PSYCHOLOGICAL CASE RECORD

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By

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CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. BOBBY THOMAS KOKKATT** during the year 2005-2007. I also certify that this record is an independent work done by the candidate under my supervision.

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CASE RECORD

Name	: G
Age	: 25 years
Sex	: Male
Marital status	: Single
Religion	: Hindu
Socioeconomic status	: Middle SES
Education	: BSc discontinued
Occupation	: Nil
Informants	: Father
Information	: Reliable

PRESENTING COMPLAINTS

Repetitive thoughts

Repetitive washing and checking

Fearfulness

Duration :

4 years

Mode of onset :

Insidious

Precipitating factors :

Sexual abuse (doubtful)

HISTORY OF PRESENT ILLNESS

The patient was apparently all right till four years back. During the second year of PUC patient complained to his parents that he had been sexually abused by an elderly male person while he was in a park. He was severely distressed and was taken to a psychologist where he

underwent therapy. Following this he was apparently all right and had joined a catering course. He was staying in a hostel in his second year. During this time he was reportedly sexually abused by his hostelmates and when he had tried to resist, had been threatened that he would be killed. Since then, has been expressing that he had frequent repetitive thoughts that semen was continuously passing out of him. He felt that the anal region had some sticky sensation on standing, making him have the urge to pass stools. He also felt that there was a snake inside his abdomen and whenever he touched a metal piece he had the thought that it may become a sickle and cut his body into pieces. Hence he deliberately avoided touching any metal. He says that these thoughts were recurrent, recognizing that it is partly true, struggling to dismiss these thoughts because of its disturbing nature but unable to do so. He had less control over the obsessions and upto fifty percent of time was successful in diverting the attention by imagining that these problems were transferred to another person .

He also had compulsive symptoms like cleaning, washing compulsions, checking compulsions, and repeated rituals like bathing for prolonged period of time using excesses amount of water and cleaning mouth frequently due to the fear of contamination. He dusted his clothes ten or fifteen times followed by repeatedly saying that nothing was inside the shirt. He did it for similar number of times before wearing it thinking that some knife was kept inside and that it would harm him. He says these compulsions were intended to reduce the anxiety as it was partly true, following which he became partly successful in overcoming the anxiety .He had little control and a strong drive to perform the behavior to completion.

Because of this severe continual weighing of pros and cons about nonessentials he had significant trouble in making decisions about little things that other people might not think twice about .He also had moderately prolonged routine activities and was slow in completing tasks.

The patient said that initially he could hear intermittently some human voices when he was alone and fully awake, talking with each other. He was not able to elaborate further on this. He also had similar voices heard when he was about to sleep .He was expressing fearfulness to different situations, places and things made of metal. Because of this he was avoided specific situations but was not able to understand fully the rationality of this. For the past one year he was seen awake at night and wandering most of the days and sleeping in the daytime. Many times he had to be searched to find his whereabouts and had to be brought back by different people including the police

There was no history suggestive of any first rank symptoms or mood symptoms or suicidal ideas. There were no histories suggestive of any organicity .There were no history of abnormal movements or impulsive behavior or features suggestive of body dysmorphic disorder or hypochondriasis belonging to the OCD spectrum disorders . There were no histories of substance abuse

PAST AND TREATMENT HISTORY

He was treated with clofranil 75 mg and riscalm 2 mg with about sixty percent improvement in the symptoms .For the last eight months prior to the visit he was on siddha medicines without any significant improvement .

FAMILY HISTORY

Patient was staying in a nuclear family. He was the second of the three siblings born out of a non-consanguineous marriage .Elder sister was married and younger sister was a school teacher Two of his second degree relatives were diagnosed to have chronic mental illness and one of them had committed suicide .

PERSONAL HISTORY

Birth and developmental history was within normal limits

Educational history – he discontinued studies due to illness in the second year of BSc .He was reported to have been a brilliant student .He had good relationship with teachers but had friends younger to him .

OCCUPATIONAL HISTORY

Patient helped his parents in their provisional store in the evening time

SEXUAL HISTORY

Patient did not give an appropriate answer regarding masturbation or about the sexual orientation. However was not hesitant to elaborate on the homosexual abuse.

PREMORBID PERSONALITY

He was an introverted person with poor social skills compared to other siblings .He was not a person who took initiative or much responsibility in work and according to the father he was not given enough opportunities since childhood .

MEDICAL HISTORY

There were no significant past medical history except that he had right eye strabismus since birth.

