MADRAS MEDICAL COLLEGE AND
RESEARCH INSTITUTE
CHENNAI

PSYCHOLOGY CASE RECORD

Submitted to

The Tamilnadu Dr. M. G. R. Medical University

In Partial Fulfillment of the Requirements

for

DPM Final Examination

March 2009

By

Dr. VANI. P

INSTITUTE OF MENTAL HEALTH, KILPAUK

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BONAFIDE CERTIFICATE

This is to certify that this is a bonafide record of the work done by Dr. VANI. P in partial fulfillment of the requirement for the DPM Final Examination of the Tamilnadu Dr. M. G. R. Medical University during the period May 2007 - March 2009.

Assistant Professor of Psychology and Clinical Psychologist
Institute of Mental Health
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Chennai – 600 003
ACKNOWLEDGEMENT

I am very much grateful to the Dean, Madras Medical College, Chennai - 600003, who has given his kind permission to interview the patients for preparing this case record.

I thank the Director, Institute of Mental Health, Chennai - 600 010, who has given his kind permission to interview the patients for preparing this case record.

I am equally grateful to Mr. K. Vijaya n, M.A., D.M. & S.P., and Mrs. Smita Ruckmani M.Phil, Clinical Psychologists of the Institute of Mental Health, Chennai – 600 010 for the guidance given in the preparation of this case record.

I would also like to thank the patients and their family members who cooperated for undergoing the tests and gave the necessary details required.
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PATIENT 1

Name : Mr. R
Age : 23 yrs
Sex : Male
Religion : Hindu
Education : XII standard
Marital Status : Single
Occupation : Unemployed
Socio economic : LSES
Informants : Father
Information : Reliable, Adequate and consistent

REASONS FOR CONSULTATION:

1. Decline in academic performance - 5 yrs
2. Remaining quiet and withdrawn - 4 yrs
3. Accusing family members of trying to poison him
4. Talking to self  
5. Poor personal care  
   \[ \text{3 yrs} \]

HISTORY OF PRESENT ILLNESS:

Mr. R, an above average student, began to fare very badly in exams during his + 2 period. He complained of inability to memorise and was often noted to be lost in
thoughts. His interactions with friends and later with family members declined gradually after he discontinued his studies. He also became suspicious of his own family members, frequently argued and shouted at them for minor events and later accused them of trying to kill by poisoning his food. During daytime he was found sitting alone and muttering to himself. His self care deteriorated and he grew a long beard; wore the same clothes for days together.

No h/o substance abuse, seizures, head injury or LOC.

No treatment to date.

**PAST HISTORY:**

Nil significant.

**FAMILY HISTORY:**

Suicide by his mother’s brother - ? Impulsive.

**PERSONAL HISTORY:**

Full term normal delivery

Normal milestones

Above average in studies.

**PREMORBID PERSONALITY**

Well adjusted, no substance abuse
PHYSICAL EXAMINATION:

General examination WNL
CVS – S1, S2 heard
RS – NVBS heard
Abdomen – Soft, nontender, no organomegaly
CNS – Clinically normal.
BP – 110/70 mm Hg.
Pulse – 80/min

MENTAL STATUS EXAMINATION:

General Appearance: Patient was found wearing a shabby attire, gaze avoidance observed, rapport was established with difficulty.
Psychomotor activity normal
Talk – Decreased productivity, relevant and coherent
Affect – Constricted affect.
Thought – Persecutory delusions
Perception – III person auditory hallucinations. Commenting male voices.

PRIMARY MENTAL FUNCTIONS:

Attention aroused but poorly sustained
Memory immediate, recent and remote intact.
General information average
Calculation average
Poor abstract ability

**INVESTIGATIONS:**

Blood WNL

CT scan NAD.

**DIAGNOSTIC FORMULATION:**

23 yrs old unmarried male with 5 yrs h/o decline in academic performance, poor interaction, hostility towards family members, poor self-care, muttering, suicide by maternal uncle, MSE revealing decreased speech productivity, gaze avoidance, constricted affect, delusions of persecution, III person auditory hallucinations commenting type.

