PSYCHIATRY CASE VIGNETTES

Dr Manoj Shettar & Dr Anil Kakunje

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Foreword

There has to be, if one may modify the Bard's famous words, method in madness.

Learning about psychopathology is at one level very interesting, at another, it is challenging and quite often it can be baffling, especially to a recent entrant to the field of mental health and illness. Trying to understand psychological disorders from dry text book descriptions is hardly ever helpful.

This book of case vignettes is one that helps overcome these deficiencies. Dr Shettar & Dr Anil have chosen appropriate examples of various illnesses. The many vignettes are supplemented with chapters such as the one on history taking; mnemonics which enhances the value of the text.

This book will find a respectable place in the young and the aspiring mental health professionals' aids. My congratulations and best wishes to the authors.

Foreword

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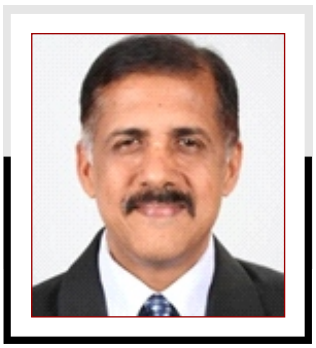

FOREWORD

This **Case Vignettes** book authored by Dr Manoj Shettar, Asst. Professor SDM hospital, Dharwad and Dr. Anil Kakunje, Mangalore is a valuable addition to our knowledge reservoir. We are happy; this book will be published by Indian Psychiatric Society- Karnataka Chapter and will be released at the upcoming KANCIPS at Dharwad. The fact, this will be made freely available online is a big bonus.

The contents are arranged under the following chapters.

1. History taking in Psychiatry.
2. History taking format.
3. Case vignettes.
4. Projective psychological tests.
5. Commonly used psychotropic drugs with doses & side effects
6. Common psychotherapies for individual disorders
7. Duration criteria for diagnosis of psychiatric disorders
8. Intelligence Quotient Tests.

The format is easily readable and user friendly. I am confident this book will be especially useful to Residents in Psychiatry undergoing post graduate courses, interns and students. This should also be useful to all psychiatrists and other mental health professions.

My congratulations to Dr Manoj Shettar for this work. Let me also appreciate Dr Anil Kakunje and others who have facilitated this work. Wishing all success for the book.

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Foreword

I am pleased to write foreword for the book written by Dr Manoj and Dr Anil related to case vignettes in psychiatry. Psychiatry is a fascinating field; it is about understanding human behaviour and human interaction. Literature and books in Psychiatry are necessary not only to create awareness among medical professionals but also to enhance their knowledge in the field especially the younger ones who are on the pathway of becoming professionals. People have a belief that psychiatry is all about treating mad people, but in fact it is about modifying human behaviour and helping human society. Many issues that bring conflicts between people like mother and son underlie the basic principles of human interaction the human interaction. Understanding Psychiatry may help to grow one's personality and the mind. Such books will help in making psychiatry and mental health related subjects more student and people friendly.

Foreword

Dr VV Mohan Chandran, DPM, MD
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It is with great delight I pen these words. I deem it a privilege and honour at the same time; that I am asked to write a foreword for this book. All the more so, because one of the author is Dr. Manoj who had been my student, to whom I have initiated to the study of human mind. I was fortunate enough to see his growth and just like any teacher committed to his calling, I was watching him maturing from a young man at times timid but hard working all the time, into a committed compassionate clinician. He indeed is a promise for the future.

The other author is my esteemed colleague whom I know for a decade. I am very well aware that it is more an instinctual desire, to pass on the pearls of wisdom he acquired to the coming generation in our speciality, my scholarly colleague Dr. Anil Kakunje.

Just a glance would suffice to get convinced that the whole text is so well planned and meticulously made to suit the needs of clinicians in Psychiatry both young and old. It can be a useful reference manual for those young ones pursuing higher studies in psychiatry and those seasoned clinicians to go through as a refresher. I am well aware that the case vignettes are actual disturbed lives which Dr. Manoj had seen, handled and helped. Apart from the case descriptions, the book also provides a nice description of an approach to a patient in a sensible manner and also provides briefly the management strategies.

There can't be better judges than the readers and with the fervent hope that you would find the book useful, I wish and pray the authors great success in their future endeavours.

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Head, Dept of Psychiatry
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Foreword

It is a matter of great pride that two budding psychiatrists from Karnataka Dr Manoj & Dr Anil have brought out a much needed book covering not just case vignettes but also basics about psychiatry & psychological tests which are so needed in the day to day learning of post-graduates curriculum.

The book is well designed in topics starting from mental status examination, case vignettes, basics of psycho-pharmacology & psychotherapy. The topics on duration for diagnosis, assessments for psychological disorders especially IQ assessment are unique to this book.

Indian Psychiatric Society-Karnataka Chapter is proud of Dr Manoj & Dr Anil who have brought out a book which is a must read for all students, interns and post-graduates not only from this state but also in other states of our country.

Preface

I am happy that my wish of writing a book on case vignettes in Psychiatry has come true. I dreamt of this since my post graduation and I was recording the cases I was seeing. After completion of my post graduation when I discussed this matter with Dr Anil Kakunje who is the co-author of this book and my guide during post graduation, he whole heartedly accepted it and guided me throughout the process of this book.

Psychiatry though a fascinating subject is a neglected field in medical sciences. Exposure to psychiatry during under graduation is less. Acquiring the skills of understanding the patient during a short period of posting is of prime importance. I hope this book will help and guide the students for the same.

This book contains 73 case vignettes; ICD-10 criteria for the cases, why and how the particular diagnosis was made, facts and definitions are added where ever necessity was felt, treatment and differential diagnosis are given.

This book is the result of strong support from Dr Anil Kakunje, my senior and junior colleagues, SDM Medical College and Hospital, all the members of IPSKC and my parents. I am thankful to each one of them.

I extend my thanks to Chetana Printers, Mangalore for their cooperation.

I request readers to give valuable feedback, suggestions and corrections.

Dr Manoj Shettar
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Contents

CASE VIGNETTES LIST

1. Alzheimer's Dementia
2. Delirium not induced by alcohol and other psychoactive substances.
3. Mental and behavioural disorder due to use of alcohol; dependence syndrome; uncomplicated withdrawal.
4. Mental and behavioural disorder due to use of alcohol; dependence syndrome - complicated withdrawal. (Delirium tremens with convulsions)
5. Mental and behavioural disorder due to use of tobacco; dependence syndrome; currently using the substance.
6. Mental and behavioural disorder due to use of cannabinoids: Cannabis induced psychotic disorder schizophrenia like.

   Mental and behavioural disorder due to use of Tobacco: Dependence syndrome, currently using the substance.
7. Paranoid Schizophrenia.
8. Paranoid schizophrenia (With all five sensory hallucinations).
9. Hebephrenic Schizophrenia.
10. Undifferentiated Schizophrenia.
11. Post Schizophrenic Depression.
12. Residual Schizophrenia.
13. Schizotypal Disorder.
14. Delusional Disorder (Parasitosis).
15. Delusional Disorder (Love).
16. Delusional Disorder (Infidelity).
17. Olfactory Reference Syndrome.
18. Delusion of Dysmorphophobia.
19. Acute and Transient Psychotic Disorder (Acute schizophrenia like psychotic disorder).
20. Hypomania.
21. Mania without psychotic symptoms.
22. Mania with psychotic symptoms.
23. Bipolar Affective Disorder Current Episode Mania with Psychotic Symptoms.

24. Bipolar Affective Disorder Current Episode Moderate Depression.
25. Mild depression without somatic syndrome.
26. Moderate depressive disorder with somatic syndrome.
27. Severe depression with psychotic symptoms.
28. Severe depression with psychotic symptoms.
29. Recurrent depressive disorder current episode mild depression without somatic syndrome.
30. Dysthymia.
31. Agoraphobia with panic disorder.
32. Social phobia.
33. Specific phobia (Acrophobia).
34. Panic disorder.
35. Generalised anxiety disorder.
36. Obsessive compulsive disorder, mixed type.
37. Acute stress reaction.
38. Post traumatic stress disorder.
39. Adjustment disorder; Brief depressive reaction.
40. Dissociative convulsions.
41. Dissociative motor disorder.
42. Trans and possession disorder.
43. Somatization disorder.
44. Undifferentiated somatoform disorder
45. Hypochondriacal disorder.
46. Somatoform autonomic dysfunction of upper and lower gastrointestinal tract.
47. Persistent somatoform disorder.
48. Other somatoform disorder (Globus Hystericus)
49. Non organic insomnia.
50. Nonorganic disorder of the sleep-wake cycle/ schedule.
51. Failure of genital Response.
52. Premature ejaculation.
53. Puerperal psychosis.
54. Postpartum depression.
55. Abuse of non-dependence producing substances.
56. Paedophilia with dissocial personality disorder.
57. Emotionally unstable personality disorder; Borderline type.
58. Histrionic personality disorder.
59. Anankastic(Obsessive) personality disorder.
60. Anxious avoidant personality disorder.
61. Dysthymia with pathological gambling.
62. Trichotillomania.
63. Skin picking disorder.
64. Mild mental retardation.
65. Stuttering/ Childhood onset fluency disorder.
66. Childhood autism.
67. Disturbance in activity and attention.
68. Conduct disorder.
69. Separation anxiety disorder of childhood.
70. Pica of infancy and childhood.
71. Dhat syndrome.
72. Malingering.
73. Childhood depression.

CHAPTER 1

HISTORY TAKING IN PSYCHIATRY

History taking in psychiatry is more challenging than in other branches of medicine. In psychiatry one has to interview patient who have disturbances in thought, speech and behaviour which may interfere in history taking. One needs to be skilful in interviewing the patient to develop a rapport, make a diagnosis and to initiate appropriate treatment.

The interviewer should take history not only from the patient but collateral information should also be collected from significant others. When patient does not have awareness about their illness the job at hand is doubly challenging.

The interviewer has to club together the symptom behaviours presented by the patient and understand ICD criteria, match patient's symptoms and ICD criteria to come to a conclusion for making the diagnosis.

Many a times it takes multiple interviews to make a diagnosis. There are no laboratory investigations to prove our diagnosis hence we have to rely entirely on skilful interview. A final diagnosis is made when all the information needed is collected and then treatment could be successful.

Socio-demographic data:

Name :

Name is for identification purpose. Good to address the person in one's first name.

Gender :

Knowing gender of the patient is important as certain psychiatric disorders like depression and anxiety disorders are more likely to occur in females than in males, illness like schizophrenia has better prognosis in females than in males. Conduct disorders and antisocial personality

disorders are more common in males than in females. Specific learning disabilities, ADHD are more common in boys than in girls.

Age :

Certain disorders are identified at a younger age like ADHD, autism, mental retardation, separation anxiety disorder, nocturnal enuresis. Depression, schizophrenia tends to occur more commonly in 2nd to 3rd decade of life. Alzheimer's dementia occurs in elderly patients. New onset of depression, psychosis or change of personality presenting for the first time in elderly, one has to rule out organic causes for the same.

Education :

Patients with mental retardation, specific learning disabilities, autism, ADHD have poor performance in school and academic activities which becomes evident during early days of schooling. Adolescents when they develop psychosis, due to psychotic symptoms and neurocognitive deficits their achievement in education may get affected. If psychotic illness develops in 3rd decade of life, by then the patient would have completed his education, he would be holding a job which are good prognostic indicators.

Occupation :

A patient holding a job has a better prognosis. Frequent changes in job in very short period of time can be seen in persons with mania or substance dependence. A person who is psychotic and performs poorly at work slides down the socio-economic status.

Religion :

Knowing the religion of the person is important as symptom presentation is frequently coloured by prevailing religious practices. The knowledge of the religious customs and rituals will help in understanding the patients better.

Location :

It gives an idea of his background, availability of mental health resources in the area. Address of the patient should be collected as he can be contacted in the community during community based management and home visits can be done to understand the way he interacts with family members, his adjustment to home environment.

Socio-economic status:

Affordability of treatment

Language of the person affects the way we ask the questions and the interpretation of the answer. It is always a good idea to speak in patient's language.

Information about the patient from informant's perspective is also important as patient might feel that his behaviour might be normal as he lacks insight into his illness. Information (history) collected is said to reliable if it is **continuous, corroborative, consistent and credible** obtained from a person who is in **close contact.** Adequacy is whether the history obtained is sufficient to make a diagnosis or not.

Chief complaints:

Chief complaints should be collected from both patient and the informant. Chief

complaints should be in patient's own words. They should be written in chronological order .i.e. chief complaint appearing first should be written first. Duration of each complaint should be noted down.

History of present illness:

Here make a note since when the patient was apparently well and since when the illness started. Provide information about the mode of onset (acute, sub-acute, or gradual) course (continuous, episodic, fluctuating) predisposing factors, precipitating factors and perpetuating factors. How each symptom began and how it progressed should be elaborated. Changes in biological functions like sleep, appetite, sexual activity, bowel and bladder habits should be explained; also enquire about how the illness has affected person's functioning in society and at work place. A typical day's routine can be described during the well period and during the illness phase.

A note of treatment history should be done, if patient has visited other doctors before presenting to you. What were the medicines prescribed to him, for what duration the medicines were prescribed, for how long patient took medicines, dose of each medication, how much improvement did the person experience with medicines and whether he was compliant with the treatment.

Many times the patients approach faith healer for curing the illness, it is important to ask about this as faith healers would have offered treatment which can have impact on symptoms and also produce significant side effects. This may also delay seeking care from psychiatrist.

It is important to record negative history; this would help in ruling out the differential diagnosis and coming to a conclusion. Enquire about medico-legal issues; use of alcohol and other recreational substances by the person.

Past psychiatric history:

History of similar illness and other psychiatric illness in the past. Check for symptom presentations in the past episodes. Enquire whether the patient took treatment for the previous episodes. Enquire what treatment was taken by him, effectiveness of the treatment, for how long he took the treatment, compliance with the treatment. Enquiry should be made regarding ECT and psychotherapy treatment if any. Alcohol and other recreational substances used should be mentioned.

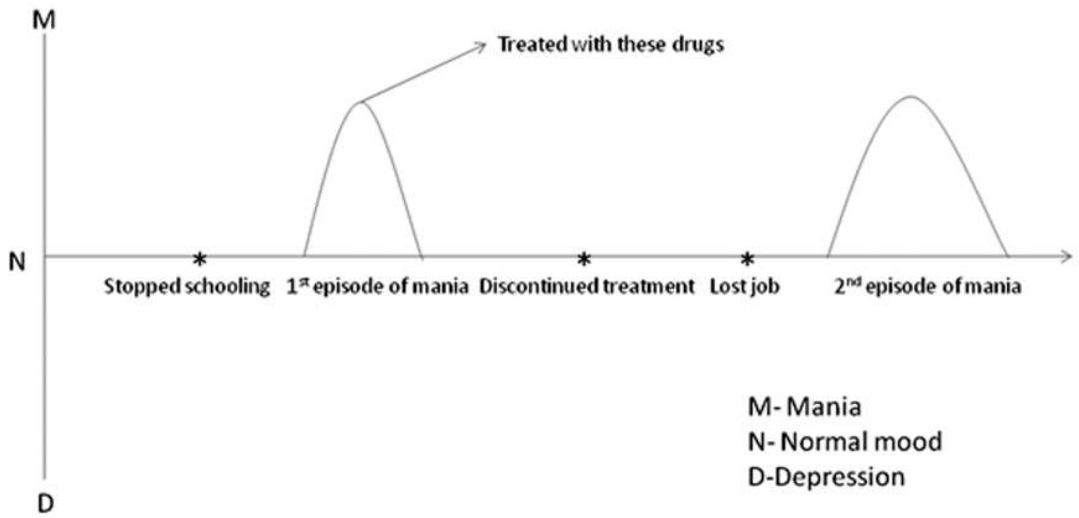
Medical history:

Current and past significant medical illnesses suffered should be mentioned. Enquire regarding any operations, head injury, neurological illnesses, diabetes mellitus, hypertension, cardiac, renal, hepatic diseases or if individual has been hospitalized for any reason. Sexually transmitted disease like HIV, HBsAg, Syphilis and others should be documented.

Life charting:

Represent course of the illness, its past episodes, severity, frequency of occurrence, treatment details, and stress factors.

Ex:



Family history:

Collect details about family of origin of the patient. Birth order and consanguinity in parents, type of family (nuclear, joint or 3 generation family), age of each family member, education and occupation of family members, head of the family, medical illness, psychiatric disorders, alcohol and other substance use disorders, death within family members and cause of the death especially suicides in family members should be asked.

Describe the interpersonal relationship of the patient with other family members; involvement of patient in family decision making, attitude of the family members towards patient's mental illness should be enquired. Nominal and functional head of the family noted.

Three generation pedigree chart of the family should be drawn.

Personal history:

History of patient's life from infancy to the present to be included.

1. **Perinatal history:** Details of mother's pregnancy status, difficulties faced by patient's mother during pregnancy, medical co-morbidities like diabetes mellitus, hypertension, alcohol and other recreational substance use, psychiatric illness suffered by her, whether the birth of the baby was hospital delivery/ home delivery, full term delivery or not, normal vaginal delivery/instrumental delivery/caesarean delivery, whether baby cried immediately after birth, NICU care to the baby and any birth defects.
2. **Early childhood history:** From birth till the age of 3 years, breast feeding practices, weaning, early development, and developmental mile stones.
3. **Middle childhood history:** From 4-11 years of age. Toilet training, early schooling history, adjustment to school, attitude towards school friends, playmates and siblings, thumb sucking.
4. **Later childhood history:** From 12-

18 years of age. Interest in studies, relationship with friends, truancy, bullying, complaints from school.

5. **Puberty:** Appearance of secondary sexual characters in boys and girls, masturbatory practices, knowledge about puberty should be asked.
6. **Menstrual history in females:** Age of menarche, duration of menses, length of each cycle, regularity, associated mood changes before and during menses.
7. **Adulthood history:**
   a. **Occupational history:** Age of starting 1st job, job satisfaction, changes in job, reason for changing job, attitude and relationship with co-workers and senior staff in each job, description about present job, income from present job.
   b. **Sexual history:** how the person acquired knowledge about masturbation, frequency of masturbation, fantasies about it, sexual activity during adolescent period, premarital and extramarital sexual relationships and deviant sexual practices should be enquired.
   c. **Marital history:** Draw family of procreation pedigree chart, whether the marriage is love or arranged one, inter caste or inter religion marriage, whether the marriage was done with consent of the person, emotional and sexual adjustment between couple, duration of marriage, marital satisfaction. If there are separations or divorce, reason for the same.

Pre-morbid personality :

Personality of the patient before the onset of mental disorder is assessed. Look for individual's behaviour and his capacity to handle relationship with near and dear ones. His ability to handle the task and the way he was approaching the task given to him at home and at work place. See if he was introvert or extrovert. His cultural beliefs and religious practices are enquired. How the person used to react and handle the stress is enquired. Decision making capacity of the person is also assessed. His life goals, his future planning, the steps he was taking to achieve them are assessed. His food likings and usage pattern of substances of abuse are enquired. His biological functions before the onset of illness are mentioned.

1. Interpersonal relationship:
2. Attitude towards work and responsibility:
3. Attitude towards self and others:
4. Moral and religious standards:
5. Leisure activities:
6. Predominant mood:
7. Role performance:
8. Fantasy life:
9. Habits:

Mental status examination: Psychological equivalent of physical examination.

General appearance and behaviour: describe person's appearance, grooming, dress, built, nourishment and handedness.

Attitude towards examiner: whether friendly, guarded, hostile, evasive, and cooperative for interviewing.

Rapport: it is spontaneous establishment of a therapeutic relationship.

Eye contact: maintained or not.

Facial expressions and posture: This can give a clue to the diagnosis. Like anxiety, depression etc.

Gait: Observe as he walks into your room.

Movements: Observe for extra pyramidal symptoms, tics, myoclonus

Psychomotor activity: it is combination of psychic activity and motor activity.

Speech:

Rate: it is the speed with which the person is talking. (Increased/pressured/ decreased)

Rhythm: it is the ups and downs in speech or intonations in speech. (Dysarthria, slurred)

Volume: high volume/ low volume/ mute.

Coherence: whether speech makes sense.

Relevance: whether the answer is appropriate/ relevant to the question asked.

Spontaneity: look for whether the speech is spontaneous or not, see if spontaneity is reduced.

Mood and affect: *(affect is like weather today and mood is the like the season; affect is cross sectional, mood longitudinal)*

Mood: ask the patient how has your mood been over the last two weeks?

Affect: it is the emotional state as we observe. Look for whether it is euthymic, euphoric, elation, exaltation, ecstasy, dysphoric, anxious or irritable.

Range : whether the person can express his emotion to full extent or not. Look for whether range is full or it is restricted, constricted, flat, blunted.

Reactivity : ability of the person to react to different emotional cues.

Congruence and appropriateness : whether the emotions expressed are appropriate to the situation or they are inappropriate to the situation.

Stability : Stable / labile

Thought:

Stream : it is flow of thought. Look for overabundance of ideas, paucity of ideas, flight of ideas.

Form : assess for formal thought disorders.

Content : thoughts pre-occupied by the person. Assess for delusions and over-valued ideas, look for guilt feelings, suicidal thoughts.

Possession : every individual understands that whatever he thinks are his own thoughts. In psychiatric illness control over one's own thought is lost like in obsessions, compulsions. Imaginary psychic boundary line that helps in differentiating whether the thoughts are of self or others is lost like in thought insertion, thought withdrawal, thought broadcasting.

Perceptual disturbances:

Here look for presence of hallucinations,

illusion depersonalization and de-realization phenomenon.

Hallucinations : false perception without external stimulation.

Illusions : it is false perception due to misinterpretation of external object which are existing in reality.

Depersonalization : it is 'as if' phenomenon where person has feeling of unreality with the self.

De-realization phenomenon : it is 'as if' phenomenon where person has feeling of unreality with the surrounding.

Cognitive function tests:

Consciousness:

Check for level of consciousness, it can vary from complete arousal to coma. If there is clouding of consciousness it is better to rate using Glasgow Coma Scale.

Orientation:

- Orientation of the person is checked for time, place and person.
- *Orientation to time :* enquire the time, date, day, month, year and season.
- Passage of time is a very sensitive indicator.
- *Orientation to place :* ask where is he? Name of the building? Which floor of the building? In which locality is the building? City, state and the country of location?
- *Orientation to person :* check if he can identify his family members, doctors and nursing staff around him.

Attention:

This is checked by asking the patient to do digit forward and digit backward testing. *(One letter/second, random numbers to be given and not in any sequence)*

Normal digit span forward : 5 to 7

Normal digit span backward : 3 to 5

Concentration:

Tested by serial 7 subtraction test. Subtract 7 serially from 100. He should do this in 120 sec, if he is unable to do this then try with 40-3 in 60 sec, if person is unable to do this then 20-1 in 30 sec. It can be tested by asking the person to say months and week day's forward and backward direction.

It can also be tested during interview by checking if the person is able to pay attention to us and reply back appropriately to the questions asked.

Memory:

Check for immediate, recent and remote memory.

- Immediate memory: Give 3 unrelated words, say the words monotonously, one word per 1sec, instruct the person to repeat the words immediately after you say it. Digit span test also can be used for the same.
- Recent memory: After the person repeats 3 words immediately, instruct him to remember those 3 words and you will be asking him to recollect it after 5 minutes. Then distract his mind for 5 minutes and later ask him to repeat those 3 words.

It can be assessed by asking how he came to the hospital. What he had for the breakfast that day morning?

- *Remote memory:* where he was born and brought up? Where was his early schooling? Check if he can recollect date of marriage, birth date of self and other family members?

Test atleast 3 times for each type of memory especially if memory is affected. What were the examiners question, patient's responses for each and what is the inference needs to be recorded.

(Patients with dementia initially present with loss of immediate and recent memory. As the illness progresses in later stages remote memory gets disturbed. Confabulations are seen in patients with dementia, Wernicke-Korsokoff's syndrome where there gaps in the memories are filled by fabricated stories)

Intelligence:

General fund of knowledge: This should be checked keeping in mind the education and background of the person. For illiterate persons one can ask what is the cost of 1 litre of milk, 1kg of rice, how to prepare tea or coffee for a home maker, which rivers are flowing in his place? How to grow a paddy in fields? For literate person one can ask the questions based on his interest, like who is prime minister of India? Capital of the country?

- Arithmetic ability: check for person's arithmetic ability based on his educational background.

Abstract thinking:

- *Differences and similarities:* ask the person to say differences and similarities between 2 objects which are familiar ex: apple and orange, table and chair, dog and tiger.
- *Proverb testing:* ask the person to say a proverb which he knows and to tell the literal meaning and the hidden meaning of it. If he is unable to tell then familiar proverbs are given up to 3 and he is asked to interpret them. Response is graded as abstract, semi-abstract and concrete.

Comprehension:

It is ability of the person to understand the question and reply appropriately to it.

Insight:

Awareness about one's mental illness.

If patient understands that he has mental illness which needs treatment for the same then insight is good, if patient does not understand and accept the fact that he has mental illness then insight is poor. Good insight is seen in neurotic disorders, poor insight is seen in psychotic disorders.

Judgement:

Ability of the person to take a valid decision appropriate to that situation is judgment.

- *Personal judgement:* judgement of the person with regard to personal decisions (Future plans).
- *Social judgement:* behaviour in social situations.

- *Test judgment:* It is assessed by asking the patient about his response in certain test situations. Ex: what he would do when he sees a house on fire?
- What he would do if he sees a man drowning?
- What he would do if he sees a sealed envelope with address on it fallen on road?

Stage of motivation: It is assessed when patient has substance abuse.

General physical examination:

A detailed general physical examination should to be carried out from head to toe.

Vital signs: Record blood pressure, pulse rate, temperature, respiratory rate.

Special emphasis is given for examination of thyroid, as thyroid disorders can present with psychiatric signs and symptoms.

Height, weight, abdominal circumference, BMI= weight in kilograms/ (height in meter) 2 is recorded.

Systemic examination: To rule out medical illnesses presenting with psychiatric signs and symptoms.

Investigations: There are no specific investigations for diagnosis of psychiatric disorders, but investigations are carried out to rule out medical illnesses presenting with psychiatric symptoms. Investigations are needed as a baseline, to monitor side effects or as a requirement before starting particular medications.

Types of diagnosis:

Definitive diagnosis: Diagnosis is clear

Differential diagnosis: Two or more possibilities which needs to be considered written in the order of preference

Provisional diagnosis: A diagnosis is based on the available information, however more information is waited. (Till investigation reports, more information from informants)

Tentative diagnosis: A diagnosis is based on the available information, however NO further information is expected.

CHAPTER 2

HISTORY TAKING FORMAT

Name:
Age:

Sex:
Education:

Occupation:
Socio-economic status:

Religion:
Language:

Location:
Informant:

Reliable:
Adequate:

Chief complaints:

Patient's version:

Informant's version:

History of present illness:

Past psychiatric history:

Medical history:

Family history:

Personal history:

1. Perinatal history:
2. Early childhood history:
3. Middle childhood history:
4. Late childhood history:
5. Puberty:
6. Menstrual history:
7. Adulthood history:
   a. Occupational history:
   b. Sexual history:
   c. Marital history:

Pre-morbid personality:

1. Interpersonal relationship:
2. Attitude towards work and responsibility:
3. Attitude towards self and others:
4. Moral and religious standards:
5. Leisure activities:

6. Predominant mood:
7. Role performance:
8. Fantasy life:
9. Habits:

Life charting:

MENTAL STATUS EXAMINATION:

General appearance and behaviour:

1. Eye- eye contact:
2. Facial expressions and posture:
3. Attitude towards examiner:
4. Rapport:
5. Gait:
6. Movements:

Psychomotor activity:

Speech:

1. Rate:
2. Rhythm:
3. Volume:
4. Coherence:
5. Relevance:
6. Spontaneity:

Mood and affect:

Mood:

Affect:

1. Quality:
2. Range:
3. Reactivity:
4. Congruence and Appropriateness:
5. Stability:

Thought:

1. Stream:
2. Form:
3. Content:
4. Possession:

Perceptual disturbances:

Cognitive function tests:

1. Consciousness:
2. Orientation: To time, place and person.
3. Attention and concentration:
4. Memory: immediate, recent, remote.
5. Intelligence:

a. General fund of knowledge:

b. Arithmetic ability:

6. Abstract thinking: Differences and similarities, proverb interpretation.
7. Comprehension:

Insight:

Judgment: personal, social, test.

Stage of motivation:

General physical examination:

Systemic examination:

Investigations:

Diagnostic formulation:

Diagnosis:

CHAPTER 3

CASE VIGNETTES

Case 1

A 69 years old married male person with education up to MA was a retired clerk from an urban background belonging to middle socio-economic status, was brought for consultation by his son with complaints of forgetfulness since 4 years. He had no significant medical history.

His son tells that from past 4 years, patient has become forgetful and does not remember whatever he does, he does not remember what he has eaten, he keeps asking for food frequently saying he did not have any food. He forgets where he has kept the money, his bike key and blames family members that they are misplacing them. He has stopped going for a morning walk, meeting friends and reading newspapers. Though he is staying in the colony from past 40 years; he is missing the way to home from 2 years and lands up in neighbour's house.

He does not brush the teeth properly, after brushing and washing mouth; the lather would still remain back around his mouth. In the same way after bathing, water and lather would remain on the body. While dressing up he forgets to button up shirt buttons. He spills food items out of the plate while eating. His family members are helping him every day for brushing teeth, taking bath and in dressing from past 1 year.

On mental status examination he appeared ill kempt. Eye to eye contact was made but ill sustained. He was co-operative with examiner, rapport was poor.

He gave wrong answers for time, day, date, month and year; he could not say which season was going on. He could not identify where he was, in which floor of the building, how he travelled to reach the place; but he could identify family members.

Immediate and recent memories were impaired. He was unable to recollect 3

unrelated words given to him immediately and after 5 minutes. His remote memory was intact as he could recollect and say where he was born and brought up, in which school he did studies. Confabulations were seen.

Fund of knowledge was poor, abstract thinking was at concrete level. He gave wrong differences between apples and orange, he was unable to tell similarities. He was able to do single digit arithmetic calculation with prompts. Insight was poor.

Laboratory investigations ruled out any systemic illness to explain the symptoms.

Diagnosis: Alzheimer's Dementia.

ICD-10 Diagnostic criteria:

a. Presence of dementia.
b. Insidious onset, progressive course and slow deterioration.
c. Clinical evidence and investigations do not suggests other forms of dementia.
d. Not of sudden onset and not in association with neurological signs of focal damage.
e. Duration: 6 months

Why this diagnosis?

1. History of forgetfulness, inability to remember and recollect day to today activities, he was missing the way back to home are suggestive of dementia.
2. Insidious onset of illness; with illness duration of 4 years, progressive deterioration initially in the form of inability to recollect things done some time back, later forgetting the way back to home and with further advancement of illness, he could not carry out daily activities and was in need of assistance from family members.
3. Investigations ruled out dementia due to other causes.

Whether patient needs inpatient care?

Yes, as patient needs detailed evaluation and his condition is at a moderate level.

Goals in management of the patient:

1. Before making the diagnosis of Alzheimer's dementia, rule out reversible and treatable causes of dementia.
2. Psychoeducation of the family, treatment of symptoms.
3. To address family's burden due to illness in the patient.

Investigations:

1. Complete blood count, FBS, PPBS.
2. Liver function tests, renal function tests.
3. Thyroid function test.
4. Serum levels of Vitamin B12, Calcium
5. Tests to rule out syphilis and HIV infection.
6. MRI brain to look for degenerative changes in cortex.

Treatment:

Psychological:

Psycho-education about illness, course, prognosis, need for compliance, side effects of drugs, regular follow up should be explained to family members.

Behavioural:

1. Patients should be in well lit, quite, calm room.
2. Repeated reorientation to time, daily activities shouldn't be changed frequently.
3. Take precautions so that patient does not wander away from home, name and contact details card to be kept with the patient.
4. Activity scheduling and regularising sleep.
5. Daily personal care.
6. Taking care of bowel and bladder habits.
7. Calendar with big dates.
8. Direction can be displayed

Pharmacological:

Acetylcholinesterase inhibitors used in the treatment are Donepezil, Rivastigmine, Galantamine. Memantine an NMDA receptor antagonist is also used in dementia.

Definitions and facts:

Confabulations: filling gaps in memory with fabricated events that appear real.

Dementia:

A disease of the brain which is chronic and progressive in nature characterised by disturbance of multiple higher cortical functions including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgment without impairment of consciousness.

Amnesia:

it is partial or total loss of memory.

Acetylcholine deficiency is implicated in Alzheimer's dementia.

Step ladder pattern of progressive dementia is seen in multi-infract dementia.

Early onset Alzheimer's disease: onset before the age of 65 years.

Most common cause of dementia: Alzheimer's dementia.

Normal pressure hydrocephalus: triad of symptoms-

1. **A**taxia.
2. **B**owel and bladder incontinence.
3. **D**ementia.

(Pneumonic: **ABD**e Villiers a famous cricket player.)

Frontotemporal dementia:

Also known as Pick's disease. It is characterized by atrophic changes in frontotemporal region and Pick's bodies are seen. Predominant presentation is with changes in personality and behaviour with preservation of other cognitive functions.

Lewy body dementia:

It is characterised by presence of dementia in association with visual hallucinations, Parkinson's symptoms and fluctuations in the level of alertness.

Transmissible dementia:

1. Creutzfeldt Jacob Disease (rapidly progressive)
2. Kuru.
3. Fatal familial insomnia.
4. Gerstmann-Straussler-Scheinker disease.

Differential diagnosis:

1. Delirium: in delirium there is clouding of consciousness which is not seen in dementia.
2. Substance intoxication: due to substance intoxication impairment in attention, concentration, immediate and recent memory impairments can be seen. But once patient is out of intoxication state, impairments recover.
3. Substance withdrawal delirium: cognitive impairments in delirium are short lasting and once patient recovers from delirium; cognitive impairments are not seen. While in Alzheimer's dementia, cognitive deficits deteriorate as the days pass.
4. Mental retardation: mental retardation has onset since childhood, while Alzheimer's dementia has onset during later life.
5. Schizophrenia: mild impairment in cognitive functions can be seen in schizophrenia, schizophrenia has onset during early age, while dementia has onset during late life.
6. Dissociative amnesia: it involves memory loss for particular traumatic event.
7. Pseudo-dementia: it is seen in depression, where person gives don't know answers, with encouragement his performance in answering improves. Whereas as in dementia, the patient has confabulations. Onset is recent.
8. Factitious disorder: the patient produces symptoms to seek for medical attention.
9. Malingering: patient feigns symptoms for monetary gains like sick leaves, abstinence from duties, court cases.

Case 2

A 55 year old married man with education till 6th standard was a milk vendor from rural background belonging to middle socio-economic status. He had a fall and sustained fracture of femur, he was operated and was in post-operative ward for monitoring.

A psychiatry consultation was sought for him as he was restless and irritable; he removed IV cannula and was frequently trying to move out of his bed. His talk was barely understandable to treating doctors and nursing staffs. Though repeated instructions were given to him to be on bed, he did not follow them. Whenever treating doctor or nursing staffs approached him, he became aggressive and he scolded them with filthy words. He was not sleeping at night when other patients could sleep. His behaviour was disturbing neighbouring patients and he had to be physically restrained.

He had no past history of alcohol and other substance use. No past history of depression, anxiety or psychosis was seen. No family history of psychiatric illness.

Pre-morbidly his memory and cognition were intact.

On examination, he had increased psychomotor activity. There was clouding of consciousness, he was not oriented to time, place and person. His attention was ill sustained and could not maintain concentration. He described that he is seeing snakes moving on the wall and insects crawling on his body (visual hallucinations). He feared that they will bite him. There was impairment in immediate and recent memory.

Diagnosis: Delirium not induced by alcohol and other psychoactive substances.

ICD-10 Diagnostic criteria:

Symptoms should be present in each of the following areas:

a. Impairment of consciousness and attention.
b. Global disturbance of cognition.
c. Disturbance in psychomotor activity
d. Altered/ disturbance in sleep-wake cycle.
e. Emotional disturbances

Rapid onset with diurnal fluctuation. Total duration of illness less than 6 months.

EEG: slowing of background activity.

Why this diagnosis?

1. Clouding of consciousness, disorientation to time place and person, ill sustained attention and concentration which suggests impairment of consciousness and attention.
2. Global disturbance of cognition as patient, impairment in immediate and recent memory, impaired comprehension as patient did not understand and follow doctors and nurses instructions.
3. Increased psychomotor activity in patient.
4. Not sleeping at night which suggests altered sleep wake cycle.
5. Emotional disturbance
6. Visual hallucinations.

Whether patient needs in patient care?

Yes, delirium is a medical emergency the cause should be detected and treated.

Goals in management of the patient:

1. Delirium is medical emergency prompt identification is of utmost importance.
2. Identification of underlying causative factor and treating it.
3. Behavioural treatment as patient would be agitated and paranoid, patient and people surrounding him should be safeguarded.

Investigations:

1. Complete blood count.
2. Serum electrolytes.
3. Thyroid function test.
4. Liver function test.
5. Renal function tests.
6. Urine analysis.
7. ECG, EEG.
8. Screening tests for drugs of abuse.

Treatment:

Behavioural:

1. Patients should be kept in well lit, quite, calm room accompanied by relative.

2. Repeated reorientation to time place and person.
3. Take precautions so that patient does not wander away.
4. Daily personal care.
5. Calendar with big dates.
6. Direction to be displayed for washroom.
7. Soft leather restraints if patient is harmful to self and to others (only when absolutely necessary)

Pharmacological:

1. Maintain hydration
2. Identification and treatment of underlying causative factor.
3. IV antipsychotics like haloperidol help to control agitation and provide sedation. Have a watch on side effects. Oral antipsychotics like Risperidone, Olanzapine and Quetiapine are also used. Benzodiazepines can also be used on SOS basis.

Other names:

1. Acute confusional state.
2. ICU psychosis.
3. Encephalopathy.
4. Sun downing illness
5. Organic Brain Syndrome.

Definitions and facts:

Delirium: It is an acute confusional state having a fluctuating course characterized by impairment in the level of consciousness, attention, psychomotor activity, global disturbance of cognition, altered sleep-wake cycle, with emotional disturbance.

Most common type of hallucinations seen in delirium: visual followed by auditory.

Most common cause of delirium in elderly: poly-pharmacy.

Most common cause of delirium in elderly patients with dementia: UTI.

Differential diagnosis:

1. ***Substance intoxication delirium:*** features of delirium are present. Associated with it evidence of substance intoxication are present from history, physical examination and laboratory investigations.
2. ***Substance withdrawal delirium:*** it is has features of delirium associated with it the individual also has history of substance use with either recent reduction or total zero intake of substance along with withdrawal symptoms of substance.
3. ***Mental retardation:*** individuals with mental retardation show poor performance in cognitive function tests, they might not sustain attention and concentration, might not answer correctly while checking for orientation and memory.
4. Schizophrenia: patients with schizophrenia most commonly present with auditory hallucinations and delusions, whereas patients with delirium present with visual hallucinations. Patients with schizophrenia do not have impairment of consciousness. While patients with delirium have impairment of consciousness.

5. ***Severe depression:*** patient with severe depression may present with disturbances in attention, concentration, they may also complain of memory disturbances. Memory disturbance in depression is pseudo dementia, psychotic symptoms in severe depression would be of delusion of guilt, nihilistic delusions, delusion of poverty, and auditory hallucinations of derogatory type. Whereas patients with delirium present with visual hallucinations, persecutory delusions along with other features of delirium.
6. Manic episode: patient with manic episode presents with disturbances in attention and concentration, hyperactivity. But he would have delusions of grandiosity. While patients with delirium have visual hallucinations and persecutory delusions.
7. Dementia: cognitive function tests impairment is seen in dementia and delirium. Delusions of persecution and visual hallucinations can be found in both dementia and delirium. But delirium has sudden onset, while dementia has insidious onset. Clouding of consciousness is seen in delirium and not in dementia.

Case 3

A 41 year old married male patient with education up to 10th standard was a vegetable vendor from rural background belonging to low socio-economic status was brought by his wife with complaints of alcohol consumption from last 12 years.

