PSYCHOLOGY CASE RECORD

Submitted to the Tamil Nadu Dr. M.G.R. Medical University in partial fulfilment of the requirements for the Diploma in Psychological Medicine Examination 2017

By
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ACKNOWLEDGEMENTS

I am very much indebted to Mrs. Sushila Russell, Mr. Joseph Noel, Mrs. Nandini Kathale and Mrs. Merlin Jemi, Clinical Psychologists, Department of Psychiatry, for their valuable guidance and supervision.

I express my gratitude to our Head of Department, Dr.Anju Kuruvilla, and to Dr.K.S. Jacob, Dr. Deepa Braganza, Dr. Anna Tharyan and Dr. Priya Mammen for allowing me to administer tests to the patients under their care.

I would like to thank my parents, family and colleagues for their support.

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

CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. Tanay Maiti** during the years 2015-2017. I also certify that this record is an independent work done by the candidate under my supervision.

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CASE RECORD – 1 : Personality Assessment

Name	: Ms. PM
Age	: 23 years
Sex	: Female
Marital status	: Unmarried
Religion	: Hindu
Language	: Bengali
Education	: Bachelor of Science
Occupation	: Student
Socio-economic status	: Middle
Residence	: Semi Urban
Informant	: Ms PM and her parents

Presenting complaints

Repetitive intrusive thoughts with fear of contamination - Five years

Episodes self injurious behaviours - Five years

History of present illness:

Ms. PM presented with five years history of repetitive, intrusive thoughts with content of dirt, contamination, doubts of stealing or losing things, blasphemy associated with ritualistic washing, bathing, cleaning, checking and mental

rituals. Ms PM gradually developed problems with any kind of dirt, along with repeated washing of hands and taking a full body bath, lasting hours. This problem became worse with time to an extent that she had displayed the urge to wash her hands or have a bath even on seeing dirt at a distance. She had frequent doubts as to whether she had actually touched the dirt or not. She used to wash her hands or pour water while bathing for a fixed number of times with a belief that these rituals will calm her and reiterate the fact that she in fact has not been in contact with any form of dirt. Apart from doubts regarding dirt, she also began to have doubts regarding her own activities. She began to have doubts that she had stolen objects when she held in her hands. She also complained of repeated ruminations of various blasphemous thoughts which she was unable to control despite realising and knowing that they are false or baseless. All these symptoms caused significant distress due to her inability to control them despite adequate resistance and caused marked interference in her daily functioning and academic performance.

There is also a history of persistent pervasive pattern of attention seeking behaviour. Parents reported that she used to speak in a particular manner and dress provocatively, not in keeping with her cultural background or upbringing. She also displayed self-dramatizing behaviour, associated with shallow and labile affect characterised by loud crying, being easily tearful and at the same time laughing and giggling, frequently. She also showed persistent patterns of behaviour where she gets easily influenced by the environment and circumstances or even strangers. Multiple instances of self harming behaviour

like head banging, hitting self against wall or with hard objects, and suicidal attempts like over consumption of prescribed medications, attempt to slash her wrist or strangulate herself were present since middle adolescence to early adulthood. All these symptoms were extremely high in impulsivity with variable degree of lethality and intentionality.

Poor interpersonal relationship with peers was evident since her early adolescence. Her relationship with her father remained strained mostly due to her impulsive behaviour, and critical comments of the father himself. An enmeshed relationship with the mother has been noticed since her childhood which further continued through her adolescence till date.

There was no history suggestive of psychosis, pervasive mood syndrome, pervasive developmental disorder, conduct disorder, or anxiety disorder.

Treatment history

She has been treated at various psychiatric centres, predominantly with medications. She has had trials of Escitalopram up to 10mg along with Clonazepam 0.5mg, and Paroxetine up to 50mg, with poor response.

Family history

She is the only child of her parents. Her father is 50 years old and works as a teacher. Her mother is 47 years old and is a homemaker. They stay as a nuclear family. There is no family history of any neuropsychiatric illness in the family.

Developmental history

The antenatal period was supervised and uneventful. Her delivery was full term caesarean, with no birth asphyxia, neonatal seizure or jaundice. Her postnatal period was uneventful. Her motor and language developmental milestones were reported to be within normal limits.

Educational history

She is currently pursuing Bachelors in Science in Mathematics. Her academic performance was reportedly above average upto 10^{th} standard. Since then her performance began to decline and she lost a year of studies due to an exacerbation of her symptoms.

Sexual development

She had female gender identity and heterosexual orientation. She denied high-risk sexual behaviour. There is no history of any sexual abuse reported.

Marital history

She was unmarried

Premorbid personality

She was described to be sensitive, stubborn and was occasionally impulsive in nature. She had high moral standards. She had only a few friends.

Physical examination

Her vitals were stable. She had multiple corrugated skin ridge prominences in the digits of all four limbs probably due to excessive contact with water. Her systemic examinations were within normal limits.

