PSYCHOLOGICAL CASE RECORD

SUBMITTED TO THE DR. M. G. R. MEDICAL UNIVERSITY IN PART FULFILLMENT OF THE REQUIREMENTS FOR THE DIPLOMA IN PSYCHOLOGICAL MEDICINE EXAMINATION 2010

BY

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VELLORE-632002

CERTIFICATE

This is to certify that this psychological case record is a bonafide record of work done by **Dr. Cattamichi Vinila** during the period 2008-2010. I also certify that this record is an independent work done by the candidate under my supervision.

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DR. CATTAMICHI VINILA

CONTENTS

CASE RECORD 1

Name	: Mr.MS
Age	: 23 years
Sex	: Male
Marital status	: Unmarried
Religion	: Hindu
Language	: Bengali
Education	: 10th standard
Occupation	: Electronic mechanic
Socio-economic status	: Middle
Residence	: Urban
Informant	: Parents

Presenting complaints

Recurrent episodes of complex partial seizures - since eight years of age

Mode of onset - abrupt

History of presenting illness

The episodes started when Mr. MS was eight years of age. Episode starts with lip smacking, rubbing his hands together clinching with vacant stare look. He would be found unresponsive on call. After twenty to thirty seconds, he became responsive. There was no major confused state after the episode. When tried to clarify by others nearby what was happening, he could not recollect whether any such episode has happened. There was a history of post ictal state with left lower and upper limb

weakness associated with fever. By 3 days fever subsided and his weakness improved to normal by one month. There was no aura or hallucination. There was no a tonic-clonic movement or incontinence or frothing or loss of consciousness with postural fall suggestive of generalized tonic-clonic seizure.

Four years later he had second episode of similar semiology except no history of limb weakness or association with fever. Since then starting the frequency of episodes used to be 1-2 times per month but past three years frequency increased to 5-6 times per week.

Patient had poor scholastic performance due to seizures so dropped of school after 10^{th} standard. Patient had few episodes occur at work place. Patient had injury during the episodes and sometimes while working as he develops seizures.

Frequent episodes which started affecting his daily activities and also increased in frequency of episodes, and uncontrollable on medication he was brought to CMC for expert opinion. In view of mostly daily episode of seizures and poor control with antiepileptic and side effects of medicine option of surgery was considered. There was a one year history of recent memory impairment and increased anger outburst.

There was no history of apathy or emotional labiality or sexual disinhibition.

There was no history of forgetfulness or difficulty in speech.

There was no history of apraxia or difficulty in calculation.

There was no history suggestive of psychosis or syndromal depression or mania.

There was no history of deviant personality traits or obsessions or compulsions.

There was no history of phobia or panic attacks.

There was no history of head injury.

His biological function was reportedly normal. He still continued to his basic and instrumental activities of daily living independently.

TREATMENT HISTORY:

Initially patient was started on Carbamazepine. Within two weeks he developed Steven Johnsons syndrome like bulbous lesion with fever, tachycardia and hypotension for which Carbamazepine was stopped but no details on dose. He was then started on valproate but stopped himself as there was no reduction in frequency of episodes. Patient was irregular on medication since 2001. For past one year he was restarted Tegrital and added in-between Clobazam with Levitracetam regularly. Currently on Zen retard 600mg twice daily with Levitracetam nearly 2500mg but frequency reduced from 5-6 to 3-4 episodes per week.

Family history

There was no known relevant neuropsychiatric morbidity in his family.

Birth and development history

He was born to non-consanguineous union in 1986. The pregnancy was planned and the antenatal period was supervised and uneventful. Delivery was full term normal vaginal; with no birth asphyxia and birth weight of 3.0 kgs. Postnatal period was uneventful. The developmental milestones were reported to be normal.

Educational history

He had studied up to 10^{th} standard. He was described to be average in academics. He discontinued studies due to poor scholastic performance and increased frequency of seizures. His relationship with his peers and his teachers was warm.

Occupational history

He was working and in his own electronic shop like repairing cell phones for the past eight years after 10^{th} standard. He was regular to work. There were a few episodes of work-related injuries due to him developing seizure episodes while working.

Sexual history

He had heterosexual orientation. He denied any premarital high risk sexual behavior. There was no masturbatory guilt or any sexual misconception.

Marital history

He was unmarried.

Premorbidly personality

He was described to be a sociable and hardworking person. He was religious and responsible towards work and his family. There was no history of any substance use.

Physical examination

His vitals were stable. There was no pallor or lymphadenopathy. Post traumatic scars on forehead. There was no gingival hypertrophy. His cardiovascular system examination, respiratory system examination and gastrointestinal system examinations was normal.

Central nervous system

Higher function – Mini Mental Status Examination (MMSE) 30/30

Cranial nerves – No cranial nerve palsies

Motor system

Bulk - Normal bilaterally

Tone - Normal tone bilaterally

Power - Grade 5 power bilaterally

No involuntary movements

Sensory system

Crude touch, Pain, Temperature - Normal bilaterally

Light touch, Vibration and Joint position sense - Normal bilaterally

Reflexes

Superficial abdominal reflex - Present all four quadrants

Plantar reflex - Flexor bilaterally

Deep tendon reflexes - 2+ bilaterally

Cerebellar functions - No signs of cerebellar dysfunction

Gait - Normal

Meningeal signs - Absent

Skull and spine - Normal

Investigation:

EEG: (24/2/09) interictal record of generalized seizures.

EEG WITH TELEMETRY (24/6/09): Suggestive of right temporal onset and fast spread to other region.

MRI BRAIN: Right hippocampal sclerosis

Mental status examination

He was well built and nourished, and was adequately kempt. Eye contact could be maintained. Rapport was established. There was no restlessness or over activity or abnormal involuntary movements. His primary mental function was intact. Attention and concentration could be aroused easily and was sustained. He had good immediate, recent and remote memory. He was oriented to time, place and person. Speech was audible with no deviation.