Patient started consuming alcohol along with friends during party once a month; he was initially consuming beer (1/2 pint), in next 2 years he increased the quantity to 1 pint consuming 3-4 times in a month. Later he shifted to whisky in a year which he was consuming 1-2 pegs. In this way he kept increasing the percentage and the quantity of alcohol as he could not experience same amount of pleasure he experienced previously. He was consuming 1 quarter of whisky every day when he presented to hospital.

He consumed it every day in the evening at bar after work along with friends. The desire to consume was so strong that if he did not consume; he used to become restless, could not concentrate on the work he did and was not getting good sleep at night.

He was aware that alcohol is harmful to health but he was unable to quit. Because he spent most of the free time in the bar, he was unable to spend quality time with family members and fulfil their needs.

His wife reported that he quarrelled at home under the influence of alcohol. He used to spend most of the money he earned for alcohol and his debts increased.

Whenever he consumed alcohol on empty stomach he suffered weakness and abdominal distress due to which he could not go for work.

No history of other substance use, no history of confused behaviour and involuntary movements when he was off alcohol for 1-3 days. No history of yellowish discoloration of eyes, abdominal distension, blood in vomitus, dark coloured stools.

During interview he was sweating, there were tremors, he was able to maintain good eye contact and rapport was established. Psychomotor activity was normal, he appeared dysphoric and he rationalized his alcohol consumption.

No perceptual abnormalities were elicited. Cognitive function tests were normal. Insight was poor. Personal judgement was impaired, social and test judgements were intact. He was in pre-contemplation stage of motivation.

His BP: 160/ 90 mmHg, PR: 100 Beats/ min.

Diagnosis: Mental and behavioural disorder due to use of alcohol; dependence syndrome; uncomplicated withdrawal.

ICD-10 Diagnostic criteria for substance dependence:

a. Craving: Intense desire or compulsion to take the substance.
b. Loss of control for substance use.
c. Withdrawal state or symptoms.
d. Tolerance: increased doses of the substance are required to achieve the effects originally produced by smaller amounts.
e. Salience: progressive neglect of alternative pleasurable activities and increased spending of time for procuring the substance and to recover from its effects.
f. Use despite harm: continued use of substance in spite experiencing its harmful consequences.

Duration criteria: 1 year.

For definitive diagnosis 3 or more of the above criteria for the duration of 1 year is necessary.

Narrowing of personal repertoire: It is the pattern and environment related to substance use (like same time, same bar, same table, and same friends)

Why this diagnosis?

1. Patient is using substance for the duration of 12 years.
2. Craving for alcohol intake was seen in the form of strong desire to consume it and without consumption he experienced restlessness, insomnia, irritability, inability to concentrate on work.
3. He had tolerance as initially he started with beer which contains lesser percentage of alcohol; he kept increasing its quantity as he did not get the same effect, later shifted to whisky.
4. Withdrawal symptoms were seen in him in the form of sweating, tremors of hand on waking up in the morning. And during examination he was sweating; had tremors of hands, dysphoric affect, BP: 160/ 90 mmHg, PR: 100 Beats/ min.
5. Use despite harm was seen, as he

continued to consume alcohol even when he was experiencing its harmful consequences.

6. Above described symptoms present for more than 1 year

Whether patient needs inpatient care?

Yes, the withdrawal symptoms need to be handled and motivation enhanced

Goals in management of the patient:

1. Treatment of acute withdrawal.
2. Enhancing the motivation for abstinence.
3. Preventing relapse.
4. Craving control techniques
5. Addressing psycho-social, occupational, interpersonal issues.

Treatment:

Pharmacological:

1. Thiamine supplementation.
2. Detoxification: It is treatment of withdrawal symptoms. Ex: Lorazepam. If liver condition of the patient is normal then long acting benzodiazepines like Chlordiazepoxide, diazepam or nitrazepam can be used.
3. Once the patient is out of withdrawal state, future relapse of alcohol use is prevented by use of anti-craving drugs like Acamprosate, Naltrexone, Baclofen. Aversive agent like Disulfiram is can be used.

Psychological:

1. Psycho-education about illness, course, prognosis, need for compliance, side effects of drugs, regular follow up should be explained to family members.
2. Intervention for relapse prevention:

A. Motivation enhancement Therapy: It is based on principles of **FRAMES** and **DARES**.

FRAMES

Feedback: provide feedback about negative consequences of substance use.

Responsibility: make emphasis on the fact that he is responsible for making his own decision.

Advice: give advice on modifying drug use.

Menu of options: give menu of options in modifying substance use behaviour and decision making.

Empathy: to be empathic while discussing with patient.

Self-efficacy: self-efficacy is one's own capacity to produce desired result.

DARES

Develop discrepancy: create discrepancy for individual's desired state of being and actual state of being.

Avoid argumentation: do not argue with individual during counselling as it develops negative attitude towards therapist.

Roll with resistance: overcome the resistance offered by the individual about substance use by empathic listening.

Express empathy: create an empathic situation where the individual feels his problems are accepted and he would find a solution.

Support self-efficacy: encourage individual's own capacity to bring the desired result and help in taking up actions for desired result.

B. Relapse prevention strategies:

Face the problems and solving them, teaching skills to solve problems, life style modification by involving into activities like meditation, exercise, spiritual practices, talking with friends who do not take drugs, refuse the drug when offered. Avoid cues that remind of alcohol. Use substitute drinks; do not be hungry as it can increase craving, keep stomach filled.

C. Alcohol Anonymous:

It is a 12 step programme where members of the group admit that they are powerless over alcohol and need help from higher power (God).

Definitions and facts:

Legal limit of blood alcohol concentration for driving in India: 30mg/100ml.

Alcoholic black out: it is loss of memory for the events after heavy alcohol consumption, during the event the person may be aggressive and assaultive, it is followed by prolonged sleep and when person wakes up he does not remember the events.

What is **CAGE** questionnaire?

C: Have you ever tried to **C**ut down alcohol intake?

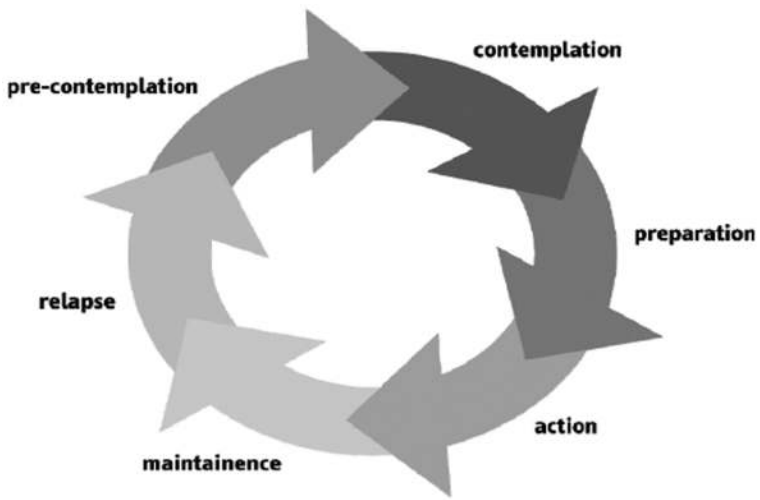
A: Have you ever felt **A**nnoyed by people talking about your alcohol intake?

G: Have you ever felt **G**uilty about your alcohol intake?

E: Do you require **E**ye opener?

Motivation cycle: Given By Prochaska and Diclemente.

1. **Pre-contemplation stage:** Person does not accept that substance use is harmful.



Transtheoretical Model of Change
Prochaska & DiClemente

2. **Contemplation stage**: Person accepts that substance use is harmful, but he is not ready to stop it.
3. **Preparation stage:** Person prepares himself to stop it. He fixes date and time to stop substance use, if he thinks medical help is necessary he would plan and meet a Doctor.
4. **Action stage:** He stops using the substance.
5. **Maintenance stage:** He maintains abstinence for variable period.
6. **Relapse:** He restarts using the substance due to variety of issues.

Biological markers of alcohol dependence:

1. Gama Glutamyl Transferase.
2. Mean corpuscular Volume.
3. Alkaline phosphatase.

Other drugs causing Disulfiram like reaction:

1. Metronidazole.
2. Griseofulvin.

1 unit of alcohol: 10 ml or 8 grams of pure alcohol.

Units of alcohol in beverages:

1. 25 ml glass of whisky (40%) -- 1 unit.
2. 250 ml glass of wine (12%) -- 3 units.
3. 330 ml bottle of beer (5%) - 1.65 units.
4. 1 pint (approximately 500 ml) of beer (4%) -2 units.

Differential diagnosis:

1. Medication induced: symptoms of hyperarousal can occur due to certain drugs for ex thyroid hormone which may mimic withdrawal symptoms, but alcohol use evidence would not be there and history of medication use would be found.
2. Panic disorder: in panic disorder the patient presents with panic attacks which has symptoms of autonomic hyperarousal which mimics withdrawal symptoms. In panic disorder, the patient does not have substance use evidence.
3. Harmful use of substance: here substance use is not at dependence level but has produced damage to mental or physical health of the person.

Case 4

A 35 years old married male patient, with marital life of 12 years educated up to 10thstandard, was an auto-driver by occupation, from semi-urban background; belonging to low socio-economic status was brought to hospital by his wife.

She complained that he is talking irrelevantly and is unable to identify family members since yesterday and 1 episode of involuntary movements just before bringing him to hospital.

Patient's wife reported that she is been observing him since the time of their marriage that he consumes big bottle of alcohol every day at home. If he does not consume his sleep would be disturbed and

would experience tremors of hands. Under alcohol influence he keeps scolding neighbours and family members; due to this reason neighbours have beaten him several times. She says that patient avoids going to relatives home as alcohol consumption is not allowed there. He consumes alcohol during functions and festivals.

Since yesterday he has stopped alcohol use due to lack of money and family members have seen that he is having tremors of hand, he appeared tensed, got irritable over trivial issues. At night he appeared confused, talked irrelevantly as if he is speaking to auto passengers and could not identify that he is at home. He did not sleep at night, kept roaming around in the home and in streets, he undressed himself for no apparent reason near neighbour's home and family members had to cover him with bed sheet and they dragged him inside. At home he urinated in the kitchen so he was locked in the bedroom.

In some time after locking him in the bedroom, he screamed and when family members opened the door, they saw that he was having involuntary movements of upper and lower limbs in tonic and clonic fashion. He had frothing from mouth with up rolling of eyes. He defecated during this time. He was given key bunch to hold in his hand by family members. The movements stopped after 2 minutes and he was taken to hospital immediately.

No history of other substance use, yellowish discoloration of eyes, abdominal distension, or passage of black coloured stools.

Diagnosis: Mental and behavioural disorder due to use of alcohol; dependence syndrome - complicated withdrawal. (Delirium tremens with convulsions)

ICD-10 Diagnostic criteria for alcohol withdrawal delirium/ delirium tremens:

1. Symptoms of delirium:

a. Impairment of consciousness and attention.

b. Global disturbance of cognition.

c. Psychomotor disturbance.

d. Sleep-wake cycle alteration.

e. Emotional disturbances.

2. Symptoms of tremens, .i.e. symptoms of withdrawal- tremors, anxiety, irritability, hypertension, tachycardia, sweating.

Convulsions due to alcohol withdrawal are **always Generalized Tonic Clonic Seizures** (GTCS) type. Symptoms are characterized by tonic phase where there is sudden contraction of muscles lasting for 10-20 seconds, followed by clonic phase where there are rhythmic muscular contractions, flexion and extension alternating with each other.

Why this diagnosis?

1. Patient meets the criteria for alcohol dependence, as he was consuming big bottle of alcohol suggestive of tolerance. He was experiencing sleep disturbance and tremors of hands suggesting withdrawal state. He was

consuming it even after experiencing harmful effects which means there is use despite harm. These have been occurring since the time of marriage (12years), and duration criteria for alcohol dependence is 1 year.

2. Patient was in delirium tremens as he had confused behaviour (impairment of consciousness), irrelevant talk as if he was talking to auto passengers, undressing himself in inappropriate places, urinating in kitchen (disorientation and impairment of cognition), roaming around in home and in streets at night (psychomotor hyperactivity), did not sleep at night (sleep-wake cycle alteration). These are suggestive of delirium. He was noticed by family members to have tremors of hands, tension and irritability suggestive of withdrawal state.
3. Screaming, involuntary movements of upper and lower limbs in tonic and clonic fashion with up rolling of eyes are suggestive of GTCS type of seizures.

Whether patient needs inpatient care?

Yes, as patient is in delirium and had convulsions which suggest that he has severe alcohol withdrawal.

Goals in management of the patient:

1. Prompt identification and treatment of delirium and alcohol withdrawal seizures.
2. Once individual is out of withdrawal symptoms, assess for motivation for stopping substance use.
3. Motivation enhancement.
4. Preventing relapse.
5. Addressing psycho-social, occupational and interpersonal problems.

Treatment:

Psychological:

Psycho-education about illness, course, prognosis, need for compliance, side effects of drugs, regular follow up should be explained to family members.

Pharmacological:

1. Acute treatment:
   a. Thiamine replacement.
   b. Benzodiazepines parenteral.

Behavioural:

i. Patients should be in well lit, quite, calm room.
ii. Repeated reorientation to time, place and person.
iii. Take precautions so that patient does not wander away and his safety
iv. Daily personal care.
v. Taking care of bowel and bladder habits.
vi. Calendar with big dates.
vii. Direction to be displayed for washroom.
viii. Soft leather restraints if patient is harmful to self and to others.

2. Long term treatment: relapse prevention.

Other names:

1. Alcohol withdrawal delirium: Delirium tremens.
2. Alcohol withdrawal seizures: Rum fits.

Differential diagnosis:

1. Non alcohol withdrawal delirium: patient presents with delirium but evidence of alcohol use from history, examination, laboratory check up is not found.
2. Schizophrenia: patients might have visual hallucinations in schizophrenia but clouding of consciousness is not seen.
3. Delusional disorder: here visual hallucinations are not present like in delirium. Clouding of consciousness is not seen in delusional disorder but is seen in delirium.

Case 5

A 50 year old married male patient, educated up to BE, engineer by occupation from urban background, belonging to middle socio-economic status was accompanied by wife to the hospital. He was diagnosed with chronic obstructive pulmonary disease. Patient was referred to Psychiatry OPD by pulmonary physician to address the problem of smoking.

Patient has been smoking cigarettes for the last 12 years. He started it when he was in college along with friends. Initially he smoked 1-2 puffs from a cigarette once in a week with friends, in 3 months he started smoking 1 cigarette one to two times per week at night increasing it to 1 every day after lunch. By the time he finished college education he was smoking half packet of cigarettes daily.

He kept increasing the number of cigarettes he smoked. When he presented to Psychiatry OPD he was smoking two packets per day. He gets the desire to smoke which he cannot control, which he described as the magnet which pulls him towards cigarette. If he tries to control the desire he becomes restless, gets angry over trivial issues and he won't be able to concentrate on work.

He knew cigarette smoking is harmful to health as it causes diseases of lung including cancer. His wife used to say that she does not like him smoking and the smell that comes after smoking is intolerable and smoking would affect not only him and her, but even their children adversely, even then he was unable to quit smoking.

He said every day he tries to cut down the number of cigarettes he smokes but he fails to do it and finally lands up smoking 2 packets.

No history of other substance use.

Diagnosis: Mental and behavioural disorder due to use of tobacco; dependence syndrome; currently using the substance.

ICD-10 criteria for diagnostic criteria for substance use are given in case 3.

Why this diagnosis?

a. Duration of substance use is 12 years.

b. From 1-2 puffs from a cigarette once a week he reached 2 packets/ day. This is suggestive of tolerance.

c. Intense desire to smoke, becoming restless, getting angry over trivial issues, inability to concentrate on work without smoking are suggestive of craving.

d. Knowing and experiencing harmful effects of cigarette smoking he continued to smoke. This suggests use despite harm.

e. He has met dependence criteria for more than 1 year.

Whether patient needs inpatient care?

No, as tobacco dependence does not cause immediate harm to the patient. He is not harmful to himself and to others. He has good insight.

Goals in management of the patient:

1. Motivation enhancement.
2. Advising nicotine replacement regimens to help in quitting and later relapse prevention

Treatment:

1. Psychological:
   a. Motivation enhancement therapy.
   b. Psycho-education about the illness and available treatment options.
2. Pharmacological:

Nicotine replacement therapy: with Nicotine chewing gums, Nicotine pastilles, Nicotine patches, Nicotine inhaler, E-cigarettes.

Non-nicotine drugs:

a. Bupropion: Reduces craving due to dopamine and noradrenergic action.

b. Varenicline: $\alpha 4\beta 2$ nicotinic acetyl choline receptor agonist.

c. Clonidine: Reduces sympathetic over activity and thereby reducing craving and withdrawal symptoms.

d. Benzodiazepines: Reduces withdrawal symptoms and craving.

3. Other interventions:

a. Public education and awareness programmes.

b. Prohibiting sale of tobacco near school and colleges.

Facts:

Most common substance abused in India is tobacco.

Scale to assess nicotine dependence: Fagerstrom scale.

Case 6

A 24 year old unmarried male with BA education was working as sales man from semi-urban background of a middle socio-economic status family was brought with complaints of smoking cigarettes from 4 years, smoking 'ganja' from 3 years, anger and irritability from 2 weeks.

Patient started smoking cigarette along with friends initially he smoked 1 cigarette occasionally; he kept increasing the number and frequency of smoking. When he presented, he was smoking 1 packet per day. He told that cigarette helps him in increasing the concentration while working and controlling tension of work. Every 2-3 hours he gets craving and he has to smoke otherwise he would become irritable. He knew that smoking is harmful to health as it is shown in media advertisements. But he was unable to quit smoking.

3 years back one of his friend introduced him to 'ganja' during party. He smoked 1 joint which made him feel relaxed, he felt he is totally shut off from the world. He could feel the dance of music rhythm in air. It gave him lot of excitement and it increased the appetite. Since then he smoked 1 joint every week to ward of boredom and for excitement.

1 year back he lost job and since then he increased the quantity of joints to 4 per day, as he had to stay alone at home and all other family members would go for work.

2 weeks before presenting to hospital family members noticed a change in his behaviour that he keeps talking to self and smiling to self, he appeared fearful most the time; he was irritable over trivial issues. There was impairment in daily routine activities. He had early insomnia. His appetite was reduced. He continued to smoke joints every day.

He used hear the voice of 6 priests who were passing derogatory comment, they were discussing about him among themselves and kept scolding him saying that he is not following the norms of the religion and he would face a miserable death. This made him feel fearful and used to lookout for strangers around the home who would harm him.

On mental status examination he was ill-kempt, appeared fearful, co-operative for interview, and eye to eye contact was made. Psychomotor activity was normal, speech was normal, he appeared fearful. He had delusion of persecution, 2nd and 3rd person auditory hallucination. Insight was poor. Judgement was impaired.

Diagnosis: Mental and behavioural disorder due to use of cannabinoids; Cannabis induced psychotic disorder schizophrenia like.

Mental and behavioural disorder due to use of Tobacco: Dependence syndrome, currently using the substance.

ICD-10 definition:

Substance induced psychotic disorder:

A cluster of psychotic phenomena that

occur during or immediately after psychoactive substance use and are characterized by vivid hallucinations, misidentifications, delusions, psychomotor disturbance (excitement or stupor), abnormal affect which may range from intense fear to ecstasy with clear sensorium.

ICD-10 criteria for substance induced psychotic disorder:

Psychotic disorder occurring during or immediately after drug use (within 48 hrs.) which is not due to drug withdrawal state with delirium.

Late onset psychotic disorder: onset more than 2 weeks after substance use.

Most of the symptoms resolve at least partially within 1 month and completely within 6 months.

Why this diagnosis?

1. Patient is using 'ganja' since 3 years, from 1 joint every week to 4 joints per day.
2. While he was using joints a change in his behaviour was noticed by family members in the form of talking to self, smiling to self and fearfulness and irritability for 2 weeks.
3. Impairment in carrying out daily routine activities was seen along with early insomnia and reduction in appetite.
4. Hearing voices of 6 priests who were passing derogatory comment to him and also were discussing about him among themselves.
5. Acting out behaviour in the form of being fearful and looking out for strangers around home was seen.
6. Delusions of persecution

Whether patient needs inpatient care?

Yes, patient is having florid psychotic symptoms

Goals in the management:

1. Quitting 'ganja' and tobacco.
2. Improving psycho-social functioning.
3. Occupational rehabilitation.

Treatment:

Psychological:

1. Psychoeducation about illness, course, prognosis.
2. Motivation enhancement therapy for cannabis and tobacco.

Pharmacological:

1. Treatment with atypical antipsychotics (Risperidone, Olanzapine, Quetiapine) which reduces psychotic symptoms, improves sleep and appetite can be tried.

Definitions and facts:

Active substrate of cannabis is delta 9-Tetra Hydro-Cannabinol.

Cannabis produces amotivational syndrome.

Differential diagnosis:

1. Harmful use of substance: substance use that causes damage to health. Physical damage like hepatitis or mental which is secondary to heavy consumption of alcohol.

2. Medication induced psychotic disorder: here medications are the cause of psychotic disorder.
3. Substance induced delirium: here there is impairment in level of consciousness, where as in substance induced psychotic disorder there is no impairment in level of consciousness.
4. Substance induced delusional disorder: here patient presents with predominantly delusions and no other features of schizophrenia are seen.

Case 7

A 40 year married male with secondary school education, working in a factory; from urban background belonging to middle socio-economic status was brought to OPD by his wife. She complained that patient is suspicious over her, children, other family members and co-workers from last2 years.

Patient said that his wife is against him, she had planned to kill him, so she has set his children, family members and co-workers against him. She adds poison to the food while she cooks it, so he makes his wife to eat the food first then he eats after confirming that she did not die. While sleeping at night he gets a foul smell, and believes that his wife and children vaporize invisible liquid; inhaling which he may die, so he sleeps in another room.

He believed that birds in the nest near to his home are set by his wife against him, birds make chirping sound and direct people in his locality to kill him. Also people in his locality talk about him and spread slanderous stories about him.

He tells that co-workers from factory have installed secret software in his computer, which controls him and his bike steering while he rides it, so that he meets with an accident and dies. Software also induces heat in his body by focusing sunlight on him through invisible lens, heat moves from foot to head which creates an intense pain in head. He even hears voices of two people speaking about him among themselves that he is not a good person; he is of no use to anyone.

His talk is reduced; he is not mingling with friends, he is not attending functions and not carrying out pleasurable activities, his appetite is reduced and even experiences sleep disturbances.

During interview, patient was sitting in interview room with suspicious look scanning the room; he appeared anxious and harboured

1. "My wife, children and co-workers are against me and are planning to kill me"-Delusion of persecution.
2. "Computer controls me and my bike steering through software, so that I meet with accident and die"- Delusion of control.

3. "Computer software is inducing heat in my body which moves from foot to head causing intense headache"- Somatic passivity.
4. "I hear voices of two people speaking about me among themselves, they say that I am not a good person and I am of no use to anyone"-Third person auditory hallucinations.
5. "I get foul smell of vapours from an invisible liquid, inhaling which I may die"-Olfactory hallucination.

His cognitive function tests were normal, insight was poor. Personal and social judgements were impaired, test judgement was intact.

Diagnosis: Paranoid Schizophrenia.

ICD-10 Diagnostic criteria:

a. Thought echo, insertion, withdrawal or broadcasting.
b. Delusion of control, influence or passivity.
c. Running commentary type of auditory hallucinations, voices discussing the patient among themselves.
d. Bizarre delusion/ delusions those are culturally inappropriate and completely impossible.
e. Persistent hallucinations in any modality, with fleeting or half formed delusions.
f. Break in the train of thought, neologisms.
g. Catatonic behaviour.
h. Negative symptoms.
i. Significant and persistent change in personal behaviour like loss of interest, aimlessness, idleness, self absorbed attitude, social withdrawal.

Duration: 1 month.

For diagnosis - 1 symptom criteria (2 or more if less clear cut) from (a) to (d) and 2 symptoms criteria from (e) to (i) for a duration of 1 month.

Paranoid schizophrenia:

Predominant presentation is with paranoid delusions and hallucinations.

Why this diagnosis?

a. Patient has delusion of control, delusion of persecution, somatic passivity.
b. 3rd person auditory hallucinations .i.e. is voices speaking/ discussing about him among themselves.
c. Patient had olfactory hallucinations.
d. Presence of negative symptoms in the form of reduced talk reduced mingling with friends, not attending functions and not carrying out pleasurable activities.
e. The patient has met the criteria for schizophrenia and predominant presentation is with paranoid delusions and accompanied by hallucinations.
f. Duration of illness is from 2 years.

Whether patient needs inpatient care?

Yes, patient needs inpatient care as he lacks insight; compliance with medications would be an issue with him.

Goals in management of the patient:

1. Developing a good rapport with patient.

2. Symptom reduction with treatment.
3. Addressing expressed emotions.
4. Addressing compliance issues.
5. In long term reduce disability arising out of chronic psychosis and rehabilitation.

Treatment:

Pharmacological:

Atpical antipsychotic treatment like Risperidone, Olanzapine or Quetiapine is preferred as risk of EPS is less compared to typical antipsychotic drugs, they help in improving his appetite which is reduced also improves sleep.

Psychosocial treatment:

1. Psycho-education about illness, course, prognosis, need for compliance, side effects of drugs, regular follow up should be explained the patient and to family members.
2. Family therapy: to address expressed emotions like critical comments, hostile behaviour over involvement etc.
3. Involving in group therapy for social skill training.
4. Occupational therapy.

Definitions and facts:

Most common type of schizophrenia: Paranoid schizophrenia.

Psychosis: means a person having psychotic features like hallucinations, delusions, excitement and over activity, marked changes in psychomotor activity, catatonic behaviour, and/or negative symptoms.

Delusion: **f**alse, **f**irm, **f**ixed belief not keeping in touch with cultural context. It is disorder of thought. (Pneumonic: 3 **f)**

Delusion of persecution: the patient has delusional belief that other people are ill-treating them, planning against them.

Delusion of control: the patient has delusional belief that alien or outside agency is controlling their activity by some means.

Somatic passivity: the patient has delusional belief that he is passive recipient of body sensations induced by an alien or out-side agency.

Delusion of self-reference: the patient has delusional belief that the people around him are talking in reference to him or the things happening around him are in reference to him or carry special significance to him.

Hallucination: perception without external stimulation. It is disorder of perception.

Elementary hallucinations: hallucinations of simple sounds. Ex: sound of ringing bell, humming bee; or of vision. Ex: flashes of light, colours, geometric shapes etc.

Complex hallucinations: hallucinations of sounds. Ex: voices; or of vision. Ex: images or scenes.

First person auditory hallucinations: Hearing one's own thought spoken aloud.

Second person auditory hallucinations: Hearing voice of the person directly addressing the patient or in the form of running commentary about the patient's activities, or ordering/ commanding the patient to do the activities they say.

Third person auditory hallucinations: Hearing voices of people discussing about the patient in third person.

Formication: a form of tactile hallucination where the person feels grains of sand under the skin or insects crawling under the skin. It is seen in cocaine abuse. Also known as cocaine bugs.

Functional hallucinations: here perception of sensation and hallucination occur in same modality. Ex: whenever the dog barked, the patient heard the voice of persecutor scolding her with filthy words.

Reflex hallucinations: here perception of sensation and hallucinations occur in different modality.

Hypnogogic hallucinations: hallucinations that occur when person is falling asleep.

Hypnopompic hallucinations: hallucinations that occur when person is waking up from the sleep.

Thought insertion: a disorder of thought possession where the patient has conviction that alien or outside agency is inserting thoughts in his/her mind.

Thought withdrawal: a disorder of thought possession where the patient has conviction that alien or outside agency is withdrawing thoughts from his/her mind.

Thought broadcasting: a disorder of thought possession where the patient has conviction that people around him/her are thinking in unison with him/her

or

The patient has conviction that thoughts of their mind are known to people around them without the patient telling them.

or

A medium (Ex: TV, radio, machine) understands their thought and it is broad casting the thoughts to other people.

Thought block: here the flow of thought in patient's mind gets blocked and an entirely new thought begins.

Late onset schizophrenia/ paraphrenia: schizophrenia onset after 60years of age.

Pfropf's schizophrenia: schizophrenia in patients with mental retardation.

Van Gogh syndrome: dramatic self mutilation in schizophrenia.

Oneroid state of schizophrenia: acute onset schizophrenia with clouding of consciousness, disorientation, dream like state, with hallucinations and delusions.

Schizophreniform psychosis: schizophrenic symptoms lasting less than 6 months. It is included in DSM-5.

Life time risk of schizophrenia is 1%.

Prognostic indicators in schizophrenia:

Good prognosis	Poor prognosis
1. Late age of onset.	1. Early age of onset.
2. Female sex.	2. Male sex.
3. Higher education level	3. Low education level
4. Holding a job.	4. Not holding a job.
5. Married.	5. Unmarried.
6. From rural background.	6. From urban background.
7. Acute or abrupt onset.	7. Insidious onset.
8. First episode.	8. Chronic psychosis.
9. Presence of precipitating factors.	9. Absence of precipitating factors.
10. Presence of stress.	10. Absence of stress.
11. Predominant presentation with positive psychotic symptoms.	11. Predominant presentation with negative psychotic symptoms.
12. Presence of catatonic features.	12. No catatonic features.
13. Presence of mood symptoms.	13. Absence of mood symptoms.
14. Presentation to hospital early in the course of illness.	14. Presence of associated substance use disorder.
15. Good family support	15. Poor family support.
16. Good social support.	16. Poor social support.
17. Family history of mood disorder.	17. Family history of psychosis.
18. No medical co-morbidities.	18. Presence of medical co-morbidities.
19. No associated substance use disorder.	19. Presence associated substance use disorder.
20. No family history of psychosis.	20. Presence of personality disorders like paranoid, schizoid, schizotypal in premorbid personality.
21. Well-adjusted premorbid personality.	21. Blunted or flat affect.
22. Well preserved affect.	22. Presence of negative expressed emotions in family.
23. Good compliance to medications.	23. Poor compliance to medications.
24. From developing countries.	24. Multiple changes in Doctor Consultation.
25. Presence of positive expressed emotions in family	25. From developed countries.
	26. Family history of psychosis

Differential diagnosis:

1. Substance induced psychotic disorder: history of substance use is seen, psychotic disorder has the onset when the person is using substance or within 48hrsof stopping substance.
2. Psychotic disorder due to medical condition: medical condition is the can cause of psychotic disorder (ex: Wilson's disease) and there should be temporal correlation between medical condition and onset of psychotic disorder.
3. Acute and transient psychotic disorder: symptoms have acute onset .i.e. within 2 weeks, where as schizophrenia has symptom duration of 1 month.
4. Schizoaffective disorder: it has presence of both psychotic symptoms suggestive of schizophrenia and affective symptoms. Whereas schizophrenia has psychotic symptoms only.
5. Delusional disorder: here delusions are seen without prominent hallucinations unlike in schizophrenia. Delusional disorder has duration of 3 months for diagnosis. In delusional disorder patient's functioning in areas that does not involve delusions are normal, whereas in schizophrenia affects person's functioning in all areas of life.
6. Personality disorder: schizoid, schizotypal, paranoid personality primarily have symptoms of personality disorder, they may have sub threshold psychotic symptoms.
7. Mood disorder with psychotic symptoms: it has mood symptoms and associated mood congruent psychotic symptoms.

Case 8

A 32 year old married lady with primary school education, homemaker from urban background belonging to middle socio-economic status was brought by her husband for consultation.

Her husband complained of suspiciousness, talking to self, smiling to self, poor self care, begging and not doing household work for the last 5 years.

Patient says that she sees three black men and four black women who are nude with uncombed hairs carrying a magical whip and roaming around her. She can see them but unable to feel or touch them. They speak among themselves about her that she is a bad woman, she has sexual relationship with many men and her morals are of poor standards. They even speak with her directly and order her to beg to ward off the sins she has committed. If she does not to follow their command, she would be hit with the magical whip they carry; it induces severe pain. She knows that if she does not follow their orders she would be beaten till death.

When she is fallen asleep, she feels that the black men are having sexual intercourse with her; she feels their genital organ in her vagina and gets the smell of ejaculation which is highly distressing to her, so she tries not to sleep. They do black magic which generates a cursed powder in her mouth and her saliva develops a dirty taste. If she swallows it she would die.

Patient does not do household work, self care is poor. She does not mingle with neighbours and relatives. She does not talk much and when others talk with her she would reply in 1-2 words.

On mental status examination she was ill-kempt and affect was restricted. She had delusion of persecution, visual hallucinations, third person auditory hallucinations, second person auditory hallucination command type, olfactory hallucination, gustatory hallucination, tactile hallucinations.

In cognitive function tests, she could not answer similarities between apple and orange. Proverb interpretation was at concrete level. Insight was poor. Personal and social judgements were impaired.

Diagnosis: Paranoid schizophrenia (With all five sensory hallucinations).

ICD-10 criteria for diagnosis of schizophrenia is given in case 7

Why this diagnosis?

1. Patient has Delusion of persecution, Visual hallucinations, Third person auditory hallucinations (or voices discussing the patient among themselves .i.e. criteria c), second person auditory hallucination command type, Olfactory hallucination, Gustatory hallucination, tactile hallucination (persistent hallucinations in other modality .i.e. criteria e).
2. Not doing house hold work, poor self care, not mingling with neighbours and relatives, alogia which suggests that there is significant change in quality of personal behaviour (Criteria i).
3. As the patient has met criteria c along with criteria e and i, for 5 years (duration criteria: 1 month).

Description of patient's psychopathology:

"3 black men and 4 black women have magical whip, they use it to beat me, this induces severe pain they order me to beg and if I do not follow their order; they would be beat me till death"- Delusion of persecution.

"I hear voice of them speaking about me among themselves saying that I am a bad woman, I sexual relationship with many men and my morals are of poor standards"-Third person auditory hallucinations.

"Voices order me beg to ward off the sins I have committed with multiple sexual relations"-Second person auditory hallucination command type.

"I see 3 black men and 4 black women, who are nude with uncombed hairs. I can see them but unable to feel or touch them"- visual hallucinations.

"I get the smell of ejaculation when

those black men have sex with me and ejaculate"-Olfactory hallucination.

"Black magic done by them generates a cursed powder in my mouth and the saliva develops a dirty taste"- Gustatory hallucination.

"While I am sleeping, black men have sexual intercourse with me and I experience their genital organ in my vagina"-Tactile hallucination.

Whether patient needs inpatient care?

Yes, patient needs inpatient care as he lacks insight; compliance with medications would be an issue with him.

Goals in management of the patient:

1. Developing a good rapport with patient.
2. Symptom reduction with treatment.
3. Addressing expressed emotions.
4. Addressing compliance issues.
5. In long term reduce disability arising out of chronic psychosis and rehabilitation.

Treatment:

Pharmacological: Atypical antipsychotic. Aripiprazole or Lurasidone would be preferred in her as they do not cause hyperprolactinaemia, this would prevent menstrual irregularities and amenorrhoea. Added advantage of these two drugs is that they do not cause metabolic syndrome and sedation is less.

Psychosocial: as described in case 6.

Definitions and facts:

5 types of sensory hallucinations: Auditory, visual, olfactory, gustatory, tactile hallucinations.

1. Auditory hallucinations: hallucinations thorough **ear.**
2. Visual hallucinations: hallucinations thorough **eyes.**
3. Olfactory hallucinations: hallucinations thorough **nose.**
4. Gustatory hallucinations: hallucinations thorough **tongue.**
5. Tactile hallucinations: hallucinations thorough **skin.**

Command type of hallucinations: these are 2nd person auditory hallucinations where the voice gives command to the person to carry out the activity.

Case 9

A 30 years old women, separated from husband, with primary school education, home maker, from rural background belonging to low socio-economic status was brought to OPD for consultation by her parents.

Her parents complained of occasional muttering to self and smiling to self, poor self-care, odd behaviour, not doing household work, wandering aimlessly in streets, eating from dustbin for 10 years.

Patient as a child was dull in studies, clearing exams was a tough task for her and she discontinued her education after primary schooling. Since then she stayed in home doing household work, helping her mother. Since childhood she socialized less, had few friends, and was not attending functions and festivals.

She got married in teenage, several months following marriage her parents received continuous complaints that she does not do household work properly and she grew careless about it as days passed, so she was sent back to her parent's home. Her parents observed that she did not mingle with others, talked less, self care was poor and she had to be told repeatedly for brushing teeth, bathing, for having food and other daily activities. At times she used to wander aimlessly in streets, beg from strangers, eat from dustbin, urinate and defecate openly in public even when people used to be around. Quite sometimes she used to mutter to herself, had silly smile and showed odd gesturing. Her symptoms slowly progressed and deteriorated in spite of receiving treatment.

On mental status examination, patient appeared unkempt and dishevelled, had stinking smell. She had giggles and grimaces, she had blunted affect. She was not found to harbour any hallucinations and delusions at the time of interview.

Diagnosis: Hebephrenic Schizophrenia.

ICD-10 diagostic criteria for hebephrenic schizophrenia:

1. General criteria for schizophrenia should be met.
2. Prominent affective symptoms.
3. Fleeting and fragmentary hallucinations and delusions.
4. Shallow inappropriate mood with giggling, self absorbed smile, grimaces, mannerisms, pranks, hypochondriac complaints.
5. Thought disorganization, rambling and incoherent speech.
6. Tendency to remain solitary, behaviour appears empty of purpose and feelings.
7. Age of onset: 15-25 years
8. Rapid development of negative symptoms.

Why this diagnosis?

1. As per history patient has talking to self and smiling to self, which suggests probably she had auditory hallucinations.
2. Presences of negative symptoms in the form of alogia, asociality, amotivation, apathy were seen.
3. A change in overall quality of personal behaviour, aimlessness, social withdrawal.
4. So the patient meets the general diagnostic criteria for schizophrenia.
5. Along with above criteria patient has occasional smiling to self and muttering to self (fleeting hallucinations), blunted affect, giggling and grimaces, odd gesturing (mannerisms), predominant negative symptoms. No drive and determinations, aimless wondering, disorganized behaviours (begging from strangers, eat from dustbin, urinate and defecate openly in public even when people used to be around). So the diagnosis of hebephrenic schizophrenia is made.

Whether patient needs inpatient care?

Yes, patient has psychotic symptoms, has poor insight and has disorganized behaviour.

Goals in management of the patient:

1. Developing good therapeutic alliance with patient and family members.
2. Symptomatic improvement and to reduce disorganized behaviour.
3. Disorganized behaviour can give rise to negative expressed emotions which should be addressed.
4. Reducing the disability.
5. Rehabilitation.
6. Address care giver burden.

Treatment:

Psychological:

1. Psycho-education about the illness, course and prognosis, need for taking medications and compliance issues.
2. Positive and negative reinforcement to reduce unwanted behaviours of disorganization, and promote self care and to do house-hold work. This can be applied through token economy, family therapy.

Pharmacological:

Olanzapine, Amisulpride, clozapine have greater efficacy in treating negative symptoms of schizophrenia. Typical antipsychotics should be avoided as they can increase negative symptoms.

Definitions and facts:

1. Positive symptoms: hallucinations, delusions, catatonia, disorganized thought.
2. Negative symptoms:
   a) Apathy: lack of motivation to do the work.
   b) Alogia/ abulia: diminished speech output.
   c) Asociality: reduced socialization.
   d) Anhedonia: lack of pleasure in activities.
   e) Affective blunting: marked reduction in emotional response.

Other name for hebephrenic schizophrenia: Disorganized schizophrenia.

Differential diagnosis:

1. Amotivational syndrome: patients who use 'ganja' for long term may develop amotivational syndrome which is characterized by reduced motivation in doing activities at home and at work place, they develop apathy, their interaction would be reduced and people may feel he is lazy, but mannerisms, giggling, self absorbed smile, grimaces and other features of hebephrenia are not seen and substance use evidence would be found.
2. Depressive disorder: patient with depressive disorder also present with reduced interest in activities, but psychotic symptoms and other features of hebephrenia are not seen.
3. Dysthymia: here patients have chronic low mood for long time, but reduced interest in activities is not seen and characteristic features of hebephrenia are not found.

