PSYCHOLOGY CASE RECORD

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The Tamil Nadu Dr. MGR Medical University

In partial fulfilment of the requirements for the

Diploma in Psychological Medicine Examination 2018

By

Dr. Poornima Sunder

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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. Poornima Sunder** during the year 2016-2018. I also certify that this record is an independent work done by the candidate under my supervision.

Dr. Mary Anju Kuruvilla
Professor and Head,
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INDEX

CASE RECORD 1: Personality Assessment

Name	: Mrs. K
Age	**: 30 years**
Gender	: Female
Marital status	: married
Religion	: Hindu
Language	: Tamil, English
Education	: BE
Occupation	: Housewife
Socio-economic status	: Upper middle
Residence	: Urban
Informant	: Mrs. K, her husband and her father.

Presenting Complaints:

Issues with anger management	-	four years
Marital issues	-	four years

History of Presenting Illness:

Mrs. K was described as an individual with low self esteem, high rejection sensitivity, adamancy and feeling of insecurity since her adulthood. She currently presented with history of having significant interpersonal issues with husband and his family since the time of her marriage as she feels that he is not taking up enough responsibilities at home. The problems escalated after birth of her child as she became over involved with upbringing of her child and would have anger outbursts for perceived neglect from her parents or husband's side. Over the past four years, there has been an increase in her anger outbursts wherein when irritable, she resorts to physical violence and justifies the same saying that it is the others who provoke her and they are to be blamed. She quit her job in December 2014 to look after her child but now regrets the same. She also has complaints of disturbed sleep with pattern suggestive of global insomnia. She has been functional throughout this period and has been able manage her household chores. She also has complaints of feelings of emptiness and low mood secondary to multiple stressors including financial issues. There was no history of organicity or substance use.

There was no history suggestive of head injury, loss of consciousness, automatisms. There was no history of pervasive mood syndrome or psychotic symptoms

There was no history of obsessive compulsive symptoms or generalized anxiety disorder.

Treatment History:

At the time of her index visit to MHC, she was on Oxcarbazepine 600mg per day, Risperidone 3mg per day, Trihexyphenidyl 2mg per day and Propranolol 20 mg per day. These medications were started in CADABAMS in February 2017 with a possible consideration of a mood episode.

Family History:

She was born out of a nonconsanguineous marriage. She is the eldest of two siblings. She has a younger sister who is a doctor and is doing her post-graduation in PGI, Chandigarh. There is family history of probable mood disorder in one maternal aunt who is on treatment.

Developmental History:

The antenatal period was supervised and uneventful. Her delivery was at term by Lower Segment Caesarean Segment and she weighed 3.5 kilograms at birth. There was no history suggestive of birth asphyxia or neonatal seizure. Her postnatal period was uneventful. Her developmental milestones were reported to be normal.

Educational History:

She was described as average in academics in school. She secured about 85% in her 10^{th} and 12^{th} board exams and later on completed her Bachelor's degree in Engineering.

Occupational History:

After finishing her BE she worked as a software engineer. However, she quit her job in December 2014 and has been a housewife since then.

Sexual Development:

Her sexual orientation was heterosexual. She denied any high risk behaviour. Her menstrual cycles were irregular, she was evaluated for the same and diagnosed to have Polycystic Ovarian Disorder.

Marital History:

She is married for five years. She has a two and half year-oldson. There are significant interpersonal issues with husband since marriage

Premorbid Personality:

Premorbidly, she has been described as a person with low self-esteem, high rejection sensitivity, adamancy, fear of separation and feelings of insecurity.

Physical Examination:

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

Mental Status Examination:

Mrs. K was a well built and well kempt person. She was able to sustain eye contact and rapport was established. There were no fluctuations in consciousness. She could follow simple and

complex orders. Her posture was erect, with normal level of activity. Her goal-directed movements were appropriate, purposeful and smoothly coordinated. There were no non-adaptive movements. Her speech was spontaneous, fluent, and audible, with normal reaction time and speed. Her comprehension was good. Her mood was dysphoric but affect was reactive. She denied any suicidal ideas. There were no abnormalities in the form and stream of thought. Her thought content revealed worries and concerns in several domains including child care, finances, her career and her relationship with her spouse and parents. There was no abnormality of perception. Her attention, concentration, and memory was intact and she was oriented to time, place and person. Her intelligence was clinically average. Her insight was partial and judgment was intact.

Differential Diagnosis:

1. Emotionally unstable personality disorder with stress related accentuation of personality traits.
2. Mood disorder.

Aim for Psychometry:

- To clarify the diagnosis
- To identify and explore significant personality factors influencing the psychopathology

Tests Administered and Rationale:

1. **Sack's Sentence Completion Test:** 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.
2. **Thematic Apperception Test:** It is a projective test 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.
3. **Neo Five Factor Inventory Questionnaire:** The NEO-FFI is a 60-item test. It provides a quick, reliable and accurate measure of the five domains of personality and is particularly useful when time is limited and when global information on personality is sufficient.

Behavioural Observation:

Mrs. K was extremely cooperative during the assessment. Her comprehension was adequate and she was able to understand the instructions easily. There was no performance anxiety observed and she did not report of any fatigue.

Test Findings:

- **Sentence Completion Test:**

She feels that her family as a whole was biased and favoured her younger sister because of which she never had a happy family life like others did. Though she describes her father as being affectionate towards her shefeels that her father does not understand her dreams. She also attributes her current consideration of aggression being a normal way of reacting to situations to her father's behaviour towards mother. She feels that her mother was not affectionate towards her and showed preferential treatment towards her sister because of which she finds it difficult to get along well with her mother even now. There seems to be no conflicts in her ideas about sexual life. She considers women as being sentimental and prone to gossiping. She expects friendships to be sincere and everlasting though she does not have any friends that she considers as ideal currently. She seems to have cordial relationship when it comes to superiors as well as her subordinates and tends to believe that justice should be done to one and all. In areas of self-concept, she expresses guilt feelings about aborting her first conception, she also expresses fear of darkness, though she expresses bitterness about past has positive outlook about future and has belief in her ability to achieve the same.