PHYSICAL EXAMINATION

General physical examination and systemic examination were normal

MENTAL STATUS EXAMINATION

Patient was moderately build and nourished He was poorly kempt ,ill shaven and shabbily dressed .He looked anxious but was maintaining eye contact .Psychomotor activity was within normal limits without any fluctuations. He was alert ,conscious ,and cooperative .Attention concentration , memory and orientation were intact .Speech was audible but hesitant most of the time.Reaction time was increased.Productivity was less without any deviation in speech .There were no abnormality in form of thought but the stream of thought was retarded with content of thought showing predominant obsessive ideas, depressive ideas and some persecutory ideas. There were no possession of thought abnormalities . The abstract thinking was normal .He denied any perceptual abnormality .Mood was subjectively described to be sad , objectively the reactivity was decreased and affect was blunted .There were no suicidal ideas .He had obsessions related to contamination, and sexual obsession with few compulsive phenomena like cleaning washing and repeating rituals .There were no volitional abnormality and longitudinally his intelligence seemed average .He had partial insight with normal test judgment . The personal and social judgment was impaired and his general information was fair .

DIFFERENTIAL DIAGNOSIS

1. Obsessive compulsive disorder
2. Undifferentiated Schizophrenia

AIM OF PSYCHOLOGICAL TESTING

The onset of illness for Mr Gopal was in the early adulthood and since then it was a continuous illness characterized predominantly by obsessions and compulsions .He also expressed suspiciousness and fear of people and things with significant impaired socio occupational functioning and self care. Though obsessive-compulsive symptoms were predominating, the presence of psychotic symptoms had to be ruled out. Testing was done to assess the underlying psychopathology.

TESTS ADMINISTERED

1.Multiphasic Personality Questionnaire (MPQ)

2.Yale – Brown Obsessive Compulsive Scale

3.Yale – Brown Obsessive Compulsive symptom checklist

4.Draw a Person Test (DAPT)

5.Thematic Appreciation Test (TAT)

6.Object Sorting Test (OST)

7.Rorschach Ink Blot test

RATIONALE FOR TESTS ADMINISTERED

MPQ was administered to order to assess the clinical dimension of the personality. It also helps in finding the psychopathology of the patient

Y-BOC scale and symptom checklist was done to find out patients target obsessions and compulsions and their severity.

DAPT a projective test was done to look into patient's psychopathology and personality.

TAT was done to find out the level of psychopathology and throw light on patient's personality and interpersonal relationships.

OST was done to study thought process, concept formation an abstract thinking.

Rorschach ink blot test was done to find details of thought processes, content, and interpersonal functioning.

BEHAVIORAL OBSERVATIONS

Patient was motivated for psychometric testing He could comprehend instructions adequately. However he took a long time to answer whether it was oral or writing. He looked anxious throughout the period of testing. Preoccupation was noticed at times.

TEST FINDINGS

Multiphasic personality questionnaire

He had scored above the cut-off on scales of anxiety and depression. His lie score was not significant. The findings were indicative of a person who is tense and anxious. He is frightened of social situations and feels the need to be alone. Has difficulty in interpersonal relationships. He is often disturbed by various thoughts and has the tendency to worry and ponder long over things. Wishes to die and feelings of unreality are also present.

Y – BOCS

Patient had predominant sexual obsessions sexual images and thoughts ,content involving homosexuality with aggressive obsessions like fear that he might harm self or others.He also had few repeating rituals, cleaning and washing compulsions and checking compulsions . Scale showed that he had severe obsessions which were very frequent intrusions, with short symptom free interval .He had severe, substantial impairment in social and occupational functions .He

makes some effort to resist with little control in stopping or dismissing obsessions. The compulsive behaviors were mild with relatively long symptom free interval with mild interference with activities and with relatively moderate distress .His insight was poor.

DAPT

The patient drew a figure of a man .The placement of the picture was in extreme left upper part of the page. Only the upper half of the body was drawn without hands. He took a long time to draw and was observed to be repeatedly erasing and shading He took extra care to have symmetry in the figure. His drawings were indicative of anxiety, timidity and lack of confidence. Indecisiveness and under assertiveness were also evident. There was an obsessive quality in his drawings.

TAT

There were few narrative stories. The conflict in heterosexual areas was evident. He was found preoccupied throughout the test. There was a need for dependence and support. He found the obstacles in the environment threatening and fearful. He attempted to escape from stressful situations and did not have the confidence to face them. The outcomes in all the stories were unfavorable.

OST

His responses were marked by adequate responses and abstraction was fair. There were no indications of a thought disturbance.

Rorschach inkblot test

Mentation was slow. Thought process and imaginable capacity were poor. Intellectual capacity was not very high and creativity was poor. Popular responses were few indicating poor group conformity. There was poor ego strength. He had poor logic for his responses. There was a tensed and constricted state of mind. Organizational capacity was poor. There was deep-rooted anxiety and lack of confidence. His productivity was fair. He was able to maintain reality orientation to some extent in spite of his preoccupation. Pathognomic signs were not present.

The protocol reveals defensiveness and avoidance.

The subject has a tendency to back away from responses. He avoids complexity and has no motivation to perform the task presented. Obsessive and perfectionist tendencies were evident. He approaches tasks with caution and thoroughness.

