PSYCHOLOGY CASE RECORD

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Examination 2016.

By

DR. ALKA SINGH

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Most of all, I would like to thank The Almighty God for all His blessings.

CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. Alka Singh** during the year 2014-2016. I also certify that this record is an independent work done by the candidate under my supervision.

Dr. Anju Kuruvilla, MD.,
Professor and Head
Department of Psychiatry
Christian Medical College
Vellore 632 002

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Mrs. Sushila Russell, M.Phil,
Reader in Clinical Psychology
Department of Psychiatry
Christian Medical College
Vellore 632 002.

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CASE RECORD 1: Diagnostic Clarification

Name	: Ms. PS
Age	: 16 years
Sex	: Female
Marital status	: Unmarried
Religion	: Christian
Language	: Tamil, English
Education	: 12th standard
Occupation	: Student
Socio-economic status	: Middle
Residence	: Urban
Informant	: Ms. PS, mother and aunt

Presenting complaints

Decreased self confidence	6 months
Feeling low and dull	6 months
Worries a lot about studies	6 months
Decline in academic performance	6 months
Lack of interest and hopelessness	2 month
Recurrent suicidal thoughts and attempts	2 months

History of presenting illness

Ms. PS presented with complaints of low self confidence, feeling low and dejected, gradual decline in academic performance, anxiety regarding her studies, inability to attend school and concentrate in studies for the past six months and feeling of hopelessness, worthlessness and recurrent suicidal thoughts and attempts of deliberate self harm, three times in last two months. Those attempts were of high intention and lethality but she did not have any permanent morbidity following those attempts. There were no temperamental problems reported during her childhood. The low mood had a pervasive pattern for the past few months. There were clear melancholic features associated with her mood symptoms. She from being an above average student in her class discontinued her schooling due to the above said symptoms. She had periodic exacerbation of her mood symptoms following stressors at various points of time.

There is no history of any similar complaints in the past prior to the onset of symptoms 6 months ago.

There is no history of any first rank symptoms in the past.

There is no history of any manic or hypo manic symptoms in the past.

There is no history of any obsessive-compulsive symptoms in the past.

There is no history of phobia or panic attacks.

There is no history of any psychoactive substance use in an abuse or dependence pattern.

There is no history of any organicity around the time of onset of her symptoms.

Family history

She is the only child born out of a non consanguineous union of her parents. She lives with maternal grandparents and their family along with her mother. Her father left the family when she was 5 years old due to marital disharmony.

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 milestones were reported to be normal.

Educational history

She was studying in 12^{th} standard at the time of presentation. She is reported to be an above average, hard working and sincere student at school.

Sexual development

She had female gender identity and heterosexual orientation. She attained menarche at the age of 12 years. She denied any high risk sexual behavior.

Marital history

She was unmarried.

Premorbid personality

Premorbidly she is described as being introvert and reserve person. She had limited social interactions. She was hard working and sincere in her studies. She had good moral standards.

Physical examination

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

Mental status examination

She was moderately built and nourished. She was well kempt with good eye contact. Speech was relevant with good comprehension. Content of thought revealed depressive cognitions and somatic symptoms. She denied perceptual abnormalities in any modality. Her mood was depressed with restricted reactivity. She expressed suicidal ideation but denied any active plans. Her higher mental functions were intact She had partial insight into her illness and her personal and social judgment was impaired.

Differential Diagnosis

1. MODERATE DEPRESSION WITH SOMATIC SYMPTOMS
2. PRODROME OF SCHIZOPHRENIA

Aim for Psychometry

To clarify symptomatology, psychopathology and diagnosis.

Tests administered

1. Sack's Sentence Completion Test
2. Thematic Apperception Test
3. Rorschach Inkblot Test
4. Beck's Depression Inventory

Rationale for the tests

Sacks Sentence Completion Test is a projective test developed by Dr.Sacks and Dr.Levy. It consists of 60 partially completed sentences to which the respondent adds endings. It elicit the attitudes and conflicts in the areas of family, interpersonal relations, sex and self concept.

Thematic Apperception Test is a projective test used to measure the person's pattern of thought, attitudes, observational capacity and emotional responses to ambiguous test materials. The tests assess the personality dynamics of the individual and find the level of psychopathology.

Rorschach Ink Blot Test is 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.