**DIAGNOSIS:**

F 20.0 Paranoid Schizophrenia.

**PSYCHOLOGICAL ASSESSMENT:**

Mr. R is provisionally diagnosed as a case of paranoid schizophrenia. He is assessed for his personality, psychopathology and confirmation of diagnosis.

**Tests administered and their rationale:**

1. **Symptom Sign Inventory:** It is used to arrive at a diagnosis by rating his symptoms on various diagnostic categories.
2. **Sentence Completion Test**: it is a semi projective test used to assess his attitudes toward his self, family, friends, colleagues and superiors. It is also used to assess his attitudes towards future aims and goals in life and the possible guilt in his life.

3. **Thematic Apperception Test**: It is a structured projective test to assess his interaction, conflicts and outlook toward future.

4. **Rorschach**: It is an unstructured projective test used to assess his personality and to arrive at a diagnosis.

**BEHAVIOURAL OBSERVATION:**

He is cooperative for testing but is not very spontaneous or enthusiastic. He looks concerned in between and thinks for a long time in-between. He has an indifferent mood most of the time.

He has elevated scores on the dimension of paranoia and schizophrenia. Some of the paranoid items scored are feeling that his family is plotting against him, accusing him of things that he has not done and trying to harm him. Some of the schizophrenic items given by him are that of strange and unique experiences, getting confused, and confusion over thinking.

He has negative feelings towards his parents and friends as seen from Sentence completion test. He feels he is isolated in the world and no one cares for his wellbeing. He also feels overwhelmed by the hostility expressed by the world around him.

Thematic Apperception Test → His stories on TAT are brief and appear to be ordinary contents reveal themes of poverty, vengeance, interpersonal conflicts; aggression and hostility. Feeling of loneliness is expressed here and there.
Rorschach reveals that he has no clear cut concepts and clear boundaries to his responses. Poor recall ability of his responses was noted. His popular and human responses show low human interaction and his poor touch with reality. The F responses given by him depicts psychiatric process. Contents also reveal hostility and loneliness, poor ego strength and negative perception of life.

SUMMARY:

1. Definitive psychotic perception in Rorschach
2. Elevated scores on paranoia, schizophrenia on SSI.
3. Themes of conflicts, aggression, hostility, vengeance in TAT.

Findings favour a diagnosis of Paranoid Schizophrenia.

FINAL DIAGNOSIS:

F 20.0 Paranoid Schizophrenia.

MANAGEMENT:

PHARMACOLOGICAL -- Atypical antipsychotics – Olanzapine 15 mg/day

PSYCHOTHERAPY- Distraction techniques for auditory hallucinations

OCCUPATIONAL THERAPY
PATIENT 2

Name : Mr. N
Age : 21 yrs
Sex : Male
Marital Status : Single
Occupation : Unemployed
Religion : Hindu
Education : V Standard
Socio economic : LSES
Informants : Parents
Information : Reliable, Adequate and Consistent

REASONS FOR CONSULTATION:

Delayed milestones
Scholastic backwardness} Since birth

Not able to perform well in social and occupational areas – for past 4 - 5 years
Not regular to work

HISTORY OF PRESENT ILLNESS:

The patient was born of a non consanguineous marriage, full term normal delivery. Mother’s age at time of conception was 24 years and father’s age was 28 years.
No history of any drug intake, fever or exanthematous eruptions in antenatal period. No antenatal checkup. No history of radiation, injury, malnutrition, vaginal bleeding.
Delivery was conducted by an ayah. Cried soon after birth, breast fed after a short while.

No history of neonatal seizures or difficulty in feeding. No history of jaundice. Breastfed upto 1 year. No weaning difficulties.

Milestones obtained are tabulated below.

