PSYCHOLOGY CASE RECORD

Submitted to the Tamil Nadu Dr. M.G.R. Medical University in partial fulfilment of the requirements for the Diploma in Psychological Medicine Examination 2018

By
DR. MONISHA KANYA SAVARIMUTHU

ACKNOWLEDGEMENTS

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

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

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

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

CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. Monisha Kanya Savarimuthu** during the years 2016-2018. I also certify that this record is an independent work done by the candidate under my supervision.

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

CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. Monisha Kanya Savarimuthu** during the years 2016-2018. I also certify that this record is an independent work done by the candidate under my supervision.

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

INDEX

CASE RECORD – 1 : Personality Assessment

Name	: Ms PM
Age	: 16 years
Gender	: Female
Marital status	: Unmarried
Language	: Bengali
Education	: 8th Grade
Occupation	: Student
Socio-economic status	: Middle
Residence	: Semi-urban
Informant	:Ms PM and her parents

Presenting complaints:

- Frequents quarrels with family members
- Anger outbursts with occasional assaults
- Low mood
- Lack of interest in studies
- Multiple Suicidal threats

Duration: One and half years history

History of presenting complaints:

Ms PM presented with one and half years history of gradual decline in her academic performance following ending a relationship with a boy. She complained of feeling low for most days however not a pervasive pattern. Her social interaction with her family members worsened with frequent anger outbursts characterised by shouting, and becoming assaultive on occasions, when her demands were not met immediately. She made threats of self harm when her family members disagreed with her ideologies or refused to meet her demands. She indulged in cutting herself with a blade or burning herself with a matchstick for the same. This behaviour may sometimes last for three or four days in a row. Parents also report reduction in sleep and excessive use of mobile phones at bed time which affect her sleep regimen. There is history suggestive of alleged abuse by her boyfriend. The above symptoms emerged a few months after the breakup. Parents also mentioned that she started talking to another boy following her break up, however parents were stringent and laid restrictions on

her. In addition she gives history of ruminating thoughts when criticized, intrusive images of her throwing God's idol when praying and fear of blurting out inappropriate things without much severe consequences to the same.

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

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

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

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

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

There is no history of intellectual disability, pervasive developmental disorder, oppositional defiant disorder or conduct disorder in the past.

Treatment history:

She was treated at different centres with multiple antidepressants of various classes along with low doses of antipsychotics. At one instance she was treated with Valproate 1000 mg and Risperidone 2mg for four years. However there was little improvement in her symptoms with the medications. At the time of index presentation she was already on T Lithium 300 mg, T Fluoxetine 40 mg, Propranolol and Bupropion 150 mg. Medication side effects of weight gain were present.

Family history:

She was born out of a non-consanguineous union. She is the younger of two siblings. There is nil significant neuropsychiatric family history. She was attached to her mother while she grew up but at the same time mother faced the brunt of her anger outbursts.

Birth and developmental history:

Her mother's antenatal period was supervised and uneventful. Birth was full term Lower Segment Caesarean section (indication: cervical incompetence) with no birth asphyxia or perinatal complications. There is no history of birth asphyxia, neonatal seizures or jaundice or other complications. Her post-natal period was uneventful. Her developmental milestones were reported to be normal.

Educational history:

She is currently a drop out for the last two years secondary to problems. She has completed till the 8^{th} standard. Her scholastic performance was average. She was good in extracurricular activities such as classical dance and singing. She has many friends in school and was involved in two relationships in the past.

Sexual history:

She had female gender identity with heterosexual orientation. She denied any high risk behaviour. There is history of alleged sexual abuse from her boyfriend in the past.

Marital history:

She is unmarried

Premorbid Personality:

She is premorbidly described as a child with increased activity, poor adaptability, low threshold for responsiveness, high intensity of reaction, negative quality of mood, easily distractible and poor persistence. Patient is the youngest in her family, hence pampered and demands met since childhood. Overall a difficult child with increasing adamant behaviour.

Physical examination:

Her vitals were stable.

On general physical examination marks of multiple blade cuts on the left forearm and burn scars from matchstick were noted.

Systemic examination was within normal limits.

Mental status examination:

She was moderately built and nourished. She was well kempt and maintained good eye-contact. She was alert and lucid. She was cooperative towards the examiner. She was expressive and gesticulated excessively during her interview. Her facial expressions were exaggerated. Her speech was spontaneous, dramatic, fluent with normal reaction time, garrulous productivity and normal speech. Her mood was euthymic with normal range and reactivity of affect. She denied

suicidal ideation. There were no abnormalities in the form and stream of thought. Her content of thought revealed feelings of inadequacy with strong desire to prove herself before the world; dichotomy in her appraisal of people and in her decision making and hatred towards society. She denied delusions. There were no abnormalities in her perception. She was oriented to time, place and person. Her memory was intact. Her attention could be aroused and sustained. Her intelligence was above average. She had partial insight into her problems. Her test judgement was intact while her social judgement was impaired.

Provisional diagnosis:

- Emotionally Unstable Personality Traits

Aim for psychometry:

To identify and explore significant personality factors influencing psychopathology.