Mental Status Examination

Ms. PM was moderately built, adequately nourished and appropriately groomed. She maintained eye contact throughout. She was cooperative for the interview. Rapport was established with ease. She was alert and lucid. There was no hyperactivity, under activity or fluctuation in motor activity. Her speech was audible and coherent, with normal rate, tone, volume and reaction time. Her mood was subjectively dysphoric and objectively anxious, with full range and reactivity, inappropriate to her surroundings though congruent to her thought content. She expressed occasional death wishes though no suicidal intent could be elicited. She denied active suicidal ideas. There were no abnormalities in the form and stream of thought. Her thought content revealed obsessions of dirt, obsessive doubts, and dichotomous thinking. There were no perceptual abnormalities. She was oriented to time, place and person. Her immediate, recent, recent past and remote memory were intact. She had difficulty in sustaining attention during the interview and concentration was poor throughout. She had a good general fund of knowledge, could successfully tell the similarity, dissimilarity of the given objects and meaning of multiple proverbs. Her

arithmetic skill was adequate with good vocabulary reserve. Overall her intelligence seems to be average and age appropriate.

Insight into her illness was partial, and intact test judgement, while personal and social judgments were impaired.

Provisional Diagnosis

Obsessive Compulsive Disorder, mixed type.

Mixed personality traits, under evaluation.

Aim for psychometric tests

To identify and explore significant personality factors influencing the Psychopathology.

Tests administered and rationale for the same

1. **The International Personality Disorder Examination (IPDE)-ICD 10 Modulescreening questionnaire**

   The IPDE, developed by Dr. Armander B. Loranger and colleagues, is a semi-structured clinical interview that provides a means of arriving at the diagnosis of major categories of personality disorders. The screening questionnaire is a tool used to eliminate individuals who are unlikely to have a personality disorder.

2. **Sack's Sentence Completion Test**

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

3. **Thematic Apperception Test**

   It 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.

Behavioural observation

She was cooperative attentive during the assessment. She was able to sustain her attention through the course of the assessment. She was able to comprehend the instructions well and was able to communicate appropriately and relevantly. There was no performance anxiety observed.

Test findings:

The IPDE-ICD 10 Module screening questionnaire

The screening questionnaire indicates a high loading in anankastic and anxious traits. She tends to worry a lot that people may not like her and prefers to mingle with people only when she is sure that they like her. She tends to be fearful and

worried about a lot of things that appear not to bother others. She tends to spend much time on doing things perfectly. She has difficulty in adjusting to a change in her usual structure of routine way of doing things.

Sacks Sentence Completion Test

It reveals an enmeshed relationship with her mother and a disturbed relationship with father. She feels that her father lacks belief in her and that he does not understand her well as a person. Her fears mainly related to her symptoms and she expresses distress about the impact it has had on her functioning. There is guilt and regret regarding specific actions in her past which have led to negative consequences in her life. There is a strong need to be perfectionistic in everything she does and failure to achieve these high ideals result in guilt, distress and low self esteem. There is ambivalence about her own capacity – while she believes that she has the ability to manage her life well, he also has strong doubts about using her capacity in difficult situations in life. She appears to hold a pessimistic view regarding her future. She has unrealistic ideas about how a woman should be which again indicates her need to be perfectionistic. There are conflicts in her attitude towards heterosexual relationships. She holds a negative view regarding it which seems to stem from her past experiences.

Thematic Apperception Test

The stories vary in their length and the amount of details included. While some stories are short, others are long and well detailed with importance given to trivial parts in the pictures. The language of the stories and the content of the stories indicate adequate reality testing. The dominant needs seen in the stories are a need for autonomy, achievement and aggression. Most of the characters in the story appear to have a strong need to learn, achieve and be independent but their dreams are frustrated a need to obey their parents. Conflicts between autonomy, aggression versus deference to authority figures is seen. The male characters are portrayed as dominant and aggressive and with aggressive tendencies. The stories are reveal that she tends to be passive aggressive and there is over riding dilemma between submitting to male figures and dominating them. Defence mechanisms of fantasy, reaction formation and repression are seen the common ones she uses. The characters in the story seem to have high moral standards which may be a reflection of her own standards. The fantasy or need for an ideal home or family became prominent over the elaboration of multiple cards. The dominant emotions and feelings seen are of anger, frustration, guilt, reverence and helplessness.

Summary of Test findings

The test results indicate the presence of prominent anankastic traits of being perfectionistic and rigid. Anxious traits such a need for approval and being accepted is also revealed.

Management:

Ms PM was admitted for psychological management. She was started on Fluoxetine which was titrated to 60mg/day. Various cognitive and behavioural strategies like distraction and relaxation techniques along with Exposure and Response Prevention (ERP) were applied. After initial resistance, Ms PM could follow the techniques but was inconsistent and improvement was minimal. In view of this, Fluoxetine was gradually cross tapered with Citalopram and stopped. The dose of Citalopram was titrated to 20mg/day. She also attended occupational therapy session during her in patient stay.

CASE RECORD – 2: Diagnostic Clarification

Name	: Master SM
Age	: 10 years
Sex	: male
Religion	: Hindu
Language	: Bengali
Education	: 5th standard
Occupation	: Student
Socio-economic status	: Middle
Residence	: Urban
Informant	: Master SM, and his parents

Presenting complaints

Persistent and recurrent bouts of abrupt onset cough, for 2 months.