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Age</th>
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<tbody>
<tr>
<td>Head control</td>
<td>3-4 months</td>
</tr>
<tr>
<td>Sitting with support</td>
<td>6-8 months</td>
</tr>
<tr>
<td>Sitting without support</td>
<td>8 months</td>
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<tr>
<td>Standing without support</td>
<td>1 year</td>
</tr>
<tr>
<td>Walking by self</td>
<td>1 ½ years</td>
</tr>
<tr>
<td>Running</td>
<td>3 years</td>
</tr>
<tr>
<td>Babbling</td>
<td>4-5 months</td>
</tr>
<tr>
<td>1 word</td>
<td>6 months</td>
</tr>
<tr>
<td>2-3 words</td>
<td>3 years</td>
</tr>
<tr>
<td>Named pictures</td>
<td>6 years</td>
</tr>
<tr>
<td>Understood simple instructions</td>
<td>6 years</td>
</tr>
<tr>
<td>Bladder and bowel control</td>
<td>6-8 years</td>
</tr>
<tr>
<td>Dresses without assistance</td>
<td>8-10 years</td>
</tr>
<tr>
<td>Playing with a group</td>
<td>8-10 years</td>
</tr>
</tbody>
</table>

The patient was educated upto 5th standard. He discontinued studies as he found it very difficult to pass from one grade to the other. He was working as an assistant to a mason in shifting and transporting things.
PRESENT FUNCTIONING LEVEL:

The patient is able to take care of himself like bathing, dressing, eating without assistance, he goes to neighbourhood shop and could carry out simple tasks of buying things but he frequently misses calculations. He takes care in dealing with fire, crossing roads etc.

PAST HISTORY:

No overt features of psychiatric disturbances noted.

FAMILY HISTORY:

2\textsuperscript{nd} of 3 siblings.

Younger sister is also having similar problems since childhood.

No history of seizures or any other illness in family.

PHYSICAL EXAMINATION:

General condition fair, well built, no pallor

Not jaundiced

Hypertelorism

Upslanting eyebrows

Depressed nasal bridge

PR – 76/min.

Blood pressure – 110/70 mm Hg.
CVS – S1, S2 heard, no murmur.
RS – NVBS, no added sounds.
Abdomen – Soft, nontender, no organomegaly
NS – No FND. no neurocutaneous marker.
Bilateral Fundi – Normal.

MENTAL STATUS EXAMINATION:

General appearance – conscious, ambulant

In touch with surroundings, dressed adequately, well kempt

Rapport could be established

Talk - Quantum, Tone, Rate within normal limits. Relevant and Coherent

Mood – Euthymic

Thought – No formal thought disorder, content simple

No perceptual disturbances

PRIMARY MENTAL FUNCTIONS:

Oriented to time, place and person

Attention was aroused, but ill sustained

Concentration impaired.

Memory Immediate impaired, DF-2, DB-1. Recent, Remote - intact

General information average

Judgement intact

Abstract ability impaired.
PROVISIONAL DIAGNOSIS:
ICD-10. F-70 Mental Retardation – Mild.

PSYCHOLOGICAL ASSESSMENT:
Mr. N, 21 yrs old came with history of delayed developmental milestones and poor scholastic performance. He was taken up for psychological assessment to assess his intellectual functions and social functions.
Tests administered and their rationale:
1. Seguin Form Board Test: It is a test of forms perception and is used as a test of intelligence to get the baseline intellectual abilities.
2. Binet Kamath Test of Intelligence (BKT): It is a test of intelligence mostly based on verbal activities and reflects global intellectual abilities.
3. Vineland Social Maturity Scale: It is used to assess his social maturity level.

BEHAVIOURAL OBSERVATION:
He was co-operative for testing and had adequate interest in test situation.

TEST RESULTS:
Patient was very attentive and was able to concentrate for most of tests. His psychomotor activity was within normal limits. His Gestalt functions and concept
formation of size, shape, form were adequate, has a borderline knowledge about general information, was able to do simple arithmetic and carry out simple commands without any problems. His memory span is however decreased and in Digit span test, he could not score more than 3. He has adequate knowledge about the value of currency.

He is functioning above 10 years line in his mental age as seen from Seguin form board test. In BKT his basal age was 5 years and terminal age was 11 years with mental age around 8 years (5 years + 36 months) giving rise to an IQ of around 50 placing him in mild degree of mental retardation. His social functioning is about 10 – 12 years as rated from Vineland Social maturity scale. With his parent’s report he is functioning around that age in self-help, general communication and socialization, locomotion and 8 years in occupation and 12 years in dressing.