There was no formal thought disorder. There were no depressive cognitions. But he expressed his distress associated with uncontrolled episodes. There were no delusions. There were no obsessions and compulsions. His abstract thinking was normal. He denied having any perceptual abnormalities. There were no predominant mood symptoms. He did not report of any suicidal ideation. His intelligence was average. He had grade 5 insight into illness. His personal, social and test judgments was intact.

Provisional diagnosis

Complex partial seizures – poor response to medications

Past history of hemi paresis

Aim for neuropsychological testing

1. To find out the cognitive profile of Mr. MS as posted for neurosurgery
2. To identify the neuroanatomical and neurophysiological sites of lesion
3. To have a baseline cognitive functioning prior to surgical options

Behavioral Observation:

Patient was alert during testing. He was motivated and cooperative. He was able to comprehend the instructions.

Tests administered

Mini-mental state examination:

MMSE was introduced by Folstein in 1975. It was being introduced as a screening for gross cognitive impairment. It can help to confirm diagnosis, assess the severity and, monitor the progress and outcome of treatment. MMSE measures orientation, attention and calculation, immediate and short-term recall, language, and ability to accomplish simple verbal and written instruction as well as visual construction. The total score is 30.

Test findings

The MMSE score was 30 indicating intact orientation, attention and calculation, immediate and short-term recall and language. The ability to accomplish simple verbal and written instruction as well as visual construction too was normal.

NIMHANS Neuropsychological Battery:

Developed by Dr C R Mukundan. This tests a subject's performance across lobe functions. It had been validated to suit the Indian adult population. It comprises of a series of tests that test the following functions

Frontal lobe: Attention, scanning, ideational fluency, abstraction, delayed response learning, execution of motor tasks

Parietal lobe: Perceptual (Bender visual motor Gestalt test), visual analysis and synthesis (Block design test), test for spatial relations and tests for parietal lobe focal signs

Temporal lobe: Sentence repetition, comprehension, verbal learning and memory, visual integration (Object assembly test), visual memory (Benton's visual retention test) and visual learning and memory

Test Findings:

On NIMHANS Neuropsychological Battery his attention could be aroused and sustained for an adequate length of time. His performance on test of scanning, trail making and tests of kinetic melody was adequate. He performed adequately on execution of motor tasks, kinetic melody, abstract ability and ideational fluency. There was no motor perseveration evident. His expressive and receptive speech function was adequate. However, his ability on working memory was inadequate. His visuo-spatial and perceptual functions, visual integration and visuo-constructive skills was impaired as evident on BGT (micrographia, angularation, disjointed), Block-design test as well as on copying of three dimensional diagrams. There was no evidence of any form of agnosia, apraxia or body schema disturbances. His comprehension ability, memory for simple sentences and verbal learning memory was adequate. His associate learning ability and visual learning memory was impaired.

Conclusion

Neuropsychological assessment revealed bilateral temporal and right parietal involvement with mild deficits in prefrontal cortex. These findings correlate well with the clinical presentation of complex partial seizure.

Management

Mr. MS and his parents were educated on the nature of illness and the results. The distress was acknowledged.

He was referred back to Department of Neurology for surgery right amygdala hippocampectomy which is within a week. He was advised to review after the procedure to assess the cognitive impact of neurosurgery.

CASE RECORD 2

Name : Ms. G

Age	: 19 years
Sex	: Female
Marital status	: Unmarried
Religion	: Hindu
Language	: Tamil
Education	: 12th standard complete
Occupation	: Currently unemployed
Socio-economic status	: Middle
Residence	: Rural
Informant	: Parents

Presenting complaints

Irritability	- two months duration
Decreased sleep	- two months duration
Adamant	- two months duration
Impaired activities of daily living	- two months duration

History of presenting illness

From early childhood onwards, Ms. G was reported to be adamant and demanding in nature. She had poor frustration tolerance that even for trivial incidents at school or at home she would be angry and sometimes agitated. She was brought with history of episodic illness currently being the 3rd episode with inter morbidly reaching premorbid level of functioning. Initial episode was in November 2005 being different from other two episodes. Initial episode was at age of 15 years characterized by one week history of irritability, crying spells, low mood, body aches, nihilistic

ideas that intestine and uterus was absent. She had decreased concentration in studies and decreased memory. She reported decreased sleep and appetite. She also reported hearing non existing voices. Stressor was the death of her grandfather just six months before the episode whom she loved the most. There was gross impairment of instrumental activities of daily living. She gradually improved on medication but was irregular on medication. Mother reports hearing of nonexistent voices continued during reviews which patient always denied. She completed her 10^{th} standard during that period.

The last two episodes she had was similar characterized by wandering, irritability, crying most of time, more adamant and demanding than premorbid condition. She also had hearing of non existing voices and smiling to self with decreased sleep and appetite. Previous episode she presented with one month history in August 2006 and reached premorbid functioning within one month and finished her 12^{th} standard. She was on antipsychotic only. Lost follow up for 3 years and now presented with one month history of similar symptoms as previous episode except that she can hear Gods voices who was demanding her for things like pumpkin, lemon and asking her to pray. She keeps changing clothes more than three times per day, and saying she can achieve anything in life like she can earn lot of money, buy jewels and take care of herself. She keeps fighting with her parents most of the time and blaming them as she cannot fulfill her dreams because of them not letting her to study further. She breaks things at homes when her demands are not meet immediately. Her grandmother and relative give whatever she wanted like money or get things she wanted when she becomes irritable or breaks things. There was also history of weight gain on medication and amenorrhea.

There was no history suggestive of first rank symptoms.

There was no history of expressing false belief with conviction.

There was no history of any abnormal perception.

There was no history of phobia or panic attacks.

There was no history suggestive of organicity or seizures or head injury or loss of consciousness.