Case 10

A 33 years old unmarried male, with education up to 7th standard, working as manual labourer from rural background belonging to low socio-economic status, was brought to OPD for consultation by his elder sister.

Patient's elder sister complained that he is not going to work; he has behaviour of wandering away from home with poor personal hygiene and poor appetite from last 13 years.

Till the age of 20 years he was doing well in socio-occupational functioning. Since then there was gradual decline in self care. Family members force him for daily routine activities. He became careless about work in few months following the onset of illness. Later he wandered away from home and did not return back for which patient's family members lodged a Police complaint, some months later he was found dishevelled and was begging near railway station of a nearby town. Police helped him in returning home. At home his behaviour remained same, his personal hygiene was poor, he did not go to work, instead he used to be near the bus stand picking up and hording unnecessary things from garbage. Family members believed that it would be due to curse and was taken to a faith healer where offerings were done, patient was given powder and holy water which would ward off the curse, rituals were followed for several months by spending thousands of rupees, but condition of the patient did not improve. So he was brought for consultation.

On mental status examination, patient appeared unkempt and dishevelled. He was thin with poor nourishment. His affect was restricted, with poor speech output.

He said "I am worried about two neighbouring ladies who have done black magic on me and have planned to take away my property"- delusion of persecution.

"They talk about me among themselves and scold me with filthy words"- 3rd person and 2nd person auditory hallucination.

His fund of knowledge was poor, could tell 1 difference between orange and apple, he was unable to tell similarities between them. Proverb interpretation was at concrete level. He could perform single digit arithmetic calculations.

Insight was poor, personal and social judgements were impaired.

Diagnosis: Undifferentiated Schizophrenia.

ICD-10 criteria:

a. General criteria for schizophrenia should be met.

b. Patients do not have sufficient symptoms to meet criteria for only one subtype of schizophrenia or symptoms presentation meet more than one subtype of schizophrenia.

Why this diagnosis?

1. Patient meets general criteria for schizophrenia as patient had delusion

of persecution, 2nd and 3rd person auditory hallucinations (criteria c), gradual decline in self care, carelessness in work, constant force by the family members for daily routine work suggests negative symptoms (criteria **h**). Being dishevelled, begging and hoarding unnecessary objects, social withdrawal (criteria **i**).

2. He has undifferentiated type of schizophrenia as he has symptoms of delusion of persecution associated with 2nd and 3rd person auditory hallucinations which are suggestive of paranoid schizophrenia. He also has negative symptoms as described above, decline in his functioning, along with being dishevelled, begging, picking up and hoarding unnecessary objects from garbage (disorganized behaviour) which are the symptoms of hebephrenic schizophrenia. As patient has features of more than one type of schizophrenia without predominance to particular subtype, the diagnosis of undifferentiated schizophrenia is made.

Whether patient needs inpatient care?

Yes, as patient is having a psychotic illness, has poor insight and needs supervised medications.

Goals in management of the patient:

1. Good therapeutic alliance.
2. Reduce disorganised behaviour and optimise the function.
3. Reduce disability.
4. Rehabilitation.
5. Address expressed emotion and care giver burden.

Treatment:

Psychological:

a) Psycho-education about the illness, course and prognosis, need for taking medications and compliance issues.

b) Positive and negative reinforcement to reduce unwanted behaviours of disorganization, and promote self care and to do house-hold work. This can be applied through token economy, family therapy.

Pharmacological:

Atypical antipsychotics Olanzapine, Amisulpride, clozapine are preferred here as they improve negative symptoms. Typical antipsychotics should be avoided as they can increase negative symptoms.

Definitions:

Disorganization is seen with speech, thought and behaviour.

Disorganized behaviour: disruption of normal behaviour, includes poor personal hygiene, bizarre activities such as inappropriate dressing as per weather, ex: wearing thick coat in summer, urinating and defecating at inappropriate places, eating from dust bin, eating bidis, shouting at people with no apparent reason, stripping cloths at inappropriate place.

Differential diagnosis:

1. Severe depression: here patient has lack of pleasure in doing activities and has mood congruent psychotic symptoms.
2. Substance induced psychotic disorder:

psychotic symptoms are due to substance abuse.

3. Psychotic disorder due to general medical condition: medical condition is the cause of psychotic disorder.
4. Delirium: in delirium there is impairment of consciousness, while in schizophrenia there is no impairment of consciousness.

Case 11

A 30 years old married women with secondary school education, home maker from rural background belonging to middle socio-economic status was brought for consultation by her husband as patient was expressing thoughts about ending her life.

Patient's husband said that since two years she had suspiciousness about a neighbour. She said that the person has a machine at home, the machine gets to know her thoughts and it broadcasts it to the person and his family. Knowing about her thoughts, they are planning to snatch her property, she also said that, she could hear the person's and his family member's voices discussing about her among themselves. Once a lizard entered patient's home from neighbour's area and she believed that it was sent by them to spy on her.

For these complaints she was treated by a Psychiatrist with Risperidone 4 mg and Trihexyphenydyl 2 mg, with which her suspiciousness had reduced to a great extent.

From 1 month she was feeling sad, cried frequently, she used to feel tired with little work, her appetite had reduced and there was sleep disturbance. From one week she is expressing thoughts that she has suffered a lot in life and wants to end her life, which bothered her husband and patient was brought for consultation.

On mental status examination patient was well kempt, eye to eye contact was made. She was co-operative for interview. Rapport was established.

Psychomotor activity was reduced. Speech output was reduced. She described mood as sad and appeared depressed.

She harboured ideas of worthlessness, ideas of hopelessness and suicidal ideation.

Diagnosis: Post Schizophrenic Depression.

ICD-10 criteria:

a. Schizophrenic symptoms in the person within past 12 months.
b. Some schizophrenic symptoms are still present.
c. Depressive symptoms meeting the criteria for depressive episode are present for at least 2 weeks.

Why this diagnosis?

1. History of being suspicious about a

neighbouring person that he has a machine at home which gets to know about her thoughts and it broadcasts it to neighbours is suggestive of thought broadcasting.

2. She believed that knowing her thoughts neighbours would snatch her property is suggestive of delusion of persecution.
3. She could hear person's and his family's voice discussing among themselves suggests 3rd person auditory hallucinations.
4. Points (1), (2), (3) for duration of 2 years are suggestive of schizophrenia.
5. There was significant improvement with treatment in psychotic symptoms, which means that some schizophrenic symptoms were still present within past 12 months.
6. Symptoms of sadness, frequent crying, tiredness with little work, reduced appetite, thoughts of ending the life in past 1month are suggestive of depression.
7. Presence of depressive symptoms for at least 2weeks is necessary.
8. Considering points (4), (5), (6), (7) we can make the diagnosis of post-schizophrenic depression.

Whether patient needs inpatient care?

Yes, as patient had expressed thoughts of ending life.

Goals in management of the patient:

1. Assessment for suicidal ideation.
2. Symptom improvement.
3. Enhance functioning of patient.
4. Recovery from the illness.

Treatment:

Psychological:

1. Psychoeducation about illness, course, prognosis, medication compliance.
2. Cognitive behaviour therapy: cognitive errors like "I have suffered a lot in life, I have to end my life" are addressed.
3. Problem solving skills, coping skills.

Pharmacological:

1. Mirtazapine is preferred in this case as it treats depressive symptoms along with which it helps in improving sleep and appetite. SSRI's can also be used. Tricyclic antidepressants like Amitriptyline, Dothiepin, Imipramine, Nortriptyline are other alternatives used as they help in improving mood along with sleep and appetite.
2. Patient can be treated with MECT as patient has suicidal ideation.
3. Treatment with antipsychotic Risperidone, Olanzapine for psychotic symptoms.

Differential diagnosis:

1. Depression due to substance: it occurs when person is actively using the substance, or within 48hrs of stopping the substance.
2. Depression due to general medical condition: the depression would occur secondary to general medical condition.
3. Bipolar depression: patient has episodes of mania and depression in bipolar disorder. Where as in post schizophrenic depression. The patient has schizophrenic symptoms in past and currently has depressive symptoms.

Case 12

A 34years old unmarried man with primary school education was a manual labourer from rural background belonging to middle socio-economic status was brought for consultation by his mother.

Patient was apparently normal when he wandered off from the home three and half years ago, two days later he was found in nearby jungle and was unkempt from there he was brought back home. It was seen that he is fearful, was closing doors and windows saying he is been spied by policemen, as he had the conviction that he would be arrested in robbery case. He used to hear voice of two ladies discussing about him among themselves and accusing him that he is a robber. Due to fear he did not go out of home for several months.

Worried about his behaviour, he was sent to spiritual healer with whom, he stayed for six months and spiritual offerings were done, when he came back home, much of his fearfulness and suspiciousness had reduced, but he was observed to be careless about cleanliness, his self care was poor, and appetite had reduced, he had to be called for having food. His interaction was poor; he did not go to work, he mingled little with family and friends, most of the time he used to be at home doing nothing but staring at the wall. On the advice of neighbours his mother brought for consultation to a psychiatrist.

Diagnosis: Residual Schizophrenia.

ICD-10 criteria:

a. Prominent negative symptoms of schizophrenia.

b. Presence of at least one clear cut schizophrenic episode in the past.

c. For at least 1 year florid psychotic symptoms like hallucinations and delusions are minimal and negative symptoms are present.

d. Dementia, organic brain disorders, chronic depression or institutionalization which explains the negative symptoms have been ruled out.

Why this diagnosis?

1. Patient has presented with prominent negative symptoms manifested in the form of poor self care, carelessness about cleanliness.
2. History of wandering away from home, being unkempt, appearing fearful and having the conviction that he would be arrested in robbery case. Hearing voices of two ladies discussing about him among themselves. This suggests that person had schizophrenia symptoms in the past.
3. When patient returned back from spiritual leader much of his fearfulness and suspiciousness had reduced which

suggests that his positive psychotic symptoms were less. Carelessness about cleanliness, poor self care, poor appetite, poor interaction, not doing work suggests negative symptoms, which were predominating after six months of his stay with spiritual healer. These symptoms were for 3 years.

4. Considering above points diagnosis of residual schizophrenia is made.

Whether patient needs inpatient care?

No, patient can be managed on OPD basis.

Goals in management of the patient:

1. Symptom improvement.
2. Optimising the functions.
3. Reduce disability.
4. Rehabilitation.
5. Address care giver burden.

Treatment:

Psychological:

1. Psycho-education about the illness, course, prognosis, need for taking medications and compliance issues.
2. Communication skills, occupational therapy, social skill training.
3. Group therapy.

Pharmacological:

Olanzapine, Amisulpride have greater efficacy in treating negative symptoms of schizophrenia. Clozapine treatment is given when patient fails to respond to two antipsychotic drugs tried for 12 weeks. Typical antipsychotics should be avoided as they can increase negative symptoms.

Differential diagnosis:

1. Hebephrenic schizophrenia: Early age of onset, patient has fleeting and fragmentary hallucinations and delusions, grimacing, mirror gazing and associated other features. In residual schizophrenia the patient has predominant negative symptoms and other features of hebephrenia are not found.
2. Post schizophrenic depression: schizophrenic symptoms are minimal and depressive symptoms would be present.
3. Amotivational syndrome: this occurs after chronic use of cannabis.
4. Depression: patient with depression has loss of pleasure in doing activities, whereas patient with residual schizophrenia has negative symptoms.

Case 13

A 35 year old unmarried man who had discontinued education in PUC arts, not holding a job from semi-urban background belonging to middle socio-economic status was brought by mother for consultation to OPD.

Patient was apparently doing well till 20 years of age, when family members noticed

that his interest in studies kept declining. He grew more interest in reading books on mythology, he was more religious than before, in two years he totally discontinued his studies and used to be with mythology books most of the time.

It was seen that gradually his self care declined, he used to be on same cloths for weeks together, he did not change cloths even when it had stinking smell. His hygiene was poor. Occasionally he used to be fearful and suspicious and doubt if someone has done blackmagic against him.

He used to wander in streets or be near bus stand, smoking bidis. He neither bothered when ash of bidis fell on cloths damaging it, nor when his fingers got burnt. Due to carelessness bidi ash used to fall on bed sheets and sofa cloths damaging them.

He was hospitalized at the age of 25 years and psychiatric treatment was given; there was improvement in terms of his functioning. He refused long inpatient care and was discharged. Following discharge he discontinued medications and refused follow up.

Family members kept criticizing him for his odd and eccentric behaviour, there used to be frequent arguments between them. His mother told that he had few friends during college days, from past ten years he has no friends, he does not socialize, does not mingle with relatives and does not like relatives visiting their home.

During interview patient appeared unkempt, wearing clothes that had burnt marks due to smoking. Cloths had stinking smell. He was over elaborative in expressing thoughts. His affect was constricted. Rapport was poor. He believed that he is working; he is well wisher, thinker, writer and philosopher. He added that sometimes when he was in his room; it appeared as if the colour of room paint changed from white to red.

Diagnosis: Schizotypal Disorder

ICD-10 criteria:

a. Constricted affect.
b. Odd eccentric behaviour.
c. Social withdrawal.
d. Magical thinking.
e. Suspiciousness or paranoid ideas.
f. Obsessive ruminations without inner resistance, with dysmorphic, sexual or aggressive contents.
g. Unusual somatosensory (bodily) experiences, illusions, depersonalization, derealisation.
h. Circumstantial, metaphorical, over-elaborative or stereotyped thinking.
i. Transient quasi-psychotic episodes.

3 or 4 above described symptoms should be present continuously or episodically.

Duration criteria: 2 years

Why this diagnosis?

1. Duration of illness: 15 years.
2. Odd behaviour in the form of discontinuing studies and being religious and mythological, poor self- care, not changing clothes for many days even

with stinking smell, urinating and defecating regardless of the place, being careless about ash of bidis, disorganised behaviour,

3. Transient quasi psychotic episodes in the form of occasional fearfulness and suspiciousness.
4. Paranoid ideas towards family members.
5. Few friends during college days, no friends after college, not mingling with relatives suggests social withdrawal.
6. Over elaborative while expressing the thoughts.
7. Constricted affect.
8. Change in the colour of the room from white to red is derealisation phenomenon.
9. The symptoms in patient were present continuously.

Whether patient needs inpatient care?

Yes, as there is impairment in psychosocial functioning, poor self care, paranoid ideas, and poor insight.

Goals in management of the patient:

1. Developing good therapeutic alliance.
2. Symptom improvement.
3. Address expressed emotions.
4. Rehabilitation.

Treatment:

Psychological:

a. Communication skills, occupational therapy, training in social skills.
b. Insight oriented psychotherapy.

Pharmacological:

a. Treatment is with antipsychotic drugs in small doses with either of Risperidone, Aripiprazole, Olanzapine can be given.
b. Patient has history of poor compliance to treatment and he lacks insight, so depot injections to be considered in this case. Flupentixol which has efficacy in negative symptoms can be tried.

Differential diagnosis:

1. Delusional disorder: in delusional disorder the areas of life which does not involve delusions are normal. Whereas in schizotypal disorder quasi psychotic symptoms are seen along with other features.
2. Schizophrenia: it has delusions and hallucinations which are characteristic feature, while in schizotypal quasi psychotic symptoms are seen along with other features.
3. Anxious avoidant personality disorder: here person would be willing to mingle with people which are inhibited by fear. Where as in schizotypal patient has social withdrawal and does not like mingling with people.

Case 14

A 35 year old unmarried lady who was illiterate, a home maker from rural background; belonging to low socio-economic status, accompanied by her elder sister, was referred to Psychiatrist by ENT surgeon, to whom she presented with complaint of insect inside the ear. She was not convinced after examination and investigation that there is no insect inside her ear.

Patient was travelling in a bus 3 years back, when she suddenly felt that an insect entered her ear, after reaching home she poured warm coconut oil inside the ear but insect did not come out, but she felt there is an insect inside the ear which is crawling and biting the ear which caused pain. Few days later she consulted a local doctor who after examining the ear said there is no insect. But unsatisfied with the doctor she consulted ENT surgeon who also said the same thing and patient kept moving from one doctor to another, in the mean time she started believing that the insect from her ear, made a path to her head and now it is inside the head, eating it which is causing headache.

For patient's satisfaction one of the doctor said he will perform operation and remove the insect, the doctor took the patient to OT, performed examination of ear and showed her a dead insect saying he has removed the insect. Patient said ear pain and headache has not subsided which means that the insect would have reproduced and now many insects are in her ear and head!

CT-scan of the head was done and it was normal. Doctor showed her the film and said no insect is inside her ear or head, but she continued to believe that insect is present and was suggested a psychiatry consultation.

During interview it was found that there is no change in the quality of household work she does following the onset of illness. Her biological functions were normal. She was worried about insect inside ear and head.

On mental status examination she had a firm belief about having insect in the ear and head. Insight was absent.

Diagnosis: Delusional Disorder (Parasitosis)

ICD-10 criteria for delusional disorder:

1. Presence of delusion.
2. Duration criteria: 3 months.
3. No organic cause, no history of schizophrenic symptoms.

Why this diagnosis?

1. Patient had conviction that insect is inside the ear which she believed even when multiple Doctors examined the ear and said there is no insect. She continued to believe it and said they have made path to head and are eating

the head, so she is experiencing headache; the belief persisted even when its falsity was proved with normal findings of CT-scan.

2. Patient had acting out behaviour, .i.e. patient was taking consultation for removal of insect from ear and head, which means that patient, was acting on her belief and was actively seeking consultation to get rid of her problem.
3. The patient was much worried about the insect inside the ear.
4. She was able to carry out all her house hold work, biological functions were normal.
5. Duration of illness was 3 years.
6. No history suggestive of organic aetiology, no history of schizophrenic symptoms.

Whether patient needs inpatient care?

Not needed, as patient is able to carry out all day to day activities and her biological functions are normal.

Goals in management of the patient:

1. Developing therapeutic alliance.
2. Symptom reduction.
3. Address compliance issues.

Treatment:

Pharmacological:

Low dose atypical antipsychotics or Pimozide are preferred in delusional parasitosis. Improvement occurs slowly.

Psychological:

1. Psycho-education about the illness, course and prognosis, need for taking medications and addressing compliance issues.
2. Insight oriented psychotherapy: to develop insight about the problem.
3. Cognitive behaviour therapy where therapist provides alternative explanation to the delusional belief.

Definitions and facts:

Other name of delusion of parasitosis: Ekbom's syndrome.

Different types of delusions:

Delusion of persecution: patient has delusional belief that he is been treated ill or is being harassed or harmed.

Delusion of love: here the person has the delusional belief that other person who is of higher status is in love with him/her.

Delusion of infidelity: the patient has delusional belief that his/her spouse is not faithful.

Shared delusions: same delusional belief is shared by 2 or more people

Differential diagnosis:

1. Substance/ medication induced: Here person would be having long term use of substance and psychotic symptoms develop when he is using the substance or within 48 hrs of stopping the substance.
2. Medical conditions: Here medical condition is the aetiology for the symptom presentation.

3. Mania with psychotic symptoms: manic symptoms and the delusions would be of grandiose type.
4. Severe Depression: depressive symptoms and delusions would be of guilt, nihilism, poverty and enormity.
5. Schizophrenia: it affects all areas of person's life. In delusional disorder the only those areas of life which have involve delusion are involved.
6. Schizoaffective disorder: here patient has both schizophrenia symptoms and affective symptoms.
7. Acute and transient psychotic disorder: here symptoms have an acute onset and subside by 1 month.
8. Factitious disorder: the patient produces symptoms to seek for medical attention.
9. Malingering: patient feigns symptoms for monetary gains like sick leaves, abstinence from duties.

Case 15

A 30 years old unmarried lady with B.Com education working as clerk from urban background belonging to middle socio-economic status was brought by her parents as patient was believing that a TV actor is in love with her from 2 years.

Patient was apparently all right 2 years back when she started believing that a TV actor is in secret love with her, the belief started when the actor visited her town for a programme and many people had gathered to see him. Patient had been to the programme, as per patient the actor gave a smile to the patient which made her to believe that the actor is in love with her, since then the patient is watching all his TV programmes. She relates his acting as a means to show his love towards her. She was told by family members and other relatives that such things are just fantasies and do not occur in real life, but she was convinced that the actor is deeply in love with her and she used to be aggressive when she was confronted with this.

She wrote many letters addressed to him. She declined marriage with other person, believing that he would marry her soon. Once she booked a train ticket to meet him, without informing any one she left the home and a missing complaint was lodged and she was found in nearby city next day where she was planning her next journey. From there she was brought for consultation.

Patient was carrying out her office and household work normally, her biological functions were normal.

During interview she appeared angry that her family members are preventing her from meeting the actor who is in deeply love with her. Insight was absent.

Diagnosis: Delusional Disorder (Love)

Why this diagnosis?

1. Patient has strong belief that the actor is in love with her; she was relating

his acting as a means to show his love towards her. She used to be angry whenever her family members confronted about the love suggesting a strong conviction about the belief.

2. She was writing letters him. She declined marriage with other person. Leaving the home without informing family members to meet him suggests acting out behaviour.
3. Patient had high affective response, when she was confronted with the belief, she used to be angry.
4. She was able to carry out her office and household work normally and her biological functions were normal.
5. Belief about the love was from 2 years.
6. No history suggestive of organic aetiology, no history of schizophrenic symptoms.

Other clinical features:

1. Usually seen in women.
2. Other person of higher status is in love with her.
3. Patient believes that other person has fallen in love with her.
4. Other person makes gestures and other cues to express love towards patient.
5. Illness has chronic course.

Whether patient needs inpatient care?

Yes, for short term as patient had abandoned home to meet the actor.

Goals in management of the patient:

1. Developing therapeutic alliance.
2. Symptom reduction.
3. Address compliance issues.

Treatment:

Psychological:

1. Explaining the illness, course, prognosis, need for treatment to the patient and family members.
2. Insight oriented psychotherapy.
3. Involving patient in individual psychotherapy.

Pharmacological:

Low dose atypical antipsychotics are preferred. Aripiprazole has advantage of not causing menstrual irregularities, less weight gain and metabolic syndrome.Improvement occurs slowly.

Other names:

1. De Clerambault syndrome, Erotomanic delusion.

Differential diagnosis:

1. Bipolar disorder mania episode: here patient has hypersexuality, delusions of grandiosity and other symptoms of mania, whereas in delusion of love, love is directed towards single object; hypersexuality and other symptoms of mania are not seen.
2. Substance intoxication: here the person may exhibit disinhibition and increased sexual behaviour. Once patient is out of intoxication, he becomes normal.
3. Schizophrenia: here delusion of love can be seen, but it is associated with other features of schizophrenia.

Case 16

A 38 years old married man with BCA education working in a private firm from urban background belonging to middle socio-economic status, having two children was brought by his parents for consultation as patient doubted fidelity of his wife from last one year.

Patient was apparently alright one year back when his symptoms began gradually, a male neighbour once visited their home requesting for water and he was helped by patient's wife since then patient started believing that his wife has a relationship with the neighbour.

Patient suspected that neighbouring person visited the home to see his wife, as she is in relationship with him. Gradually his doubts aggravated and used to say that she cleans the curtains to attract him, she wears red roses to show her love to him, though his doubt was clearly denied by her, he did not believe her.

He even installed CCTV camera at home to spy on wife. There used to be frequent arguments between them in this regard. He frequently checked her inner wears to look for the stains to collect the proof that she was having sexual relation with neighbouring man, but he did not find any. She had to swear many times before God regarding this matter, but it had no effect.

Two months back she moved to her parent's home as the couple could not solve this problem. She returned back to husband's home after 2 weeks as he agreed that he would not doubt her loyalty again. But the very next day there was fight between them and he hit her while fighting. So in-laws demanded psychiatric evaluation otherwise a police complaint would be lodged against him.

Patient's socio-occupational and biological functions were normal.

During interview patient was well dressed, sitting comfortably on chair, appeared irritable on asking about his wife's behaviour.

Diagnosis: Delusional Disorder (Infidelity)

Why this diagnosis?

1. Strong conviction on wife that she has sexual relation with neighbouring person. He linked this to cleaning curtain and wearing red roses by his wife as a means to attract the person which suggests the strong conviction about the belief.
2. Checking the inner garments of her and installing CCTV to spy on her to collect the evidence suggests acting out behaviour.
3. Frequent arguments in this regard with wife shows the amount of affective response associated with the belief.
4. Socio-occupational and biological functions were normal.
5. No history suggestive of organic aetiology, no history of schizophrenic symptoms.

6. Duration of illness was 1 year.

Whether patient needs inpatient care?

Yes, marital discord has risen out the problem, by hitting wife he had harmed her, insight of the patient is poor.

Goals in management of the patient:

1. Developing therapeutic alliance.
2. Symptom reduction.
3. Address compliance issues.
4. Address marital discord arising out of the disorder.

Treatment:

Psychological:

1. Explaining the illness, course, prognosis, need for treatment to the patient and family members.
2. Insight oriented psychotherapy.
3. Cognitive behavioural therapy.

Pharmacological: Low dose atypical antipsychotics

Other name: Othello's syndrome.

Differential diagnosis:

1. Morbid or pathological jealousy: jealousy against spouse which is not at delusional level but causes social, familial, marital dysfunction. Usually seen in chronic alcoholism.
2. Schizophrenia: here patient might present with delusion of persecution against wife which may also lead to infidelity issues, but other features of schizophrenia are seen.
3. Acute and transient psychotic disorder: here patient has psychotic symptoms that last less than 1 month. Whereas in delusional disorder the symptoms lasts for many years.

Case 17

25 years unmarried male educated till PUC working in a poultry farm from rural background belonging to middle socio-economic status was referred by physician for consultation as patient believed that he emits foul smell.

Patient was doing well till 8 months ago when his belief started that he emits a foul smell. Due to this people are avoiding him. He thought that business is going dull as people do not like to come near him. If a person does not sit beside him while travelling in the bus he would relate this to the smell he emits. To suppress the smell he used lot of perfumes but his belief did not subside. Whenever a person near him rubbed their nose or winced the face he believed it is due to the smell that he is emitting. This made him worry a lot; he consulted a physician who reassured that there is no smell being emitted from his body, but he was not convinced and his belief persisted, so the patient was referred for psychiatric evaluation.

Seizures and organic causes were ruled out in him.

Diagnosis: Olfactory Reference Syndrome

Why this diagnosis?

1. Strong belief that he emits foul smell so people avoid him, persistence of the belief even with reassurance by Doctor.
2. Linking business activities and behaviour of other persons to his strongly held belief that because of the foul smell, business is going dull and other people are avoiding him.
3. Using lot of perfumes to suppress the smell suggests acting out behaviour.
4. No seizures and organic causes for the symptom presentation.

Whether patient needs inpatient care?

No, the patient can be treated on OPD basis, as he is able to do his work normally; he is not threat to self or to others.

Goals in management of the patient:

1. Developing therapeutic alliance.
2. Symptom reduction.
3. Address compliance issues.
4. Reducing morbidity due to illness.

Treatment:

Psychological:

1. To explain about illness, its course and prognosis along with need for treatment.
2. Insight oriented psychotherapy.
3. Cognitive Behaviour Therapy.

Pharmacological: Low dose atypical antipsychotic drug

Differential diagnosis:

1. Seizure disorder: seizure disorder involving uncinate process (uncinate fits) may produce olfactory hallucinations, therefore seizure disorder should be ruled out.
2. Schizophrenia: schizophrenia may also present with olfactory hallucinations, but it is associated with other features of schizophrenia. In olfactory reference syndrome apart from actions and behaviours related to delusions, other areas of life are unaffected.
3. Acute and transient psychotic disorder: here symptoms last for less than 1 month, whereas in delusional disorder symptoms last for many years.
4. Factitious disorder: the patient produces symptoms to seek for medical attention.
5. Malingering: patient feigns symptoms for monetary gains like sick leaves, abstinence from duties.

Case 18

A 37 years old married male patient educated up to BBA, working as a businessman from middle socio-economic status was referred by plastic surgeon as the patient had belief that his lips are thick from 1 year.

Patient's belief started 1 year back when patient experienced burning sensation on his lips following application of a lip balm. The next day when he saw himself in mirror he felt his lips have thickened. So he enquired his family members if his lips have thickened, they replied saying his lips appear normal.

As the days passed he became more pre-occupied with the belief and spent much time in front of mirror staring, eventually he started putting mask to face to hide the lips and his friends and co-workers made fun of him for wearing mask. He stopped going to work and also reduced socializing. He consulted a plastic surgeon for correction, plastic surgeon reassured him that there is no fault with lips and they appear normal, but his belief continued and once patient threatened the surgeon for operation. So he was referred for psychiatric consultation.

Mental status examination revealed presence of an unshakeable belief regarding his lips being thick, impaired judgment and poor insight.

Diagnosis: Delusion of dysmorphophobia.

Why this diagnosis?

1. Strong conviction about the belief that the lips are thick even with reassurance from family members, plastic surgeon.
2. Pre-occupation with belief was to such an extent that he was initially he was staring at mirror, later worn mask to hide lips, eventually stopped going to work and reduced socialising.
3. Wearing mask to hide the lips suggests acting out behaviour.
4. Being irritable and repeated consultation from plastic surgeon suggests emotional reaction associated with the belief.

Whether patient needs inpatient care?

Yes. The disorder has caused socio-occupational dysfunction, he had threatened surgeon for operation which means he is harmful to others.

Goals in management of the patient:

1. Developing therapeutic alliance.
2. Symptom reduction.
3. Address compliance issues.
4. Reducing morbidity due to illness.

Treatment:

Psychological:

1. To psychoeducate about illness, its course and prognosis along with need for treatment.
2. Insight oriented psychotherapy.

3. Cognitive Behaviour Therapy.

Pharmacological:

Pimozide is preferred to treat this disorder as it has shown greater efficacy.

Differential diagnosis:

1. Body dysmorphic disorder: it is an anxiety disorder where person has insight towards his illness; belief is shakeable, where as in delusional disorder insight is poor.
2. Anxious avoidant personality disorder: here person avoids social activities due to anxiety, while in delusion of dymorphophobia it is due to poor insight.
3. It should also be differentiated from malingering and factitious disorder.

Case 19

A 45 year old married male patient with MA degree working in gram panchayat from semi-urban background belonging to middle socio-economic status was brought by his wife for consultation.

Patient from 1 week is appearing fearful that a political leader has set a group of people to spy on him; because political leader is under belief that patient has done a fraud of five lac rupees to him, which is actually not true. Patient also believed that a secret chip is been installed in his mobile phone by his persecutors when he was asleep, the chip conveys his location to them; also it broadcasts his thoughts to them. The programme in the chip helps them to withdraw his money from bank account in this way they would control him in each and every activity.

He could hear persecutor's voice discussing among themselves on how he should be killed. This made him feel fearful and he stopped going to work, he was closing doors and windows at home. He was even advising his family members not to go out of home. His food intake was reduced and due to fear he was spending sleepless nights.

Patient had no history of substance abuse.

On mental status examination he was fearful, was suspiciously looking around in the room.

1. He said "Political leader has set a group of people to spy on me, as political leader believes that I have done a fraud of 5 lac rupees, people set by him against me will take money from my bank account and they will kill me"- delusion of persecution.
2. "They have installed a secret chip in my phone, which conveys my location and broadcasts my thought to them and also helps them to take money from my bank account"- thought broadcasting.
3. "I hear their voice discussing about me among themselves how the money should be taken away from me and

how I should be killed"- 3rd person auditory hallucinations.

Patient's cognitive functions were normal, insight was poor, personal and social judgments were impaired.

Diagnosis: Acute and Transient Psychotic Disorder (Acute schizophrenia like psychotic disorder)

ICD-10 criteria for acute psychotic disorder:

1. Acute onset: within 2 weeks.
2. Abrupt onset: within 48 hours.
3. Polymorphic presentation: rapidly changing and variable symptoms of hallucinations and delusions, with changes in type and intensity from day to day or time to time.

ICD-10 criteria for acute schizophrenia like psychotic disorder:

a. Onset should be acute .i.e. within 2 weeks.

b. Symptoms should fulfil criteria for schizophrenia for majority of time.

c. Criteria for acute polymorphic psychotic disorder should not be met.

Why this diagnosis?

1. Duration of symptoms from 1 week, i.e. onset of psychotic symptoms is within 2 weeks.
2. He has delusion of persecution, thought broadcasting, 3rd person auditory hallucinations.

Whether patient needs inpatient care?

Yes, for short term for detailed evaluation and to plan further management.

Other names:

1. Brief psychosis.
2. Reactive psychosis.
3. Psychogenic psychosis.
4. Hysterical psychosis.

Goals in management of the patient:

1. Symptom improvement.
2. Addressing associated stress if present.
3. Compliance.

Treatment:

Psychosocial:

1. Psycho-educating the patient, family members and care givers about the illness, course, prognosis, need for taking medications, maintaining compliance.
2. Coping skills.

Pharmacological:

Treatment is with atypical antipsychotics like Risperidone, Olanzapine which can help in improving sleep also.

Differential diagnosis:

1. Schizophrenia: it is diagnosed when psychotic symptoms are present for more than 1 month.
2. Schizoaffective disorder: it is characterised by presence of both schizophrenia symptoms and affective symptoms, whereas as acute and transient psychotic disorder may present with polymorphic features where the individual presents with

markedly variable symptoms which change from hours to hours or days to days.

3. Delusional disorder: it is characterised by presence of delusions that lasts for many years.
4. Mania with psychotic symptoms: here patient presents with delusions of grandiosity and other features of mania.
5. Medication induced psychotic disorder: here symptoms are due to medications for ex: steroids.

Case 20

A 16 year old PUC student from rural background belonging to middle socio-economic status was staying in hostel. He was brought for consultation by hostel warden accompanied by his friends with complaints of reduced sleep, excessive talking, self praising from 5 days.

Patient was doing well till 5 days back when his roommate and friends noticed that he is sleeping too little, appears more energetic and enthusiastic and he keeps cracking many jokes which is unusual for him. He praises himself as most attractive person in college and says he is so brilliant that he will be topper in next exam. He is sleeping less and is studying more, he is giving lot of advice to friends about how to study and score more marks, he was cross questioning the teachers in class which even teachers find difficulty in answering.

He keeps singing songs, demands tasty food from hotel, says he will be a successful person in future and will earn lot of money. He proposed to a classmate and when this event was brought in front of class teacher, he argued with them saying he is most jolly person and one should fall in love at this age and fought with teacher so he was brought to hospital for consultation.

Patient's parents were contacted and it was found out that he had no past history suggestive of mania, hypomania and no history suggestive of depression. One of his cousins had an episodic psychiatric illness and was under treatment.

On mental status examination he appeared friendly, he was playful, was easily distractible, he was praising himself. Psychomotor activity was increased, speech rate was increased and he said he felt happy that everyone is admiring him, affect was euphoric, no delusions and hallucinations were seen.

Diagnosis: Hypomania

ICD-10 criteria:

1. Mild persistent elevation of mood.
2. Increased energy levels and activity.
3. Marked feelings of wellbeing.
4. Increased sociability, talkativeness, over familiarity, increased sexual energy, decreased need for sleep.
5. Impaired concentration.

6. Diminished ability to settle down the work or to relax and leisure.
7. Symptoms do not lead to severe disruption of work or result in social rejection.
8. Not accompanied by hallucinations and delusions.
9. Duration: 4 days.

Why this diagnosis?

1. Persistent mood elevation, cracking many jokes, singing songs. He was happy and appeared euphoric.
2. Increased energy levels and activity in the form of appearing more energetic and enthusiastic.
3. Talkativeness.
4. Self praising as most attractive person in the college and that he was so brilliant that he will be topper in the next exam. Demanding tasty food from hotel.
5. Increased psychomotor activity.
6. Increased speech rate.
7. No hallucinations and delusions.

Whether patient needs inpatient care?

No. as there is no socio-occupational dysfunction, no psychotic symptoms; he is not threat to self or to others.

Goals in the management:

1. Symptom improvement.
2. Stabilizing the mood.
3. Medication compliance.

Treatment:

Psychotherapy:

1. Psycho-educating the patient, family members and care givers about the illness, course, prognosis, need for taking medications, maintaining compliance.
2. Interpersonal and Social Rhythm Therapy (IPSRT): therapy involves teaching the patient to maintain good interpersonal relationships and social relationships. He should also maintain good biological functions like sleep, as sleeplessness can trigger occurrence of episode of bipolar illness.

Pharmacotherapy:

1. Lithium is preferred in this case as the individual is euphoric affect; it is used in acute treatment and for maintenance treatment. During acute treatment serum lithium levels are maintained between 0.8-1.2 mEq/L. During maintenance phase serum lithium levels are maintained between 0.6-0.8 mEq/L.
2. Short term use of antipsychotic like Risperidone, Olanzapine, Quetiapine can be considered which helps in improving sleep and decreasing psychomotor activity.

Definition and facts:

Hierarchy of mood elevations in mania:

1. Normal mood.
2. Elevated mood.
3. Euphoria.
4. Elation.
5. Exaltation
6. Ecstasy.

Labile mood: rapid shift of mood state to another extreme mood state. Ex: sudden and rapid shift of mood from being happy to crying to anger.

Communicable affect: emotional response of the patient to the event gets communicated to others.

Infectious affect: emotional response of the patient to the event gets communicated to very large number of people.

Flight of ideas: the thoughts follow each other in rapid succession and connection between the thought would be by chance. It is seen in mania.

Differential diagnosis:

1. Mania: It is characterised by elevated mood and clinical features are more severe compared to hypomania, so mania may warrant in patient care, mania has psychotic symptoms, while hypomania can be treated on OPD basis as it is not severe. Hypomania does not have psychotic symptoms.
2. Bipolar 1 disorder: bipolar 1 disorder has episodes of mania and depression, while episodes of hypomania and depression occur in Bipolar 2 disorder.

Case 21

A 23 year old married lady with primary school education, homemaker from rural background belonging to middle socio-economic status was brought for consultation by her mother.

Patient was doing well till 3 months back when she got married; following marriage it was noticed that she has become more talkative, she kept talking without getting tired. While talking she frequently changed the topic. She appeared unusually happier and cheerful. She used to get angry on trivial issues, she scolded her family members and was spitting on them. She felt decreased need for sleep. While doing household work before completing the task in hand she was moving to the next task. She demanded new cloths with bright colours, she was spending money recklessly. She socialized with men more which was unusual for her earlier. Family members thought that her behaviour could be due to happiness as she has got married recently, but her behaviour aggravated as the days passed. So in laws demanded a psychiatric evaluation and she was brought for consultation.

There was no past history suggestive of depression and mania in patient. No history of substance abuse.

On mental status examination she appeared over friendly, she was wearing bright coloured new cloths, she was co-operative for interview and rapport could be established. Psychomotor activity was increased, speech rate and volume was increased and she appeared euphoric. No

hallucinations and delusions were elicited. She could not pay attention and sustain concentration, during proverb interpretation when she was asked to say a proverb; instead she said 'shayaris'. She had no insight.

Diagnosis: Mania without psychotic symptoms

Manic symptoms

1. Elevated/ irritable mood.
2. Increased energy levels resulting in over activity, pressure of speech.
3. Decreased need for sleep.
4. Normal social inhibitions are lost.
5. Attention cannot be sustained.
6. Marked distractibility, flight of ideas.
7. Elevated self-esteem.
8. Grandiose ideas.
9. Appreciation of colours as vivid, bright and beautiful.
10. Pre-occupation with fine details of texture.
11. Spending money recklessly.
12. Age of 1st episode: 15-30 years.
13. Symptoms should be severe to disrupt ordinary work and social activities.
14. No psychotic symptoms.
15. Duration criteria: 1 week.

Why this diagnosis?

1. As per history she was happier and cheerful, on mental status examination she appeared euphoric.
2. Talkativeness in the patient.
3. Frequent change in the topic while talking, shifting to other task before completing the task in hand suggests marked distractibility and flight of ideas.
4. Getting angry on trivial issues, scolding family members, spitting on them suggests loss of normal social inhibitions.
5. She was demanding bright new coloured cloths, she was spending money recklessly.
6. Increased socialization with men.
7. Appearing over friendly on mental status examination.
8. Increased psychomotor activity, increased speech rate and volume.
9. She could not pay attention and sustain concentration suggests distractibility.
10. Saying "shayaris"instead of proverbs also suggests elevated mood.

Whether patient needs inpatient care?