**SUMMARY:**

He has sub average intellectual functioning. His IQ score of 50 places him in mild MR and his social maturity and acceptability shows that this individual can be well trained to earn his livelihood to some extent to help others in family.

**FINAL DIAGNOSIS:**

ICD-10. F-70 Mental Retardation – Mild.

**MANAGEMENT:**

1. No medications are necessary as he has no psychomotor or behavioural problem.
2. He can be guided to various rehabilitation schools and training schools to teach him simple occupation with which he will be most benefited.
PATIENT 3

Name : Ms. F
Age : 24 yrs
Sex : Female
Marital status : Unmarried
Religion : Hindu
Education : B.Sc.
Socio economic : LSES
Informants : Self, mother
Information : Reliable, Adequate and consistent

REASONS FOR CONSULTATION:

1. Repeated doubts about her activities
2. Frequent washing and cleaning
3. Fear for trivial matters

One year

Insidious onset, continuous course, I psychiatric consultation

HISTORY OF PRESENTING ILLNESS:

According to the patient, about one year back she started to worry about her routines and started to wash repeatedly her hands and used to take bath for long hours to keep herself clean. Though she preferred to keep herself clean, she excessively indulged in these acts only in recent times. The thoughts of cleanliness occurred repeatedly as intrusive ones in her mind and got partial satisfaction only after performing these acts.
This also resulted in disturbance in her work time, resulting in absenteeism and she was left feeling helpless over this issue.

She kept doubting about matters like whether she had locked the door, switched off the lights and would keep checking repeatedly even though she felt it was excessive. She also had disturbed sleep at times pondering over these issues. She felt low over this problem and consulted IMH OP, and was put on Clomipramine and Amitryptilne, following which she showed improvement.

No h/o hearing voices, suspiciousness

No h/o tall claims

No h/o head trauma or seizures

PAST HISTORY:
No significant medical or psychiatric illness.

FAMILY HISTORY:
Born of non consanguineous marriage

History of similar illness in her paternal uncle

She is the eldest of 3 children.

PERSONAL HISTORY:
Birth and milestones normal

Educated and employed.

Menarche by 13 years. Regular menstrual periods
PREMORBID PERSONALITY:
Extrovert, had many friends, religious, perfectionist, meticulous in her activities, enjoyed
gardening and reading books.

PHYSICAL EXAMINATION:
Conscious, ambulant
BP – 120/70 mm Hg.
PR-80/min.
CVS – S1, S2 heard.
RS – NVBS heard.
Abdomen – Soft, nontender, No organomegaly
CNS – Clinically normal.
Fundus – normal

MENTAL STATUS EXAMINATION:
General Appearance and Behaviour: Conscious, in touch with surroundings, well kempt,
dressed adequately. Rapport was established. Gaze contact made and maintained.
Psychomotor activity – within normal limits
Talk – relevant and coherent. Quantum, rate and tone normal. Reaction time normal.
Mood – (s) Anxious
(o) Anxious
Thought Form, stream normal
Content – No delusions, no referential ideas
Ideas of helplessness
Possession – Obsessions and washing compulsions

PRIMARY MENTAL FUNCTIONS:

Oriented to time, place and person
Attention aroused, Concentration well sustained
Digit Forward – 5
Digit Backward – 4
Memory – immediate, recent and remote – intact
General fund of information – adequate
Average intelligence
Abstract thinking intact.
Judgement to test situation intact
Insight: Grade VI – True emotional insight.

DIAGNOSTIC FORMULATION

24 years old F presenting with complaints of frequent washing and cleaning, apprehension and unpleasant repeated intrusive thoughts encompassing her occupation, MSE showed anxious mood with obsessions and compulsions.

PROVISIONAL DIAGNOSIS

F 42.2 Obsessive Compulsive Disorder, Mixed obsessional thoughts and acts.
PSYCHOLOGICAL ASSESSMENT:

Ms. F, provisionally diagnosed as a case of OCD is taken up for psychological assessment to assess her symptoms patterns, severity of illness and for personality.