Treatment history

She was initially on Fluoxetine 20 mg/day and Olanzapine 7.5mg for depression and psychotic symptoms. She gradually improved and started tapering olanzapine. She developed manic and psychotic symptoms so Fluoxetine was stooped and restarted olanzapine 10mg/day. In between for past 3 years off medication and came on carbamazepine 200mg and olanzapine 5mg started outside. She was restarted on medication and currently on Carbamazepine 600mg as mood stabilizer, risperidone 6mg as had weight gain on olanzapine and pacitaine 2mg to prevent extra pyramidal symptoms past one month.

Family history

She was the eldest of three siblings. She was born of non consanguineous marriage, from joint family. Her grandmother was described to be authoritarian in parenting. There was history of mother diagnosed bipolar affective disorder on carbamazepine prophylaxis and hypothyroidism past 15 years and also her younger sister being treated in MHC probable mood disorder details not clear.

Developmental history

The antenatal period was supervised and uneventful. Delivery was full term normal vaginal; with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. The developmental milestone was reported to be normal.

Educational history

She had finished 12th standard but her parents stopped as had to go to town 30km away from home. Her academic performance was reported to be average. She had good interaction with her peers and but limited interaction with her teachers.

Sexual development

She attained menarche at 12 years of age and had irregular cycles. She had female gender identity and heterosexual orientation. There was no masturbatory guilt.

Marital history

She was unmarried

Premorbid personality

She had been very adamant and demanding in nature and would do anything to get things done her way. She was sociable and but had only two to three close friends. She was reportedly responsible but very ambitious. She had poor moral standards.

Physical examination

Her vitals were stable. A systemic examination was within normal limits.

Mental status examination

She was moderately built. She was well kempt. Eye contact could be made and maintained. Rapport could not be established. She was irritable and restless. Her level of activity was increased and wants to go home. There was no abnormal involuntary movement. She was unco-operative. Her primary mental functions were normal. Attention and concentration could not be aroused and sustained. She had good immediate, recent and remote memory. She was oriented to time, place and person. Her speech was loud, with normal reaction time and speed. Form and stream of thought was normal. Content of thought revealed that she could earn lot of money, buy lot of jewels and take care of herself which parents feel abnormal but as per patient it is wish from small age resentment towards parents. The belief was strongly held but could be challenged. No delusions or a depressive idea was elicited. There was no thought broadcast or thought control or thought insertion. There was no perceptual abnormality. Subjectively, she expressed sad mood as parents not allowing to study and for bring her to hospital and forcing to take medication. She denied any suicidal ideas. There was no an obsession or compulsions. She had poor insight into her illness and intelligence was average. Her personal judgment was impaired.

Provisional diagnosis

Bipolar Affective Disorder currently Hypomania

Personality disorder

Aim for psychometry

1. To clarify symptomatology, psychopathology and diagnosis

Tests administered

1. Rorschach test
2. Thematic Apperception Test
3. Sacks Sentence Completion Test
4. 16 Personality Questionnaires

Behavioral Observation

During the entire exercise, she was cooperative. She could comprehend the instructions and paid adequate attention. She appeared well motivated.

Rationale & Findings:

Rorschach Ink Blot Test:

Provides an understanding of structure of the personality, needs of affection and ego strength. It also indicates degree of psychopathology.

Test Findings:

On the protocol she had given 26 responses indicating that quantitative analysis could be carried out. The Lambda score was high indicating that she has an avoidant style. Most of the responses was anatomical responses. She was chronically vulnerable to become more disorganized when there are stressors in life. Low adj D score indicated that the impact of stress creates considerable unacceptable patterns of thinking or behavior. Higher EB score indicates that she had an 'avoidant-extratensive style' indicated that she was more prone to be influenced by emotional stimuli and used emotions effectively in decision making. Potentially there was serious lapse in modulation of emotions.

There was significant meditational impairment. Reality testing was impaired and a psychotic-like process exists. Most of the responses represented distortion of reality. Less number of popular responses indicates the tendency to disregard social conventions in favor of individual needs or wants. More number of anatomical responses indicates severe impairment in reality testing and somatic preoccupation. There was increased tendency to think inflexibly and she had difficulty in attempting to think with alternative views. She had frequent distorted notions about herself. She had limited self-awareness & was very negative in decision-making and problem-solving capacity. She may be striving to accomplish more than may be reasonable in light of current functional capabilities. If this tendency occurs in everyday behaviors, the probability of failures was increased which may lead to frustrations. There was no cause of concern about the effectiveness of her meditational process however; she tends to make decisions that disregard social demands or expectations than do most people.

High Dd responses and less popular responses indicate an obsessive-like tendency toward perfectionism. She was more preoccupied by minute details of the stimulus field. On the special index of obsessive style, patient's protocol meets its criteria indicating that she had an obsessive approach to situations.

Impressions:

On the special indices, patient meets the criteria for Perceptual-thinking index (Psychosis) and Obsessive features.

Thematic Apperception Test:

Is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test

materials. It elicits information about a person's view of the world and his attitudes toward the self and others.

Test Findings:

On the TAT protocol, most of the stories were well structured. The recurrent theme was that of the hero being aggressive and acting out on her aggressive impulses. Mostly female heroes had been identified whose prominent need was need for achievement and aggression.

The environment in most of the stories has been perceived as hostile and threatening. Contemporaries had been perceived as rejecting while junior figures as deceiving. The significant conflicts that surfaced was aggression vs abasement and the main anxieties was that of deprivation and of being overpowered and helpless. The main defenses used by the hero was projection and reaction formation. Superego structure was found to be adequate.

Overall in the TAT stories, the integration of ego was found to be inadequate. However the outcome in most was realistic and happy.

Sacks Sentence Completion Test:

Projective test developed by Dr Sacks and Dr Levuy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Test findings:

On SSCT protocol patient revealed significant conflicts and disturbances in particular with Health, Fears and feeling of being rejected and unloved by father.