Abseentism from school and other activities for the same duration.

History of present illness

Master S presented with a 2 month history of abrupt onset, acute bouts of dry cough, which is episodic in nature, rarely associated with expectorant, severe in quality, frequently causing chest and abdominal pain with marked distress and chronic absenteeism from school and other academic/vocational activities. The cough started appearing without any noticeable precipitating event or respiratory

tract infection, with a typical start and exacerbation around 3pm in the evening, reaching peak within an hour and getting subsided by 6 to 7 pm in the evening. During this 2 month, the cough remained present almost everyday during the mentioned time duration which also lead to chronic absenteeism from his regular school, tuitions and acting classes. He has been evaluated by multiple physicians and paediatricians and was tried with multiple medications including bronchodilators, only to get minimal response. On two occasions he was needed to take to emergency casualty in a tertiary care hospital due to the presence of above mentioned symptoms associated with marked breathlessness, chest and abdominal pain. Repeated imaging and lung function tests revealed no detectable physical abnormalities which first invoked the possibility of any psychosomatic illness (or, psychogenic origin of the physical symptoms). Following this, he was brought to the Christian Medical College, Vellore for a detailed evaluation.

The following day after reaching the hospital he had recurrence of all the symptoms and needed to be taken to the pediatric casualty on two occasions where rapid nebulisation was done. Pediatric consultation revealed mild restrictive airway disease with unchanged FEV1 after application of bronchodilator agent. The severity of symptoms, atypical presentation, investigatory findings and rapid reversal of symptoms lead to a psychiatric referral and further detailed evaluation at our centre.

There was no history suggestive of psychosis, mood disorder, pervasive developmental disorder, conduct disorder, or anxiety disorder. There was also no history suggestive of first rank symptoms, expressing false belief with

conviction, depressive syndrome, mania, hypomania, phobia, panic attacks or substance use.

Treatment history

He was treated elsewhere at various hospitals and was on multiple medications mostly bronchodilators. He has never had a psychiatric/psychological evaluation elsewhere.

Family history

There is no family history of any neuropsychiatric illness in the family. Master S is a single child and the only son of his parents, of whom father is a businessman and mother is a homemaker. He lives in a three generation family with his parents and paternal grandparents in their own house in Kolkata. Parental over protection and high expectation from him both in scholastic and non-scholastic performances has been noticed. Strict boundaries and limit settings has been maintained in the family since the very beginning. The child is more attached to his grandparents, particularly to grandmother than his parents.

Developmental history

The antenatal period was supervised and uneventful. Delivery was full term, normal, vaginal delivery, with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. The developmental milestones were reported to be normal. He reportedly had a difficult temperament and was described to be

sensitive, stubborn as well as attention seeking. Impulsive behaviours were also noted.

Educational history

Master S is currently in 5th standard. . He was studying in a English medium school and remained mostly regular only to have significant school absenteeism in the last 2 months due to his clinical problems. Though he enjoys his school and activities done there but at the same time he remains mostly anxious over the heavy schedules followed in the school with very frequent exams and high parental expectations over it. His own need for achievement and perfection also contributed to his anxiety in the school related matters. He mentions frequent bullying done by some of his peers in the school.

Sexual development

He had male gender identity and there was no history of any sexual abuse or inappropriate sexualized behaviours.

Hobbies and Interests

He enjoyed drawing activities and playing outdoor games.

Physical examination

Her vitals were stable. Systemic examinations were within normal limits.

Mental Status Examination

Master SM was a well kempt and well groomed individual. He made good eye contact and rapport was established with ease. The rate, tone, volume and reaction time of his speech was normal. His affect was anxious and thought content revealed preoccupation about his school, studies and pressure of exams. He also revealed how his packed schedule left no time for his play or other activities that he enjoyed.

Aim for psychological testing

He has been having recurrent cough symptoms which are medically unexplained. This had lead to significant impairment in his academic and social functioning. In view of this a detailed psychological assessment was undertaken to identify and explore underlying psychopathology and possible stressors.

Tests administered and rationale for the same

1. **Child Behaviour Checklist (CBCL)** is a widely used method of identifying problem in the children a questionnaire form for the parents. It is originally a component of the Achenbach System of Empirically Based Assessment developed by Thomas Achenbach.
2. **Screen for Child Anxiety Related Disorder (SCARED)** is a child and parent self-report instrument used to screen for childhood anxiety disorders including general anxiety disorder, separation anxiety disorder, panic

disorder and social phobia. In addition, it assesses symptoms related to school phobias.