Tests administered:

1. **Hamilton Depression Rating Scale (HAM-D)**
2. **Children's Yale- Brown Obsessive Compulsive Scale (CYBOCS)**
3. **Draw a Person Test (DAP)**
4. **Sacks Sentence Completion Test (SCT)**
5. **The International Personality Disorder Examination (IPDE) - ICD 10 Module Screening Questionnaire and Interview Module**

Rationale for the tests:

1.Hamilton Depression Rating Scale (HAM-D): A depression rating scale of 21 items of which the first 17 are scored. It was originally published in 1960 with revised editions in 1966,1967,1969 and 1980. Test was administered due to presence of mood symptoms and due to common presence of dysphoria in patients with obsessions.

2. Children's Yale Brown Obsessive Compulsive Scale (CYBOCS): The CY-BOCS is an adaptation from the adult Y-BOCS that was designed by Wayne K Goodman in 1989 and contains 8 elaborated obsessions and 7 elaborated compulsions with a total score of 40 and rates severity on 10. The Y-BOCS has good inter-rater reliability, validity and sensitivity for obsessive-compulsive symptoms. Scores children from 6 to 17 years of age.

3. Sacks Sentence Completion Test (SCT): It is a semi 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 personal experience of life. It helps to elicit ideas of self-perception.

4.Draw a person test (DAP): Draw A Man Test was originally developed by Florence Goodenough in 1926, initially a supplement for Stanford Binet Intelligence test, that underwent subsequent adaptations. In 1949 Karen Machover came up with Draw a Person test as the first

measure of figure drawing as a personality assessment. 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.

5.IPDE Screening Questionnaire:

The IPDE, developed by Dr. Armander B. Loranger in 1988 and colleagues, is a self reported questionnaire 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.

6. IPDE ICD 10 Interview Schedule: It is a semistructured clinical interview that is effective in diagnosing personality disorders. It is based on ICD 10 personality disorders and contains six domains: work, self, interpersonal relationships, affects, reality testing and impulse control. Ages from 15 years onwards are included.

Test findings

1. Children's Yale Brown Obsessive Compulsive Scale (CYBOCS): She had obsessions of fear of blurting out obscenities and intrusive violent religious images with severity of 6/20. No compulsions were noted.

2. Hamilton Depression Rating Scale (HAM-D) : 12/66 indicative of mild depression.

3. Sacks Sentence Completion Test (SCT)

Behavioural observation:

During the entire period of assessment, she was co-operative and enthusiastic. She could comprehend the instructions and paid adequate attention. She was able to communicate appropriately. There was no performance anxiety observed.

Test findings

The SCT reveals her to have a strong bond with her mother. However, she feels that her mother does not appreciate her. Her relationship with her father appears strained. Although she feels that her father is a good person, she feels that he lets her down often. Overall,her attitude towards her family as a unit appears positive. She has a positive outlook on her own abilities and hence hopeful about the future, despite many regrets about her past. Her regrets lie in being in a relationship that was futile. However her future goals are simple and clear of her wishing to be a dancer and she is confident in achieving it. She believes in herself and has a healthy coping mechanism in the event of failures (through

crying). She attaches no value on trust in her friendships with female gender and her responses reveal mistrust towards her friends mainly secondary to jealousy. She does not have work experience but she holds herself in high self esteem of future good relationships with her colleagues. Her attitude towards women is negative as she is distrustful of them and her attitude towards heterosexual relationships is mixed.

4. Draw a Person Test (DAP):

Test Findings:

The figures were schematic and adequate sized. The female figure drawn was immature depicting a cartoon like figure with disproportionate body parts. The drawings showed struggles with intellectual powers and social balance, elements of narcissism and aggression (Disproportionately large head, toes) . They also suggested low frustration tolerance and sexual precocity (over emphasized cupid lips). Drawings also indicate possible attraction towards opposite gender (smile on boy's face) Extended arms suggest good relations with the environment. . The strokes were mostly continuous lines made with reduced pressure. The male figure was smaller in size and relatively immature in comparison with the female figure. This reflected a feeling of dominance and feelings of male being non threatening. Impulsivity was noted in drawings as well as in her behaviour like snatching the pencil from the examiner's hand even before the instructions could be completed.

5. IPDE Screening Questionnaire:

In the IPDE Screening questionnaire, Ms PM's answers indicated high loading in the borderline and histrionic personality traits.

6. IPDE ICD 10 Interview Schedule:

She had significant scores in the areas of impulsive, borderline and histrionic dimensions.

Conclusion:

The assessment indicates that she is prone to exhibit maladaptive behaviour under stressful situations. She has significant interpersonal conflicts and poor adjustments in social situations. The impulsive nature of her personality, low frustration tolerance, low threshold for criticism, aggressive tendencies, needs for immediate gratification of needs, low threshold for criticism, confirm the presence of emotionally unstable personality traits.

Final Impression:

Emotionally Unstable Personality Traits

Management:

Miss PM was admitted for psychological management and diagnostic clarification of her personality traits and mood state. Though there was no depressive episode, she was maintained on a low dose of selective serotonin reuptake inhibitors to reduce aggression and impulsivity.

Rapport was established with Miss PM and her family members. Her cognitive errors were brought out in sessions and attempts were made at correcting them. Behavioural techniques like activity scheduling and reinforcement strategies were also employed to deal with her personality traits. She was taught relaxation training, coping strategies and problem solving approach. Obsessions improved with these strategies. Special focus was laid on academic training.

Her family was allowed to ventilate and were psychoeducated about the nature, course and prognosis of her condition. Suicidal risks and precautions were explained. Family dynamics, structure and communication patterns were explored and parents were made aware and empowered.