Yes. As patient has socio-occupational dysfunction, impairment in biological functions, impaired insight and judgement.

Goals in the management:

1. Symptom improvement.
2. Stabilizing the mood.
3. Addressing compliance.
4. Addressing family issues that would have arisen due to illness.
5. Addressing use of psychotropic drugs when patient plans pregnancy.

Treatment:

Psychosocial treatment:

1. Psycho-educating the patient, family members and care givers about the

illness, course, prognosis, need for taking medications, maintaining compliance.

2. Interpersonal and Social Rhythm Therapy (IPSRT).
3. Stress management skills and coping skills so as to handle stress, as stress would lead occurrence of future episode.

Pharmacological:

1. Patient has euphoric/ happy mania so mood stabilizer lithium is preferred in this case. During acute phase serum lithium levels are maintained between 0.8 mEq/L to 1.2 mEq/L. During maintenance phase serum lithium levels maintained between 0.6 mEq/L to 1.2 mEq/L.
2. Short term use of atypical antipsychotics like Risperidone, Olanzapine or Quetiapine

Definitions and facts:

Mood stabilizers used:

1. Lithium.
2. Sodium valproate.
3. Carbamazepine.
4. Oxcarbazepine.
5. Lamotrigine.
6. Levetiracetam.

Lithium and sodium valproate are the 1st line mood stabilizers. Others are 2nd line mood stabilizers.

Before starting lithium, investigations to be done at baseline include CBC, LFT, RFT, ECG, Thyroid function tests, BMI, FBS, PPBS and pregnancy test in females (when needed). After starting lithium, serum lithium levels should to be determined after 5 days (lithium t1/2: 5 days). For treatment of acute episode serum lithium levels should be between 0.8-1.2 mEq/l. For maintenance phase lithium levels should be between 0.6-0.8 mEq/L. Regular monitoring of serum lithium levels has to be done along with regular monitoring of renal function tests and thyroid function tests.

Antiepileptics are used as mood stabilizers as repeated sub threshold stimulus results in appearance of full blown episode of mood disorders (kindling phenomenon). Mood stabilizers prevent kindling phenomenon.

Differential diagnosis:

1. Hypomania: it is less severe form. It does not have psychotic symptoms and can be treated on OPD basis.
2. Schizophrenia: it has psychotic symptoms, along with other features.
3. Schizoaffective disorder: it has symptoms of both schizophrenia and mood disorder.
4. Substance/medication induced manic disorder: here symptoms are due to substance abuse or induced by medications.
5. Substance intoxication: due to substance intoxication, the person may become euphoric and may appear disinhibited which gives the cross sectional appearance of mania, but when person is out of intoxication effects, he becomes normal.

Case 22

A 26 years old unmarried male, with secondary school education, working as waiter from semi-urban area belonging to low socio-economic status was brought by his father for consultation.

Father complained that the patient is having frequent fighting behaviour, reckless spending of money and reduced sleep since 1 month.

Patient was apparently alright 1 month back when he started picking up frequent fights; he wanted everyone to listen to him or he was scolding them with filthy words so he used to get hit by others on the same issue. While working as waiter, he was missing orders and was giving different dishes to customers which were not ordered by them, he even scolded customers. As a result he was removed from work.

He roamed around in the town at night, saying he is great person and nothing can happen to him. He was demanding chicken, mutton, fish dishes every time he had food, many times he threw away eating plate as his demand was not met. He spent money recklessly buying costly cloths, and distributing them to people. He sold his bike for twenty thousand rupees and spent in buying new cloths and distributing them to people.

He believed that he is messenger of God, he is sent by God with a mission to convert everyone on this earth to his religion. He was saying that God speaks through him. He was praying to God several times a day, while praying he used to get distracted by things around.

At home he was not sitting at one place and used to pace around, if a household work was told to him, he used to get angry and was saying he is not meant to do such silly work, he is different and is been sent to earth with different mission which they have to understand and help him in accomplishing it.

On mental status examination patient was wearing bright coloured new cloths, he was carrying a mala which he used to chant God's name and he appeared overfriendly. Speech rate and volume was increased. He appeared irritable during interview saying his family members were not helping him in accomplishing his goals.

He said "I am supreme; I have been sent to earth with a mission to spread teaching of the God and God speaks through me, I will convert everyone on this earth to my religion"- Delusion of grandiosity.

No perceptual disturbances were observed in him. He was unable to pay attention and sustain concentration. His insight was poor. Personal and social judgements were impaired.

Diagnosis: Mania with psychotic symptoms

ICD-10 criteria for mania with psychotic symptoms:

1. Symptoms of mania are present with greater severity.
2. Delusion of grandiosity, religious delusions.
3. Duration criteria: 1 week.

Why this diagnosis?

1. Predominantly angry mood and appearing irritable on mental status examination.
2. Elevated self esteem so he wanted everyone to listen to him.
3. Missing the orders and giving different dishes to customers not actually ordered by them suggests easy distractibility.
4. Roaming around in the village at night suggests reduced need for sleep in him.
5. Demanding tasty food for self also suggests elevated self-esteem and he considers himself as most important person.
6. Reckless spending of money.
7. Increased demanding behaviour.
8. He considered himself as the person sent by God to convert everyone on this earth to his religion and telling that God speaks through him and saying that he is on earth for a special mission is grandiose delusion
9. Not sitting at one place, roaming around suggests increased psychomotor activity.
10. Wearing bright coloured cloths, carrying a mala which he used to chant God's name.
11. Appearing over friendly suggest increased socialization.

Whether patient needs inpatient care?

Yes, as there is impairment in socio-occupational function, impaired biological function; family members have found difficulty in handling him at home; he has psychotic symptoms there is impairment in insight and judgment.

Goals in the management:

1. Symptom improvement.
2. Stabilizing the mood.
3. Addressing compliance.
4. Addressing family issues that would have arisen due to illness.

Treatment:

Psychological:

1. Psycho-education about illness, course and prognosis, medication compliance.
2. Interpersonal and Social Rhythm Therapy (IPSRT).

Pharmacological:

1. Mood stabilizer like Lithium or sodium valproate
2. Short term use of atypical antipsychotics like Risperidone, Olanzapine, Quetiapine

Definitions and facts:

Delusion of grandiosity: also known as megalomania, the person has delusional belief of extreme self-importance with elevated self-esteem. It is seen in mania.

Differential diagnosis:

1. Schizophrenia: here patient has psychotic symptoms like delusion of control; somatic passivity etc. While in mania with psychotic symptoms patient has euphoria, delusion of grandiosity and other features of mania.
2. Schizoaffective disorder: patient has symptoms of both schizophrenia and mood disorder.
3. Substance induced: here symptoms are due to substance of abuse.
4. Delirium: hyperactive delirium may appear as mania due to increased activity and increased talk, but in delirium there is impairment of consciousness, which is not seen in mania.

Case 23

A 24 year old unmarried male, educated up to BSc mathematics teacher by profession from urban background belonging to middle socio-economic status, was brought by his elder brother for consultation as he was removed from the school on the grounds that he is not regular to the work from past 1 month.

Patient keeps elaborately describing about himself that he is a great mathematician and he is working on the project, which will find the formula how the world has been formed, the truth behind the existence of the earth, that everyone should feel proud about him and he would get a Nobel prize for the same.

He used to speak continuously without getting tired and appeared to have lot of energy. His speech used to be so fast that it would be difficult to follow. His colleagues were increasingly becoming irritated by his talk on the project. He had sold his bike and had spent his entire bank savings to set up the laboratory for research. He was working late night in a room where he had planned to set up the laboratory.

His brother gave history of sadness, tiredness, poor concentration in studies, anger, not attending classes, being on bed most of the time with poor interactions 2 years back when the patient was in final year BSc. Psychiatry consultation was sought and antidepressants were prescribed, he was not compliant and stopped medications in few days, however he improved in 4 months' time and never returned to psychiatrist for follow up.

In the interview room he was pacing around saying he has no time to talk, time is precious for him and he cannot waste it sitting for consultation. He was speaking continuously with high speed. He appeared euphoric during interview, he had delusion of grandiosity. Insight was absent, personal and social judgements were impaired.

Diagnosis: Bipolar Affective Disorder Current Episode Mania with Psychotic Symptoms

ICD-10 criteria:

1. The current episode should meet criteria for mania with psychotic symptoms.
2. At least another affective episode (hypomania, mania, depressive, mixed) in the past.

Why this diagnosis?

1. Patient has presented with self-praise, elaborately describing about himself as great mathematician, suggests elevated self-esteem.
2. Working on a new project, which would find the truth behind how the world has been formed, truth behind existence of the earth which would fetch him Nobel Prize suggests grandiose delusions.
3. Talkativeness and increased energy levels.
4. Selling bike and spending entire bank savings to set up laboratory for research suggests reckless spending of money.
5. Appearing euphoric during interview.
6. Duration of illness was for 1 month.
7. Points from 1 to 6 suggest that current episode is mania with psychotic symptoms.
8. Sadness, tiredness, poor concentration, anger, not attending classes, being on the bed most of the time, poor interaction are suggestive of depressive episode which he suffered when he was in BSc final year.
9. Considering points 7 and 8 we can establish the diagnosis.

Whether patient needs inpatient care?

Yes, impairment in socio-occupational function, impaired biological function, presence of psychotic symptoms, increasing financial burden due to his decisions; absent insight and impaired judgement suggests that he needs inpatient care.

Goals in the management:

1. Symptom improvement.
2. Prevention of recurrence of episodes in future.
3. Addressing compliance as the patient needs long term treatment.
4. Occupational rehabilitation.

Treatment:

Psychosocial treatment:

1. Psycho-educating the patient, family members and care givers about the illness, course, prognosis, need for taking medications, maintaining compliance.
2. Interpersonal and Social Rhythm Therapy (IPSRT).

Pharmacological:

1. Patient has euphoric/ happy mania so mood stabilizer lithium is preferred in this case. During acute phase serum lithium levels are maintained between 0.8 mEq/L to1.2 mEq/L. During maintenance phase serum lithium levels maintained between 0.6 mEq/L to 1.2 mEq/L.
2. Patient also has psychotic symptom (delusion of grandiosity), which needs

treatment with antipsychotics. Atypical antipsychotics like Risperidone, Olanzapine, Quetiapine is preferred.

Definitions and facts:

Bipolar disorder: It is a mood disorder characterized by episodes of mania/ hypomania and episodes of depression interspersed with period of normalcy.

Rapid cycling bipolar disorder: occurrence of at least 4 mood episodes per year either (mania/hypomania/ depression). The episodes are separated by at least 2 months gap or no gap if of different polarity.

Ultra rapid cycling bipolar disorder: change in mood episode from mania/ hypomania to depression or vice versa in few days.

Ultra ultra-rapid cycling bipolar disorder/ ultradian: change in mood episodes from mania/hypomania to depression or vice versa in few hours.

Cyclothymia: A persistent cyclical mood changes with multiple brief episodes of mild depression and mild elation.

Differential diagnosis:

1. Bipolar 2 disorder: patient in bipolar 2 disorder have episodes of hypomania and depression.
2. Schizophrenia: it has psychotic symptoms like delusion of control, 3rd person auditory hallucinations, whereas in BPAD mania patient presents with delusion of grandiosity.
3. Schizoaffective disorder: patient has symptoms of both schizophrenia and mood disorder.
4. Substance induced manic episode: here symptoms are due to substance of abuse.
5. Delirium: hyperactive delirium may appear as mania due to increased activity and increased talk, but in delirium there is impairment of consciousness, which is not seen in mania.

Case 24

A 28 years old married female with MCA degree working at an office from urban background belonging to middle socio-economic status was brought by her husband with complaints that from 4 months she is neither able to do household work nor work at office properly.

She is appearing dull, her interaction has reduced, she appears tired with little work, she used to look after house hold chores in a perfect manner before 4 months, which has become difficult for her these days, she is taking a long time for preparing food at home and does mistakes while cooking food.

She is unable to work with enthusiasm in office like before; from past 2 months she is irregular to work and has taken many sick leaves on the grounds of generalized body weakness. From 2

months she is experiencing sleep disturbances, her usual sleep time was from 10 PM to 6 AM, while now though she gets sleep by 10 PM she wakes up at 4 AM and keeps tossing in the bed till 8 AM. Family members have to frequently say her to move out of bed and to start with daily activities. She is observed to be tearful these days over trivial issues. Her food intake has also reduced significantly from past 1 month and her clothes are getting loose.

Patient did not have history suggestive of worthlessness, hopelessness and death wishes.

Past history of being cheerful, spending money recklessly, being over enthusiastic at work, appearing more energetic, doing multiple tasks at a time, making new friendships, watching many films, wearing bright coloured cloths, being more religious was seen in the patient 2 years back when she was treated with T. Lithium 400 mg BD and T.Quetiapine 200 mg BD and she had improved well. Later she was on T. Lithum 300 mg BD for 1 year, 8 months back Tab Lithium was tapered down and stopped.

No other episodes of mania and depression were seen in the patient.

During interview patient was sitting with down cast eyes, skin folds on forehead were increased, psychomotor activity was reduced, she was talking slowly, with low tone.

Her thoughts consisted of the things that she is not like before; she is unable to do household chores and office work, unable to enjoy life like before. She attributed her symptoms to generalized body weakness. She had good insight, personal and social judgements were intact.

Diagnosis: Bipolar Affective Disorder Current Episode Moderate Depression

ICD-10 criteria:

a. Current episode should fulfil criteria for depressive episode (mild/ moderate/severe)

b. At least one hypomanic, manic or mixed affective episode in the past.

Why this diagnosis?

1. Appearing dull, reduced interaction, tiredness with little work, taking long time for preparing food, difficulty in doing house hold chores, reduced enthusiasm, irregular to work, generalised body weakness, terminal insomnia, being tearful, reduced appetite with symptoms duration for 4 months, suggests that current episode is moderate depression.
2. Cheerfulness, reckless spending of money, over enthusiasm at work, more energy levels, doing multiple tasks at a time, making new friendships, wearing bright coloured cloths, increased religiosity and treatment with Tab. Lithium, Tab Quetiapine, suggests that the episode was mania.
3. An episode of mania in the past and current episode of moderate depression establishes the diagnosis.

Whether patient needs inpatient care?

No, as patient does not have suicidal

tendencies, though there is impairment in socio-occupational dysfunction along with impairment in biological functions, her insight is preserved.

Goals in the management:

1. Symptom improvement.
2. Prevention of recurrence of episodes in future.
3. Addressing compliance as the patient needs long term treatment.

Treatment:

Psychological:

1. Psychoeducation about illness, course, prognosis, medication compliance.
2. Cognitive Behavioural Therapy.

Pharmacological:

1. Patient can be treated with lithium to which she had responded well earlier. FDA approved combination tablet of Olanzapine plus fluoxetine or Lurasidone can be added. Tab. Lamotrigine is also used in bipolar depression.

Differential diagnosis:

1. Depressive disorder: here patient has no past episodes of mania.
2. Medication/substance induced: symptoms are due to medication/ substance used by the individual.

Case 25

A 25 years old married women educated up to BSc a homemaker from urban background belonging to middle socio-economic status, was accompanied by her mother who came to hospital with complaints that she is feeling low from past 8 months following her marriage. Her husband consumes alcohol and there would be frequent quarrels between them.

She described her mood as being low throughout the day and feels fatigued while carrying out household chores; she had lost interest in daily activities, her concentration while working was reduced, she used to feel less confident for doing activities. She thought her life changed due to her marriage.

She denied any physical or sexual assault by husband. There were no disturbances in sleep, appetite, bowel and bladder activities. She denied experiencing worthlessness, pessimistic views about future and suicidal thoughts. She did not have depression or mania episodes in the past.

There was no history of using alcohol, tobacco or other illicit substances. No family history of mood disorders, other psychiatric illness or suicide.

On mental status examination she was comfortably sitting in the interview room, her speech was normal, mood was sad and appeared depressed, her thoughts were filled with worries about husband's

alcohol usage. There were no perceptual disturbances, and her cognitive functions were normal and insight was good and judgement was intact.

Diagnosis: Mild depression without somatic syndrome

ICD-10 criteria for depressive episode:

Major symptoms:

a. Depressed mood/ low mood/ sadness.

b. Loss of interest and enjoyment (anhedonia).

c. Reduced energy and easy fatigability.

Minor symptoms:

a. Reduced attention & concentration.

b. Reduced self-esteem and self-confidence.

c. Ideas of guilt and unworthiness.

d. Bleak and pessimistic views about future.

e. Ideas or acts of self-harm and suicide.

f. Disturbed sleep.

g. Diminished appetite.

Duration criteria: minimum 2 weeks.

ICD-10 criteria for mild depressive episode: At least 2 of the typical symptoms and at least 2 of the other common symptoms for at least 2 weeks.

ICD-10 criteria for moderate depressive episode: At least 2 of the typical symptoms and at least 3 (preferably 4) of the other common symptoms for at least 2 weeks.

ICD-10 criteria for severe depressive episode without psychotic symptoms: all 3 of the major typical symptoms and at least 4 of the other common symptoms which should be of severe intensity should be present for 2 weeks.

If symptoms are of rapid onset and are very severe then diagnosis of severe depression can be made even if symptom duration is less than 2 weeks.

ICD-10 criteria for severe depressive episode with psychotic symptoms:

1. The episode symptoms meet diagnostic criteria for severe depression without psychotic symptoms; along with this patients have delusions, hallucinations or depressive stupor.

   Delusions are of sin/ guilt, poverty, imminent disaster (for which the patient assumes he is responsible)

   Auditory hallucinations can be of defamatory type or voices accusing the patient.

   Olfactory hallucinations can be of decomposing flesh.

   One can specify that hallucinations and delusions are of mood congruent or incongruent type.

Somatic syndrome symptoms: (4/8 should be present)

1. Loss of interest or pleasure in activities those are normally enjoyable.
2. Lack of emotional reactivity to normally pleasurable surroundings.
3. Waking up 2 hours or more before usual time.

4. Depression worse in morning.
5. Objective evidence of definite psychomotor retardation or agitation.
6. Marked loss of appetite.
7. Weight loss more than 5% in one month
8. Marked loss of libido.

Why this diagnosis?

1. Patient has pervasive sadness.
2. Easy fatigability.
3. Loss of pleasure in daily activities.
4. Her concentration while working was reduced.
5. Reduction in self-confidence.
6. Duration of the symptoms is for 8 months.

Whether patient needs inpatient care?

No, as patient's insight is good and there are no suicidal tendencies.

Goals in the management:

1. Symptom improvement.
2. Addressing compliance.
3. Improving psycho-social functioning.

Treatment:

Psychotherapy:

1. Psychoeducation about illness, course, prognosis, medication compliance.
2. Cognitive behaviour therapy:
3. Family therapy
4. Mild depression can be treated only with psychotherapy.

Pharmacotherapy:

1. Pharmacotherapy is preferred if patient is not willing for psychotherapy. In this case patient is treated with SSRIs like Escitalopram, Sertraline, Fluoxetine.

   Duration of treatment is for 6-9 months.

Definition and facts:

Anergia: lack of energy.

Anhedonia: lack of pleasure in activities that were once pleasurable.

Most common psychiatric problem in females on OC-pills: Depression.

Pseudo dementia features are seen in depression.

Atypical depression:

1. Hypersomnia.
2. Hyperphagia.
3. Depression that is reactive to positive external emotional cues.
4. Increased rejection sensitivity.
5. Laden paralysis (heaviness in arms and legs).

Atypical depression is most commonly seen in patients with bipolar disorder. If atypical depression is present then rule out underlying bipolarity.

Other name for somatic syndrome: melancholia.

Differential diagnosis:

1. Medical conditions: medical conditions like hypothyroidism produce symptoms like reduced energy levels, reduced activity level, easy fatigability which mimics symptoms of depression.

2. Substances: alcohol is primary CNS depressant, so chronic alcohol use can produce symptoms of depression.
3. Psychotic disorder: patients with mild and moderate depression do not have psychotic symptoms.
4. Anxiety disorder: anxiety symptoms can appear in depression, but they are secondary to depression.
5. Bipolar disorder: patients with bipolar disorder have episodes of depression and mania/ hypomania. If there is a past history of mania/ hypomania, then diagnosis would be bipolar disorder.
6. Cyclothymia: it has several episodes of mild depression and mild mood elevations lasting for longer duration of time.
7. Dysthymia: here patient has chronic low mood for at least 2 years that is not as severe as depressive disorder.
8. Adjustment disorder: it occurs when a person is unable to adjust to a stressful situation; it starts within 1 month and resolves by 6 months.
9. Somatoform disorder: here patient presents with multiple changing somatic symptoms for which there is no physical etiological cause.

Case 26

A 35 years old married male with education up to secondary school working as manual labourer from rural background belonging to low socio-economic status accompanied by his mother; presented to OPD with sadness from past 3 weeks.

His mood was low consistently; it was worse in the morning and felt better as the day passed, his energy levels were reduced. His appetite was markedly reduced. He was not finding pleasure in work, self confidence had reduced, and he had frequent crying spells. His sleep was disturbed; previously he slept between 11 pm to 7 am, from last 3 weeks he wakes up by 4 am. He did have not suicidal ideation.

He denied pervasive low mood or mood elevations in the past. There was no history of alcohol, tobacco and illicit substance use. No family history of depression and other psychiatric disorder.

On mental status examination patient appeared well dressed and groomed. He appeared tired with increased skin folds over the forehead. Psychomotor activity was reduced, with slow speech rate and volume, spontaneity was reduced. He described mood as sad and appeared depressed. Thought content was filled with worries about not being able to carry out daily activities. He did not have perceptual disturbances. Cognitive function tests were normal. His insight was good and judgements were intact.

Physical examination revealed normal

vital signs, thyroid examination and systemic examination was normal.

Diagnosis: Moderate depressive disorder with somatic syndrome

ICD-10 criteria and somatic syndrome criteria are mentioned in case 25.

Why this diagnosis?

1. Sadness.
2. Reduced energy levels.
3. Reduced self confidence.
4. Frequent crying spells.
5. Making mistakes while working suggests reduced concentration.
6. Sleep disturbance.
7. Depression worse in the morning.
8. Marked reduction in appetite.
9. Not finding pleasure in work like before.
10. Waking up 3 hours before than usual time.
11. Points 1 to 5 suggests that patient has moderate depression, points from 7 to 10 suggests that patient has somatic syndrome.
12. Duration of the illness is 3 weeks.

Whether patient needs inpatient care?

No, as patient's insight is good and there are no suicidal tendencies.

Goals in the management:

1. Symptom improvement.
2. Addressing compliance.
3. Improving psychosocial functioning.

Treatment:

Psychotherapy:

1. Psychoeducation about illness, course, prognosis, medication compliance.
2. Psychological interventions for depression can be combined with pharmacotherapy.

Pharmacotherapy:

1. Mirtazapine helps in improving mood symptoms, appetite and sleep.
2. SSRI's or Tricyclic antidepressants Amitriptyline, Nortriptyline, Imipramine, Dotheipin can also be tried.
3. Duration of treatment is for 6-9 months.

Definitions and facts:

Omega sign: increased skin folding on forehead which gives the appearance of Greek letter 'Ω'. Corrugator muscle is involved in producing Omega sign.

Muscle of human suffering: corrugator muscle.

Veraguth fold/sign: it is a skin fold appearing in upper eye lid in medial 1/3 part seen in depression.

Differential diagnosis:

1. Medical conditions: medical conditions like hypothyroidism produce symptoms like reduced energy levels, reduced activity level, easy fatigability which mimics symptoms of depression.
2. Substances: alcohol is primary CNS depressant, so chronic alcohol use can produce symptoms of depression.
3. Anxiety disorder: anxiety symptoms can appear in depression, but they are secondary to depression.

4. Bipolar disorder: patients with bipolar disorder have episodes of depression and mania/ hypomania. If there is a past history of mania/ hypomania, then diagnosis would be bipolar disorder.
5. Cyclothymia: it has several episodes of mild depression and mild mood elevations lasting for longer duration of time.
6. Dysthymia: here patient has chronic low mood for at least 2 years that is not as severe as depressive disorder.

Case 27

A 21 years old unmarried lady, B. Ed degree holder working as primary school teacher from rural background belonging to middle socio-economic status was brought by her father saying that she has become lazy, not doing any activity, always on bed, not interacting with any one, not going to work since 2 months and talking to self from 15 days.

2 months back she had visited a temple, where unexpectedly she menstruated, as per her culture menstruating women should not visit holy places like temple, if done so it is a great sin. She felt guilty for the same reason and believed that God would punish her so severely that she would go to hell and she would rotten there. She was sad; she neither found interest in talking to others, nor going to work, she was feeling fatigued to carry out daily routine activities. She kept crying whole day. She could not share her feelings with others due to fear. She had loss of appetite and sleep disturbances. She had no hopes that her life would be better in future. She had guilt feelings. She thought that life without the blessings of God is not worth living and it is better to be dead.

From the last 15 days she could hear the voice of a lady who was passing derogatory comments to her saying she is a bad woman; she should be killed. She could hear this even when no one was around her.

No past history of depression, mania, suicide attempts. No history of substance abuse.

On mental status examination patient appeared too much tired, tears were rolling down, and forehead skin folds were increased. She had a down cast look. Psychomotor activity was severely reduced. Her speech had a slow rate, with reduced spontaneity; quantity of speech output was reduced. She appeared disinterested in the conversation; ideas of worthlessness and hopelessness were present.

She said "It's a great mistake to menstruate in temple, menstruating women should not visit temple. Now God will punish me and will go to hell. No one would do such a great mistake, I am a guilty person and I deserve punishment"- Delusion of guilt.

"I hear voice of a lady who pass

derogatory comments, she says I am a bad woman and I should be killed"- Second person auditory hallucinations.

Her insight was poor and personal and social judgements were impaired.

Diagnosis: Severe depression with psychotic symptoms

Why this diagnosis?

1. Sadness.
2. Loss of interest in working.
3. She was feeling fatigued to carry out daily routine activities.
4. Poor interaction.
5. Crying.
6. Loss of appetite.
7. Sleep disturbance.
8. No hopes .i.e. pessimistic views about the future.
9. Unworthiness feelings as she assumed she won't receive blessings of God.
10. Death wishes.
11. Delusion of guilt.
12. Second person auditory hallucination.
13. Duration of sadness was of 2 months.
14. Patient has all 3 typical symptoms of depression, has more than 4 common symptoms of depression along with this she even has delusion of guilt and second person auditory hallucination.

Whether patient needs inpatient care?

Yes, as patient has hopelessness it is strong predictor of suicide, she has psychotic symptoms, insight into the illness is absent and she is unable to take care of self

Goals in the management:

1. Assessment and management of thoughts of self harm.
2. Symptom improvement.
3. Addressing compliance.

Treatment:

Psychological:

1. Psychoeducation about illness, course, prognosis, medication compliance.
2. Cognitive behaviour therapy: Once she is slightly better. Cognitive errors like I have done greatest unpardonable mistake for which I deserve punishment are addressed.
3. Problem solving skills, coping skills.

Pharmacological:

1. MECT is recommended in this patient as she has severe depression with psychotic symptoms, worthlessness, hopelessness and death wishes.
2. Antidepressants like SSRIs Escitalopram, Fluoxetine, Paroxetine, Sertraline can be used. Mirtazapine, Amitriptyline, Nortriptyline, Dotheipine can also be used.
3. For treatment of psychotic symptoms atypical antipsychotic drugs are needed.
4. Duration of treatment is for about 9 months.

Definitions and facts:

Agitated depression: it is type of severe depression seen in elderly patients which is associated with motor restlessness or agitation.

Delusion of guilt: the patient has delusional belief that he has done a great mistake

for which he deserves serious punishment.

Delusion of ill-health: the patient has delusional belief that he is ill.

Delusion of poverty: the patient has delusional belief that he is poor.

Most successful attempts of suicide: by males.

Maximum suicide attempts: by females.

Predictors of suicide: hopelessness and past history of suicide.

Life time risk for suicide in patients with mood disorder is 10-15%.

Differential diagnosis:

1. Medication/ substance induced psychotic disorder: symptoms are due to medications/ substance of abuse.
2. Schizoaffective disorder: it has both schizophrenia symptoms and affective symptoms.
3. Schizophrenia: it is characterised by presence of delusions of control, 3rd person auditory hallucinations and other associated features, while severe depression has delusions of guilt, nihilism, poverty, ill health and enormity.
4. Delusional disorder: in delusional disorder patient's functioning in areas other than that involving delusions are normal.

Case 28

27 year unmarried male, ITI holder, working in supermarket from urban background, belonging to middle socio-economic status was brought by his mother with complaints of being tearful from 1 month, she was worried as he kept saying that he is not alive and is dead.

The patient was in love with a girl from 8 months, they were in good cordial relationship with each other. 1 month back they had a sexual intercourse, from the following day girl stopped speaking with him, saying she is no more interested in him. Since then the patient had worries that he cheated her, he has destroyed the pure love by having sexual intercourse. He thought that this is the reason why she stopped speaking to him.

The worries aggravated as the days passed. He felt low; he did not get pleasure in doing work and daily activities, he felt fatigued with less work, he used to get distracted by the above thoughts and could not concentrate while working. His interaction reduced, food intake reduced, he experienced sleep disturbances. He stopped going to work from 15 days. He kept crying whole day. From 15 days he is frequently telling that he has not cheated anyone and took repeated reassurance about the same from family members. From past 1 week he is telling that God as taken away his life for the mistake he has done, he does not exist and is dead.

There was no episode of depression

and mania in the past, no history of substance abuse.

During interview it was observed that his clothes were too loose for him, he cried during interview, his speech output was reduced, he appeared low.

He said "I have destroyed pure love by having sexual intercourse and cheated her, this is the grave sin for which God has taken away my life and I am not existing and I am dead"- Delusion of guilt and nihilistic delusion.

No perceptual distortions were seen. Insight was absent and social and personal judgements were impaired.

Diagnosis: Severe depression with psychotic symptoms

Why this diagnosis?

1. Feeling low.
2. Not getting pleasure in doing work and daily activities.
3. Feeling fatigued with less work suggests reduced energy levels.
4. Repeated reassurance seeking suggests reduced self-confidence.
5. Reduced concentration at work.
6. Reduced interaction.
7. Sleep disturbance.
8. Reduced food intake which suggests appetite disturbance.
9. Crying whole day.
10. Delusion of guilt, nihilistic delusion.
11. Duration of illness for 1 month.

    Considering points from 1 to 11 the diagnosis is made.

Whether patient needs inpatient care?

Yes, as patient's depression is severe, he has psychotic symptoms; he is unable to take care of self, for which he needs in patient care.

Goals in the management:

1. Assessment and management of thoughts of self harm.
2. Symptom improvement.
3. Addressing compliance.

Treatment:

Psychological:

1. Psycho-education to the family members and patient about illness, its course, treatment options, compliance issues.
2. Supportive psychotherapy.
3. Cognitive Behavioural Therapy: once the patient gains insight. Cognitive errors like I did mistake, its greatest mistake that I have done, I deserve punishment for the same are addressed.

Pharmacological:

1. Patient should be treated with an antidepressant (SSRI, SNRI, or Tricyclic) and an atypical antipsychotic are preferred. Modified Electro Convulsive Therapy (MECT): Is a good option in this patient, as there will be quick improvement in both mood symptoms and psychotic symptoms.

Definitions and facts:

Delusion of nihilism: the patient has delusional belief that he does not exist, the world around him does not exist and everything has come to an end.

Case 29

35 year old married male educated up to BA businessman from urban background belonging to middle socio-economic status came to psychiatry OPD seeking help for sleeplessness from 2 weeks. On enquiry he said to have been experiencing sadness from 1 month following a business loss of 3 lac rupees. The thoughts about the loss in business kept intruding into his mind every time due to which he was unable to concentrate while working, could not enjoy the work and felt fatigued. He admits that when he goes to bed for sleep, worrying thoughts come to mind due to which he is unable to fall asleep. His appetite was normal; he harboured no thoughts of worthlessness, hopelessness, and suicidal ideations.

He added that he had experienced sadness for 7 months, when he could not clear his BA exams 12 years back, during that time he preferred to stay alone in the room, did not mingle with friends and did not find the activities enjoyable. He recovered from the problem spontaneously without any medications.

There were no other episodes of pervasive low mood or elevated mood in the past, no use of substances.

On mental status examination, he was sitting comfortably while interviewing, with good eye contact, and was co-operative with examiner. Psychomotor activity was normal, speech output was normal, his mood was sad, he appeared depressed. He was preoccupied with thoughts of business loss. No perceptual disturbances were seen. Cognitive functions were normal, insight was good and judgment was intact.

Diagnosis: Recurrent depressive disorder current episode mild depression without somatic syndrome.

ICD-10 criteria:

a. More than one episode of depression.
b. No episodes of mania.
c. Recovery between the episodes is complete.
d. The episodes should be separated by a period of normalcy of at least 2 months.

Current episode can be mild, moderate or severe. Mild, moderate episodes are specified with or without somatic syndrome. Severe episode is specified with or without psychotic symptoms.

Why this diagnosis?

1. Sadness from 1 month secondary to business loss of 3 lac rupees.
2. Easy fatigability.
3. Loss of interest in work as he could not enjoy working.
4. Reduced concentration at work.
5. Sleeplessness.
6. These suggest that patient has mild depression in current episode.

In past he had sadness for 7 months associated with loneliness, staying at

home, inability to enjoy the activities, suggests that the episode was depression.

2 depressive episodes (past and the current episodes) separated by more than 2 months (12 years in this case) suggests recurrent depressive disorder.

Whether patient needs inpatient care?

No, as patient does not have thoughts of self harm.

Goals in the management:

1. Symptom improvement.
2. Prevention of future recurrence.
3. Addressing compliance.

Treatment:

Psychological:

1. Cognitive Behavioural Therapy is recommended during acute episode and also during maintenance period. If patient is not willing for psychotherapy then pharmacotherapy is preferred. Cognitive errors like I am loser, I cannot succeed in life are addressed.

Pharmacological:

Antidepressant treatment. SSRIs are generally preferred.

Definitions and facts:

Double depression: major depressive disorder occurring superimposed on dysthymia.

Differential diagnosis:

1. Medication/ substance induced: RDD can appear due to recurrent use of substances like alcohol.
2. Dysthymia: it is chronic low mood with minimum duration of 2 years for the diagnosis. At times the patients' mood may be normal for weeks, but in dysthymia symptoms are not as severe as depressive disorder, and mood would never be normal stretching for 2 months.
3. Bipolar disorder: it has episodes of depression and episodes of mania/ hypomania.
4. Cyclothymia: it has several episodes of mild depression and mild mood elevations lasts for longer duration of time.

Case 30

23 year old unmarried male, BA drop out, a bus driver by occupation from rural background belonging to middle socio-economic status presented to the OPD accompanied by his mother with low mood from the last 3 years. Following the death of his father three years back patient being eldest son had to bear the full responsibility of the family which has twelve members. He had to give up his studies to work and support the family financially.

He took up the responsibility of continuing education of 3 younger brothers and 2 younger sisters. These issues made

him feel stressful and he felt low. The mood was low most of the time every day, but he was able to carry out his work like before. He enjoyed mingling with friends, and celebrating festivals. But he was feeling low due to stress of family care taking. At times during the periods of economic crisis his sleep would be poor, but used to recover once the crisis got over. His appetite was normal; he did not report feeling of worthless, having pessimistic views about future and death wishes.

He denied having experienced pervasive low mood or elevated mood in the past, there was no substance abuse history.

During mental status examination he was well dressed, comfortably sitting on the chair, with good eye contact and was co-operative with examiner. Psychomotor activity was normal. Speech was normal. He appeared depressed. His thoughts consisted of worries about running the family. No perceptual disturbances were elicited, cognitive functions were normal. He had good insight, judgement was intact.

Diagnosis: Dysthymia

ICD-10 criteria:

Chronic low mood which is not severe enough to fulfil the criteria of depressive disorder. It begins in early adult life and lasts for several years and sometimes indefinitely.

Duration: 2 years.

Why this diagnosis?

1. Low mood for 3 years.
2. Was feeling stressful as he had to give up studies and took up the responsibility of whole of the family.
3. He was able to carry out work like before, which suggests that easy fatigability was not seen.
4. Even with low mood. He could enjoy mingling with friends, celebrating festivals which suggest that there was no loss of pleasure in activities.
5. During economic crisis his sleep would be poor but was recovering once crisis got over.
6. So this person has chronic low mood from 3 years which is not fulfilling the criteria for recurrent depressive disorder beginning in early adult life.

Goals in the management:

1. Symptom improvement.
2. Addressing compliance stressing on the fact that the disorder needs long term treatment.

Treatment:

Psychological:

1. Supportive psychotherapy.
2. Cognitive Behavioural Therapy.

Pharmacological:

Antidepressant treatment. Low dose SSRIs, SNRI's, tricyclics are generally preferred.

Whether patient needs inpatient care?

No, as there is no impairment in daily functioning, biological functions are normal, insight is good, there are no self-harm or behaviour of harming others.

Differential diagnosis:

1. Substance abuse: depressive symptoms produced are due to substance abuse.
2. Depressive disorder: patient presents with low mood, loss of interest in activities, easy fatigability which occur pervasively for at least 2 weeks, whereas in dysthymia patient has chronic low mood which is not severe to meet the criteria for depressive disorder.

Case 31

A 23 year old unmarried female with B.Com education, currently not working from urban background belonged to middle socio-economic status came to OPD alone.

She had been to a shopping mall 2 months back where there was a crowd, when she had sudden onset of breathlessness, sweating, tremors, racing heart beats, dizziness and she felt she is going crazy. Moving out of that situation was too difficult for her. She ran out of the mall and came back to her home. The episode lasted for 20-30 minutes. She experienced similar attack when she had been to a different shopping mall 1 month back, so she is avoiding going out alone to any place.

Two weeks back she got a job in a supermarket; while working she experienced uneasiness, sweating, tremors and dizziness which was unbearable and she quit the job. On advice of her friends she visited the psychiatric clinic.

She had no history of other psychiatric symptoms, no substance abuse. Thyroid function tests were normal.

Diagnosis: Agoraphobia with panic disorder

ICD-10criteria:

a. Psychological or autonomic symptoms are the primary manifestations of anxiety.
b. Anxiety is restricted to at least 2 of the following situations: crowd, public places, travelling away from home, travelling alone.
c. Avoidance of phobic situation is a prominent feature.

Agoraphobia is most often associated with panic disorder. Therefore whenever agoraphobia is diagnosed, diagnosis is represented as with or without panic disorder.

Why this diagnosis?

1. Experiencing intense anxiety in a shopping mall where there was a crowd.
2. Finding difficulty in moving out of the crowed place.
3. She avoided the situation by moving out of the mall and coming back to home.
4. Episode duration was of 20-30 minutes.
5. Experiencing anxiety symptoms in a

supermarket, she avoided the situation by quitting the job.

Whether patient needs inpatient care?

No, the disorder is not a serious mental illness and patient can take care of self, he has good insight. She came alone for consultation.

Goals in the management:

1. Symptom improvement by reducing fear.
2. Addressing cognitive distortions.
3. Improving occupational functioning.

Treatment:

Psychotherapy:

1. Cognitive Behaviour therapy: cognitive errors like something bad will happen to me when I am in crowd are addressed.
2. Supportive psychotherapy.
3. Relaxation exercises.
4. Virtual reality: Here the patient is exposed to 3-dimentional computer generated situation which the person can handle with electronic devices.

Pharmacological:

1. SSRIs (Escitalopram, Paroxetine, Sertraline) are preferred.
2. SNRIs (Venlafaxine, Desvenlafaxine) can be used in treatment of this disorder.
3. Short term use of benzodiazepines like Clonazepam, Etizolam, Alprazolam or on SOS basis gives quick relief from panic attacks. Mouth dissolving formulations of clonazepam are also available. Alprazolam produces euphoria and has higher propensity to cause dependence.
4. Beta blockers like propranolol can be given to the patient which reduces few physical symptoms. Duration of treatment is for 6-9 months.

Definitions and facts:

Agoraphobia:

Fear of market place, open space, crowd (old definition).

Fear of being in place from where escape might be difficult (new definition).

It is commonly seen in females. Onset is early in adult life.