3. **Draw A Person Test (D.A.P.T)** developed originally by Good enough in 1926, this test was first known as the Goodenough Draw-a-Man test. It was later revised and extended as a personality test and is currently known as Draw a Person Test. It is a projective test used mostly in children and adolescent population to assess personality dimensions like self esteem, body image, gender identity and emotional factors.
4. **Sacks Sentence Completion Test** is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds the endings. The respondent projects the attitudes towards personal experience of life. It helps to elicit ideas of self-perception.
5. **Controlled projection test** it is a variant of projective test, mostly used in the child and adolescent population, where projective technique is applied over a story guided by the interviewer along with child who is also engaged in a free drawing at the same time. This test helps to examine, interpersonal relationships conflicts, hopes, fears, dreams self image.

Behavioral observation

During the entire period of assessment, he was calm and cooperative. He could comprehend the instructions and his attention was adequate. He appeared well motivated to persist on the task. At times he was apprehensive about whether his responses were appropriate.

Test findings:

Child Behaviour Checklist (CBCL) revealed his need to be perfect, dissatisfaction with self and guilt proneness. Somatic concerns were also high. The overall protocol was indicative of anxiety traits.

Screen for Child Anxiety Related Disorder (SCARED) showed higher scores on separation anxiety and school avoidance. This was indicative of significant anxiety traits which mostly centred on his school and study related issues with marked anxiety over the separation with parents.

Draw A Person Test. He drew a boy going for a walk along with a dog. The drawing was neat, accurate and well proportioned. Pencil stroke was even, connected and controlled. Size of drawing was adequate. His verbalizations on the drawing were that he was happy to be with the dog and to take care of it. This reflected his need for nurturance and the need for companionship that was non-threatening. There was a fondness for non-human subjects. The drawing reveals anankastic traits, need for accuracy and perfection.

Sacks sentence completion test suggested that he had over dependency on parents in view of his inability to deal with interpersonal situations. He appeared to be distressed about bullying at school, peer rejection and lack of acceptance from teachers. His anxiety over school and academic performance were marked. There was a sense of frustration at his inability to keep up to the expected standards. Self esteem was low and he lacked confidence.

Controlled projection test shows his difficulties in social interaction with peer group, anxiety about parental fights, perfectionist tendencies and significant attachment to dogs. In addition he appeared to have social anxiety which seemed to force him to hold onto pets for comfort and security. Guilt proneness was also evident.

Summary of test findings:

The test findings revealed significant anxiety in Master SM, especially over separation from the parents. Social anxiety is also evident and he uses avoidant coping strategies to deal with the challenging situations. The tests also suggested generalised anxiety traits and anxiety over school going issues. He also showed significant anankastic traits with need for perfection, neatness and clarity. His expectation from self also seems to be high with a tendency of self criticism. There were no indicators of any mood or psychotic symptoms.

Management

He was evaluated for diagnostic clarification and appropriate management. The treatment was planned based on non-pharmacological principles. The parents were allowed to ventilate and the nature of his problem was explained. Mind body relation and psychogenic stress originating various bodily symptoms remained the main focus of discussion in the sessions of psycho-education. With the patient, his perspective of the problem was taken and understood without

being judgemental. He was helped to change his coping mechanisms from an avoidant coping style to a problem solving style. The need to improve his social skills and provide him opportunities for social interaction, in a non-threatening environment was emphasized. In view of his anxiety to liaison with the school and to provide him with appropriate social support. Stress reduction technique like JPMRT, Deep breathing exercise was demonstrated. His anxiety over school and exam related issues were dealt cognitively and adequate support was provided. Plan for pharmacological intervention has been kept as a future option in case further worsening of anxiety symptoms.

CASE RECORD – 3 : Diagnostic Clarification

Name	: Master A
Age	: 17 years
Sex	: Male
Marital status	: single
Religion	: Hindu
Language	: Hindi
Education	: ITI course
Socio-economic status	: Middle
Residence	: Semi urban
Informant	: Mr A and his parents

Presenting Complaints:

Odd behaviour, solitary activity since childhood

Unprovoked aggression, abnormal behaviour since last 2 years

History of present illness:

Master A is a 17 year old single male, currently perusing his vocational training course in ITI in Ranchi, Jharkhand. He has been described as a shy introvert individual growing up with very minimal friends, with almost nil involvement in outdoor activities/games, preferring the indoor games mostly. Temperamentally he has been described as a difficult child. However, with this background, Master A was managing his studies quite satisfactorily, which started declining since his 9^{th} standard. He often started complaining having difficulties in attention, concentration and understanding the subject matter. His self care started getting poor, not changing clothes for days, with increased amount of time spending in his room. With assistance, he cleared his board exam with assistance and went for a vocational training course against his will due to parental pressure which remained a significant area of conflict thereafter.

As Master A shifted to another town for his studies and started living in a hostel, other people there noticed further abnormality in his behaviour, like odd manner of talking, poor sleep hygiene, inappropriate laughter, laughing in a loud or odd manner without any significant context, with occasional muttering to self. He also used to remain preoccupied about his worries of poor general health in an exaggerated and inappropriate manner. To improve his general health, he started consuming some herbal products, over which he started having abnormal behavioural symptoms like unprovoked aggression, self talking, roaming around in inner garments and dancing throughout the day, which needed his involuntary admission locally. He improved on admission and treatment however following

discharge, he stopped medication within a fortnight. He somehow managed his studies; however his odd behaviours, mentioned earlier, remained persistent, with a steady decline, and poorer interpersonal relationship with the parents, specially with the father. In view of his behavioural problems, he was been brought to our centre for detailed assessment, evaluation and further management.