The **Beck Depression Inventory** (**BDI**), created by Aaron T. Beck, is a 21-question multiple-choice self-report inventory, one of the most widely used instruments for measuring the severity of depression. The questionnaire is designed for individuals aged 13 and over, and is composed of items relating to symptoms of depression such as hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms such as fatigue, weight loss, and lack of interest in sex.

Behavioral observation

The entire psychological testings were done in 4 sessions. She was cooperative during the testing. She could comprehend the instructions and paid adequate attention. She appeared motivated and interested.

Test Findings

Sacks Sentence Completion Test

Severe conflicts are present in family and self concept, moderate conflicts in interpersonal and mild conflict in sex area. She tends to have high regards for her mother and overall satisfaction towards other family members. However her feelings about her father are mixed. At times she feels he was not a trustworthy person but she felt his absence throughout and thinks that life would have been easier for her in his presence. Her interpersonal relationship seems to be good with friends, colleagues and teachers. However she has high expectations from them. She

has good hopes for future and believes that future will be bright for her. However, she contradicts her statement by saying that she has poor self confidence. She reveals a pessimistic attitude towards own ability.

Thematic Apperception Test

On TAT, most of the stories were descriptive. A major portion of the stories were inconclusive and did not have a clear ending. Needs motivated by power, property are achievement, emotional aggression. Needs motivated by affection, sympathy, love were affliation, succorance and nurturance. The inner states encountered frequently were dejection, distrust and conflicts. Presses were loss, rejection and nurturance. The dominant feelings in the story include anxiety and fear. The environment in most of the stories has been perceived as difficult. However, the outcomes of most of the stories were sad.

Rorschach Ink Blot Test

Rorschach protocol is valid protocol with 38 responses. Presence of more than 5 popular responses indicate the touch with reality. Presence of high F+%, A response, shading response with more major details and less color, W response along with the content of darkness and decay is indicative of depression.

Beck Depression Inventory (BDI)

Ms. PS scored 21 out of a possible 66 which is suggestive of moderate depression and required further interviews and serial ratings to confirm diagnosis.

Conclusion

The tests were inconclusive of clear psychotic phenomena. The everyday situations seemed difficult for her; however she was showing willingness to a certain extent to correct or overcome them. She was prone to exhibit maladaptive behavior under stressful situation. The environment was perceived mostly as threatening and insecure. A current working diagnosis of Moderate Depression with somatic symptoms was considered.

Management

1. An inpatient stay to be considered in view of increased agitation and high suicidal risk.
2. To do serial MSEs and clinical assessments.
3. Pharmacologically, start antidepressants for mood symptoms.
4. Psychoeducate the family about the nature and course of illness. Issues related to compliance, and the need for regular follow up.
5. Activity scheduling to regularise daily activities and incorporate JPMR in daily schedule.
6. Address issues related to maladaptive behaviour and poor coping skills.
7. Start psychotherapeutic interventions based on cognitive behaviour therapy
8. Discuss coping skills.

CASE RECORD 2: Personality Assessment

Name	: Mr RKS
Age	: 23 years
Sex	: Male
Marital status	: Unmarried
Religion	: Hindu
Language	: Tamil, English
Education	: M.B.B.S
Occupation	: Doctor
Socio-economic status	: Middle
Residence	: Urban
Informants	: Mr. RKS and his parents

Presenting Complains

Anxiety in social situation	5 years
Opioid abuse	4 years
Low self-confidence	4 years
Problems in relationship with parents	4 years

History of presenting illness

Mr. RKS presented with history of multiple substance use over the last four year. He initially began to experiment with Tab. Tramadol, upto 200-300mg/day and

cough syrup, especially containing codeine and Dextrometharphan upto 100-300ml/day, which he continued for 2 years. However, as he gradually began to not get the “high” he craved, he began to use intramuscular and intravascular injections**.** He also began to use tobacco, alcohol, benzodiazepines and cannabis for various durations and at various amounts but did not continue as they failed to produce the effect he wanted. However, he continued to use opioids in the form of Inj. Ramadol, Inj. Fentanyl, Inj. Pentazocin, Morphine and Pethidine.

He has had made multiple attempts to quit but has been unsuccessful due to the withdrawal side effects of loose stools, anxiety symptoms, insomnia and piloerction. He also reported using the substances primarily for relief from anxiety. Over the last two years, there is a significant preoccupation with substances including reading exclusively about various substances, their effects and side effects. His activities have been focused on procuring drugs.

There is no history of first rank symptoms.