- **Thematic Apperception Test:**

The stories are very detailed in their description and well-structured. The length and range of her stories were reality oriented. The language of the stories is appropriate. The predominant needs seen in the stories are those for need for achievement, nurturance, affiliation, autonomy, blame avoidance and recognition. Conflicts between need for harm avoidance and aggression;

deference and autonomy can be seen in the themes of the stories. The stories have been mostly written from a third person's perspective and the she has not identified herself with the hero of the story. In a majority of the stories, the female characters are portrayed being independent and confident enough of being able to pursue their goals and desires. The male characters are portrayed as responsible and caring with a positive outlook. Each of the stories portray a moral and philosophy. The predominant presses seen in the stories include dominance, nature and significant others. The outcomes of the stories are extremely optimistic.

- **Neo FFI:**

In the NEO FFI, she scores high on openness and average on neuroticism, extroversion, conscientiousness. She scores low on agreeableness. It indicates that she is sensitive of her inner feelings and experiences a wide range of emotions. She is open to new ideas, experiences and has intellectual interests. She has a tendency to be disagreeable, egocentric and sceptical of others intentions. She also tends to be competitive and is less cooperative. She experiences a normal amount of psychological stress and is typically able to balance satisfaction and dissatisfaction in life. Has difficulty dealing with stress however is able to manage most of the time. She prefers company rather than being alone most of the time and engages in social interactions.

Summary of Test Findings:

The test results were suggestive of a personality disorder rather than Mood disorder. So a diagnosis of emotionally unstable personality disorder was made and further management of the same was done.

Management:

Serial mental state examinations revealed interpersonal issues with spouse, parents and other relatives which were being compounded by various stressors. No psychotic symptoms or mood symptoms were observed while in the ward. Risperidone and propranolol were gradually tapered and stopped. Rapport was gradually established. In sessions she was allowed to ventilate and her distress was acknowledged. The need for change was discussed with Mrs K. Sessions were focused on anger management and self-esteem related issues. In sessions with the couple, the need for better communication was discussed. She was encouraged to attend occupational therapy sessions where the focus was on improving her coping skills especially in times of stress. Her family members were allowed to ventilate and they were supported. They were educated about the nature of diagnosis, course and prognosis.

CASE RECORD 2: Diagnostic Clarification

Name : Mr. AA

Age : 22 years

Sex : Male

Marital status : Unmarried

Religion : Hindu

Language : Tamil

Education : BE Mechanical

Occupation : Unemployed

Socio-economic status : Middle

Residence : Rural

Informant : Mr AA, his mother

Presenting Complaints:

Reduced sleep - Three months

Physical Aggression - Three months

Expressing wishes to die - Three months

History of Presenting Illness:

Mr AA was reportedly functioning well till three months ago. He had completed his Bachelor's degree in engineering in May 2017 and was preparing common entrance exams for Master's degree at home. During this time, he was noticed to be getting irritable towards family members over trivial issues which normally did not bother him before. There was a decline in his social interaction with his family members as well as he friends. His sleep was disturbed at night and he reported to having difficulty in falling asleep. He started complaining that he was not able to concentrate on his studies and often found himself to be preoccupied with thoughts. His irritability towards his parents escalated gradually and from verbal abuse, he began to assault his family members, especially his mother. He blamed his mother for his decline in self-confidence, increase in his preoccupation and difficulty in concentration and hence reported that he assaulted her. Over the last one month, he gradually began to claim that his personality had been replaced and felt that he was not his old self. He began to claim that he was unable to feel emotions like he used to before and that his pro social attitude and behaviour had completely changed. Even when reassured by his family about the contrary he held on to this belief firmly and refused to accept any alternative explanations from the family and would become assaultive. He also started expressing death wishes as he felt there was no point in living as he felt hopeless and believed he could not be his old self again.

There was no history of any organicity around the time of onset of his illness, any psychoactive substance use in a dependence pattern in the past.

There is no history of any other clear first rank symptoms, any pervasive mood symptoms, anxiety spectrum symptoms, primary sleep problems or sexual dysfunction.

Treatment History:

He had not undergone any psychiatric treatment in the past.

Family History:

He was born of non-consanguineous union. His father was fifty years old and worked in a company in Andaman Islands. His mother was forty- four years old and used to work as a teacher and currently takes tuitions at home. There was family history of alcohol use in paternal uncle and history suggestive of probable schizoid traits in father.

Developmental History:

The antenatal period was supervised and uneventful. His birth was full term by Lower Segment Caesarean Section with no birth asphyxia or neonatal seizure and the postnatal period was uneventful. His developmental milestones were reported to be attained age appropriately.

Educational History:

He completed his Bachelor's Degree in Mechanical Engineering from a private college in May 2017. He was reported to be an average student from his school days. His interaction with his teachers and peers was good.

Occupational History:

He has never been employed and is currently preparing for GATE exams.

Sexual Development:

He has male gender identity and heterosexual orientation. There was no masturbatory guilt. He denied any sexual dysfunction or high risk sexual behaviour.

Marital History:

He was unmarried.

Premorbid Personality:

Premorbidly he is described to have paranoid traits and high sensitivity to criticism. He is said to be an introverted individual who preferred to spend time by himself with limited number of friends. He had good moral and religious values.

Physical Examination:

His vitals were stable and his systemic examinations were within normal limits.