CONCLUSIONS

Thought processes lacked clarity. Obsessive nature of thinking was predominant. There was fear of being harmed. Interpersonal relations were poor and group conformity also was poor .His mentation was slow. Inability and inferiority were evident. There was low ego strength and under productivity. Anxiety and depressive features were also evident. Findings revealed that his reality orientation was not very strong; however he did not have responses that were suggestive of a psychosis. There were indicators of a severe level of emotional disturbance. Patient would improve significantly with psychotherapy and medication.

DIAGNOSIS

Obsessive-compulsive disorder with predominant obsessions

MANAGEMENT

Patient was started on anti- obsessional agent, clomipramine in titrating doses in view of the significant response with the same medication in the past. He was also started on risperidone in view of his severity of symptoms. The patient and family members were educated about the illness and the need for regular medication and the side effects of the medicines. He was taught relaxation techniques and advised regular follow up for psychological management. High expressed emotion in the family was also addressed and the need for proper vocation also was stressed.

CASE RECORD II

Name	:	TBN
Age	:	64 years
Sex	:	Male
Marital status	:	Married
Religion	:	Hindu
Socioeconomic statu:		Middle SES
Education	:	12th standard
Occupation	:	Rtd Senior LIC officer
Informant	:	Wife

PRESENTING COMPLAINTS

Impaired memory

DURATION

Eight years

MODE OF ONSET

Abrupt

PRECIPITATING FACTOR

Stroke

HISTORY OF PRESENT COMPLAINTS

The patient is a known diabetic and hypertensive since fifteen years. In 1998 in his office he was found unconscious and probably not attended for about an hour. In the hospital his blood pressure was found to be high. The CT scan revealed gross intraventricular hemorrhage with large hypo dense area in right tempro-occipital region, small intra cerebral hematoma in left Para ventricular region with few lacunar infarcts on both sides. He regained consciousness in 3 to 4 hours time. The details of his physical status were not known as he was admitted in intensive care unit. The relatives did not notice any features suggestive of any neurological deficits during his stay in the hospital and was discharged in the eighth day. Following the discharge he was found to have problems in memory. He was not able to identify close relatives and used to let strangers into the house. He was not able to remember his address, not aware of the current events, misplace things and forget what he had for the breakfast. He was unable to understand what is spoken and had difficulty in finding correct word. He also had difficulty in using familiar objects like tooth brush and had difficulty in performing simple tasks at home. He was almost fully dependent in ADL like feeding, toileting, bathing, dressing and grooming. He also had difficulty in relating to news paper or TV. He also had difficulty in managing finance or give advice to people regarding the insurance. He also was unable to engage in social activities and behave in socially appropriate way. He improved gradually after a period of 3 to 4 months and has improved up to fifty percent in one year period. He did not show much improvement after these.

There was no history of any difficulty in vision or diplopia or any problem in visual field or in eye ball movement or in identifying colors. There was no history of any sensory symptoms on the face or difficulty in mastication. There was no history of deviation of angle of mouth or any problem in hearing or swallowing. There was no history of motor weakness or wasting of muscles. There was no history of any sensory symptoms or any in

coordination of gait or abnormal movements. There was no history of features suggestive of cardiac, respiratory, or gastrointestinal problem. There was no history suggestive of mood symptoms or psychotic symptoms.

CURRENT FUNCTIONAL STATUS

He is able to identify close relatives but has problem in identifying unfamiliar people .He has difficulty in remembering recent events misplace things. He is able to do the ADL independently. He has temporal lobe features characterized by loss of memory for immediate and recent things. His memories for remote events were intact. There was no difficulty in field of vision. His speech was reported to be spontaneous, fluent, without any word finding difficulty or impaired grammar. His judgment was reported to be intact and able to give advice related to his job appropriately. There was no history of disinhibited behavior and was interested with the daily events. He was reported to have difficulty in planning ahead and get angry and irritable and happy frequently unlike in the past suggestive of some frontal lobe features. There was no history suggestive of sensory or motor neglect or any difficulty in using familiar objects or any right left disorientation or problem in calculation suggestive of parietal lobe dysfunction. There was no history of difficulty in vision or identifying colors or identifying familiar picture or difficulty in reading or naming things suggestive of occipital lobe dysfunction.

PAST AND TREATMENT HISTORY

In 1994 following a sudden onset of severe headache, the CT scan revealed mild intraventricular hemorrhage. He was treated in Calcutta conservatively and he recovered soon without any neurological deficits. Current medications are antihypertensives, antidiabetics and antiplatelet agents.

FAMILY HISTORY

He is the second of the two siblings born out of a non –consanguineous marriage. His father died at a younger age for the cause is not known. His mother had a stroke at eighty years of age and died two weeks later.

PERSONAL HISTORY

He was a chronic smoker till1998. There was no history of any other substance abuse. His sleep and appetite was normal and the bowel and bladder habits were normal.

His birth and development history were not available. He completed his 12th standard and joined in the LIC. He received promotion in the job appropriately and was retired as senor officer. He was married at the age of forty to a woman who was twelve years younger to him. He has one son who is twenty two years old studying for engineering. He stays in a nuclear family and family life was satisfactory. He was heterosexually oriented and was not having any high risk behaviour. After the onset of the illness he did not had any sexual intercourse.