There is no history of any pervasive low or elated mood symptoms.

There is no history of any obsessive-compulsive symptoms.

There is no history of any organicity or sexual dysfunction.

There is no history of any other substance abuse in dependence pattern.

Treatment history

He was treated in a Government hospital with anti-depressants and antipsychotics. His compliance to the medication was poor and he tended to adjust the drugs and dosages on his own without consulting with his treating doctor. There was not much symptomatic improvement.

Family history

He was the younger of two siblings born out of a non-consanguineous union of his parents. He maintains a distance from his parents and is much closer to his elder sister. There is no history of any neuropsychiatry illness in the family.

Birth and Developmental history

His antenatal and perinatal period were uneventful. There was no history of birth asphyxia or neo natal seizures during or after birth. There is no history to suggest any delay in development of speech or other motor milestones.

Educational history:

He has completed his M.B.B.S. course and was working as a house surgeon till a few months ago. He was reported as an average student at school.

Sexual development

He had male gender identity and heterosexual orientation. He denied any high risk sexual behavior.

Marital history

He was unmarried

Premorbid personality

Premorbidly he was being described as a sensitive, anxious and introverted person. There were no other specific personality traits as reported by his parents.

Physical examination

His vitals were stable. His systemic examinations were within normal limits. He had multiple small healed scar marks over both upper and lower limbs.

Mental status examination

Mr.RKS was thin built and nourished. He was well kempt and groomed. He maintained eye contact. Rapport could be established. There were no abnormal motor movements. His speech was spontaneous, fluent and audible with normal pitch, speed, reaction time, productivity and good comprehension. His mood was euthymic with normal range and reactivity of affect. He denied suicidal ideation. There were no abnormalities in the form and stream of thought. His thought content

revealed anxious and depressive ruminations and concerns about future. He also expressed distress regarding his current level of functioning, difficulty in maintaining abstinence and inability to cope during periods of distress. He appeared motivated to quit his substance and his locus of control was internal. He denied delusions and hallucinations and other perceptual abnormalities. There were no obsessive-compulsive symptoms. He was oriented to time, place and person. His immediate, recent and remote memory was intact. His attention could be aroused and sustained. His intelligence was average. He had partial insight into his problems.

Provisional diagnosis

Opioid Dependence—currently abstinent in protected environment.

Anxious Avoidant Personality Traits.

Problems in relationship with parents.

Aim for psychometry

To identify and explore significant personality factors influencing the psychopathology.

Tests administered

1. Sack's Sentence Completion Test
2. The International Personality Disorder Examination Questionnaire (IPDE) - ICD 10 Module
3. The 16PF Personality Assessment Tool
4. Thematic Apperception Test

Rationale for the tests

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 endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

16PF Test This was originally developed by Raymond Cattell and measures the 16 primary personality traits and the big five secondary personality traits. This was used to assess the prominent personality traits of Mr.RKS.

IPDE (WHO) - The IPDE developed by Dr.Armand.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 and of assessing personality traits in a standardized and reliable way. This was chosen to screen for prominent ICD 10 personality traits.

Thematic Apperception Test 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.

Behavioural observation

During the entire period of assessment, he was cooperative. He could comprehend the instructions and paid adequate attention. He appeared interested initially but later felt bored and started taking a passive approach, however he was able to complete all of the tests employed.

Test Findings

Sacks Sentence Completion Test

The SCT reveals him to have a negative attitude towards his mother. He feels that she is old fashioned, pestering and does not any share common interests with him. He feels that his father is overprotective and worries about him excessively due to that and does not appreciate that. He feels that his family treats him like a victim and that they are over involved in his affairs. He reveals fear of authority and social situations and that these fears drive him towards abusing substances. He expresses regret about his dependence on opioids. His attitude towards his current profession is ambivalent and shows an avid interest in literature. He expresses a pessimistic attitude about his own ability and resorts to drugs when things do not go according to his way. He expresses a need to become independent from his family. His attitudes towards his friends are negative as he feels they are judgemental towards

him. He loathes his superiors and feels that his colleagues do not like him. His attitude towards women is negative as he feels they are predictable and simple and is indifferent towards heterosexual relationships.