Differential diagnosis:

1. Social anxiety disorder: individual has phobia towards social situation.
2. Specific phobia: individual has phobia towards specific object or situation.
3. Post-traumatic stress disorder: individual avoids situations which trigger memories of traumatic event.
4. Separation anxiety disorder: individual avoids being in situations that separates him from major attachment figure.
5. Medication and substance induced: here medications and substance use is the etiology of the disorder.

Case 32

A 20 year old unmarried male pursuing B.Com from middle class urban family was accompanied by his friend who presented with feelings of tension and apprehension while standing on the stage.

When he goes on stage for presentations/speech, he feels fearful, gets nervous and sweats a lot; there would be nervousness on the face, trembling of whole body and urinary urgency. He forgets the prepared matter for speech and is unable to face the audience.

He feels that audience will negatively scrutinize him, so he avoided going to the stage. As far as he could remember he is experiencing these symptoms since high school. He used to feel fearful to read out a paragraph from the chapter in front of classmates. Fear made him feel embarrassed. So he always avoided speaking in front of crowd or on stage. He admits that he is supposed to present a seminar in front of his classmates (a crowd of 100 people) next week which made him to seek psychiatry consultation.

Diagnosis: Social phobia

ICD-10 Criteria:

a. Psychological or autonomic symptoms are the primary manifestation.
b. Anxiety is restricted to social situations.
c. Phobic situation is avoided whenever possible.

Why this diagnosis?

1. Patient had presented with tension and apprehension when on stage and had experienced the same during school days when he was made to read out a chapter in front of classmates.
2. Autonomic arousal symptoms when he is on stage and while performing in front of his classmates' .i.e. social situation.
3. Feeling of getting negatively scrutinized by audience.
4. History of him avoiding going on the stage.

Whether patient needs inpatient care?

No, as the disorder is not a serious mental illness and patient can take care of self, he has good insight.

Goals in the management:

1. Symptom improvement by reducing fear.
2. Addressing cognitive distortions.
3. Medication compliance.
4. Improving academic functioning.

Treatment:

Psychotherapy:

1. Cognitive Behavioural Therapy: cognitive errors like that audience negatively scrutinize him are addressed.
2. Systemic desensitization.
3. Relaxation exercises.
4. Biofeedback.

Pharmacotherapy:

1. SSRIs (Escitalopram, Paroxetine, Sertraline) are generally preferred.
2. Benzodiazepines on SOS basis or for short time helps.
3. Beta blockers like propranolol helps in performance anxiety and reducing few physical symptoms.

Differential diagnosis:

1. Generalized anxiety disorder: patient has anxiety in all situations, which is described as free floating anxiety. While in social phobia it is the fear that makes person to social situation.
2. Panic disorder: patient experiences panic attacks which occur out of the blue. While in social phobia the person has fear for social situation.
3. Specific phobia: patient has phobia to specific object or situation. While in social phobia fear for social situation.
4. Post-traumatic stress disorder: patient avoids situations which trigger memories of traumatic event. While in social phobia avoidance is due to fear for social situation.
5. Separation anxiety disorder: patient avoids being in situations that separates him from major attachment figure. While in social phobia avoidance is due to fear for social situation.
6. Depressive disorder: patient prefers loneliness in depressive disorder so avoids social situation. While in social phobia avoidance is due to fear for social situation.

Case 33

A 20 year old unmarried man came to psychiatric clinic alone with fear of inability to be on tall buildings, as he goes to upper floors, he gets dizziness and vomiting. He feels that he may fall down from the building.

Few days back he had been to friend's home, which is in eighth floor of the apartment. While moving up in the elevator, he experienced intense anxiety and felt he is going crazy so he held hand of his friend tightly, the fear was so overwhelming that he stopped the elevator in the middle and ran down the apartment. His friends made fun of him about this.

Diagnosis: Specific phobia (Acrophobia)

ICD-10 Criteria:

a. Psychological or autonomic symptoms are the primary manifestation.
b. Anxiety is restricted to specific object/ situation.
c. Phobic situation is avoided whenever possible.

Why this diagnosis?

1. Manifestation of autonomic symptoms due to anxiety.
2. Symptom manifestation occurs only when the person is on tall buildings (specific situation).

3. He was avoiding going on tall buildings.

Whether patient needs inpatient care?

No, the disorder is not a serious mental illness and patient can take care of self, he has good insight.

Goals in the management:

1. Symptom improvement.
2. Addressing cognitive distortions.
3. Medication compliance.
4. Improving social functioning.

Treatment:

Psychological:

Cognitive Behaviour Therapy and systemic desensitization is advised. Hierarchy generation for fear producing situation is done, patient is taught relaxation exercises and graded exposure to fear producing situation is done. When patient experiences anxiety symptoms, he does relaxation which helps him in acclimatizing to the fear producing situation. He is slowly moved from lower level anxiety situations to higher level situations. Previously flooding was used to treat specific phobia, where the person was directly exposed to phobic object/ situation and he would experience intense anxiety. The anxiety would suddenly reach the peak.

Pharmacological:

1. SSRIs (Escitalopram, Paroxetine, Sertraline) are generally preferred.
2. Benzodiazepines on SOS basis or for short time helps.
3. Beta blockers like propranolol helps in reducing few physical symptoms.

Definitions and facts:

Claustrophobia: phobia of closed space.

Zoophobia: phobia of animals.

Hydrophobia: phobia of water.

Pyrophobia: phobia of fire.

Differential diagnosis:

1. Generalized anxiety disorder: patient has anxiety in all situations, which is described as free floating anxiety. While in specific phobia it is due to fear to specific object or situation.
2. Social phobia: patient has phobia for social situations which he avoids. While in specific phobia it is due to fear to specific object or situation.
3. Panic disorder: patient experiences panic attacks which occur out of the blue. While in specific phobia it is due to fear to specific object or situation.
4. Post traumatic stress disorder: patient avoids situations that trigger memories of traumatic event. While in specific phobia it is due to fear to specific object or situation.
5. Separation anxiety disorder: patient avoids being in situations that separates him from major attachment figure. While in specific phobia it is due to fear to specific object or situation.
6. Depressive disorder: patient avoids being in social situations in depressive disorder due to lack of interest. While in specific phobia it is due to fear to specific object or situation.

Case 34

A 25 year old unmarried female with education up to BBA working as a clerk in an office from urban background, middle socio-economic status family presented to the casualty with complaints of sudden onset of rapid heartbeats and heaviness in chest, which made her worry that she is having a heart attack. Clinical and laboratory evaluation were normal, she was then referred to psychiatry department.

She elaborated saying since 2 months she is been experiencing episodes of intense fear along with palpitations, sweating, tremors, breathlessness, dizziness, chest pain which gave the feeling that she would die due to heart attack and she is going crazy. The episodes lasted for 15-20 minutes. During the episodes she consoled herself by drinking lot of water and chanting God's name. Episodes occurred 2-3 times in a week. After recovering from the episodes she had constant worry that she may experience another such attack. She however could manage her work and travelled alone to office.

She had no history of other psychiatric symptoms, no substance abuse. Thyroid function tests were within normal limits.

Diagnosis: Panic disorder without agoraphobia.

ICD-10 criteria:

a) Panic attacks in places where there is no objective danger.

b) Occurring in unpredictable situations.

c) No anxiety symptoms between the attacks other than anticipatory anxiety.

d) Duration: 1 month (several panic attacks in this period).

In panic disorder there are recurrent attack of severe anxiety (panic attack) not restricted to particular situation. They are not predictable .i.e. they appear out of the blue. Frequency of attacks is variable. Attacks usually last for minutes, rarely longer.

Symptoms of panic attacks include palpitations, chest pain, chocking sensation, dizziness, feelings of unreality (depersonalization or derealization) associated with secondary fear of dying, losing control or going mad.

Why this diagnosis?

1. Symptoms of panic attack are seen.
2. Episodes lasted for 15-20 minutes.
3. Presence of anticipatory anxiety.
4. No anxiety symptoms between the episodes.

Whether patient needs inpatient care?

No, as the disorder is not a serious mental illness and patient can take care of self, he has good insight.

Goals in the management:

1. Rule out medical and substance induced causes.
2. Symptom improvement.

3. Addressing cognitive distortions.
4. Addressing compliance.

Treatment:

Psychological:

1. Cognitive Behavioural Therapy: it addresses distorted cognitions that the person harbours. The person might think that he might be going crazy, having serious illness in chest or suffering a heart attack, such thoughts are addressed and behavioural changes should be brought.
2. Relaxation exercises helps in relieving anxiety symptoms. Deep breathing exercises help in quick relief of panic attack.
3. Bio-feedback is also helpful.
4. Mindfulness also helps during maintenance treatment.

Pharmacological:

1. SSRIs (Escitalopram, Paroxetine, Sertraline) are preferred while fluoxetine is avoided as it has activating effect and may aggravate symptoms during initial period of treatment. Paroxetine though it has sedating effect but has advantage of anxiolytic property.
2. SNRIs (Venlafaxine, Desvenlafaxine) can be used in treatment of this disorder.
3. Tricyclic antidepressants (Amitriphtyline, Nortriptyline, Dotheipin, Imipramine) can also be used in treatment of this disorder but anticholinergic, sedative and weight gaining effects are not acceptable in this case.
4. Mirtazapine is avoided as it causes sedation and weight gain.
5. Short term use of benzodiazepines like Clonazepam, Etizolam, Alprazolam on as and when required basis gives quick of relief from panic attack. Mouth dissolving formulations of clonazepam are also available.
6. Beta blockers like Propranolol can be given to the patient which controls autonomic symptoms of panic attacks.

Definition and facts:

Fear: it is feeling of apprehension about definite external threat.

Anxiety: it is feeling of apprehension about something with unknown outcome.

2 types of anxiety:

1. Trait anxiety: it is anxiety experienced by the individual as an inherent behaviour.

2. State anxiety: it is the anxiety experienced by the individual in a particular situation.

Panic attacks: these are brief episodes of sudden intense anxiety that appear unexpectedly or out of the blue.

Differential diagnosis:

1. Panic attacks can occur due to variety of medical conditions including cardiac, endocrine, malignancies, neurologic disorders, pulmonary diseases, malignancies, neurologic disorders which should be ruled out before

coming to the conclusion of panic disorder.

2. Substance intoxication: alcohol, amphetamine, cocaine, hallucinogens intoxication can produce panic attacks.
3. Substance withdrawal: alcohol, sedatives or hypnotics substance withdrawal, patient may experience panic attacks.
4. Substance induced: chronic use of substance is the aetiology for panic disorder.
5. Depressive disorder: patient experiences panic attacks which are the part of depressive disorder.
6. Anxiety disorders: panic attacks can occur in social anxiety disorder, specific phobia, post-traumatic stress disorder, OCD, Body focused repetitive behaviour. But in panic disorder between two panic attacks episodes there are no anxiety symptoms; accept for preoccupation with thoughts of having another panic attack, where as in other anxiety disorders panic attacks are associated with other features of that particular disorder.

Case 35

A 32 year old married male with high school education working as farmer from rural background belonging to middle socio-economic status accompanied by his wife came to OPD for the evaluation of constant worries throughout the day from last 2 years. He worried about daily work and felt apprehensive while carrying it out, worry was constant and was present all thorough the day. He experienced it wherever he is.

He kept preplanning the daily routine work, as he felt he may do mistakes while working which can cause embarrassment. This increased his worries, so he could not concentrate on work and would do some minor mistakes which resulted in nervousness, trembling, muscle tension, sweating, racing heart beats and discomfort in stomach lasting for 20 to 30 minutes.

He said he is unable to relax throughout the day. The only time he felt relaxed was during sleep.

There were no symptoms of depression, no substance abuse.

During interview he was well dressed and groomed. He was fidgeting with fingers and shirt buttons, frequently adjusting his position in chair. He asked us to excuse him if he does not answer our questions appropriately. He was moving his legs to and fro. He was co-operative for interview.

He described mood as tensed and appeared anxious. His thoughts were filled with worries and apprehension about daily work and possibilities about doing mistakes while working. Cognitive functions were

intact. Insight was good; judgement was intact.

Diagnosis: Generalised anxiety disorder

ICD-10 Criteria:

1. Anxiety symptoms should be generalized, persistent and not restricted to particular situation (.i.e. free floating).
2. Continuous feelings of nervousness, trembling, muscular tension, sweating, light headedness, palpitations, dizziness, epigastric discomfort.
3. Primary symptoms of anxiety for most of the days for at least 6 months associated with
   a. Apprehension.
   b. Motor tension.
   c. Autonomic hyperactivity.

Why this diagnosis?

1. Constant worries throughout the day for daily work and feeling apprehensive about it.
2. Preplanning daily work, worries that he would do mistakes which can cause embarrassment to him.
3. Constant worries would lead to reduced concentration resulting in some minor mistakes triggering autonomic symptoms and apprehension which would last for 20-30 minutes.
4. Inability to relax throughout the day which suggests that anxiety symptoms are present for most of the days.
5. Duration of symptoms for 2 years

   Considering points 1 to 5 the diagnosis is made.

Whether patient needs inpatient care?

No, the disorder is not a serious mental illness and patient can take care of self, he has good insight.

Goals in the management:

1. Symptom improvement.
2. Addressing cognitive distortions.
3. Medication compliance.

Treatment:

Psychotherapy:

1 Cognitive Behavioural Therapy: cognitive errors like I do mistakes while working and this leads to embarrassment are addressed.

2 Relaxation exercises.

3 Biofeedback.

Pharmacotherapy:

1. SSRI (Escitalopram, Paroxetine, Sertraline) are preferred agents for the treatment.
2. SNRI (Venlafaxine, Desvenlafaxine), Tricyclic antidepressants (Amitriptyline, Nortriptyline, Dotheipin) are also used.
3. Short term treatment with benzodiazepines (Clonazepam, Alprazolam, Etizolam) or Beta blockers (Propranolol) helps.
4. Duration of treatment is generally 12 months.

Differential diagnosis:

1. Substance intoxication: anxiety symptoms are due to substance intoxication. When person is out of intoxication, symptoms subside.

2. Substance induced: substance is the etiological factor for production of symptoms.
3. Medications: medications are the etiological factors for the production of symptoms.
4. Panic disorder: here patient experiences episodes of panic attacks with inter episode normalcy and anticipatory anxiety, where as in GAD, the anxiety is free floating.
5. OCD: in OCD anxiety occurs due to obsessions, whereas in GAD anxiety is free floating.
6. PTSD: here anxiety occurs when traumatic memories are recollected.

Case 36

A 20 year unmarried male pursuing BBA hailing from urban background belonging to middle socio-economic status, accompanied by his mother took consultation from psychiatrist for repeated thoughts in the mind from the past 6 months.

Patient had a fight with classmates 6 months back, during the fight he was scolded with filthy words; he was abused that he is a dirty person with dirty mind. Since then the thoughts that he is a dirty person were intruding his mind repeatedly, which made him feel uneasy and caused lot of distress to him. He could not concentrate while studying as the thoughts were repeatedly coming to his mind. He tried to resist and distract himself by involving into games, listening to music or watching TV but he could not succeed in it. He knew that such thoughts are senseless and consume lot of time. To reduce the distress due to repeated thoughts he chanted God's name which made him feel better, but this was temporary and again he felt uneasy. As the days passed, repetitive thoughts increased in frequency, they were intruding in each and every activity he did.

He admits that when he went to washroom, while taking mug, if he had repetitive thought, then he would keep the mug back, chant God's name and then lift the mug, because of repetitive acts it would take more than 30 minutes to come out. Thoughts disturbed him in each and every activity he did. He could not concentrate while studying and performance in exams reduced drastically. This made him to seek psychiatry consultation.

Patient denied having low mood, sleep problem or use of substances.

On mental status examination, he was found to be ambiguous while sitting; he was repeating the statements many times. He appeared anxious during the interview. Reported of distressing thoughts and repeated actions. No perceptual disturbances were seen. Cognitive function

tests were normal. Insight was good. Personal judgement was impaired, social and test judgements were intact.

Diagnosis: Obsessive compulsive disorder, mixed type

ICD-10 Criteria:

a. Individual recognises that the thoughts are of his own.

b. Unsuccessful resistance of the thoughts by the individual.

c. Thoughts of carrying out the acts should not in itself be pleasurable.

d. Thoughts are unpleasant and are repetitive.

e. Duration: 2 weeks.

Why this diagnosis?

1. Repetitive thoughts from 6 months.
2. Thoughts started following fight with classmates.
3. Thoughts were repetitive, irresistible, anxiety provoking, senseless and ego dystonic.
4. Thoughts made him feel uneasy and were distressing to him this suggests that thoughts were provoking anxiety in him, to reduce the anxiety he tried to resist and distracted himself by involving into games, listening to music, watching TV and chanting God's name.
5. Thoughts were senseless and consumed lot of time.
6. He tried to resist the thoughts as they were time consuming, but could not do it.
7. He could identify the thoughts as irresistible suggests that thoughts were appearing against his will .i.e. ego dystonic.
8. Repetitive acts to like chanting God's name, keeping the mug back and lifting it again after chanting God' name suggests compulsive behaviour.

Whether patient needs in patient care?

Yes (Optional, based on severity) as patient is having significant distress due to symptoms, he is spending lot of time in carrying out rituals. Drug therapy and psychotherapy can be better monitored in an in-patient setting.

Goals in the management:

1. Symptom improvement.
2. Preventing recurrence of symptoms.
3. Medication compliance.
4. Patient to be taught about anticipation and management of stress as it can exacerbate symptoms.
5. Reducing morbidity and disability in long term.

Treatment:

Psychological:

1. Psycho-education about the illness to the patient and family members, course, prognosis, need for treatment should be discussed.
2. Exposure and response prevention: the patient and the therapist discuss and grade the anxiety producing stimulus (ex: dirt) from least to most. Relaxation techniques are taught to the patient. Then patient is exposed to least anxiety producing stimulus like

imagination of dirt in mind this produces anxiety in him then he thinks of performing the compulsion that is for example washing (.i.e. response), which is prevented. The anxiety that is produced by preventing the response is alleviated by advising relaxation exercises.

3. Cognitive Behaviour Therapy: cognitive errors for example where person thinks that if he does not act on the thoughts then his beloved person would meet with catastrophic event are addressed.

Pharmacological:

1. Among tricyclic antidepressants Clomipramine (75-250 mg/day) was the first drug which was approved by FDA for the treatment of OCD. SSRI (Escitalopram, Fluoxetine, Sertraline, Fluoxamine, Paroxetine) are used in the treatment. In OCD drug dosage is higher compared to antidepressant dosage.
2. Antipsychotics like Risperidone and Aripiprazole in small doses are used as augmenting agents.
3. Benzodiazepines like Clonazepam, Lithium, Buspirone can also be used as augmenting agents.

Definitions and facts:

Obsessions: they can be **ideas, images or impulse.**

1. They are **repetitive, intrusive and irrational.**
2. Anxiety provoking,
3. They appear even when person tries to resist them,
4. They appear against the will of the person.

Compulsions: these are repetitive behaviours performed by the individual to reduce the anxiety generated by obsessions. They are of 2 types: **mental, motor.**

Ruminations: repetitive thoughts over neutral thought. Ex: why the sky is blue?

PANDAS: Paediatric Autoimmune Neuro-psychiatric Disorder Associated with Streptococcal infections. This disorder occurs in children who suffer from group A-β haemolytic streptococcal infection.

Suchi bai syndrome: excessive concern about cleaning seen in women

Most common obsession these days: obsession of dirt.

Most common obsession olden days: obsession of sex.

Differential diagnosis:

1. OCD due to medical conditions: secondary to neurological illness
2. Medication induced: medications like olanzapine and clozapine have been implicated in inducing and aggravating OC symptoms.

3. Body dysmorphophobia: here patient has repeated thoughts about a particular body part that it is dysmorphic with other body parts. While in OCD patient has many obsessions.
4. Trichotillomania: it is an impulse control disorder where the person gets repeated impulse to pluck own body hairs.
5. Delusional disorder: here patient get repeated thoughts about the delusional belief and insight is poor, while in OCD insight is good and it has many obsessions.

Case 37

A 20 year old unmarried female with education up to PUC who works in a departmental store from semi-urban background belonging to middle socio-economic status was brought to the OPD by a Police officer accompanied by her mother for her mental health check up.

The patient was sexually assaulted in the morning. She was frightened and shaken by the event. She was screaming during the traumatic event, in two minutes she felt numb for the surrounding, she could not understand what was going on around her. She could neither feel fear nor the pain. She had a harrowing experience. She did not get to know when the person fled away. She was woken up by people walking near the farm. She says since then she is feeling fearful and could not speak anything, as the time passed from past 1 hour she is able to say few words, she feels angry towards the man and said he should have a miserable death.

She denied having hopelessness and suicidal ideation.

There is no past history of any psychiatric illness and denied substance use.

On mental status examination, she appeared tired; she was sweating, trembling and tears were rolling down from eyes. She said she is feeling fearful and sad. Thoughts were preoccupied about the event, she had experienced derealisation phenomenon during the event. Cognitive functions were normal. Insight was good.

Diagnosis: Acute stress reaction

ICD-10 Criteria:

a. Mixed and usually changing picture, initial state of daze, depression, anxiety, anger, despair, over activity, withdrawal, but none of the symptom predominates for long time.
b. Resolves rapidly (within few hours) if the person is removed from the stressful situation. If stressful situation continues, then symptoms diminish after 24-48 hours and are minimal after 3 days.

There must be an immediate and clear temporal connection between

catastrophic/exceptional stressor and onset symptoms. Onset is within few minutes.

Why this diagnosis?

1. The lady had experienced catastrophic event of sexual assault.
2. Feeling fearful, frightening experience, screaming suggests anxiety symptoms.
3. Feeling numb for surrounding, not understanding what is happening around her, neither feeling fear nor pain, suggests acute reaction to the situation.
4. Being fearful after she is woken up by the people is an emotional reaction of the patient.
5. Reduction of symptoms suggests that symptoms were resolving.

Whether patient needs inpatient care?

Yes, until patient recovers psychologically.

Goals in the management:

1. Symptom improvement.
2. Prevent development of PTSD.

Treatment:

Psychosocial treatment:

1. Crisis intervention.
2. Removing the patient from the site of trauma.
3. Supportive psychotherapy.
4. Debriefing technique: encouraging the patient to speak about the traumatic event.

Pharmacological treatment: Treatment with benzodiazepines (Clonazepam, Alprazolam, Etizolam) and beta blockers (Propranolol) helps during the acute phase.

Differential diagnosis:

1. Medical conditions: in head injury person may experience confusion and daze.
2. Substance intoxication: when person is intoxicated, it may present with changing picture similar to acute stress reaction.
3. Seizure disorder: when person experiences convulsions, the symptoms may mimic that of acute stress reaction.

Case 38

A 30 year old unmarried man educated till BSc, working in dairy farming from urban background, belonging to middle socio-economic status presented to psychiatry OPD with complaints that he is feeling upset from the past 2 months after he witnessed his mother committing suicide by burning herself.

He described the event as too terrible; though he was there at the site of event he could not help his mother to survive. He is feeling guilty about the same. Frequently he gets reminded of the event, which creates such an intense emotion in him that he would become numb to the surroundings. While sleeping he would get dreams about the same event, which would wake him up in a terrified manner, due to

this he was finding difficulty in falling asleep. He avoided match sticks, fire lighter and seeing fire in live or in television, as it would remind him of the event. He had changed home to reduce getting reminded of the event.

He denied depressive symptoms, suicidal ideations, substance abuse and past psychiatric illness.

On mental status examination, he appeared well kempt, eye to eye contact was made and sustained, psychomotor activity was normal, speech was normal, he described mood as normal except related to those memories. Thought content consisted of repeated recollection of disturbing thoughts surrounding the event. Perceptual disturbances were absent. Cognitive function tests were normal. Insight was good and judgement was intact.

Diagnosis: Post traumatic stress disorder

ICD-10 diagnostic symptoms:

1. Traumatic event of exceptional severity/ catastrophic event.
2. Flashbacks: recurrent intrusive memories.
3. Sense of numbness, emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, avoidance of activities and situations reminiscent of the trauma.
4. Fear and avoidance activities, situations and cues that remind traumatic events.
5. Autonomic hyperarousal with hyper vigilance.
6. Enhanced startle response.
7. Insomnia.
8. Anxiety and depressive symptoms can be seen.
9. Latency period for onset of symptoms: few weeks to 6 months.

Why this diagnosis?

1. Witnessing catastrophic event.
2. Frequent recollection of the event.
3. Getting numb to surroundings due to recollection of the traumatic memories.
4. Terrible dreams about the event.
5. Insomnia due to terrible dreams.
6. Avoiding match sticks, fire lighter, seeing fire in live or in television. Changing the home to reduce getting reminded of the event.
7. Onset of symptoms within 6 months (.i.e. 2 months in this case).

   Points from 1 to 7 suggest post traumatic stress disorder in him.

Whether patient needs inpatient care?

No, patient does not have suicidal thoughts; he is able to manage himself and carry out daily activities and insight is good.

Goals in the management:

1. Symptom improvement.
2. Management of suicidal ideations if present.
3. Improving psycho-social support.
4. Improving quality of life.
5. Medication compliance.

Treatment:

Psychosocial therapy:

1. Eye Movement Desensitization and Reprocessing: The person is encouraged to recollect the distressing traumatic memories, during recollection the therapist uses hand motion technique to guide the person's eye from side to side.
2. Cognitive Behaviour Therapy: It explores traumatic memories, helps the person to cognitively process the traumatic memories and relive stress associated with them through cognitive restructuring.

Pharmacological:

1. Selective Serotonin Reuptake Inhibitors (SSRI) like Escitalopram, Fluoxetine, Paroxetine, Sertraline, and Serotonin Norepinephrine Reuptake Inhibitors (SNRI) like Venlafaxine, Desvenlafaxine used in the treatment in reduce re-experiencing the symptoms, avoidance, emotional numbing and hyper-arousal. Antidepressants are started at low doses and dose titration is done based on clinical response and side effect tolerability. It takes around 2 weeks for the antidepressants to show their effects.
2. Benzodiazepines (Clonazepam, Alprazolam) used for short duration for treating anxiety symptoms and sleep disturbance.

Definitions and facts:

After Vietnam War, the term Post Traumatic Stress Disorder was coined.

Post-traumatic stress disorder: it is a disorder that occurs when a person witnesses or experiences catastrophic event. Catastrophic events can be war situations, sexual assaults, facing life threatening situations, experiencing torture etc.

Differential diagnosis:

1. Adjustment disorder: the person develops psychological symptoms due to stress that is not catastrophic. Adjustment disorder develops within 1 month of stress and resolves by 6 months.
2. Prolonged grief reaction: it is person's response to loss of loved once, but symptoms last for more than 6 months.
3. Acute and transient psychotic disorder: it can develop following stress, but resolves by 1 month; it has psychotic features unlike PTSD.

Case 39

A 31 year old married male with education up to BCA, working in office, from urban background from middle socio-economic status came to psychiatry OPD with wife and two year old kid. He complained of sadness from past 1 month. He told doctor that he was unable to work with full efficiency in office like before and he had to avail many sick leaves. He reported of sleep disturbances and worries related to his son's health and future of the family.

Patient reported that his son was diagnosed with congenital heart disease 1 month back; it needed surgical intervention. He was finding it difficult to arrange the finances for the same.

Patient denied substance use and past psychiatric illness.

Patient cried during interview, psychomotor activity was normal, he described mood as sad, and appeared depressed, his thoughts were preoccupied with worries about son's illness and regarding operation. No perceptual disturbances were seen, cognitive function tests were normal. Insight was good and judgements were intact.

Diagnosis: Adjustment disorder; Brief depressive reaction

ICD-10 Diagnostic features:

1. Presence of stressful situation or event.
2. Manifestation varies and can be in the form of depressed mood, anxiety, worry, inability to cope, plan a head.
3. Manifestation can be in the form of conduct disorder in children or regressive phenomenon like return to bed-wetting, babyish speech and thumb sucking.
4. Onset is within 1 month of symptom onset and does not exceed 6 months.

Why this diagnosis?

1. Presence of stressful situation .i.e. his son getting diagnosed with congenital heart disease.
2. Patient feeling sad about it, inability to work with full efficiency in office, availing many sick leaves suggests depressive reaction to the stressful event.
3. Onset of symptoms within 1 month of the stressful situation.
4. If his son is treated then person's depressive symptoms might resolve.

Whether patient needs inpatient care?

No, patient can take care of self, he has good insight and he has no suicidal thoughts.

Goals in the management:

1. Symptom improvement.
2. Stress management and improve coping skills

Treatment:

Psychotherapy:

1. Supportive psychotherapy.
2. Relaxation exercises which helps in controlling anxiety symptoms.
3. Sleep hygiene techniques.
4. Stress management skills.

Pharmacotherapy:

1. SSRIs are preferred antidepressants.
2. Tricyclic antidepressants along with improving mood gives good sleep to the patient but have anticholinergic side effects and weight gain can be seen.
3. Benzodiazepines (Clonazepam) for short term can be used to treat sleep disturbances.
4. Duration of treatment is for 6 months.

Differential diagnosis:

1. Substance induced: here depression occurs due to use of substance.
2. Acute stress reaction
3. Post-traumatic stress disorder

Case 40

A 15 year old girl studying in 9th standard from semi-urban background belonging to middle socio-economic status, staying in hostel was brought for psychiatry consultation by her mother with episodes of un-responsiveness, movements of upper and lower limbs from last 1 month.

Patient is experiencing unresponsive episodes one to two times in a day. During the episodes initially she experiences giddiness and she slowly lies down on floor and then closes her eyes, there would be movements of upper and lower limbs in the form of folding and unfolding/ flexion and extension. Such movements would last for ten to fifteen minutes. Her mother reports that during the episode people would gather around her, give iron rod to hold and sprinkle water on face, but she would not respond. After stoppage of movements she would drink water or milk without any discomfort. Such episodes occurred whenever she was in the class room.

During the episode there was no tongue bite, injuries and involuntary passage of urine or faeces. No confusion after the episode.

When first such episode occurred in classroom, she was taken to hospital where she was treated with injections and other medications with which she improved. Such episodes kept recurring every day; and she was sent back home each time. From last 3 weeks she is not going to school. At home she never experienced such episodes, 2 days back she was told to get ready for going to school, the episode recurred and she was brought for consultation.

Patient reports that she was not willing to be in hostel, but she was forcefully sent to boarding school. At school she is unable to make new friends and feels lonely. She adds that one of her friends in the school had fits and she was sent home.

Patient had no history of low mood, substance use.

On mental status examination she appeared well dressed and kempt, co-operative for interview, eye to eye contact was made and sustained. Psychomotor activity and speech was normal, she appeared euthymic and thought content was filled with her unwillingness to be in hostel, inability to make new friends and feeling lonely. Cognitive functions were normal. Insight was partial.

Diagnosis: Dissociative convulsions

ICD-10 criteria:

a. Clinical features suggestive of pseudo-seizures.
b. No evidence of a physical disorder that explains symptoms.
c. Presence of psychologically stressful event with clear temporal association between symptom onset and stressful event.

Why this diagnosis?

1. During the episode, the patient experiences giddiness, slowly lies down on floor, closes her eyes, then there would be movements of upper and lower limbs in the form of folding and unfolding for 10 to 15 minutes. After movements stop she would drink water immediately if offered. This suggests that there was no confusion after the episode.
2. Episodes occurred whenever people were around her like in class room.
3. No tongue bite, involuntary passage of urine or faeces during the episode.
4. Points 1 to 3 suggest that the episodes are pseudo-seizures.
5. When she was in home the episodes did not occur and when she was made to get ready for school the episodes recurred.
6. Stress in the form of unwillingness to stay in hostel was present.
7. Temporal correlation between onset of symptoms and stressful situation is present.

Whether patient needs inpatient care?

Yes, as resolution of dissociative episodes is important as she is not attending school due to the disorder.

Goals in the management:

1. Abolishing the episodes.
2. Stress management.
3. Improve coping skills.

Treatment:

Psychological:

1. Family members should be convinced that patients do not fake/ feign the symptoms
2. Psycho-education about the illness to the family members that the symptoms occur due to psychological reasons.

3. Patient should be taught stress coping strategies, problem solving skills, social skills.
4. ABC analysis: It is antecedent, behaviour, consequence analysis. This is to analyse the antecedent events that give rise to the episodes, the behaviour arising out it and the consequent actions of the behaviour. With ABC analysis the sequence of the events leading to the dissociative episode should be broken down. Whenever the patient develops the episode the family members should neglect the patient's behaviour so that the primary and secondary gain that the patient takes will come down and once the patient learns that they are not getting gains the behaviour reduces.
5. Though use of aversive agents brings in temporary relief it will not help in resolution of the primary problem.
6. Supportive psychotherapy.

Definitions and facts:

Dissociation: It is a type of immature ego defence mechanism, which involves segregation of psychic activity from rest mental processes.

La belle indifference: In dissociative disorder, the patient in spite of having morbidity due to the disorder they are not concerned about it.

Serum prolactin is elevated following true seizures for 20 min. This helps in differentiating pseudo seizures from true seizures.

Differential diagnosis:

1. Seizure disorder: it is characterised by presence of same pattern of limb movements in every episode, it can occur at any place. During the episode tongue bite is on lateral aspect. Post ictal confusion is seen. Patient does not remember the episode and duration is for 30-60 sec.

   Three hard signs to differentiate true seizures from pseudo seizures during the episode are - Corneal reflex, gag reflex plantar reflex
2. Substance withdrawal seizures: evidence of substance use and withdrawal is present and during withdrawal phase the individual experiences seizures.
3. Trans and possession disorder: here the patient gets possessed with spirits and during the episode convulsive movements are not seen.

Case 41

A 36 years old married lady educated till high school, homemaker from urban background belonging to middle socio-economic status, was referred to psychiatry OPD by a neurologist.

The patient had presented with sudden onset of weakness in right lower limb, swaying while walking from 1 week. Patient had been to neurology clinic where with clinical examination and investigations ruled out organic cause for her symptoms.

Patient is experiencing such episodes from 1 week. She gets sudden weakness of right lower limb and sways while walking, seeing this her family members come to help her, they hold and support her while walking, if she is doing any work she would be told to take rest. Such episodes occur when many family members have gathered, it never occurred when she was alone. While walking due to swaying she has never fallen down, instead she holds and takes support. From 1 week she is not doing any household work.

Patient says that she heard some news about her husband who works in Dubai has married another woman and since then whenever she made a phone call to him, he has not received it. This has made her worry. She keeps thinking about the future of her 3 kids and herself.

On mental status examination, patient was well dressed and kempt, co-operative for interview, eye to eye contact was made and sustained, psychomotor activity and speech was normal, mood she said is tensed. Thought content consisted of worries about her husband having married another woman and about the future of her kids and herself. No perceptual disturbances were seen, cognition was normal. Insight was good and social judgement was impaired.

On examination she had astasia-abasia gait.

Diagnosis: Dissociative motor disorder

ICD-10 criteria:

a. Clinical feature of dissociative motor disorders are inability to move a whole or part of a limb or limbs, paralysis can be partial or complete, bizarre gait/ inability to walk (astasia- abasia gait).

b. No evidence of physical disorder.

c. Presence of psychological stress, with clear temporal association between psychological stress and symptom onset.

Why this diagnosis?

1. Weakness of right lower limb from 1 week.
2. Clinical examination and investigations had ruled out organic causes for the same.
3. Receiving the news about the husband who works in Dubai that he has married another woman and not receiving patient's phone since 1 week clearly suggests presence of

psychological stress and gives link between onset of psychological stress and onset of weakness of her limbs.

4. Patient had worries but there was no loss of interest in doing daily activities, no easy fatigability no sadness about the event, her symptoms were not at disorder level.

Whether patient needs inpatient care?

Yes, as resolution of dissociative episodes is important because due to the disorder she is unable to function well in the family, it has also caused significant impairment in family functioning.

Goals in the management:

1. Abolishing symptom.
2. Stress management.
3. Improving coping skills

Definitions and facts:

Astasia-abasia gait: it is the bizarre gait that is seen in dissociative motor disorder where patient has inability to stand and walk with good motor co-ordination as a result they sway, but never fall down like in ataxia instead take support of nearby objects, it has no underlying organic cause.

Treatment:

Psychological:

1. Ventilation
2. Family members should be convinced that patients do not fake/ feign the symptoms.
3. Psycho-education about the illness to the family members and the patient
4. Patient should be taught coping strategies, problem solving skills.
5. ABC analysis.
6. Supportive psychotherapy.

Differential diagnosis:

1. Neurological illness: Neurological illnesses that produce similar symptoms should be ruled out before making the diagnosis of dissociative motor disorder.
2. Malingering: here patient feigns symptoms for gains like availing sick leaves.

Case 42

A 40 year old married lady, illiterate from rural background, belonging to middle socio-economic status, was admitted to medicine ward with complaints of cold and cough from 2 days. At night an emergency psychiatry referral was requested to examine the patient as she was screaming in the ward. Patient was given clonazepam tablet to calm down, by the time psychiatrist reached the ward to examine the patient.

Patient's son who was around 20 years old was with her to take care of her. He described that she started screaming suddenly saying that Goddess "Kali" has

entered her body. She was so much agitated that even five people could not control her. She was scolding her husband, she was telling that he has done a mistake and he should beg pardon, as Goddess "Kali" is angry with him and if he does not then Goddess would punish so that his life would be miserable and he would start begging. Listening to the frightening words, her husband fell on her feet and begged to pardon him.

On interview it was found out that her husband had fought with her parents one month back, since then her parents have not visited her home, spoken to her and she was tensed about it. They had come to see her in the hospital that evening. Screaming episode started in ten minutes once her parents left the ward. She denied having continuous sadness and substance abuse.

Diagnosis: Trans and possession disorder

ICD-10 diagnostic features:

1. Clinical features of Trans and possession.
2. No evidence of physical disorder.
3. Presence of psychological stress, with clear temporal association between psychological stress and symptom onset.

Why this diagnosis?

1. Patient has an episode where she screamed suddenly saying that goddess "kali" has entered her body, scolding her husband telling him to beg pardon for the mistake he has done. During the episode she said that "kali" is angry on him and if he does not beg for pardoning, he would be punished and his life would be miserable and he would start begging. During the episode even 5 people could not control him. This is the Trans and possession episode she had experienced.
2. Her husband had fought with her parents 1 month back and patient's parents did not speak or visit her home since then, this was the psychological stress she was experiencing.
3. No physical cause to explain the symptoms.

Whether patient needs inpatient care?

Yes, psychiatric in patient care is necessary for resolution of possession attacks as it had caused disturbance to other patients in ward and family dysfunction

Goals in the management:

1. Abolishing episodes.
2. Stress management and improve coping skills

Treatment:

Psychological:

1. Determining the underlying causative stress factor and relieving it.
2. Psychoeducation to family members about the disorder and management plan
3. Patient should be taught coping strategies, problem solving skills

4. ABC analysis.
5. Supportive psychotherapy.

Definition:

Trans and possession disorder: It is a disorder in which there is temporary loss of both sense of personal identity and full awareness of the surroundings, the individual may act as if taken over by another personality, spirit, deity or force.

Differential diagnosis: seizure disorder

Case 43

A 35 year old married women with education till high school, home maker, from rural background, belonging to low socio-economic status, came to psychiatry OPD accompanied by mother. She was referred by physician to whom she presented with chronic multiple bodily symptoms. Physical examination and investigations were nil significant.

She presented with five years history of pain in the head, neck, hands and limbs, which is of mild aching type which aggravates on working and reduces in severity with rest. She even experienced on and off back pain, breathlessness, racing heart beats, burning pain in the middle of the chest. She tells she is unable to tolerate food these days; many times she has experienced alternating constipation and diarrhoea. She reports irregular menses. For these complaints she has consulted Orthopaedician, Neurologist, and physician at different times. Detailed evaluation and investigations suggested that there was no underlying physical aetiology which could explain her symptoms. She has taken treatment from Ayurvedic, homeopathic doctors also. Though whenever she took treatment there would be temporary relief of symptoms, but in few days the symptoms would reappear.

On further questioning she says that her husband consumes alcohol and he does not take up the responsibility of the family and she is not receiving any support from her parents and in- laws, which is worrying her.

She denied having low mood and substance abuse.