CASE RECORD – 2 : Intelligence Assessment

Name : Ms AK

Age : 13 years

Sex : Female

Marital status : Unmarried

Religion : Hindu

Language : Hindi

Education : Class 5

Socio-economic status : Lower

Residence : Rural

Informant : Parents

Reliability : Reliable and adequate

Presenting Complaints:

- Problems with vomiting
- Fair academic performance
- Duration : Since four years.

History of Presenting Complaints:

Ms AK was apparently normal till four years ago when she experienced frequent vomiting after meals. She was evaluated in several hospitals for the same and was reported normal. At about the same time she was noted to have shifted schools. Based on low intelligence she was demoted to a lower class of 5th instead of 8th. Teachers reported below average performance in her academics. Additional perpetuating stressors was being bullied by her peers and also at home for her illness. There was no history of socioоccupational or biological decline. She was primarily admitted here for evaluation of vomiting in the background of multiple stressors.

There was no history of pervasive developmental disorder in childhood.

There is no history suggestive of head injury, seizures or neurological deficit.

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

There is no history of any psychotic symptoms in the past.

There is no history of any pervasive mood symptoms in the past.

There is no history of any anxiety spectrum symptoms in the past.

There is no history suggestive of eating disorders or body dysmorphic disorder in the past.

There is no history of any specific personality traits in the past.

Past & Treatment History:

There is no past history of psychiatric or significant medical illnesses.

Family History:

There is no family history of neuropsychiatric morbidity. There is no history of intellectual disability in her family. Her parents had a non consanguineous marriage. She has two younger brothers who are well.

Birth and Development History:

Her birth was a spontaneous pregnancy with supervised antenatal period. Mother's antenatal period was uneventful. She was born of a full term normal vaginal delivery at a hospital. Her birth weight was not remembered by her father. Her neonatal period was uneventful as remembered by father and there were no other complications like jaundice, birth asphyxia or seizure. She was adequately immunized for age. Developmental milestones were within normal limits.

Emotional Development and Temperament:

She was described to be an introverted child but with good social interaction. There were no features suggestive of restricted interests, lack of social communication, stereotypies or hyperactive behaviors.

School History:

She is currently doing her 5th grade. Her medium of instruction is Hindi. She had average scholastic performance barely passing her exams. She had changed from a government school to a private school, but was demoted to a lower class based on her intelligence.

Personal History:

She is independent in self care and is able to perform activities of daily living by herself without prompts or supervision. She is able to travel by herself in her hometown, make minor purchases and engage in adolescent group activities. However, she does not enjoying reading books and newspapers.

Physical Examination:

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

Mental Status Examination:

She was well built, nourished and was appropriately kempt. Rapport could be established. There were no abnormal motor movements. Her speech was spontaneous, normal intensity and tone and relevant. Her mood was euthymic with normal range and reactivity. She denied delusions, hallucinations and obsessions. She was oriented to time, place and person. Her memory was intact. Her attention could be aroused and sustained. She had emotional insight and good judgement.

Provisional Diagnosis:

Intellectual disability.

Aims Of Psychological Testing:

As history was suggestive of poor academic performance, we decided to do a formal intelligence assessment.

Test Administered:

1. Binet-Kamat Test of General Mental Abilities
2. Vineland Social Maturity Scale(VSMS)

Rationale for the Test:

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

2. VSMS was administered to assess the socio-adaptive functioning.

Behavioural Observations:

Ms AK was cooperative for testing and was able to comprehend the simple and complex instructions but with some difficulty in comprehension of more complex instructions. She was not anxious and appeared confident during the test. She was able to sustain her attention over the course of the assessment and was able to communicate adequately.

Test Findings:

1. On BKT, the basal age attained was 6 years, terminal age was 14 years and the mental age was 10 years with the corresponding IQ being 72, indicating borderline mental retardation.

   Function-wise Classification

   Language – 9 years

   Meaningful memory- 10 years

   Non-meaningful memory- 9 years

   Conceptual thinking- 10 years

   Non-verbal thinking- 12 years

   Numerical reasoning- 9 years

   Visuo-motor skills- 10 years

   Social intelligence- 12 years

Scatter is seen in the assessment – her performance is poor in items measuring verbal reasoning. However, on items that involve non verbal thinking and social intelligence, her performance is better. Her language function, meaningful and non meaningful memory, conceptual thinking, numerical reasoning and visuo-motor functions was average.

2. On VSMS, her social adaptive functioning was at an age equivalent of 12.3 years.

   Self-help General- 7.28 years (maximal score)

   Self-help dressing- 12.38 years

   Self help eating- 9.03 years (maximal score)

   Communication- 11.58 years

   Self direction- 13.00 years

   Socialisation- 12.30 years

   Locomotion- 9.43 years

   Occupation- 11.25 years

Impression:

The tests are suggestive of Borderline intelligence

Management:

Parents were psychoeducated about the nature & course of her problems. Study techniques and integrating various modalities and styles of learning was explained. The need for repetition during learning, for reducing academic pressure and for focussing on key topics and terms was emphasized. Focusing on extracurricular strengths (singing in her case) was emphasized which would

improve self esteem among peer group and in that regard facilitate faster learning. Parents were allowed to ventilate & support was provided.

