depression. Also in Yale Brown Obsessive Compulsive scale the scores were significant. The Psychometric tests confirmed the diagnosis of Obsessive Compulsive Disorder with Depression- severe. This gives,

OBSSESIVE COMPULSIVE DISORDER. With both obsession and compulsion. **F42.2** with co morbid **RECURRENT DEPRESSIVE DISORDER**, current episode **severe** without psychotic symptoms **F33.2** as final diagnosis.

DISCUSSION AND MANAGEMENT

He was admitted and treated with:

Cap.Fluoxetine – 20 mg bd

Tab.Imipramine – 100 mg in divided doses

Tab. Risperidone – 2 mg bd

Tab. Diazepam at night

He had **5 ECTs** & showed good improvement and was discharged and advised to attend psychiatry O.P regularly. Behavior therapy was also tried.

CASE: 3

PARANOID SCHIZOPHRENIA

Name : **Mrs.Muthu Kamatchi**

Age : 30 years

Sex : Female

Educational status : 12th standard

Occupation : Unemployed

Marital status : Married

Socio Economic status : Low

Religion : Hindu

Informant	Competency	Reliability
5. Muthu Kamatchi – Patient	Fair	Fair
6. Kamala - Mother	Good	Good

REASONS FOR PSYCHIATRY CONSULTATION

1.Suspiciousness

2.Talking and muttering to self

3.Disturbed sleep

4.Poor personal care

5. Staying aloof

6. Anger out burst

7.Wandering

Duration : 4 years

Mode of onset : Insidious

Course : Progressive

Precipitating Factors : Nil

History of presenting illness:

Patient was apparently alright about 4 years back. She developed suspicious ideas about her husbands' fidelity. She became emotionally withdrawn denied her family members that they are not her relatives. She stayed aloof and didn't do any house hold work. At times, she found standing under the sun for long time. Once she wandered away without informing anybody. Also reported that her parents are against her and her mother does not take care of her properly. She used to accuse mother of giving affection only for her elder brother and because of which he is a lawyer now. Patient also would report to her parents that people talk and discuss about her on the streets and she apparently would pick up fights for the same. She was found smiling and muttering to herself at various times. She hears unknown female voices when no one could hear which threatens her and gives commands. She feels that people can know her thoughts without she telling it out . She would not take bath and did not have good personal care. She was also found to have disturbed sleep, frequent quarrels with her parents and assaulted them at times thinking that they were against her.

No history of

Suicidal ideas Seizures

Head injury

Febrile illness

Repeated rituals

Bladder or bowel incontinence.

Past History :

No history of hypertension, diabetes, seizure disorder, or tuberculosis.

Family History:

1. No family history of mental illness
2. History of alcohol dependence present in her father
3. History of suicide by hanging present in her paternal aunty

Personal history:

Patient was born out of a full term normal delivery.

Developmental milestones attained at appropriate age.

Scholastic performance:

Studied up to 12^{th} standard , average student.

Menstrual history : Menarche at the age of 13 years. Regular periods4/30 days

Marital history : Arranged marriage, now separated for the past four years.

Sexual history : No history of pre or extra marital contact:

Premorbid personality : Sociable, cheerful and easygoing

Physical examination :

Conscious, a febrile, not anemic, not jaundiced, no goiter

Pulse-80 / min, BP- 120/80, mm of Hg, CVS –normal. RS- normal, PA- soft. CNS- normal

Mental state examination :

Patient was unkempt, alert, dressed shabbily, made eye to eye contact, but not sustained. Rapport was difficult to establish. Made gestures and mutter to self. Obeyed commands occasionally and suspicious and scanning the room with her eyes.

Psychomotor activity was decreased.

Speech:

Reaction time increased and had relevant coherent speech.

Initiation : Speaks when spoken to

Rate : Slow

Quantity : Decreased

Volume : Decreased

Tone : Normal

Prosody : Maintained

Thought – Form & Stream:

Tangentiality present,

Loosening of association present.

Content:

People are talking about me—Delusions of reference

People are against me, hears voices which threatens her —Delusion of persecution,

People can know my thoughts without me telling it out.--thought broad casting present.