Treatment history

He was treated with low dose of antipsychotic Olanzapine (upto 10mg/day) with poor compliance and minimal response. He presented to our centre off to any medication for 1 month.

Family history

He is the middle child of his parents with one elder sister and younger brother. There is no family history of any neuropsychiatric illness. Father is described as a rigid and controlling person who often had a dominant role on the pt leading to resentment and a strained relationship..

Developmental history

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

normal. However he had deficits in the area of social and communication skills. Did not mingle or adjust with other easily.

Educational history

He has completed his 10^{th} standard with 60 percent marks. Currently he is studying in ITI final semester. Reportedly faces educational difficulties..

Sexual development

He had male gender identity and heterosexual orientation. No history of any sexual abuse was mentioned by him.

Premorbid personality

He was described to be a shy, sensitive, stubborn individual with very few friends. He had a lot of rigidity in his behaviours and tended to follow rules conscientiously.

Physical examination

His vitals were stable. Systemic examinations were within normal limits.

Mental Status Examination

Master A was a moderately kempt individual with average build and nutrition. He interacted with the interviewer in an odd manner with constant avoidance of eye contact and laughing frequently and inappropriately, mostly without any

reason. His speech remained hesitant though relevant with normal rate tone and volume. Mood irritable and congruent to thought. He denied of any psychopathology and insight to his illness/problem was nil, (grade 1/6).

Aim for psychological testing

History was suggestive of odd behaviours as well symptoms of smiling and talking to self. There was also a period of time when he was disorganized with deterioration in self care. In view of this assessment was undertaken to identify and explore underlying psychopathology and significant personality factors influencing the psychopathology.

Test administered and Rationale for the same:

1. The **Brief Psychiatric Rating Scale** (**BPRS**) is rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behaviour.[1] Each symptom is rated 1-7. The scale is the one of the oldest, widely used scales to measure psychotic symptoms.
2. The **Young Mania Rating Scale** (**YMRS**) is an eleven-item multiple choice diagnostic questionnaire which psychiatrists use to measure the severity of manic episodes in children and young adults.
3. **Draw a Person Test (DAPT)**: Developed originally by Goodenough in 1926, this test was first known as the Goodenough Draw-a-Man test. Dr Dale Harris later revised and extended the test and currently more known

as Draw a Person test. It is a psychological projective test used in various purpose mostly in children and adolescent population.

4. **Sack's Sentence Completion Test(SSCT)** : It is a projective test developed by Dr.Sacks and Dr.Levy. It consists of 60 partially completed sentences to which the respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self perception.

5. **Thematic Apperception Test (TAT)**: **It** is a projective test used to measure the person's pattern 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 towards the self and others.

6. **Rorschach (inkblot) Test**: It is also a projective test which provides an understanding of structure of the personality, probable psychosis if any, affectional needs and the ego strength. It also indicates degree of psychopathology.

Behavioral observation

During the entire period of assessment, he was cooperative. He could comprehend the instructions and paid adequate attention. He appeared well

motivated to persist on the task. He showed lack of confidence while giving his responses. He needed constant assurance to proceed with the task.

Test Findings

BPRS: He didn't score significantly in any of the domains which indicated that there was no signs of psychosis currently.

YMRS: in the areas of elevated mood, irritability and disruptive aggressive behaviour he showed significant scores suggestive of probable hypomania in current clinical scenario.

DAPT: Master A was anxious and reluctant initially to perform this test, as he repeatedly said he can't draw anything. However, with persuasion, he drew a male figure which lacked details and was immature. The drawing was proportionate and depicted a person who was cheerful. He did not elaborate about the drawing. Overall, the drawing reflected his poor imaginative power and lack of flexibility in thoughts. There was no regressive tendencies or bizarreness in the picture drawn.

Sacks Sentence Completion Test

Most of Master A's responses were brief and not elaborative. There were conflicts in the area of attitude towards family and self, especially with the father. The attachment with his father has been poor since the early childhood

and it has further worsened over the years due to his punitive nature and critical comments. In view of this he had strong feelings of rejection. However relationship with mother was loving and caring. There were conflicts in the area of interpersonal relationships. His responses also showed high expectation from self and need for perfection in the scholastic areas. Fear of failure and fear of abandonment were present.

Thematic Apperception Test

Test Findings

In the TAT, the stories are extremely short and mostly concrete. He gave very brief responses in simple and single sentences. He lacks imaginative power and there is also lack of creativity. Rigidity of thought process was present. He had strong needs for acceptance and achievements. He was unable to attribute appropriate emotions to the characters in the story, which reflected poor emotional maturity. The male characters are mostly of dominant and stubborn in nature where female character shows submissive traits. he viewed the environment as being hostile and not nurturing. Most of the stories didn't show a favourable outcome specifically in the family context. There was no unusual or bizarre themes indicative of a psychotic thought process.