CASE RECORD – 3 : Diagnostic Clarification

Name	: Miss S
Age	: 22 years
Sex	: Female
Marital status	: Unmarried
Religion	: Christian
Language	: Tamil
Education	: Class 12
Socio-economic status	: Lower
Residence	: Rural
Informant	: Miss S, mother and grandmother

Presenting Complaints:

- Crying spells
- Anger outburst with yelling
- Repetitive thoughts
- Deterioration in daily activities

Duration : For the past six months with acute onset

History of Presenting Illness:

Miss S was apparently normal until six months ago. In December 2016, she developed acute onset of symptoms of unprovoked anger and assaultive behavior towards family and strangers, crying spells and suicidal behaviors of low intentionality secondary to repetitive thoughts of three particular incidents – the first being her mother having pawned her jewellery at a store, the second being her aunt having trimmed her hair for superstitious purposes and the third being an incident of molestation. The onset of symptoms was acute, would occur everyday and last briefly from half an hour to nearly 2 hours per day. Symptom severity included verbal and physical aggression towards family, along with low intentionality suicidal attempts such as self strangulation. Triggers for these episodes were presence of grandmother at home, with whom the patient has poor relations premorbidly. Symptoms have progressively worsened over six months with declining biological functions and impairment in socioоccupational functioning. These symptoms are sometimes associated with brief fainting spells (few seconds) in the absence of injuries, tongue bite, incontinence or uprolling of eyes, tonic clonic movements or post ictal state. These episodes would resolve by self or with sprinkling water on her face.

There is no history of seizure, head injury, or other organicity.

There is no history of any pervasive mood syndrome.

There is no history of any generalized anxiety or panic attacks.

There is no history of intellectual disability or pervasive developmental disorder.

Treatment History:

She had been treated for these problems since January 2017. She failed trial of Risperidone 6-8 mg for three weeks with a combination of Fluoxetine 40 mg. She was then admitted for diagnostic clarification and rationalization of treatment.

Past History:

There is history of hearing impairment and speech impairment since birth with the use of a hearing aid till 3rd grade.

Family History:

She is the eldest of a non consanguineous union and nuclear family. Her father worked in the army and passed away two years ago and her mother is a home maker. She has two brothers with history of hearing impairment in one of her brothers. No other neuropsychiatric illness in the family.

Birth and Developmental History:

The antenatal period was supervised and uneventful. Birth was a full term normal vaginal delivery at home, with delayed birth cry and normal motor, with normal developmental milestones in the domains of gross motor, fine motor and cognition. Due to hearing impairment, speech was delayed.

Educational History:

She started schooling at the age of 3 years with medium of instruction being Tamil. She is described to have an average scholastic performance. She passed her tenth and twelfth exams in her first attempt. Following that she joined diploma in nursing but discontinued for varied reasons. She then completed a computer course of two years. She joined type writing course and discontinued following the onset of symptoms.

Premorbid personality:

She is described to have a difficult temperament with adamant traits and low frustration tolerance.

Personal History:

She is described to be an extroverted person with many friends. She enjoys spending time praying and visiting churches. She takes initiative in daily house hold tasks and performs her work efficiently. She has good emotional expressivity.

Unusual traumatic life events:

Past history of molestation by her maternal uncle 4 years ago.

Physical Examination:

Her vitals were stable. She had a body mass index of 26.3. Systemic examination was within normal limits. Speech was noted to be slurred without dysarthria or dysphasia. Hearing was mildly impaired.

Mental Status Examination:

She was moderately built and adequately kempt. Rapport was established. She was cooperative towards the examiner and made eye contact. She was alert and lucid and cooperative for the examination. Normal motor activity noted. Her speech was slurred but spontaneous and relevant with normal rate and productivity. Her mood was euthymic with normal range and reactivity. She denied having any suicidal ideations. There were no abnormalities of form, stream or content of thought. Her content of thought revealed distress secondary to the repetitive thoughts of her haircut, her mother selling her jewellery and the incident of abuse. No delusions or perceptual abnormalities were noted. She was oriented to time, place and person. Her memory was intact. Her attention was aroused and sustained. She was able to read and write in Tamil and English without difficulty however she had difficulty in interpreting the material. Her ability to abstract was normal. She was able to perform simple arithmetic calculations. Her general fund of knowledge appeared to be adequate for her age. Her insight was impaired. Her personal, social and test judgement were intact, but based on history overall judgement is impaired.

Provisional Diagnosis:

Psychotic disorder-Not Otherwise Specified

Obsessive Compulsive Disorder- predominantly obsessions

Problems related to alleged sexual abuse of child by person within primary support group

Speech and Hearing impairment

Aim for Psychological testing:

To clarify symptomatology, psychopathology and diagnosis as psychopathology was not clear and could not be elicited.

Tests Administered:

1. Brief Psychiatric Rating Scale(BPRS)
2. Yale Brown Obsessive Compulsive Scale (Y-BOCs)
3. Thematic Apperception Test (TAT)
4. Rorschach Inkblot Test
5. Sack's Sentence Completion Test (SCT)

Rationale:

1. Brief Psychiatric Rating Scale (BPRS):

The Brief Psychiatric Rating Scale (BPRS) is rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety,hallucinations and unusual behaviour. Each symptom is rated 1-7 and

depending on the version between a total of 18-24 symptoms are scored. The scale is the one of the oldest, widely used scales to measure psychotic symptoms and was developed by Dr. John Overall and Donald Gorham in 1962. It has been tested to have reliability, validity and sensitivity.