16 PF questionnaires:

Measures a set of 16 traits that describe and predict a person's behavior in a variety of contexts. It aims to provide comprehensive information about an individual's whole personality, revealing potential, confirming capacity to sustain performance in a larger role and helping identify development needs. It is an empirically based tool that helps to remove the subjectivity inherent in the interview or assessment process.

Test findings:

High scores on factors E, I and M indicate that she is very assertive, self - assured and independent. They tend to be austere, a law unto themselves, hostile or extra punitive, authoritarian and disregarding of authority. She was very emotionally sensitive, day-dreaming, artistically fastidious and fanciful. Sometimes she seemed to be demanding attention and help, impatient, dependent, temperamental and not realistic. In a group she might had difficulty in getting along and would upset group morale by undue fussiness. She was very unconventional, unconcerned over everyday matters, self-motivated, imaginatively creative, more absorbed in thought. Her inner directed interests sometimes lead to unrealistic situations accompanied by expressive outbursts. Her individuality cans her to be rejected in group activities. Low score on factor ‘O’ indicates that she had a strong sense of obligation and high expectation of

herself. She was more anxious and guilt-stricken over difficulties. She does not feel very comfortable to participate in groups.

Summary of Psychological Tests:

To summarize the findings, Rorschach findings showed predominant animal responses. There were very few popular responses and most of the responses did not show good form quality. They were minimal human responses and minus form quality lead the responses to fit into the perceptual thinking index which suggest impaired reality testing indicating the presence of psychotic features. TAT revealed inadequate integration of ego. However the outcome in most was realistic and happy. On SSCT, significant conflicts in areas of health and family context especially fears and feeling of being rejected and unloved by father was observed. 16P F revealed she was very assertive, self – assured, independent and authoritative. She had a strong sense of obligation, high expectation of herself and very anxious and guilt-stricken over difficulties.

Final Diagnosis:

Bipolar affective disorder currently hypomania

Management:

Rapport was established. Supportive psychotherapy was employed to expand personal abilities and skills. The need for cognitive behavioral approach for correcting negative automatic thoughts was discussed. The importance of addressing unlovable core beliefs was emphasized. Behavioral strategy with differential reinforcement of skill and maladaptive behavior was discussed. Structured schedule was discussed and developed. Problem-solving skills training were initiated with the help of occupational therapy department.

Ms. G was continued on carbamazepine as mood stabilizer and in view of good response to carbamazepine in her mother. Atypical antipsychotic, Risperidone, was continued in view of psychosis and for control of aggression.

Patient's parent was allowed to ventilate. They were psycho educated. The implication of test findings was discussed. At discharge Ms G was euthymic.

CASE RECORD 3

Name	: Ms. TL
Age	: 17 years
Sex	: Female
Marital status	: Unmarried
Religion	: Hindu
Language	: Bengali
Education	: 11th standard
Occupation	: Student
Socio-economic status	: Middle
Residence	: Urban
Informant	: Grand parents

Presenting complaints

Vomiting	- 10-12 months duration
Loss of weight 20 kgs	- 1 year duration
Impaired activities of daily living	- 1 year duration

History of presenting illness

Patient was apparently well till February 2008, except for anxiety during her exams manifested as tremors and palpitations. In February 2008 during her 10std final exam preparation she had been skipping meals and studying the whole night. She had loss of interest in pleasurable activities and had gradual decrease in appetite along with vomiting. She consulted a Gastroenterologist who diagnosed probable gastro

paresis and functional vomiting and started her on Itopride and setraline. Her appetite improved on medication but she continued to have vomiting and was referred to Psychiatry for further management. She was diagnosed to have Somatoform autonomic dysfunction upper GIT and asked to come for inpatient admission for detailed evaluation. Currently she presented with history of increased vomiting immediately after food, bloating following food intake, and loss of weight of nearly 20 kgs in the last one year, constipation and generalized weakness. She also had history of amenorrhea since past 6 months. There was no body image distortion. Her sleep was normal with no pervasive mood symptoms reported. Her symptoms had led to significant impairment in her daily routine and academic performance following which she eventually dropped out of school.

There was no history suggestive of first rank symptoms. There was no history of expressing false belief with conviction. There was no history of any abnormal perception. There was no history of mania or hypomania or phobia or panic attacks. There was no history suggestive of organicity or seizures.

Treatment history

She was on Setraline 25mg daily with Itopride for 6 months. She had stopped medication for the past one year.

Developmental history

The pregnancy was planned and the antenatal period was supervised and uneventful. Delivery was full term normal vaginal; with no birth asphyxia. The birth weight was 3.5kgs. Postnatal period was uneventful. The developmental milestone was reported to be normal.

Emotional development and temperament

She was described as a child with an easy temperament however was reported to be a very anxious person especially during exams.

Sexual development

She attained menarche at 12 years of age and had been having regular cycles, but amenorrhea was present for the past 6 months. She had female gender identity and heterosexual orientation.

School history

She started schooling at 4 years of age in a Bengali medium school. Her academic performance was reportedly average and she scored around 63% in her 10^{th} standard exam. There had been no failures.

Personal History

She preferred the company of children of the same age, however interaction was limited. She had few close friends. She was religious and followed social norms. There was no traumatic life events reported.

Family background

She was the eldest of two siblings from a non consanguineous marriage. Her father aged 42 years had studied up to 10^{th} and runs a business, her mother is a 33 year old and had studied up to 9^{th} standard. She comes from a middle socio economic background. She had younger brother studying in 9^{th} standard. From the time of her birth she was brought up by her maternal grandparents. She continued her schooling

in the same place as the facilities was better. She currently stays with them. There was no significant family history of neuropsychiatric morbidity.

Physical examination

She weighed 30kg with BMI 13.9. Mild pallor was present. Hers vitals and systemic examinations was within normal limits.