The 16 PF Test

The 16PF indicates him to be very reserved and aloof and showing interest and pleasure in interacting with others. He tends to pursue his own independent ideas, activities and opinions despite their being a strong pressure to conform. He also tends to be temperamental, emotional and reacts easily to stress. He may resort to immature ways of handling problems and his ability to bounce back from problems may be poor. He tends to be serious, sober and introspective on occasions and sceptical of others' motives and intentions. He tends to hold grudges with others and is often vigilant and suspicious. He tends to be self-absorbed and may be absentminded and often impractical in his thinking. He tends to be insecure, lack self-confidence and apprehensive about various things in life. However, he tends to be liberal in this idea and open to change and experimentation. He values his autonomy, prefers to make his own decisions and is a loner. He tends to be casual, follow his own urges, ill-disciplined and not goal oriented.

IPDE

The International Personality Disorder Examination ICD 10 screening questionnaire indicates a high loading on paranoid, schizoid, impulsive and anxious traits.

TAT

The TAT stories vary from short to detailed. However, the stories are more descriptive of the stimuli and less like stories with the patient giving more importance to the language being used rather than the content of the stories. He identifies with the hero in some of the stories with the predominant needs being need or autonomy, adventure. The dominant press include that from the environment in the form of parents. The stories reflect emotions of guilt, resentment and anger. The outcomes of majority of the stories are pessimistic.

Conclusion

The tests reveal the presence of prominent traits of being temperamental, a preference to be aloof, low self-confidence, a tendency to hold grudges and poor ability to cope with distress. He has significant issues with his parents and feels that they repress his inhibitions and ideals. The test findings are suggestive of an emotionally unstable personality with impulsive subtype.

Management

An inpatient stay was considered for de-addiction. After admission withdrawal symptoms were managed symptomatically. Motivational interviewing techniques were used to enhance his motivation to remain abstinent. His motivation to remain abstinent was very poor. He was given feedback about the harmful effects of drugs that he had already experienced and possible medical, socio-occupational and legal

complications that might arise with continued drug use. He cited craving and anxiety being the major cause of continued use and multiple relapses. Tab Escitalopram was started and JPMR was taught to reduce anxiety. However his reports of anxiety did not correlate with his behaviour. His ambivalence regarding drug use was dealt in non-judgmental manner, and he was encouraged to acknowledge and discuss his ambivalence openly. Tab. Naltrexone was started to help control his craving. Cue identification and management strategies to deal with them were discussed. Parents were taught to recognize the signs of intoxication as well as withdrawal symptoms and to promptly seek help for the same. They were allowed to ventilate and their distress was acknowledged. By the time of discharge he remained ambivalent about complete abstinence.

CASE RECORD 3: Diagnostic Clarification

Name	: Ms. AJ
Age	: 22 years
Sex	: Female
Marital status	: Unmarried
Religion	: Hindu
Language	: Hindi
Education	: Biotech. Student
Occupation	: Student
Socio-economic status	: Middle
Residence	: Urban
Informant	: Ms. AJ and her mother

Presenting complaints

Repetitive Intrusive thoughts	5 years
Repetitive actions of washing	5 years
Repetitive mental rituals	5 years
Social withdrawal	5 years
Poor self care	3 years
Social dysfunction	3 years
Interpersonal conflicts with father	5 years
Academic deterioration	5 years

History of presenting illness

Ms. AJ was brought by her mother with illness of more than 5 year duration, with worsening of symptoms in last one year, characterized by repetitive intrusive sexual thoughts on seeing people of opposite gender as well as of same gender leading to sexual arousal, poor eye contact, social withdrawal, academic deterioration and associated compulsions in form of mental rituals, shaking her body and touching her textbooks in a particular way. Repeatedly asking for reassurance, irritability and anger and decreased concentration. There is history of ideas of reference that people are watching her and listening to her while taking bath and odd believes like having a bad day if some problem takes place in morning and she being pure and others impure. She attempted self harm twice within a period of last three months. She repeatedly says that her parents do not love her and there is history suggestive of pervasive low mood and guilt secondary to sexual obsessions. There is history of marked deterioration in self care, she refuses to change clothes and take bath secondary to her obsessions.

There was no history of mania or hypomania.

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 any known medical comorbidity or seizures.

Treatment history

No treatment sought prior to index visit.

Family history

There is family history of obsessive compulsive traits in father.

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 milestones were reported to be normal.

Educational history

She is doing Biotechnology, currently in her second year. Her academic performance was average and was reportedly well adjusted with her peers and teachers.