2. Yale Brown Obsessive Compulsive Scale (Y-BOCS):

The adult version of the Y-BOCS, or the Yale–Brown Obsessive Compulsive Scales (Y-BOCS), is a 10 item clinician administered scale designed to rate severity of obsessive compulsive symptoms.The Y-BOCS was designed by Wayne K Goodman in 1989 and contains 8 elaborated obsessions and 7 elaborated compulsions with a severity scale of 5 questions each on obsessions and compulsion with a total score of 40. The Y-BOC has good inter-rater reliability, validity and sensitivity for obsessive-compulsive symptoms.

3. Thematic Apperception Test (TAT):

It is a projective test used to measure the person's pattern of thought, attitudes, observational capacity and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes towards the self and others.

4. 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.

5. Sack's Sentence Completion Test (SCT):

It is a semi 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 personal experience of life. It helps to elicit ideas of self-perception.

Test findings:

1. Brief Psychiatric Rating Scale (BPRS): Total score- 37

She scored highest in Unusual thought content and hostility.

2. Yale Brown Obsessive Compulsive Scale (Y-BOCs):

She did not have any of the obsessions listed in Y BOCS except for the three symptoms that she described throughout history. Severity was 8.

3. Thematic Apperception Test:

In the TAT, the stories are extremely descriptive and informative of her past. All the stories were in the third person however, there was an element of self-reference in most of the stories. The test depicted needs for nurturance, affiliation, cognizance, expositron, sentinence, recognition, playmirth and adventure. With positive presses of succorance and affiliation towards the allied object. Many of her stories also reveal conflicts within her family and male dominance. Theme of sexual abuse was described in a wholesome manner including elements such as hunger prior to the incident, daylight incident and family's response to the event.

4. Rorschach Ink Blot Test:

In the Rorschach, she has given only 11 responses indicative of low productivity and hence a quantitative analysis could not be done. The responses indicate perseveration in content with a lack of variety in in content. This is indicative of a low intellectual functioning and a narrow range of interests.

5. Sack's Sentence Completion Test (SCT):

The test was attempted but had very few responses hence could not be interpreted.

Conclusion:

There was no evidence suggestive of depressive features. Psychoses was considered given atypical presentation, severe consequences and poor insight.

Final Diagnosis:

Psychotic disorder-Not Otherwise Specified

Problems related to alleged sexual abuse of child by person within primary support group

Speech and Hearing impairment

Management:

She was admitted for diagnostic clarification and appropriate treatment. Pharmacologically, her medications were tapered and stopped. Quetiapine trial upto 700mg per day was initiated after Serial MSEs and observation in Ward.

Due to worsening of symptoms, side effects of pedal edema Quetiapine was cross tapered with Trifluoperazine. ECTs were initiated. With this she showed much improvement. An activity schedule was given for her day to day routine work. She was engaged in Occupational Therapy during the hospital stay and tasks included type writing which she performed well. Anxiety reduction techniques like Jacobson's Progressive Muscular Relaxation Techniques and Deep Breathing exercise were demonstrated. Face saving measures were taught for the dissociations. Her mother was allowed to ventilate and the nature of her problem was explained. She was supported and was advised compliance. OT activities were given to engage her in simple structured activities. Regular follow up was suggested with plan to monitor for psychotic symptoms.

CASE RECORD –4 : Diagnostic Clarification

Name	: Mr. T
Age	: 24 years
Sex	: Male
Marital status	: Unmarried
Religion	: Christian
Language	: Telugu
Education	: Diploma in mechanics
Occupation	: Unemployed
Socio-economic status	: Middle
Residence	: Semi urban
Informant	: Mr. T and his mother

Presenting Complaints:

- Preoccupation
- Anxiety
- Repetitive thoughts of cleanliness
- Repetitive doubts and checking behaviour
- Decreased socialisation

- Socio-occupational decline
- Defecation in odd places
- Urinary incontinence
- Decreased sleep and appetite

For 10 years

History of Presenting Illness:

Mr. T was apparently functioning well until ten years ago when he presented with history of problems characterized by obsessions of contamination, doubt, sexual themes and compulsions of washing and arranging with socioоccupational decline. He has diurnal enuresis and encopresis secondary to his obsessions and behaviour problems in context of his obsessions and compulsions. Secondary to the above mentioned problems he has developed low mood, feelings of worthlessness and referential ideas. These factors are perpetuated by his premorbid state of low self esteem and a gullible laid back attitude of being responsible and tendency to procrastinate duties.

There is no history of seizure, head injury or PANDAS.

There is no history of any first rank symptom or other psychoses.

There is no history suggestive of any pervasive mood syndrome.

There is no history of any generalized anxiety or panic attacks.

Treatment History:

He sought medical aid and was treated with a cocktail of psychotropics with inadequate trial of clomipramine, sertraline, fluoxetine, risperidone and aripiprazole and two inpatient stay with 50% improvement. Current medications are adequate trials of Escitalopram and Amitriptyline augmented with Aripiprazole. However he continued to have symptoms hence inpatient stay was planned for diagnostic clarification & rationalization of medication.

Family History:

He is the second child born to his parents from a non-consanguineous union. There is no family history of any neuropsychiatric illness.

Birth and 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. He weighed 3.5 kilograms, received all immunizations with exclusive daily breast feeds from day 1 till 8 months of age. Developmental milestones were reported to be normal. Neonatal history had no further complications.

Educational History:

He has completed diploma in mechanics. His academic performance was reported to be poor since childhood . He had good interaction with his peers and teachers until the onset of his symptoms.