Investigation:

Routine blood investigation was within normal limits except potassium 3.3

Mental status examination

She was thin built and poorly nourished. She was adequately kempt. She was co-operative and rapport was established. Eye contact was made and maintained. There was no abnormal involuntary movement. Her primary mental function was normal. Her speech was of low tone, monotonous and with normal reaction time. Significant preoccupation with her physical symptoms was noted with overvalued ideas pertaining to health issues. No body image disturbances could be elicited. There was no feature suggestive of a formal thought disorder. No perceptual abnormalities or compulsive phenomena or volition abnormality was noticed. No suicidal ideation. Her intelligence was average. She had partial insight into her illness and her judgment was intact.

Provisional diagnosis

Anorexia nervosa

Psychogenic vomiting

To rule out mood and anxiety symptoms

Aim for psychometry

1. To rule out any underlying mood symptoms
2. To elicit probable stressors

Tests administered

1. Sacks Sentence Completion Test
2. Thematic Apperception Test
3. High School Personality Questionnaire
4. Machover Draw a Person Test
5. Rorshachs Ink Blot test
6. Vineland Social Maturity Scale
7. Binet- Kamat Test

Behavioral Observation:

The patient was cooperative and her attention and concentration was adequate. She was able to comprehend the instructions given.

Tests administered and rationale for the same:

High school personality questionnaire:

To measure personality factors under various dimensions.

Sacks Sentence Completion Test:

Projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Thematic Apperception Test:

Projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others

Machover Draw-a-Person Test:

Projective test to indicate personality and person’s psychopathology.

Rorshachs Ink Blot Test:

Provides an understanding of structure of the personality, affection needs and ego strength. It also indicates degree of psychopathology.

Vineland’s Social Maturity Scale:

Measures social competence, self-help skills, and adaptive behavior from infancy to adulthood. It can be used from birth up to the age of 30, consists of a 117-item interview with a parent or other primary caregiver. Personal and social skills are evaluated in the following areas: daily living skills (general self-help, eating,dressing); communication (listening, speaking, writing); motor skills (fine and

gross, including locomotion); socialization (interpersonal relationships, play and leisure, and coping skills); occupational skills; and self-direction. Raw scores are converted to an age equivalent score (expressed as social age) and a social quotient.

Binet – Kamat Test:

To assess the intelligence of the subject. It includes both verbal and performance tests. It can be administered to subjects aged 3 to 22 years.

Test findings:

High School Personality Questionnaire:

The patient's responses revealed her to be an individual with low ego strength, tendency to be affected by feelings, emotionally less stable, sentimental, conservative and expedient. She also had high expectation for self. The test also showed features such as anxious tensed, practical, careful, conventionality with the tendency to be reserved, sober and shy.

Sacks Sentence Completion Test:

A conflict was identified mainly in the areas of studies especially mathematics leading to low self esteem. However she had indicated optimism towards achieving future goals. There was a negative attitude towards her father whom she saw as being distant and cold. Interpersonal relations with selected people appeared to be fair.

Thematic Apperception Test:

On the TAT protocol, most of the stories were well structured. The recurrent themes were that of the people facing difficulties in life and then actively fighting

back the pressure. The environment in most of the stories had been perceived as threatening and unsupportive. The significant conflict that surfaced was insecurity. The outcome in most stories was realistic, positive and happy. There was evidence of approach avoidance conflict in her stories. Need for achievement, understanding and affiliation were prominent. The emphasis the patient places on education was also evident in the stories. She emphasized that prayers, hard work and confidence could achieve anything. Fear of abandonment was also evident.

Draw-a-Person Test:

The patient drew both pictures representing a school going boy and girl. Both figures were proportionately normal in size. There was also omission of body parts viz. only four fingers was drawn in one hand and both ears of both figures. The drawing was immature which may be indicative of lowered cognitive ability. Her verbalizations on the drawings reflected concern about academic performance and need of friends.

Rorschach's Ink Blot Test

In this test, the patient was not very productive with 23 responses. Reaction time was variable (15-45 seconds). Her approach was W dominant, indicating her ability to organize and perceive the whole gestalt aspect. Many space responses were present indicating her oppositional tendencies. Form quality was high revealing good reality contact. Less than average number of color responses was present, indicating shallow emotionality. Regarding the content of her responses, a large number of animal responses was present indicating stereotypical thinking; anatomical responses was very less indicating her preoccupation with her physical state. Only two human

responses were present indicating her lack of interest in the environment and fellow human beings; popular responses were also below average indicating her inability to conform to social norms.

Vineland's Social Maturity Scale:

She had an age equivalent score was 12.30, while her chronologic age was 17 years 5 month. She had scored in the normal range in the self-help categories. However her performance in communication and socialization was slightly low.

Binet – Kamat test:

Binet-Kamat test she had low average intelligence as indicated by an IQ of 85. Her visuo motor was fair and numerical reasoning was fair. Verbal and conceptual was inadequate. Her ability to read in English was poor however she was relatively better in Bengali which was her native language.

Summary of psychological testing :

Findings suggestive of a personality characterized by timidity, under assertiveness and anxiety. She had high expectations for self; howerever was frustrated at her failure to achieve goals. Her primary area of conflict was related to her under achievements in the academics area leading onto low self esteem. Problem solving skills was poor and she tended to use an emotional and avoidant coping style. There was no features indicative of a mood however negative cognitions in relation to her academic performance were present. Her intellectual functioning was low average intelligence with significant deficits in adaptive functioning.

Diagnostic formulation:

A 17 year old girl studying in 11th standard comes from middle socioeconomic urban, Bengali speaking background. Premorbidly she was reported to have anxious traits. There was no past or family history of neuropsychiatric illness. Presented with one year history of vomiting immediately after taking food, bloating following food intake, loss of weight nearly 20kg, constipation, generalized weakness, with history of amenorrhea since 6 months and significant impairment in her daily routine functioning and academic performance. There was no cognitive distortion or other behavioral manifestations suggestive of anorexia. Mental status examination revealed preoccupation with her physical system. Psychometry revealed low average intelligence and very timid, under assertive and anxious person. There was no features indicative of a mood however negative cognitions in relation to her academic performance was present

Final diagnosis:

Psychogenic vomiting

Low average intelligence

Management:

After admission smaller frequent meals was advised and water intake immediately after food was reduced, following which her vomiting subsided. She gained 5kg and at time of discharge her weight was 35kg. ADL and behavioral chart with reinforcement contingent on non-vomiting and weight gain was given. She was started on naturolax powder and antacid for constipation and sensation of abdominal fullness after meals.