Mental Status Examination:

He was moderately built and nourished. He was well kempt and maintained good eye contact. Rapport was superficial. He was alert and lucid. There were no fluctuations in consciousness. He could follow simple and complex orders. He did not have depersonalization or derealisation experiences. His posture was erect with normal level of activity. His goal-directed movements were appropriate, purposeful and smoothly coordinated. There were no non-adaptive movements. His speech was spontaneous, fluent, audible, with normal reaction time and speed. His comprehension was good. His mood was dysphoric and affect was blunted with restricted range and reactivity. He expressed suicidal ideations however denied any active planning. Content of thought revealed ideas of reference and depressive cognitions. There were no abnormalities in form or stream of thought. He denied perceptual abnormalities. No obsessive compulsive phenomena were observed. He was oriented to time, place, person. His memory was intact. His attention could be aroused and sustained. His general information was adequate and clinically, his intelligence was average. He had partial insight and impaired judgement.

Differential Diagnosis:

1. Delusional disorder
2. Severe depression with psychotic symptoms
3. Prodrome of schizophrenia
4. Stress related accentuation of personality traits

Aim for Psychometry:

To clarify the diagnosis.

Tests Administered and Rationale:

1. **Sack's Sentence Completion Test:** 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.
2. **Neo Five Factor Inventory Questionnaire:** The NEO-FFI is a 60-item test. It provides a quick, reliable and accurate measure of the five domains of personality and is particularly useful when time is limited and when global information on personality is sufficient.
3. **Rorschach Ink Blot Test:** It 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.

Behavioural Observation:

Mr. AA was cooperative during the assessment. His comprehension was adequate and he was able to understand the instructions easily. There was no performance anxiety observed.

Test Findings:

- **Sentence Completion Test:**

The SCT reveals conflicts in the areas of family, self concept and interpersonal relationships. His attitude towards mother as well as mothers in general was found to be positive however says that they tend to trust blindly and not realise real world demands on their kids. He expresses that he has a friendly relationship with his mother. He feels that she trusts and cares for him however tends to put him down on most of the occasions. He tended to hesitate on answering questions related to his father initially and needed prompts for answering the same. Though he says his father is a nice person he feels that he was neglected by him and was never supported in his endeavours. He feels that a family as a unit is supposed to be sympathetic and compassionate however his family is not something he is proud of as they treat him badly and tend to look at him as a failure. He tends to suppress his fears and prefers to not acknowledge their existence as he feels he has nothing to be scared of anymore. He expresses guilt about not obeying his parents and regrets choosing his home for preparation of GATE exams, however he feels that these are good learning experiences. He wants to achieve the impossible and help the downtrodden. He says that he is happiness is not dependent on external factors however he states that his ambition is to be loved and understood by others. Though he feels strongly that his future looks bleak at present he believes he will be able to turn the odds in his favour and achieve his ambitions. He does not seem to have any close friends. He respects his superiors and finds them to be worthy of being his role models. He also prefers to be considerate to his juniors, however would prefer doing tasks by himself rather than giving other responsibility for the same as he finds people too complex to handle. He has a feel women should be affectionate and loyal however in his experience he has found them to be lazy, relying on others and stubborn. No clear conflicts could

be elicited in his attitude towards heterosexual relationships as he did not attempt questions about sex life, however expressed positive ideas about marriage.

- **Neo FFI:**

In the NEO FFI, he scores high on neuroticism, low on extroversion, openness and conscientiousness, whereas he scores very low on agreeableness. It indicates that he is susceptible to psychological distress with a tendency to experience feelings that are upsetting. He has a tendency for being introverted with very few close friends. He likes being practical and traditional in his views. He has a preference for familiar compared to novel ideas and his emotional experiences tend to be comparatively muted. He tends to be disagreeable, egocentric and extremely sceptical of others intentions. He is also competitive and is less cooperative with others. He has very little need for achievement and usually accomplishes work in haphazard manner with inability to set goals. He has more of a relaxed attitude towards duties and obligations and prefers not to make commitments.

- **Rorschach Ink Blot Test:**

In the Rorschach protocol, he has shown low productivity and quick and hurried mentation. The protocol indicates he tends to supress his impulses in favour of conscious values suggestive of inner conflicts, tension and excessive control. There is a preoccupation with egocentric needs but this tends to be manifested more in the form of neurotic or somatic symptoms rather than as impulsive behaviour. He tends to be restrained in his interactions with others and tends to find it

difficult to make warm and close affectional contacts. He tends to be highly ambitious but may lack the necessary capacity to fulfil his ambitions resulting in adjustment difficulties. The inability to fulfil his capacity may also be due to interference from his emotions. There is an under-emphasis of D responses but with good form level suggestive of a lack of recognition of everyday problems and solutions due to poor perceptual abilities. High percentage of Human responses indicates an empathetic attitude and interest in people. Unrealistic human content indicates anxiety about interpersonal relations. There are adequate number of popular responses indicative of ties with reality. There are no clear indicators of a psychosis.

Summary of Test Findings:

Assessment revealed prominent personality traits of neuroticism with poor ability to deal with stress. There were no indicators of psychosis or pervasive mood syndrome.

Management:

He was mainly admitted for Diagnostic clarification and for planning further management. Pharmacologically to control his agitation he was started on Olanzapine. Suicide precautions were enforced by the nursing staff and family members. Blood investigations and Brain imaging was done and was found to be within normal limits. He was observed in different settings and was found to be calm with no proxy indicators of psychosis. This was confirmed by the psychological assessment. He reported to have lost all his emotions and remaining numb, but in sessions seemed to have a reactive affect and was angry when this was pointed out and rationalised his reactivity as responses due to logical thinking. Discussions were done with the

treatment team and it was found to be his symptoms were more suggestive of personality disorder rather than psychosis. However due to his acting out behaviour, socio occupational dysfunction and family loading of cluster A traits, a plan was made to keep him under regular follow up and watch for symptoms of evolving psychosis. He was prematurely discharged at family's request hence further plans for tapering of medication and psychotherapy on Out-patient basis was made.