Sexual History:

He has male gender identity and heterosexual orientation. He denied any high risk sexual behaviour but agreed to masturbatory activities with presence of guilt.

Marital History:

He is unmarried.

Premorbid Personality:

Premorbidly he is described to be less responsible and procrastinate duties.

Past Medical History:

Impaired Glucose Tolerance, Obesity, Hypovitaminosis D, Folate Deficiency

Physical Examination:

His vitals were stable and systemic examination was within normal limits.

Mental Status Examination:

He was an obese individual who was moderately kempt. He maintained eye contact and rapport could be easily established. He was cooperative, appeared anxious, had a normal level of motor activity and speech was normal. He was euthymic. There were no abnormalities in the form and stream of thought. He reported obsessions of contamination, doubt and sexual themes. His higher mental functions were intact. Insight was partial and social and personal judgement was impaired.

Provisional Diagnosis:

1. Obsessive- compulsive disorder- mixed
2. Secondary Enuresis and Encopresis

Aim for Psychometry:

To clarify symptomatology, psychopathology and diagnosis

Tests Administered:

1. Yale Brown Obsessive Compulsive Rating Scale (Y BOCKS)
2. Hamilton Depression Rating Scale (HAM-D)
3. Sack's Sentence Completion Test(SCT)
4. Rorschach Inkblot Test

Rationale for the tests:

1. **Yale Brown Obsessive Compulsive Rating Scale (Y BOCKS):**

The adult version of the Y-BOCS, or the Yale–Brown Obsessive Compulsive Scales (Y-BOCS), is a 10 item clinician administered scale designed to rate severity of obsessive compulsive disorder .The Y-BOCS was designed by Wayne K Goodman in 1989 and contains 8 elaborated obsessions and 7 elaborated compulsions with a severity scale of 5 questions each on obsessions and compulsion with a total score of 40. The Y-BOC has good inter-rater reliability, validity and sensitivity for obsessive-compulsive symptoms.

2. **Hamilton Depression Rating Scale (HAM-D)**:- A depression rating scale of 21 items of which the first 17 are scored. It was originally published in 1960 with revised editions in 1966,1967, 1969 and 1980. Test was administered due to presence of mood symptoms and due to common presence of dysphoria in patients with obsessions.
3. **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. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self perception.
4. **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

Behavioural Observation:

He was cooperative to do the assessment. He was able to sustain his attention over the course of the assessment. There was slight performance anxiety observed but was able to overcome those with persuasion and encouragement. He was able to communicate without any difficulty.

Test findings:

1.Yale- Brown Obsessive Compulsive Scale:

Obsessions	Severity	Compulsions	Severity
Religious obsessions	6	Repeating rituals	15
Aggressive obsessions (blurting obscenities, embarrassing, responsible for accidents or robbery)	9	Excessive concern with animals	19
Symmetrical obsessions	9	Cleaning or washing compulsions	19
Fear of losing things	11	Excessive concern with contaminants	20
Religious obsessions	13	Bothered by sticky substances or residues	20
Miscellaneous obsessions Need to know or remember	18	Checking locks, stove and checking did not make a mistake	20
3 superstitious fears	19	Need to tell ask or confess	20
		Ordering and arranging compulsions	20

2.Hamilton's Depression Rating Scale:

Scored 7 in the domains of low mood, feelings of guilt and no productivity which corresponds to normal.

3. Sacks Sentence Completion Test:

In SCT, conflicts were found in the domains of self-ability, future and friends and acquaintances. He appears to be respectful of his parents and holds an attitude of inner responsibility towards his father. He also harbors guilt towards his family for being rude on numerous occasions. Although respectful, overall he looks down on his family unit. His fears in completing routine tasks has extended to other domains such as work related tasks leading to development of insecurities at work and high rejection sensitivity towards colleagues. As a result a fearful approach towards the future with major conflicts in the interpersonal domains with friends and colleagues. There were no major conflicts regarding heterosexual relationships and he has positive feelings towards women, in general.

4. Rorschach Ink Blot Test – Klopfer System:

Behavioral observation:

He was cooperative for the assessment. He was able to comprehend the instructions well and he was able to communicate appropriately. There was no performance anxiety observed.

Test Findings:

The protocol indicates low productivity with average mentation. The protocol indicates a tendency to be able to balance his impulsivity and his value system. He tends to have a high need for affection resulting a fear of possible rejection and inhibition in his overt reaction to others. It indicates a neurotic constriction indicative of his tendency towards inhibition of his responses. There is a lack of responsiveness towards environmental influence. He tends to have a high level of aspiration with the ability to back it up. He tends to have a low abstract ability and takes a concrete approach towards problem solving. Content analysis reveals high percentage of animal responses indicative of stereotypical thinking and a tendency towards adjustment difficulties. The presence of human like responses is indicative of anxiety.

Conclusion:

The overall test findings show no indicators of psychosis or mood. The findings are suggestive of obsessive compulsive disorder.

Final impression:

Obsessive Compulsive Disorder – mixed

Secondary Enuresis and encopresis

Management:

He was admitted for diagnostic clarification. For enuresis and encopresis, EEG and MRI brain was done which were within normal limits. He was started on Clomipramine upto 175 mg/day for his obsessive and compulsive symptoms and

enuresis. Nonpharmacological measures of relaxation strategies like Jacobson's Progressive Muscular Relaxation, Deep Breathing Exercises and thought stopping techniques were taught. Behavior strategies were employed to address the secondary enuresis and encopresis and the frequency of it had reduced. Cognitive behavioural therapy for symptoms and problem behaviors was provided. An activity schedule was given for his day to day routine work. He was engaged in Occupational Therapy during the hospital stay. He was psychoeducated about the nature, course and prognosis of illness.The parents were allowed to ventilate and the nature of his problem was explained to them. Their distress was acknowledged and they were supported.