PREMORBID PERSONALITY

He was well adjusted, responsible in work and had good social interactions. He was interested in religious activities and interested in visiting religious places. He was also interested in gardening.

GENERAL PHYSICAL EXAMINATION

Vital signs were normal. Autonomic function tests were normal. There was no pallor, icterus, pedal edema clubbing, or generalized lymphadenopathy. There were no features of vitamin B12 deficiency or any features of hypothyroidism. Fundus showed hypertensive changes.

Hyporeflexia in angle jerk. Mild activated rigidity present without any other features of EPS .Other CNS examination were normal. Examination of other systems were normal .

MENTAL STATUS EXAMINATION

Patient was moderately built and adequately kempt. He looked adequately nourished and maintained eye contact .A fairly good rapport was established initially .Mild psychomotor agitation was noted during the interview and patient refused to cooperate further .There were no abnormal movements noted .He was alert and conscious

Attention -was aroused without prompting.

Digit repetition – Normal (5 digits forward and 3 digits backward.)

Concentration – Serial subtraction (100-7 or 20-3) Impaired.

But on tasks he was able to sustain his attention.

Vigilance – Random letter tap test –indicated only twice

Orientation – Not oriented to year, season, month, day of the week, date and time, hospital, floor and room .

Oriented to country, state and place.

Oriented to self, spouse, nurse and doctor.

Comprehension – Able to follow three step command.

Language – Right handed.

Spontaneous speech – initiation, content, volume, prosody grammar, word finding,

Paraphasias, semantic, phenomic – Normal

No neologisms .

Word output – less

Fluency – word output less ,

mental flexibility, word output, semantic, phenomic – Normal

Naming and word finding – confrontation naming – Normal

Repetition – Normal .

Reading and comprehending - Reading aloud - Normal

Comprehension – Absent

Writing – Copy - letter, words, sentences - Normally .

From memory – Absent .

Spelling – dictated words – Normal

Memory – Registration (digit forward) normal

Working memory -5 to 7 digits backwards / two step mental calculation absent

Semantic memory- Last chief minister -Normal

Current CM -Not able to

Episodic – DOB, first school, and family - Normal .

New Learning ability – Verbal memory and visual memory (5unrelated words and 5 hidden objects)

1 minute – one ; 5 minutes – two ; 30 minutes – nil

Thought did not reveal any abnormalities in thought processes, content or possession

There were no hallucinations .

Mood was subjectively and objectively happy ,reactivity was increased but was appropriate .

There were no suicidal ideas ,compulsive phenomena or abnormalities in volition .

His intelligence was not able to assess due to the predominant memory problems .

His insight was not able to be assessed due to the predominant memory problems .

His judgement was adequate .

PROVISIONAL DIAGNOSIS

Dementia Causes – D/D Vascular dementia (multi infarct state)

To r/o reversible causes of dementia .

Old intracerebral bleeds - Causes –D/D Hypertensive bleed

Amyloid angiopathy

Diabetes mellitus type 2 with neuropathy

Essential hypertension with retinopathy

Old Ischemic heart disease .

AIM OF PSYCHOLOGICAL TESTING

The patient was apparently alright and functioning well .Following the stroke he developed sudden onset of memory problems which improved mildly in the initial few months but remained static after an year .A neuropsychological testing was considered to corroborate the diagnosis, assess cognitive profile and lobe functions and to assess the progress and plan rehabilitation .

LOBE FUNCTION TESTS

FRONTAL LOBE

No evidence for frontal release signs .

No evidence for aphasia or contra lateral hemiparesis apathy or abulia.

Attention was aroused but was not vigilant

Associated with poor insight (due to memory problems)

No disinhibition or environmental dependency syndrome

No echopraxia / echolalia

Concept formation –Normal

Abstract thinking – impaired

Reasoning – Not attempting

Effective perfast –Not attempted

Alternate use test – Normal

Perseveration – Alternate motor pattern – only twice

Repetitive sequential pattern – impaired

Go – no – go test –impaired

Motor impersistance – Not present

TEMPORAL LOBE

Visual field defect – inferior quadrant in both eyes defective

Memory –Recent and new learning – impaired

Remote – Normal

PARIETAL LOBE

Cortical sensations - Normal (stereognosis ,2-point discrimation ,tactile stimulation ,graphasthesia

and barognosia)

Eye – No optokinetic nystagmus ,visual field defect or forced eye closure .

RIGHT

Neglect –Spatial neglect –Line bisection test normal.

Sensory neglect – Double simultaneous stimulation and face hand test –Normal .

Motor neglect – Normal (reacting to stimuli coming from that side)

Geographic – Not able to localize places in a house or draw a plan and show nursing station .

Apraxias – Able to copy diamond, 2Dcross and overlapping pentagon..