Sexual development

She had female gender identity and heterosexual orientation. She use to masturbate frequently, secondary to her obsessive compulsive symptoms and had guilt related to the same. She denied any high risk sexual behavior.

Marital history

She was unmarried.

Premorbid personality

She had good social interaction. She was described as a person with low frustration tolerance and adamant behavior. She had high moral standards.

Physical examination

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

Mental status examination

She was thin built and adequately nourished individual with ill sustained eye contact. Rapport could be partially established. She was conscious and cooperative. Her speech was relevant and coherent with occasional stammering. Her mood was euthymic with normal affect. Content of thought revealed excessive repetitive thoughts and images with sexual theme causing distress and guilt. She also expressed some overvalued ideas of reference and some odd believes. No thought alienation phenomena or perceptual abnormalities were present. Higher mental functions were intact. Intelligence was average. She had partial insight into her illness with impaired personal and social judgment.

Provisional diagnosis

OBSESSIVE COMPULSIVE DISORDER – MIXED

PRODROME OF SCHIZOPHRENIA

Aim for psychometry

To clarify symptomatology, psychopathology and diagnosis

Tests administered

1. YBOCS with Checklist
2. Sentence completion Test
3. Thematic Apperception Test
4. Rorschach Test

Rationale for the tests

YBOCS is Yale-Brown Obsessive Compulsive Scale which is the instrument of choice for assessing symptom severity in Obsessive compulsive Disorder designed by Wayne Goodman and colleagues.

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 endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

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.

Rorschach Ink Blot Test 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 exercise, she was alert and cooperative, her attention could be aroused and sustained and she could comprehend the instructions adequately and perform accordingly.

Test findings

YBOCS checklist

She had predominantly sexual obsessions currently, causing physiological arousal and extreme distress followed by masturbatory behavior and guilt associated with it. She had excessive concerns regarding morality and holding odd believes. Compulsions of excessive hand washing, bathing for long hours were present in past. Repetitive need for reassurance and mental rituals were present. YBOCS total score was 34, indicating extreme form of OCD.

Sacks Sentence Completion Test

On SCT protocol, she revealed significant conflicts and disturbances in the domains of family. Though she gets along fairly well with her mother, there are major interpersonal issues with her father. There are no conflicts with superiors and subordinates. She expresses fear regarding interaction with opposite gender and guilt associated with masturbation. She also revealed conflicts related to low esteem and ambivalence about the future.

Thematic Apperception Test

Most of the stories were short and concrete. The recurrent themes were that of hero facing difficulties in life. Mostly female heroes were identified whose prominent needs were needs for secureness and affliation. The female characters in most stories are portrayed as meek and submissive. The environment in most of the stories has been perceived as threatening and unsupportive. The main anxieties were that of failure to achieve, being deprived and helpless.

The significant conflict that surfaced was acceptance versus rejection. Superego structure was found to be adequate and integration of ego was found to be inadequate. Overall the outcomes in most stories were sad.

Rorschach Ink Blot Test

In Rorschach, the total numbers of responses were insufficient, as a result of which quantitative analysis by Exner method cannot be done. However, the protocol had popular responses and nothing about it was suggestive of psychosis.

Conclusion

The tests done were suggestive of Ms.AJ having obsessive compulsive disorder rather than schizophrenia. No clear psychotic symptoms came up in the test. Hence the working diagnosis was kept as obsessive compulsive disorder. Plan was made to observe her longitudinally during reviews for the evolution of any new symptoms which may warrant a change in the diagnosis.

Management

Ms. AJ was managed initially on outpatient basis. Blood investigations were done. She was found to have Hypothyroidism and low serum vitamin B12 level for which she was referred to Medicine and treated accordingly. Cap. Fluoxetin was initiated and dose was built up to 80mg/day. Risperidone was also started for augmentation. As there was no significant improvement, an inpatient stay was considered, Fluoxetin was tapered off and stopped and Citalopram upto 40mg/day was started along with psychotherapeutic interventions. But due to insufficient response to Citalopram, decision to start Clomipramine was taken and a therapeutic dose was established. During her stay in hospital she developed myoclonic jerks while on

Clomipramine and Tab Carbamazepine was started for that. Her mother was educated about the nature, course and prognosis of her illness. She was allowed to ventilate and her distress was acknowledged. Ms. AJ was reluctant to attend occupational therapy unit and to participate in behavioral therapy initially. But later she was treated with behavioral interventions and reinforcement strategies. Eventually it was graded up to gradual exposure and response prevention. She showed marked improvement.