Case Record-5 : Neuropsychological Assessment

Name	: Mr. M.A
Age	: 9 years
Sex	: Male
Language	: Hindi
Education	: Class 3
Religion	: Muslim
Socio-economic status	: Lower
Residence	: Rural
Informant	: Parents

Presenting complaints:

- Seizures
- Increased irritability and assaultive behaviors
- Decline in school performance

Duration :Since one year.

History of presenting complaints:

He was apparently normal till about 1 year ago when he developed high grade fever and headaches for two days followed by status epilepticus with prolonged and several episodes of loss of consciousness, uprolling of eyes and frothing of the mouth for a few minutes each. He was admitted in a local hospital in the intensive care unit for about twenty days for the same. Neurological deficits were severe with two months of similar type of seizures, atleast twice a day. Seizures described as frothing or tonic movements of limbs for about two to three minutes followed by a post ictal state of physical aggression for about one to two minutes, despite antiepileptics. There is history of neuroregression from these events, for two months with gradual recovery to premorbid state. Neuroregressed behaviors such as gross motor (climbing stairs) and fine motor decline (eating with hand or buttoning) and childish talk and laughter were present. Marked cognitive decline in working memory (short term), speech and naming were also present. Biological functions were within normal limits.

He gradually grew increasingly angry and irritable when demands were unmet, with sudden impulsive physical assaults to his classmates or parents..There is no history of delayed developmental milestones and pervasive developmental disorder.

There is no history suggestive of psychosis.

There is no history of manic, hypomanic or depressive symptoms.

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

Past history:

There is no history of other medical co-morbidities.

Family history:

There is no history of neuropsychiatric illness in the family.

Birth history:

He was born from a non consanguineous union, unplanned pregnancy that was supervised and uneventful, full term normal vaginal delivery, no history of birth asphyxia with birth weight of 3 kilograms.

Developmental History:

Age appropriate milestones attained in gross motor, fine motor, speech, language and socioadaptive milestones.

Educational history:

He is currently in Class 3 with below average performance since the illness. Premorbid performance was adequate.

Premorbid personality:

He is described to have an easy temperament with parents and friends, moderate in activity, high adaptability to circumstances. His communication and sociability were described to be good.

Physical examination:

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

Central Nervous System Examination:

Higher Mental Function- Indian Pediatric MMSE 31/37

Cranial Nerves- No cranial nerve palsies

Sensory system:

Crude touch, Pain, Temperature- normal bilaterally

Fine touch, Vibration sense and Joint position Sense- normal bilaterally

Motor System:

Bulk- Normal in all muscle groups

Tone- Normal in all muscle groups

Power- Grade 5 power in all four limbs

There were no involuntary movements

Reflexes:

Superficial abdominal reflex- present in all four quadrants

Plantar reflex- flexor bilaterally

Deep tendon reflexes- 2+ bilaterally

Cerebellar functions- no signs of cerebellar dysfunction

Gait- normal

Signs of meningeal irritation- absent

Skull and spine- normal

No signs of frontal release signs.

Mental Status Examination:

His general appearance was neat and kempt. He had a normal gait and a pleasant predisposition. He was cooperative and friendly with the therapist and rapport could be established. He made good eye-contact. Regressed behaviours were noted in terms of over friendly childish reactions to questions posed. No non adaptive movements were noted. He was oriented to time, place and person. His immediate memory was intact however, his recent and remote memory were impaired. His attention was aroused but difficult to sustain. His intelligence seemed markedly affected with poor arithmetic and reduced vocabulary. Speech had a loud tone, slow response and increased reaction time with decreased ideas.

Thought form, stream and content were normal. There were no perception abnormalities. Insight was preserved with impaired judgement.

Final diagnosis:

Acute Encephalitis and post encephalitic sequelae

Aims for Neuropsychological Assessment:

1. To find out the cognitive profile of Master M.A
2. To relate the findings to clinical presentation

Tests Administered:

1. **Binet Kamat's (BKT)** was used to assess intelligence as it is a standardised I.Q test for the Indian population
2. **Vineland's Social Maturity Scale (VSMS)** for adaptive functioning
3. **NIMHANS Neuropsychological Battery for Children**

Rationale for the Test:

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

2. VSMS was administered to assess the socio-adaptive functioning.

3. NIMHANS Neuropsychological Battery for Children is a formal battery that elaborately assesses the cognitive functions of each of the lobes of the brain.

He was cooperative for the assessment. There was no active resistance in doing the assessment. He was able to comprehend most of the instructions well. His

verbal communication was adequate. There was no performance anxiety observed.

Test Results:

1. **Binet Kamat's (BKT):**

   On BKT, the basal age attained was 3 years and the terminal age was 9 years and the mental age was 6 years 4 months with the corresponding IQ being 67, indicating mild mental retardation.

   Function-wise Classification

   Language – 5 years

   Meaningful memory- 5 years

   Non-meaningful memory- 6 years

   Non-verbal thinking- 6 years

   Numerical reasoning- 8 years

   Visuo-motor skills- 7 years

   Social intelligence- 6 years

Scatter is seen in the assessment – his performance is poor in items measuring conceptual thinking and verbal reasoning. However, on items that involve numerical reasoning, his performance is better.