Tests Administered and Their Rationale

1. **Eysenck Personality Questionnaire** was used to assess the different dimensions of her personality.

2. **Sentence Completion Test** was used to elaborate on her attitude towards family, parents, and his interpersonal relationships.

3. **Thematic Apperception Test**, a projective test of personality used to assess her interpersonal relationship, goals and conflicts.

4. **Rorschach test**, a projective test of personality used to assess her personality structure and diagnosis.

5. **Hamilton Anxiety Scale** is used to assess the severity of anxiety

6. **Yale Brown Obsessive Compulsive Scale**: It is used to rate the severity of obsessive and compulsive symptoms.

7. **Hamilton Rating Scale for Depression** used to estimate the level of depression

BEHAVIOURAL OBSERVATIONS DURING TESTING:

Rapport could be established easily. She came out with her problems by herself. She was cooperative and regular to the sessions.
**Test results:**

Eysenck’s Personality Questionnaire Her scores indicate severe degree of neuroticism with low psychoticism and moderate extroversion.

Sentence Completion Test – She has positive feelings towards friends, superiors, teachers, marriage and women in general. She has negative feelings towards her father. She showed feelings of inferiority and high sensitivity, longing for affection from others. She is apprehensive about minor conflicts.

Thematic Apperception Test – Her stories are productive imaginative and projective of her childhood experience as a neglected child. Her parents have highly conflicting attachments which has resulted in her fears and conflicts about marriage and sex. She is also highly neurotic with fears of darkness and loneliness.

Rorschach test – Her responses reveal that she is highly imaginative which at times leads to unwanted thoughts, preoccupations and emotional reactions. She has highly disturbed personality with highly critical attitude which even amounts to paranoid ideations. She has adequate ego strength inspite of neurotic fears which favours the receptivity of psychotherapeutic interventions.

Rating Scales – reveal mixed symptoms of obsessions and compulsions with features of anxiety and a certain amount of depression due to life stressors.

**SUMMARY:**

She scored high on various neurotic dimensions on personality indicating that she is highly neurotic in her thoughts, feelings and reactions to the environment with which we can diagnose her as a case of mixed neurosis with obsessive symptoms.
FINAL DIAGNOSIS

F 42.2 Obsessive Compulsive Disorder, Mixed obsessional thoughts and acts.

MANAGEMENT

PHARMACOLOGICAL:

T. Clomipramine 25 mg 1-0-1
T. Clonazepam 0.5 mg 0-0-1

PSYCHOTHERAPY:

Cognitive Behavioural Therapy to change and modify irrational thoughts.

Exposure and response prevention to manage the compulsions

Thought Stopping to manage the obsessions

As she has high dependency needs and insecurity, she was treated with supportive psychotherapy. Behaviour counselling is also undertaken. Family therapy is of utmost importance and occupational rehabilitation is also a part of therapy.
**Patient 4**

<table>
<thead>
<tr>
<th>Name</th>
<th>Ms. L</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>25 yrs</td>
</tr>
<tr>
<td>Sex</td>
<td>Female</td>
</tr>
<tr>
<td>Occupation</td>
<td>Unemployed</td>
</tr>
<tr>
<td>Religion</td>
<td>Hindu</td>
</tr>
<tr>
<td>Education</td>
<td>B.A. discontinued</td>
</tr>
<tr>
<td>Socio economic</td>
<td>MSES</td>
</tr>
<tr>
<td>Informants</td>
<td>Self, mother</td>
</tr>
<tr>
<td>Information</td>
<td>Reliable, Adequate and consistent</td>
</tr>
</tbody>
</table>

**REASONS FOR CONSULTATION:**

1. Low mood
2. Dull and withdrawn
3. Easily irritable 3 months
4. Sleep disturbance
5. Loss of appetite and fatigue
6. Suicidal attempt 2 weeks ago

IV episode, gradual in onset,
Precipitated by shift of residence,
I psychiatric consultation
HISTORY OF PRESENT ILLNESS:

Ms. L was apparently normal 3 months ago, when she was noticed to be quieter than usual since changing residence, looked dull and less communicative. She felt low most of the day, did not feel like doing anything, felt intensely tired and a distinct lack of interest in doing things she used to enjoy earlier. She kept worrying over minor matters and became annoyed and irritated at the slightest provocation. She had difficulty falling asleep and maintaining sleep – got up frequently during the night. She had loss of appetite. She felt giddy, tremulous, sweating at times when she went out. She had taken an over dosage of tablets 2 weeks ago following a quarrel at home.

No history of hearing voices.

No history of substance abuse, head injury, fits.

PAST HISTORY:

I episode – 8 yrs ago, precipitated by the death of her father, lasting 1 year characterised by low mood, less communicative, confining to home, suggestive of depressive episode, improved spontaneously.

II episode – A period when she was generally cheerful, active, developed many new interests, very sociable, kept herself busy from morning to night, was a bundle of energy, needed less sleep than usual, lasting 1 year and 3 months.

III episode – Precipitated by the breaking up of a love affair, characterised by low mood, crying spells, loss of interest, decreased activity, dull, withdrawn behaviour and self-harm behaviour, improved without treatment.
FAMILY HISTORY:
She is the 3rd of 4 children, born of non consanguineous marriage.
H/o alcohol dependence in father and paternal uncle both died due to physical complications of alcohol use.
MR in cousin. Hypothyroidism in mother.

PERSONAL HISTORY:
Has worked as a saleswoman in various shops, as tailor, in marketing and as LIC agent.
Menstrual irregularity present. 3/45 days.

PREMORBID PERSONALITY:
She was shy, kept to herself, had very few friends, calm and quiet, attached to father and younger brother, was sensitive, not adjustable, religious, introvert.

PHYSICAL EXAMINATION:
Conscious, ambulant
Linear scars Left forearm.
BP – 110/70 mm Hg.
PR-80/min.
CVS – S1, S2 heard.
RS – NVBS heard.
Abdomen – Soft, nontender, No organomegaly
CNS – Clinically normal.
Fundus – normal

MENTAL STATUS EXAMINATION:

General Appearance and Behaviour: The patient was well kempt, alert, took the seat offered, cooperative, Gaze contact was made and maintained. Rapport was established. In touch with the surroundings.

Psychomotor activity: Normal.

Talk: Relevant and coherent, Quantum, Tone, Rate normal. Reaction Time normal.

Mood (s) Depressed

 (o) Depressed. Reactivity present.

Thought – Form, stream normal

Ideas of guilt and worthlessness, Ideas of hopelessness, depressive ruminations

Perception – No perceptual disturbances.

PRIMARY MENTAL FUNCTIONS:

Oriented to time, place and person

Attention arousable, Concentration well sustained

Digit Forward – 5

Digit Backward – 4

Memory – immediate, recent and remote – intact

General fund of information – adequate

Average intelligence
Abstract thinking intact.
Judgement to test situation intact
Insight: Grade V.

INVESTIGATIONS:
Haemotological investigations – Normal
ECG – normal
EEG – normal
Thyroid profile – normal
Chest X-ray – NAD

PROVISIONAL DIAGNOSIS
ICD-10: F 31.30 Bipolar affective disorder, current episode moderate depression, without somatic symptoms.

PSYCHOMETRY:
Ms. L was assessed for her personality, psychopathology and diagnosis with rating scales and projective tests.

TESTS ADMINISTERED
1. Eysenck Personality Questionnaire was used to assess the different dimensions of her personality.
2. **Symptom Sign Inventory** to assess symptom loading on various diagnostic categories.

3. **Multiphasic Questionnaire** – to assess her personality. Hamilton Rating Scale for Depression

4. **Young Mania Rating Scale** was used to rate intensity of various symptoms she was exhibiting.

5. **Sentence Completion Test** was used to elaborate on her attitude towards family, parents, and her interpersonal relationships.