CASE RECORD 4: Intelligence Assessment

Name	**:** Ms. P
Age	: 7 years and 10 months
Gender	**:** Female
Education	: Std. 1
Marital status	: Unmarried
Informants	: Parents
Reliability	: Reliable and adequate

Presenting Complains

Decreased concentration in studies	3 years
Inattentive in class-	3 years
Unable to sit at one place	3--4 years
Adamant behavior	3--4 years

History of Presenting Complains

Ms. P was born out of non-consanguineous union with no prenatal and perinatal complications. There is history suggestive of delayed motor and speech development. She was reported to be a child of difficult temperament with adamant behavior. She started schooling at the age of 5 years. Her academic performance was poor. She was restless and inattentive in class and needed multiple prompts to complete her task. There were complaints from school that she pushes and hits other

children without knowing the consequences. She was able to verbally and gesturally communicate her needs and was partially dependent on her mother for activities of daily living. She had poor sense of modesty. Her parents felt that her social and academic performance is not appropriate for her age.

There is history of squint in both eyes but there was no visual impairment. Parents never consulted to any ophthalmologist.

There is no history to suggest any speech disorder or hearing impairment.

There is no history to suggest any PDD features.

There is no history to suggest eating and elimination disorder.

There is no history of seizure disorder or any other organicity.

Birth and Development History

Prenatal History: Planned pregnancy with no history of trauma, bleeding, infection or any other illness.

Perinatal History: Full term, forceps delivery due to prolonged labor in hospital after 37 weeks.

Birth weight was 3.5Kgs. She cried immediately after birth. There was no pallor, icterus, cyanosis or any other complications.

Postnatal History: She was adequately immunized for her age.

Motor milestones and speech development: Head control at six months, crawling at one year, walking by two years, first word at two years and full sentence by 5/6 years.

Emotional Development and Temperament

She was reported to be a child with difficult temperament. There is history suggestive of inattention and hyperactivity. There is no history to suggest any Pervasive developmental disorder features.

School History

She started schooling at the age of five years. She is currently studying in Std. 1 and the medium of instruction is English. She can write alphabets but cannot write simple words. Her general performance is below average. She attends school regularly.

Family History

She was born out of non- consanguineous union and is younger of two siblings. Her elder brother is studying in Vth Std. There is no history of neuropsychiatry illness in family.

Physical Examination

Vitals and systemic examination was within normal limits. There was squint in both eyes, right eye> left eye. There were no other peculiar features or deformities to suggest any syndromal cause for her symptoms.

Mental State Examination

She was moderately built and nourished. She was well kempt with good eye contact. Higher mental functions were grossly intact. Speech, thought and affect were normal. Her thought content did not reveal any psychotic or mood symptoms. She had difficulties in sustaining attention. She was unable to sit quietly even for a minute and was found to be restless and fidgety

Provisional Diagnosis

- Intellectual Disability-unspecified
- Attention Deficit Hyperactivity Disorder

Aim of Psychological Testing

History was suggestive of delayed development milestones. Her social and academic performance was not appropriate to her age. As there was no history to suggest any organic cause of her illness, IQ assessment was imperative.

Tests Administered

1. Binet Kamat Test of general mental abilities (BKT)
2. Vineland Social Maturity Scale (VSMS)

Rationale for the test

1. Binet Kamat Test (BKT) was used to assess intelligence as it is a standardized I.Q test for the Indian population
2. VSMS was used as to assess the social adaptation and social age

Behavioral Observations

Ms.P was cooperative and was willing for the assessment in a structured setting however she was restless and hyperactive. She was able to complete the assessment with multiple breaks and verbal prompts. She was able to understand the instruction but was found to be inattentive and restless for each task to complete. She gets distracted easily. She could initiate and sustain eye contact. Rapport could be established easily. She was able to communicate adequately.

Test Findings

1. Binet Kamat Test

   Mental age –5 years

   Chronological age—7 years 10 months

   IQ-64

   Function wise classification:

Language	5 years
Meaningful memory	5 years
Non-meaningful memory	4 years

Conceptual thinking	not yet developed
Non verbal thinking	4 years
Verbal reasoning	not yet developed
Numerical reasoning	5 years
Visuo-motor	4 years
Social intelligence	6 years

2. VSMS

The social age of Ms. P was 5.13 years, which was lower for her age. The profile of age levels across the functions were as follows:

Self help general	2.85 years
Self help dressing	4.80 years
Self help eating	2.43 years
Communication	5.23 years
Socialization	3.75 years
Locomotion	5.83 years
Occupation	5.13 years

Impression

Tests revealed that Ms. P had significant impairment in language, meaningful and non-meaningful memory, conceptual thinking, visuomotor and social intelligence. The IQ according to the Binet-Kamat test was 64, suggestive of mild intellectual disability.