A grandparent was allowed to ventilate. An attempt was made to educate the grandparents about the problem. The grandparent over involvement and tendency to reinforce patient's health seeking behavior and secondary gains was briefly addressed. The implication of low intelligence on academic performance was discussed. A step down in curriculum with reduced pressure in academics was encouraged. Coping skill training, assertiveness training, and relaxation technique training were practiced.

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CASE RECORD 4

Name	: Ms. SA
Age	: 17 years
Sex	: Female
Marital status	: Unmarried
Religion	: Hindu
Language	: Tamil
Education	: 12th standard
Occupation	: Student
Socio-economic status	: Middle
Residence	: Semi urban
Informant	: Father

Presenting complaints:

Withdrawn behavior	-4 months duration
Suicidal ideas	- 4 months duration
Disturbed sleep	- 4month duration
Not regular to school	- 2 months duration

History of presenting illness

Patient reported that since childhood she had been having difficulty in adjusting with her mother whom she regarded as being uninvolved and uncaring. She reported that both her father and brother had similar problems with her mother. Frequent

parental conflicts had been present and reportedly father and patient had been verbally and physically abused by the mother. She described her mother as career – minded, constantly preoccupied about money at the cost of neglecting the children's needs for love and affection. She had often spent less time at home in an attempt to avoid conflicts with her mother. The last six months her mother had been increasingly assaultive and abusive towards her after the loss of her job.

She had apparently been doing fairly well in her academics despite the problems at home till about 4 months back when she was noticed to be more withdrawn and dull. Crying spells was present. She expressed feeling sad and dull. Although she attended school she was not able to concentrate in studies or complete homework. She lacked confidence in self, felt tired and did not enjoy reading or browsing internet like before. She reported having disturbed sleep and difficulty in initiating sleep. She felt very dull in the morning but slightly better by evening. She had decreased appetite. She expressed suicidal ideas saying that she wanted to die as she had feelings of helplessness and hopelessness. She had guilt feelings of being a burden for her father and brother who was taking care of her. For the past two months, she was irregular to school and started expressing fear of class tests and eventually stopped going to school.

The past one year it was observed that patient was easily angered, unable to forgive insults, and having a low frustration tolerance. She had become very sensitive, very doubtful and cautious. She was always preoccupied with details, rules and order. She expected things to be done in perfect way which interfered with her daily task like studies.

There was no history suggestive of first rank symptoms. There was no history of expressing false belief with conviction. There was no history of any abnormal

perception. There was no history of grandiosity, hyperactivity or elation of mood any time. There was no history of phobia or panic attacks. There was no history suggestive of head injury, fever, seizures, and loss of consciousness or substance abuse.

Developmental history:

The pregnancy was planned and the antenatal period was supervised and uneventful. Delivery was full term normal vaginal; with no birth asphyxia with normal birth weight of 3.0kg. Postnatal period was uneventful. The developmental milestone was reported to be normal.

Emotional development and temperament:

She was reported to be a fairly responsible child. However it was reported that she had rigidity and inflexibility in certain behaviors. She socialized less and preferred solitary activities like reading.

Sexual development:

She attained menarche at 12 years of age, 28 days cycle, and regular 3-4 days. She had female gender identity and heterosexual orientation.

School history

She started schooling at 4 years of age in an English medium school. Her academic performance was reportedly good, with 90% in her 10^{th} exam. She was currently in 12^{th} standard. Her academic performance had been declining over the past one year.

Personal History:

She had many friends but only three close friends. Her hobbies was reading, listening to music, browsing internet and photography. She was religious and followed social norms. There had been a series of traumatic events due to the problems prevailing at home.

Family background:

She is the second of two sibling from non consanguineous marriage. Her father was a 53 year old male, diabetic, working as assistant accountant, mother 43 year old lecturer in a engineering college. She came from a middle socio economic background. She had elder brother working as a software engineer. There was history of severe marital discord. Since childhood, patient had been having a poor relationship with her mother and for past one month her father and brother were living separately. There was history of anankastic personality in patient's mother and mental retardation with seizures in first cousin.

Physical examination:

Her vitals were stable. Her systemic examination was within normal limits.

Investigation:

Routine blood investigation was within normal limits.

Mental status examination:

She was moderately built and well nourished. She was adequately kempt. She was co-operative and rapport was established. Eye contact was made and maintained. Her psychomotor activity was normal. There was no abnormal involuntary movement.

Her primary mental function was normal. Her speech was of low tone, monotonous and with normal reaction time. There was no abnormality in form, stream or possession of thought. Her thought of content revealed hopelessness, worthlessness and helplessness with no delusions. No perceptual abnormalities or compulsive phenomena or volition abnormality was noticed. Her mood subjectively sad, objectively appeared labile. The range and reactivity was normal with thought congruent, appropriate and infectivity. She expressed suicidal ideation. Her intelligence was good. She had partial insight into the nature of illness and her judgment was intact.

Provisional diagnosis:

Moderate depression with somatic symptoms

Differential of Mixed personality or anankastic personality traits

Aim for psychometry:

1. To clarify symptomatology, psychopathology and diagnosis
2. To clarify the underlying personality traits

Tests administered:

1. Cattell's 16 PF
2. Sacks Sentence Completion Test
3. Thematic Apperception Test
4. Draw a person test
5. Rorschach's Ink Blot test

Behavioral Observation:

The patient was cooperative and her attention and concentration were adequate. She was able to comprehend the instructions given.