Rorschach Ink Blot Test

Master A gave a total 16 responses which showed poverty of content and lack of creativity. He showed variable reaction time and took an exceptionally long time on selected cards. He had very few Whole responses with good form level reflecting poor organization skills. He included colours occasionally in his responses. There were more animal responses and less human responses with lack of movement which indicated poor emotional maturity. His form level was not high and he was unable to improve on the quality of the responses. This indicates that he lacks confidence as well as has poor ego strength. However the positive attributes were adequate number of popular responses which showed that his reality orientation was fair. There were no positive signs of a mood disorder. However he showed difficulties in giving appropriate responses as well as having frequent card turning which may reflect anxiety traits. There was no contamination, confabulation or perseveration in his responses, which indicated that he didn't have a psychotic thought process.

Summary of test findings:

The test findings revealed his low intellectual capacity, poor creativity and organization skills. In addition, there was rigidity of thought and poor flexibility. Anxiety traits were present. There was significant disturbances in the interpersonal area resulting in feelings of rejection. His ability to initiate and maintain relationships were markedly affected. He also had high achievement needs however did not have the personal resources to back it up leading to

feelings of frustration and low self esteem. Although he scored positively on selected items on the YMRS, there were no significant findings suggestive of hypomania on other tests. His overall responses on the various tests didn't show any positive indicators for depression or psychosis. There seemed to be an underlying developmental disorder (Pervasive Developmental Disorder) which would need further clarification.

Management

He was admitted for diagnostic clarification and appropriate treatment. The parents were allowed to ventilate and they were psycho-educated about the nature of his problem. Parents were helped to understand his psychological needs and distress experienced. The need to respect his views and choices were emphasised. A collaborative approach to parenting was encouraged. Focus was given on improving the family dynamics with specific targets on modifying the father-son subsystem. Reality based expectations were emphasises for both the parents and Master A. Educational targets of re-starting his academics in a graded manner was planned till next review.

CASE RECORD – 4 : Neuropsychiatric assessment

Name	: Mr. K
Age	: 60 years
Sex	: Male
Marital status	: Married
Religion	: Hindu
Language	: Bengali
Education	: 11th Grade
Occupation	: Agricultural worker
Socio-economic status	: Middle
Residence	: Rural
Informant	: Mr. K and his wife and son

Presenting complaints:

Decline in memory	: two years
Poor attention and concentration	: two years

History of presenting illness:

Mr K was reportedly well till two years ago. Since then, there was a gradual and progressive deterioration in his memory. He initially had difficulty in remembering the names of his close relatives and needed cues to remember them. He began have difficulty in remembering where he had placed his wallet

and keys and had to search for them or needed help from his family members to locate them. He began to have difficulty in remembering details such as his home address, home phone number and names of locations. He had difficulty in filling up official forms which required personal details to be filled in and had to be accompanied by a family member to assist him with it. He also had difficulty in concentrating and paying attention which led to forgetting recent information and events. However, he did not have any difficulties in the identification or naming of objects.. Gradually, his memory deficits and the difficulties associated with it resulted in distress and dysphoria. He began to complain about his difficulties and began to socialize less and remain aloof. Despite his deficits and his distress, he was independent in his activities of daily living and did not need any prompts or assistance for the same. There were no difficulties in performing routine motor activities. There were no impairments in his language skills. He was able to comprehend and communicate adequately and appropriately. His biological functions were normal.

There was no history of seizure, head injury, loss of consciousness, or delirium.

There was no history of ideas or attempts of deliberate self harm.

There was no history suggestive of any first rank symptoms.

There was no history of any psychoactive substance abuse.

There was no history of any manic or hypomanic symptoms.

There was no history of any melancholic features.

There was no history of any obsessive-compulsive symptoms or panic symptoms.

There was no history of any other specific personality disorders.

Past and Treatment history:

There was no significant past history of neuro-psychiatric morbidity.

Family history

There was no family history of any neuro-psychiatric illness in his family.

Birth and development history

There was no information available about his antenatal period. Details about his birth history were not available. There was no information was available about birth asphyxia or any other perinatal complications. The developmental milestones were reported to be not delayed.

Educational history

He had studied upto 1tth standard and could read and write fluently in Bengali.

Occupational history

He was an agriculture worker.

Sexual history

He had a heterosexual orientation and had a male gender identity. There was no history of any high risk sexual behaviour.

Marital history

He has been married for thirty years to Ms S. He had two daughters and two sons.

Premorbid personality

He was described to be a sociable person who was energetic in work. He had a strong sense of responsibility towards work and his family. He had high moral and religious standards.

Medical history

There was no history of hypertension, diabetes mellitus, hypothyroidism, heart disease, liver disease or dyslipidemia.

Physical examination

His vitals were stable and systemic examination was within normal limits. There were no focal neurological deficits.