6. **Thematic Apperception Test**, a projective test of personality used to assess her interpersonal relationship, goals and conflicts.

7. **Rorschach test**, a projective test of personality used to assess her personality structure and diagnosis.

8. **Bell’s Adjustment Inventory**

9. **State and Trait Anxiety Inventory** – used to assess her anxiety levels.

**BEHAVIOURAL OBSERVATION:**

Rapport was established. Attention could be aroused and sustained. Talk was relevant and coherent. She was able to comprehend the instructions. Crying spells were present in initial sessions.

**TEST FINDINGS:**

Personality and Interpersonal:

On Eysenck Personality Questionnaire, her lie scale is high. So, the protocol needs to be interpreted with caution. High on neurotic traits in her personality. State and Trait Anxiety scale shows a generalised trait anxiety is present in the patient and also
high on state anxiety. Bell’s Adjustment Inventory showed average home adjustment, average health adjustment, retiring in social adjustment, unsatisfactory in emotional adjustment with average occupational adjustment.

On Sentence completion test, she has an optimistic outlook about her future, poor motivation to overcome her problems and uncertainty about her future.

Thematic Apperception Test has shown there is a strong need for affection and belongingness. Stories have projected on guilt feelings, depressive feelings, pessimistic and insecure feelings, worried about her past. The main themes of the stories are based on worries, problems and family life.

Diagnostic:

On Symptom Sign Inventory, scores were significantly elevated on Anxiety scale, Depression scale and Paranoid scale. Hamilton Rating Scale for Depression has shown moderate amount of depressive feelings. The scores were not significant on Young Mania Rating Scale.

On Rorschach, total responses were 16 with average mentation time. Patient has given 7 popular responses, 9 originals with fluctuations in form level rating. Content analysis shows animals, humans, anatomical and decay.

**IMPRESSION:**

Patient with adequate cognitive functions with high on trait anxieties, poor adjustment on emotional area and social area with evidence of depression.
SUMMARY:

She has symptoms of moderate depression with features of anxiety on various tests indicating that the patient is suffering from mood disorder currently depression.

FINAL DIAGNOSIS:

ICD-10: F 31.30 Bipolar affective disorder, current episode moderate depression, without somatic symptoms.

MANAGEMENT:

PHARMACOLOGICAL

Patient is on
C. Fluoxetine 20 mg 1-0-0
T. Propranolol 40 mg 1-0-0
T. Sodium Valproate 200 mg 1-1-1

PSYCHOLOGICAL

Cognitive Behavioural Therapy – to correct her cognitive distortions and negative schemas.

Activity scheduling was done.

Interpersonal psychotherapy to improve her social skills and adjustment with others.
Patient 5

Name : Mr. M
Age : 70 yrs
Sex : Male
Marital status : Married
Religion : Hindu
Education : Uneducated
Socio economic : LSES
Informants : Sons
Information : Reliable, Adequate and consistent

REASONS FOR CONSULTATION:

Memory disturbance
Decrease in personal hygiene \[\text{one year, more for past 6 months}\]
Sleep disturbance
Insidious onset, progressive course, no obvious precipitating factors
I psychiatric consultation

HISTORY OF PRESENT ILLNESS:

The patient who was brought by his sons was apparently normal till one year back. Then, his elder son noticed that the patient repeatedly searched for certain common things in the house. He would forget simple things in the house like the way for going to toilet. At times he also found it difficult to return to his house after going for a walk. In
course of time, he was not able to identify his close relatives and called his son as his brother. He was not able to remember whether he had taken his food or not. His personal hygiene decreased gradually due to not taking bath and improper dressing. He would pass urine inside the house itself at times. He sleeps for very little time and would wake up in the wee hours of the night and keep pacing inside the house.

**PAST HISTORY:**

No history of similar illness in the past.

No history of head injury, seizures or fever.

No history of Hypertension or Diabetes Mellitus.

No history of substance use.

**FAMILY HISTORY:**

No history of mental illness, suicide or absconders in the family.

**PERSONAL HISTORY:**

Early childhood history was not known.

Born of consanguineous marriage.

Married at the age of 25 years.