VSMS is indicative of low social adaptive function level.

Assessments for Attention deficit hyperactivity disorder were also done for her.

Final Diagnosis:

1. Mild ID with Behavior problems
2. ADHD

Management

1. To educated the parents about her dual diagnosis and its implications. Clarify their doubts.
2. Teach the parents about the importance of maintaining Activities of Daily Living Chart and Behavioral Chart.
3. To learn about the Behavioral Modification techniques to increase skill behavior and reduce the problem behavior.
4. Discuss the need for scaling down academic expectation in view of mild ID with parents and to inform the school authorities to avoid putting undue academic pressure.
5. For addressing ADHD, Tab Atomoxetine was suggested, after taking ECG, EEG & cardiac clearance
6. Re assessment of IQ after an adequate trial of Atomoxetine.
7. Expert opinion from Ophthalmologist regarding squint was also suggested.
8. The need for in-patient care in light of failure of behavioral strategy was discussed.

CASE RECORD 5: Neuropsychiatric Assessment

Name	**:** Mr. SR
Age	**:** 68 years
Sex	**:** Male
Marital status	**:** Married
Religion	**:** Hindu
Language	**:** Tamil
Education	: 10^{th} Grade
Occupation	: Teacher
Socioeconomic status	: Middle
Resident	: Rural
Informant	: Wife

Presenting Complaints

Decreased communication	3 years
Irritability towards family members	3 years
Poor memory	3 years
Inability to recognize familiar people	3 years
Decline in socio occupational functioning	3 years

History of presenting illness

Mr. SR was reportedly asymptomatic till three years back when he began to appear dull and showed a gradual decline in activities that he enjoyed earlier. He began to withdraw from devotional and religious activities which he was very prompt with and enjoyed following his retirement from school as a teacher. He began to have difficulty in recognizing familiar people and would forget information and details often. There was gradual decline in his socialization with Mr. SR often giving mono syllabic responses or no response to questions. There were fluctuations in his mood state with Mr. SR expressing anger and irritability towards his family for trivial issues at times and being extremely dull and withdrawn at others. He would often get irritable and angry when guests visited his house. There were also episodes of crying spells for which he would give no explanation. There was decline in his self-care with Mr.SR becoming disinterested in performing his activities of daily living and becoming resistant when he was prompted to do so. However, he was able to do his self-care activities on his own and did not require at assistance for the same. He was found to be apathetic towards household affairs which he used to take responsibility for earlier. There was no impairment in his sleep pattern and he continued to wake apathetic up at 4:30 am which was his premorbid self but he did not engage in his routine devotional activities as usual.

There is no history suggestive of any head injury, seizure disorder or episodes of disorientation

There is no history suggestive of any substance use

There is no history suggestive of first rank symptoms or any other psychotic symptoms

There is no history of any manic or hypomanic symptoms in past

There is no history of any melancholic features in past

There is no history of any obsessive-compulsive symptoms or panic symptoms

There is no history of any speech difficulty, visual or hearing impairment

Past History

There is no history of substance abuse or any known medical comorbidity

Family History

There is family history of probable dementia in his father and probable psychotic illness in his elder sister.

Birth and Developmental History

Details of birth and development are not available but history is suggestive of achievement of age appropriate developmental milestones.

Educational history

He is formally educated up to 10^{th} grade.

Occupational History

He worked as an elementary school teacher and retired in 2005.

Sexual history

He had heterosexual orientation. He denied any premarital high risk sexual behavior.

Marital History

He is separated from his first wife and remarried. He currently stays with his second wife. He has one daughter with this first wife and a son with his current wife. His son is 16 years old and is currently studying in 12^{th} Grade.

Premorbid personality

He is reported to be a simple, reserved and spiritual person with high moral and ethical values. He is also reported to be very rigid in his ideals.