Perception:

Hears unknown female voices when no one could hear which threatens her and gives commands. Auditory hallucination present

Cognition:

Attention and concentration was aroused and sustained,

Oriented to time, place and person,

Immediate, recent and remote memory was intact

General intelligence; average

Insight : Grade 1

Impaired test judgment.

Diagnostic formulation:

A 30 year old female was brought with the compliance of sleeplessness, suspiciousness, talking and muttering to self, anger outburst, food refusal, hearing voices, wandering tendency and neglecting personal hygienic. On examination patient was found to be pre occupied making gestures, talking irrelevantly. She has ideas of reference, thought broad cast and auditory hallucination. Patient lacks insight and his judgment impaired .On psychometry, she was found to be a introverted individual, her abstract thinking was impaired over inclusive thinking present. Projective test reveals definite evidence of schizophrenia

Aim of psychological testing : Since patient had some affective symptoms, psychological testing was done to rule out possibility of mood disorder.

PSYCHOMETRY

Psychometry was done in 3 sittings and She was cooperative during the test. Constration and comprehension were adequate. Irrelevant talk notice occasionally. Psychometry was done to access and to investigate the following areas.

1. Personality and Inter personal areas
2. Thought process
3. Concept formation

I Questionnaires

Eysenck's personality questionnaire :

Extraversion : 6

Neutroticism : 7

Psychotism : 12

Lie scale : 7

Patient has scored high on Psychotism, Lie scale and Introversion

Multiphasic personality inventory:

Anxiety : 8

Hysteria : 2

Depression : 2

Mania : 3

Schizophrenia : 11

Paranoia : 8

Psychopathic deviation :10

K Scale : 4

She scored high on Schizophrenia and Paranoid Scales

II Projective Tests

Thematic apperception Test

Nature of stories : Descriptive

Identification : Poor

Predominant Theme : Absent

Predominant emotion : Depression

Associative disturbance : Present (Loosening of association)

Rorschach Ink blot Test

Mental Productivity : Average with 12 responses

Mentation : Adequate

Personality introversive.

Psychotic features present (unusal details reponse)

Draw a person and house-tree person Test

Drawing were Primitive with body image disturbance and Penetration

No evidence of bizarreness and penetration

III . Thought process

Proverb Test

Was given 5 proverbs and She expressed Concrete and Abstract responses to only 2 proverbs.

Objective sorting Test

Evidence of over inclusive thinking

SUMMARY OF PSYCHOMETRY:

Patient was cooperative. She was found to be introverted individual with elevated scores on Schizophrenia and paranoid scales. Her abstract thinking was impaired. Evidence of over inclusive thinking present. Projection test reveals definitive evidence of Schizophrenic Psychosis.

Based on history presenting symptoms clinical and psychometric findings showed the presence of formal thought disorder, possibly **Paranoid Schizophrenia - F20.0**

DISCUSSION AND MANAGEMENT

Antipsychotics

Tab.Olanzepine 10 mg divided dose

Feedback to the family members on test findings and the role of psychopathology in influencing his current maladaptive functioning.

Family Therapy

Suggestions for vocational rehabilitation can be discussed with patient and family.

Behavioral Therapy:

Behavioral techniques like token economy, interpersonal communication and social skill training

Group Therapy:

Focus on real life plans problems and relationships

Individual Psycho Therapy:

Schizophrenic patient can be helped by individual psycho therapy that provide positive treatment relationship and therapeutic alliance's

CASE:4

BIPOLAR AFFECTING DISODER current episode MANIA with out Psychotic features.

CASE REPORT

Name : **Mr.Balamurugan**

Age : 24 yrs.

Sex : Male

Education : M.A.,B.Ed

Language : Tamil

Occupation : Unemployed at present

Socio Economic status : Middle Class

Religion : Hindu

Informant	Competency	Reliability
7. Balamurugan – Patient	Good	Good
8. Krishnaveni- Mother	Good	Good

REASONS FOR PSYCHIATRY CONSULTATION

10. Sleep disturbance
11. Excessive talk
12. High self esteem
13. Increased personal care
14. Disinhibited behavior
15. Overspending
16. Singing songs and dancing
17. Aggressive and assaultive

Present for past 3 months, increased for past 1 month, no major precipitating factors.