Living with 1 daughter and 3 sons.
PREMORBID PERSONALITY:

Adjustable and Easy going.

Tolerant to criticism, responsible.

Highly religious.

He was able to do simple mathematical work and handled money and financial matters without others’ help.

PHYSICAL EXAMINATION:

Thin built, not anemic, not jaundiced, no pedal edema.

Pulse – 68/min

BP – 120/80 mm Hg

CVS – S1, S2 heard.

RS – NVBS heard.

Abdomen – Soft, nontender, No organomegaly

CNS – Clinically normal.

Fundus – normal

MENTAL STATUS EXAMINATION:

General Appearance and Behaviour: Conscious, ambulant, Rapport established with difficulty, not cooperative for interview, neatly dressed, no tics or mannerisms.

Psychomotor Activity – increased.

Talk – He is not well communicable, answered in monosyllables after asking simple questions, that too repeatedly.
Mood – (s) Feels good
   (o) Restless and irritable

Thought – No delusions.

Perception – No perceptual disturbances.

PRIMARY MENTAL FUNCTIONS:

Not oriented to time and place. Oriented to person.

Attention aroused with difficulty

Concentration impaired.

Digit Forward – 2

Digit Backward – 0

Memory – recent, remote and immediate memory are impaired.

Intelligence, abstractability and judgement could not be assessed as he could not comprehend the question.

Insight – Absent.

PROVISIONAL DIAGNOSIS:

Dementia.

PSYCHOLOGICAL ASSESSMENT:

Mr. A, who was provisionally diagnosed as a case of dementia is taken up for psychological testing to establish the diagnosis and to assess the severity of illness.
TESTS ADMINISTERED AND THEIR RATIONALE:

1. **Mini Mental Status Examination (MMSE)** – It is a screening test to identify the organic aetiology and also to assess the course of illness.

2. **Wechsler Memory Scale** – Used to assess his memory functions.

3. **Bender Gestalt test** – Used to assess the perceptual visuomotor functions

4. **Brief Psychiatric Rating Scale** – Used to assess associated psychiatric problems.

5. **Seguin form board test** – A form perception test and also used as a test of intelligence.

6. **Dementia Rating Scale** – Used to assess the severity of dementia.

BEHAVIOURAL OBSERVATION:

The patient was made to sit in the chair by his sons and he frequently stood up during the interview. He was very much irritable and not cooperative for examination. Questions had to be repeated many times to get an answer.

**Test results:**

He obtained a very low score of 9 out of 30 in mini mental status examination showing a severe degree of impairment.

In Wechsler memory scale, he was not able to answer the questions because of poor concentration and on repeated questioning he answered irrelevantly. He was not able to draw a figure properly in Bender Gestalt test. He simply scribbled over a paper which showed the organic nature of the disease and visuomotor disturbance.

Brief psychiatric rating scale revealed his uncooperativeness, psychomotor agitation, inappropriate affect and disorientation to time and place all of which showed an
organic nature and major psychiatric symptoms such as delusions and hallucinations were not present.

He could not perform Seguin form board test and he even could not understand the way to perform the test. Dementia rating scale revealed his inability to perform household tasks, inability to find ways, inability to recall recent events, dressing without buttons, purposeless hyperactivity and diminished emotional responsiveness all of which indicates a severe degree of impairment.

**SUMMARY:**

There is marked impairment in his cognitive functions and visuo spatial perception. There is also deterioration in personal hygiene and personality.

**FINAL DIAGNOSIS:**

Organic mental disorder – Dementia.

**MANAGEMENT:**

**PHARMACOLOGICAL:**

Cholinesterase inhibitors are useful. They potentiate the cholinergic neurotransmitter.

Very low doses of antipsychotics for behavioural problems.

**BEHAVIOURAL:**

Family counseling to provide awareness to the family members about the guarded prognosis for this patient and the importance of rehabilitation.
Relatives were advised to give an understanding atmosphere to the patient and help her not to get confused.

Importance of proper follow-up is stressed to monitor the condition of patient and to help the family members in dealing with the patient adequately.