Physical Examination

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

Central nervous system

Higher function – MMSE 26/27

Cranial nerves – No cranial nerve palsies

Motor system

Bulk - Normal bilaterally

Tone - Normal tone bilaterally

Power - Grade 5 bilaterally

Peri-oral movements present

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 – Normal

Meningeal signs - Absent

Skull and spine –Normal

Mental status examination

He was a thin built individual and was appropriately kempt. Rapport could be established with difficulty. There were abnormal movements of the mouth which fluctuated during the interview. His speech was slow with increased reaction time

and minimal productivity. He appeared dysphoric with restricted range, decreased reactivity and constricted affect. He denied suicidal ideation. There was retardation in stream of thought poverty in content of thought. Content of thought did not reveal any obsessions, delusions or depressive cognitions. There were no perceptual abnormalities present. He was oriented to time, place, and person. His remote memory was intact. However, his recent memory was impaired but there was no confabulation. His attention could be aroused but was difficult to sustain. He was easily distracted. His intelligence was average. His insight was poor and judgment was impaired.

Provisional Diagnosis

1. Evolving Dementia
2. Severe Depression without psychotic symptoms
3. Organic Mood Disorder

Aims for neuropsychological testing

1. To find out the cognitive profile of Mr. SR

2. To relate the findings to clinical presentation

Tests administered

1. Addenbrooke's Cognitive Examination-Revised (ACE- R)
2. NIMHANS Neuropsychological Battery (Specific Subtests)

Behavioral Observation

He was not very cooperative for the examination and often showed disinterest in continuing with the assessment. He was able to comprehend instructions adequately but on occasion required them to be repeated. There was persistent chewing movement of the mouth and fidgeting when idle and these movements subsided when his attention was diverted on to the task at hand. His communication was minimal and often monosyllabic.

Rationale and findings

Addenbrooke's Cognitive Examination (ACE-III)

It is a brief neuropsychological assessment of cognitive functions and a development on the Mini mental state examination, which it incorporates. The test is widely used for determining mild cognitive impairment and dementia. The test includes tests for measures of language, memory, visuospatial skills and orientation. The test does not adequately assess apraxia.

Test Findings

On the ACE R, he obtained a total score of 56 out of 100. The distribution of his scores across the domains measured are as follows

Attention and Orientation	11/ 18
Memory	17/ 26
Fluency	2/ 14

Language	15/ 26
Visuospatial	11/ 16

This indicates impairment in Verbal Fluency, language and memory.

NIMHAN'S Neuropsychological Battery

The battery was developed by Shobini Rao et al in 2004. This assesses a subject's performance across various domains of neuropsychological functions. It has been validated to suit the Indian adult population. For this patient, flexible battery approach was used and only specific subtests from the battery were chosen.

Test Findings

On the digit symbol substitution test, the total time taken to complete was 529s which is at the 15th percentile, indicative of mild impairment in mental speed. On the digit vigilance test, the total time taken to complete was 974s which is at the 10th percentile and the total number of errors were 104 indicative of significant impairment in sustained attention. On the COWAT, the average new words generated was 3which is at the 10th percentile and is indicative of impairment in verbal fluency. Categorical Fluency was assessed by the Animal Names Test. The total new words generated was 7, which is at the 5th percentile, indicative of impairment in categorical fluency. On the auditory verbal and learning test, the total number of correct words recalled is 28, which is at the 5th percentile; the immediate recall and delayed recalls are at 3 and 0 words which are at 5th percentile.

The long term percentage retention is 92.85% which is at the 75th percentile. The number of hits is 12 which is at the 15th percentile. The scores indicate impairment in verbal learning and memory with recognition less impaired. This is suggestive of deficits in retrieval of information than in storage. In the logical memory test, the immediate recall is 3 and the delayed recall is 0 which are at the 10th percentile and 5th percentile respectively. This is suggestive of impairment in logical memory. On the ROCF, the copying score is 17, which is at the 5th percentile. The immediate recall score is 2 and the delayed recall score is 1.5, both of which are at the 5th percentile. This indicates impairment in the area of visuo constructive ability and visual memory.

Conclusion

Cognitive assessment indicates the presence of significant deficits in the areas of verbal fluency, verbal learning and memory, visual memory and visuospatial ability.

Management

Mr.SR and his family were educated on the nature of illness and, about the assessment results. He was treated on in-patient basis and attended occupational therapy classes. He was maintained on Quetiapine 25 mg twice a day to reduce his agitation and for sleep disturbance. Reviews and further assessments as per need were scheduled.