First episode, insidious in on set progressive

HISTORY OF PRESENT ILLNESS

He was apparently normal 3months back. He developed sleep disturbances. Found doing works and studying throughout the night .He became over talkative. He found himself more distractible at class room and could not sustain his attention. He developed over inflated ideas about his knowledge. And claimed that he can acquire any job. He prayed three to four times a day He took bath several times in a day and became much aware of his personal appearance. He exhibited disinhibition in his behavior and changed his dresses publically. He became over spending for his friends by borrowing the money from others. He sang songs and cracked jokes inappropriately. For the one month, he became more aggressive and assaultive towards his family members whenever questioned about his behavior.

PAST MEDICAL HISTORY

History of restlessness in class rooms and bullying others present two years back. During September 2009, he became more restless, over talkative and had sleeplessness for 2 months for which he was treated by local psychiatrist with complete recovery in three weeks. Later he discontinued treatment.

No past history of seizures head injury / encephalitis hypertension / diabetes.

FAMILY HISTORY

Father : 53 years

Mother : Home Maker 49 years

Has two younger sisters.

History of alcohol dependence present in his father.

PERSONAL HISTORY

Birth and Development History : Patient was born out of a full term normal delivery.
Developmental milestones attained at appropriate age.

Home Atmosphere : Satisfactory

No behavioral and emotional problems during adolescence

Educational history : Bright student, never failed and completed his M.A., B.Ed in First class

Attitude towards his peers / teachers is friendly and enjoys their company.

Job history : Frequent job change present

Sexual History : No history of pre marital contact, masturbation

Substance abuse history : Occasional intake of bear present

PREMORBID PERSONALITY

Attached to parents, siblings, religious, sincere in work, leader and enthusiastic cannot tolerate defeat.

General Examination

Conscious, afebrile, not anemic, not jaundiced, no goiter

Pulse-80 / min, BP- 120/80 mm of hg.

CVS -normal, RS- normal, PA- soft. CNS- normal

MENTAL STATUS EXAMINATION

General appearance and behavior

Looking ones age, hair kempt, unshaven beard. Co-operative. Distractible. Eye to eye contact present. Rapport established. No abnormal gesturing – posturing, movements.

Psychomotor activity increased.

Speech

Relevant, Coherent

Reaction time : Decreased

Rate : Increased

Quantity : Increased

Volume : Increased

Tone : Normal

Prosody : Maintained

Rhyming present

Mood

Subjectively says he is happy

Objectively he is elated, reactivity of emotion present. Range of affective response present.mood congruent

Thought

Over inflated ideas about his knowledge. And claimed that he can acquire any job - Grandiose ideas.

Perception

No visual or auditory hallucinations

Attention and concentration

Attention-aroused, Concentration-impaired.

Orientation

Orientation to time, place, and person-normal

Memory

Immediate, recent, remote memory intake.

Delayed recall – slightly impaired.

General intelligence : Normal

Judgment : Intact

Insight : Grade1

DIAGNOSTIC FORMULATION

A 26 years male unmarried, educated, from middle class family with history of restlessness in class rooms and bullying others present two years back. During September 2009, he became more restless, over talkative and sleepless for 2 months for which he was treated by local psychiatrist with complete recovery. Later he discontinued treatment. He was asymptomatic till three month back, developed Sleep disturbance ,Excessive talk, High self esteem, Increased personal care, Disinhibited behavior, Overspending ,Singing songs and dancing, Aggressive and assaultive behavior which was gradually progressing. Family history of alcohol dependence present On examination there is excessive talk, elated mood, with grandiose ideas.

Clinical history and mental status examination indicate the diagnosis of F31.1 BIPOLAR AFFECTIVE DISORDER WITH OUT PSYCHOTIC FEATURE CURRENT EPISODE MANIA.

PSYCHOMETRY

He was cooperative. Distractible and irritable at times.

Test Findings:

1. Eysenck's personality questionnaire : he scored as follows:

   Extroversion : 14

   Psychoticism : 4

   Neuroticism : 8

   Lie scale : 3

   He scored high on extroversion

2. Multiphasic personality questionnaire

   Anxiety : 6

   Hysteria : 4

   Depression : 2

   Mania : 12

   Schizophrenia: 7

   Paranoia : 4

   Psychopathic deviation: 4

   K Scale : 3

He scored high on Mania

Projective Tests

Sentence completion Test

On sentence completion test his attitude towards inter personal and family were disturbed. His self concept was disturbed with grandiose and optimistic ideas.