Central nervous system

Higher function – MMSE 25/27

Poor recall

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

There were no frontal release signs

Gait – steady

Meningeal signs - Absent

Skull and spine – within normal limits

No finger anomia was noted

Right left confusion was absent

Mental status examination

Mr. K was a moderately built, well kempt and appropriately groomed. He maintained eye contact and rapport was easy to establish. He was cooperative towards the examiner. He was alert and lucid. His psychomotor activity was within normal limits. His speech was spontaneous, relevant, normal in tone, tempo and volume. His mood was anxious and worried. His affect was stable, with normal reactivity and restricted range. He denied suicidal ideations. There were no abnormalities in the form and stream of thought. His content of thought revealed distress regarding his cognitive difficulties. He denied depressive cognitions. He was oriented to time, place and person. His immediate and recent memory was impaired while his remote memory was intact. His attention could be aroused and sustained. His vocabulary and general fund of knowledge were adequate. His arithmetic ability was poor and his abstraction was at the concrete level. His personal, test and social judgement was intact. He had partial insight into his problems.

Differential diagnosis

1. Dysthymia with cognitive deficits secondary to his depressive symptoms
2. Dementia

Aims for neuropsychological testing:

1. To find out the cognitive profile of Mr. K
2. To relate the findings to clinical presentation

Tests Administered and rationale

- **Mini-mental state examination (MMSE)**

  Rationale: It was introduced by Folstein in 1975, as a screening for gross cognitive impairment. It can help to confirm diagnosis, assess the severity and, monitor the progress and outcome of treatment.

- **NIMHANS Neuropsychological Battery**

  Rationale: The battery was developed by Shobini Rao et al. This assesses a subject's performance across various domains of neuropsychological functions. It has been validated to suit the Indian adult population.

Behavioural Observation

He was cooperative for the assessment and was able to sustain his attention over the course of the assessment. There was no active resistance in doing the assessment. He was able to comprehend the instructions adequately and was able to communicate appropriately. There was no performance anxiety observed.

Test findings

Mini-mental state examination

His score on the MMSE was 25/27, with deficits in recall.

NIMHANS Neuropsychological Battery

On the digit Symbol Substitution Test, his performance is indicative of impaired mental and processing speed. In the domain of attention, there are fluctuations seen in his performance on various aspects of attention. While his performance on Colour Trails Test – 1 and 2- and the Digit vigilance test is adequate, his performance on the Triads test is poor. This is indicative that his ability to focus and sustain attention is intact. However, his ability to divide his attention between two tasks is impaired. Thus, his ability to multi task may be poor.

In the domain of executive functions, impairment is seen in the areas in verbal fluency, planning and problem solving and working memory as indicated by his performance in the Oral Word Association Test, Animal Names test, Tower of London and Verbal N Back Tests respectively. This indicates that his ability to organize and plan out complex information is impaired. However, the severity of the deficits varied across the various sub domains of executive functions.

Verbal learning and memory was assessed by the auditory verbal learning test. He is able to recall more words during the initial trials and his encoding strategies appear to be poor. His performance on the test indicates minimal learning over trials and he has impairment in his ability to store as well as recall information.

His visuo constructive ability is intact as indicated by the copy trial in the complex figure test. However, mild impairment is seen in the area of visual

learning and memory as seen by his performance in the immediate and delayed recall trials.

His comprehension was intact as seen by his performance in the Token Test and there was no evidence of any aphasia. There was no evidence of agnosia or apraxia as seen in his performance on the tests of agnosia and apraxia.

Impression

Impairment in the areas of verbal learning and memory, executive functions and intact language, procedural memory, adequate recognition and the absence of agnosia and apraxia is suggestive of cognitive deficits associated with depression.

Management

He was treated as an out patient. Mr K and his wife were educated on the nature of illness and about the results of the assessment. Their queries regarding his condition were clarified. Blood investigations revealed decreased Vitamin B_{12} level. He was started on parenteral Vitamin B_{12} supplements. Sertraline trial was initiated for his chronic depressive symptoms along with cognitive and behavioural strategies to address his dysphoria. He was taught relaxation strategies and suggested life style modifications. He was suggested to follow up after six months or earlier as per the need.

CASE RECORD – 5 : Intelligence Assessment

Name	: Master S.M
Age	: 9 years
Sex	: Male
Marital status	: unmarried
Religion	: Hindu
Language	: Bengali
Education	: 3rd standard
Occupation	: Student
Socio-economic status	: Middle
Residence	: Semi urban
Informant	: Mr. S.M. and his father
Reliability	: adequate and good

Presenting Complaints

- Poor academic performance
- Demanding behaviour
- Unexplained shoulder pain since last 2 months

History of Presenting Complaints

Master SM presented with acute onset history of right sided shoulder pain which as per his own version started after a sprain which happened during his dance

class 2 months back. He also attributes the pain to an injury which he got while having a fight over a game with one of his classmate which happened a week before the acute onset of shoulder pain. The pain has been described as localised, episodic, electric sensation like, and extremely tender which often lead Master S not allowing anyone to touch the shoulder joint during that time. The pain has been described as waxing waning course leading to inability to attend school for 4 weeks before presenting to our outpatient department, being referred from the department of Orthopedics as no bony or soft tissue injury was found clinically, which was confirmed by radiological imaging also.