On mental status examination, she appeared well dressed and kempt. She sat on chair without making much movement, wincing whenever she touched body parts while explaining symptoms. She was elaborately giving the explanations on physical symptoms. Speech was normal, she appeared euthymic. Thought content was filled with preoccupation about the physical symptoms. Cognitive function tests were normal. She had good insight and judgements were intact.

Diagnosis: Somatization disorder

ICD-10 criteria:

a. 2 years of illness characterised by multiple variable physical symptoms for which no adequate physical explanation has been found out.

b. Persistent refusal to accept the advice and reassurance by several doctors that there is no physical explanation for the symptoms.

c. Impairment of social and family functioning due to symptoms.

Why this diagnosis?

1. Multiple variable physical symptoms.
2. She consulted Orthopaedician, Neurologist and Physician at different times. Detailed evaluation and investigations by different specialists did not find any physical aetiology/ cause of physical symptoms.
3. Treatment from different disciplines of medicines could relieve her symptoms only temporarily.
4. She was facing a psychological stress that her husband was consuming alcohol and was not taking care of the family with no support from parents.
5. Duration of illness was for 5 years.

Whether patient needs inpatient care?

No, as she does not have suicidal ideation and insight is good.

Goals in the management:

1. Establishing a good rapport. Listening to patient's complaints and brief relevant physical examination.
2. Avoid unnecessary laboratory investigations.
3. Reduce stress associated with somatic symptoms.
4. Symptom reduction.
5. Stress management.
6. Addressing compliance.
7. Improving quality of life.

Treatment of somatisation disorder:

Psychosocial therapy:

1. Validate patient's symptoms.
2. Psycho-education about the illness and its course; convince that symptoms are due to mental stress.
3. Reattribution therapy: The patient is encouraged to identify the stressor and reattribute the physical symptoms to stress.
4. Stress management technique.
5. Coping strategies.
6. Relaxation exercises.
7. Biofeedback.
8. Cognitive behavioural therapy.
9. Supportive psychotherapy.

Pharmacological:

Tricyclic antidepressants (Amitriptyline, Imipramine, Nortriptyline, Dotheipin) and SNRI (Venlafaxine, Desvenlafaxine, Duloxetine) are used in this disorder, they improve both mood symptoms and physical pain symptoms.

Other name: Briquet's syndrome.

Differential diagnosis:

1. Medical conditions: medical conditions that produce somatic symptoms should be ruled out.
2. Depression: This can also present with somatic complaints.

Case 44

A 43 year old married female, illiterate, home maker from rural background belonging to low socio-economic status was accompanied by her husband and was referred to psychiatry OPD by orthopaedic department reporting that she had multiple varying physical symptoms.

Patient says that she has pain in hands and legs, back pain, difficulty in swallowing, pain in neck which was non-radiating and sometimes burning and sometimes pulling type from 6 months. She has been consulting the local general practitioner and after evaluation and investigations, no cause was found to explain her symptoms. Pain killers were prescribed to her which gave only temporary relief but as symptoms persisted, she consulted orthopaedic surgeon, whose examination and investigations were within normal limits and this was conveyed to her, but patient was not convinced with this. She requested for higher level investigations. Patient was convinced to meet a psychiatrist.

On interviewing it was found that patient's son was in love with a girl of another caste, he was forcing the family members to accept their relationship; this issue was worrying her. She denied low mood, anxiety symptoms and substance abuse.

On mental status examination she appeared well kempt with good eye to eye contact and she was co-operative for interview. She winced due to pain while talking. Psychomotor activity and speech was normal, she appeared euthymic. She was preoccupied with somatic symptoms and worries about her son's relationship. No perceptual distortions were seen. Cognitive functions were normal. Insight was good. Personal, social and test judgement were intact.

No significant abnormalities were detected on physical examination.

Diagnosis: Undifferentiated somatoform disorder

ICD-10 criteria:

1. Multiple variable physical symptoms, but complete and typical clinical picture of somatisation disorder is not fulfilled.
2. No physical basis for the symptoms.
3. Associated with psychological stress.
4. Duration: 6 months

Why this diagnosis?

1. Multiple varying physical symptoms.
2. She was consulting local general care physician for same, evaluation and investigation had revealed no cause for her symptoms.
3. Pain killer medicines gave temporary relief with persistence of symptoms.
4. Even orthopaedic consultation revealed that evaluation and investigations were normal.
5. Presence of psychological stress that her son is in love with a girl of another caste and was forcing family members to accept their relationship.

6. Illness duration of 6 months.

Considering the points from 1 to 6 the diagnosis is made.

Whether patient needs inpatient care?

No, as she does not have suicidal ideation and insight is good.

Goals in the management:

1. Avoid unnecessary laboratory investigations.
2. Validate the symptoms.
3. Reduce stress associated with somatic symptoms.
4. Symptom reduction.
5. Stress management.
6. Medication compliance.

Treatment:

Psychosocial therapy:

1. Validate patient's symptoms.
2. Psycho-education about the illness and its course; convince that symptoms are due to mental stress.
3. Reattribution therapy: The patient is encouraged to identify the stressor and reattribute the physical symptoms to stress.
4. Stress management technique.
5. Coping strategies.
6. Relaxation exercises.
7. Cognitive behavioural therapy.
8. Supportive psychotherapy.

Pharmacological:

Tricyclic antidepressants (Amitriptyline, Imipramine, Nortriptyline, Dotheipin) and SNRI (Venlafaxine, Desvenlafaxine, Duloxetine) are used in this disorder, they improve both mood symptoms and physical pain symptoms.

Differential diagnosis:

1. Medical conditions: medical conditions that produce somatic symptoms should be ruled out.
2. Depressive disorder: depression can also present with somatic symptoms, unlike in somatization disorder where varying multiple somatic symptoms, consultation to multiple doctors of different specialty, refusal to accept the fact that there is no underlying physical explanation to the symptoms and repeated requests for investigations to find out the causative factor are seen.
3. Hypochondriasis: patient presents with multiple somatic symptoms which he attributes to presence of serious underlying illness.
4. Anxiety disorder: patient with anxiety disorder may have somatic symptoms, but the main presenting feature is fear and apprehension.

Case 45

A 30 year old married male patient with B.Com education working in general stores from urban background had been to physician's OPD with six months history of coughing, breathlessness, tiredness, generalised weakness, inability to work. He attributed these symptoms to tuberculosis and told the physician that he might be suffering from tuberculosis and he must be investigated for the same. He was thoroughly investigated and no evidence for tuberculosis was found in him. But he insisted that further investigations have to be carried out to find tuberculosis in him. Even after repeated reassurances from several doctors he was not convinced, later he was referred to a psychiatrist.

No history of low mood, anxiety symptoms and substance abuse was seen.

On mental status examination, he appeared well dressed and kempt. Co-operative for interview, psychomotor activity was normal, he appeared anxious; he gave elaborative explanations about his symptoms and their connection with tuberculosis. He still wanted to rule out tuberculosis. No perceptual disturbances were seen. Insight was good. Personal, social and test judgements were intact.

Diagnosis: Hypochondriacal disorder

Definition:

a persistent pre-occupation with possibility of having one or more serious physical disorder. Patients manifest with persistent somatic complaints or persistent pre-occupation with physical disease.

ICD-10 criteria:

a. Persistent belief that one has serious physical illness for the presenting symptoms. Repeated investigations and examinations find no adequate physical explanation or persistent pre-occupation with deformity or disfigurement.
b. Persistent refusal to accept the advice and reassurance from several doctors that there is no physical illness or abnormality.

Why this diagnosis?

1. Person presented with multiple physical symptoms from 6 months, he attributed these physical symptoms to having tuberculosis.
2. Detailed examination and investigations did not find any evidence of tuberculosis in him. But he insisted for further investigations. Repeated reassurance did not convince him that he is not having tuberculosis.

Whether patient needs inpatient care?

No, as he does not have suicidal ideation and patient is able to take care of self.

Goals in the management:

1. Good therapeutic alliance.
2. Symptom reduction and improving quality of life.

3. Medication compliance.

Treatment:

Pharmacological:

1. SSRIs (Escitalopram, Sertraline, Paroxetine), SNRI (Desvenlafaxine, Duloxetine), Tricylic antidepressants are used in the treatment.
2. Short term use of benzodiazepines (clonazepam) as anxiolytic is helpful.

Psychological:

1. Reassurance to the patient.
2. Supportive psychotherapy.
3. Cognitive behaviour therapy:
4. Relaxation exercises.

Differential diagnosis:

1. Medical conditions to be ruled out
2. Depression, OCD, Delusional disorder

Case 46

A 40 year old married lady, illiterate from rural background, belonging to low socio-economic status was admitted to the medicine ward with history of burning pain in the abdomen, intermittent diarrhoea and flatulence. Symptoms present for more than 10 years.

Patient has been consulting different doctors for the same reason, detailed evaluation and investigations done during current admission previous admissions were normal. Whenever symptomatic treatment was given the symptoms used to subside, but the patient would return back with same complaints in few days, evaluation and investigations at every visit would be normal. When patient was told that physically everything was alright and no abnormality was detected, she was not getting convinced and she used insist for detailed re-evaluation. So patient was referred to psychiatry department.

When patient was interviewed it was found that she had poor interpersonal relationship with son, her son was not showing interest in studies and was not attending college regularly, was leading life lavishly, while her husband had to work hard for maintaining the family. She was worried about the same. Worries often caused symptoms like sweating, palpitations, tremors for 10-15 minutes.

She denied having low mood, anxiety symptoms and substance abuse.

On mental status examination she was sitting comfortably on chair, she was giving an elaborative explanation about symptoms with gestures. Psychomotor activity was normal, speech was normal, she described mood as normal. She appeared euthymic. She was preoccupied with thoughts about her abdominal symptoms. She had no perceptual distortions. Cognitive function tests were normal. Insight was good. Personal, social and tests judgements were intact.

Diagnosis: Somatoform autonomic dysfunction of upper and lower gastrointestinal tract

ICD-10 criteria:

a. Persistent and troublesome symptoms of autonomic arousal are present.

b. Additional subjective symptoms referred to specific organ or system.

c. Pre-occupation with and distress about the possibility of a serious disorder of the stated organ or system, which does not respond to repeated reassurance by the doctors.

d. No evidence of significant disturbance of structure or function of the stated organ.

Why this diagnosis?

1. Symptoms of autonomic arousal are present.
2. Subjective symptoms of upper and lower GI tract are present.
3. Repeated evaluation and examination, reassurance did not convince the patient that there is no underlying physical abnormality.
4. Presence of psychological stress.

Whether patient needs inpatient care?

No, as he does not have suicidal ideation, insight is good and judgement is intact.

Goals in the management:

1. Good therapeutic alliance.
2. Symptom reduction.
3. Medication compliance and improving quality of life.

Treatment:

Psychological:

1. Validate the symptoms.
2. Psychoeducation about the illness, explaining the cause that stress can lead to such symptoms.
3. Supportive psychotherapy.
4. Reattribution therapy.
5. Stress management & relaxation exercises.

Pharmacotherapy:

1. Tricyclic antidepressants or Dosulepin.

Differential diagnosis:

1. Medical conditions: medical conditions, substances and medications can cause this.
2. Somatization disorder: here patient has symptoms involving many organ systems
3. Hypochondriasis: patient presents with symptoms which he attributes to presence of a serious underlying illness.
4. Panic disorder

Case 47

A 30 year old married lady with primary school education, home maker from rural background belonging to low socio-economic status presents with pain in the head and neck region from 3 years. It was of insidious onset, she could not recollect how the pain started. The pain is severe burning type, present throughout the head, radiating to neck, it had no aggravating and reliving factors. She was unable to do household work and function well in the society like before. She had consulted different doctors for the same reason; detailed work up did not find any cause which would be attributed to the pain.

She gives history that her husband has a loan of 10 lac rupees, loan collectors keep visiting the home and scolds them which was worrying her.

On mental status examination she was conscious, co-operative for interview, she maintained good eye contact. She was euthymic. Thought stream and form were normal. She was preoccupied with the pain symptom and did not harbour delusions, suicidal ideation. No perceptual distortions were elicited. Cognitive functions were normal. Insight was good. Judgements were intact.

Diagnosis: Persistent somatoform disorder

ICD-10 diagnostic features:

1. Predominant complaint is of persistent, severe, distressing pain that cannot be explained by a physical disorder.
2. Psychological stress has causative influence on the physical pain.
3. Persistent refusal to accept the fact that there is no underlying physical abnormality.

Why this diagnosis?

1. Predominant complaint of severe burning type of headache, which was persistent and distressing.
2. The pain was causing social and occupational dysfunction.
3. Psychological stress that of loan.
4. Persistent refusal to accept the fact that there is no physical illness for the pain.

Whether patient needs inpatient care?

No, patient does not have suicidal ideation, insight is good and judgment is intact.

Goals in the management:

1. Good therapeutic alliance.
2. Symptom reduction.
3. Stress management.
4. Addressing compliance and improving quality of life.

Treatment:

Psychological:

1. Psychoeducation to patient and family

members that symptoms are related to stress.

2. Reattribution therapy.
3. Supportive psychotherapy.
4. Stress coping strategies.
5. Relaxation exercises.
6. Biofeedback.

Pharmacotherapy:

1. Antidepressants like Desvenlafaxine, Duloxetine and Tricyclic antidepressants improve the low mood and control pain symptoms.

Differential diagnosis:

1. Medical conditions: medical conditions causing similar symptoms
2. Somatization disorder: here patient has symptoms involving many organ systems.
3. Hypochondriasis
4. Depression

Case 48

A 42 year old married lady studied up to PUC, home maker from semi urban background belonging to middle socio-economic status presented with complaints of difficulty in swallowing liquid and solid food items from the last 1year.

The difficulty was not progressive. She felt as if something is stuck in her throat as a mass. This has created the difficulty in swallowing and her food intake decreased due to this. She was taking long time to eat; she eats slowly and left much of the food in plate without eating. She was losing weight due to this. It created pain which radiated to ears and to the head. Worried about this she consulted ENT surgeons; examination of throat revealed no abnormality, patient was reassured by ENT surgeons and was referred to a Psychiatrist.

Patient's husband had an extramarital relationship which she came to know 1 year back, this was totally unacceptable to her and led to stressful environment at home.

She denied low mood, anxiety symptoms and substance use.

Diagnosis: Other somatoform disorder (Globus hystericus)

ICD-10 diagnostic features:

1. Persistent feeling that a lump is in the throat that is causing dysphagia.
2. Examination and investigations reveal no lump in the throat.
3. Refusal to accept the fact in spite of repeated reassurance.
4. Presence of psychological distress.

Why this diagnosis?

1. Patient had difficulty in swallowing solid and liquid food items from 1 year which gave the feeling that a mass is stuck in the throat; it even created a pain which was radiating to ears and head.
2. Pain created dysfunction in her.
3. Examination and reassurance by ENT surgeon that throat is normal was not satisfying to patient.
4. Presence of psychological stress that her husband has extramarital relationship.

Whether patient needs inpatient care?

No, patient does not have suicidal ideation, insight is good and judgment is intact.

Goals in the management:

1. Good therapeutic alliance.
2. Symptom reduction.
3. Stress management.
4. Addressing compliance & improving quality of life.

Treatment:

Psychological:

1. Psychoeducation about illness.
2. Supportive psychotherapy.
3. Reattribution therapy.

Pharmacotherapy:

1. SNRIs (Desvenlafaxine, Duloxetine), Tricyclic antidepressants (Amitriptyline, Imipramine, Nortriptyline, Dotheipin) are used in the treatment of this disorder.

Differential diagnosis:

1. Medical conditions: medical conditions, substances and medications which cause this problem should be ruled out.
2. Somatization disorder
3. Hypochondriacal disorder
4. Depressive disorder

Case 49

A 40 year old married woman with primary school education, home maker from urban background, belonging to middle socio-economic status, came with complaints of sleeplessness from 6 months. After retiring to bed at night around 10 PM she would find difficulty in falling asleep, it would take around 30 to 45 minutes to get sleep. Sometimes it would stretch for more than an hour. She would wake up every 2 to 3 hours for using washroom; this was usual thing for her. 6 months back, after getting up she would fall back to sleep in few minutes. From the 6 months it takes around 20 to 30 minutes to get sleep. She wakes up by 5 AM in the morning. She said she takes a nap of 1 hour in the afternoon; she is doing this since 20 years. This pattern of sleep disturbance is occurring almost every

day since past 6 months. During day time she was finding difficulty in doing work as she felt tired.

She takes mobile phone with her to bed, she frequently sees the time in it to calculate the amount of time she gets sleep. She added that whenever she didn't get good sleep, she used to spend time playing in mobile or replying to messages. From past two months she keeps worrying whether she would get good sleep or not when she is in bed this made her tense.

She denied having any stressors. She had no pervasive low mood, symptoms of anxiety, use of any substances. She consulted a local doctor who treated her with Chlorpheniramine 2mg (antihistaminic) for 1 month. Though this helped her, but did not relieve her symptoms and she consulted Psychiatrist for the same reason.

Diagnosis: Non organic insomnia

ICD-10 criteria:

a. Difficulty in falling asleep, or maintaining sleep or poor quality of sleep.

b. Sleep disturbance for at least 3 times per week for at least 1 month.

c. Pre-occupation with sleeplessness and excessive concern over its consequences at night and during the day.

d. It causes marked distress or interferes with ordinary activities in daily living.

Why this diagnosis?

1. The patient has difficulty in falling asleep and maintaining the sleep.
2. This sleep pattern is happening almost every day since past 6 months.
3. She was worried about sleep whenever she retired to bed, this suggests pre-occupation with sleeplessness.
4. Because of the problem she was unable to carry out her daily work, this suggests that it was causing interference with daily activities.
5. Other psychiatric disorders that can cause insomnia were ruled out in her.

Whether patient needs inpatient care?

No, the condition is not a serious mental disorder, patient's insight is good and judgment is intact.

Goals in the management:

1. To rule out organic causes.
2. Symptom improvement.
3. Improving quality of sleep.

Treatment:

Psychological:

1. Cognitive Behaviour Therapy: helps in overcoming distorted thoughts. The thoughts like "when I go to bed I will not get sleep" needs to be addressed.
2. Relaxation exercises: Jacobson's progressive muscle relaxation exercises, deep breathing exercise, guided imagery. They help the person in feeling relaxed, and gives good sleep.
3. Biofeedback: it reduces anxiety symptoms, apprehension, feelings of tension and helps in getting good sleep.

4. Sleep hygiene techniques:
   a. Activity scheduling for exercises and other activities.
   b. Sleep hour scheduling and maintaining regular sleep hours.
   c. Have a light meal before bedtime.
   d. Do not exercise heavily before going to bed.
   e. Do not discuss or think about stressful factors during bed time, post pone them to next day morning.
   f. Let the bed room be comfortably cool.
   g. Do not have bright light while sleeping.
   h. Bed room and the surrounding area should be quiet.
   i. Use a mosquito net.
   j. Do not take watch, mobile or other electronic devises to bed.
   k. Do not use bed for activities other than sleep and sexual activities.
   l. Do not drink coffee or tea in the evening.
   m. Avoid smoking, alcohol and other recreational substance use.
   n. Do not watch TV in bed.
   o. Avoid taking naps during day time.
   p. Do not read newspaper, magazines, novels or other articles that generate curiosity or create anxiety.
   q. Drink a glass of milk near bed time.
   r. Take bath with warm water near bed time.
   s. If not getting sleep within 15-20 minutes of going to bed, then get out of bed and try relaxation exercises.

Pharmacological:

1. For non-organic insomnia sedatives like benzodiazepines (clonazepam, alprazolam) are used for short term. Mouth dissolving tablets of clonazepam is also used. Long term use is discouraged as they have dependence producing capacity.
2. Zolpidem, Eszopiclone, zaleplon can be used for short term; these have less dependence potential
3. Ramelteon: melatonin receptor agonist. Is useful in initial insomnia.
4. Melatonin: available in both tablet form and as under the tongue spray.

Definition:

Insomnia: a condition of unsatisfactory quantity or quality of sleep, which persists for a considerable period of time.

Differential diagnosis:

1. Insomnia due to other mental disorder: insomnia can occur in depression (late insomnia), anxiety disorder (early insomnia) and intermittent insomnia (alcohol use).
2. Insomnia due to medical condition: insomnia due to pain, fever.
3. Insomnia due to other substance use: insomnia due to use of substance like tobacco, cannabis, amphetamine, etc.
4. Nonorganic disorder of sleep wake cycle/ schedule: like in shift work.

5. Restless leg syndrome: here person has unpleasant sensations in the leg which reduces when he moves the leg.
6. Parasomnias: they occur in Non-rapid eye movement disorders and Rapid eye movement disorders.

Case 50

A 35 year old married man educated up to high school was working as security from urban background belonging to low socio-economic status came to OPD with complaints of sleeplessness from 1 ½ months. After going to bed he does not get sleep for 2-3 hours. Seeing other family members getting good sleep he thinks why he is unable to sleep like others. Later when he falls asleep it would last for 1-2 hours, later he would wake up again and won't be able to fall back to sleep again. Due to this he feels worried, this worry off lately has increased and this has curbed his sleep. He gets good sleep in the morning between 5-7 am before going to duty.

1 ½ months back he was doing night shift, he had to be awake till morning and used to sleep between 8 am to 3 pm. From 1 ½ months his night shift duty got over and he is doing day duty. Sleeplessness has reduced his work performance, and feels drowsy while on duty.

He denied of having low mood, feeling anxious apart from worries about not getting adequate sleep. He also denied of using substances.

Diagnosis: Nonorganic disorder of the sleep-wake cycle/ schedule

ICD-10 criteria:

a. Individual's sleep-wake pattern is out of synchrony with the sleep-wake schedule that normal for particular society and is shared by most individual in same socio cultural environment.
b. Insomnia during major sleep period and hypersomnia during the waking period nearly every day for at least 1 month.
c. It causes marked distress or interferes with ordinary activities in daily living.

Why this diagnosis?

1. Individual's sleep wake pattern is not synchronous with other family members. This has happened after his night shift got over.
2. He was experiencing insomnia when most of the family members were sleeping and had drowsiness while doing duty .i.e. when others were awake.
3. This pattern of sleep has interfered with his work as he feels drowsy while doing duty.

Whether patient needs inpatient care?

No, the condition is not a serious mental disorder, she is able to manage his daily activities, his insight is good and judgment is intact.

Goals in the management:

1. To rule out organic causes.
2. Symptom improvement.
3. Improving quality of sleep.

Treatment:

Psychological:

1. Maintaining a sleep schedule.
2. Sleep hygiene techniques.
3. Cognitive Behaviour Therapy
4. Relaxation exercises

Pharmacological:

1. Use of sleep inducing medications (Benzodiazepines, Z-drugs, antihistamines, melatonin receptor agonists) for short duration of time.

Definition:

Disorder of sleep wake schedule: lack of synchrony between individual's sleep-wake schedule and the desired sleep-wake schedule for the environment resulting in either insomnia or hypersomnia.

Differential diagnosis: are same as those listed for non-organic insomnia.

Case 51

A 35 year old married man educated till B.Com working as sales person from semi-urban background belonging to middle socio-economic status came for consultation with complaints of inability to maintain erection for desired time from 8 months.

Patient had a marital life of 2 years, his wife's age was 22 years, she had been studying for 2 years after marriage, she returned back to husband's home after studies. Couple was maintaining abstinence from sexual intercourse for 2 years following marriage as wife had to continue with studies.

Couple started sexual activity 8 months back, during their first act, husband could not attain full erection and turgidity worn off before the completion of sexual intercourse. As a result wife was not satisfied. Couple thought that it could have resulted as it is the first act but in subsequent intercourses penile turgidity worn off before completion of sexual intercourse.

This created stress in husband about the performance, worry in him caused anxiety which further reduced the performance. So couple thought of getting evaluation for the same.

Husband did not have history of low mood, substance use.

Neither of the couple had premarital or extramarital sexual relationship.

Diagnosis: Failure of genital Response (Erectile dysfunction)

ICD-10 criteria:

Definition: It is difficulty in developing or maintaining erection suitable for satisfactory intercourse.

If there is erection during masturbation, sleep or with different partner then cause can be psychogenic.

Why this diagnosis?

Here the man has presented with failure for maintaining good erection for desired time and turgidity reduces before completion of the act within 1 min, form 8 months.

Whether patient needs inpatient care?

No, the condition is not a serious mental disorder, OPD basis treatment would be reasonable.

Goals in the management:

1. To rule out organic causes.
2. Symptom improvement.
3. Addressing interpersonal issues between couple.
4. To improve sexual life of couple.

Investigations to rule out organic causes for erectile dysfunction:

1. Monitoring nocturnal penile tumescence: to monitor erections occurring during sleep.
2. Penile plethysmograph: to measure blood pressure within the penile artery.
3. Doppler flow meter: to measure blood flow within internal pudendal artery.

Treatment:

Psychological:

1. Dual sex therapy: Given by Masters and Johnson. Based on the concept that couple as a unit is involved in production of symptoms. Both husband and wife are treated even if only one person is dysfunctional in relationship. Therapist team involves both male and female therapists.

   Round table discussions are held and therapist discusses the problems and clarifies doubts with the couple. During discussion couple's current problem is discussed along with anatomy, physiology and psychological aspects of sexual functions are discussed, misconceptions are corrected and education is given. Advice to be followed by the couple during sexual intercourse is suggested.

   Sensate focused therapy: needs and fantasies of both functional and dysfunctional partner are considered. Couple is encouraged for discussion about their needs between them without hesitation. During initial stages of therapy they are advised to explore and discover partner's body except genitalia. Couple is advised to explore each other's body areas. While exploring they have to focus on sensations i.e. "sensate focus" and manipulation which gives sexual arousal. When either of the partners gets sexually aroused, the other should calm them down either by genital method or oral method.

Pharmacological:

1. Oral medications used for erectile dysfunction are Sildenafil, Tadalafil, Vardenafil and these are Phosphodiesterase-5 inhibitors.

Physical devises:

1. Suction devises: it is applied to penis

and negative pressure is applied, this draws blood into the penis and penile erection occurs.

2. Prosthetic devices: prosthetic device are implanted in the penis which keeps the penis erected. But this can cause embarrassment to the person as penis appears big and erected all the time.
3. Self-controlled inflatable prosthetic device: here the prosthetic device is implanted in the penis which is connected to a small machine which is also implanted. The person with help of button can control inflation and deflation of the prosthesis which creates penile erection with inflation and reduction in erection with deflation.

Surgical interventions:

1. Vascular surgeries are carried out when vascular insufficiency is detected to penis.

Differential diagnosis:

1. Erectile dysfunction (ED) due to medical conditions: ED due to DM, hyper-cholestrolemia, neuropathy etc.
2. ED due to substance use: ED secondary to use of alcohol, tobacco etc.
3. ED due to mental disorders: ED secondary to depression, psychosis where desire for sexual activity is reduced.
4. ED due to marital discord: where person's desire for sexual activity is reduced due to poor interpersonal relationship with wife.

Case 52

A 30 year old married man with high school education, manual labourer from rural background belonging to low socio-economic status came for consultation alone to OPD with complaints of early ejaculation since last 3 years.

Since the time of marriage patient was worried that during sexual activity he ejaculates within 30 seconds of initiating the act. This decreased couple satisfaction related to sexual activity. This thought made him anxious while carrying out sexual activity. Couple had a cordial relationship between them. He had no past history of any relationships or sexual contacts.

He denied of having low mood, anxiety symptoms for other causes, substance abuse.

Diagnosis: Premature ejaculation (PE)

Definition and ICD-10 diagnostic guidelines: it is inability to control ejaculation sufficiently for both partners to enjoy sexual interaction.

In severe cases ejaculation can occur before vaginal entry or in the absence of erection.

It is usually a psychological reaction to

organic impairment ex: erectile failure or pain.

Why this diagnosis?

The person had ejaculation before completion of satisfactory sexual intercourse, pre-occupation with performance resulted in anxiety which in turn had reduced his performance.

Whether patient needs inpatient care?

No, patient is treated on OPD basis, as it is not serious illness.

Goals in the management:

1. To rule out organic causes.
2. Symptom improvement.
3. Addressing interpersonal issues between couple that arises due to sexual dysfunction..
4. To improving sexual life of couple.

Treatment:

Psychological:

1. Dual sex therapy.
2. Squeeze method: here the female partner is advised to squeeze the coronal ridge when the male partner gets the sensation of ejaculation which he communicates to his partner.
3. Start and stop technique: during sexual intercourse when male partner gets the sensation of ejaculation penile stimulation is stopped and when the sensation of ejaculation reduces, sexual activity is restarted.

Pharmacological:

1. Depoxetine 30-60 mg and Paroxetine have short half life and delay ejaculation as a side effect so they are used in the treatment.

Differential diagnosis:

1. PE due to medical conditions: PE due to DM, hyper-cholestrolemia, neuropathy.
2. PE due to substance use: PE secondary to use of alcohol, tobacco etc.
3. PE due to mental disorders: PE secondary to depression, psychosis where desire for sexual activity is reduced.
4. Performance anxiety: performance anxiety on sexual activity causes premature ejaculation.
5. Poor interpersonal relationship between couple can lead to PE.

Case 53

A 26 year old married woman with primary school education, house wife; mother of 3 year old child from rural background belonging low socio economic status was in OBG ward after the delivery of second baby through caesarean section.

On 5th day of post-partum period a psychiatry referral was sought for the patient as she was agitated and was speaking out filthy words which disturbed neighbouring patients.

Patient's husband said that since last night she has not slept, she is in angry mood; she has not fed the baby. She has not brushed her teeth nor took bath that day morning. She did not even eat breakfast.

During interview she said that two men from her neighbouring village have plotted against her so that she becomes ill. She could hear persecutor's voice that they are now in her village plotting how she should be killed. Men sent by them might reach the town any time and she would be killed. Neighbouring patients are giving information to her persecutors and that is the reason why she is angry on them.

On mental status examination she was ill kempt, eye to contact was made, co-operative with examiner. She was irritable; she had delusion of persecution, 2nd and 3rd person auditory hallucination, extracampine hallucinations. Her insight was poor. Personal and social judgements were impaired.

Diagnosis: Puerperal psychosis

Clinical features:

1. It occurs in women who have recently delivered a baby.
2. Patient may present with severe depression with delusions, hallucinations and thoughts of harming self or the baby.
3. If delusion involve that baby is defective or baby would suffer miserably like her, then mother may harm the baby, even homicide of the baby can occur.
4. Hallucinatory content may involve voices commanding the patient to kill the baby.
5. They may also present with only psychotic symptoms like delusions and hallucinations of persecutory type.
6. Symptoms begin within 2-3 weeks following delivery.
7. They may also present with excessive concern about baby's health.

Why this diagnosis?

1. Onset on 5th day of post-partum.
2. Reduced sleep, anger and irritability.
3. Poor self-care.

4. Not taking care of baby.
5. Presence of persecutory delusions, 2nd and 3rd person auditory hallucinations, extra-campine hallucinations.
6. Poor insight and impaired judgement.

Whether patient needs inpatient care?

Yes, patient is psychotic, her symptoms are disturbing neighbouring patients, her insight is poor and self-care is poor.

Goals in the management:

1. Symptom improvement.
2. Medication compliance.
3. Addressing use of psychotropic drugs during lactation.
4. Improving infant-mother bonding.
5. Functional improvement.

Treatment:

Pharmacological:

1. Patient is treated with Olanzapine as its secretion through breast milk is less compared to other antipsychotics.
2. MECT is another option

Psychological:

1. Psycho-education about the illness to family members.
2. Need for drug treatment.
3. Compliance issues to be addressed.
4. Insight oriented psychotherapy.
5. Parenting skills.
6. Early infant interventions.
7. Maternal-infant bonding.

Definitions and facts:

1. <1% of new mothers develop postpartum psychosis.

Breast feeding practices:

1. Psycho-education should be done to the patient and family members about the symptoms of the illness, course, prognosis, need for medication treatment during post-partum period.
2. Side effects of medications on lactating women and on baby should be discussed.
3. Pros and cons of breast feeding when the patient is on psychotropics should be discussed with the mother.
4. Open choice should be given to the lactating women to make decision about whether to breast feed the baby or not.
5. If lactating women opts for breast feeding then breast feeding practices should be advised.
6. For lactating women it is good practice to give once daily dosage than giving the drug in divided doses.
7. When drug is given in once daily dosage the women would be experiencing peak serum levels only once. Whereas if the drug is given in divided doses then women would pass through multiple serum peak levels. With multiple peak levels the baby would be exposed to more drugs than with single peak level.

8. Use minimum effective dosage of the drug.
9. Avoid poly-pharmacy.
10. Prescribing the drug at night is more advantageous than during day time, as it is expected that women would be lactating more times during day than during night time.
11. Patient should be advised to breast feed the baby and then take the tablet.
12. She is also advised to express the breast milk and reserve it for night time.
13. In the morning she should express the breast milk collected over night and should discard it as it would contain maximum concentration of secreted drug, as the drug would have passed through peak levels during this time.
14. She can breast feed the baby with milk that gets collected later.
15. If patient opts not to breast feed the baby, then nutritional supplements and others alternative methods available for baby's nutrition.

Differential diagnosis:

1. Postpartum blues: it appears in nearly 75% of the women following delivery with onset within few days and subsides by 2 weeks.
2. Post partum depression

Case 54

A 30 year old married lady studied till BA working as a clerk in an office from urban background belonging to middle socio-economic status was in 5th week of postpartum. She was referred to psychiatrist by gynaecologist when she had gone for routine follow up consultation.

Patient had an uneventful antenatal period; she had undergone caesarean section for delayed labour, she had delivered a baby girl. Patient and her family had high expectation that the second child would be a baby boy. The first one was a girl child, who was now 3 years old.

This issue had made her worry a lot. She felt she was unable to meet the expectation of husband and other family members as few times her family members had expressed the thought that a baby boy would have been better.

Due to same reason she was feeling sad from past 1 month, she experienced tiredness. She was unable to take care of baby, had reduced concentration, her sleep was disturbed and her food intake reduced.

She denied having suicidal ideation and thoughts of harming the baby.

No history of mood symptoms during 1st pregnancy, no family history of mood disorder, anxiety, substance abuse and suicide.

On mental status examination, patient was well kempt, appeared tired, she had down cast eyes, psychomotor activity was reduced, speech was reduced, she described mood as sad and appeared depressed, she felt guilty that she was could not meet the expectation of family members. Perceptual disturbances were not elicited. Cognitive function tests were normal. Insight was good and personal judgment was impaired, social and test judgement was intact.

Diagnosis: Postpartum depression

Why this diagnosis?

1. Feeling sad from 1 month.
2. Sadness secondary to stress that the baby was girl.
3. Tiredness with little work.
4. Inability to take care of the baby.
5. Reduced concentration.
6. Sleep disturbance.
7. Reduced food intake.
8. Above symptoms had onset during post-partum period.

Whether patient needs inpatient care?

No, as patient does not have suicidal ideation, no ideas of harming the baby and there is no impairment in self-care.

Goals in management:

1. Symptom improvement.
2. Medication compliance.
3. To assess risk of self-harm and thoughts of harming the baby.
4. Addressing use of psychotropic drugs during lactation.
5. Prevention of recurrence.

Treatment:

Psychological:

1. Psycho-education about the illness to the patient and family members.
2. Supportive psychotherapy
3. Interpersonal therapy
4. Family therapy

Pharmacological:

1. Aim is to treat the patient with antidepressant drug that are least secreted in breast milk and least harmful to the baby. Sertraline is least secreted in breast milk and is preferred. It is least secreted as it is more plasma protein bound.
2. ECT is considered if patient has severe depression.

Differential diagnosis:

1. Postpartum blues: it appears in nearly 75% of the women following delivery with onset within few days and subsides by 2 weeks, there would be sad mood.
2. Postpartum psychosis

Case 55

A 50 year old married female with BSc education, homemaker from urban background belonging to middle socio-economic status, accompanied by husband came to OPD with complaints of headache for more than 15 years.

Pain was present all through the head, burning type, present throughout the day, it aggravated when patient did work that required mental concentration and she would find some relief on resting. It was not associated with photophobia, phonophobia, nausea and vomiting.

She was diagnosed to have nonspecific headache elsewhere and was on a tablet Amitriptyline 10 mg from last 15 years. She would take the tablet every day at night, which made her feel better. Whenever she missed the tablet she worried that headache would reappear, this made her anxious due to which her sleep would be disturbed and anxiety would increase. In case of sleep disturbance the previous night she would experience headache the next day and her entire day would be affected. The fear that headache would reappear made her to be on tablet even when she did not have headache. Family believed she is unnecessarily spending on the tablets.

The medical shop from where she was fetching the tablet without prescription had shut down from past 1 week and another shop denied giving the medicines without prescription which made her to consult psychiatrist.

After detailed examination and interview patient was advised to discontinue the tablet but she was irritable, resisted discontinuation and insisted to give prescription for the tablets.

Diagnosis: Abuse of non-dependence producing substances

ICD-10 diagnostic criteria:

1. Medication might have been prescribed or recommended in the first instance for particular illness.
2. The person continues to take medication after cure of the illness for which it was recommended.
3. Continued intake would be prolonged, unnecessary and often excessive dosage will be taken by the person.
4. This continued intake would be facilitated by the availability of the substance without medical prescription.
5. Persistent and unjustified use is associated with unnecessary expense, unnecessary contacts with medical professionals and sometimes intake marked by harmful physical effects of the substances.
6. Attempt to forbid the use is met with resistance.

7. No development of dependence or withdrawal symptoms.

Why this diagnosis?

1. Patient was prescribed medication for non-specific headache.
2. She continued to take the tablet for 15 years without prescription.
3. She used to feel anxious whenever she missed the tablet this anxiety resulted in sleeplessness causing worsening of anxiety.
4. The tablet was easily available to her in medical shop without prescription.
5. The fear that headache would return without tablet made her to continue the tablet
6. She denied stopping the tablet and was irritable when advised to do so.

Whether patient needs inpatient care?

No, as patient has good insight, good family support system.

Goals in the management:

1. Good therapeutic alliance.
2. Stressing the ill effects of substance on health.

Treatment:

Psychological:

1. Supportive therapy: creating awareness about harmful side effects of substance.
2. Cognitive behaviour therapy: here patient's distorted thoughts like without the tablet my headache will reappear and anxiety associated with this thought are addressed.

Differential diagnosis:

1. Abuse of dependence producing substances
2. Medical conditions: medical conditions for which the patient would be taking the medications.

Case 56

A 23 year old unmarried male who dropped education at PUC II not holding a job from semi-urban background belonging to middle socio-economic class was brought to consultation by police officers with history that he has allegedly committed a sexual assault on a girl aged 12 years.

As per victim the accused allegedly had sexual contact with her from past 3 months almost once fortnightly. He was a neighbour who would lure her with gifts and later threatened her that if she reveals the act to anyone then she would be killed.

The person as a child was not much interested in studies; he used to frequently skip classes, involve in bullying juniors and was suspended several times.

He was involved in quarrels and physical fights. He was punished twice for entering girl's toilet in a neighbouring school and kissing a school girl.

He started using alcohol, tobacco and cannabis for recreational purpose when he was in college. He dropped education in PUC II, when he could not clear it. He was beaten up by the public for stealing money once. On police enquiry he revealed that he spends money in bar and costly restaurants.

Later though he joined hands with father to look after family business, but he never took responsibility, he frequently stole money from father's shop and lied saying he has distributed it to poor people while he had used the money for recreational activities and substance abuse. He tried to sexually assault one of the female workers in the shop, which was settled down by parents who believed that he should be given a chance to improve.

His parents reported that whenever he did mistake and it was told that such things are not appropriate, he never felt remorse about it since childhood.

During interview when he was asked about sexual assault he initially denied and later agreed saying it's his weakness.

Diagnosis: Paedophilia with dissocial personality disorder

ICD-10 criteria for Dissocial personality disorder:

a. Callous unconcern for the feelings of others.

b. Irresponsibility and disregard for social norms, rules and obligations.

c. Incapacity to maintain enduring relationships without having any difficulty in establishing them.

d. Low frustration tolerance, low threshold for discharge of aggression including violence.

e. Incapacity to experience guilt.

f. Blames others or gives rationalizations for the behaviours that has brought him into conflicts with society.

Why this diagnosis?