Thematic apperception Test

Mental productivity : Average

Identification : Fair

Predominant conflict : Self

Predominant emotion : Irritability, expansiveness

Associative disturbances: Present

Rorschach Ink blot Test

Mental Productivity : Above average – 28; responses (Normal 10-20)

Mentation : Rapid 15 seconds; Normal 30 sec.

Personality : Extrovert

Psychotic features : Not present (increased color responses with form level, sexual and aggressive responses, contamination).

Draw a person and house-tree person Test

Drawing was expansive over macro graphic.

No evidence of body image disturbances or penetration

Thought process

Proverb Test

He was given 4 proverbs. He expressed familiarity to 3 proverbs and gave abstract meanings.

Object sorting Test

No evidence of over inclusive thinking

Young mania Rating scale : 39

Brief Psychotic rating scale : Scored more in grandiosity and Tension

SUMMARY OF PSYCHOMETRY:

Psychometric tests were done for:

1. Establishing the diagnosis

2. Assessing the severity of the illness.

Patient was cooperative but distractible. He was found to be an extraverted individual. Projective test revealed that no evidence of Psychosis of affective type. His abstract thinking was intact. No evidence of over inclusive thinking. Construct formation adequate.

DISCUSSION AND MANAGEMENT

The provisional diagnosis of mania was confirmed by Psychometric. Based on the history presenting symptoms clinical and psychometric findings showed the presence of mood disorder. The probable diagnosis is **F31.1 Bipolar affective disorder without Psychotic features. Currently in manic episode.**

In view of aggressiveness, he was admitted and treated with:

Tab. Sodium Valporate 1500 mg in divided dose

Tab. Risperidone 4 mg in divided dose

Tab. Trihexyphenidyl 2 mg

Tab.Diazepam 5 mg during night

He showed good improvement and was discharged with advice to attend Psychiatric department regularly.

CASE:5

DISSOCIATIVE CONVULSION

CASE REPORT

Name : **Ms. Mahalakshmi**

Age : 14 years

Sex : Female

Education : 9th Standard

Language : Tamil

Occupation : Student

Socio Economic status : Low socio Economic class

Religion : Hindu

Informant	Competency	Reliability
9. Mahalakshmi – Patient	Good	Good
10. Kasiammal - Mother	Good	Good

REASONS FOR PSYCHIATRY CONSULTATION

1. Giddiness
2. Generalized Involuntary movements

   (Duration 1 month, sudden onset and not progressive).

HISTORY OF PRESENT ILLNESS

Patient was apparently normal one month back. She has night blindness and she was criticized about this by her hostel in mates.

Following which she complaint of giddiness. This was associated with involuntary movements involving all 4 Limbs, Side to side movement of head, screaming, crying and pelvic thrusting lasted for more than 30 minutes to 1 hour.

<u>This episode not associated with the followings:</u>

1. Loss of consciousness
2. Tongue biting
3. Un concerned urination
4. Frothing in mouth

No history of upward gaze of eye ball

No history of post ictal confusion

No history of any nocturnal event

Never injured herself

Never occurred when she was alone

She had repeated such episodes and some time 2 to 3 times / day

She was consulted Neurology department

As there was no significant neurological deficit. EEG recording normal & suggestion test positive, She was referred to Psychiatry Department.

PAST HISTORY

History of Possession attacks present twice in the last year

No history of Headache / vomiting / Febrile illness

No history of head Trauma / Seizure disorder

No history of any Drug abuse

FAMILY HISTORY

Father : 55 years

Mother : Home Maker 45 years

Has one elder brother and three sisters.

History of alcohol dependence present in father

History of possession attack present in her maternal uncle.

PERSONAL HISTORY

Birth and Development History :

Full term normal delivery, No history of Birth Asphyxia.

Achieved Developmental mile stones at the appropriate age

Home Atmosphere :

Not Satisfactory – Economical constrainment present

History of behavioral and emotional problems in the form of temper tandrum, nail biting during child hood present. She used to pick up fight when criticized

EDUCATIONAL HISTORY

Studying in a government boarding school, average in studies

Menstrual History : Attained menarche at 13 years, periods regular

PREMORBID PERSONALITY

Attached to parents, siblings, and friends few, character sensitive to criticism, religious

General Examination

Conscious, afebrile, not anemic, not jaundiced, no goiter Pulse-80 / min, BP- 120/80mm/Hg, CVS, RS- normal, PA- soft.