Detailed history revealed Master S was having academic difficulty since last 1 year as frequently been mentioned by the teachers as not able to understand, memorise or express like his same age peers. His academic performance was on a decline too in the last few weekly exams causing much distress to him. His father also reported that he has his terminal exam within a month, about which he was remaining much preoccupied and anxious when this physical discomfort took place leading to his visit to multiple local doctors followed by visit to our institution.

Past & Treatment History

No past history of any medical or psychological illness was present.

Family History

There is no family history of neuropsychiatric morbidity. There is no history of mental retardation in his family. His father is self-employed and his mother is a housewife. He does not have any siblings. The family keeps a moderately high expectation from Master S.

Birth and Development History

His birth was from a planned pregnancy with supervised antenatal period. He was born full term, normal vaginal delivery, at hospital. His birth weight was 2.5 kg. He had immediate birth cry and there is no history suggestive of birth asphyxia. No history of any perinatal complication was present. He was adequately immunized for age. His developmental milestones (gross motor, fine motor and play) were mostly appropriate to same age peers except 2-3 months delay in language functions, which he later compensated like the same age peers. He also lacked social and adaptive skills appropriate for his age and mostly prefers young age peer group for play and other joint activities.

Emotional Development and Temperament

Tempermentally he has been described as a difficult child. His father described him as a shy child, but he loves specific outdoor activity with very selected and limited numbers of peers. There were no features suggestive of attention deficit/hyperactive disorder or oppositional defiant disorder.

School History

He had completed his 2nd standard and currently in 3rd standard. His academic performance was average till now, though on few occasions teachers have mentioned about his slow writing speed and frequent spelling mistakes. His medium of instruction was Bengali and he found English difficult.

Occupational History

He was a student and had not held a job so far.

Sexual History

He identifies himself as an individual of male gender.

Physical Examination

His vital signs were stable. Systemic examination was within normal limits.

Mental Status Examination

He was average built, well-nourished and was appropriately kempt. Rapport could be established easily. There were no abnormal motor movements, though he was moving his right shoulder visibly less than the left one. His speech was spontaneous, with normal rate tone volume and reaction time. His mood was anxious with normal range and reactivity. Thought content revealed preoccupation about his bodily symptom(shoulder pain). He also revealed his difficulties in school, specially in language class where the apparently the

teacher makes him ‘write too much’; also says about some other teacher who is very strict and occasionally physically abuses the students (including him) too. He denied delusions, hallucinations and obsessions. He was oriented to time, place and person. His memory was intact. His attention could be aroused but was difficult to sustain. Higher mental function revealed impairment in tests of abstraction, arithmetic and general knowledge. Intelligence was below average. Insight was partial and judgment was intact.

Provisional Diagnosis

Somatoform disorder, unspecified

Borderline to mild intellectual disability, with behavioural problems

Aims Of Psychological Testing

As history was suggestive of developmental delay in language function, gradually declining academic performance, various complain from his school regarding his scholastic performances, and mental status examination revealed impairment in tests of abstraction, arithmetic and general knowledge, IQ assessment was imperative.

Test Administered

Binet-Kamat Test of General Mental Abilities

Vineland Social Maturity Scale

Rationale for the Test

Binet-Kamat Test (BKT) was used to assess intelligence as it is a standardised I.Q test for the Indian population.

Vineland Social Maturity Scale:

Vineland's Social Maturity Scale measures social competence, self-help skills, and adaptive behaviour from infancy to adulthood. 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.

Behavioural Observations

Mr. S.M.was cooperative for testing and was able to comprehend the simple instructions but had difficulty in comprehension of more complex instructions. He appeared quite anxious and had be reassured periodically. He was able to sustain his attention over the course of the assessment and was able to communicate adequately. His eye contact was poor however.

Test Findings

On BKT, his mental age was 7 years and 8 months, chronological age was 9 years with the corresponding IQ being 85, after applying the Flynn effect(considering BKT is an old test), his intelligence found to be of borderline level. However, scatter is seen in the assessment – his performance is poor in items measuring abstract ability such as conceptual thinking or verbal or numerical reasoning. However, on items that involve rote learning, his performance is better. His social intelligence and language function was average. On VSMS, he showed deficits in the areas of occupation, self help dressing and self directedness appropriate for his age.

Impression

Although the IQ is found to be in borderline category, his performance in rote learning is better. But being poor in conceptual thinking and reasoning, his overall performance came in the borderline zone which is probably affecting his school performances also.

Management

His skill deficits and anxious traits were discussed with the father. Mind body relation, and possibility of anxious traits originating bodily symptoms (including overemphasis of normal bodily perception) has been discussed. Secondary gain and role of reinforcement has also been discussed in plain language.

Father was psychoeducated about the nature & course of his problems. He was allowed to ventilate and support was provided. Appropriate educational plans were discussed including letting the child go in his own pace and to consider a step down if academic difficulties sustained (after liaising with the school) also been advised.

Behavioural techniques such as systematic study routine, one to one teaching were adviced. Differential reinforcement for his behavioural problems were employed.