CASE RECORD 3: Intelligence Assessment

Name : Mr. AV

Age : 19 years

Gender : Male

Marital Status : Single

Religion : Hindu

Language : Malayalam

Education : 9th standard

Occupation : Unemployed

Socio-economic status : Middle Class

Residence : Kerala

Informant : Parents

Reliability : Complete, Consistent, Competent

Presenting Complaints:

- Shouting and assaultive behaviour
- Adamant and demanding behaviour
- Running away from home

Duration:

- Ten years with an exacerbation over the past one year

History of Presenting Complaints:

Mr. AV was brought by his mother with approximately ten years' history of progressive worsening of behavioural problems with marked increase over the last one year. His behavioural problems included abusing, shouting, assaulting family members and running away from home when his demands were not gratified immediately. He would throw and break objects when asked to do things he did not like and had significant difficulty in controlling his anger. His behavioural problems have also resulted in risks to his and his parents' life and conflicts with the law. He has complained against his father at thepolice station multiple times over trivial issues. He is independent in activities of his daily living and is able to carry out simple chores at home when instructed. He is said to have difficulty in making minor purchases and doing simple arithmetic problems. He is able to socialise with others. However, he finds it difficult to anticipate group needs and behave according to norms. He manages to move around alone in his hometown. He had academic difficulties and poor adjustment since joining school.

There is also history of seizures since one and half years of age which is of variable semiology with the current presentation suggestive of complex partial seizures with automatisms. He is on multiple anti-epileptic medications for the same.

There was no history of apathy or emotional lability or sexual disinhibition. There was no history of apraxia. There was no history of head injury, substance use, psychosis or mood syndrome,

obsessive compulsive phenomena, phobia or panic attacks. There was no history of poor eye contact, lack of socialization or repeated movements or behaviours

Past History:

He was on multiple anti-epileptic medications from Neurology. He is also on Tab. Risperidone 1.5 mg /day from the Mental Health Centre since February 2016 for control of his agitation and aggression.

Birth and Development History:

It was a planned pregnancy with no relevant history. He was born at term by Lower segment caesarean section. He cried immediately at birth and there were no neonatal complications. He was immunised for age. He had no postnatal complications till about sixty second day of life when he developed seizures probably secondary to an infectious aetiology. He has been on treatment with various antiepileptic drugs since then.

Developmental history is suggestive of normal gross motor, fine motor and language milestones. However there is history of delay in socio adaptive milestones.

Emotional Development and Temperament:

He was adamant and with difficult temperament.

School History:

There is history of academic difficulties and poor adjustment in school since four years of age. He studied up to 9th standard but passed with significant difficulty.

Family History:

He is second born of a third degree consanguineous union. His father was employed and his mother was a home maker. He has an elder brother who is twenty-three years old has done B.Tech and is currently working in a shipyard. There is no history of any neuropsychiatric illness in his family.

Medical History:

There is history of pneumonia at three years of age and bronchial asthma till six years of age. There is also history of facio-maxillary cosmetic surgery done at the age of twelve years.

Physical Examination:

Mr.AV was moderately built and nourished. His vitals were stable and systems were within normal limits.

Mental Status Examination:

Mr.AV was a well built, well-nourished and well kempt individual. He maintained eye contact. Rapport was difficult to establish. There were no abnormalities of expressive, reactive or goal directed movements. His speech was normal with normal reaction time. His mood was irritable with normal range and reactivity of affect. He denied any suicidal ideation. There were no abnormalities in the form, stream and possession of thought. Content of thought revealed depressive cognition. He denied perceptual abnormalities. No obsessive compulsive phenomenon was present. He was orientated to time, place and person. His attention could be aroused but was difficult to sustain. He had below average intelligence and poor insight. His personal and social judgment was impaired with intact test judgment.

Provisional Diagnosis:

- Unspecified intellectual disability with behavioural problems.
- Seizure disorder.
- Conduct disorder.

Aims of Psychological Testing:

For diagnostic clarification, quantification of Intelligence Quotient was imperative.

Tests Administered and Rationale:

1. **Vineland's Social Maturity Scale** was used to assess social age and adaptation. It measures social competence, self-help skills, and adaptive behaviour from infancy to adulthood. It can be used from birth up to the age of 30, consists of a 117-item interview with a parent or other primary caregiver. Personal and social skills are evaluated in the following areas: daily living skills (general self-help, eating, dressing); communication (listening, speaking, writing); motor skills (fine and gross, including locomotion); socialization (interpersonal relationships, play and leisure, and coping skills); occupational skills; and self-direction. Raw scores are converted to an age equivalent score (expressed as social age) and a social quotient.

2. **Binet – Kamat Test** assesses the intelligence of the subject. It is a standardised Indian adaptation of Stanford Binet test. It includes both verbal and performance tests.

Behavioural Observations:

He was cooperative and completed the tests with minimal breaks in between the tests. During the assessment, he was attentive, and followed the instructions given accurately. His attention could be aroused and sustained. His eye contact was adequate. He could comprehend simple commands and instructions. There was no performance anxiety observed

Test Findings:

- **Binet-Kamat Test of General Mental Abilities:**

The test was administered with minimal breaks in between in one single session

On BKT, the basal age attained was 9 years and the terminal age was 14 years. His mental age was found to be 10 years and the corresponding IQ was 62.5, indicating Mild intellectual disability.