Draw to command- Clock – drew the number but not the needle .

LEFT

Ideomotor –Buccofacial – Normal (blow out a match)

Limb – Normal (salute / comb hair)

Whole body – Normal (stand as if praying)

Ideational - Patient was uncooperative, so not done

Left right finger gnosis - Patient was uncooperative, so not done

Calculation – Mental calculation – Not able to do .

Paper pencil calculation – Verbal rote – Uncooperative for this .

Verbal complex - Uncooperative for this .

Written complex – Normal

OCCIPITAL LOBE

Vision –acuity –Normal

Field – Impaired

Color – Ischiara chart – Normal

Face gnosis / known pictures –Not given to do

Simultagnosia - Not given to do

LEFT

Color identification and naming –Normal

Color matching - Not able to do .

Object gnosis – Show and ask name – Normal

Alexia without agraphia - Not present

RIGHT

Enviornmental agnosia – Not present

CONCLUSION

Deficit was evident across lobe functions.

MANAGEMENT

The diagnosis of Dementia was discussed with family members and psychoeducation was given. Tab.Donapezil 5 mg was started after discussing with family members. Serial reviews and further assessment was planned.

REHABILITATION MEASURES

Detailed discussion was held with family members and suggested frequent reorientation and small changes in home environment to avoid confusion.

CASE REPORT III

Name : James

Age : 28 years

Sex : male

Marital status : single

Religion : Christian

Socioeconomic status : middle socioeconomic status

Education : engineering graduate

Occupation : unemployed

Informants : brother not a reliable informant as he was staying with the patient only for the past two days.

PRESENTING COMPLAINTS

Irritability and Suspiciousness since three to four months

Tall claims assaultiveness and decreased sleep since four days

MODE OF ONSET

Insidious

PRECIPITATING FACTORS

Nil

HISTORY OF PRESENTING ILLNESS

Ten yeas back when patient presented with depressive symptoms like anhedonia, easy fatigability, low mood decreased concentration and memory feeling of worthlessness

and hopelessness he was treated with antidepressants but discontinued the medication in less than a month due to the side effects. Details of his clinical status were not known but he had consultations with multiple medical practitioners and underwent numerous investigations over the next five to six years. During this period he completed his PUC, BSc and had joined for MIT in Chennai. In 2004 he was treated with antidepressants and antipsychotics when he presented with depressive symptoms with psychotic features. He seemed to have been on regular antidepressants till date when he presented .While on medication he presented with three to four months history of suspiciousness towards family members ,talkative ,had spoken proud of himself, and was hyperactive . He had engaged in odd behaviors like sending telegrams that his family members were dead etc He presented with high irritability , assaultiveness and occasionally threatened to kill himself or other family members . He claimed that he had lodged a complaint with the supreme court and CBI regarding his threat and they were on their way to catch the relatives .The symptoms were worse when he claimed that he heard strange noises that people were coming to kill him .Patient claimed that God had given him information with which he had escaped from several attempts in his life .There were no history of head injury ,high grade fever , loss of consciousness ,seizure, or vomiting preceding this episode There was no history of any substance abuse .

TREATMENT HISTORY

Patient had received parental antipsychotic before being brought here .

PAST HISTORY

Patient had been on antidepressants and antipsychotics at various period of time following a diagnosis of depression and psychotic depression . He was also treated as somatization disorder at various point of time .

FAMILY HISTORY

Patient was the youngest of the two siblings of a non consanguineous marriage . He was adopted by his paternal uncle as they did not have any children. There was no family history of any mental illness

PERSONAL HISTORY

Birth and development history was within normal limits .He was a brilliant student and and a rank holder in BSc .He joined electronics and currently was preparing for his GATE exam.

PREMORBID PERSONALITY

He was described to be an introverted, responsible and affectionate person

MEDICAL HISTORY

There was no significant medical history .

PHYSCICAL EXAMINATION

Patient was well build , ill-kempt, was argumentative and restless . He was not cooperative but playful and irritable. He was distractible but able to carry out simple orders . Primary mental functions were intact .The speech was loud ,excessive, spontaneous, garrulous and over familiar .No formal thought disorder was noticed . Mild acceleration of thought processes was seen .He had persecutory delusions that his relatives were trying to harm him .This delusion was the prominent presenting symptom during presentation He had grandiose beliefs and denied perceptual abnormalities. Mood was subjectively reported to have been happy and confident .He denied any suicidal ideas. Objectively he appeared cheerful and was irritable frequently .Intelligence was average. He had no insight and judgment was impaired

DIFFERENTIAL DIAGNOSIS

1.Bipolar affective disorder currently mania with psychotic symptoms

2.Schizoaffective disorder - bipolar type

AIM OF PSYCHOLOGICAL TESTING

The two differentials were considered because of lack of a clear history .The cross-sectional picture had sub-syndromal manic symptoms, but the mood incongruent

psychotic beliefs dominated the picture .Again in the past there were depressive symptoms but the psychotic syndrome persisted in excess of mood symptoms .So a psychological testing was essential to clarify the diagnosis .