Rationale & Findings:

Cattell's 16 PF:

To measure personality factors under various dimensions

Sacks Sentence Completion Test:

Projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Thematic Apperception Test:

Projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others

Draw-a-Person Test:

Projective test to indicate personality and person's psychopathology.

Rorshachs Ink Blot Test:

Provides an understanding structure of the personality, needs of affection and ego strength. It also indicates degree of psychopathology.

Test findings:

16 Personality Factor Questionnaires:

The patient's responses revealed her to be an individual who was less sociable, aloof and emotionally less stable. She was distrustful and not adaptable. Her responses also revealed that she was conscientious, persistent and rigid.

Sacks Sentence Completion Test:

Conflict with mother and intense hatred towards her was predominant. She considered her father as a person who was under assertive, weak and incapable of handling issues. She had adjustment problems with teachers and had no trusting relationships with her peer group. It appeared that she did not want to conform to the expected norms and wished to be independent and free from restraints. She did not have strong feelings of worthiness and had a low self esteem. There was a need to achieve and excel.

Thematic Apperception Test:

On the TAT protocol, most of the stories was well structured. The recurrent theme was that of being dominated by people and the need to free her and be independent. The environment in most of the stories had been perceived as threatening and unsupportive. There was a strong need to fight against obstacles in her path. One of the stories emphasized the need to deviate from the traditional gender role. The need for nurturance and love were also evident in some of the stories. There was a need to do things her own way, despite societal norms. The significant conflicts

that surfaced were secureness. There was a need for perfection in self and others. The outcomes in most stories was not favorable.

Draw-a-Person Test:

She drew a figure of a boy and girl. Both figures was proportionately drawn. There was also omission of body parts viz. fingers not clearly drawn and both ears missing. The drawings was immature which may be indicative of lowered cognitive ability. Her verbalizations on the drawings was about the feeling of happiness one feels when they are able to do what they want.

R**orschach's Ink Blot Test:**

In this test, the patient was very productive with 42 responses. Reaction time was delayed (55 seconds – 4 minutes). Her approach was less W dominant, indicating her ability to organize and perceive the whole gestalt aspect as poor. Many space responses were present indicating her oppositional tendencies. High Dd responses and less popular responses indicate an obsessive-like tendency toward perfectionism. She was more preoccupied by minute details of the stimulus field. On the special index of obsessive style, patient's protocol meets its criteria indicating that she had an obsessive approach to situations. Form quality was high revealing good reality contact. Less number of popular responses indicates the tendency to disregard social conventions in favor of individual needs or wants .Less than average number of color responses was present, indicating shallow emotionality. Regarding the content of her responses, a large number of animal responses were present indicating stereotypical thinking. There was many of anatomical responses. She was chronically vulnerable to become more disorganized when there are stressors in life. More number of

anatomical responses indicates severe impairment in reality testing and somatic preoccupation. There was increased tendency to think inflexibly and she had difficulty in attempting to think with alternative views. Only five human responses was present indicating her lack of interest in the environment and fellow human beings.

Summary of psychological testing:

Finding was suggestive of a personality characterized by perfectionism, rigidity and distrustfulness. She was independent in her thinking and did not easily submit to the ideas of others. Her primary area of conflict was regarding the relationship with her mother. Problem solving skills was poor and she tended to use an emotional and avoidant coping style. There was a feature indicative of a depression with negative cognitions in relation to life, parents and to her academic performance.

Diagnostic formulation:

A 17 year old girl studying in 12th standard, from a middle socioeconomic semi urban, Tamil speaking background, premorbidly reported to be a person with rigidity and conscientiousness. Family history of mental retardation and seizures in first cousin and an anankastic personality in mother presented with four month history of being withdrawn, dull, crying, not able to concentrate in studies, low self esteem, anhedonia, anergia, disturbed biological function with depressive and suicidal ideas. There was a two months history of being irregular to school and expressing fear of class test. There was history of relationship problem with her mother since childhood, which has worsened over the past six months. In addition there was a one year history of being unable to forgive insults, low frustration tolerance, hypersensitiveness, distrustfulness, cautiousness and preoccupation with details, rules and order. Mental

status examination revealed depressive and suicidal ideation. Psychological testing revealed an underlying anankastic personality traits and features indicative of depression.

Final diagnosis:

Moderate depression with somatic symptoms

Anankastic personality traits.

Management:

C.Fluoxetine 20mg per day was administered to control the depressive symptoms. Suicidal risk and precautions for the same was addressed. Supportive measure was used to reduce her distress level. Aims of psychotherapy was to improve her inter personal relationships, especially with her mother, problem solving, coping and self help skills. In addition she was helped to modify her maladaptive ways of dealing with problems and issues. The patient and her family members was psycho educated regarding the nature of her illness, the need for continuing medication for adequate length of time and regular psychotherapy. They were also explained about the benefits of family therapy and to encourage the mother to attend individual psychotherapy. Patient was encouraged to resume her studies in a graded manner.

CASE RECORD 5

NAME : MS. M.N.

AGE : 16years

SEX : Female

EDUCATION : 1st standard

RELIGION : Hindu

OCCUPATION : Nil

MARITAL : single

INFORMANT : Father

RELIABILITY : Good

CHIEF COMPLAINTS:

1. Needing help to do daily activities
2. Not able to talk properly

DURATION:

Since childhood

MODE OF ONSET:

Gradual, with no apparent precipitating factors.

HISTORY OF PRESENTING COMPLAINTS:

Since childhood, she had been noticed to be deficient in various skills compared to other children of her age. She had difficulty in understanding and learning new skills. She lacked the ability to take up minor responsibilities. She preferred the

company of younger children but did not have the appropriate skills to play with them. Solitary play was more predominant. Her communication skill was not adequate and she had difficulty in expressing her thoughts.

She required assistance in performing certain self care activities and her daily routine needed supervision. Her biological function was normal. There was no history to suggest psychotic symptoms, persistent mood changes, unconsciousness, seizures or other features of organcity. There was no specific periodicity to these complaints. Her delay had been noticed since 3 years of age.