Function-wise classification of items adapted to the Binet-Kamat test of Intelligence:

Language	14 years
Memory	14 years
Conceptual thinking	14 years
Reasoning	10 years
Visuo-motor	12years
Social intelligence	9 years

His performance on items assessing language, memory and conceptual thinking was much better than those measuring, reasoning, visuo-motor and social intelligence.

- **Vineland's Social Maturity Scale:**

On VSMS, his social age was at 9.15 year level with a social quotient of 57.18

The profiles of scores were as follows:

Self-help general	7 years and 4 months
Self-help dressing	9 years and 4 months
Self-help eating	9 years and 4 months
Communication	11 years
Self-director	9 years and 4 months
Socialization	10 years and 4 months
Locomotion	9 years and 4 months
Occupation	8 years and 8 months

Management:

His parents were educated about the intellectual disability and the prognosis. They were allowed ventilation and psychological support was provided. They were educated about the need for vocational rehabilitation and the importance of regular structured training of household chores and other skills. Behavioural techniques such as activity scheduling for a structured routine and differential reinforcement for his behavioural problems were also discussed with them. The need to continue the antiepileptic medication and follow up regularly with the neurologist were emphasized and compliance issues were discussed with them.

CASE RECORD 4: Neuropsychiatric Assessment

Name	: Mr. K
Age	: 41 years
Sex	: Male
Marital status	: Married
Religion	: Hindu
Language	: Tamil
Education	: 10th standard
Occupation	: Weaver
Socio-economic status	: Lower
Residence	: Rural
Informant	: Wife

Presenting Complaints:

Alcohol use since	: eighteen years
Confusion and memory loss	: two days

History of Presenting Illness:

Mr. K presented with history of alcohol use for the past eighteen years. He initially started consuming alcohol with his friends out of curiosity and experimentation. He initially drank with friends during get-togethers and other social occasions, which occurred once a month. He began drinking about one bottle of beer initially and later began to drink about 90 ml of hard liquor with which he would get intoxicated. Over the next few years, his frequency of drinking increased to more than twice a week and he began to drink about 180 ml of hard liquor as he needed that amount for his intoxication. Gradually, he began to develop an intense urge to consume alcohol and he started drinking everyday over the past seven years. He began to have difficulty in controlling the amount of alcohol he drank once he started drinking and began to experience tremors, decreased sleep and irritability if he did not drink alcohol in a day. He became more and more preoccupied with procuring alcohol and would plan his day in such a way that he would be able to consume alcohol after work. Slowly, he became irregular to work and his interaction with and attention towards his family declined. He began to spend all his earning on buying alcohol and did not support his family financially. Secondary to his alcohol use, he has had frequent quarrels with his wife and other family members. He has made multiple attempts to quit alcohol in the past, mostly due to his wife's insistence, with the maximum period of abstinence being about three weeks. He relapsed due to his craving and reported that his primary reasons for consuming alcohol were to satisfy his craving and for pain relief following physical labour.

Over the last one month, there was been an increase in his alcohol consumption following a property dispute. His daily consumption of alcohol increased to about 225 ml of hard liquor. Following an episode of fever three days ago, he stopped his alcohol use abruptly. He began to

experience sudden onset of memory loss. He was found to be unable recall recent events and conversations and was found to be confabulating information.

There was no history of ataxia, tremulousness, fluctuation in orientation or perceptual abnormalities.

There was no history of similar complaints in the past.

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

There was no history of hematemesis, melena or jaundice.

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

There was no history of difficulty in speech, apraxia or difficulty in calculation.

There was no history suggestive of psychosis, mood syndrome, obsessive compulsive phenomenon, phobia or panic attacks.

There was no history suggestive of any legal issues.

Treatment History:

In view of atypical presentation, he was referred to a general hospital where he was evaluated and CT scan of brain was found to be normal and hence he was sent back to be treated as alcohol withdrawal related amnestic syndrome. There was no history suggestive of any past treatment.

Family History:

There was no family history suggestive of any mental illness, suicide, substance abuse or epilepsy.

Birth and Development History:

He was born to a non-consanguineous union. The antenatal period was uneventful. The birth was at full term by normal vaginal delivery. There was no history suggestive of birth asphyxia. All his developmental milestones were reported to be within normal limits.

Educational History:

He had studied up to 10th standard and then discontinued. Had average scholastic performance throughout.

Sexual History:

His sexual orientation was heterosexual. He denied sexual dysfunction or high risk behaviour.

Marital History:

He was married with two children. There were marital issues secondary to his alcohol use between the couple.

Premorbid Personality:

He had anxious personality traits. He had a tendency to worry excessively over trivial issues.

Physical Examination:

His vitals were stable. There was no pallor or lymphadenopathy. His cardiovascular system examination, respiratory system examination and gastrointestinal system examinations were normal.

Central Nervous System:

Cranial nerves – No cranial nerve palsies

Motor system

Bulk - Normal bilaterally

Tone - Normal tone bilaterally

Power - Grade 5 power bilaterally

No involuntary movements

Sensory System:

Crude touch, Pain, Temperature - Normal bilaterally

Light touch, Vibration and Joint position sense - Normal bilaterally

Reflexes:

Superficial abdominal reflex - Present all four quadrants

Plantar reflex - Flexor bilaterally

Deep tendon reflexes - 2+ bilaterally

Cerebellar functions - No signs of cerebellar dysfunction

Gait - Normal

Meningeal signs - Absent

Skull and spine - Normal

Mental Status Examination:

He was moderately built and was appropriately kempt. He maintained eye contact. Rapport was established. There were no abnormal involuntary movements. His speech was hesitant, audible with delayed reaction time. His mood was euthymic with normal range and decreased reactivity. He denied suicidal ideations. There wereno abnormalities in the form and stream of thought. He denied depressive cognitions and delusions. There were no obsessions and compulsions. He denied having any perceptual abnormalities. His attention could be aroused easily but was difficult to sustain. He was oriented to time, place and person. Immediate memory was impaired and he was initially, found to be confabulating. However, his recent and remote memory was intact. His intelligence was average. He had poor insight into his condition. His personal, social judgment was impaired.