BEHAVIOURAL OBSERVATION:

The subject was neatly dressed and well groomed. He maintained eye contact but had a blank expression on his face. He would seldom smile and would be irritable most of the time. He approached the tasks presented to him in a mechanical fashion but completed each task well. He was concerned about his performance on the tests.

PSYCHOLOGICAL TOOLS USED:

1. Eysencks Series of Digit Span Tests (E.S.D.S.T.)
2. Bender Gestalt Test (B.G.T.)
3. Sacks Sentence Completion Test (S.S.C.T.)
4. Thematic Apperception Test (T.A.T.)
5. Rorschach Ink Blot Test

DETAILS OF TEST FINDINGS:

On ESDST the subject had a fair level of attention and concentration

On BGT the drawings were indicative of intact visuomotor functioning

On the SSCT conflicts were noted in the area of family especially with the father. He also has a very strong attachment with his mother. There appears conflict in the area of self, related to fear and guilt about past. There is a strong desire for achievement and the future is viewed as positive.

On the TAT, the stories were brief, structured and the themas were simple. There is a high need for succorance and the hero in most stories shows dependence on others. The environment is anxious and indicates interpersonal conflicts but the outcome of the stories is positive and optimistic. Strong achievement needs are also seen.

On the Rorschach, the protocol is suggestive of an individual who has difficulty identifying the most economical ways of handling a task demand. He is a victim of

unfulfilled needs, desires and conflicts. This orientation arises from a need to avoid failure. The individual has very low tolerance for stress. He has sufficient resources to deal with stress but they are not organized in a manner that makes them accessible. He has an introversive style in that he is prone to use his inner life for basic gratification. He has constraint over his affect but maybe aggressive under unmet need states. He often experiences frustration due to striving to accomplish more than is reasonable. Thus he invests more effort in the task than is necessary. He also tends to have control over affective displays.

He has atypical ways of thinking and tends to translate stimulus inputs with difficulty. He is experiencing severe psychopathology but does possess cognitive flexibility. He has avoidance tendencies but has adequate level of self-concern.

IMPRESSION

The individual is experiencing severe psychopathology. He is having delusions and hallucinations and is impulsive and aggressive. He has conflicts with father and has fear and guilt. He needs succorance and has a high need for achievement. He has unfulfilled needs and strives to avoid failure. He has low frustration tolerance but has a strong positive outlook.

DIAGNOSIS

Schizoaffective Disorder

MANAGEMENT

Pharmacological – Atypical antipsychotic.

Non Pharmacological

- Education and support of family
- Supportive therapy for patient
- Cognitive therapy for negative cognitions

CASE RECORD IV

Name	:	R M J
Age	:	16 years
Marital Status	:	Single
Religion	:	Christian
Socioeconomic status	:	Middle socioeconomic status
Education	:	9 th standard
Occupation	:	Student
Informants	:	parents

PREENTING COMPLAINTS

Abnormal movements of the body

DURATION

3 months

MODE OF ONSET

Sudden

PRECIPITATING FACTORS

Problem in relationship with opposite gender

HISTORY OF PRESENT ILLNESS

Patient had the first episode of abnormal movements of the body three months back. It occurred at school and was characterized by hyperextension of both upper limbs, with

flexion of the neck with eyeball moving upwards followed by a loud cry. Patient was fully conscious but could not speak. Each episode lasted for ten to fifteen minutes. This was not associated with any incontinence or generalized tonic clonic movements. Such episodes had occurred multiple numbers of times at school. At times this used to occur three to four times in succession in a short span of time with full recovery in between the episodes. Such episodes were very infrequent at home. There were no such episodes during sleep. Last episode was ten days back. There were no history of headache or vomiting or any features suggestive of neurological deficits. There were no histories of head injury or substance abuse. There were no histories suggestive of depressive, manic or psychotic or obsessive compulsive or anxiety symptoms.

The onset of symptoms had a temporal correlation with few stressors following a warning by the headmistress and parents, for the love affair with a boy of the same school And in the same week some unknown person make some sexual advances towards her. Other stressors elicited were, difficulty in studies, the problem in relationship with younger sibling and the critical attitude of the parents.

PAST AND MEDICAL HISTORY

A neurologist treated her as a case of seizure disorder. She was started on carbamazepine in adequate dosages and duration, but with no improvement in the symptoms. She was also seen by a psychiatrist in the initiative of the parents as she had attempted suicide six months prior to this following an argument with mother .She was also treated with benzodiazepines and beta blocker without any improvement in the symptoms .In CMC the CT scan was reviewed and endocrinology consultation was made as she had been treated elsewhere on the basis of abnormal findings on this. However there were no abnormality in these on detailed workup and organicity was ruled out .EEG was also normal.