1. Missing school, truancy, back arguments with elderly.
2. Entering girl's toilet, kissing girl during school days.
3. Sexual assault on girl of 12 years old at the age of 23 years, he had also tried to sexually assault female worker suggests that he had disregard for social norms and rules.
4. Frequent quarrels and physical fights suggest low frustration tolerance.
5. Early onset use of recreational drugs.
6. Not taking responsibility of family's business though he had agreed to do so.
7. Not feeling remorse/ guilty for the acts he had done like bullying, stealing, lying, sexual assaults, .i.e. incapacity to feel guilt.

Whether patient needs inpatient care?

Yes, as patient has substance use, addressing personality issues and to plan for further management.

Goals in the management:

1. Symptom improvement.
2. Addressing substance use.
3. Diverting sexual urges to socially acceptable acts.

Treatment:

Patient is usually brought for evaluation and treatment by police officers when the person involves himself into crime otherwise person as self does not seek help for their personality.

Psycho-social therapy:

1. Psychoeducation and diverting sexual urges to socially acceptable acts like masturbation.
2. Motivation enhancement therapy for quitting substance use.
3. Anger management.
4. Individual psychotherapy.

Pharmacotherapy:

1. Impulsive behaviour is treated with Carbamazepine, Oxcarbazepine, Valproate.
2. Irritability is treated with small dose of antipsychotics.

Differential diagnosis:

1. Organic personality disorders: there would be marked change in behaviour/ personality of the person compared to his pre-morbid behaviour. Expression of emotions, needs, impulses are changed. Cognitive disturbances, alteration in flow of speech, sexual behaviour changes are seen. Exhibiting impulses are due to organic cause rather than because of callous concern. These changes are secondary to organic causes.
2. Manic episode: here patient does activities without regard of others feelings which occur due to elevated mood, it is associated with other features of mania, whereas in dissocial personality it is due to callous concerns which drive them to do activities.
3. Substance intoxication: during substance intoxication like alcohol which causes dis-inhibition, results irresponsibility, manipulative behaviour. Symptoms subside once person is out of intoxication.

Case 57

A 22 year old unmarried woman pursuing B.Sc. nursing from rural background, belonging to middle socio-economic status came to the emergency department accompanied by her friends with complaints that she is experiencing giddiness and stomach pain of sudden onset from past half an hour.

Patient was doing well till half an hour back when she started experiencing giddiness and stomach pain of sudden onset. She revealed to emergency physician that she had consumed 8 tablets of Chlorpheniramine (CPM) which were prescribed to her for common cold last week. She was given appropriate treatment and was stabilized.

A psychiatrist consultation was sought, and she reported that she had a fight with her boyfriend over the issue that he did

not pick up her phone call even after calling him several times. She felt much tensed. She could not understand what to do; due to tension she immediately consumed 8 tablets of CPM without thinking about the consequences. In some time she experienced stomach pain and her friends brought her to emergency department. She tells that she had no intension to die. She didn't even think that taking many tablets at a time would be harmful to health. She said she feels guilty that she did such an act and her friends had to suffer due to it. Said she will not repeat the act of self harm.

On further interviewing she revealed that she had slashed her wrist with blade 2 years back, when she was not selected in a dance competition and instead her elder sister was selected. That made her feel tensed and had slashed her wrist following which she felt better. She adds that while doing the act she did not get the thought that such an act was not appropriate, she got the thought in mind and she carried it out.

Whenever someone does not speak to her, she feels upset and lonely. She feels no one cares for her. Her friends said that she had changed boyfriends frequently over last 2 years. The main reason for broken relationships was her intense anger over trivial issues.

When her parents were called they informed that the patient gets angry over trivial issues. During the episode she throws objects in her hand, she frequently says that she would run away from home or would commit suicide. She would not talk to anyone, she would not eat food that day, sometimes she would lock herself in a room, which makes her parents worry that she might harm herself. They even add that she can build friendships very easily, but fights with them and breaks friendships fighting over trivial issues.

She denied having continuous low mood, symptoms of anxiety, substance abuse or sexual contact.

Diagnosis: Emotionally unstable personality disorder; Borderline type

Definition:

Impulsivity: acting on a thought when it pops up in the mind without thinking about its future consequences.

Types of Emotionally Unstable Personality Disorder (EUPD):

1. Impulsive type
2. Borderline type

General features of EUPD:

1. Marked tendency to act impulsively.
2. Affective instability.
3. Ability to plan a head is minimal.
4. Out bursts of intense anger leading to violence and behavioural explosions.
5. Intense anger is precipitated when impulsive acts are criticized by others.

ICD-10 criteria for Impulsive type:

1. Emotional instability.
2. Lack of impulse control.
3. Outbursts of violence or threatening behaviour when other criticizes them.

ICD-10 criteria for Borderline type:

1. Emotional instability.
2. Patient's own self-image, aims, internal preferences are unclear.
3. Chronic feelings of emptiness.
4. Intense and unstable relationships lead to emotional crises.
5. During emotional crises excessive efforts are made to avoid abandonment.
6. Series of suicidal threats or acts of self-harm.

Why this diagnosis?

1. Fighting over the issue that her boyfriend did not pick up her call, feeling tensed for not getting selected in dance competition, getting angry over trivial issues, throwing down the objects in hand, not talking to anyone, not eating food when stressed, locking herself into the room when angry suggests that she was getting intense anger when her wishes were not met. Getting intense anger suggests that her emotions were unstable.
2. Above events have led to take up impulsive decision of harming self which was giving her relief.
3. Repeated suicidal threats and acts of self-harm.
4. Feelings of being lonely that no one is with her when other do not speak was making her feel stressed suggest that she had feelings of emptiness which made her feel that others are abandoning her so they are not talking with her.
5. Her ability to build friendships easily but inability to maintain them due to fights.
6. As per history given by her friends she had changed boyfriends frequently over last 2 years, the main reason for changing was breakdown in relationship due to intense anger she was getting over trivial issues.

Whether patient needs inpatient care?

Yes, patient needs ICU admission initially till she is out of toxic effect of the tablets she had swallowed; later psychiatry inpatient care should be given for detailed assessment and management with regard to personality assessment, suicidal ideation and planning further management.

Goals in the management:

1. Good therapeutic alliances as patients have all or none thinking.
2. Symptom improvement.
3. Stress management.

Treatment of EUPD:

Psychological:

1. Dialectical Behaviour therapy: Here patient is taught not to resort to self-injurious behaviour and is taught methods for coping with stress.
2. Mindfulness.
3. Supportive psychotherapy.
4. Anger management.
5. Psychoanalytical psychotherapy is also

beneficial.

Pharmacological:

1. Carbamazepine, Oxcabazepine, Lamotrigine, Valproate used in treating impulsivity, mood changes, anger and irritability.
2. Small dose of antipsychotics like Risperidone, Aripiprazole, Flupenthixol are also tried

Differential diagnosis:

1. Organic personality disorders: there would be marked change in behaviour/ personality of the person compared to his pre-morbid behaviour. Expression of emotions, needs, impulses are changed. Cognitive disturbances, alteration in flow of speech, sexual behaviour changes are seen. These changes are secondary to organic causes.
2. Histrionic personality disorder: the personality has theatricality and attention seeking behaviour while emotionally unstable personality has unstable emotions, frequent suicidal threats and self-harming behaviour.
3. Antisocial personality disorder: this personality has manipulative behaviour, callous concerns for others feelings. Whereas EUPD has unstable emotions and self harming behaviour.

Case 58

A 20 year old unmarried female from urban background, pursuing BA belonging to middle socio-economic status was brought to the OPD accompanied by her mother with complaints of anger for trivial issues for more than 2 years.

Mother said that the patient was not interested in studies; she used to be with books but does not study. When asked to concentrate in studies she would get angry and back answer to parents.

She spent most of the time on mobile phone, texting her friends or making phone calls. Her parents found that she texts mostly boys and texts would be filled with seductive content and photos. When questioned about this she gets angry, throws tantrums, shouts at parents and locks herself inside the room and does not take food the whole day.

She rakes up minor issues and gives an elaborative explanation about it. She spends lot of time in makeup. She always gave more importance to external appearance. She wishes to wear modern western cloths that men find more attractive.

Whenever she attends a function she wants people gathered there to appreciate

her and does not tolerate when she is ignored. Whenever someone appreciated her and gave her suggestions she used to act out on them.

During interview patient was sitting comfortably, eye contact was good, she gave an elaborative explanation with gestures and facial expression about how well she studies and said even with that her parents keep criticizing. She at times touched the examiner while speaking. She appeared cheerful, she described her mood as being normal and affect was euthymic. No perceptual disturbances were seen. Cognitive function tests were normal. Personal & social judgements were impaired.

Diagnosis: Histrionic personality disorder

ICD-10 criteria for histrionic personality disorder:

a. Self-dramatization, theatricality, exaggerated expressions of emotions.
b. Suggestibility; easily influenced by others or circumstances.
c. Shallow and labile affect.
d. Continuous seeking for excitement and activities in which patient is centre of attraction.
e. Inappropriate seductiveness in appearance and behaviour.
f. Over concern with physical attractiveness.

Associated features: egocentricity, self-indulgence, continuous longing for appreciation, feelings that are easily hurt, persistent manipulative behaviour to achieve own needs.

Why this diagnosis?

1. Raking up minor issues and giving an elaborative explanation about it suggests theatricality.
2. Wanting people to appreciate whenever she is in social gathering like functions and not tolerating it when ignored suggests her willingness to be the centre of attraction and longing for appreciation.
3. Giving more importance for physical appearance as she was spending lot of time in makeup and gave more importance to external appearance.
4. She was spending time with mobile phone, texting friends, making a phone call suggests that she preferred to do those activities that gave her excitement.
5. Her dressing was attractive to male; she was also involving in texting boys which consisted of seductive content.
6. Easy suggestibility as she was carrying out the activities suggested by other whenever she was appreciated.

Whether patient needs inpatient care?

A short term in patient care can be given for assessment of personality and to plan further management.

Goals in the management:

1. Symptom improvement.
2. Stress management.
3. Improving quality of life.

Treatment:

Psychotherapy:

1. Supportive psychotherapy.
2. Anger management.
3. Psychoanalytical psychotherapy.
4. Insight oriented psychotherapy.

Pharmacotherapy:

1. Small dose of antipsychotics helps in controlling anger and irritability.
2. Treatment with Carbamazepine, Oxcarbazepine for impulsive behaviour.

Differential diagnosis:

1. Organic personality disorders: there would be marked change in behaviour/ personality of the person compared to his pre-morbid behaviour. Expression of emotions, needs, impulses are changed. Cognitive disturbances, alteration in flow of speech, sexual behaviour changes are seen. These changes are secondary to organic causes.
2. Emotionally unstable personality disorder: it is characterised by presence of emotional instability, impulsivity, threatening behaviour, acts of self harm while histrionic personality is characterised by presence of self-dramatization, theatricality, suggestibility, labile affect excessive concern with physical attractiveness.
3. Dissocial personality disorder: it has manipulative behaviour callous concerns for other's feelings, irresponsibility while histrionics have self-dramatising behaviour.

Case 59

A 40 year old married male with BE education, engineer by occupation from urban background belonging to higher socio-economic status was brought by wife saying that there are frequent arguments between them for more than 10 years.

12 years back they got married; relationship between them was going great, as years passed his wife felt that he no longer loves and cares for her. She even felt that he does not give good care to children. She tells that he spends long hours at work and rarely takes off from work.

He takes excessive caution for minor details and calls himself as a perfectionist. He calls himself a prospering engineer due to long working hours which he calls as hard work. Whenever she tried to convey to this to him he used to argue with her and go to work.

He always avoided going on vacation, instead he would send his wife and children

believing that it would be a waste of time to go on a vacation and preferred to spend time working.

He was not involving himself in household activities, on insistence whenever he was involved; he would make the process of household work too lengthy and would insist that like him even she should concentrate on minor details.

Even with lot of requests he was not changing his routine. He was saying that his wife and children should follow the schedule what he prepares for them. Several workers have left the job as he gets upset and scolds them if they don't follow his scheduled orders. He would reach for meetings too early and was a strict disciplinarian at workplace.

She said that he was never romantic and wished that his wife should understand the importance of his responsibility and devotion to work. Whenever family members did not follow what he wanted them to do, he got angry and this has led to frequent arguments between them.

Diagnosis: Anankastic personality disorder

Other name: obsessive compulsive personality disorder.

ICD-10 criteria:

a. Feelings of excessive doubt and caution.
b. Preoccupation with details, rules, lists, order, organization or schedule.
c. Perfectionism interferes with task completion.
d. Excessive conscientiousness, scrupulousness, undue preoccupation with productivity to the exclusion of pleasure and interpersonal relationships.
e. Excessive pedantry and adherence to social conventions.
f. Rigidity and stubbornness.
g. Unreasonable insistence that others should submit to exactly his/her way of doing things or unreasonable reluctance to allow others to do things.
h. Intrusion of insistent and unwelcome thoughts or impulses.

Why this diagnosis?

1. Spending long hours at work, rarely takes off from work.
2. Taking excessive caution for minor details.
3. Calling self as perfectionist.
4. Avoiding going on vacation and belief that vacation would be a waste of time.
5. Making working procedure lengthy by concentrating on minor details and insisting others to do the same.
6. He was always preoccupied with productivity.
7. He was rigid and did not follow wife's requests.
8. Arguments with family members when they did not follow what he wanted them to do.

Whether patient needs inpatient care?

No, as he does not have serious mental

illness, he is able to do daily activities by self.

Goals in the management:

1. Symptom improvement.
2. Improving family relationships

Treatment:

Psychotherapy:

1. Insight oriented psychotherapy: to increase awareness of the individual's behaviour and to bring about changes in it.
2. Cognitive Behaviour Therapy.
3. Individual therapy.

Pharmacotherapy:

1. SSRI, SNRI antidepressants help in controlling anxiety symptoms.

Case 60

A 23 year old male student doing his graduation from urban background belonging to middle socio-economic status came alone to OPD with complaints of feeling fearful for more than 5 years.

Patient says that he feels fearful and stressed out throughout the day. From the time he wakes up in the morning, he gets preoccupied with work that has to be done on that day. He keeps planning ahead about work to be done; he keeps preparing the list of work in mind and keeps rehearsing it as he thinks that he may forget one or two among them, this makes him feel fearful, stressed and tensed.

He said that when he carries out any work in presence of others, he feels that they are watching him and they would criticize him about the work he is doing. He feels shy and inferior to other so he avoids mingling with people.

He has few friends and he avoids making new friends as meeting new people makes him feel apprehensive. So he meets only close friends occasionally as he feels comfortable with them and feels better when he is in company of persons whom he knows very well.

He avoids attending functions; social gathering as they make him feel uncomfortable since he thinks others would reject him.

Diagnosis: Anxious avoidant personality disorder

ICD-10 criteria:

a. Persistent and pervasive feelings of tension and apprehension.
b. Belief that one is socially inept, personally unappealing or inferior to others.
c. Pre-occupation of being criticized or

rejected in social situations.

d. Unwillingness to get involved with people unless certain of being liked.

e. Restricting the life style because of need to have physical security.

f. Avoiding social or occupational activities that involve significant interpersonal contact because of fear of criticism, disapproval or rejection.

Why this diagnosis?

1. Feeling fearful and stressful in throughout the day suggests persistent and pervasive tension and apprehension.
2. Feelings that he would be criticized by others as he thinks that they watch him.
3. He feels shy and inferior to others so avoids mingling with people.
4. Having few friends, avoiding new friends as it would make him feel apprehensive.
5. He had restricted lifestyle by avoiding functions and social gathering as they would cause uneasiness in him.

Whether patient needs inpatient care?

No, as patient has good insight, judgment is intact with good family support.

Goals in the management:

1. Symptom improvement.
2. Reducing avoidance behaviour.
3. Improving socio-occupational functioning.

Treatment:

Psychotherapy:

1. Cognitive Behavioural Therapy: Focuses on distorted thoughts that people would criticise me, feelings of inferiority, avoidance behaviour and helps in improving social skills.
2. Social skill training.
3. Communication skills.
4. Relaxation exercises.
5. Biofeedback.

Pharmacotherapy:

1. SSRI (Escitalopram, Sertraline, Paroxetine, Fluvoxamine), SNRI (Venlafaxine, Desvenlafaxine, Duloxetine), Tricyclic antidepressants (Amitriptyline, Imipramine, Nortriptyline, Dotheipin) improve anxiety symptoms.
2. Benzodiazepines (Clonazepam, Etizolam, Alprazolam) used for short duration till antidepressants start acting.

Case 61

A 30 year old unmarried male educated up to BE working as contractor from semi-urban background belonging to middle socio-economic status came to OPD alone for consultation, with complaints of low mood since last 4 years.

He was able to carry out his day to day work like before, but felt he is not enjoying the work. Patient's biological functions were normal.

On further interviewing he tells that he keeps playing cards since last 4 years, and does betting on cards, this started when he met a new neighbour, who once took him to the playing venue. During initial days he was playing once in 2 to 3 months with small amount of money. In the last 2 years, he increased the frequency and increased the amount of money used for betting. Over the last year his friends circle for betting and gambling increased, they met more regularly and played cards betting over huge money. Due to betting he lost several lakhs of rupees. This resulted in debts. To overcome debts he had to sell his farm land. Due to shortage of money he could not get married. Whenever his mother opposed gambling, he quarrelled with her and threatened saying he would end up his life if he is not allowed to play.

He consumed alcohol occasionally; he denied having any other substance use. No anxiety symptoms were seen in him.

On mental status examination he appeared well kept, eye to eye contact was made and sustained. Psychomotor activity was normal. Speech was normal, he described his mood as low and appeared depressed, he was pre-occupied with thoughts of having lost farm land for gambling. No perceptual disturbances were seen. Cognitive functions were normal. Insight was good. Personal judgement was impaired, social and test judgments were normal.

Diagnosis: Dysthymia with pathological gambling

Other name: compulsive gambling.

ICD-10 criteria:

1. Persistent repeated gambling.
2. Gambling continues and often increases despite adverse social consequences like impoverishment, impaired family relationships, disruption of personal life.

Why this diagnosis?

1. The person had persistent and continuous sadness for 4 years, but was able to carry out all his day to day work like before however he was unable to enjoy work, with normal biological functions suggests presence of dysthymia in him.

2. Patient was gambling with increased frequency betting over larger amount of money suggests persistent repeated gambling.
3. He continued even when he experienced financial stress, had to stay single.
4. He had to quarrel with mother and threaten her to continue playing .i.e. he was playing even when there was impairment in family relationships.

Whether patient needs inpatient care?

No, as patient has good insight, good family support system.

Goals in the management:

1. Addressing dysthymia.
2. Quitting the gambling behaviour.
3. Social skills.
4. Interpersonal skills.

Treatment:

Psychological:

1. Motivation Enhancement Therapy: working on same principles as that of substance dependence.
2. Gamblers Anonymous: similar to that of alcoholic anonymous.
3. Insight oriented psychotherapy.
4. Group therapy.
5. Relaxation exercises.

Pharmacological:

1. Treatment with antidepressant Bupropion an NDRI improves mood symptoms and also reduces anxiety that appears when person gets impulse for gambling.
2. SSRIs (Escitalopram, Fluoxetine,Fluoxamine, Paroxetine, Sertraline) also improve mood symptoms and reduce impulse to gamble.
3. Short term use of benzodiazepines (Clonazepam, Alprazolam, Etizolam) reduces anxiety symptoms.
4. Carbamazepine, Oxcarbazepine, valproate reduces impulsivity and aggression.

Differential diagnosis:

1. Non pathological gambling: like gambling in social gathering which does not cause psychosocial dysfunction.
2. Mania episode: increased and reckless gambling can be seen in mania. Mania has other features like elevated mood, increased activity levels, easy distractibility etc.

Case 62

A 23 year old unmarried female was pursuing BA from urban background belonging to middle socio-economic status presented to dermatologist accompanied by her mother with complaints of hair loss from 2 years.

Dermatologist after examination referred the patient to a psychiatrist, as it was found that the patient pulls the hair from the scalp.

While reading or when deeply thinking about a matter, unknowingly she was pulling hairs. Whenever she felt tensed or did not understand the concept which she was reading hair pulling behaviour increased. Hair pulling reduced the tension. Once the hair was pulled, she used to see the length of the hair and stretch it to see how strong it is and was rolling it between fingers.

As the days passed hair puling increased and this resulted in patchy hair loss, she hid the hair loss area by applying mascara. This was noticed by her mother and patient was taken to dermatologist for treatment from where she was referred to a psychiatrist.

On examination the patchy hair loss was on right parietal area which had hairs of different growing length.

Diagnosis: Trichotillomania

Other names: hair pulling disorder.

ICD-10 definition:

a disorder characterised by noticeable hair loss due to a recurrent failure to resist impulses to pull out hairs.

Features of trichotillomania:

1. Recurrent impulses to pull out the hairs.
2. Hair pulling is preceded by mounting tension and is followed by sense of relief or gratification.
3. Recurrent hair pulling results in patchy hair loss.
4. The area of hair loss consists of hairs at different stages of growth.
5. Diagnosis is not made if hair fall is due to pre-existing skin inflammation or if hair pulling is due to delusion or hallucination.

Why this diagnosis?

1. Increased tension before pulling the hairs.
2. Reduction of tension after the hair is pulled out.
3. Manipulating the hair once it is pulled out in the form of stretching it to see its strength, rolling between the fingers.
4. Camouflaging the area with mascara.
5. Patchy area of hair loss with hairs of different growing length.

Whether patient needs inpatient care?

No, the condition is not serious mental illness, she is able to take care of self, she

has good insight and judgment is intact.

Goals in the management:

1. Symptom improvement.
2. Improving psycho-social functioning.
3. Reducing social anxiety and the stigma faced by patient.
4. Medication compliance.

Treatment:

Psychological:

1. Habit reversal therapy: Here the patient is made aware of hair pulling and then he develops a competing response .i.e. when he gets the urge to pull the hair, he does activities like fist clenching or holding the table until the urge to pull the hair subsides. As he develops new behaviour and reduces hair pulling, he is motivated by praising which is done by family, friends and therapist. Once he adopts the new skill of reduced hair pulling he is advised to extend the new skill to other situations.
2. Insight oriented psychotherapy.
3. Biofeedback helps in controlling anxiety symptoms.
4. Relaxation exercises.

Pharmacological:

1. SSRI, SNRI, tricyclic antidepressants help in treatment of anxiety symptoms that occur while pulling out the hair.
2. Benzodiazepines can be used for short term treatment for alleviation of anxiety symptoms.

Differential diagnosis:

1. Medical conditions: medical conditions causing hair loss should be ruled out before diagnosing hair pulling disorder.
2. Mental retardation: hair pulling could also be due to mental retardation where person does hair pulling to relieve stress which they are unable to communicate.
3. Schizophrenia and other psychotic disorders: here hair pulling occur secondary to psychotic symptoms like hallucinations and delusions.
4. If hair pulling is done for aesthetic purpose which does not cause psychosocial and occupational dysfunction then hair pulling disorder is not diagnosed.

Case 63

A 23 year old married female with BCA education, home maker; from urban background belonging to middle socio-economic status came to OPD with her mother.

She had acne since the age of 18 years. She was fed up of acne. She had tried herbal medicines, with no much improvement. She felt that the acne pimples should be squeezed and removed from its root only then they get cured. So she was spending lot of time squeezing them out.

She used to get tensed while squeezing them and felt relaxed when some amount of pimple with skin comes out. But again she used to feel that the whole pimple should be squeezed out, which was making her feel tensed. So again she used to squeeze the pimple and the cycle would continue until any of her family members scolded her saying not to do such thing.

Diagnosis: Skin picking disorder

Definition: It is a type of impulse control disorder where the person gets repeated impulses for skin picking. There would be mounting tension before skin picking and it is followed by relief or gratification.

Why this diagnosis?

Mounting tension before she picked at skin and feeling relaxed when some amount of pimple comes out. The above cycle would continue until family members tell her not do.

Other names: excoriation disorder.

Comments: The diagnosis of skin picking disorder is not included in ICD-10; it is included in DSM-5 under obsessive compulsive spectrum disorder.

Whether patient needs inpatient care?

No, the condition is not serious mental illness, she is able to take care of self, she has good insight and judgment is intact.

Goals in the management:

1. Decreasing the symptoms.
2. Improving socio-occupational functioning.
3. Improve quality of life.
4. Medication adherence.

Treatment:

Pharmacological:

1. SSRI, SNRI are used in the treatment of this disorder.

Psychological:

1. Habit reversal therapy.
2. Relaxation exercises.
3. Supportive therapy.
4. Biofeedback.

Differential diagnosis:

1. Medical conditions: medical conditions causing hair loss should be ruled out before diagnosing hair pulling disorder.
2. Substance abuse: in cocaine abuse the person picks at the skin due to tactile hallucination .i.e. cocaine bug.
3. Schizophrenia and other psychotic disorder: here skin picking disorder occur secondary to psychotic symptoms like hallucinations and delusions. It can also appear as a part of Von Gogh syndrome.

Case 64

A 9 year old boy of 3rd standard studying in Kannada medium from semi-urban background belonging to middle socio-economic status was brought for consultation with complaints of poor scholastic performance from the time he has joined school.

The boy started going to school at the age of 4 years, since the time he has joined the school he is poor in academics, he had difficulty in understanding what has been taught, taking down the notes written on board, and he could not answer the questions asked to him. He disturbs classmates when class is going on; he picks up fights with classmates. Parents have received frequent complaints regarding his studies and behaviour. He had difficulty in passing exams and every time he had to be given grace marks to pass.

If he is sent to general stores he cannot remember 3-4 items told to him and makes mistakes for getting the appropriate change of money.

He is able to carry out all activities of daily living.

He was born out of difficult labour, he did not cry immediately after birth. He was given NICU care for 2 days after birth. Milestones were delayed compared to other siblings. Immunization was appropriate for the age.

Diagnosis: Mild mental retardation

ICD-10 criteria:

1. Delay in acquiring language but they have ability to hold conversation.
2. They achieve full independence on self-care (eating, washing, dressing, bowel and bladder control).
3. Rate of development is slower than normal.
4. Mainly difficulties are seen in academic school work.
5. IQ range: 50-69.
6. Organic aetiology is identifiable in minority of individuals.

Why this diagnosis?

1. Boy was brought with complaints of poor scholastic performance since the time he had joined school.
2. Not understanding what is been taught in class.
3. Difficulty in reading and writing.
4. Inability to remember 3-4 items.
5. Making mistakes for getting appropriate change of money.
6. Delivery through difficult labour.
7. Not crying immediately after birth, NICU care for 2 days.

8. Delay in mile stone achievements.

Points 6, 7, 8 suggest that there is cerebral insult in perinatal period.

He was able to carry out all the activities of daily living without assistance.

Whether patient needs inpatient care?

No, as the child does not have aggressive behaviour.

Goals in the management:

1. Reducing morbidity and disability.
2. Improving psycho-social capacity.
3. Skill development.

Treatment:

Psychosocial treatment:

1. Family psycho-education about the diagnosis.
2. Parent management technique.
3. Behavioural shaping: in this a complex task is be broken down into simple small steps. Each step should be made to practice repeatedly and learning of each step should be reinforced with positive reinforcement like praising the child for doing the task correctly and giving the items (reward) that the child likes. All family members should be involved in behavioural shaping of the child. It should be carried out at home as well as in school. Parental support and training is necessary to carry out this. This approach can be used to teach the child basic skills and activities of daily living.
4. Speech therapy: It is recommended for children who have reduced speaking ability.
5. Educational planning: special school learning for children with moderate to severe mental retardation.
6. Activity scheduling.
7. Vocational rehabilitation.
8. Getting a disability certificate.
9. Concession passes to travel in road and railway system.
10. Occupational therapy: This can be given to the child as per his/her intellectual ability.
11. Government jobs for differently abled.

Preventive aspects:

1. Genetic counselling for parents who are "at risk".
2. Prevention of infections during pregnancy.
3. Maintaining good nutrition before, during and after pregnancy.
4. Regular antenatal and postnatal check-ups.
5. Adequate immunization during pregnancy.
6. Hospital delivery.
7. Preventing pre-mature delivery.
8. Following adequate immunization to children. Encouraging universal immunization.
9. Early detection and treatment of in born errors of metabolism like phenylketonuria.
10. Educating the general public about the causes and mode of prevention.

Definitions and facts:

Classification of Mental retardation:

1. Mild: 50-69.
2. Moderate: 35-49.
3. Severe: 20-34.
4. Profound: less than 20.

Intelligence quotient: mental age/ chronological age X 100.

Syndromes associated with mental retardation:

1. Down's syndrome: most common cause of mental retardation. Occurs due to 21st trisomy. Risk of dementia after the age of 40 years is more likely.
2. Kleinfelter's syndrome: it has 47 XXY type of genotype. It has less body hairs, gynecomastia, long stature, hypogonadism.
3. Fragile X syndrome: Occurs due to repetition of CGG within Fragile X mental retardation 1 gene. It is characterised by long face, long ears, increased flexibility of fingers, and large testis.
4. Cri-du chat syndrome: due to deletion in chromosome 5. The patient exhibit cat like cry due to laryngeal abnormality. With further development of larynx cat like cry disappears.
5. Prader-Willi syndrome: small deletion in chromosome 15. Patient has increased food intake, obesity, hypogonadism, short stature, hypotonia, small hands and feet.
6. Tuberous sclerosis: Mental retardation, Adenoma sebaceum, convulsions.

Differential diagnosis:

1. Specific learning disability: here impairment is restricted to specific area of academic achievement for example in reading, spelling, written expression etc.
2. Communication disorders: here impairment is seen in speech or in language area.
3. Childhood autism: here there is restricted repetitive behaviour, deficits in social interaction, impairment in communication.

Case 65

A 9 year old boy studying in 3rd standard in English medium school from urban background belonging to middle socio-economic status was brought by his mother for stuttering.

The parents observed stuttering in him around the age of 2 ½ years, the abnormalities of speech were continuous whenever he spoke. He has reported to the parents that his classmates and other children mock at him whenever he spoke. This was the reason why he remained silent in the class. He avoided answering in class; he avoided giving speech and

stage performance. However he liked playing and socializing but avoided it due the fear of getting humiliated. Parents said that he is the topper of the class and stuttering has made him lag behind.

Prenatal, natal and postnatal histories were normal, developmental milestones were normal for the age. There was nil contributory medical history.

The boy denied symptoms of mood and anxiety.

During interview he displayed dysfluency in speech, repetition of syllables and words, pauses after beginning the word. He had blinking, facing grimacing, shoulder shrugging, upper limb movements, he was seen to catch hold of chair or the table in order to reduce the movements that he exhibited while talking.

He appeared anxious while talking. The grammar, vocabulary knowledge and syntax were appropriate for the age.

Diagnosis: Stuttering/ Childhood onset fluency disorder

ICD-10 definition:

Speech that is characterized by frequent repetition or prolongation of sounds or syllables or words or frequent hesitations or pauses that disrupt the rhythmic flow of speech.

Why this diagnosis?

The boy had dysfluencies in speech, repetition of syllables and words, pauses after beginning the word and associated body movements like blinking, facial grimacing, shoulder shrugging, upper limb movements.

Whether patient needs inpatient care?

No, as the child has not exhibited aggression and stuttering is not a serious mental illness.

Goals in the management:

1. Symptom improvement.
2. Reducing the social anxiety due to disorder.
3. Functional improvement.

Treatment:

Psychological:

1. Parent management technique: Praising the child when he does not stutter and asking the child to correct itself when he stutters.
2. Speech therapy.
3. Relaxation exercises.
4. Cognitive Behavioural Therapy

Pharmacological:

1. SSRI (Syrup Fluoxetine) to treat associated social anxiety if present

Differential diagnosis:

1. Mental retardation: here intellectual ability is reduced where as in stuttering it is not.
2. Social phobia: when the child is in social situation due to anxiety the child may stutter, after coming out of social situation stuttering comes down.
3. Autism disorder: here impairment in communication is seen but stuttering is not found.

Case 66

A 6 year old boy of 1st standard from rural background was brought by his parents with complaints that he plays solitary and has poor social activity since 3 years of age.

Mother reports he does not have friends; he does not like mingling with other kids. He does not like sharing his toys with other kids. He always wished to play alone. He does not talk much; he does not like listening to stories like other children. He does not like visiting relatives home.

He wants everything to be done in particular order; he wants his mother to feed him every time, in the same plate. He always wants to be seated in the veranda when he is been fed. His likings with food items were also restricted. Any change in routine schedule would make him stressful and leading to tantrums during tantrums he was banging his head to wall repeatedly. He did not like relatives visiting home as it would change his daily routine.

If dolls are given to him he would take a bucket and would just keep throwing them into it. When bucket is full, he would empty it and restart throwing dolls into it. If a toy like bus is given to him, then he would repeatedly keep rotating its wheel. He stares at a rotating fan for long time till someone intervenes.

Language mile stones were delayed compared to his siblings. He keeps making a screeching noise repeatedly.

Whenever he throws tantrums, he screams loudly, bangs his head to wall and cries out loudly which parents are finding difficult to control. He was poor in academics.

During interview he did not make eye contact. He was making repeated screeching noise.

Diagnosis: Childhood autism

ICD-10 definition:

A pervasive developmental disorder defined by presence of abnormal and/ or impaired development manifesting before the age of 3 years characterised by abnormal functioning in all 3 areas:

1. Social interaction.
2. Communication.
3. Restricted repetitive behaviour.

ICD-10 diagnostic features:

1. Impairment in reciprocal social interaction: inadequate appreciation of socio-emotional cues shown as lack of response to other people's emotions, lack of modulation of behaviour to social context. Poor use of social signals and weak integration of social emotional and communicative behaviours, lack of socio-emotional reciprocity.

2. Impairment in communications: lack of social usage of language skills, impairment in make-believe and social imitative play, poor synchrony and lack of reciprocity in conversational interchange, poor flexibility in language expression, relative lack of creativity and fantasy in thought processes, lack of emotional response to other people's verbal and non-verbal overtures, impaired use of variations in cadence or emphasis to reflect communicative modulation, lack if gesture to aid meaning in spoken communication.
3. Restricted repetitive stereotyped patterns of behaviour, interests and activities. It can take the form of rigidity in day to day activities and play patterns, unusual specific attachment to non-soft objects. They insist on performing routines in rituals of a non-functional character. Stereotyped interests in dates, routes or timetables, motor stereotypes, specific interest in non-functional elements of objects like smell or feel, resistant to changes in the routine.
4. Onset: before 3 years of age.

Other names:

1. Autistic disorder.
2. Infantile autism.
3. Kanner's syndrome.

Why this diagnosis?

1. 6 year old boy has come with history of playing solitary and poor social activity since 3 years of age.
2. He wanted every routine to be done in particular order.
3. His likings in food items were restricted.
4. Inability to tolerate change in routine schedule.
5. Stereotyped playing pattern.
6. Not mingling with kids.
7. He did not like relatives visiting home as it would change his daily routine.
8. Staring at fan for long time.
9. Delay in language milestones.
10. Repeated screeching noise made by him suggests vocal stereotypy.
11. Repeated banging of head to wall at the time of tantrums suggests motor stereotypy/ repetitive behaviour.
12. Poor in academics.
13. Poor eye to eye contact.

Whether patient needs inpatient care?

Yes, as boy has anger, irritability and tantrums which parents are finding difficulty in managing at home.

Goals in the management:

1. Symptom improvement.
2. Rule out mental retardation.
3. Skill development.
4. Reducing morbidity and disability.
5. Rehabilitation.

Treatment:

Psychosocial:

1. Family psycho-education about the illness.

2. Speech therapy.
3. Parent management techniques and behavioural modification to reduce unacceptable behaviour like head banging, biting ect.
4. Behavioural shaping to help in learning new materials.
5. Behavioural modification and behavioural shaping is done through positive and negative reinforcement.

Pharmacotherapy:

1. SSRI (Syrup Fluoxetine) used to treat repetitive behaviour.
2. Risperidone has shown efficacy in treatment of irritability and repetitive behaviour.
3. Aripiprazole has also been used for treatment of irritability.

Definitions and facts:

Who coined the term autism: Leo Kanner.

Asperger's disorder: abnormalities of reciprocal social interaction associated with restricted, stereotyped, repetitive behaviour, interests and activities. No delay in language development. Seen in boys.

Rett's syndrome: commonly seen in girls, it is characterised by normal early development, followed loss of purposive hand movements and acquired fine motor skills, deceleration of head growth. Onset is between 7-24 months of age. There is loss of language development.

Hand wringing, stereotypies, hyperventilation, loss of purposive hand movements are seen. Social and play development get arrested at first between 2-3 years. Social interest is maintained. Hypotonia develops resulting in trunk ataxia, apraxia, scoilosis, kyphoscoliosis tend to develop during childhood, choreo-athetoid movements may develop. Even seizures may develop.

Gene implicated in Rett's syndrome: MECP2.

Stereotyped movements: repetitive, purposeless, non-goal directed motor activity.

Mannerisms: odd purposeful movements.

Social reciprocity: ability to initiate social interaction and to hold a back and forth conversation.

Idiot savant syndrome: isolated very well developed skills seen in autistic children. Ex: musical ability, computation etc.

Differential diagnosis:

1. Rett's syndrome: it is seen in girls and there is early normal development followed by loss of acquired hand skills and speech along with deceleration in head circumference. Onset is between 7-24 months.
2. Asperger's syndrome: here abnormalities of reciprocal social interaction associated with restricted, stereotyped, repetitive behaviour, interests and activities. No delay in language development and occurs in boys.
3. Childhood disintegrative disorder: it is characterised by normal development up to 2 years of age followed by loss of acquired skills associated withloss

of interest in environment, restricted repetitive patterns of behaviour, impairment in social interaction and communication.

4. Schizophrenia: in children with schizophrenia subtle impairment in cognitive functions can be seen resulting in poor social interactions, communication deficits which can be confused with those of Autism
5. Childhood OCD: obsessions and compulsions in OCD can be confused with repetitive patterns of behaviour in Autism. In OCD compulsive actions are to relieve the anxiety generated by obsessions, while in autism repetitive behaviours are stereotypic.

Case 67

A 7 year old boy studying in 2nd standard from urban background belonging to higher socio-economic status was brought by his mother with complaints that the boy is not attentive and over active in doing work which is been noticed by family members and school teachers since the time he has joined pre-nursery.

Teachers complain that he does not pay attention while class is going on; it seems that his mind is somewhere else; he even disturbs children sitting around him. He runs around in the classroom as well as in the corridor. Teacher has to frequently call out his name to draw his attention, he makes mistakes and skips words while copying down the notes that is been written on the board. He finds difficulty in following the sequences and he losses materials like pencil and rubber. He does not stand in queue and frequently jumps the queue.

At home he does not sit at a place and runs around. He does not finish his home work, his attention gets distracted quickly without any obvious distracters and parents have to be behind him, so that he completes homework. If parents raise voice and make him sit at a place, then he keeps tapping hands or feet. He keeps talking excessively and interrupts when others are speaking.

In the interview room, the boy was unable to sit in a place; he was constantly moving around, playing with materials in the room until his mother raised her voice to make him sit. He frequently intruded when his mother was being interviewed.

Diagnosis: Disturbance in activity and attention

Other name: Attention Deficit Hyperactivity Disorder (ADHD).

ICD-10 diagnostic features:

1. Onset: before 6 years.
2. Impaired attention and over activity in more than 1 situation (ex: home, classroom, and clinic).
3. Over activity means the child would

be excessively restless, running and jumping around, getting up from seat, excessive talkativeness, noisiness, fidgeting, wriggling.

4. Avoiding activities that require cognitive involvement.
5. Tendency to move from one activity to another without completing previous.
6. Children are reckless, impulsive and prone to accidents, find themselves in disciplinary troubles.
7. Frequent breaching of social rules.
8. Relationships with adults are socially disinhibited with lack of normal caution.
9. Intruding or interrupting others activities.
10. Prematurely answering questions before they have been completed.
11. Difficulty in waiting for turns.

Why this diagnosis?