CNS- cranial nerves-normal

Motor and sensory system normal

Reflexes normal

MENTAL STATUS EXAMINATION

General appearance and behavior

Patient is conscious, dressed adequately and colorfully, well groomed. She is in touch with the surroundings. No gestures and mannerisms. Eye contact present. Rapport easily established.

Speech

Relevant, Coherent

Initiation : Speaks when spoken to

Reaction time : Normal

Rate : Normal

Quantity : Normal

Volume : Normal

Tone : Normal

Prosody : Maintained

Mood

Subjectively – she expresses happiness.

AFFECT - objectively she is euthymic

Thought

No delusion, has somatic preoccupation. Has ideas of worthlessness, hopelessness

Perception

No visual or auditory hallucinations

Attention and concentration

Attention-aroused, Concentration-sustained

Orientation

Orientation to time, place, persons-normal

Memory

Immediate, recent, past memory intake. Delayed recall – slightly impaired.

General intelligence : Average

Judgment : Average

Insight : Grade2

DIAGNOSTIC FORMULATION

Miss.Mahalakshmi-14 years presented with complaints of Giddiness, and generalized convulsion without loss of consciousness, or unconcerned urination or tongue bite and associated with pelvic thrusting, crying, and side to side movement of head. On examination there was demonstrative behavior and suggestibility. Based on

history presenting symptoms, clinical finding-She is diagnosed as a case of **F.44.5-DISSOCIATIVE CONVULSION**

PSYCHOMETRY

Aim: Psychometry was attempted to investigate personality interpersonal dynamics and thought process and concept formation.

She was cooperative during the test.

I Questionnaires

Eysenck's personality questionnaire :

Extraversion : 16

Neutroticism : 22

Psychotism : 6

Lie scale : 3

Multiphasic personality inventory:

Anxiety : 7

Hysteria : 8

Depression : 3

Mania : 3

Schizophrenia : 2

Paranoia : 3

Psychopathic deviation : 6

K Scale : 6

She scored high on Hysteria scale

II Projective Tests

Sentence completion Test

Attitude towards family : No significant disturbance

Attitude towards sex and marriage productivity : Disturbed

Attitude towards interpersonal relationship : Disturbed

Attitude towards self : Disturbed

Attitude towards past, present and future : No significant disturbance

Thematic apperception Test

Nature of stories : Fairly productive

Identification : Patient identified with the story and with the main figure

Main needs : Need for understanding affection

Conception of environment : Need for understanding affection

Significant conflict : Interpersonal

Nature of anxiety : Related to fear of rejection, deprivation and disapproval along with helplessness.

Rorschach Ink blot Test

Mental Productivity : Total response 18

Mentation : 65 seconds

Personality : Extratensive

Neurotic constriction : Presnt

Psychotic features : Absent

Organic features : Absent

House-tree person Test

No evidence of bizarreness, Penetration or body image disturbance.

III . Thought process

Proverb Test

Was given 4 proverbs and she expressed familiarity to all proverbs. She gave abstract and concrete responses.

Objective sorting Test

No evidence of over inclusive thinking

Similarities test

Patient scored 10 concept formations as seen on this test was within normal limits.

SUMMARY OF PSYCHOMETRY:

Patient was cooperative for the testing. She was found to be extraverted individual with elevated scores on neuroticism. Projective tests and rating scales reveal disturbed attitude towards interpersonal and sexual area. No evidence of psychosis. Based on history, presenting symptoms, clinical findings she is diagnosed as **DISSOCIATIVE CONVULSION F44.5**

DISCUSSION AND MANAGEMENT

Pharmacological: For the patient anxiolytics and antidepressants may be supplemented temporarily.

Psychological:

Psychological approach to manage the problem should be tried and the therapy will focus on issues of stress and coping.

When symptoms are incapacitating aversion therapy with suggestion may be tried.

For correction of psychopathology – behavior therapy such as relaxation and abreaction may be used.