Provisional Diagnosis:

- Alcohol dependence syndrome with associated amnesic syndrome
- Wernicke's encephalopathy

Aims for Neuropsychological Testing:

- To assess cognitive profile of Mr. K
- To correlate findings to clinical profile

Tests Administered and Rationale:

- **NIMHANS Neuropsychology Battery:** 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 for the test duration. However, in view of fatigue, the assessment had to be split into two sessions. There was no active resistance in doing the assessment. He was able to comprehend the instructions well. His verbal communication was adequate. There was no performance anxiety observed.

Test Results:

- **Mental Speed:**

On the digit symbol substitution test, the total time taken to complete was 442s which is below the 13th percentile, indicative of significant impairment in mental speed.

- **Sustained Attention:**

On the digit vigilance test, the total time taken to complete was1133s which was below the < 3rdpercentile, and the total number of errors was omission was 1, which was above 94th percentile. This is indicative of significant impairment in sustained attention.

- **Divided Attention:**

On the Triads Test, the total errors were11, which is below the 3rd percentile, indicative of impairment in his ability to divide attention between two tasks.

Executive Functions:

- **Phonemic Fluency:**

Phonemic fluency was assessed by the Controlled Oral Word Association Test (COWAT). On the COWAT, the average new words generated was 7.3 which is at the 40th percentile and is indicative of impairment in phonemic fluency.

- **Categorical Fluency:**

It was assessed by the Animal Names Test. The average new words generated was 9, which is below the 10th percentile, indicative of impairment in categorical fluency.

- **Verbal Working Memory:**

Was assessed by N back test. In 1 back test hits were 8 which was at the 40th percentile and errors were 2 which was at the 57th percentile. In 2 back test hits were 2 which was less than 5th percentile and errors were 7 which was at the 17th percentile. These scores are indicative of impairment in working memory.

Planning:

Planning was assessed by Tower of London Test. The total number of problems solved in the minimum number of moves is 9, which is at the 70thpercentile. The mean time taken, the mean moves and the number of problems with minimal moves are as follows,

No of moves	Time taken (minutes)	Percentile	Mean moves	Percentile	No of prob with minimal moves
2 moves	9	25^{th}	3	22^{nd}	1
3 moves	12.75	58^{th}	3	71^{st}	4
4 moves	16.05	63^{rd}	4.75	56^{th}	2
5 moves	25.5	44^{th}	6.75	59^{th}	2

Fluctuations in scores indicate the probability of attention and concentration impairing his problem solving ability rather than actual deficits in problem solving per se. His percentile of 70 for the number of problems solved with minimum number of moves is also indicative of this.

Response Inhibition:

Response inhibition was assessed by the Stroop Test. The Stroop Effect was found to be 81 which is at the 90th percentile, indicative of no significant impairment in response inhibition.

Verbal Learning and Memory:

On the auditory verbal learning test, the total number of correct words recalled is 49, which is at the25thpercentile; the immediate recall and delayed recalls are at 8 and 7 words which are below the 15thpercentile. The long term percentage retention is 70% which is below the 15th percentile. The number of hits in the recognition trial is 14 which is at the 25th percentile. This indicates the presence of deficits in verbal learning and memory. His recognition also is impaired.

On the Logical Memory Test, he was able to recall 6 details in the immediate recall trial and 5 details in the delayed recall trial, which are below the 10th percentile. This is indicative of impairment in Logical Memory.

Visuo- Spatial Construction and Visual Learning and Memory.

On the ROCF, the copying score is 33, which is at the 15th percentile. The immediate recall score is 17.5 and the delayed recall score is 16, which are below25th percentile. This indicates impairment in visual memory.

Impression:

The Test findings suggest impairment in most domains of neuropsychological functioning including attention, motor speed, executive functions, verbal and visual memory and visuo constructive ability. The profile is suggestive of a global deficit across the frontal, temporal and parietal regions.

Management:

Following admission, Mr K was started on fixed dose reduction regimen of Lorazepam upto 6mg/day. Differential diagnosis of Wernicke- Korsakoff syndrome was considered and started on parenteral thiamine supplementation. He was regularly monitored for response and once it plateaued, thiamine was tapered gradually. Oral vitamin supplementation was also given. His wife was allowed to ventilate and emotional support given. Patient continued to be in contemplation stage of motivation, interviewing techniques to enhance motivation was used. Discrepancy was created regarding alcohol use and the risks involved. Cue identification and craving management techniques were discussed with him. Relapse prevention plan was initiated. Though CT scan initially showed nil significant study, subsequently MRI scan was considered in view of persisting immediate memory deficits and atypical presentation. The MRI showed

Thalamic infarction with signs suggestive of deep vein thrombosis for which neurology consultation was sought and patient was advised to be transferred to neurology for admission and further management.