PAST HISTORY:

There was a history suggestive of rickets at birth following which she was unable to walk until 5 years of age.

FAMILY HISTORY:

She was the first child born of a non-consanguineous union. Her father was a 38 year old, farmer educated up to 7^{th} standard while her mother a 28 year old housewife, studied up to 8^{th} standard. She had a younger brother aged 12 studying in 8^{th} standard. They lived in a joint family. A parent was overprotective towards the girl. There was no history of an adverse family situation or family history of mental retardation, epilepsy, psychosis or substance abuse.

PERSONAL AND DEVELOPMENTAL HISTORY:

She was born at full term by a normal hospital delivery. There was no complication during the antenatal period or during labour. The patient breathed and cried at birth and there was history of rickets at birth as mentioned earlier.

Immunization was inadequate. Delay in milestone was present as she walked and spoke her first word after six to seven years. Her father reported that currently she could speak in short sentences however speech was unclear. Her memory and comprehension were not adequate for her age. Her socialization skill was limited to that of a younger child. Patient was fairly independent with regard to her self help skills however needed assistance in dressing and menstrual hygiene. She could do simple household activities under supervision however the quality of work was poor. She started schooling at the age of 8years but was unable to progress after the 1st standard. Her writing skills was poor and she was able to write only a few names and numbers. There was no history of hyper activity, disruptive behaviour or other behaviour problems.

PHYSICAL EXAMINATION:

Her head circumference was 52cm, height 140cm, and bilateral clinodactly was present. Vitals were stable. System examination was normal.

INVESTIGATIONS:

Baseline investigations was normal however her TSH and absolute esonophil count was raised.

MENTAL STATUS EXAMINATION:

Patient was thin built. She walked into the room without support and was neatly and appropriately dressed. She was conscious and alert; eye contact was established but difficult to maintain. She was able to comprehend only simple commands. She was observed to be restless at times; attention was aroused but was not well sustained.

She was oriented to person and place but not to time. Memory for general events was inadequate. No abnormality of thought and perceptions was noticed. Speech was loud and she was able to speak in short sentences and communicate her needs. She spoke in two word sentences; comprehension was poor. No abnormality of mood was noticed. No volitional abnormalities or compulsive phenomena was observed. Her intelligence was below average; her general information was poor, as was concept formation and calculations. Insight was absent and social judgment was impaired.

PROVISIONAL DIAGNOSIS:

Mental retardation - unspecified.

RATIONALE FOR PSYCHOMETRY

l. To confirm the diagnosis of mental retardation

2. To quantify the severity of mental retardation

3. To assess social skills - assets and liabilities

TESTS ADMINISTERED

1. Binet -Kamat Test of Intelligence (BKT)

2. Vinelands Social Maturity Scale (VSMS)

TEST BEHAVIOUR:

Patient was cooperative for the test procedure. She was able to concentrate fairly well for short periods. Her comprehension of test instructions was fair.

RATIONALE OF THE TESTS SELECTED:

Binet – Kamat Test:

To assesses the intelligence of the subject. It include both verbal and performance tests. It can be administered to subjects aged 3 to 22 years.

Vineland's Social Maturity Scale:

Measures social competence, self-help skills, and adaptive behavior from infancy to adulthood. It can be used from birth up to 25 + years. It consists of a 117-item interview with a parent or other primary caregiver. Personal and social skills are evaluated in the following areas: daily living skills (general self-help, eating, dressing); communication (listening, speaking, writing); motor skills (fine and gross, including locomotion); socialization (interpersonal relationships, play and leisure, and coping skills); occupational skills; and self-direction. Raw scores are converted to an age equivalent score (expressed as social age) and a social quotient.

TEST FINDINGS:

Binet-Kamat Test:

The I.Q. in BKT was found to be 21 and her mental age was 3 years and 4 months.

Her I.Q was calculated as follows:-

I.Q. = Mental age/chronological age x 100

I.Q. = 3.4/16 x 100 = 21

These indicate a severe level of mental retardation. Her profile on the various domains was as follows:-

Language	3 years
Meaningful Memory	3 years
Non-meaningful Memory	4 years
Conceptual Thinking	below 7 years
Non- verbal Thinking	below 3 years
Verbal Reasoning	below 12 years
Numerical Reasoning	below 4 years
Visuo- motor	below 4 years
social intelligence	4 years

Vineland Social Maturity Scale:

The social skill profile obtained was as follows:-

SHG - Self help general -	3 yrs & 8 months
SHD - Self help dressing -	6 yrs & 8 months
SHE - Self help eating -	8 years
SD - Self direction -	5 yrs & 8 months
S - Socialization -	3 years & 7 months
L - Locomotion –	5 years & 8 months
0 - occupation –	3 yrs & 5 months
C - Communication -	3 yrs & 2 months

Her self-care skills were fairly adequate however her socialization, occupation and communication skills was very poor. She over all social maturity was around 5.13 years level with a social quotient of 56

DIAGNOSTIC FORMULATION:

M.N was a 16 year old single Hindu female coming from middle Socio economic, rural background. There was no significant family history of neuropsychiatric illness or mental retardation. She presented with history of rickets and delayed milestones in both motor and language, poor scholastic performance as well an inadequacy in social skills. Her mental status examination revealed poor comprehension, inadequate communication skills and sub-average intelligence, confirmed by an I.Q. of 21 in the Binet Kamat test and an S.Q. of 56 on the Vineland's Social Maturity Scale.

FINAL DIAGNOSIS:

Severe Mental Retardation without behavioral problems

MANAGEMENT:

1. To teach her functional academic skills required in daily life such as simple money management, estimation of time and basic reading and writing.

2. To teach her simple household activities

3. To improve communication, concepts and social skills

4. To plan out a vocation corresponding to the patient's abilities and area of interest.

5. To educate the parents on the nature of the chronic disability and how to cope with it.