DEVELOPMENTAL HISTORY

All the developmental milestones were normal She was adaptable to situations but her intensity of reaction used to be high. No abnormal behaviors were otherwise observed. She started her schooling at five years of age. She had changed school twice due to the

academic difficulties from a high functioning to a low functioning school. Currently she was studying in tenth standard.

PERSONAL HISTORY

She had very few friends of the same gender and most of them were younger to her. She preferred to be alone and spent time watching television. She was quite adamant and harsh in her relationship with the younger sibling. Her moral and religious values were adequate.

FAMILY HISTORY

She was the eldest of the two siblings. The youngest sibling was eight years old and studying in third standard. Father was an electrical supervisor working in Saudi Arabia for the last twelve years. He came home once in two years. Mother was a housewife and had studied up to PUC. Both the parents have high expectations of the patient to get her into either engineering or a medical profession. The mother mainly did disciplining. Patient was more attached to her father .He seemed to yield to many of her demands. They stayed in a nuclear family and had good social support from neighbors and relatives One of her second-degree relatives had epilepsy. There were no significant family histories.

PHYSCICAL EXAMINATION

General physical examination and systemic examination was normal.

MENTAL STATUS EXAMINATION

The patient was thin built and was dressed appropriately. She looked anxious and defensive but maintained eye contact. Her attention was aroused but concentration could not be assessed as patient was anxious and did not cooperate for formal assessment. Reading and writing were normal. Rate of speech, tone and quantum was reduced. Reaction time was increased and she needed frequent prompting. Stream of thought was retarded, but there were no abnormalities in the form and possession of thought. Abstraction could not be assessed .She looked mildly anxious but subjectively

said that she was happy. There was no perceptual abnormality or suicidal ideas. Her defense organization was immature and the intelligence could not be assessed as she was defensive .Her test judgment was normal, insight was impaired and self-esteem seemed to be poor. Her adaptive capacities and coping strategies and problem solving skills needed further detailed assessment, as she was not cooperative.

DIFFERENTIAL DIAGNOSIS

1. Dissociative convulsions

2. Cluster C personality traits

3. Low average intelligence

AIM OF PSYCHOLOGICAL TESTING

Patient seemed to have been an introverted person with, poor coping and poor adaptability. There was a clarification needed to know whether any personality trait was contributing or causing these problems. During her inpatient stay it was observed that her comprehension, general vocabulary, responsiveness, drawing ability and calculation were poor. Hence it was decided that her intelligence be quantified.

TESTS ADMINISTERED AND RATIONALE FOR THE SAME.

1.High School Personality Questionnaire (HSPQ)

To find out the personality profile across various personality dimensions.

2.Thematic Apperception Test (TAT)

It was given to find the level of psychopathology and to throw light on patient's personality and inter personal relationships

3. Modified Jaloweic Coping Scale

It was administered to assess the adaptability and type of coping skill used.

4.Incomplete sentences blank-High school form

It was administered to evaluate patient's attitude, adjustment, interpersonal functioning and self-concept.

5. Binet- Kamat Test (BKT)

It is a tool well standardized for the Indian population. Apart from giving an overall IQ it also gives a function wise classification of the patients mental age

6. Ravens Progressive Matrices (RPM)

It is a test used to assess nonverbal intelligence.

BEHAVIORAL OBSERVATIONS

Patient was motivated for testing. Her comprehension of instructions was adequate. She appeared to lack confidence and needed to be initiated into each task. Her attention and concentration were adequate. There was difficulty in accepting failures.

SUMMARY OF TEST FINDINGS

She was found to have low average level of intellectual ability. There was difficulty in meeting the expectations of others leading to feelings of frustration and low self-esteem. Her ability to achieve was poor. There was fear of authority and difficulty in facing situations, which she considered threatening. She was unable to overcome obstacles. Feelings of helplessness and worthlessness were evident. Strong dependency needs were present. Uncertainty, timidity and insecurity were present. She was evasive and did not use a confrontative coping style. An emotional coping style was more predominant.

CONCLUSIONS

Tests revealed feelings of decreased self-esteem, anxiety, uncertainty, insecurity and apprehensiveness about issues in life. High affection and dependency needs were present and this had lead to helplessness and suffering. Her low average intelligence

and poor coping skills and the high expectation of the relatives contributed to her problem. Test findings were suggestive of cluster C personality traits.

DIAGNOSIS

1. Dissociative convulsions
2. Cluster C personality traits
3. Low average intelligence

MANAGEMENT

Rapport was established with the patient the secondary and primary gains were addressed the various stressors were elicited .The poor coping and adaptability, lack of assertiveness and low self-esteem were addressed. Based on the low average IQ it was advised to reduce the stress related to studies and to have realistic expectation. Parent's worries and concerns were also addressed.

CASE RECORD V

Name	:	RG
Age	:	14 years 6 months
Sex	:	male
Religion	:	Hindu
Socioeconomic status	:	Middle
Education	:	7 th standard
Informants	:	parents

PRESENTING COMPLAINTS

Poor scholastic performance since early school days

Dislike in attending school since six months.