CASE RECORD 5: Diagnostic Clarification

Name : Ms. ST

Age : 18 years

Sex : Female

Religion : Hindu

Language : Tamil

Education : B.Sc Nursing

Occupation : Student

Socio-economic status : Lower

Residence : Rural

Informant : Self and mother

Presenting Complaints:

Withdrawn behaviour - three years

Hopelessness and worthlessness - three months

Suicidal ideation - three months

Disturbed sleep - three months

Decreased Appetite - three months

History of Presenting Illness:

Ms ST was apparently well until three years back when she was noticed to become more withdrawn and interact less with others. According to her, after joining college she was not able to interact with others as they would play pranks on her without any obvious reasons. Gradually over the past one year she started losing interest in previously pleasurable activities and became incapable of experiencing happiness. She had studied in a Christian school from 9-12th standard during which time she had become interested in Christianity. The stressful experiences of college and the increased sense of unhappiness made her more drawn to her Christian faith. She started joining others in prayers and reading Bible as she found solace in the same. This became a reason for dissent with her mother who had different religious view. Since three months, she has become more preoccupied and would have crying spells expressing fearfulness without giving any reasons for the same. About two months ago her friends found a suicide note written by her following which she confessed that she had been having suicidal ideations. Multiple suicidal plans have been made by her, however has never executed the same as she is scared of dying. She started spending most of her time in prayer as she felt burdened by the suffering of people around her. She gradually became more withdrawn and lost interest in studies and other leisure

activities. She says that she feels helpless about her current situation, hopeless about her future and has a sense of worthlessness. Her capacity to concentrate in class has also decreased over this period of time. She also reports that though she has always been an anxious person her anxiety levels have considerably increased over past few months and is associated with autonomic symptoms. She also describes a chronic feeling of emptiness which she finds as distressing. She had decreased appetite and her oral intake reduced due to which she lost about 10kgs in one year. She also had sleep disturbance the pattern being more suggestive of a global insomnia.

In college it was noted that though she managed to continue with her academic activities without much trouble she was found to be preoccupied and not communicating with others. There were no formal complaints from college as per mother's report.

There is no history suggestive of injury to head, vomiting or blurring of vision.

There is no history suggestive of hearing non- existent voices or suspiciousness or thoughts being inserted or withdrawn.

There is no history suggestive of panic attacks or Obsessive-compulsive symptoms or phobias.

There is no history suggestive of intellectual disability.

There is no history suggestive of physical altercation or cruelty to animals or people/ setting fire or destroying property intentionally/ temper tantrums.

Treatment History:

Her index visit to Child and Adolescent psychiatry department of Mental Health centre was in August 2017 following which she was started on Escitalopram which was titrated up to a dose of 5 mg per day. She also attended regular psychotherapy sessions on Out-patient basis. In view of persisting symptoms an In-Patient treatment was planned for.

Birth & Developmental History:

The antenatal period was supervised and uneventful. Birth was full term normal vaginal delivery with no birth asphyxia or perinatal complications. Postnatal period was uneventful. Both motor and language developmental milestones were reported to be normal. Her self-care was adequate and would also help in certain household activities.

School History:

She has been described as an average student who used to score between 50-60%. She has history of multiple school changes. She was in a boarding school till 5^{th} grade following which she stayed at a relative's place and attended school in an urban area. However she found it difficult to adjust there. She continued her 7^{th} and 8^{th} standard in a school back in her home town. She insisted that she wanted to study in a boarding school hence school was again changed and she continued from 9^{th} – 12^{th} standard in a Christian missionary boarding school. She joined for

B.Sc nursing wherein in her first and second year she managed to get about 70% marks and currently has completed her 3rd year exams.

Emotional Development and Temperament:

She is described to have being a reserved and timid individual with difficult temperament, poor coping skills, intense anxiety, low frustration tolerance and stubbornness.

Family History:

She is the first born of the three siblings from a non-consanguineous union. There is family history of completed suicide in one maternal aunt by consuming poison secondary to marital discord. Her father is a 41 year old carpenter mother is a homemaker. Her sister is studying in 12th standard and brother in 8th standard. Father is working in Saudi Arabia and has been an absent parent both emotionally and financially. She has mainly been brought up by mother, however has been staying in hostel for a considerable period of time.

Physical Examination:

Pulse rate: 82/min, BP: 100/70 mm hg. Systemic examination was within normal limits.

Central Nervous System:

Higher function – MMSE 27/27

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:

Ms ST was thinly built, moderately nourished and well kempt. She was attentive and cooperative towards the examiner. Eye contact was made however not sustained. She was noted to be anxious and fidgety throughout interview with certain mannerisms. She displayed normal adaptive movements with no abnormalities in motor function. Her attention could be aroused and sustained. She was oriented to time place and person. Her memory was intact. Speech was minimal and to the point with low tone, normal reaction time with no deviations. No formal thought disorder was noted. Content of thought revealed suicidal ideation with no active planning and predominantly religious themes. No perceptual abnormalities were noted. Her mood was dysphoric with preserved range and reactivity of affect. Her intelligence was average. Her judgment was fair with partial insight into Illness.

Provisional Diagnosis:

1. Depressive episode
2. Anxiety Disorder
3. Emerging personality traits

Aim of Psychological Testing:

To identify whether it is a depressive episode or an anxiety disorder and also to clarify contribution of personality traits in maintenance of her current symptoms.

Behavioural Observation:

During the entire period of assessment, she was co-operative and enthusiastic. She could comprehend the instructions and paid adequate attention. She preferred communicating through writing and answered queries with minimal words. She was noted to be fidgety and exhibited certain mannerisms when addressed directly. Performance anxiety was observed and she preferred to do the writing or drawing without showing the examiner.

Tests Administered and Rationale for the Same:

1. **Childhood Depression Rating Scale-R:** is a semi-structured, clinician-rated interview for the assessment of depression in children and adolescents. It was originally intended as rating scale for the age group from 6 to 12 years, but is also widely used in adolescents. The CDRS-R is a clinician administered 17-item interview, with item ratings between 1 (=no difficulties) and 5 or 1 and 7(=clinically significant difficulties) (adding up to a total score between 17-113). It has been proposed, that a score of ≥40 indicates depressive symptomatology, whereas a score ≤28 was often used as indicative of remission.