1. Add over activity to chief complaints.
2. Inattentiveness since pre-nursery.
3. Inattentiveness was noticed by family members and school teacher which means that it occurred in 2 different settings.
4. Not paying attention while class is going on.
5. Disturbing the children sitting around him.
6. Running around in the classroom and in corridor.
7. Need for frequent calling out of name to draw attention.
8. Making mistakes and skipping words while copying down notes from board.
9. Difficulty in following sequences.
10. Frequently loosing pencil and rubber.
11. Not standing in queue and jumping the queue.
12. Not sitting at a place and running around in home.
13. Quick distraction of attention while doing home work.
14. Talking excessively, interrupting when others are speaking.
15. Inability to sit at a place, moving around constantly, playing with materials in the interview room.

Whether patient needs inpatient care?

No, as he has not exhibited aggression and parents can manage the child at home.

Goals in the management:

1. Symptom improvement.
2. To rule out mental retardation.
3. Improving functioning at home and in school.

Treatment:

Psychological:

1. Psycho-education about the illness,
2. Social skill training.
3. Academic skill training.
4. Parent training.
5. Behavioural modification to be done in both home and at school.
6. Helping children to structure their room.

Pharmacotherapy:

1. It is the first line for the treatment.
2. Stimulants treatments include methylphenidate, dexmethylphenidate, dextroamphetamine,
3. Non stimulants include Atomoxetine. Alpha agonists like Clonidine and Guanfacine.

Differential diagnosis:

1. Conduct disorder: it is characterised by impulsive behaviour like in ADHD, but other features of conduct disorder like truancy, fire setting, lying are not seen in ADHD.
2. Oppositional defiant disorder: it is characterised by presence persistent negativistic, hostile, defiant, disruptive behaviour. The child actively defies adult's requests.
3. Mental retardation: children with mental retardation may present with inattention if they are involved in activities that are not appropriate for their intellectual capacity as the child does not understand the concept.
4. Childhood mania: childhood mania also presents with hyperactivity, inattention, impulsivity, in childhood mania the child would be irritable rather than being happy.
5. Specific learning disorder: if child has SLD, the child may become inattentive as he does not understand the subject.

Case 68

A 10 year old boy of 4th standard from semi-urban background belonging to middle socio-economic status was brought by his mother with complaints that his school performance has reduced from 2 years.

The boy was doing well in 1ststandard; in 2nd standard he was not showing interest in studies. He did not listen to class teacher. His class room notes used to be incomplete. He was involving in activities other than studies. He did not do homework. Whenever teacher asked him about this he back answered to them.

He was picking up frequent quarrels with classmates, and had physical fights with senior students in the school. He had bullied a classmate for not giving the fancy pencil which he was possessing. Many times he had taken departure from home saying he would be going to school, but he did not attend classes. Instead he had spent time near the film theatre.

At home he picks up frequent fights with elder brother. He lies frequently. Parents have caught him stealing money from their purse. He stays outside home for long time and returns home late, when questioned he tells lies.

He had demanded for a cycle, when parents denied it he became so aggressive

that he hit a street puppy till it died, for this his father had beaten him with belt but later bought him a cycle. Parents have received complaints that he rides cycle very rashly, if neighbours advise him not to do it, then he mocks at them and does actions as if he would hit them with cycle which has worried neighbours.

He threatens parents that if his demands are not met then he would run away from home.

During interview no symptoms suggestive of mania, depression, psychosis, hyperactivity, and pervasive developmental disorder were seen.

Diagnosis: Conduct disorder

ICD-10 diagnostic features:

1. Excessive levels of fighting or bullying.
2. Cruelty to animals or other people.
3. Severe destructiveness to property.
4. Fire setting.
5. Stealing.
6. Repeated lying.
7. Truancy from school and running away from home.
8. Unusually frequent and severe temper tantrums.
9. Defiant provocative behaviour.
10. Persistent severe disobedience.
11. Any one of the above categories if marked is sufficient for the diagnosis.
12. Child's developmental age should be considered before diagnosing this as temper tantrums are normal part of children up to 3 years old.
13. Conditions like schizophrenia, mania, pervasive developmental disorder, hyperkinetic disorder, depression should be ruled out.
14. Duration criteria: 6 months or longer.

Types:

1. Conduct disorder confined to the family context: conduct behaviour restricted entirely to the home.
2. Unsocialized conduct disorder: disturbed peer relationships or lacking friendships.
3. Socialized conduct disorder: has adequate and lasting friendships.

Why this diagnosis?

1. Involving in activities other than studies.
2. Back arguing with elderly when punctuality is expected.
3. Frequent quarrels with classmates and elder brother.
4. Physical fights with senior students.
5. Bullying the classmates.
6. Truancy from school.
7. Frequent lying.
8. Stealing money.
9. Staying outside the home for long and returning back late.
10. He had hit the street puppy till its death.
11. Riding the cycle rash and mocking at neighbours when they advise him.
12. Threatening the parents.

Whether patient needs inpatient care?

Yes, the boy needs inpatient care for short term as the activities and behaviour of him are disturbing his family and neighbours.

Goals in the management:

1. Symptom improvement.
2. Improving functioning.

Treatment:

Psychological:

1. Parent management technique: child's undesired behaviours are modified and desired behaviours are encouraged. It is based on the principle of operant conditioning. When the child shows desired behaviour it is positively reinforced by praising, gifting the child and undesired behaviour it is ignored.
2. Parent child interaction training: positive communication between parents and children is encouraged. Parents are advised not to be physically or verbally aggressive with child, not to pass critical comments. Positive communication between the child and parents is encouraged.
3. Parents and teachers should be involved in therapy and it should be induced both at home and in school.
4. Social skill training.
5. Communication skill training.
6. Play ground behaviour training.
7. Behaviour with friends training.
8. Periodical home visits.
9. Anger management.

Pharmacological:

1. Atypical antipsychotics like Risperidone either in tablet form or oral solution, Aripiprazole can be used in the treatment of aggression.
2. Co-morbid ADHD is highly likely in children with conduct disorder which needs to be identified and treated. Treatment of ADHD with stimulants not only helps in improving ADHD symptoms it helps to reduce aggression.
3. Impulsive behaviour treated with carbamazepine.

Differential diagnosis:

1. Oppositional Defiant Disorder: it is characterised by presence persistent negativistic, hostile, defiant, disruptive behaviour. The child actively defies adult's requests. In conduct disorder the child has persistent bullying, stealing, repeated lying, cruelty towards animals and other associated features.
2. Intermittent explosive Disorder: episodes of impulsive aggression resulting in serious assaults or property destruction.
3. ADHD: in this disorder hyperactivity, impulsivity, inattention is seen but features of conduct disorder like bullying, stealing, lying, violating others rights are not seen.
4. Mania episode: it is characterised by irritable mood in children but other features of conduct disorder is not seen.

Case 69

A 10 year old boy of 5th standard from urban background belonging to middle socio-economic status was brought by his mother with complaints that he is not willing to attend school from 1 month.

He was doing well till 1 month back when his mother met with an accident and had leg fracture, the boy was at home with nurse who was helping his mother for 1 month, he had to stay in home as he was the only child to mother and his father was staying in another city for job, who would visit the home once in a month.

He used to be with mother all the time, staying beside her. He was sleeping in her room, though he had separate room for himself. His mother recovered 1 month before the consultation.

Since 1 month whenever the boy is made to sleep in his room, he frequently wakes up after some time and comes to mother's room and sleeps there. He has experienced nightmares of demons trying to kill his mother and he was unable to save his mother.

If he is sent to school, he comes back to home saying his mother might be ill or some bad event would have occurred to her in his absence. If teacher does not allow him to return to home he throws tantrums in school.

The boy was slow to warm up temperamentally.

During interview he was with mother, and insisted that he should be interviewed in presence of his mother.

Diagnosis: Separation anxiety disorder of childhood

ICD-10 criteria:

Key feature: Excessive anxiety when separated from individuals to whom the child is attached, this anxiety is not a part of generalised anxiety of multiple situations.

Anxiety can take the form of:

a. Unrealistic worry about possible harm to major attachment figure or a fear that they will leave and never return.

b. Unrealistic worry that some untoward event like child being lost, kidnapped, admitted to hospital or killed will separate him or her from major attachment figure.

c. Persistent refusal to go to school due to fear of separation.

d. Persistent refusal to go to sleep without being near major attachment figure.

e. Repeated nightmares about separation.

f. Repeated occurrence of physical symptoms like nausea, vomiting, stomach ache, headache when separated from attachment figure or when sent to school.

g. Excessive recurrent distress as shown by anxiety, crying, tantrums, misery, apathy, social withdrawal in anticipation of or immediately following separation from major attachment figure.

Why this diagnosis?

1. Unwillingness to attend school from 2 months.
2. At home he used to be with mother all the time to help her.
3. When made to sleep in his room he was frequently waking up and was going to mother's room to sleep.
4. Experiencing nightmares with contents of separating him from mother.
5. Returning back to home if sent to school thinking that some untoward event would happen to his mother.
6. Throwing tantrums when returning to home was not allowed.

Whether patient needs inpatient care?

No, the boy has not exhibited aggression; he is not threat to self or to others.

Goals in the management:

1. Symptom improvement.
2. Reducing avoidance behaviour.

Treatment:

Psychological:

1. Relaxation exercises, psycho-educating parents, Parent management techniques.
2. Involving child in psychotherapy and educating him that his mother will be safe and would not encounter untoward events in his absence.
3. During initial stages of therapy, mother can be asked to accompany the child to school and stay with him in till he adjusts to class environment. Gradually the period for which the mother stays in classroom can be reduced so that the child can adjust to the class environment. For the above things to happen school headmaster and class teacher should be involved.

Pharmacological:

Fluoxetine is used to control mood and anxiety symptoms.

Differential diagnosis:

1. Generalised anxiety disorder: here the anxiety is present in multiple areas not restricted to separation from significant attachment figure.
2. Panic disorder: here panic attacks appear out of the blue and are not restricted to a particular situation like in separation anxiety disorder where the child gets anxious on separating from significant attachment figure.
3. Social phobia: here intense anxiety appears when the child faces social situation and anxiety is not seen in other situation.
4. Childhood depression: due to low and irritable mood the child may present with excessive clinging behaviour with adults whereas in separation anxiety disorder the child becomes anxious and irritable on separation from attachment figure.

Case 70

A 5 year old girl studying in LKG from rural background had been to paediatrician with mother for the complaints of eating mud, charcoal, licking wall from 1 year.

The girl was evaluated by paediatrician in detail and iron deficiency anaemia was found in her which was treated. She was referred to psychiatry for behavioural management.

The girl was 3rd child out of 5 children to the parents. The mother of the girl had insignificant prenatal history. Delivery of the baby was in hospital and it was normal vaginal delivery. Post natal immunization care was adequate.

During interview it was found that her parents were living in joint family. Most of the family members were involved in farming and girl's mother for most of the time was involved in cooking and other house hold work in free time she used to feed her 4th and 5th kid. She could not spend much time in rearing and supervising the activity of the girl.

Girl temperamentally was seen to be slow to warm up type of child. Intellectually she was normal.

Diagnosis: Pica of infancy and childhood

ICD-10 diagnostic features:

It is persistent eating of non-nutritive substances (soil, paint chippings, etc). It can be a symptom of other psychiatric disorder like autism or an isolated psychopathological behaviour.

Most commonly associated with mental retardation.

Why this diagnosis?

The girl had presented with complaints of eating mud, charcoal, licking wall; it constitutes to intake or consumption of non-nutritive substances.

Common causes like iron deficiency anaemia was found in her which was treated.

Temperamentally the girl was slow to warm up type of child. Intellectually she appeared normal.

Whether patient needs inpatient care?

Yes, as detailed evaluation of the child is necessary to rule out medical causes for the presentation and for instituting behavioural management.

Goals in the management:

1. Rule out medical causes.
2. Symptom improvement.
3. Behavioural modification.

Treatment:

Psychosocial:

1. Correcting neglect of the child by the parents.
2. To detect and eliminate lead from the patient's environment.

3. Behavioural modification by positive reinforcement.
4. Parental monitoring of activities of the child.

Pharmacological:

1. Rule out medical causes for the pica.
2. To investigate and treat iron and zinc deficiency.

Differential diagnosis:

1. Medical causes: zinc and iron deficiencies that cause pica should be ruled out.
2. Mental retardation: here due to reduced intellectual ability, the child may develop pica.
3. OCD: here eating non-nutritive substance may occur due to obsession.
4. ADHD: here putting non-nutritive substance in mouth by child can be due to impulses.

Case 71

A 27 year old unmarried male with education up to 7th standard, manual labourer from rural background; belonging to low socio-economic status came with complaints of generalized weakness and multiple body pains from 5 years whenever there is passage of white fluid from genital organ.

Patient from past 5 years was experiencing generalized weakness of the body, pain in head, shoulder, back and hip region. The pain was dull aching type, non-radiating which would aggravate with work and would reduce in severity with rest. He tells that this would happen following passage of white fluid from genital organ which would occur one to two times in a week during sleep; morning he used to notice that the inner wear is wet. He added that especially pain in hip would aggravate following passage of white fluid.

He kept worrying about the same as he was unable to carry out work due to generalized weakness and multiple body pain.

He adds that he had read in an advertisement in public urinals that white fluid of the body is highly precious, body utilizes lot of energy and 60 drops of blood for producing the fluid and loss of it can cause weakness, serious problems of the body with huge impact on future sexual life. This had made him worry about it.

He had thought of discussing this problem with friends but felt shy. He consulted a faith healer for this, he was given a powder to have with milk and he used this treatment for 6 months which did not help in any way. He consulted general physician and he referred the patient to a psychiatrist.

Diagnosis: Dhat syndrome

Clinical features:

It is included under other specified neurotic disorders in ICD-10.

It is a type of culture bound syndrome which occur secondary to the belief that passage of semen has debilitating effects.

Culture bound syndromes has strong association with locally accepted cultural beliefs and patterns of behaviours which are not delusional.

In Dhat syndrome patient presents with multiple body pain following passage of semen (dhatu). It may pass while the patient is sleeping, during masturbation or following sexual intercourse. Patients often complain of weakness especially of hip region, easy fatigability, palpitations, multiple body pain, anxiety symptoms and sometimes low mood which they attribute to loss of vital fluid "dhatu". As they believe that it takes around 60 drops of blood for the formation of 1 drop of dhatu.

Why this diagnosis?

1. Male patient had presented with weakness and multiple body pain which would appears following passage of white fluid from genital organ.
2. Persistent worry that 60 drops of blood is utilised by the body for the formation of white fluid and this would have huge impact on future sexual life.

Whether patient needs inpatient care?

No, the condition is not a serious mental illness, patient has good insight, he can take care of self, he not threat to self or to society.

Goals in the management:

1. Symptom improvement.
2. Correcting misconceptions.
3. Reducing morbidity.

Treatment:

Psychotherapy:

prevalent beliefs about semen among their community and friend's circle are explored. Psychotherapy is directed at addressing the misconception the person has with regard to semen productions and its loss. Some patients may require psycho-education about masturbation, nocturnal loss of semen during sleep.

Pharmacotherapy:

1. SNRI (Venlafaxine, Desvenlafaxine, Duloxetine), Tricyclic antidepressants (Amitriptyline, Imipramine, Dotheipine,Nortriptiline) are more effective in the treatment. They help in improving symptoms of pain and also improve mood symptoms the person is experiencing due to stress.

Other culture bound syndrome:

1. Koro: here the person has morbid fear that genital organs (penis and scrotum in males, breast and vulva in females) are growing small and retracting, when it gets completely absorbed into abdomen he dies.
2. Jhin-Jhini: literal meaning of 'Jinjinia' in Assamese means tingling. Here the person presents with tingling and numbness which leads to muteness, collapse and sense of impending death.

3. Amok: it is seen in Malaysian males, it is a dissociative episode, during the episode person initially would be in deep worry followed by aggression and homicidal behaviour later resulting in exhaustion. Once the person is out of the episode he has amnesia towards the event.
4. Possession syndrome: seen usually in females who are under stress and are unable to express and handle it. The individual gets possessed by spirits and during the episode they may speak in different voice, become aggressive and scold others. If they are possessed by God, they may demand for certain valuable items or other things. Once the episode subsides the person does not remember what had happened during the episodes. It is included in somatoform disorder as Trans and possession disorder in ICD-10.
5. Mass hysteria: it is seen usually in females. During the episode individuals get possessed simultaneously and exhibit a particular behaviour. These are seen during religious gathering.
6. Latah: seen usually in females characterized by exaggerated startle response to trivial stimulus, automatic obedience and mimicking the action of other person. It is seen in Malaysia and Indonesia.

Case 72

A 12 year old girl studying in 6th standard from urban background had presented to surgeon for swallowing a pin while pinning the scarf to get ready to go to school. She was holding the pin between the teeth while pinning the scarf. She was immediately taken to hospital and through endoscopy the pin was removed. She was advised rest for 2 days and she did not attend school. The act of swallowing pin was unintentional. Due to same reason she missed the class test that day. Two days later she recovered and attended school and she was given grace marks for passing the exams.

After 1 month the girl was readmitted to hospital for swallowing the pin. She told to surgeon that she was holding it between the teeth for pinning the scrap. Through endoscopy the pin was removed. Her parents told to Surgeon that, she was suppose to give test that day and now she has missed it.

A psychiatric evaluation was sought for repeated swallowing of pin.

During interview patient admitted that she had not prepared well for the exam and she swallowed the pin, so that on sickness grounds she will not be made to

write exams and would be passed with grace marks like how it happened during previous test.

The act done by her was purely to avoid giving exams without intention to harm self.

There was no history suggestive of low mood, anxiety. Her biological functions were normal.

Diagnosis: Malingering

ICD-10 Definition:

It is intentional production or feigning of either physical or psychological symptoms or disabilities, motivated by external incentives.

Common external motives for malingering:

1. Evading criminal prosecution.
2. Obtaining illicit drugs.
3. Avoiding dangerous military duty.
4. Attempts to obtain sickness benefits.
5. Improvements in living conditions like housing.

Why this diagnosis?

1. The girl had learnt that she would be given concession for exams and grace marks to pass when the act of swallowing pin was done 1st time by her which was unintentional.
2. The act of swallowing pin done by her 2nd time was to avoid giving exams which could be done if she projects herself with sick role.

Whether patient needs inpatient care?

No, patient has feigned the symptoms to get concessions from exams, if she is given in patient care, then her behaviour would get reinforced and in future she may exhibit same symptoms. So inpatient care is not necessary.

Goals in the management:

1. Reducing gains.
2. Improving social skills.
3. Stress management skills.

Treatment:

1. Malingering is not an illness to treat, creating awareness on negative consequence to the patient for feigning the symptoms and helping the patient to adopt acceptable behaviour.
2. In children treatment is instituted by behavioural modification.

Differential diagnosis:

1. Factitious disorder: induction of symptoms in this disorder is to seek medical attention.
2. Somatization disorder: patient presents with multiple varying physical symptoms for which there is underlying physical aetiology. The cause would be psychological stress.
3. Dissociative disorder: here patient presents with dissociative symptoms which occur due to psychological stress. The patient does not have any kind of incentive gain.

Case 73

A 14 year old boy studying in 8th standard in English medium school from urban background was brought by his parents with complaints of poor academic performance since 1 year.

The boy was doing well till 7th standard when he scored 94% marks. In 8th standard it was observed by class teacher that he is not concentrating when teaching is going on, it appeared that he is lost in some thinking. If he is asked to say what is being taught then he would not be able to tell it. He was not writing notes dictated in the class. He was performing poorly in class tests.

He was not doing home assignments. He was not interacting with friends and classmates. He preferred to be alone. He was not participating in sports and cultural activities conducted.

At home parents had seen that he used to be with book open but without reading it. He used to sit looking somewhere else. Even with reminding that he should pay concentration while studying, his concentration would wane off quickly.

He used to be off mood most of the time. He did not like doing household work or comply with helping parents. He was back answering parents and teachers which he was not doing previously. He was picking up fights with friends frequently which were usual for him before.

He spent most of the time watching TV or spent being alone in his room. He used to eat only if his favourite dish is prepared, while before 1 year he used to eat all kinds of dishes.

During interview; the boy appeared irritable when his parents were describing his behaviour, he shouted back at them saying they always keep complaining about him. He said that he is not finding any interest in studying and in playing. He likes watching TV and he does it, which is opposed by his parents. He said that he is not getting good sleep.

He denied of having thoughts of self harm. History suggestive of recurrent depressive disorder was present in his mother.

There was no past history of depression and mania.

Diagnosis: Childhood depression

Diagnostic features:

1. Depressed or irritable mood.
2. Diminished interest or pleasure in activities.
3. Significant weight change.
4. Sleep disturbance.
5. Psychomotor agitation or retardation.
6. Fatigue or loss of energy.
7. Feelings of worthlessness or guilt.
8. Diminished concentration or decisiveness.

9. Recurrent thoughts of death or suicidality.
10. Duration: 2 weeks.

Why this diagnosis?

1. Poor academic performance since 1 year.
2. Reduced concentration in class.
3. Poor performance in class tests.
4. Not doing home assignments.
5. Poor interaction.
6. Being alone.
7. Being angry most of the time.
8. Picking up fights with friends.
9. Reduced appetite.
10. Irritability during interview.

Whether patient needs inpatient care?

No, as patient does not have suicidal ideation.

Goals in the management:

1. Symptom improvement.
2. Medication compliance.
3. To rule out suicidal thoughts.
4. Look out for bipolarity.
5. Improving academic performance.

Treatment:

Psychological:

1. Cognitive behavioural therapy.
2. Supportive therapy.

Pharmacological:

1. Among SSRIs Fluoxetine is used for treatment of childhood depression.

CHAPTER 4

PROJECTIVE PSYCHOLOGICAL TESTS

Projective tests for adults:

1. Thematic Apperception Test (TAT): it was developed by Henry Murray and Cristiana Morgan. It has 31 achromatic cards along with 1 blank card. The cards consist of human beings of both sexes and different ages doing variety of activities. During test the person is shown individual card and he needs to tell the story for each card. The story is analyzed. Indian version was developed by Uma Choudhary.
2. Rorschach Inkblot Test: it was developed by Swiss psychiatrist Hermann Rorschach. It consists of 10 cards. Cards have ambiguous symmetricalinkblots.

   Achromatic cards number: 1, 4, 5, 6 and 7.

   Partially chromatic cards number: 2, 3.

   Completely chromatic cards: 8, 9, 10.

   During test the individual should explain what the card looks like. The response is analyzed.
3. Sentence completion test: in this test individual is presented with incomplete sentences, the individual is asked to complete the sentences. Completed sentences are analyzed. This helps in understanding psychological conflicts, interpersonal issues and other stresses.

Projective personality tests for children:

1. Draw a person test: it was developed by Karen Machover. Here the individual is asked to "draw a person". Drawing is analyzed with regard to body parts, clothing etc.
2. Children's Apperception Test (CAT): It was developed by Leopard Bellakand Sonya Sorel Bellak. It is used for children between 3-10 years of age. It consists of 10 cards. Cards consist of animal figures doing variety of activities.

Uses of projective personality tests:

1. Understanding the personality.
2. Knowing the psychological conflicts.
3. Knowing Interpersonal conflicts.
4. Knowing Family dynamics.
5. Making the diagnosis.
6. Helps in planning treatment.
7. Research purpose.

CHAPTER 5

COMMONLY USED PSYCHOTROPIC DRUGS

Antidepressants	Dose (mg/day)	Side Effects	Indications
Tricyclic antidepressants			
Amitriptyline	25-250	Dry mouth, urinary retention, constipation, blurring of vision, sedation, orthostatic hypotension, aggravating narrow angle glaucoma, sexual dysfunction, arrhythmias, weight gain.	Depressive disorder, Migraine. Neuro pathic pain, Anxiety disorders, Treatment resistant depression, Somatoform disorder, Clozapine induced enuresis, Insomnia, Nocturnal enuresis
Clomipramine	75-250	Seizures, same as for Amitriptyline	OCD, Neuropathic pain, Anxiety disorders, Treatment resistant depression
Dothiepin/ Dosulepin	25-225	Same as for Amitriptyline in a lesser degree	Depression Anxiety disorder Insomnia Treatment of depression Neuropathic pain
Imipramine	25-250	Same as for Amitriptyline but sedation is less	Depression Nocturnal enuresis
Nortriptyline	25-225	Same as for Amitriptyline but anticholinergic, sedative side effects are less	Depression Nocturnal enuresis Neuropathic pain

Selective Serotonin Reuptake Inhibitors

Escitalopram	10-20	Nausea, vomiting, abdominal pain, diarrhea, Insomnia Sexual dysfunction, Hyponatremia	Depressive disorder Panic disorder Agoraphobia Social phobia Generalized anxiety disorder OCD
Citalopram	20-40	Same as escitalopram, QT interval prolongation	Same as escitalopram
Fluoxetine	20-60	Same as escitalopram but insomnia more common so given during morning hours	Depression in adults Childhood depression OCD Bipolar depression in combination with olanzapine Bulimia nervosa
Fluvoxamine	50-300	Same as escitalopram	OCD Depression
Sertraline	50-200	Same as escitalopram	Depression, panic disorder, social phobia, OCD, PTSD, other anxiety spectrum and OCD spectrum disorder, Depression during pregnancy and postpartum depression
Paroxetine	10-60	Same as escitalopram Sedation more common	Depression, OCD, panic disorder, social phobia, PTSD, GAD
Depoxetine	30-60	Nausea, headache,	Premature ejaculation diarrhea, insomnia.

Serotonin Norepinephrine Reuptake Inhibitors

Venlafaxine	75-225	Nausea, vomiting sedation, sexual dysfunction, QT-interval	Depression Depression with somatic symptoms

		prolongation, hyponatremia, hypertension, seizures, discontinuation syndrome	GAD Social phobia Panic disorder Pain syndromes Depression and co-morbid cocaine use PTSD, PMDD
Desvenlafaxine	50-100	Same as venlafaxine	Same as venlafaxine, but more effective than venlafaxine for pain syndromes.
Duloxetine	20-60	Nausea, vomiting sedation, increased sweating, sexual dysfunction, hypertension, hyperglycemia, hepatotoxicity,	Depression, Pain syndromes

Noradrenergic and Specific Serotonergic Antagonists

Mirtazapine	7.5-45	Sedation, weight gain.	Depression disorder with insomnia and reduced appetite.

Noradrenergic Dopaminergic Reuptake Inhibitors

Bupropion	150-450	Nausea, vomiting, hypertension, psychotic symptoms, delirium, postural hypotension, seizures. Advantages: no sedation, sexual dysfunction.	Depression, To quit smoking, Cocaine detoxification, To reduce sexual dysfunction due to SSRI.

Melatonin receptor agonists

Melatonin	3-6	Nausea, disorientation, confusion, sleep walking, night mares	Non organic insomnia, Non organic disorder of sleep wake cycle.

Serotonin Partial Agonist and Reuptake Inhibitor

Vilazadone	10-40	Nausea, vomiting, gastritis is more so should be taken with food. No sexual dysfunction & weight gain	Depressive disorder

Mood stabilizers:

Lithium	Based on Lithium level Usually 600-1200 mg/day	Nausea, vomiting, sedation, weight gain, tremors, acne, hypothyroidism, diabetes insipidus, Ebstein's anomaly in infants if prescribed in pregnancy	Mania, hypomania, cluster headache, Bipolar depression, Prophylaxis of bipolar disorder, augmenting agent in depressive disorder, schizoaffective disorder.
Sodium Valproate	10mg/kg/day to 40mg/kg/ day	Nausea, vomiting sedation, weight gain, hair loss, tremors, pancreatitis, hepatitis, hyperammonia resulting in encephalopathy, PCOD, Teratogenic effect: neural tube defect.	Mania, Hypomania, prophylaxis of bipolar disorder, migraine prophylaxis, impulsivity, aggression.
Carbamazepine	200-1200	Nausea, vomiting, sedation, weight gain, agranulositosis, pancreatitis, fatal hepatitis, mild rashes to Stevenson's Johnson's syndrome, hyponatremia, Teratogenic effect: Neural tube defects	Mania, hypomania, prophylaxis of bipolar disorder, post herpetic neuralgia, restless leg syndrome, temporal lobe epilepsy, impulsivity, aggression,
Oxcarbazepine	300-2400	Nausea, vomiting, sedation, hyponatremia, No side effects on blood, rashes less frequent unlike carbamazepine	Mania, hypomania, prophylaxis of bipolar disorder
Lamotrigine	25-400	Nausea, vomiting, sedation, mild rashes to Stevenson's Johnson's syndrome, hepatic failure	Bipolar depression
Levitiracetam	250-1000	Nausea, vomiting, sedation, agitation.	Bipolar mania, seizure disorder

Antipsychotic drugs:

First generation/ Typical

Chlorpromazine	100-1000	EPS, Sedation, Neuroleptic Malignant Syndrome Postural hypotension, QTc interval prolongation, dry mouth, blurring of vision, constipation, urinary retention, hyperprolactinaemia, sexual dysfunction, akathisia	Acute psychosis, Schizophrenia, Schizoaffective disorder. Mania Delusional disorder Delirium Substance induced psychotic disorder Tourette's disorder
Haloperidol	5-20	Same as chlorpromazine but EPS is more	Same as chlorpromazine
Pimozide	2-8	Same as chlorpromazine but QTc interval prolongation is more	Tourette's syndrome, delusional disorder

Second generation/ Atypical

Risperidone	1-16	Sedation, metabolic syndrome, EPS, hyperprolactinaemia	Schizophrenia, acute and transient psychotic disorder, schizoaffective disorder, acute phase of mania, mania with psychotic symptoms, severe depression with psychotic symptoms.
Paliperidone	3-12	Sedation, metabolic syndrome, postural hypotension, QTc interval prolongation, EPS, hyperprolactinaemia is more,	Schizophrenia, schizoaffective disorder

Olanzapine	2.5-20	Same as Risperidone but sedation and metabolic syndrome are more severe.	Same as Risperidone, bipolar depression along with Fluoxetine, psychosis during pregnancy, post partum psychosis.
Quetiapine	25-800	Same as Risperidone but EPS is less, sedation is more, QT-interval prolongation	Same as Risperidone
Aripiprazole	5-30	Devoid of metabolic syndrome and hyperprolactinaemia, akathisia more common.	Same as Risperidone, preferred antipsychotic drug if patient has metabolic syndrome or hyperprolactinaemia or galactorrhoea,
Amisulpride	100-800	Same as Risperidone but hyperprolactinaemia is highest among 2nd generation antipsychotics.	Same as Risperidone, Lower dose preferred when patient has negative symptoms and higher dose when patient has positive symptoms.
Lurasidone	20-160	Devoid of metabolic syndrome and hyperprolactinaemia, akathisia more common.	Bipolar depression, Schizophrenia.
Clozapine	12.5-900 Effective dose: 300-900 mg/day	Tachycardia, postural hypotension, sedation, urinary retention, constipation, sialorrhoea, agranulocytosis, metabolic syndrome, myocarditis, risk of seizures above 600mg/day	Treatment resistant schizophrenia Patients with suicidal behavior, Patients with TD, galactorrhoea, EPS

Benzodiazepines:

Alprazolam	0.5-2	Nausea, vomiting, Sedation, dizziness, forgetfulness, respiratory depression, abuse liability	Generalized Anxiety Disorder, Panic disorder Panic attacks, Other anxiety disorder Non organic insomnia, Insomnia in depression, alcohol withdrawal,
Lorazepam	1-16	Same as Alprazolam	Same as alprazolam, alcohol withdrawal
Clonazepam	0.5-2	Same as Alprazolam	Same as Lorazepam
Chlordiazepoxide	10-100	Same as Alprazolam, Hepatic dysfunction	Same as Lorazepam
Diazepam	5-40	Same as Alprazolam, Hepatic dysfunction	Same as Lorazepam
Nitrazepam	5-20	Same as Alprazolam	Anxiety disorders, insomnia.

Beta-blockers:

Propranolol	10-120	Nausea, vomiting, diarrhea, Hypotension, bradycardia, Depression,	Performance anxiety, Migraine prophylaxis, Akathisia, Lithium induced tremors, anxiety disorders, Alcohol, cocaine, nicotine, benzodiazepine withdrawal, aggression
Atenolol	25-100	Nausea, vomiting,	Same as propranolol
		hypotension, bradycardia,	

Alpha-2 agonists:

Clonidine	25 micro g-300 micro g	Nausea, vomiting, dry mouth, sedation, hypotension, bradycardia, nightmares	Opioid, alcohol, benzodiazepine withdrawal, ADHD, anxiety disorders

Anticholinergic agents:

Trihexyphenidyl	1-6	Nausea, vomiting, Urinary retention, constipation, aggravation of narrow angle glaucoma, Delirium, Hallucinations.	Drug induced parkinsonism.
Glycopyrrolate	1-6	Same as Trihexyphenidyl	To reduce sialorrhoea (clozapine induced) Pre ECT use reduces parasympathetic response to control bradycardia, oral secretion.

Cholinesterase inhibitors:

Donepezil	5-10	Nausea, vomiting, abdominal pain, Diarrhea, delirium, bradycardia.	Alzheimer's dementia.
Rivastigmaine	1.5-6	Same as Donepezil	Alzheimer's dementia
Galantamine	16-32	Same as Donepezil	Alzheimer's dementia

NMDA receptor antagonist:

Memantine	5-20	Nausea, vomiting, sedation, constipation,	Alzheimer's dementia

Phosphodiestarase-5 inhibitors:

Sildenafil	50-100	Headache, facial flushing, nasal congestion, Non-arteritic optic ischemic neuropathy, Priapism **Contraindication:** if person is on organic nitrates, there will be a sudden drop in blood pressure.	Erectile Dysfunction
Tadalafil	10-20	Same as Sildenafil	Erectile Dysfunction

Sedative Z-drugs:

Zolpidem	5-10	Dizziness, hallucinations, depression, depersonalization	Insomnia

CHAPTER 6

COMMON PSYCHOTHERAPIES FOR INDIVIDUAL DISORDERS

1	Depression	Cognitive Behavior Therapy
2	Bipolar Affective disorder	Interpersonal and Social Rhythm Therapy
3	Substance dependence	Motivation Enhancement Therapy
4	Delusional Disorder	Cognitive Behavior Therapy for delusions
5	Anxiety disorders	Cognitive Behavior Therapy
6	Phobic Disorders	Systemic Desensitization
7	Post Traumatic Stress Disorder	Eye movement Desensitization and Reprocessing
8	Obsessive Compulsive Disorder	Exposure and Response Prevention Therapy
9	Somatization and other somatoform disorders	Reattribution Therapy
10	Hair pulling disorder	Habit Reversal
11	Skin picking disorder	Habit Reversal
12	Borderline Personality Disorder	Dialectical Behavior Therapy
13	Sexual dysfunction	Dual Sex Therapy
14	Marital Discord	Couple's therapy, Marital therapy
15	Interpersonal relationship issues	Interpersonal Therapy
16	Family Dysfunction	Family Therapy
17	Relaxation exercises (Deep breathing, Jacobson's Progressive Muscle Relaxation)	Anxiety disorders and depressive disorders

CHAPTER 7

DURATION CRITERIA FOR DIAGNOSIS OF PSYCHIATRIC DISORDERS

Disorders	Duration
Dementia	6 months
Substance use disorders	1 year
Schizophrenia	1 month
Schizotypal disorder	2 years
Delusional disorder	3 months
Acute and transient psychotic disorders Acute: Abrupt:	 Within 2 weeks Within 48 hours
Hypomania	4 days
Mania	1 week
Depressive disorder	2 weeks
Dysthymia	2 years
Mixed affective disorder	2 weeks
Panic disorder	1 month
Obsessive Compulsive Disorder	2 weeks
Acute stress reaction	Few minutes to few hours
Post Traumatic stress disorder	Within 6 months of traumatic event
Adjustment disorder	Onset: within 1 month of the stressor
Somatization disorder	2 years
Undifferentiated somatoform disorder	6 months
Non organic insomnia	1 month
Non organic hypersomnia	1 month
Non organic disorder of the sleep-wake schedule	1 month
Tic disorder	1 year

CHAPTER 8

INTELLIGENCE QUOTIENT TESTS

IQ tests	Developer	Age range
Developmental Screening Test (DST)	Bharat Raj	Birth to 15 years of age
Gesell Developmental Schedule (GDS)	Arnold Gesell	1-72months
Stanford-Binet test for Intelligence	Stanford -Binet	2 to 23 years.
Wechsler Intelligence Scale: Wechsler Intelligence Scale for Children (WISC) Wechsler Adult Intelligence Scale (WAIS)	David Wechsler	6 to 16 Adults
Verbal Adult Intelligence Scale (VAIS)	Verbal adoption of WAIS in Indian population by Prasad and Verma Performance part of WAIS has been adapted for Indian population by Prabharamalinga Swamy	20-69 years
Malin's Intelligence Scale for Indian Children (MISIC)	Dr. Arthur J. Malin	6-15

Non Verbal and Performance Test

Bhatia's Performance Test of Intelligence	C.M. Bhatia	11 years of the age and above
Gesell Drawing Test	Arnold Gesell	16 months-7 yrs
Seguin Form Board Test (SFB)	O. Edouard Seguin	3-11 yrs
Vineland Social Maturity Scale (VSMS)	Edgar A. Doll	birth to 25 years
(VSMS) Indian adaptation	Dr. A.J. Malin	birth to 15 years
Behavioural Assessment Scale for Indian Children with Mental Retardation (BASIC-MR)	Peshawaria and Venkatesan	3-16 years

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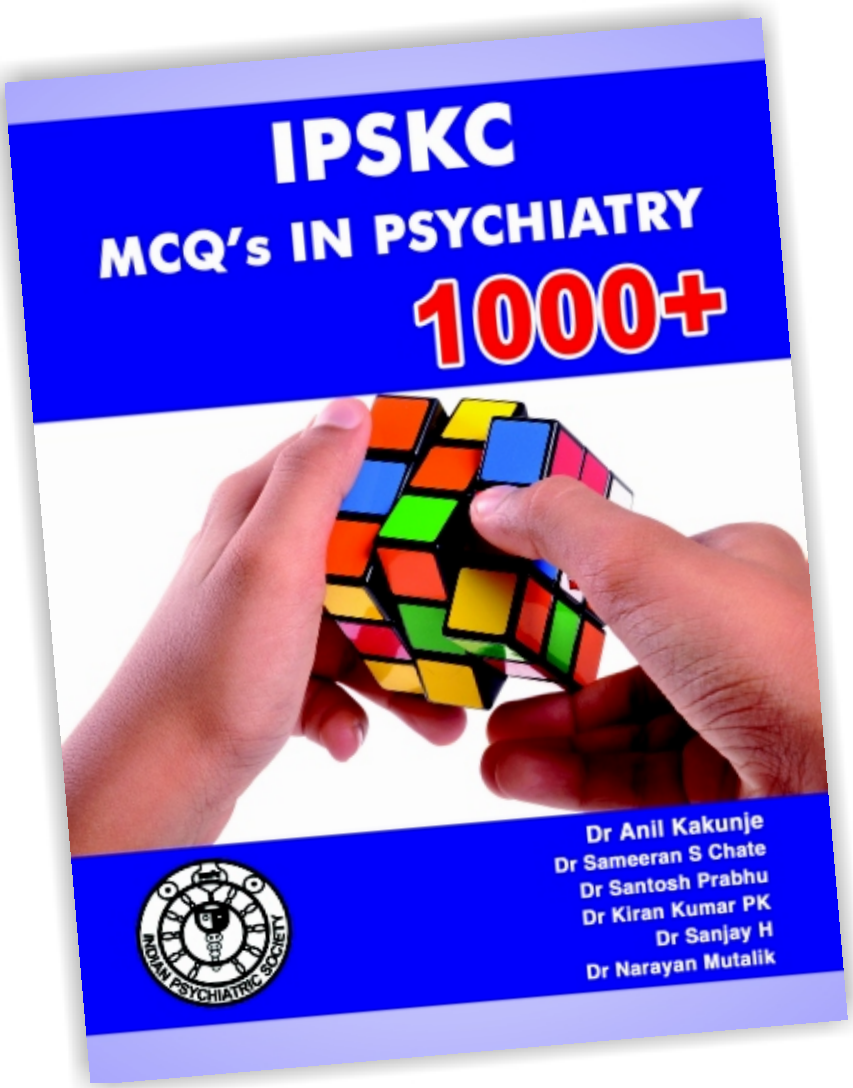

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