2. Vineland's Social Maturity Scale (VSMS):

On VSMS, his social adaptive functioning was at an age equivalent of 3.83 years.

Self-help General- 3.83 years

Self-help dressing- 4.65 years

Self help eating- 2.43 years

Communication- 1.95 years

Self direction- 5.83 years

Socialisation- 3.28 years

Locomotion- 5.83 years

Occupation- 3.55 years

3. **NIMHANS Neuropsychological Battery For Children:**

FRONTAL LOBE

FUNCTION	TESTS	RESULTS
Motor function Motor speed	Finger tapping test	Raw score of 18 on the right hand and 17.6 on the left hand corresponding to less than 5th percentile each.
Motor coordination	Handtapping test	All four trials had poor performance.
Attention Sustained attention	Colour cancellation test	Took 226 seconds to complete the test which corresponds to less than 5th percentile
Focussed attention	Colour Trails Test Trails A,B	Took 25 seconds for trail A and 35 seconds for trail B, with 40 errors corresponding to less than 5th percentile.
Repetitive speech	Repeating sounds/words	Raw score of 4/20 indicative of moderate impairment.

Nominative speech	Categorical naming	Raw score of 7/10 suggests mild impairment.
Narrative speech	Object naming	Raw score of 5/5 suggests no impairment.
	One word naming	Raw score of 4/5 suggests no impairment
	Sentence reconstruction	Raw score of 0/6 suggests severe impairment.
Executive Functions		
Verbal fluency	Phonemic Fluency	Total of 3 words suggestive of severe impairment.
Design Fluency	Design Fluency	Novel output score was 6 suggestive of severe impairment.
Verbal working memory	N back test- verbal	
	1 Back	1 Hit and 8 misses corresponds to less than 5th percentile.
	2 Back	Score = 0 indicative of less than 5th percentile.
Visuospatialworking memory	Visuospatial working memory span test	Raw score of 1 corresponds to less than 5th percentile.
	N back test visual	

	1 Back 2 Back	16 Hits suggests no significant impairment. 0 Hits suggests severe impairment.
Planning	Porteus Maze	Test age of 7.5 years corresponding to less than 5th percentile.

PARIETAL LOBE

Visuo Perceptual ability	Motor free visual perception test	Raw score of 17 corresponding to less than 5th percentile.
Visuo conceptual ability	Picture completion test	Raw score of 13 corresponding to more than 95th percentile.
Visuo constructive ability	Block design	Raw score of 2 corresponding to less than 5 percentile.
Visual recognition	Recognition: Pictured Objects	Raw score of 8/10 suggests no impairment.
Apraxia	Symbolic and sequential acts	Ideomotor and ideational apraxia not present.

Somatosensory perception		
Tactile finger localization	Finger localization	Raw score of 9/10 suggests no impairment
Tactile form perception	Tactile form perception	Raw score of 6/6 suggests no impairment
Reading	Reading a passage	Unable to read. Could identify a few alphabets indicating significant impairment.
	Reading comprehension	Significantly impaired.
Writing	Writing to dictation	Raw score is 0
	Copying	Poor legibility however able to reproduce words.
Calculation	Age appropriate sums	Could not calculate simple single digit sums thus significant impairment.

TEMPORAL LOBE

Verbal Comprehension	Token test	Raw score of 13.5 corresponding to less than 5th percentile.
Verbal learning and memory	Rey's Auditory Verbal Learning test	Total number of words learned across five trials are 29 corresponding to less than 5th percentile. Each trial corresponds to less than 5th percentile. Delayed recall was 0.
Visual learning and memory	Memory for Designs	Total number of designs learned are 7 corresponding to less than 5th percentile. Each trial corresponds to less than 5th percentile. Delayed recall was 0.

Impression:

The test findings suggest the following:

Severe impairment is seen in motor speed and coordination, sustained and focussed attention, repetitive speech, verbal and design fluency, verbal working memory, visuospatial working memory, planning, visuo perceptual ability, visuo

constructive ability, reading, writing, calculation, verbal learning, comprehension and memory and sentence reconstruction

Moderate impairment is seen in repetitive speech and nominative speech.

No impairment in visuospatial tasks, somatosensory perception, praxis and narrative speech.

Report indicates significant impairment across all lobes.

Management:

Mr MA and his family were educated on the nature of illness, the prognosis and about the assessment results. He was treated on out-patient basis for impulsive outbursts with Escitalopram. Relevant investigations at the time of illness and follow up were EEG(sleep and 1 hour awake) which was normal. MRI Brain with contrast showed post encephalitic changes of long TR hyperintensities in bilateral hippocampi, right more than left, left thalamus, corona radiate and deep white matter and mild ventriculomegaly. Non pharmacological strategies were employed to strengthen functional recovery. Various antecedents for the behavioural problems were listed which were direct brain trauma, cognitive issues such as inability to convey his emotions due to poor recall of vocabulary. Strategies to deal with the behavioural problems through differential reinforcements and time outs were discussed with the family members. Strategies to raise self esteem by listing out talents, hobbies, focussing on areas of strength from the neuropsychological assessment done was discussed. Also the need to step down in curriculum to aid with academics and informing his

teachers about the need for special attention to him using specific cognitive training techniques was counselled. Reviews and further assessments were scheduled, as per need.