MODE OF ONSET:

Insidious

HISTORY OF PRESENTING ILLNESS

He was sent to school at three years of age and was average in the studies in the initial few classes .However he gradually started having difficulty in reading complex sentences and in calculation .He was then shifted to a different curriculum in a low functioning school. In class six he had failed once and was currently in class seven during his visit to the hospital. He had been regular to school and but for the past six months prior to the visit had discontinued.

Previous consultations – at one and a half years of age he was not able to close the left eye lid with pupils rotated medially .He underwent surgery the following year,

the details of which are not known .Two years later he had a sudden deviation of angle of mouth to right side with sixth and seventh cranial nerve palsy. CT scan showed the left lateral ventricle mildly dilated with hemi atrophy features .No specific treatment was advised Five years later he developed mild weakness of the upper limb and was advised physiotherapy .In 2003 the repeat CT scan showed parenchymal volume loss in left hemisphere.

There was no history suggestive of seizures, psychosis, depression, obsessive compulsive disorder, tics or other pervasive developmental disorder.

FAMILY HISTORY

Patient was the youngest of the three siblings born out of a non consanguineous marriage. There was history of mental retardation and seizures in the second degree relative.

BIRTH AND DEVEOPMENTAL HISTORY

There was no significant prenatal history. Perinatal and postnatal period were uneventful

Milestones of development:

Motor milestones - He attained head control and turning at 4 months, sitting at 8 months, standing at 1year ,and walking at 11/2 years .

Currently motor functioning is normal except for mild weakness if right upper limb which is present since 6 years of age.

Speech and language development - cooing at 2 months ,first word at 10 months and two words at 1 year and sentences at 11/2 years .

Currently able to speak in simple sentences.Has articulation errors and speech fluency is affected.

Adaptive and play skills –involves in purposeful activities, watches TV in leisure time.

Socialization - recognized the mother at the normal time, social smile at 2 months, responded to name at 4 months

Currently interacts only with siblings and family members.He does not mingle with classmates and is socially inhibited.

Self care activities – He was independent in all activities

Schooling – He started schooling at three years of age and continued till sixth standard. He had failed in one class .He was regular to school till six months back .The school was changed from a high functioning to a low functioning one due to the difficulty in studies. He had difficulty in reading, understanding and doing simple calculation.

PHYSICAL EXAMINATION

General examination was normal .CNS examination revealed speech problems in tone, word output, articulation, comprehension, reading, writing, grammer and in calculation. Intelligence seemed to be compromised .Cranial nerve examination revealed 6^{th} nerve involvement in the left side.Motor examination showed mild weakness on right sided limbs.

Other systems were within normal limits.

PROVISIONAL DIAGNOSIS

Axis 1 - Mental retardation – unspecified without behavioral problem

Axis 2 – mental retardation and epilepsy in the family.

Axis 3 – 6 ,7 cranial nerve involvement ,hemi atrophy of the brain .

Axis 4 – Nil

Axis 5 – overprotective parents.

AIM OF PSYCHOMETRY

To quantify the severity of mental retardation and to assess his areas of relative strengths and weaknesses.To plan for intervention and management.

TESTS ADMINISTERED

Vineland Social Maturity Scale (VSMS) : This scale measures the differential social capacities of an individual .It provides an estimate of social age (SA)and Social Quotient (SQ)

Binet- Kamat Test (BKT): It is a tool well standardized for the Indian population .Apart from giving an overall IQ,it also gives a function wise classification of the patients mental age .

BEHAVIORAL OBSERVATION

Patient was cooperative through out the period of observation. He maintained eye contact and no abnormal behaviors were noticed .His attention and concentration were adequate.He could comprehend and follow instructions.

TEST FINDINGS

Vineland Social Maturity Scale

His overall social maturity was found to be around 8.53 years . With regard to the functioning of the patient across the different social capabilities the following profile was obtained .

Self help general – 7.28

Self help dressing - 8.85

Self help eating - 9.03

Communication - 6.15

Self direction - 9.38

Socialization - 5.63

Locomotion - 5.83

Occupation - 8.50

Social Maturity-8.53 years level

Binet- Kamat Test

Language – 6 years

Memory (meaningful)- 5 years

Memory(non-meaningful)- 6years

Thinking (conceptual)-below 7 years

Thinking (nonverbal)-6 years

Verbal reasoning-below 12 years

Numerical reasoning-9 years

Visuo-motor-7 years

Social intelligence-8 years

Basal age:6 years

Terminal age:10 years

Mental age: 6 years and 10 months

Chronological age: 14 years and 6 months

IQ - 47

FINAL DIAGNOSIS

Moderate mental retardation

MANAGEMENT

Parents were counselled regarding the nature of his disability, course and outcome.The need for developing his social, communication and self –help skills were emphasized. They were asked to attend the special education classes for the same. Functional academics training, occupational therapy and vocational training were planned.