2. **Screen for Child Anxiety Related Disorders** consists of 41 items and 5 factors that parallel the DSM-IV classification of anxiety disorders. The child and parent versions have moderate parent-child agreement and good internal consistency, test-retest reliability, and discriminant validity, and it is sensitive to treatment response. It shows the various categories of anxiety.

3. **International Personality Disorder Examination (IPDE)- ICD 10 Module Screening 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. Evidence suggests that it has acceptable joint- rater reliability and applicability in Indian population. The IPDE Screening Questionnaire is a self- on administered carbonless form that contains 59 ICD-10 items written at a 9-10 year old reading level. The patient responds either True or False to each item and can complete the questionnaire in 15 minutes or less

4. **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.

5. **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.

6. **Draw a Person Test (D.A.P.T):** Draw A Person Test was developed as the first measure of figure drawing as a personality assessment by Karen Machover (1949). Typically used with children and adolescents, the subject is asked to draw human figures both male and female and the picture is analyzed on a number of dimensions. Features of the figures drawn reflect underlying attitudes, concerns, and personality traits. The test provides rich clinical information which is independent from the intellectual level of the subject.

Test Findings:

- **Children's Depression Rating Scale (CDRS)**

On the CDRS she had a raw score of 40, which was suggestive of a depressive disorder scoring significantly high for sleep disturbance, depressed mood, suicidal ideation, social withdrawal and somatic symptoms

- **Screen for Child Anxiety Related Disorders (SCARED)**

On the scale, she showed significant anxiety in the area of panic disorder and somatic symptoms (18), social anxiety disorder (11) and generalised anxiety disorder (13), .Her score was at the cut off on the areas of Separation anxiety disorder (5) and school avoidance (3). Her overall score was (50) which signified the presence of an anxiety disorder.

- **IPDE:**

In the IPDE Screening questionnaire, Ms ST's answers indicated high loading in the anxious, anankastic and paranoid personality traits.

- **Thematic Apperception Test (TAT)**

In the TAT, the stories are of variable length, however most were very elaborative. All the stories were in the third person however, there was an element of self-reference in some of the stories. The dominant themes of the stories are need for autonomy, abasement, achievement, affiliation and sentience. A sense of abandonment by father was expressed in stories whereas mother was portrayed as a nurturing person. Conflict with younger sibling was also a recurrent theme in the stories. She viewed the world as hostile and was unable to face the challenges, resorting to withdrawing herself. Interpersonal conflicts were dominant in her stories. High moralistic values and poor tolerance to differing viewpoints were evident in her stories. There was a preoccupation with religious themes and stories did not have a favourable ending.

- **Draw-A-Person test**

The female figure drawn was immature depicting a cartoon like figure with disproportionate body parts. It was schematic and adequate sized. The strokes were mostly continuous lines made

with moderate pressure indicative of adequate energy levels. There was moderate use of eraser and she did not have the tendency to redraw which was reflective of her sense of confidence in her work. The placement of the picture showed good organizational skills. The female figure was seen clutching onto an object reflecting a feeling of anxiety and insecurity. The legs drawn were immature and distorted which could also portray feelings of insecurity. Poor body image and low self esteem was evident. The posture and facial expression of the female figure showed of being anxious and introverted. The overall drawing reflects a poor self image, anxiety and interpersonal conflicts.

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- **Sack's Sentence Completion Test (SSCT)**

  Her sentences reflected a need to be better understood by her parents and strained relationship with father. She expresses guilt of being alive and there is a recurrent theme of wanting to commit suicide. Though she has fond memories about her past, her views about future tend to be pessimistic. The sentences also reveal a sense of low self worth and hopelessness. She also expresses her lack of friends and deep regard for her superiors. There appeared to be significant difficulties in interpersonal situations. She lacked meaningful and close friendships. Rigid thought patterns and her inability to accommodate different views were also evident in her stories. Her attitude towards self and her future were poor.

Summary of Test Findings:

Ms. ST had significant scores on CDRS and SCARED indicating a depressive episode as well as anxiety disorder. The IPDE revealed a high loading for paranoid, anxious and anankastic traits. Interpersonal conflicts are present and she lacks the psychological resources to deal with them. Low self esteem in interpersonal context is evident. Exhibits significant preoccupation with religious themes and tends to use the same as a coping mechanism. She expresses a sense of hopelessness, worthlessness and helplessness with active suicidal ideation. She had inflexible and rigid ways of interpreting events along with poor Theory of mind. In addition she also exhibited certain mannerisms and deficits in social skills which would warrant ruling out any pervasive developmental disorders.

Final Diagnosis:

AXIS I: Moderate depression

Anxious personality traits

AXIS II: Pervasive developmental disorder to be ruled out.

AXIS III: Nil

AXIS IV: Nil

AXIS V: Problems related to primary support group.

Management:

Ms. ST and her mother were educated on the nature of illness and, about the assessment findings. She was treated on in-patient basis. Blood investigations were done which were within normal limits. Pharmacologically she was continued on Escitalopram 5mg. Suicidal risk and precautions were explained to her mother as well as nursing staff and she was closely monitored throughout. Ms ST was taught relaxation strategies for stress management and was also encouraged to practice JPMR and deep breathing exercises. She was engaged on a daily basis in Occupational therapy unit and her activities of daily living was regularised. Principles of Cognitive behavioural therapy were used to address her negative automatic thoughts and restructuring of the same was attempted. Problem solving and coping skills were taught. Social skill deficits and ways to improve the same were also addressed. The mother was also engaged in therapy in order to improve interpersonal functioning and communication.